NHS Tameside and Glossop Clinical Commissioning Group

Annual Report 2018/19

Contents

Chair's Welcome

Writing the welcome to this year's Annual Report is especially poignant for me as it marks the end of my tenure from April as Chair. While saying a few good byes I have reflected on the progress we have made over recent years – the scale of our achievements, the pace of our change – and where future years might take us.

When I first came to my practice in Gamesley – which at the time was facing closure – I spoke with the local community to understand what they wanted from their local GP. That first experience of assessing need turned into my on-going interest in commissioning. Since then I've seen many organisational forms including Health Authorities, Fundholding, Primary Care Trusts, Clinical Commissioning Groups (CCG) and currently the Strategic Commission – in my opinion the best.

When we were a Primary Care Trust we talked about bringing GPs, lay members and councillors together to make integrated funding decisions, then as a CCG we delivered it, and are now an exemplar regionally and nationally – our arrangements being a prototype for the Greater Manchester Joint Commissioning Board. Our Accountable Officer – Steven Pleasant – co-chaired that Board through 2018, and I have had the privilege to chair both Greater Manchester's Primary Care Clinical Standards and Primary Care Strategy groups.

Despite the financial austerity, we, – like other public services – have faced, we have continued to prioritise population health. Our pooled resources and innovative risk share approach means we can move money round to support organisations make savings around areas like prescribing and free up investment for preventative care.

Tameside & Glossop is amongst the highest in Greater Manchester for investment per registered patient in primary care. Our commitment to supporting primary care is evidenced through excellent outcomes. All but one of our practices is rated either good or outstanding. One of our practices featured in the top ten in Greater Manchester in the National Patient Survey and we have an Enhanced Training Practice Hub for Greater Manchester.

2018 was also a year of celebrations for the 70th birthday of the NHS in May and golden anniversaries for Donneybrook and Clarendon Medical Centres, Hyde.

We continue to be rated good overall in the annual IAF assessment of all CCGs including the green rating for quality of leadership.

Our Governing Body refreshed how it worked last year and re-organised itself across the life course so we now have Governing Body GPs for the Starting Well, Ageing Well and Living Well. We also introduced a new innovative position of post-CCT GP.

2019 will see the roll out of community based mental health services following a decision back in November by the Strategic Commissioning Board to commit an additional £1 million to mental health services. We were selected by the Innovation Unit to join the Living Well UK programme, and will deliver our growth in mental health support through the five neighbourhood teams.

In the last year we made important decisions following extensive consultation in two key areas – Intermediate and Urgent Care. We are now closing the loop from consultation, through decision to delivery. The new approach to intermediate care was implemented in 2018. One part of the Urgent Care plan – the Primary Care Access Service (PCAS) – was delivered in early 2019. And the second part – the Urgent Treatment Centre – came on-stream in April. We have delivered on our commitment to provide additional access to primary care appointments through the PCAS, and we have seen increased utilization of the Glossopdale Primary Care Center.

Our innovative work – under the Care Together umbrella – continues to receive positive exposure at both a local and national level having received recognition from both the HSJ Awards and MJ Awards.

Just as my time as Chair came to end we passed two major milestones. From the beginning of April the CCG, Tameside Council and many other organisations moved into the new Tameside One joint service centre in Ashton-Under-Lyne – a physical representation of our joined up working. At the same time, general practice configured into Primary Care Networks, meaning we are ideally placed to continue to focus firmly on care within the community and neighbourhood working.

While there is much to celebrate, there are also challenges ahead. We could easily slip back if we are too tentative and don't continue to transform. Personally, I would encourage more devolution of powers to Greater Manchester to free us up to make the changes we know are needed and will work for your communities. If I go right back to my first needs assessment when I came to the Gamesley practice the key thing I learnt then and have understood since is that the best ideas and plans come from local communities. More devolution – from Whitehall to Greater Manchester, from Greater Manchester to Tameside & Glossop, but most importantly to our neighbourhoods, services and practices – is the way forward.

I hope you enjoy reading the CCG's journey over the last 12 months and, more importantly, I hope you are already seeing some of these changes taking place.

I wish you all the very best and as my old Surgical Professor at medical school used to say, sometimes you have to be "bloody, bold and resolute" and great things will follow.

