NHS
Bolton Clinical Commissioning Group

NHS Bolton Clinical Commissioning Group

Annual Report 2017/18

LET'S MAKE IT...

Better Bolton.

Contents

Member practices' introduction

The past year has seen some exciting advances to health and social care in Bolton despite budget constraints and a particularly bad winter period for seasonal illness and flu.

NHS Bolton Clinical Commissioning Group (Bolton CCG) has worked hard to embrace the changes we foresaw in the previous year's annual report.

The ambition for closer working relationships between health and care and the desire to help patients closer to their homes, where possible, is now being realised through the Bolton Locality Plan. A major building block of the Locality Plan which is beginning to take shape is the development of neighbourhood working, bringing together Practice staff with their colleagues in health and social care.

Another major advance has been the development of the Bolton Care Record, designed to provide safe care and reduce wasted time for Practices by ensuring information to support direct patient care is available to health and care services, with patient consent.

At the time of the publication of last year's annual report, the Bolton Care Record was an embryonic project but now 45 out of the 49 GP practices in Bolton are signed up, equating to 82% of the population of Bolton.

This project has been a good example of collaborative working between Bolton CCG and practices, with regular meetings and helpful insight provided by GPs and Practice Managers to produce the best service possible.

"Over the past year, we have seen an ever closer working relationship develop between GP practices and Bolton CCG. Projects such as the Bolton Care Record and the Bolton Locality Plan have really solidified these relationships and we hope to maintain this positive way of working for a long time to come." Vera Bourn, Practice Manager, The Dunstan Partnership.

Welcome from Su and Wirin

This year has been a year for change and adaptation within Bolton CCG. The limitations of the budget and workforce shortages remain but we have used these challenging conditions as motivation to deliver positive changes by seeking greater integration and closer working relationships with our partners.

Last year we successfully secured £28.8 million as part of our Greater Manchester Health and Social Care Partnership Bid – incorporating Bolton CCG, Bolton Council, Bolton NHS Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust, Bolton GP Federation and voluntary and community partners.

Over the past year, £13.2 million of that money was allocated to transforming services across Bolton. We have invested in the local health economy and brought health and care services closer to home.

We are supporting GP Practices by commencing the work to provide access to other medical specialists such as physiotherapists, pharmacists and mental health workers. Extra money has also gone into expanding the dementia service, the improvement of care homes and the introduction new technologies to help patients receive the best and quickest treatment possible.

The Bolton Care Record now covers over 80% of the population of Bolton and the potential benefits of this system are significant. The sharing of care records will enable medical staff to see, at the click of a button, a patient's medical history, current medications or allergies - this will help staff to provide the best possible care in the quickest possible time.

There are still challenges ahead for the health services in Bolton but we have made significant progress in the last year, the work put in by everyone to reshape and modernise has been outstanding and we are confident that our population will benefit significantly as our integration agenda and partnership working progresses.

Wirin Bhatiani
Clinical Chair

Su Long
Chief Officer

PERFORMANCE REPORT

Su Long

Accountable Officer

25th May 2018

Performance Overview

The purpose of Bolton CCG is to design, arrange and buy the most effective services for local people that we can with the NHS funding available. To do this, we must balance the triple aim of:

- Improving population health.
- Best quality care and experience of care.
- Value for money.

We are judged by NHS England on whether we improve outcomes for local people, and ensure the NHS Constitution standards are met, all within the budget we are given.

The major risks to being able to achieve this are:

- The financial pressures caused by increasing demand coupled with austerity levels of funding.
- Staffing shortfalls in many professions, affecting the ability of hospitals, community and primary care services to deliver.
- Increased demand for health and care services as our population ages and develops more complex needs.
- Balancing the need to transform and re-design health and care services, whilst maintaining continuity of service for our patients.

We are proud of maintaining our strong performance in cancer care in 2017/18.The CCG has exceeded the NHS Constitutional standards for suspected cancer (two week wait) referrals and 31 day waits from diagnosis to treatment throughout the year. The CCG has also made significant improvements in the diagnosis of cancers at stages one and two and is now the best CCG in Greater Manchester for this important measure.

CCG investment in mental health is also supporting strong performance in the Improving Access to Psychological Therapies (IAPT) recovery rate, which continues to exceed the national target.

2017/18 has been a challenging year nationally for health and care services and this has been reflected in underperformance against a number of key national targets. This is notable in urgent and emergency care, where the four-hour A&E target of 95% has not been met at any point this year. Capacity and demand issues are now impacting elective care, where the 92% incomplete referral to treatment (RTT) target for planned procedures has underperformed for the first time in over five years.

In the latter half of 2017/18, the CCG has also been experiencing increases in demand for cancer services which has affected our ability to consistently achieve key performance targets. A key area of underperformance is two week wait referrals for patients with breast symptoms (where cancer is not suspected) and 62 day wait for treatment from screening services.

Performance Analysis

Bolton CCG's fifth year as a statutory organisation was both challenging and rewarding. Amongst performance and financial challenges, the CCG has maintained its level of 'good' assurance. While there has been pleasing progress with some targets, not all NHS Constitution targets have been met and local recovery plans remain in place to support improvements in performance.

Delivery against NHS England Assurance Framework

The CCG is reviewed quarterly by the Greater Manchester Health and Social Care Partnership (on behalf of NHS England) and must provide assurance on its level of delivery on a balanced scorecard of national requirements. These are:

- Well led organisation.
- Finance.

- Performance and outcomes.
- Planning.
- Delegated functions.

Last year, the CCG was assured as ‘good’ on all of these elements of the assurance framework by NHS England and we are expecting to maintain this position for 2017/18 when the end of year rating is confirmed in June 2018.

Patient and public involvement

Meaningful engagement with Bolton people has been a priority for us right from the early development of our organisation. We strive to put the patient’s voice at the heart of everything that we do.
This year we have continued to build on the successes of previous years, strengthening our innovative approach to public engagement and putting more Bolton people at the centre our decision making. We’ve again worked hard this past year to reach those who wouldn’t usually get involved as well as any groups who may find it harder to get their voice heard, whilst strengthening existing relationships with community organisations.

We have continued to strengthen our partnership with Healthwatch Bolton and Bolton CVS, holding joint engagement events, sharing patient experience intelligence to inform our activity and most importantly looked for opportunities to deliver a consistent approach to engagement across Bolton. As our locality plan has continued to develop, it has given opportunities for us to explore the possibilities of future joint engagement, and the pooling of resources to deliver ‘One Conversation’ across Bolton.

ETAG

Our Equality Target Action Group (often known as ETAG) ensures health services are accessible to a wide range of individuals in the borough.

The CCG is committed to ensuring that all patients are able to access the services they need when they need them, and for them to be provided in the most suitable way. This means that everyone in Bolton should have equal access to NHS information, services, and buildings. We want to remove any barriers to this, particularly those that may be due to factors such as age, race, disability, or gender. We know people may access services in different ways and we take steps to help support those who may have difficulties. We are committed to ensuring that Bolton's health services are culturally sensitive, inclusive, accessible, and appropriate for our residents.

This group are key to this, and continues to be reinvigorated and is now more representative of those who may face barriers due to age, race, disability or gender.

This past year, ETAG members have discussed and given valuable feedback on the following areas:

- Bolton's Care Record.
- The Children and Adolescent Mental Health Service in Bolton.
- The move of the neurological rehabilitation service better known as the Taylor Unit.
- Bolton's Locality Plan.
- The North West Sector Alliance made up of the NHS organisations in Bolton, Wigan and Salford.
- People's experiences of using mental health services in Bolton.
- Proposal to move the GP Out Of Hours Service (OOH).
- Experiences of Transgender patients in Bolton.
- People's experiences of using Diabetes services in Bolton.
- Use of Bolton's A&E department and ambulances.

CCG Roadshows

On August 3, 2017, and October, 24, 2017, the CCG held roadshow events in Victoria Square in Bolton town centre. We spoke to over 400 people at these events about their views on the flu immunisation, new roles within GP practices, and about ways in which people were trying to be healthier.

Engagement

We have continued to involve Bolton people in a number of different ways, ranging from early engagement focused on specific topics to large public events. Over the past year, the CCG has:

- Given 23 presentations to various community and voluntary groups.
- Had information stalls at 17 public events.
- Conducted 25 one-on-one interviews with members of the public.
- Attended 20 public meetings.
- Held 13 focus group events.
- Attended 15 community and voluntary sector meetings.
- Held six ETAG meetings.
- Held two Roadshow events.

During the above engagement, NHS Bolton CCG has spoken to people about their experiences and gathered their views on:

- Bolton Care Record.
- Bolton's Diabetes service.
- Trans experience.
- The Child and Adolescent Mental Health Service (CAMHS) redesign.
- Engagement with those who identify as Trans.
- Bolton's orthopaedics service.

- The launch of Maternity Voices Partnership (MVP) in Bolton.
- Carers experiences.
- The move of the Neuro Rehabilitation service better known as the Taylor Unit.
- Bolton's Locality Plan.
- Mental Health experience.
- Winter pressures on the NHS – in particular, A&E use.
- Raising awareness of Dementia in various diverse communities in Bolton.
- Mental health support over the festive season.
- Bolton, Salford and Wigan Partnership.

Everything we have heard from local people has been recorded, and used to inform decisions and shape our plans for the year ahead.

For example:

Maternity Voices Partnership

In 2016/7 NHS Bolton CCG decided to launch a new group for Bolton called Maternity Voices Partnership or MVP. This was due to previous feedback received from mums and mums to be that it would be helpful for a group specifically aimed at examining Bolton's maternity services.
A report was also published called 'Better Births' which recommended that it would be best practice to have such a group in each CCG area.

As a result, in June 2017 Maternity Voices Partnership was formally launched, and a further five sessions have happened since with mums/mums to be/dads/dads to be via activities or breastfeeding sessions taking place in Bolton's Children's Centres.

This group will be further developed throughout the coming year.

Bolton's Trans community

This year the CCG undertook a very specific piece of engagement with our Trans* community. This was undertaken in partnership with Bolton NHS Foundation Trust and a Transgender patient who kindly volunteered her time. The aim was to aid us to better understand the experiences these patients have while using the NHS in the town, to ensure both organisations fully understood these patients' needs, and identify any training needs or gaps.

It is very difficult to accurately state how many people in Bolton identify as Trans, and due to fear of prejudice and not feeling comfortable and able to identify as Trans openly, it is extremely difficult to engage with this community. Through this piece of engagement, eight Trans patients, including a patient who identifies as A gender came forward to speak to us in detail, and gave invaluable feedback and suggestions.

As part of the Bolton Quality Contract (BQC) all GP practices in Bolton have undertaken 'Pride in Practice'. Pride in Practice is a quality assurance support service that strengthens and develops Primary Care Services relationship with their lesbian, gay, bisexual and trans (LGBT) patients within the local community.
Pride in Practice is suitable for all Primary Care Services, including GP Practices, Dentists, Pharmacies and Optometrists.

* Use of the word 'Trans' will be used as an umbrella and inclusive term used to describe people whose gender identity differs in some way from that which they were assigned at birth; including non-binary people, A gender, cross-dressers and those who partially or incompletely identify with their sex assigned at birth unless otherwise stated.

Delivery against organisational objectives

Bolton CCG has set organisational objectives to monitor the delivery of the triple aim. Performance against our overall organisational objectives is summarised in the following pages.

Since March 2013, Bolton's GP registered population has increased by 11,382.
This is 3.8% growth overall and there has been 8% growth in the older age group. Growth is continuing on upward trend which is having a significant impact on demand for healthcare services in Bolton.

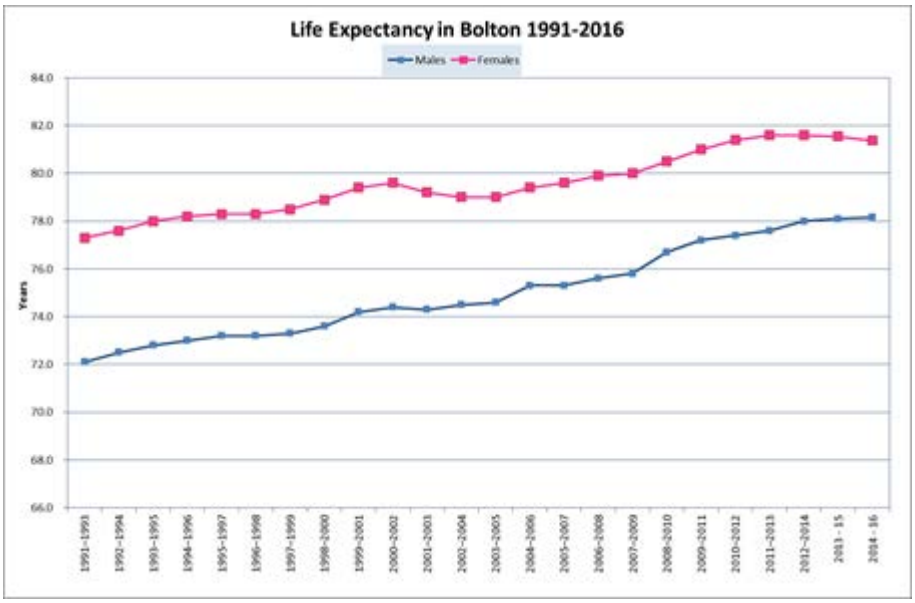
Strategic Objective 1:

Improve Health Outcomes

The aim of this objective is to reduce the overall gap in life expectancy between Bolton and England, and also to reduce the internal gap between the most affluent and most deprived populations within the town.

The Standards in the Bolton Quality Contract focus on the triple aim of population health, value for money and best care. The objectives to achieve this are to prevent disease where possible, identify health problems early, provide the very best care for people with existing conditions, and ensure that access to general practice is equitable and timely. It is an expectation that the outcomes of the 20 Standards will impact positively on Bolton's life expectancy gap.

Recent data from Public Health England indicates an overall trend of improved life expectancy for Bolton. However, over the last two years, life expectancy rates for women have decreased slightly, compared with the trend for men.



In 2011-13 the gap between Bolton and the England average was 2.3 years. The latest estimate (2014 -16) suggests the gap now stands at 1.6 years.

A wide range of work programmes have contributed to local people living longer. Worthy of note are two prevention programmes:

- **NHS Health Check** – the aim is to prevent heart disease, stroke, diabetes and kidney disease. This programme is co-commissioned with Bolton Council, but is developed and managed by the CCG.

  GP practices are supported to provide a comprehensive health check to all eligible patients aged 40 – 74 years old. Currently, Bolton tops the performance league across GM and the North of England, and is the second best performer in England (PHE, Sept 2017 data). Data from local GP surgeries shows that 70% of the eligible population have had an NHS health check.

- **Preventing Diabetes** - 86% of Bolton's eligible population, aged 40 years and over, has been screened for diabetes/at risk of diabetes over the last five years. People identified at risk of diabetes are offered a comprehensive lifestyle intervention with a Health Improvement Practitioner in their GP surgery.

Whilst these trends are positive and reflect the hard work across the health economy, there is still much work to be done. Mortality rates nationally are decreasing, for a range of conditions such as circulatory disease, ischaemic heart disease, respiratory disease and diabetes. However, liver disease bucks this trend. Alcohol is known to be a major contributor to the total mortality and impacts negatively on life expectancy. Around 25% of patients die before they get the chance to modify their drinking behaviour. Whilst Bolton is nationally renowned for the scale and coverage of our screening programme for alcohol harm, it will be necessary to further concentrate efforts in this arena. A reduction in total alcohol consumption in the population, and an increased detection of alcoholic liver disease at an earlier stage will be vital if we are to be successful in improving life expectancy further in Bolton.

Strategic Objective 2

Improve Quality of Care and Experience of Care/Ensure Compliance with NHS Statutory Duties & the NHS Constitution

Measured by achievement of quality indicators and NHS Constitution targets.

Areas where performance has been positive:

- Continued strong performance in cancer waiting times, including suspected cancer referrals and referral to treatment and diagnosis to treatment targets.
- Improving Access to Psychological Therapies recovery rate has been achieved every month in 2017/18, demonstrating the impact of significant investment and service re-design in this area.

Areas where performance has not met national targets:

- Urgent care performance remains challenging and A&E performance and ambulance response times have failed to meet the required performance standards throughout 2017/18.
- Achievement of the 18 week referral to treatment (RTT) incomplete standard has deteriorated in the latter half of 2017/18. This is consistent with national trends in this area during a period of increased demand for elective care services. It is unlikely the CCG will achieve the 18 week RTT standard for 2017/18 for the first time in five years.
- The number of patients waiting six weeks or more for a diagnostic test has increased in 2017/18 and it is unlikely the target of less than 1% of patients waiting over 6 weeks will be achieved for the year. This is largely due to a significant increase in demand for endoscopy procedures. There is a plan in place to recover this by the end of April 2018.
- There have been 114 mixed sex accommodation (MSA) breaches in 2017/18 (to January 2018). This is due to ongoing estates issues at Royal Bolton Hospital for High Dependency Unit (HDU) patients. Patient feedback is sought after every MSA breach and no negative impact on patient experience has been reported.
- There have been 27 C.Difficile infections (against a target of 19) and 2 MRSA infections (against a target of 0) reported in 2017/18 (to January 2018). All healthcare-associated infections are subject to a case review by the CCG and provider and are reviewed by the Bolton Infection Prevention and Control Committee to investigate the root cause, lessons learned and actions to prevent further infections.
- There has been significant increase in demand for two week wait breast referrals (where cancer is not suspected), and coupled with staffing issues in radiology at Royal Bolton Hospital, performance has deteriorated in this area. A contingency plan is in place to triage referrals and ensure patients continue to be treated in a safe and high quality service.

Strategic Objective 3

Deliver Best Value for Money/Deliver Financial Balance

In terms of value for money, Bolton CCG has worked hard to ensure that commissioning decisions prioritise services that have the strongest impact on health. The CCG has met all statutory financial requirements due to the success of our focus on value for money and joint working.

The Bolton Quality Contract has contributed to improving the capacity in general practice to meet standards that will set the groundwork for shifts in care closer to home. Non-elective attendances for the CCG have reduced by 3.5% from 16/17 for the first 10 months of the year through work at Bolton FT to support people with rapid tests to prevent an admission.

NHS Performance Targets

Our Board receives monthly performance reports in relation to our performance against key national and local targets. These include:

Key achievements:

- Improving Access to Psychological Therapies (IAPT) recovery rate has been achieved every month in 2017/18. Year to date (to January 2018) we have achieved the recovery rate of 50% with performance of 58.5%. Expansion and improvement of IAPT services has been a key CCG priority in 2017/18 and has been subject to investment from the Bolton Transformation Fund.
- Continued strong performance in the majority of cancer waiting times, including suspected cancer referrals and referral to treatment and diagnosis to treatment targets. The CCG far exceeds some national targets in this area, including performance of 97.6% for suspected cancer referrals seen within two weeks against a target of 93%.

- The most recent ‘My NHS’ ratings show Bolton CCG has made improvements in 3 of the 4 cancer domains in the last year. The CCG is now the top performing in Greater Manchester for cancers diagnosed at an early stage and cancer patient experience.
- In recent months, performance against the target of 75% of emergency A&E referrals to RAID to be assessed within 1 hour for patients experiencing a mental health crisis has significantly improved, most recently to 87% for January 2018.This is due to the launch of a new mental health A&E diversion service at Royal Bolton Hospital to ensure mental health patients are seen quickly in the most appropriate environment.

Areas where performance has not met national constitution targets:

- Urgent care performance remains a key area of challenge. The A&E 4 hour performance has not met the required 95% for the year and ambulance response times are below target in what continues to be a challenging environment. This remains a key area of focus for the CCG and locality partners and recovery plans have been developed to support improvement in line with targets set out in the 18/19 national planning guidance.
- Mixed Sex Accommodation: this is due to estates issues at Royal Bolton Hospital. An action plan is in place to mitigate breaches where possible with support from the Greater Manchester Health and Social Care Partnership. Patient feedback is sought after every MSA breach and no negative impact on patient experience has been reported.
- Clostridium Difficile and MRSA: policies, antibiotic stewardship, increased resource for the infection prevention and control team, ownership at a local level and improved collaborative working with the CCG through the Community Infection Prevention and Control Committee continues to mitigate cases where possible.

- Diagnostic waiting time target (no more than 1% to wait more than 6 weeks): demand for endoscopy services has continued to grow throughout 18/19. This is a notable trend across Greater Manchester and nationally. The CCG has commissioned additional capacity at the Royal Bolton Hospital site from InHealth and a service re-design project to encourage collaborative working across acute and community endoscopy provision is due to commence in early 2018/19.
- Achievement of the 18-week referral to treatment (RTT) incomplete standard has deteriorated in the latter half of 2017/18. This is consistent with national trends in this area during a period of increased demand for elective care services. It is unlikely the CCG will achieve the 18-week RTT standard for 2017/18 for the first time in five years. The CCG and Bolton FT are working together to develop detailed capacity and demand plans for 18/19 to help recover and sustain performance.
- Two week wait breast referrals (where cancer is not suspected): performance against this indicator has deteriorated throughout 2017/18 due to increased demand and capacity issues at Royal Bolton Hospital. The CCG has been monitoring the situation closely and receives regular updates, in addition to agreeing contingency and recovery plans with the hospital to maintain the service and ensure quality is not impacted.

Bolton CCG continues to be fully committed to working closely with all providers from which services are commissioned for the local population to achieve improvements in performance, quality and patient experience. Any areas of failing or poor performance are raised immediately with the relevant provider with a request for a remedial action plan against which performance is monitored.

Case Study Examples of positive work delivered towards organisational objectives

The Bolton Locality Plan

Neighbourhoods

As part of the Bolton Locality plan there have been various innovations which are designed to improve the health and wellbeing of people in Bolton.

Bolton has configured the borough into nine ‘Neighbourhoods’, which are based on populations of 30,000 to 50,000 people.

Focusing on neighbourhoods supports bringing care closer to home by organising health and social care services based on the needs of the population of that neighbourhood. By working with our Community, Social and Voluntary Care sector in neighbourhoods, we will be helping local people to access support in their own community. We are supporting GP leads of each neighbourhood to bring together health and social care professionals to create better and closer working relationships, aimed at reducing gaps and duplication for individual patients.

Support for General Practice

We have introduced other highly-qualified healthcare professionals to support the work done by local GPs.

The addition of these clinical professionals means that health and social care can be delivered in an increasingly flexible and diverse way – providing the best possible care in the shortest possible time.

In Bolton, we have introduced Clinical Pharmacists, Musculoskeletal Specialists and Mental Health workers to local practices to complement the work done by GPs.

Depending on the particular issue or illness, patients can now book an appointment with one of these healthcare professionals in the same way you would with your GP.

This will reduce the time patients have to wait to be seen by a healthcare professional and also frees up more time for local GPs to spend time with their most vulnerable and complex patients.

We have recruited 20 Clinical Pharmacists already and they are now operating out of local GP practices, Mental Health workers are currently in the process of being recruited and are expected to be in their posts by September and Musculoskeletal Specialists are expected to be in place by the end of the year.

On top of this, we have also increased the number of Health Improvement Practitioners (HIPs) in Bolton from 20 to 50; this will mean that all surgeries in Bolton will boast a substantial HIP presence - helping people to stay well and to prevent ill health. This service is particularly important when supporting patients who may be at risk of developing heart disease, stroke or other long-term conditions to improve their health and lifestyles.

We have also entered into a process of upskilling the primary care workforce, such as Practice Nurses, to enable them to deal with more complex conditions and take the strain away from GPs.

Community Asset Navigators

We have introduced Community Asset Navigators (CANs) to provide a much-needed service within the Neighbourhoods.

CANs are people within local communities who can provide closer connections for residents with the services which are happening on their doorstep.

The programme has been designed to bring together health and social care workers and the diverse voluntary and community sectors in Bolton.

The introduction of CANs, who have been seconded from local voluntary and community organisations, provides a greater focus on promoting prevention and self-care across Bolton.

Part of the wider vision for the Bolton Locality Plan, CANs are an example of how we are looking to bring health and social care closer to the community and expand the range of services we have at our disposal.

A navigator will have a chat either over the phone or in person to find out what you like doing and are interested in, and your strengths and what you have to offer - and then tell you what is available in Bolton – the navigators can also go along with you to a group or activity.

There have already been 30 referrals since February 2018 and the service has been able to connect people to many activities including helping them learn how to cook, connecting them to social and physical activities and supporting them into volunteering – volunteering itself can have a big impact on your health and well-being.

There are five key themes: Physical Activity, Ageing, Young People, Emotional Well Being and Social Inclusion.

The organisations that will be running the service have a long-standing, deep knowledge of their communities and a very strong understanding of what is available in their specialist areas and this, along with the great work being done in the area by Bolton Community and Voluntary Services (Bolton CVS), ensures that we will be able to connect people to the most suitable service for them and identify areas for development.

People can self-refer via the Bolton CVS website, by calling them up or can go to their doctor where they can receive a Well Being Prescription.

The Bolton Care Record

The Bolton Care Record (BCR) has been implemented as a way to share clinical information between health and social care partners in Bolton.

44 out of the 49 GP Practices in Bolton are now signed-up to the BCR, with discussions on-going with the remaining five. Nearly 90% of the population of Bolton is now covered by the BCR, which is a huge achievement considering we started with nine 'early adopters' in October 2017.

The BCR is designed to improve patient safety and patient experience and ensure staff caring for a patient at hospital, in the community or within the GP out of hours service are able to access important clinical information.

A commonly used example of the benefits of the BCR is the patient who arrives at A&E in the early hours of the morning after suffering a major trauma, the patient is unable to communicate to medical staff an requires urgent attention. The BCR now allows staff to access the patient's medical records and see if they have any pre-existing medical conditions or allergies and recent medical history that could support decision making on the best treatment – significantly boosting the speed of the service in a scenario where time is of the essence.

The organisations which currently feed into the BCR are: Bolton Foundation Trust, Greater Manchester Mental Health NHS Foundation Trust (GMMH), Bolton Council, GP Practices and The Christie NHS Foundation Trust.

Those who will be able to view the BCR are: Bolton Foundation Trust, GMMH, GP Practices, BARDOC (out-of-hours service) and the North West Ambulance Service (NWAS).

Future Focussed Finance (FFF) Level 3 Accreditation

In 2018 NHS Bolton Clinical Commissioning Group (Bolton CCG) became the first CCG in the country to attain the highest level of NHS finance accreditation.

The Future Focussed Finance (FFF) Level 3 Accreditation is issued by the National Finance Leadership Council and was awarded to Bolton CCG to recognise the outstanding work the organisation has done to meet industry best practice in NHS finance.

The Level 3 accreditation will be retained for three years, at which point the CCG will have to apply again.

It provides external confirmation, in this case from the National Finance Leadership Council, that the Bolton CCG Finance Team provides a superior service enabling the wider organisation to deliver the best care services possible.

One contributing factor to this achievement is the close working relationship which is enjoyed at Bolton CCG between clinical and finance staff, working together to provide services rather than being separate entities.

Commissioning

The past year has been a major period for our Commissioning Team, with many new projects which have been introduced to help improve the health service in Bolton.

We have seen the full launch of enhanced Primary Care to Care Homes; this has been to create a closer relationship between health and care services. Now, every Care Home in Bolton is directly linked to a specific GP practice. Care Home also received a £227,000 in improvement grants to improve the health and wellbeing of residents with complex needs.

Kooth, a new service to help children and young people with their emotional wellbeing through online tools and counselling was launched. This service actively engages with schools, GP practices and community groups to raise awareness of the help which is available to children and young people in this area. Kooth received 60 new registrations to the service in the first month alone.

Virtual Eye Clinics, a new ophthalmology service based at Waters Meeting Health Centre, was launched successfully and has contributed to an increased service capacity of 5,750 appointments per year – slashing waiting times at the hospital eye clinic.

Mental Health Crisis Care Diversion for A&E was launched at the Royal Bolton Hospital to provide expedient and appropriate emergency care to patients experiencing a mental health emergency.

In line with current national objectives, there has been a reduction in Community Healthcare (CHC) assessments being carried out in hospital. We are now seeing more patients in the community which has proven benefits to both the patient and the NHS service. Assessments being undertaken in hospital were at 0% in February 2018, this is from a high of 80% a year ago.

Assurance

The CCG is assured quarterly through the NHS CCG Improvement and Assurance Framework (IAF). The IAF was introduced in 2016 and brings together the previous CCG assurance framework with a greater focus on striving for improvement in the following areas:

- Better health.
- Better care.
- Sustainability.
- Leadership.

The 2017/18 IAF comprises of 51 indicators across these four domains upon which the CCG is assessed and awarded an assurance status ranging from ‘outstanding’ to ‘inadequate’. Bolton CCG achieved ‘good’ in 2016/17 and is expected to maintain

this when the 2017/18 statuses are confirmed in June 2018. Progress against the IAF is presented quarterly to the CCG Executive and Board, with a year-end summary presented following confirmation of the year-end position.

Quarterly CCG assurance in line with the IAF process is carried out by the Greater Manchester Health and Social Care Partnership (GMHSCP) on behalf of NHS England. As a ‘good’ CCG, Bolton is only required to undergo a formal assurance meeting in alternate quarters (Q2 and Q4 in 2017/18). As part of a devolved Greater Manchester health economy, this process has evolved in scope to assurance of the overall locality rather than just the CCG and the leadership of all partner organisations participate in this.