Dr Alan Dow
(Chair NHS Tameside and Glossop and Strategic Commissioning Board)

Our Vision and Principles

Vision

Your Clinical Commissioning Group (CCG) is led by local GPs. By inspiring all NHS colleagues, and through close working with partners, we will ensure the development of excellent, compassionate, and cost-effective care leading to longer, healthier lives.

Principles

1. We agree that an integrated system of health and social care is the best way to ensure optimum health and care outcomes for our population whilst ensuring collective financial sustainability.

2. We will, at all times, consider and promote ways of working that release the most benefit to the population we serve rather than protect the interest of any one organisation.

3. We will work together to identify opportunities to integrate further services and develop collaborative arrangements with other providers and commissioners to benefit the people of Tameside and Glossop.

4. We are committed to prevention, of early intervention, and of people being treated within the most appropriate setting (ideally their homes or in the community where it is clinically appropriate to do so).

5. We remain committed to the direction of the Contingency Planning Team's final report of 28 July 2015. This includes the prospective transfer of Adults Social Care, closer alignments IIM & physical health teams and support for primary care.

6. We agree that the ICFT continues to represent the best legal delivery vehicle for the integrated care system subject to an amended Foundation Trust licence and constitution to enable a new legal entity of an Integrated Care Foundation Trust. Such an organisation will be appropriately representative of all stakeholders including primary care and the voluntary sector, which will be reflected in its constitution.

7. Will uphold a robust governance structure that ensures representation, involvement, and transparency between all parties involved in the provision of effective and efficient health and social care services. This will include representation from other local councils, NHS Organisations, regulators, voluntary, charities, and faith providers. This governance will be focussed on the Care Together Programme Board with consistent outward reporting and liaison to all other relevant boards to ensure inclusion.

8. We will uphold a robust governance structure that ensures representation, involvement, and transparency between all parties involved in the provision of effective and efficient health and social care services. This will include representation from Pennine Care, other local councils, other NHS Organisations, regulators, voluntary, charities, and faith providers. This governance will be focussed on the Care Together Programme Board with consistent outward reporting and liaison to all other relevant boards to ensure inclusion.

9. We acknowledge that integrating health and social care will not resolve the significant budget challenges facing us all but it goes someway to reducing these. We are committed to continuing to work closely together to address the Locality deficit as far as possible and we will involve other stakeholders in this.

10. We agree that the economy budget deficit is our joint responsibility regardless of where the deficit may lie. Our priority is that we work collaboratively to reduce the total health and social care deficit rather than focus on the financial position of any one of our organisations.

11. We agree that the Tameside and Glossop updated Locality Plan, as approved by the Tameside Health and Wellbeing Board in October 2015 and by Derbyshire County Council Health and Wellbeing Board in April 2016, outlines how we will work together to drive up the health and social care outcomes and eliminate health inequalities for our population. We agree the successful delivery of a new integrated health and social care model is a key component of this plan.

12. We agree that strong and effective Integrated Neighbourhoods, encompassing the wider public sector, are central to delivery and achievement of improved Healthy Life Expectancy and will be a priority focus over the coming year. We will work as an economy to support the emerging, innovative model of care to deliver improved quality of Tameside and Glossop Provision.

13. We will work together to support the creation of a wider Public Service Reform Board to strengthen integrated neighbourhood working.

14. We will work together to help shape the future GM Operating Model.

15. We agree that the governance arrangements will be kept under regular review and be revised from time to time.

Performance Report

Steven Pleasant
(Accountable Officer)

22 May 2019

Performance Overview

This section of our annual report is intended to provide you with an overview of the CCG's performance over 2018/19. It covers both operational performance (including the targets set out in the NHS Constitution) as well as our financial performance.

Background

The CCG is responsible for the commissioning of primary care services, secondary care (hospital) services, community health services, and mental health services for the population of Tameside and Glossop. The CCG received £402.49m from the Department of Health via NHS England during 2018/19 to do this.

The CCG formed a Strategic Commission with Tameside Metropolitan Borough Council and these two organisations have pooled a proportion of their funds to form an integrated commissioning fund. By pooling our resources (both our finances and our staff) we believe that we will be able to make better commissioning decisions by removing any duplication from the two organisations' contracting arrangements and by doing so we will also have more resources available to commission the services that our population needs. It also ensures that our provider organisations (such as Tameside and Glossop Integrated Care NHS Foundation Trust and Pennine Care NHS Foundation Trust) have clarity by receiving a single set of commissioning intentions. In summer 2017 the Strategic Commission introduced a Single Leadership Team to support this alignment of commissioning intentions.

We are committed to improving the health and care outcomes of the people of Tameside and Glossop. We believe that the Strategic Commission is the best way of developing and procuring the services that our population tells us they require. We are continuing supporting our colleagues at Tameside and Glossop Integrated Care NHS Foundation Trust (the ICFT) to become an Integrated Care Organisation which will facilitate the delivery of smooth pathways of care. We believe that this is the best vehicle for bringing together community services, acute services, social care services, and Primary Care provision within a 'neighbourhood hub' model of delivery to help people access care as close to their home as is appropriate.

We are aware of a number of risks and issues to the delivery of our plans:

- health and care services are currently under a great deal of pressure as the demand for services increases. We are committed to maximising the patient outcomes we can commission from our financial allocation
- the three locality partner organisations (the CCG, the local authority, and the ICFT) are each subject to different regulatory regimes. We are working closely with regulators to help them to understand our ambitions for the population of Tameside and Glossop with the aim of helping to influence the development of regulation that works at the locality level rather than at the organisational level
- we are working with our partner organisations to deliver safe and effective solutions for data sharing between different organisations with the aim of being able to deliver seamless services and to prevent people having to repeat their personal situations to a number of different professionals.

Statement of the Accountable Officer

I am pleased once again to be writing my Statement for the CCG's Annual Report.

This has been another eventful year for the CCG and one where the structure and work of our strategic commission has embedded and the work of the system develops further at scale and pace. All the signs show that our system is working well .

During 2018/19 the Strategic Commission have continued to work closely with colleagues at Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) and member practices. Great work has been achieved within the five neighbourhoods which are highlighted within this annual report. We have also continued to strengthen our Single Leadership Team with the permanent appointments Director of Population Health, Director of Children's and a Director of Growth. The team continue to work with the shared vision to improve the health outcomes and life opportunities for the people of Tameside and Glossop.

I'm pleased to also report that this year we have for the first time, developed and approved a joint Corporate Plan for the Council and the CCG (the Strategic Commission). It outlines our aims and aspirations for Tameside and Glossop and its people, and how we commit to work 'For everyone, every day'. The plan spans across the life course (from birth through to death), what we are trying to achieve for our people and our communities – underpinned by ensuring Tameside and Glossop is a great place with a vibrant economy. The plan is also underpinned by a set of principles, which sets out the way we will work together to achieve our aims and aspirations. We are not starting from a blank sheet; there is so much excellent work we are doing already from which to build. Our challenge for the coming year will be to work across our organisations and with our partners building from where are to bring these ambitions to life. Here's our corporate plan principles:

- A new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An asset based approach that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits.
- Behaviour change in our communities that builds independence and supports residents to be in control
- A place based approach that redefines services and places individuals, families, communities at the heart
- A stronger prioritisation of well being, prevention and early intervention
- An evidence led understanding of risk and impact to ensure the right intervention at the right time
- An approach that supports the development of new investment and resourcing models, enabling collaboration with a wide range of organisations.

Delivering

Bringing people together is important and the 30 January 2019 gave us the opportunity to do just that when we help our inaugural Neighbourhood Summit whereby over 150 people came together to share how services are being transformed in Tameside and Glossop. The summit celebrated our ground-breaking partnership work, and gave inspiration for further developments as we lead the drive for public services and community and voluntary groups to work closer together – putting people at the heart of what we do, rather than process and systems.
It has also been good to see systems come together, taking part in the NESTA 100 day challenge which looked to improve the way in how neighbourhoods support people. Empowering our front line to bring about system change and improvement based on real life experiences of those communities they support on a daily basis was a fundamental element of this work.

We have had another year of strong performance against the NHS Constitution indicators including:

- The vast majority of Tameside and Glossop residents waited 18 weeks or less from referral to treatment (with our main provider, the ICFT, achieving the target of 92% for the year)
- Patient waits for diagnostic tests (the ICFT has achieved the standard of no more than 1% of patients having to wait longer than six weeks)
- The majority of our patients were assessed within two weeks of an urgent referral for cancer
- We met all of our statutory financial targets.

There are some areas of performance that have been more challenging during the last year including:

- 4 hour waits at the ICFT's Emergency Department. We are seeing that many of the people attending the Emergency Department have more complex health needs than was previously the case.
- The number of Tameside and Glossop residents waiting over 52 weeks to start their treatment has increased. The ICFT continue to ensure no one waits longer than 52 weeks however a number of people waiting over 52 weeks were identified by another GM Foundation Trust when they reviewed their patient administration systems. As the year progressed these patients have been treated.