Transformation Fund

Health and care partners in Bolton have received £28.8 million of Transformation Funding over three years (2016/17 – 2018/19) to support system transformation and new initiatives to reform health and social care. Key highlights from 2017/18 have included:

- Development of a new primary care workforce, including MSK and mental health professionals, pharmacists and health improvement practitioners to provide a broad range of services close to home.
- £227,667 of grants awarded to care homes to improve resident experience and wellbeing, including sensory areas, garden improvements and on-site facilities eg: cinema room, café, hairdressers.
- Implemented ED streaming to re-direct patients at A&E to the most appropriate service, including an on-site GP.

- Launch of Immedicare in Bolton care homes, which will provide virtual access to healthcare professionals for advice and guidance to avoid admission to hospital.
- Trialling of health and care apps to support physical and mental wellbeing.
- Employing community asset navigators to support people to look after their health and wellbeing by engaging with facilities and opportunities in their local communities.
- £550,000 prevention grants scheme for the community and voluntary sector, enabling them to bid for funding to support local community projects which help promote health and wellbeing.

Joining up health and social care

Joining up health and social care is a key priority set out in our five-year Locality Plan for Bolton. The CCG is working closely with partners from across the local health and social care system (including the council, NHS trusts, community and voluntary sector, GP Federation and Healthwatch) to develop and implement initiatives which will enable seamless integrated care throughout the patient journey.

Key projects include:

- Bolton Care Record – a confidential electronic record accessible by appropriate health and social care staff across Bolton (including GPs, hospital specialists, district nurses and social care professionals).
- Neighbourhood working – integrating health and care professionals and the community and voluntary sector in local neighbourhoods to provide a joined up, comprehensive care offer closer to home.
- Development of an Integrated Care System – bringing together different organisations under one umbrella to support delivery of joined-up health and care services regardless of organisational boundaries.
- Pooling of some health and social care budgets through section 75 arrangements which are overseen by a joint Commissioning Partnership Board.

This includes £42.4m of ‘Better Care Fund’ monies and discussions are underway to pool further budgets as part of our integrated commissioning plans with the council.

Care at Home

The CCG is working with partners from across Bolton to re-design health and care services to support people to receive care at home (where appropriate) or stay in their homes for longer. This may include:

- Intermediate care and reablement re-design – supporting patients to recover from a hospital admission in their own home or avoid hospital admission altogether.
- Use of technology – investing transformation funds into trialling technology support in the home, including monitoring blood pressure, medication dispensers and falls alerts.
- ‘Think Home First’ – a joint campaign across system partners to start preparing patients for discharge from hospital as soon as medically fit and working jointly across the system to put in place any support required.

Workforce Shortages

Vacancies in both nursing and medical roles are a national challenge for the NHS. The recent Provider Performance Report published by NHS Improvement (NHSI) for Quarter 3 of 2017/18 outlined that there were 97,000 vacant posts across the NHS; from that number, there were over 35,000 Nursing vacancies, and over 9,500 Medical vacancies.

Despite rolling recruitment campaigns and international recruitment, the Trust has not been able to fill all nursing vacancies.

In addition, Recruitment into Consultant roles for certain medical specialties, such as Dermatology and A&E, has also been a challenge and the Trust also faces challenges to recruiting into Middle-Grade medical roles.

The Trust also has areas of high turnover, in particular, current posts impacted include Healthcare Assistants and Allied health professionals which leads to further challenges in recruitment.

Vacancies in patient-facing roles inevitably require cover and this contributes to Trust spend on temporary staffing. Spending on agency is a high priority for NHS NHSI and is currently a financial risk to the Trust.

A number of initiatives are already in place and also under development to support the Trust to address the issues around workforce shortages include; the introduction of new posts and training opportunities such as Trainee Nurse Associates and Physicians Associates. Work is also being carried out to improve retention and develop recruitment strategies to attract a wider pool of candidates.

Mental Health and Wellbeing

There have been several mental health specific transformation fund schemes introduced including:

Mental health specific A&E diversion commenced in December 2017 consisting of a qualified mental health practitioner in A&E who between the hours of 1.00pm and 2.00pm will triage anyone presenting with mental health issues and divert them to more appropriate services.

Support staff are also in post who work in a designated ambulatory care area and offer input to anyone waiting on further assessment. This has resulted in shorter waits in the A&E department, and almost half of patients being diverted away from RAID which in turn has freed up capacity for RAID to support admission avoidance and expedite discharges.

The Sanctuary were also relocated in June 2017 from the community to GMMH on the Royal Bolton site which has improved referral numbers and enabled the development of a more integrated clinical/non-clinical model with GMMH A&E staff. This model will be further embedded in 2018/19.

In April 2017 a seven-day AMHP Hub service was rolled out following a successful pilot. A team of Approved Mental Health Practitioners are now in place daily which has taken pressure off the Emergency Duty Team, RAID and A&E.

Improving Access to Psychological Therapies (IAPT) has been enhanced through additional investment, and the introduction of the Silverwellbeing service through 1 Point. This has proved popular with people who want an alternative to standard NHS provision. The service is delivered by voluntary sector partners and address issues such as loss/bereavement, signposting, and wider emotional health and wellbeing input.

Additional investment was made into the Autistic Spectrum Conditions (ASC) assessment service to reduce waiting times and offer a post-diagnostic support and complex case management element in addition to the existing assessment service.

Sustainable Development

Sustainable Development is about balancing social, economic and environmental considerations – ensuring future generations do not suffer because of the way we live today. The CCG recognises that good maintenance and care of the environment contributes to the long term health of people, their social wellbeing and economic prosperity.

The CCG is committed to promoting environmental sustainability and to continually improve the quality of their services and their environmental performance. The CCG is committed to further embedding behaviours by staff and other partners, concentrating on the reduction of paper, increased recycling and energy and carbon reduction.

The information below gives comparative figures over the last 2 years on electricity, gas and water consumption:-

Financial Data (Spend):	Units	2017/18	2016/17
Total Energy Cost (all energy supplies)	£	23,447	27,780
Electricity Cost	£	16,208	23,229
Gas Cost	£	4,999	2,351
Water Cost	£	2,239	2,200
Resource Use:	Units	2017/18	2016/17
Electricity Consumed	kWh	161,199	193,574
Gas Consumed	kWh	176,701	74,709
Water/Sewerage Consumed	m^3	794	769

Improving Quality

In 2017/18, the CCG had a poster accepted at the Institution for Healthcare Improvement IHI/BMJ Conference on Quality and Safety in Healthcare entitled: Bolton's Journey to Establishing a Population Based Patient Safety Culture and awarded an AQuA Leadership for Improvement Fellowship worth up to £6K to look at Quality Improvement and Patient Safety in the context of Behaviours, Motivation and Purpose.

Health and wellbeing strategy

The performance report summarises the key contributions the CCG has made to health improvement, as a member organisation of Bolton Health and Wellbeing Board. In addition, the Health and Wellbeing Board has agreed a five year Locality Plan with clear expected health outcome improvements as a result of the workstreams in the Locality Plan.

The CCG continues to work as a key partner in the delivery of the Locality Plan, in order to contribute to the Bolton Health and Wellbeing Strategy.

The CCG has engaged with the Bolton Health and Wellbeing Board and presented its contribution to health outcomes throughout the year at regular meetings.

Greater Manchester Health and Social Care Partnership

In April 2016 Greater Manchester took charge of its health and care system as one Partnership spanning NHS and local government, commissioners and providers of both physical and mental health. In doing so, we embarked upon the most radical health and care transformation programme in the country. We are now approaching the third year of the delivery of our strategy Taking Charge. Two years into our journey, we can see a health and care landscape in Greater Manchester that looks fundamentally different. Our approach to this change has been guided by a core principle: identifying who contributes to health creation and how they can be better connected.

Through our programme of reform and investment we now see our way to the system architecture in GM that will be in place as a legacy of Taking Charge. This will comprise these recognisable and consistent features:

- The establishment of 10 Local Care Organisations (LCOs) integrating provision;
- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten localities;
- New models of hospital provision seeing hospitals working together in Greater Manchester at a much greater scale than ever before to a set of consistent quality standards;
- A Greater Manchester-wide architecture where it makes sense to do things at greater scale – including the GM Commissioning Hub, Health Innovation Manchester, a Digital Collaborative, a Workforce Collaborative and a ‘one public service estate’ strategy.

ACCOUNTABILITY REPORT

Su Long

Accountable Officer

25th May 2018

Corporate Governance Report

Director's Report

Member Profiles

The names and responsibilities of the board executive and non-executive directors were as follows:

Dr Wirin Bhatiani, Clinical Chair (3 year term of office from election to March 2021, 6 month notice period).
Su Long, Chief Officer (6 month notice period).
Annette Walker, Chief Finance Officer (to July 2017).
Jackie Murray, Acting Chief Finance Officer (from July to September 2017).
Ian Boyle, Chief Finance Officer (from October 2017, 6 month notice period).
Dr Barry Silvert, Clinical Director, Commissioning (6 month notice period).
Dr Stephen Liversedge, Clinical Director, Primary Care and Health Improvement
(6 month notice period).
Dr Jane Bradford, Clinical Director, Governance and Safety (from April 2017, 6 month notice period).
Dr Shri Kant, Elected non-executive GP
(3 year term of office from election to April 2019, 6 month notice period).
Dr Tarek Bahkt, Elected non-executive GP
(3 year term of office from election to April 2019, 6 month notice period).
Dr Jane Bradford, Elected non-executive GP (to April 2017)
Dr Dharmesh Mistry, Elected non-executive GP (from November 2017)
(3 year term of office from election to September 2020, 6 month notice period).
Dr Charles Hendy, Elected non-executive GP
(3 year term of office from election to April 2019, 6 month notice period).
Alan Stephenson, Lay Member
(3 year term of office to July 2019, 3 month notice period)
Zieda Ali, Lay Member Public Engagement
(3 year term of office to September 2019, 3 month notice period)

Tony Ward, Lay Member, Governance
(3 year term of office to August 2018, 3 month notice period).
Mary Moore, Chief Nurse (to September 2017).
Professor Romesh Gupta, Secondary care Doctor (3 year term of office to January 2021, 3 month notice period).
David Herne, Director of Public Health, was a key attendee of the Board in 2017/18.

Member Practices

There are 49 Member practices which form Bolton Clinical Commissioning Group:

Practice Name	**Address**
3D Medical Centre	3D Medical Centre, 200 Deane Road, Bolton, BL3 5DP
Alastair Ross Medical	Breightmet Health Centre, Bolton BL2 6NT
AlFal Medical Group	The Pikes Lane Centre, Deane Road, Bolton, BL3 5HP
Dr Barua & Partners	Farnworth Health Centre, Frederick St, Bolton, BL4 9AH
Beehive Surgery	108 Crescent Road, Bolton, BL3 2JR
Bolton Community Practice	Waters Meeting Health Centre, Bolton, BL1 8TU
Bolton General Practice	Marsden House, Marsden Road, Bolton, BL1 2AY
Bolton Medical Centre	Rupert Street, Great Lever, Bolton, BL3 6RN
Burnside Surgery	Waters Meeting Health Centre, Bolton BL18TU
Cornerstone Surgery	469 Chorley Old Road, Bolton, BL1 6AH
Crompton View Surgery	Crompton Health Centre, 501 Crompton Way, Bolton, BL1 8UP
Dr Counsell & Partners	The Pikes Lane Centre, Deane Road, Bolton, BL3 5HP
Dalefield Surgery	Avondale Health Centre, Avondale Street, Bolton, BL1 4JP
Dr Dakshina-Murthi	The Pikes Lane Centre, Deane Road, Bolton, BL3 5HP
Deane Clinic (Dr Selvarajan)	Deane Clinic, Horsefield Street, Deane, Bolton, BL3 4LU
Deane Medical (Dr Kumar)	155-157 Deane Road, Bolton, BL3 5AH
Dunstan Partnership	Breightmet Health Centre, Bolton, BL2 6NT

Edgworth Medical	Egerton/Dunscar Health Centre, Darwen Road, Bromley Cross, Bolton, BL7 9RG
Fig Tree Medical	Farnworth Health Centre, Frederick St, Bolton, BL4 9AL
Garnet Fold Surgery	374/376 St Helens Road, Bolton, BL3 3RR
Great Lever One (Dr Newgrosh)	Great Lever Health Centre, Rupert Street, Bolton, BL3 6RN
Dr Hallikeri & Partner	Little Lever Health Centre, Mytham Road, Bolton, BL3 1JF
Harwood Group Practice	Harwood Health Centre, Hough Fold Way, Bolton, BL2 3HQ
Heaton Medical Centre	2 Lucy Street, Heaton, Bolton, BL1 5PU
Dr Hendy & Rizwan	The Halliwell Surgery, Lindfield Drive, Bolton, BL1 3RG
Dr Jain & Subrumanian	Little Lever Health Centre, Mytham Road, Bolton, BL3 1JF
Dr Jeyam & Jesudas	The Halliwell Surgery, Lindfield Drive, Bolton, BL1 3RG
Dr Karim & James-Authe	46 Wyresdale Road, Bolton, BL1 4DN
Kearsley Medical Centre,	Jackson Street, Kearsley, Bolton, BL4 8EP
Kildonan House Surgery	Ramsbottom Road, Horwich, Bolton, BL6 5NW
Dr Kirby & Partners	Crompton Health Centre, 501 Crompton Way, Bolton, BL1 8UP
Dr Liversedge & Partners	Egerton/Dunscar Health Centre, Darwen Road, Bolton, BL7 9RG
Dr Loomba & Partners	Lever Chambers Centre for Health, Ashburner St, Bolton, BL1 1SQ
Dr Lowe & Partners	Tonge Fold Health Centre, Hilton Street, Bolton, BL2 6DY
Dr Lyon & Partners	Lever Chambers Centre for Health, Ashburner St, Bolton, BL1 1SQ
Mandalay Medical Centre	933 Blackburn Road, Bolton, BL1 7LR
Olive Family Practice	The Pikes Lane Centre, Deane Road, Bolton, BL3 5HP
Orient House Medical	216 Wigan Road, Deane, Bolton, BL3 5QE
Pike View Medical Centre	Albert Street, Horwich, Bolton, BL6 7AN
Shanti Medical Centre	Shanti Medical Centre, 160 St Helens Road, Bolton, BL3 3PH

Springhouse Surgery	Springhouse Surgery, 555 Chorley Old Road, Bolton, BL1 6AF
Spring View Medical	Spring View Medical Centre, Mytham Road, Bolton, BL3 1HQ
Dr Sidda & Partners	Waters Meeting Health Centre, Bolton, BL1 8TU
Stonehill Medical	Stonehill Medical Centre, Piggott Street, Bolton, BL4 9QZ
Swan Lane Medical Centre	Swan Lane, Bolton, BL3 6TQ
Stablefold Surgery	119 Church Street, Westhoughton, Bolton, BL5 3SF
Dr Uddin & Partners	The Halliwell Surgery, Lindfield Drive, Bolton, BL1 3RG
Unsworth Group Practice	Peter House Surgery, Captain Lees Road, Westhoughton, Bolton, BL5 3UB
Dr Zarrouk & Partner	65 Bradford Street, Bolton BL2 1HT

Review of the Member Eligibility Policy

A review of the CCG's Member Eligibility Policy is undertaken by the Chief Officer every two years and was last completed in September 2016.