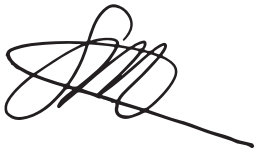
I would also like to extend my thanks to the staff of the Strategic Commission for their focus and delivery during what has been another challenging year for the public sector.

As I look ahead into 2018/19 we will work towards developing the place based Primary Care Networks in Tameside and Glossop. The footprint of our established Neighbourhoods is our ambition for Primary Care Networks in Tameside and Glossop. This is due to the significant and extensive work to build community health, social care, children's integrated teams, social prescribing, community, safety partnerships amongst others, around our place with general practice at the heart. There have been many successes to date by these Neighbourhoods and established collaboration across those footprints.

We are also looking to develop the Mental Health Model (Living Life Well) within Neighbourhoods and the Integrated Children's Model.

My summary of 2018/19 is that the CCG has had a further year of strong performance and has met its statutory financial targets. On this basis it is my assertion that NHS Tameside and Glossop Clinical Commissioning Group continues to be is a going concern.

There is additional information on the CCG's management of risk within the Annual Governance Statement which follows later in this Annual Report.



Steven Pleasant
(Accountable Officer)

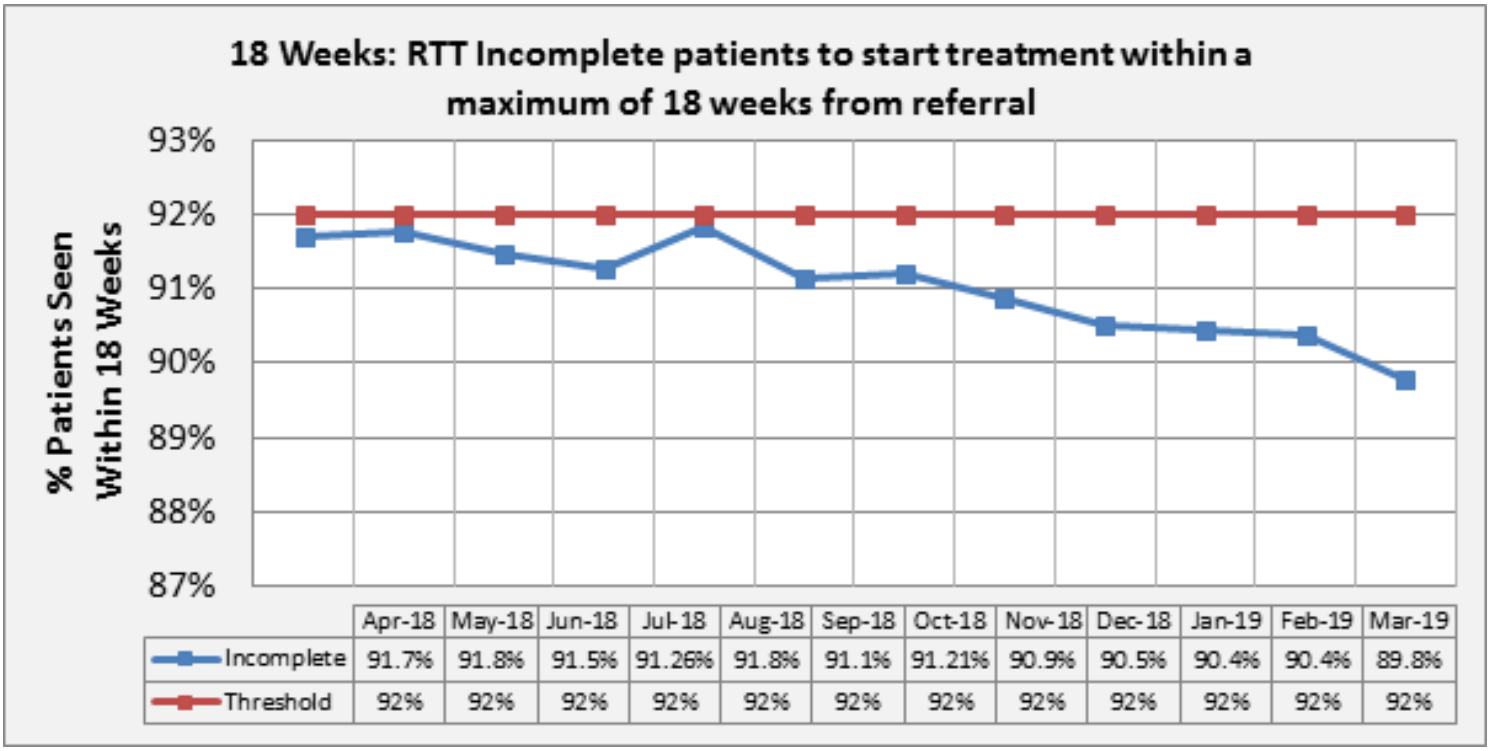
22 May 2019

Performance Analysis

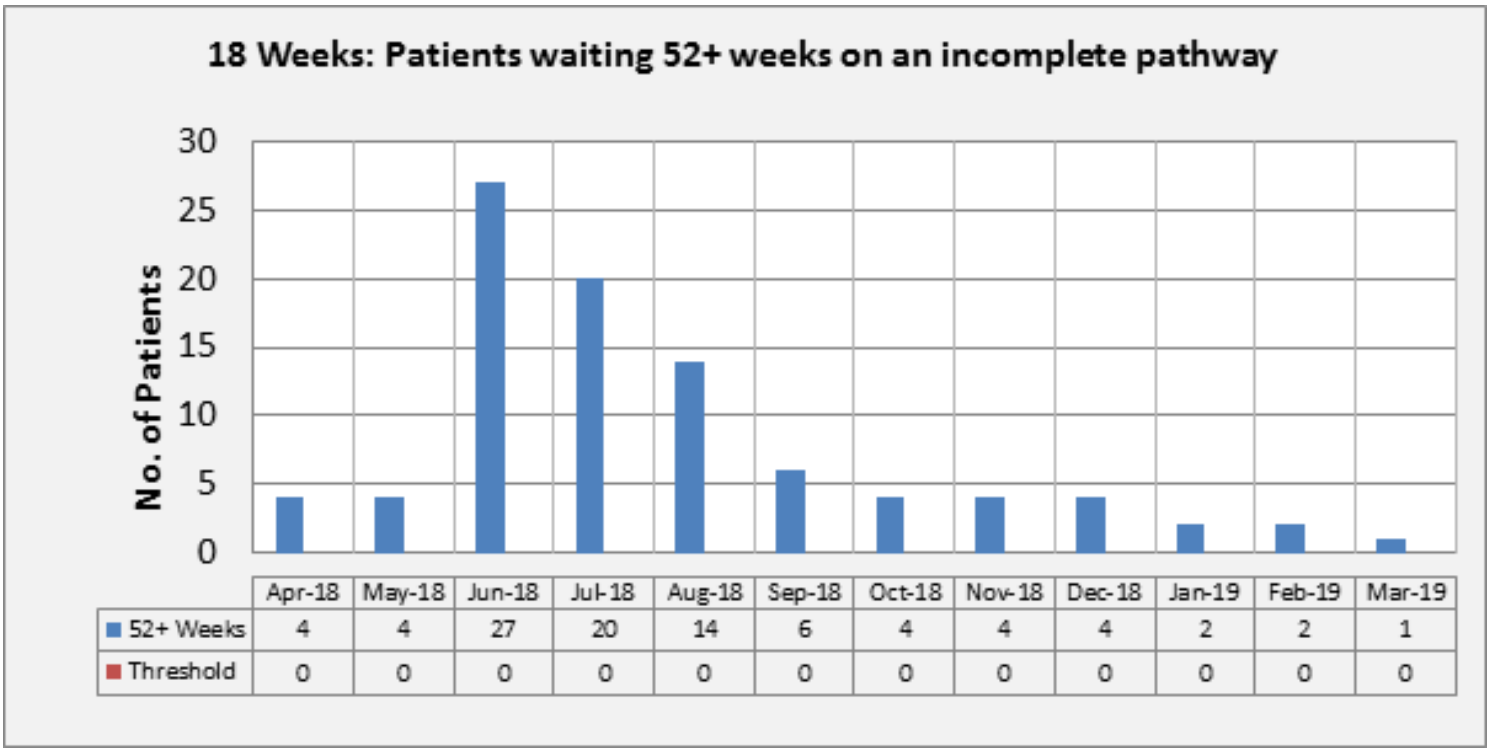
Are patients able to access healthcare treatment?