Outcome of the Review

Number of applications received for GP practices to become members of NHS Bolton CCG (for the period 2014 to 2018).	0
Number of terminations received from GP practices (for the period 2014 to 2018).	1*

***(two APMS contracts expired in 2017 and were re-procured as one, merged contract).**

Composition of Governing Body

From 1 April 2017 to 31 March 2018, NHS Bolton CCG was led by a board, which was legally accountable to the people of Bolton for the work of the organisation. The constitution of the Board ensured that there was a majority of GPs, headed by a Clinical Chair. The Chair, Dr Wirin Bhatiani, and Chief Officer, Su Long, have held their positions throughout the 2017/18 year.

The CCG is designed to be clinically led, with:

- A majority of Board members being clinicians,
- CCG Directorates led by Clinical Directors and
- decision making informed by engagement with CCG membership and with a Clinical Standards Board formed from primary and secondary care clinicians.

The CCG Board sets strategic direction and holds accountability for delivery. The CCG Board has Executive members who have responsibility for operational delivery and implementation of Board decisions. The other Board members play a non-executive role, scrutinising and challenging proposals, and chairing sub committees of the Board to ensure that co commissioning responsibilities, audit and finance, and conflicts of interest are managed effectively.

The CCG Board receives reports monthly to monitor how the organisations accountabilities and objectives are met.

Committee(s), including Audit Committee

The members of the Audit Committee during 2017/18 were:

Tony Ward (Chair)
Charles Hendy
Tarek Bakht
Alan Stephenson
The Chief Finance Officer was invited to attend audit committee meetings.

Further detail on the CCGs sub-committees, membership and attendance can be found in the Governance Statement on Page 45.

Register of Interests

NHS Bolton CCG has appropriate policies and procedures in place to record conflicts of interests and these can be found on the website. The Registers of Interests and Gifts & Hospitality are reviewed by the Audit Committee and Conflicts of Interests Committee at each meeting.

They are regularly updated and available on the CCG website via the following link:
Declarations of Interest

Personal data related incidents

NHS Bolton CCG has reported no Serious Untoward Incidents constituting significant data breaches to the Information Commissioners Office for the financial year 2017/18.

The organisation's Information Governance Toolkit compliance score as at 31 March 2018 was 88%.

Statement of Disclosure to Auditors

Each individual who is a 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

NHS Bolton CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer are set out under the NHS Act 2006, 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;
- Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction;
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error;
- Safeguarding the CCGs 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 NHS Act 2006 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006; and

- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

Under the NHS Act 2006, NHS England has directed each CCG 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 CCG 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,
- Assess the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use 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.

To the best of my knowledge and belief, and subject to the disclosure set out below, I have properly discharged the responsibilities set out under the NHS Act 2006, 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; and

- 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.

Su Long

Accountable Officer

NHS Bolton CCG

25th May 2018

Governance Statement

Introduction and context

NHS Bolton Clinical Commissioning Group 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 1st April 2017, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Bolton CCG commissions healthcare for a registered GP population of 308,824 (as at 31 March 2018) with the engagement of patients, GP practices, Bolton Council, the local Health and Wellbeing Board, Bolton NHS Foundation Trust and other healthcare providers, Healthwatch Bolton, Voluntary Sector providers and NHS England, including specialist commissioning.

Our mission is:
"To commission services that improve the health of the population, ensures best care for patients; delivers services that demonstrate value for money and high levels of positive patient experience. We will commission for outcomes and focus on whole patient pathways from prevention to end of life care".

Our strategic aims are to:

- improve population health;
- improve the care provided and the health care experience to individuals;
- work with the public and patients to promote self-care;
- improve efficiency and value for money with robust financial efficacy to ensure financial balance.

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.

On 18 April 2018 the Audit Committee completed a review of its effectiveness. This was based on a review of each element of the Committee's responsibilities as set out in its Terms of Reference. The conclusion was that the Audit Committee is delivering the majority of its duties effectively and well and is alert to the changes that need to be made to better integrate governance arrangements.

There are structures and systems in place to ensure appropriate governance is applied across the organisation. These include:

- The CCG Constitution, Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies and delegation arrangements which specifically address governance; the role of the board and its sub-committees; the role of the chairman, chief executive and senior staff; accountability arrangements; and partnership working arrangements.
- Open meetings of the board and the publication of board meetings and related board reports.
- The publication and dissemination of performance reports, annual report and accounts, annual audit letters, equality and diversity strategy, joint strategic needs assessments, service strategies and other key documents, many of which are produced jointly with partners.
- The monitoring and accountability arrangements between Bolton CCG and Greater Manchester Health and Social Care Partnership are exercised by the monitoring of the CCG Assurance Framework formal mid-year and year-end reviews between to review performance and development issues.
- Regular meetings between the Greater Manchester Health and Social Care Partnership and the accountable officer that include regular review of performance. In 2016/17 Bolton CCG was rated a 'Good' CCG by NHS England and performance levels have been maintained. NHS England will release their ratings for 2017/18 in June 2018.

- The CCG accounts for its contribution to the health economy through strategic partnerships, public meetings and the publication of documents such as CCG Board papers and the Annual Report that are available on its website.
- Collaboration with CCGs across a wider footprint and with Greater Manchester Health & Social Care Partnership to ensure that specialist services provided on a Greater Manchester basis are fit for purpose and reflect the needs of the Bolton population.
- Reporting to the Bolton Health and Wellbeing Board
- Membership of the Greater Manchester Healthier Together Committees in Common.

  Responsibilities of CCG Directors and the Terms of Reference of the Board and its sub-committees are outlined in the Constitution and can be found at:

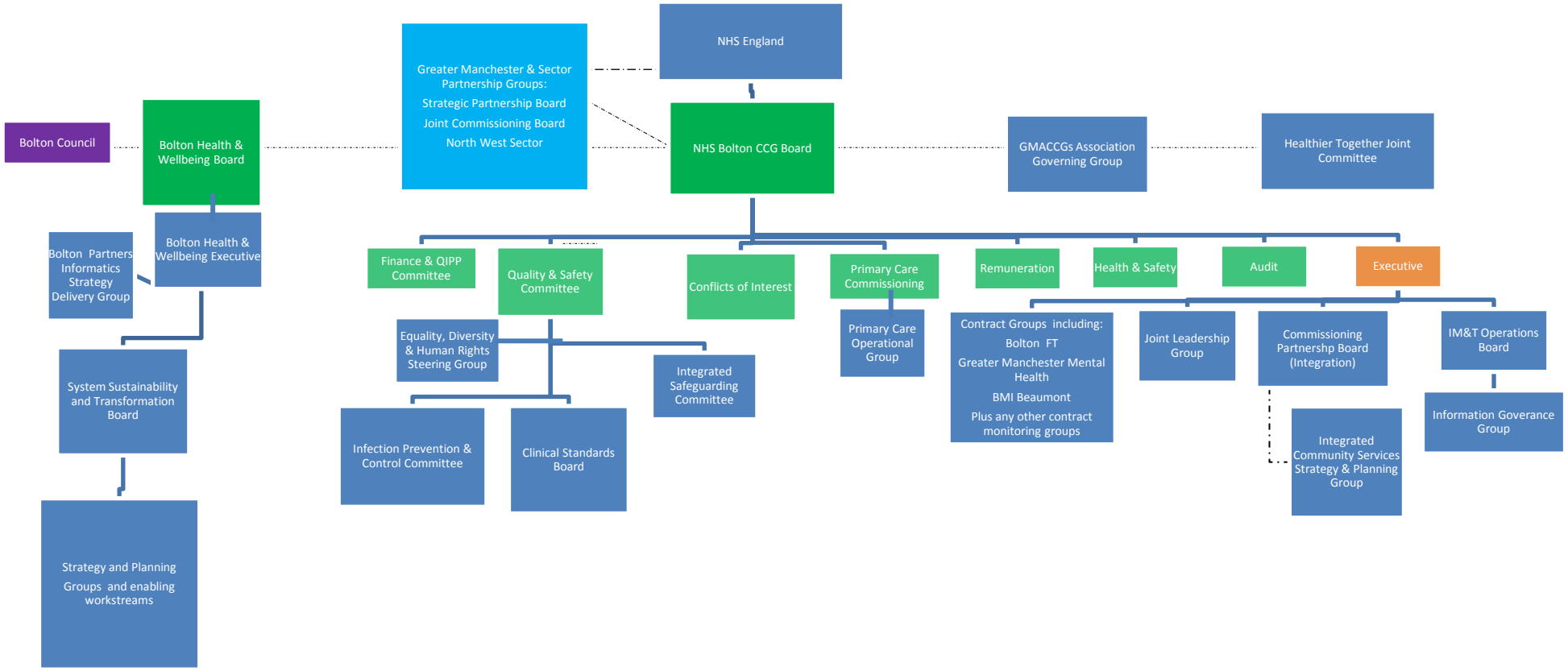
  CCG Constitution
- Bolton CCG website contains the minutes of the Board, Sub-committees and Joint Committees at:

  Board Meetings and Sub-Cttees

The governing body has met throughout the year as summarised below:

- Monthly public Board meetings.
- Monthly Board Development meetings.

Local Governance/Committee Structure (as at March 2018)



NB: GM & Sector Partnership Groups - not yet decision making bodies – will be brought into the CCG's local governance structure at the point the boards approve any strategic decision making arrangements and delegate decisions.

Key

CCG Board and formal sub-committees reporting to the Board
Other CCG sub-committees and groups (operational)
CCG Executive Committee (Management Team)
Bolton Council
GM and Sector Partnership Groups – North West Sector

Members of the Board and their attendance at Board and formal sub-committee meetings from April 2017 to March 2018:-

Member	Governing Body (12 meetings)	Audit Committee (4 meetings)	Remuneration Committee (5 meetings)	Quality & Safety Committee (12 meetings)	Finance & QIPP Committee (11 meetings)	Conflicts of Interest Committee (3 meetings)	Primary Care Commissioning Committee (6 meetings)
Dr Wirin Bhatiani, Chair	9	N/A	2	N/A	N/A	N/A	N/A
Zieda Ali, Lay Member Public Engagement	11	N/A	4	8	N/A	1	N/A
Tony Ward, Lay Member, Governance	10	4	5	N/A	11	3	N/A
Alan Stephenson, Lay Member	9	4	3	N/A	10	N/A	6
Dr Stephen Liversedge, Clinical Director, Primary Care & Health Improvement	11	N/A	N/A	N/A	N/A	N/A	6
Dr Jane Bradford, Clinical Director, Governance & Safety	8	N/A	N/A	10	N/A	N/A	N/A
Dr Barry Silvert, Clinical Director, Commissioning	10	N/A	N/A	N/A	N/A	N/A	N/A
Dr Dharmesh Mistry, GP Board Member (from November 2017)	3 out of 4	N/A	1 out of 1	N/A	N/A	N/A	N/A
Dr Charles Hendy, GP Board Member	10	4	N/A	N/A	5 out of 6	N/A	N/A
Dr Shri-Kant, GP Board Member	11	N/A	N/A	N/A	N/A	N/A	N/A
Dr Tarek Bakht, GP Board Member	12	3	N/A	N/A	N/A	N/A	N/A
Su Long, Chief Officer *CCG CO is required to attend 1 meeting a year.	9	1*	4	N/A	N/A	3	5
Annette Walker, Chief Finance Officer (to July 2017)	3 out of 4	1 out of 1	2 out of 2	N/A	2 out of 3	1 out of 1	1 out of 2
Jackie Murray, Acting Chief Finance Officer (July to September 2017)	1 out of 2	1 out of 1	0 out of 0	N/A	1 out of 2	1 out of 1	1 out of 1
Ian Boyle, Chief Finance Officer (from October 2017)	5 out of 5	1 out of 1	1 out of 2	N/A	6 out of 6	1 out of 1	1 out of 2
Mary Moore, Chief Nurse (to September 2017)	4 out of 6	N/A	N/A	5 out of 6	N/A	N/A	N/A
Romesh Gupta, Secondary Care Specialist	10	N/A	5	N/A	N/A	2 out of 3	N/A

UK Corporate Governance Code

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

Leadership

- A Board is in place, which is clinically led and made up of 15 voting members, including a mix of GPs, managers, 3 lay members and non GP clinicians. Collectively, the Board ensures the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.
- There is a clear division of responsibilities between the running of the Board and the CCG Executive responsibility for the running of the organisation. No one individual has unfettered powers of decision.
- The Chair is responsible for leadership of the board and ensuring its effectiveness on all aspects of its role.
- Non-executive members constructively challenge and help develop proposals on strategy.

Effectiveness

- The Board and its committees draw their membership from a broad pool of lay members, non-executive GP members, GP clinical leads, and NHS senior managers and staff providing the appropriate balance of skills, experience, independence and knowledge of the organisations to enable them discharge their respective duties and responsibilities effectively.
- There is a formal, rigorous and transparent procedure for the appointment of new members the Board.

- All members are able to allocate sufficient time to discharge their responsibilities effectively.
- All members and directors receive induction on joining the Board and regularly update and refresh their skills and knowledge.
- The Board is supplied in a timely manner with information in a form and of a quality appropriate to enable it to discharge its duties.
- The Board has reviewed its own performance and that of its committees via the regular Board Development meetings and via the formal governance, finance, performance and quality reports presented to Board meetings. Individual Directors are subject to formal assessment and appraisal processes.

Remuneration

- Levels of remuneration are sufficient to attract, retain and motivate directors of the quality required to run the organisation successfully. This process is overseen by the Remuneration Committee.
- There is a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director is involved in deciding his or her own remuneration. This is managed by the Remuneration Committee.

Accountability

- The Board presents a balanced and understandable assessment of the organisation's position and prospects via a number of routes including:
- Publication of a Bolton Health and Care Locality Plan – which includes a number of system wide strategic redesign programmes
- Papers presented to the Governing Body e.g. Finance, Corporate Performance and QIPP Programme, Locality Plan delivery & Transformation Fund reports and the Board Assurance Framework.

- Publication of a Compliments, PALS and Complaints Policy that complies with the statutory framework for complaints handling.
- Working in partnership with Bolton Council to develop joint strategic needs assessments and joint health and wellbeing strategies.
- Complying with the Freedom of Information Act 2000.
- Providing information to NHS England as required.
- Complying with local authority health overview and scrutiny requirements.
- Holding an Annual General Meeting in public and inviting member practices. The purpose of the meeting is to publish and present its annual report and accounts and provide updates on progress on key strategies.
- Producing annual accounts in respect of each financial year which must be externally audited.
- The Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The Board has maintained sound risk management and internal control systems as described in the "Risk and Control framework" section below.
- The Board has established formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the CCG's auditor. The Audit Committee leads on this area of work, with regular feedback and reporting to the main Board and a regular ongoing dialogue in place between the CCG and its internal and external auditors.

Relations with Stakeholders (described as shareholders in the UK Corporate Governance Code)

- There is a dialogue with stakeholders, (e.g. patients, public, GP members practices, partner organisations including North West Sector and GM Health & Social Care Partnership) based on the mutual respect and a commitment to effective communication and engagement.

- The Board as a whole has responsibility for ensuring that a satisfactory dialogue with stakeholders takes place.
- Publication of a Communications and Engagement Strategy.
- Engagement events with the public and GP member practices.
- Taking account of the communication needs of the public and patients to adopt styles of engagement so as not to disadvantage minority groups.
- Making available to the public key planning and commissioning documents and policies.
- Monthly Board meetings and the AGM, together with a wide range of other initiatives, are used to communicate with stakeholders and to encourage their participation.

Discharge of Statutory Functions

In light 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's Risk Management Strategy sets out the responsibilities of individuals, the governing body and its sub-committees of the Board for managing risks associated with meeting the clinical commissioning group's strategic aims and operational objectives.

The Head of Internal Audit Opinion issued in April 2018 confirmed that *'Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently'.*

Through the proactive and reactive management of risks, Bolton CCG was able to provide a continuous quality improvement process for the systematic identification and analysis of risks.

Risk assessments and monitoring

Risks associated with specific projects or work streams are routinely included in reports considered by CCG Executive, it sub-committees or other internal working groups for example, Strategy & Planning groups. Key risks are included in the CCG corporate risk register and the Board Assurance Framework.

The CCG has in place arrangements to involve the public in the design of services, and undertakes a proactive role in consulting with patient/public stakeholders. The organisation has effective relationships with Healthwatch Bolton, Health and Overview Scrutiny Committee, Bolton Council, Equality Target Action Groups (ETAG) and Bolton CVS.

Public stakeholders are involved in managing risk that impacts upon them. For example, the Communication and Engagement Strategy provides for patient and public involvement for new service proposals and service re-design.

Capacity to handle risk

The Risk Management Strategy defines the responsibilities of Committees and accountability of individuals including the Chief Officer, Chief Finance Officer and Executive Committee.

The Associate Director of Governance & Safety is responsible for overseeing the implementation of the Risk Management Strategy, supported by the Governance, Risk and Complaints Manager who administers the corporate risk register and Board Assurance Framework and ensures that procedures described in the strategy are in place and there are appropriate mechanisms available for staff and partner organisations to report incidents to the CCG.

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Risk management training is covered at induction for new employees and training provided in 2017/18 as part of the CCG's ongoing mandatory training programme. Learning from incidents reported by the CCG is shared with staff via our staff bulletin Staff Focus. Where an issue relates to Member GP practices, learning is discussed at GP Clinical Leads monthly meetings, articles included in the GP Practice Bulletin, GP Learning and Development Newsletter and included in education events organised by the CCG's GP Board Member who is our local GP Tutor and professional lead.

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.

The CCG's Standing Orders and Scheme of Reservation and Delegation and prime financial policies outline the control mechanisms in place during 2017/18 and can be found in the Constitution.

The Board Assurance Framework and corporate risk register are reviewed by CCG Executive Committee. Significant and high level risks were reported to the Audit Committee and high level risks included were reported to the governing body in August and October 2017 and in February and April 2018 via the Board Assurance Framework. In addition to routine reporting or risks, the governing body received individual reports on specific risk areas for example, Urgent Care.

A monthly Corporate Performance Report indicating performance against key delivery priorities against which the CCG is nationally measured was submitted to the governing body in 2017/18. The Corporate Performance Report included a monthly dashboard of risks contained in the Board Assurance Framework.

Copies of these reports can be found with the monthly board papers on the CCG website.

Annual audit of conflicts of interest management

Statutory guidance on managing conflicts of interest 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.

The CCG carried out its annual internal audit of conflicts of interest in 2018 and was assessed as partially compliant.

Data Quality

The CCG has rigorous data quality routines in place for all datasets that flow into the organisations data warehouse. Reports on the data are used to feedback to providers to improve the quality of the data received and then reported upon. These data quality checks are usually on how complete and how valid the data is – CCG analysts using the data then also report on whether the data meets business rules and feed back to the provider.

The CCG work closely with other organisations who supply datasets to ensure that data used for analysis and reporting is as complete and accurate as possible.
The CCG also make data available to member practices who are able to feed back any concerns.

Information Governance

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

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

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

The CCG achieved 88% satisfactory compliance with the toolkit. There are processes in place for incident reporting and the investigation of information governance related serious incidents requiring investigation (SIRI) and the CCG has an information risk assessment and management procedures and an Information Governance Policy to fully embed an information risk culture throughout the organisation.

There were no CCG information governance SIRIs reported to the Information Commissioner's Office in 2017/18.

Data Security

We submitted a satisfactory level of compliance with the information governance toolkit assessment. There were no data security SIRIs that needed to be reported to in 2017/18.

NHS Digital declared the cyber-attack on NHS systems that took place on Friday 12 May 2017 as a major incident. Approximately 10% of the Bolton primary care estate including the CCG was affected by the wannacry malware. The CCG's IT Partner (Greater Manchester Shared Services) acted in collaboration with NHS Digital to remove the virus. PC security patching procedures have been tightened and security threats are monitored through the GMSS Cyber Security Group and the CareCert Cyber Security Network.

Business Critical Models

The CCG is supported in delivering its statutory duties through the engagement of the GMSS (Greater Manchester Shared Service) as its delivery partner. Regular oversight is maintained of service delivery, including regular Executive Committee updates and reports to the Governing Body.

During 2017/18, Greater Manchester Commissioning Support Unit transitioned to become a shared service with hosting responsibilities taken on by Oldham CCG. Governance arrangements were put in place, ensuring safe transition of support services. Oversight of GMSS performance is reviewed at monthly Greater Manchester Chief Finance Officer meetings.

Third party assurances

NHS Bolton Clinical Commissioning Group reports to NHS England on a quarterly basis and in 2017, NHS England rated the CCG as good.

Control issues

There were no major control issues identified by Internal Audit or by the Audit Committee within the clinical commissioning group for 2017/18.

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

Bolton CCG has well developed systems and processes for managing its resources including the following:

- NHS Constitution.
- Standing Orders.
- Scheme of Reservation and Delegation.
- Prime Financial Policies.
- Strict controls on vacancy management, recruitment and use of agency staff.
- Devolved budget management throughout the CCG.
- The CCG Executive (acting as QIPP Programme Board) is responsible for reviewing and agreeing proposed schemes, and subsequent monthly monitoring, with oversight by the CCG's Finance and QIPP Committee.

The governing body gains assurance on the delivery of its financial duties from the Finance and QIPP Committee and Executive on a monthly basis following their review of detailed financial and performance information. Included in the monthly CFO Finance Report which is reported to the Executive Committee and the governing body, are updates on the CCG Allocation, performance against the QIPP target, contract performance and spend against the CCG Allocation for Running Costs. The CCG has developed a budgetary control and monitoring policy which was approved by the CCG Executive Committee and the governing body and this will be reviewed on an annual basis.

Assurance is also provided to the governing body via the Audit Committee, which receives regular reports from both Internal and External Audit to ensure that controls are operating effectively and to advise on areas for improvement.

All Internal Audit Reports relating to finance functions have reported significant assurance during the year. The CCG's routine audit programme will provide on-going assurance to the Board.

The ratings for the Quality of Leadership indicator of the CCG Improvement and Assessment Framework 2017/18 is expected to be confirmed by NHS England in June 2018 and the expectation is that Bolton CCG will be rated green.

Delegation of functions

NHS Bolton CCG delegates IM&T support, EUR, EDHR, FOI, HR, IG and Data Quality functions to the GM Shared Service (GMSS). Oversight of GMSS performance is provided by the Greater Manchester Chief Finance Officers who meet on a monthly basis.

With the exception of some issues in the delivery of the IM&T product, no major control issues exist and performance is satisfactory. The issues relating to operational delivery of IM&T services to the CCG and member practices were raised with Oldham CCG as the host organisation for the shared service in collaboration with the other 11 CCGs in Greater Manchester. As at 31 March 2018, continued delivery of IM&T service by GMSS remains an issue for the CCG and this will continue to be monitored by the IM&T Operational Board in 2018/19.

Counter fraud arrangements

The CCG has a Local Anti-Fraud, Bribery and Corruption Policy, Conflicts of Interests Policy and a Gifts, Hospitality and Commercial Sponsorship Policy in place to help reduce the risk of fraud or deception. Reminders to staff were issued via the staff bulletin during 2017/18 and staff briefings. Posters are in place throughout St Peters House and staff surveys conducted.

An Accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks. The CCG Audit Committee receives a report against each of the Standards for Commissioners at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks. The Chief Finance Officer is a member of the executive board and is proactively and demonstrably responsible for tackling fraud, bribery and corruption.

Appropriate action is also taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

Mersey Internal Audit Agency

Director of Audit Opinion and Annual Report 2017/18

NHS Bolton Clinical Commissioning Group

1. Introduction

1.1 Purpose of this Report

The purpose of this Director of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will assist the Board in the completion of its Annual Governance Statement (AGS), along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation. Section 3 of this report provides additional information to support your AGS.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS is facing a number of challenging issues and wider organisational factors.

1.2 Roles and Responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievements of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Public Sector Internal Audit Standards, the Director of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below. The outcomes and delivery of the internal audit plan are provided in Section 3.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its AGS.

2. Director of Internal Audit Opinion – Executive Summary

My opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary

2.1 Basis for the Opinion
1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
2. An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of systems reviewed and management's progress in respective of addressing control weaknesses identified.
3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

My opinion is one source of assurance that the organisation has in providing its AGS other third party assurances should also be considered. In addition the organisation should take account of other independent assurances that are considered relevant.

2.2 Overall Opinion

My overall opinion for the period 1 April 2017 to 31 March 2018 is:

High Assurance, can be given that there is a strong system of internal control which has been effectively designed to meet the organisation's objectives, and that controls are consistently applied in all areas reviewed.	
Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.	✓
Moderate Assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk.	

Limited Assurance, can be given that there is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls impacts on the overall system of internal control and puts the achievement of the organisation's objectives at risk.	
No Assurance, can be given that there is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the organisation's objectives.	

2.3 Commentary

The overall opinion is underpinned by the work conducted through the risk based internal audit plan, including Key Financial Systems, Board Reporting and Performance Management.

This opinion is provided in the context that the Clinical Commissioning Group like other organisations across the NHS is facing a number of challenging issues and wider organisational factors.

Financial Position	The CCG's financial plan has been rated as Green by NHS England. Key financial targets have been achieved as at the year end and report to Board.
QIPP	The savings target for 2017/18 for the CCG was £4.2m; all of which was achieved at year end and reported to Board.
CCG Annual Assessment	The CCG has been rated as Green by NHS England in its annual assessment of performance against key performance indicators.
Senior Management Changes	Senior management within the CCG has remained stable during 2017/18, with a new Chief Finance Officer being appointed in year.
Provider Performance	The CCG has continued to regularly report providers' performance against a range of targets. The CCG's primary provider, NHS Bolton Foundation Trust has consistently met the key national cancer standards for 31 and 62 day treatment targets but has struggled to maintain required performance levels for the four hour A&E target and 18 week referral to treatment (RTT) target.

Greater Manchester Health & Social Care Partnership	The health and social care landscape in England is changing, with huge funding pressures across all public services. The Trust creation and direction is underpinned by 'Taking charge of our Health and Social Care in Greater Manchester, The Manchester Agreement'. The CCG together with Bolton NHS Foundation Trust, Bolton Council and other health and social care provider organisations have worked jointly to develop Bolton's Health and Care Locality Plan with the aim of delivering real improvements in health and wellbeing for Bolton people and make services more sustainable for the future, in terms of money and patient care. Moreover, these arrangements are part of a broader strategy for Greater Manchester that is aimed at achieving improved health outcomes for the region.

In providing this opinion I can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. I also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

Tim Crowley

Director of Audit, MIAA
March 2018

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

Area of Audit	Level of Assurance Given
Leadership	
Board Reporting	Significant assurance
Assurance Framework Opinion	NHS requirement met
Information Governance Toolkit	Significant assurance
Conflicts of Interest	Partially compliant
Follow-up of MIAA Recommendations	Good progress
Better Health & Better Care	
Performance Management	Significant assurance
Bolton Care Record	Significant assurance
Broadcare	Limited assurance
Planning & Management	Report due May 2018
Finance and IM&T	
Financial systems & QIPP	Significant assurance

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

The Board Assurance Framework and corporate Risk Register itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its 2017/18 objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and other sub-committees, a plan to address any identified weaknesses and ensure continuous improvement of the system is in place.

The CCG had systems and processes in place to support good governance across the organisation and help prevent the risks occurring and the risk of fraud. Further details can be found in the CCGs Prime Financial Policies, Whistleblowing (Raising Concerns at Work) Policy and Procedure, Conflicts of Interest Policy, Local Anti-Fraud and Corruption Policy, Compliments, PALS and Complaints Policy Complaints. The organisation received support from Internal Audit and External Audit in monitoring compliance with its systems and processes.

The CCG's operational risk registers record risks identified, risk rating and actions being taken in mitigation. Risks relating to CCG functions and work streams were routinely reviewed by the Executive Committee during 2017/18. Risks rated 12 (significant) or above were included in the corporate risk register, reported to the Audit Committee and those assessed 15 (high) or above reported to the governing body.

The CCG Executive monitored progress against the organisation's 2017/18 strategic objectives and reviewed the Board Assurance Framework prior to submission to the Audit Committee and governing body. A summary of the year end position is outlined below.

Performance and Board Assurance Framework

The CCG's vision sets out our triple aim to:

- Improve health outcomes through reducing gap in life expectancy.
- Improve quality of care and experience of care.
- Deliver best value for money.

Below is how the CCG has delivered the objectives for 2017/18:-

Objective 2017/18	Year End Position	Comments
Deliver Year 2 of the Bolton Locality Plan		**On track with managing associated risks.**
Ensure compliance with the NHS statutory duties and NHS Constitution		**As reported in the performance section of the Annual Report, some targets have not been met at year end.**
Deliver financial balance		**Achieved in year.**

There were seven high level risks with a score of 15 or above at the end of the financial year as shown below:

Risk Ref	Description	Risk Score
F6	Year on Year Increases in acute activity and pressures	**16**
O1	Primary care capacity	**16**
O2	System wide workforce shortages	**16**
O3	Pressures on quality & performance leading to failure to meet targets	**16**
O5	Demand and capacity issues leading to compliance failure	**16**
S6	Funding for estates configuration	**16**
S7	Demand for healthcare increases and cannot be controlled	**20**

Several of these high level risks are related to the same issue, which is the pressure caused by the rise in demand for NHS services at a time NHS resources are very limited.

External risks were also identified by the CCG as having a significant impact on the achievement of its objectives.

High external risks are shown below:

Risk Ref	Description	Risk Score
240	Potential closure or suspension of care homes due to Regulator concerns/financial sustainability and failure of some providers to sustain improvements leading to lack of nursing bed availability.	**16**
241	Failure to meet infection control targets (Cdiff 19 and MRSA target zero)	**16**
247	A&E resilience and failure to meet 4 hour 95% target	**20**
248	NWAS response times and ambulance handover targets not met for 2017/18.	**20**

All incidents, complaints, Patient Advice & Liaison Service (PALS) enquiries from patients and potential claims were reported via the CCG's Safeguard Reporting System. In 2017/18 reporting of these learning points and the outcomes of improvements has been via the CCG's Quality and Safety Committee and to CCG Board via exception.

The CCG has a system in place to performance manage Serious Incidents (SIs) that occur in Provider organisations such as hospitals, care provided by community services, nursing and care homes. All SI's are reported via the Strategic Executive Information System (StEIS) which is centrally managed by NHS England. SI's are investigated internally by provider organisations and the reports shared with the CCG for review and assurance. There were no SIs attributable to Bolton CCG during 2017/18.

The Quality and Safety Committee received regular performance reports from commissioned Providers and the CCG Integrated Governance Team on themes from SUIs, incidents, complaints and risks. A Quality Matrix that outlined risks in relation to quality of services provided across the health economy was presented to the Quality and Safety Committee on a monthly basis. Lessons learned from incidents/complaints/PALS were shared with Clinical Governance Leads from CCG member practices at a monthly meeting and also via a GP Learning and Development Newsletter which is disseminated to GPs, Practice Managers and Practice Nurses.

Risks associated with the CCG's Quality Improvement Productivity & Prevention (QIPP) Programme which aims to improves productivity and eliminate waste while focusing on clinical quality were regularly reviewed by the CCG Executive Committee and reported to the Board. The Finance & QIPP Committee monitored progress and associated risks and reported directly to the governing body.

The QIPP Programme supported the CCG objectives to improve the quality of care and patients' experience of care and to improve efficiency and value for money.

The CCG Executive reported to the governing body every month and minutes of the Quality and Safety Committee, Governance & Risk Committee and Audit Committee and QIPP reports are routinely submitted to the Board. They can be found on the CCG website.

Conclusion

No significant internal control issues were identified during 2017/18 and as Accountable Officer, I am satisfied that Bolton Clinical Commissioning Group has properly discharged its responsibilities and complied with its statutory duties under the Health and Social Care Act 2012.

I am also satisfied that the organisation has a sound system of internal control embedded within the organisation that supports the organisation meet its objectives and statutory obligations.

Su Long

Accountable Officer

25th May 2018

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee determines the pay of the Governing Body members and the most senior executives within the organisation in line with national guidance; no performance related pay is made. Details of membership, the number of meetings held throughout the year and each member's attendance is detailed in the Governance Statement.

Policy on the remuneration of senior managers

The Chair and four elected GP Board Members were appointed to the Governing Body following an election process according to the process and tenure laid out in the CCG Constitution. The Executive Governing Body members' contracts are subject to a notice period of 6 months. All board members are appointed in accordance with the CCG Constitution. There are no provisions for compensation for loss of office.

Remuneration of Very Senior Managers

Please see table on the attached page.

Senior manager remuneration (including salary and pension entitlements)

2017-18					
Name and Title	**Salary (bands of £5,000)** £000	**Other Salary payments (For non - Board post held) Bands of £5,000** £000	**Expense Payment (taxable) Rounded to the nearest £100** £000	**All Pension Related Benefits Bands of £2,500** £000	**Total Bands of £5,000** £000
Dr Wirin Bhatiani Chair	100 - 105	0	0	0	100 - 105
Susan Long Chief Officer	120 - 125	0	0	25 - 27.5	145 - 150
Annette Walker Chief Finance Officer to 16-7-17	35 - 40	0	0	0	35 - 40
Jackie Murray Acting Chief Finance Officer From 17-7-17 to 30-9-17	15 - 20	0	0	2.5 - 5	20 - 25
Ian Boyle Chief Finance Officer from 1-10-17	50 - 55	0	0	2.5 - 5	55 - 60
Dr Stephen Liversedge Clinical Director	60 - 65	40 - 45	0	0	105 - 110
Dr Barry Silvert Clinical Director	60 - 65	0	0	0	60 - 65
Dr Jane Bradford Clinical Director from 1-4-17	60 - 65	0	0	52.5 - 55	115 - 120
Dr Shri Kant GP Board Member	20 - 25	0	0	0	20 - 25
Dr Tarek Bakht GP Board Member	20 - 25	70 - 75	0	12.5 - 15	105 - 110
Dr Charles Hendy GP Board Member	20 - 25	0	0	0	20 - 25
Dr Dharmesh Mistry GP Board Member from 1-11-17	5 - 10	0	0	0	5 - 10
Tony Ward Lay Member	10 - 15	0	0	0	10 - 15
Alan Stephenson Lay Member	5 - 10	0	0	0	5 - 10
Zieda Ali Lay Member	5 - 10	0	0	0	5 - 10
Prof Romesh Gupta Secondary Care Specialist Board Member	10 - 15	0	0	0	10 - 15
Mary Moore Chief Nurse to 30-9-17	20 - 25	0	0	0	20 - 25

The 2016-17 table is included for comparative purposes:

2016-17					
Name and Title	**Salary (bands of £5,000) £000**	**Other Salary payments (For non - Board post held) Bands of £5,000 £000**	**Expense Payment (taxable) Rounded to the nearest £100 £000**	**All Pension Related Benefits Bands of £2,500 £000**	**Total Bands of £5,000 £000**
Dr Wirin Bhatiani Chair	100 - 105	0	0	0	100 - 105
Susan Long* Chief Officer	115 - 120	0	0	42.5 - 45	155 - 160
Annette Walker Chief Finance Officer	105 - 110	0	0	25 - 27.5	130 - 135
Dr Stephen Liversedge Clinical Director	60 - 65	40 - 45	0	0	100 - 105
Dr Barry Silvert Clinical Director	60 - 65	0	0	0	60 - 65
Dr Colin Mercer to 31-3-17 Clinical Director	60 - 65	0	0	0	60 - 65
Dr Shri Kant GP Board Member	20 - 25	0	0	0	20 - 25
Dr Tarek Bakht GP Board Member	20 - 25	70 - 75	0	2.5 - 5	95 - 100
Dr Charles Hendy GP Board Member	20 - 25	0	0	0	20 - 25
Dr Jane Bradford GP Board Member	20 - 25	25 - 30	0	17.5 - 20	70 - 75
Tony Ward Lay Member	10 - 15	0	0	0	10 - 15
Alan Stephenson Lay Member	5 - 10	0	0	0	5 - 10
Gerry Donnellan Lay Member to 30/04/16	0 - 5	0	0	0	0 - 5
Zieda Ali Lay Member from 12/09/16	5 - 10	0	0	0	5 - 10
Prof Romesh Gupta Secondary Care Specialist Board Member	10 - 15	0	0	0	10 - 15
Mary Moore Chief Nurse	40 - 45	0	0	25 - 27.5	65 - 70

*prior year restated

Salary includes actual remuneration for governing body members. Other remuneration includes salaries for non-governing body roles held within the CCG. Expense payments (taxable) are the benefit in kind arising from the provision of a lease car or lease car allowance. There were no payments made to former senior managers during the financial year, and there was no provision for compensation for early termination of contracts at the year end.

All pensions' related benefits are calculated as the increase in estimated pension and pension lump sum at the start of the year, adjusted for inflation, compared to the estimate at the end of the year, as provided by NHS Pensions Agency, and multiplied by a factor of 20 in accordance with NHS Pensions guidance. Officers new to the post will show an increase in the first year of employment and is based on the whole time equivalent for the post and total pensionable service.

Pension benefits as at 31 March 2018

Name and 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 1 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employers Contribution to partnership pension
2017 – 18	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Susan Long Chief Officer	2 - 2.5	0 - 2.5	25 - 30	70 - 75	370	416	46	0
Annette Walker Chief Finance Officer to 16-7-17	0 - 2.5	0	30 - 35	85 - 90	486	498	41	0
Jackie Murray Acting Chief Finance Officer From 17-7-17 to 30-9-17	0 - 2.5	0 - 2.5	25 - 30	65 - 70	389	402	13	0
Ian Boyle Chief Finance Officer from 1-10-17	0 - 2.5	0	35 - 40	90 - 95	542	564	22	0
Mary Moore Chief Nurse	0 - 2.5	2.5 - 5	25 - 30	40 - 45	559	602	44	0
Dr Tarek Bakht GP Lay Member	0 - 2.5	0 - 2.5	15 - 20	40 - 45	241	261	20	0
Dr Jane Bradford GP Board Member	2.5 - 5	0 - 2.5	10 - 15	30 - 35	174	213	39	0
2016-17								
Susan Long Chief Officer	2.5 - 5	0 - 2.5	25 - 30	70 - 75	328	366	37	0
Annette Walker Chief Finance Officer	0 - 2.5	0 - 2.5	30 - 35	85-90	448	481	32	0
Mary Moore Chief Nurse	0 - 2.5	2.5 - 5	25 - 30	75 - 80	509	553	43	0
Dr Tarek Bakht GP Lay Member	0 - 2.5	0	15 - 20	40 - 45	217	256	38	0
Dr Jane Bradford GP Board Member	0 - 2.5	0	10 - 15	25 - 30	148	171	23	0

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

There were no payments for compensation on early retirement or for loss of office.

Payments to past members

There were no payments to former members.

Pay multiples

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

The banded remuneration of the highest paid director/Member in Bolton CCG in the financial year 2017/18 was £170k - £175k (2016/17: £165k - £170k). This was 4.7 times (2016/17: 4.5) the median remuneration of the workforce, which was £36k (2016/17: £39k).

In 2017/18, no employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £6k - £170k (2016/17: £16k - £168k)

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.

Staff Report

Number of senior managers

The number of senior managers (at Board and Executive level) is listed below:-

Board 6

Executive 11

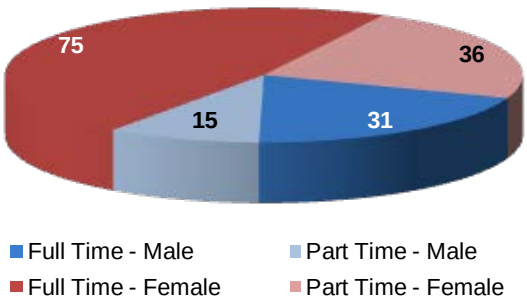
Staff numbers and costs

The average number and cost of people employed is calculated as the whole time equivalent number of employees, is disclosed in note 4.2 and 4.1 of the annual accounts respectively.

Staff composition

The breakdown of staff by gender and working time split (as at end of March 2018) is detailed below:-

GENDER & WORKING TIME SPLIT						
Gender	Staff	%	Employment Category	Staff	%	GM %
Male	46	29%	Full Time - Male	31	19.7%	19.0%
			Part Time - Male	15	9.6%	13.1%
Female	111	71%	Full Time - Female	75	47.8%	43.5%
			Part Time - Female	36	22.9%	24.5%



The breakdown of Governing Body members by gender is also detailed below:-

Male	Female
11	3

Sickness absence data

	2017-18	**2016-17**
	Number	**Number**
Total days lost	1,288	1,081
Total staff years	118	111
Average working days lost	10.9	9.74

Staff policies

Recruitment

The CCG has a Recruitment & Selection Code of Practice Policy which provides guidance to recruiting managers. All applications are available to managers with personal details withheld so that they are shortlisted fairly on the information that the applicant has provided about their skills and experience. In addition the CCG follows the Positive about Disability guidance and where candidates have identified themselves as disabled and meet the essential criteria they will be offered an interview. Applicants are also asked if they require any support or adjustments to facilitate their attendance and participation in the interview process.

Training

All managers have the opportunity to attend Key Skills for Managers training which covers Equality and Diversity including guidance around providing support and making adjustments for existing and new employees and Attendance Management which provides guidance to managers to ensure sickness absence is managed fairly. Managers work closely with Occupational Health and people service in consultation with employees to ensure the appropriate adjustments are put in place where required. The Attendance Management Policy is used to support managers where employees have been off sick to discuss adjustments and seek advice from Occupational Health and Access to work if appropriate. A range of adjustments and support have been put in place for current employees which have included phased returns after long term absence, adjustments in working hours and duties and provision of adaptations/equipment. In addition the CCG Flexible Working Policy is available to all employees and outlines the process for making a request to work flexibly for any reason which may include supporting an employee with a long term medical condition/disability to remain in work.

Requests for training and development are considered following the guidance set out in the Education, Training & Development Policy. The policy requires that the allocation of available funding for courses and conferences will be: transparent, equitable and fair. In addition, all requests for funding from the Learning & Development budget are required to be reported to the Chief Officer to monitor fair and consistent application of the policy.

Expenditure on consultancy

Consultancy expenditure in 2017/18 was £5k. This can be compared to expenditure in 2016/17 of £49k.

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	1
Of which, the number that have existed:	
for between one and two years at the time of reporting	1

These engagements are provided by temporary staffing companies and have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: New off-payroll engagements

For all new off-payroll engagements between 01 April 2017 and 31 March 2018, 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 2018	5
Of which:	
No. assessed as caught by IR35	5
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity)	1
No. engagements reassessed for consistency/assurance purposes during the year	0
No. engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	17

Exit Packages and other departures

There were no exit packages or other departures agreed between 1st April 2017 and 31st March 2018.

The Trade Union (Facility Time Publication Requirements) Regulations 2017

The statutory instrument requires relevant public sector employers to publish, on an annual basis, a range of data in relation to their usage and spend on trade union facility time.

NHS Bolton CCG does not have any Trade Union representation and therefore has no information to report on usage and spend on trade union facility time.

Parliamentary Accountability and Audit Report

NHS Bolton CCG is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of the Annual Accounts. An audit certificate and report is also included in pages 3 to 7 of the Annual Accounts.

ANNUAL ACCOUNTS

Su Long

Accountable Officer

25th May 2018

Bolton Clinical Commissioning Group

NHS Bolton Clinical Commissioning Group

Annual Accounts

2017-18

V1final

Index

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BOLTON CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Bolton Clinical Commissioning Group ("the CCG") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or

inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 41 of the Annual Report, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs 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.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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 conform to the authorities which govern them.

Report on the 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 the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 41 of the Annual Report, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) 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.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- 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 issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Bolton 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, as a body, 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 Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

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

Robert Jones
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One St Peter's Square
Manchester
M2 3AE

Foreword to the Accounts

NHS Bolton Clinical Commissioning Group

The clinical commissioning group was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

These accounts for the year ended 31 March 2018 have been prepared by NHS Bolton Clinical Commissioning Group under section 17 of schedule 1A of the National Health Service Act 2006 (as amended) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The National Health Service Act 2006 (as amended) requires clinical commissioning groups to prepare their Annual Report and Annual Accounts in accordance with Directions issued by NHS England.

Statement of Comprehensive Net Expenditure for the Year Ended 31st March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(254)	(1,167)
Other operating income	2	(649)	(370)
Total operating income		**(903)**	**(1,537)**
Staff costs	4	6,366	6,378
Purchase of goods and services	5	450,516	428,407
Depreciation and impairment charges	5	0	0
Provision expense	5	(167)	300
Other Operating Expenditure	5	558	2,625
Total operating expenditure		**457,273**	**437,710**
Net Operating Expenditure		**456,370**	**436,173**
Finance income		0	0
Finance expense		0	0
Net expenditure for the year		**456,370**	**436,173**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**456,370**	**436,173**
Other Comprehensive Expenditure		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**456,370**	**436,173**

The notes on pages 12 to 50 form part of this statement.

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment		0	0
Total non-current assets		0	0
Current assets:			
Trade and other receivables	8	3,014	2,634
Cash and cash equivalents	9	108	128
Total current assets		**3,122**	2,762
Current liabilities			
Trade and other payables	10	(25,921)	(24,410)
Provisions	11	(110)	(311)
Total current liabilities		**(26,031)**	(24,721)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(22,909)**	(21,959)
Non-current liabilities			
Provisions	11	(1,058)	(1,058)
Total non-current liabilities		**(1,058)**	(1,058)
Assets less Liabilities		**(23,967)**	(23,017)
Financed by Taxpayers' Equity			
General fund		(23,967)	(23,017)
Total taxpayers' equity:		**(23,967)**	(23,017)

The notes on pages 12 to 50 form part of this statement.

The financial statements on pages 8 to 11 were approved by the governing body on 25th May 2018 and signed on its behalf by:

Susan Long

Accountable Officer

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2018

	General fund £'000	Revaluation reserve £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18			
Balance at 01 April 2017	**(23,017)**	0	**(23,017)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18			
Net operating expenditure for the financial year	(456,370)	0	(456,370)
Total revaluations against revaluation reserve	**0**	**0**	**0**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(456,370)**	**0**	**(456,370)**
Net funding	455,420	0	455,420
Balance at 31 March 2018	**(23,967)**	**0**	**(23,967)**

	General fund £'000	Revaluation reserve £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17			
Balance at 01 April 2016	**(24,207)**	**0**	**(24,207)**
Net operating costs for the financial year	(436,173)		(436,173)
Total revaluations against revaluation reserve	**0**	**0**	**0**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(460,380)**	**0**	**(460,380)**
Net funding	437,363	0	437,363
Balance at 31 March 2017	**(23,017)**	**0**	**(23,017)**

The notes on pages 12 to 50 form part of this statement.

Statement of Cash Flows for the Year Ended 31 March 2018

	Note	**2017-18 £'000**	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(456,370)	(436,173)
(Increase)/decrease in trade & other receivables	8	(380)	(110)
Increase/(decrease) in trade & other payables	10	1,511	(964)
Provisions utilised	11	(34)	(425)
Increase/(decrease) in provisions	5	(167)	300
Net Cash Inflow (Outflow) from Operating Activities		**(455,440)**	(437,372)
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(455,440)**	(437,372)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		455,420	437,363
Net Cash Inflow (Outflow) from Financing Activities		**455,420**	437,363
Net Increase (Decrease) in Cash & Cash Equivalents	9	**(20)**	(9)
Cash & Cash Equivalents at the Beginning of the Financial Year		**128**	137
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**108**	128

The notes on pages 12 to 50 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 2017-18 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 the going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health and Social Care Group

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

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ accounts.

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and

expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.7.2 Key Sources of Estimation Uncertainty

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

1.7.2.1 Prescribing expenditure

The clinical commissioning group receives financial information from NHS Business Services relating to the costs of drugs prescribed by clinical commissioning group's prescribers (member GP Practices). The information available for actual drug costs prescribed in the year is 2 months in arrears, therefore the actual data received at the Statement of Financial Position date is to 31st January 2018 only, and estimates for February and March are required. These estimates have been calculated using forecast information provided by NHS Business Services with adjustments for local knowledge, note 10 refers.

1.7.2.2 Provisions for Continuing Care

In accordance with Accounts Directions issued by NHS England, the clinical commissioning group has estimated provisions for continuing care cases for previously un-assessed periods of care that transferred to the clinical commissioning group by transfer orders issued under the Health and Social Care Act 2012. The estimate takes into account the likelihood of all retrospective claims being assessed as eligible by the Continuing Care Panel, note 11 refers.

1.7.2.6 *Provisions for dilapidations and transition costs*

The charging methodology issued by NHS Property Services includes charging tenants for dilapidation costs of leased buildings. An estimate has been included in the financial statements for dilapidation and transition costs of the headquarter building of the clinical commissioning group, note 11 refers.

1.8 Revenue

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

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

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

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

1.9.2 Retirement Benefit Costs

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

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

1.10 Other Expenses

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

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

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

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

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

1.11.2 Valuation

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

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

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

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income

generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

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

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

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

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

1.14 Donated Assets

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

1.15 Government Grants

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

1.16 Non-current Assets Held For Sale

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

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

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

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

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

1.17 Leases

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

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.17.2 The Clinical Commissioning Group as Lessor

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

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

1.18 Private Finance Initiative Transactions

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

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

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

1.18.1 Services Received

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

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

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

1.18.4 Lifecycle Replacement

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

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

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

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

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

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

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 Inventories

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

1.20 Cash & Cash Equivalents

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

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

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 0.56% (previously: minus 0.80%)

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

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

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Continuing Healthcare Risk Pooling

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

1.25 Carbon Reduction Commitment Scheme

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

1.26 Contingencies

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.27 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.27.1 Financial Assets at Fair Value Through Profit & Loss

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

1.27.2 Held to Maturity Assets

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

1.27.3 Available For Sale Financial Assets

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

1.27.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.28 Financial Liabilities

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

1.28.1 Financial Guarantee Contract Liabilities

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

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

1.28.2 Financial Liabilities at Fair Value Through Profit & Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be

ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.28.3 Other Financial Liabilities

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

1.29 Value Added Tax

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

1.30 Foreign Currencies

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

1.31 Third Party Assets

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

1.32 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they

are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

1.33 Subsidiaries

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Associates

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

1.35 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as ‘held for sale’ are measured at the lower of their carrying amount or ‘fair value less costs to sell’.

1.36 Joint Operations

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

1.37 Research & Development

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

1.38 Accounting Standards that have been Issued but have not yet been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2017-18, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019).

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2 Other Operating Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
Recoveries in respect of employee benefits	66	43	23	0
Education, training and research	34	0	34	52
Charitable and other contributions to revenue expenditure: non-NHS	200	0	200	169
Non-patient care services to other bodies	220	0	220	1,115
Non cash apprenticeship training grants revenue	3	3	0	0
Other revenue	380	24	356	201
Total other operating revenue	**903**	**70**	**833**	1,537

3 Revenue

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4 Employee Benefits & Staff Numbers

4.1 Employee benefits

	2017-18 Total	2017-18 Permanent Employees	2017-18 Other	2016-17 Total
	£'000	£'000	£'000	£'000
Employee Benefits				
Salaries and wages	5,262	4,730	532	5,363
Social security costs	505	504	1	475
Employer Contributions to NHS Pension scheme	589	587	2	540
Apprenticeship Levy	10	10	0	0
Termination benefits	0	0	0	0
Gross employee benefits expenditure	**6,366**	**5,831**	**535**	6,378
Less recoveries in respect of employee benefits (note 4.1.2)	**(66)**	**(66)**	**0**	0
Net employee benefits	**6,300**	**5,765**	**535**	6,378

4.1.2 Recoveries in respect of employee benefits

	2017-18 Total	2017-18 Permanent Employees	2017-18 Other	2016-17 Total
	£'000	£'000	£'000	£'000
Employee Benefits				
Salaries and wages	(53)	(53)	0	0
Social security costs	(5)	(5)	0	0
Employer Contributions to NHS Pension scheme	(8)	(8)	0	0
Gross employee benefits expenditure	**(66)**	**(66)**	**0**	0

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Total	**130**	**123**	**7**	123

There were no employees engaged on capital projects.

Ill-health retirement costs are met by the NHS Pension Scheme. There was 1 ill-health retirement during the 2017-18 financial year £47k (2016-17, nil).

4.3 Exit packages and severance payments agreed in the financial year

There were no exit packages and severance payments during 2017-18.

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 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:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with

updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers’ contributions of £589k were payable to the NHS Pension Scheme (2016-17: £540k) at the rate of 14.38% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on

HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.

5 Operating Expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	5,829	2,709	3,120	5,830
Executive governing body members	537	537	0	548
Total gross employee benefits	**6,366**	**3,246**	**3,120**	**6,378**
Other costs				
Services from other CCGs and NHS England	926	643	283	846
Services from foundation trusts	269,869	129	269,740	252,856
Services from other NHS trusts	13,151	0	13,151	12,236
Purchase of healthcare from non-NHS bodies	71,091	0	71,091	64,612
Chair and non-executive members	228	228	0	237
Supplies and services – clinical	4	0	4	1
Supplies and services – general	154	35	119	27
Consultancy services	5	0	5	49
Establishment	1,407	336	1,071	1,073
Transport	0	0	0	1
Premises	1,828	498	1,330	2,700
Audit fees	45	45	0	68
Other non-statutory audit expenditure	30	30	0	0
Prescribing costs	50,015	0	50,015	50,223
General ophthalmic services	31	0	31	21
GPMS/APMS and PCTMS	41,694	8	41,686	42,808
Other professional fees excl. audit	52	40	12	15
Legal Fees	88	29	59	112
Grants to Other bodies	330	0	330	2,378
Education and training	123	86	37	147
Provisions	(167)	0	(167)	300
CHC Risk Pool contributions	0	0	0	612
Non cash apprenticeship training grants	3	3	0	0
Other expenditure	0	0	0	10
Total other costs	**450,907**	**2,110**	**448,797**	**431,332**
Total operating expenses	**457,273**	**5,356**	**451,917**	**437,710**

6 Better Payment Practice Code

6.1 Measure of compliance

The Better Payment Practice Code requires the clinical commissioning group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

	2017-18 Number	**2017-18 £000**	2016-17 Number	2016-17 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,515	128,857	10,789	122,842
Total Non-NHS Trade Invoices paid within target	10,071	126,375	10,351	120,321
Percentage of Non-NHS Trade invoices paid within target	**95.8%**	**98.1%**	95.9%	97.9%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,309	288,839	2,495	274,161
Total NHS Trade Invoices Paid within target	2,114	288,288	2,440	273,761
Percentage of NHS Trade invoices paid within target	**91.6%**	**99.8%**	97.8%	99.9%
Total Percentage of invoices paid within target	**95.0%**	**99.3%**	96.3%	99.3%

7 Operating Leases

7.1 As lessee

The clinical commissioning group undertakes transactions with NHS Property Services Ltd and Community Health Partnerships Ltd which convey the right for the clinical commissioning group to use the property. Although there are no formal leases in place these arrangements contain leases and as such are accounted for in accordance with IAS17 as an operating lease.

The minimum lease payments comprise the payments made to NHS Property Services Ltd and Community Healthcare Services Ltd during the 2017-18 financial year, which includes subsidy and void costs of buildings used for the provision of healthcare in the community. These costs have arisen due to the arrangements in place in the previous commissioning framework prior to April 2013 when the clinical commissioning group was formed. Whilst the management of the properties has passed to NHS Property Services Ltd and Community Healthcare Services Ltd, the liability for these costs remains within the commissioning sector.

7.1.1Payments recognised as an expense

	Buildings £000	Other £000	2017-18 Total £000	2016-17 Total £000
Payments recognised as an expense				
Minimum lease payments	1,895	9	**1,904**	2,519
Contingent rents	0	0	**0**	0
Sub-lease payments	0	0	**0**	0
Total	**1,895**	**9**	**1,904**	2,519

7.1.2 Future minimum lease payments

	Buildings £000	Other £000	2017-18 Total £000	2015-16 Total £000
Payable:				
No later than one year	23	0	**23**	27
Between one and five years	92	0	**92**	76
After five years	46	0	**46**	76
Total	**161**	**0**	**161**	179

Whilst our arrangements with Community Health Partnerships Limited and 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 unless there is a signed lease in place.

8 Trade & Other Receivables

	Current 2017-18 £000	Non-current 2018-18 £000	Current 2016-17 £000	Non-current 2016-17 £000
NHS receivables: Revenue	475	0	701	0
NHS prepayments	857	0	859	0
NHS accrued income	81	0	387	0
Non-NHS receivables: Revenue	872	0	225	0
Non-NHS prepayments	325	0	285	0
Non-NHS accrued income	269	0	154	0
VAT	135	0	22	0
Other receivables & accruals	0	0	1	0
Total Trade & other receivables	**3,014**	**0**	2,634	**0**
Total current and non-current	**3,014**		2,634	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

8.1 Receivables past their due date but not impaired

	2017-18 £000	2016-17 £000
By up to three months	590	247
By three to six months	22	77
By more than six months	0	0
Total	**612**	324

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2018 (31 March 2017, nil). None of the amount above has subsequently been recovered post the statement of financial position date.

8.2 Provision for impairment of receivables

The clinical commissioning group has reviewed the receivables past their due date in accordance with its policy and conclude there was no requirement to include a provision for impairment of receivables at 31 March 2018 (31 March 2017, nil).

9 Cash & Cash Equivalents

	2017-18 £000	2016-17 £000
Balance at 01 April 2017	128	137
Net change in year	(20)	(9)
Balance at 31 March 2018	**108**	128
Made up of:		
Cash with the Government Banking Service	108	128
Cash in hand	0	0
Cash and cash equivalents as at 31st March 2018	**108**	128

No patients' money is held by the clinical commissioning group.

10 Trade & Other Payables

	Current 2017-18 £000	Non-current 2017-18 £000	Current 2016-17 £000	Non-current 2016-17 £000
NHS payables: revenue	2,285	0	546	0
NHS accruals	2,872	0	2,401	0
Non-NHS payables: revenue	2,560	0	3,560	0
Non-NHS accruals	15,272	0	15,434	0
Social security costs	81	0	72	0
Tax	72	0	65	0
Other payables	2,779	0	2,332	0
Total Trade & Other Payables	**25,921**	**0**	**24,410**	**0**
Total current and non-current	**25,921**		**24,410**	

There are no liabilities included above that are due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2017, nil).

Other payables include £501k outstanding pension contributions at 31 March 2018 (31 March 2017, £360k) the increase reflects the inclusion of GP pension contributions as a result of primary care delegated co-commissioning.

Non NHS accruals and deferred income includes estimates for prescribing costs for February and March of £8,197k (2016-17 £8,247k), and £595k (2016-17 £885k) for the Bolton Quality Contract, a local enhanced primary care service aimed to address the growing demand and rise in pressure on health services.

11 Provisions

	Current 2017-18 £000	Non-current 2017-18 £000	Current 2016-17 £000	Non-current 2016-17 £000
Continuing care	45	0	108	0
Other	65	1,058	203	1,058
Total	**110**	**1,058**	**311**	**1,058**
Total current and non-current	**1,168**		**1,369**	

Other provisions includes £65k (2016-17, £39k) in respect of Individual Funding Requests and Individual Prior Approval cases and £1,058k (2016-17, £1,122k) for dilapidations and stranded costs relating to the closure of buildings.

The NHS Litigation Authority did not hold any liabilities in respect of clinical negligence liabilities of the clinical commissioning group in its provisions as at 31 March 2018 (31 March 2017, nil).

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group that were previously identified by the former Bolton Primary Care Trust. However, the legal liability remains with the clinical commissioning group. The total value of legacy NHS continuing healthcare provisions accounted for by NHS England on behalf of the clinical commissioning group at 31 March 2018 is £48k (31 March 2017 £989k). In addition, the clinical commissioning group has accounted for further claims totaling £45k for previously un-assessed periods of care arising after 31st March 2013, (2016-17 £108k).

	Continuing Care	Other	Total
	£000s	£000s	£000s
Balance at 01 April 2017	**108**	**1,261**	**1,369**
Arising during the year	0	26	**26**
Utilised during the year	(14)	(20)	**(34)**
Reversed unused	(49)	(144)	**(193)**
Balance at 31 March 2018	**45**	**1,123**	**1,168**
Expected timing of cash flows:			
Within one year	45	65	**110**
Between one and five years	0	1,058	**1,058**
Balance at 31 March 2018	**45**	**1,123**	**1,168**

12 Contingencies

The clinical commissioning group had no contingent assets not otherwise included in these financial statements as at 31 March 2018. The clinical commissioning group has no contingent liability (2016-17, £254k) in respect of continuing healthcare claims for previously un-assessed periods of care, this is an estimate of costs that may arise should every retrospective claim received be found eligible by the Continuing Care Panel.

13 Financial Instruments

13.1 Financial risk management

International Financial Reporting Standard 7: Financial Instrument: Disclosure requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

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

13.1.2 Currency risk

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

13.1.3 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.

13.1.4 Credit risk

Because the majority of the clinical commissioning group's revenue comes from NHS England, the clinical commissioning group has low exposure to credit risk. The

maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.5 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament.

The clinical commissioning group draws down cash to cover expenditure from NHS England as the need arises, unrelated to its performance against resource limits. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

13.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £000	Loans and Receivables 2017-18 £000	Available for Sale 2017-18 £000	Total 2017-18 £000
Receivables:				
· NHS	556	0	0	**556**
· Non-NHS	1,141	0	0	**1,141**
Cash at bank and in hand	108	0	0	**108**
Other financial assets	0	0	0	**0**
Total at 31 March 2018	**1,805**	**0**	**0**	**1,805**

	2016-17 £000	2016-17 £000	2016-17 £000	2016-17 £000
Receivables:				
· NHS	1,088	0	0	1,088
· Non-NHS	379	0	0	379
Cash at bank and in hand	128	0	0	128
Other financial assets	1	0	0	1
Total at 31 March 2017	**1,596**	**0**	**0**	**1,596**

13.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £000	Other 2017-18 £000	Total 2017-18 £000
Payables:			
· NHS	5,158	0	5,158
· Non-NHS	20,610	0	20,610
Total at 31 March 2018	**25,768**	**0**	**25,768**

Payables:	2016-17 £000	2016-17 £000	2016-17 £000
· NHS	2,947	0	2,947
· Non-NHS	21,326	0	21,326
Total at 31 March 2017	**24,273**	**0**	**24,273**

14 Operating Segments

The clinical commissioning group has only one segment: commissioning of healthcare services.

15 Pooled Budgets

2017-18 is the third year of operation of the Better Care Fund, a national policy initiative designed to promote integrated working between Health and Social Care. In line with policy requirements, Bolton Clinical Commissioning Group and Bolton Council have entered into a pooled budget arrangement under section 75 of the NHS Act 2016.

The Improved Better Care Fund (iBCF), announced in the 2015 Spending review was introduced in 2017-18. It is a grant paid to local government with a condition that it is pooled into the local BCF plan.

The funding can be spent on three purposes:

• Meeting adult social care needs

• Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready

• Ensuring that the local social care provider market is supported.

The operation of the Better Care Fund is set out in a formal section 75 agreement which confirms the spending plan and risk sharing agreement of the Fund, which is hosted by Bolton Clinical Commissioning Group.

The following table summarises the contributions made by Bolton Clinical Commissioning Group and Bolton Council along with the expenditure summarised by service area.

Funding provided to the pool	2017-18 £'000	2016-17 £'000
Bolton Clinical Commissioning Group	29,068	29,039
Bolton Council	13,332	6,070
Total funding	42,400	35,109
Expenditure met from the Pool		
Bolton Clinical Commissioning Group	10,659	11,509
Bolton Council	31,741	23,600
Total Expenditure	42,400	35,109
Expenditure met from the pooled budget		
Integrated Neighbourhood teams	4,200	4,123
Intermediate Care	14,404	14,615
Independent Living	4,838	4,545
Complex Needs	795	812
Staying Well	1,456	1,165
Carers	695	658
Care Act	754	753
Protection of Social Care Services	5,277	5,158
Protection of Health Care Services	2,000	1,693
Programme and IT Costs	195	225
Improved Better Care Fund (iBCF)	7,476	0
Additional Schemes approved in year	310	1,361
Total expenditure	42,400	35,108
Net surplus arising from the pooled budget during the year	**0**	**1**

Any surplus is shared equally by both parties.

Whilst the section 75 agreement between the parties does constitute a 'joint operation' under IFRS 11, the substance of the commissioning transactions related to the Fund's spending plan indicates that each party is acting as a single entity. Therefore, each organisation accounts for its own transactions without recognising its interest in its share of total assets, liabilities, revenue and expenditure that relate to the whole Fund.

Better Care Fund expenditure reflected in the accounts of Bolton Clinical Commissioning Group was £29,068k (2016-17, £29,039k) and this is reported as part of programme expenditure against the appropriate subjective heading in Note 5.

16 Intra-government balances

	Current Receivables 2017-18 £000	Current Receivables 2016-17 £000	**Current Payables 2017-18 £000**	Current Payables 2016-17 £000
Balances with:				
Other Central Government bodies	0	8	0	30
Local Authorities	238	367	3,145	3,872
Balances with NHS bodies:				
NHS bodies outside the Departmental Group	0	64	0	0
NHS bodies within the NHS England Group	448	670	284	150
NHS Trusts and Foundation Trusts	965	1,213	4,874	2,797
Total of balances with NHS bodies:	**1,413**	1,947	**5,158**	2,947
Public corporations and trading funds	0	0	0	0
Bodies external to Government	1,363	312	17,618	17,561
Total balances at 31 March 2018	**3,014**	2,634	**25,921**	24,410

17 Related Party Transactions

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

- NHS England (including commissioning support units);
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Bolton Council.

Governing body members and staff are required to declare any interest and related party in other organisations that seek to undertake business with the clinical commissioning group. The register of these interests can be found on the clinical commissioning group's website http://www.boltonccg.nhs.uk/about-us/declarations-of-interest.

Details of the transactions with these declared related party interests are detailed in the table below. Payments to the GP practices in which governing body members have an interest are in respect of the Bolton Quality Contract and contractual GP payments under the delegated commissioning arrangements for primary care.

Material Transactions with entities for which the Department of Health is regarded as the parent department	2017-18 Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Bolton NHS Foundation Trust	207,739	205	2,135	962
Manchester University Foundation Trust	4,388	0	689	0
Central Manchester NHS Foundation Trust	3,610	0	0	0
GM Mental Health NHS Foundation Trust	25,824	3	209	0
North West Ambulance Service NHS Trust	9,913	0	0	118
Salford Royal NHS Foundation Trust	13,373	0	23	0
Wrightington, Wigan & Leigh NHS Foundation Trust	6,646	0	2	0
Total	271,493	208	3,058	1,080
Other Government Departments				
Bolton Council	27,937	1,614	4	238

Governing Body Member	Related Party	Nature of Relationship	£'000	£'000	£'000	£'000
Dr W Bhatiani	Dr Nagle & Partners	Partner	2,411	0	0	0
Dr S Liversedge	Dr Liversedge, McCurdie & Wong	Partner	664	0	0	0
Dr B Silvert	Dr Silvert & Partners	Partner	1,822	0	0	0
Dr Shri Kant	Spring View Medical Centre	Partner	639	0	0	0
Dr C Hendy	Dr C Hendy & Partners	Partner	536	0	0	0
Dr J Bradford	Dr Coleman & Partners	Partner	1,664	0	0	0
Dr D Mistry	Heaton Medical Centre	Partner	1,323	0	0	0
Total			9,059	0	0	0
Staff Member						
Dr B Hunt	Bolton Hospice	Trustee	1,300	0	0	0
Dr L Natha	Kearsley Medical Centre	Partner	283	0	0	0
Dr A Lyon	Dr Lyon & Partners	Partner	780	0	0	0
Dr J Tabor	Dr Tabor & Partners	Partner	1,919	0	0	0
Dr S McLoughlin	Dr Wall & Partners	Partner	1,182	0	0	0
Dr E Saunders	Dunstan Partnership	Salaried GP	1,502	0	0	0
Dr S Pillon	Dunstan Partnership	Salaried GP				
Dr S Kiely	Garnet Fold Practice	Salaried GP	835	0	0	0
Dr N Ratnarajah	Dr Nagle & Partners	Partner	2,411	0	0	0
Dr H Wall	Dr Kirby & Partners	Partner	953	0	0	0
Total			11,165	0	0	0

Material Transactions with entities for which the Department of Health is regarded as the parent department	2016-17 Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Bolton NHS Foundation Trust	197,292	1791	14	253
Central Manchester NHS Foundation Trust	6,968	0	52	0
GMW Mental Health NHS Foundation Trust	24,269	10	0	0
North West Ambulance Service NHS Trust	9,472	0	0	0
Salford Royal NHS Foundation Trust	10,860	0	0	0
Wrightington, Wigan & Leigh NHS Foundation Trust	6,044	0	0	0
Total	254,905	1,801	66	253

Other Government Departments				
Bolton Council	30,073	1,680	1,534	0

Governing Body Member	Related Party	Nature of Relationship	£'000	£'000	£'000	£'000
Dr W Bhatiani	Dr Nagle & Partners	Partner	2,309	0	0	0
Dr S Liversedge	Dr Liversedge, McCurdie & Wong	Partner	621	0	0	0
Dr B Silvert	Dr Silvert & Partners	Partner	1,754	0	0	0
Dr C Mercer	Dr Fletcher & Partners	Partner	1,091	0	0	0
Dr Shri Kant	Spring View Medical Centre	Partner	619	0	0	0
Dr C Hendy	Dr C Hendy & Partners	Partner	508	0	0	0
Dr J Bradford	Dr Coleman & Partners	Partner	1,613	0	0	0
Total			8,515	0	0	0
Staff member						
Dr B Hunt	Bolton Hospice	Trustee	1,301	0	0	0
Dr L Natha	Dr Wall & Partners	Partner	292	0	0	0
Dr A Lyon	Dr Lyon & Partners	Partner	836	0	0	0
Dr Tabor	Dr Tabor & Partners	Partner	1,816	0	0	0
Total			4,245	0	0	0

18 Events after the Reporting Period

There were no events after the reporting period.

19 Losses & Special Payments

The clinical commissioning group had no losses (2016-17, nil) and made no special payments during 2017-18 (2016-17, 1 at £10k).

20 Financial Performance Duties

Clinical commissioning groups have a number of financial duties under the National Health Service Act 2006 (as amended).

The clinical commissioning group's performance against those duties was as follows:

	2017-18 Target £'000	**2017-18 Performance £'000**	**2017-18 Duty Achieved? Y/N**	2016-17 Target £'000	2016-17 Performance £'000	2016-17 Duty Achieved? Y/N
Expenditure not to exceed income	459,808	457,273	Y	445,968	437,710	Y
Capital resource use does not exceed the amount specified in Directions	0	0	Y	0	0	Y
Revenue resource use does not exceed the amount specified in Directions	458,905	456,370	Y	444,431	436,173	Y
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Y	0	0	Y
Revenue resource use does not exceed the amount specified in Directions	0	0	Y	0	0	Y
Revenue administration resource use does not exceed the amount specified in Directions	6,366	5,285	Y	6,337	5,864	Y

In accordance with these financial duties, the clinical commissioning group was allocated £458,905k (2016-17, £444,431k) with a target in year surplus of £60k (2016-17 £3,982k). As a result of an amended calculation methodology from NHS England,

the 2017/18 in year revenue allocation has been calculated on the basis of the total allocation, adjusted for the historic financial outturn of the CCG. In 2016/17 the figure was recorded as just the total in year allocation notified to the CCG.

In addition, the clinical commissioning group was required by NHS England to release a non-recurrent reserve of 0.5% (2016-17, 1%) equalling £1,989k (2016-17, £4,276) and the Category M drugs price reductions of £486k, which was previously being held by NHS England, increasing the surplus to £2,535k.

The clinical commissioning group is also required to keep administration costs below £6,366k (2016-17, £6,337k).

From 2017-18 NHS England changed the basis of measuring financial performance duties from a cumulative basis to an in-year basis.

The clinical commissioning group's achievement of these duties is as follows:

	2017-18 £'000	2016-17 £'000
Total allocation	467,163	444,431
Less historic surplus	8,258	3,850
In year allocation	458,905	440,581
Total net expenditure	456,370	436,173
In year surplus	**2,535**	**4,408**
Historic surplus as at 31st March	10,793	8,258
of which:		
Administration allowance (running costs)	6,366	6,337
Net expenditure on administration	5,285	5,864
Surplus	1,081	473
Registered Population (£000)	308	304
Net expenditure on administration	5,285	5,864
Administration expenditure per head of registered population	£17.15	£19.28