The majority of our patients wait less than 18 weeks to access healthcare treatment. The percentage of patients still waiting to start treatment during 2018/19 has mainly been just below 92% for Incomplete Patients which is the main Constitutional standard. The number of people waiting over 52 weeks has deteriorated throughout 2018/19 due to a significant issue with one of our Greater Manchester providers. It is expected that in 2019/20 we will be able to sustain performance by working closely with our local providers and others across Greater Manchester.

Ensuring diagnostic tests take place quickly is essential to delivering the 18 week commitment.

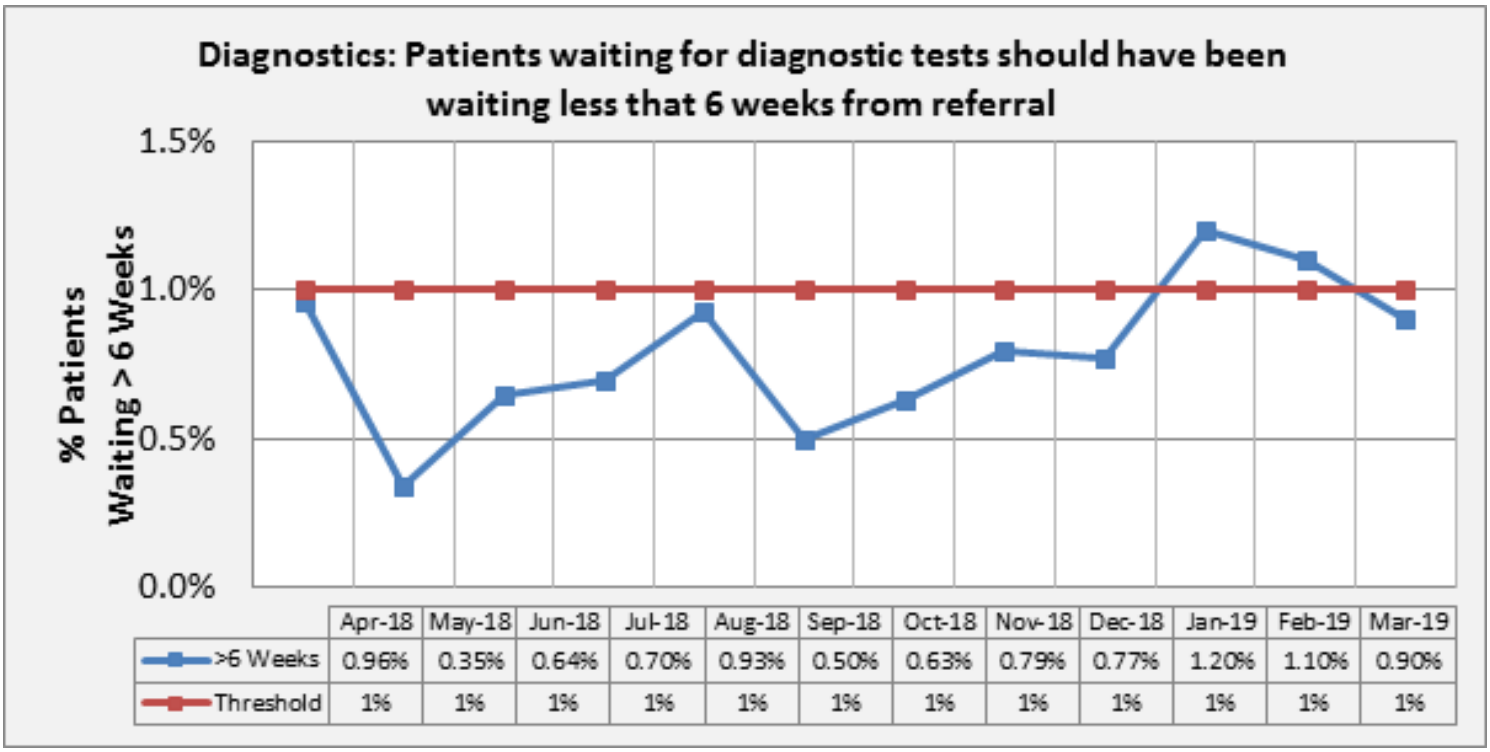


	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Incomplete	91.7%	91.8%	91.5%	91.26%	91.8%	91.1%	91.21%	90.9%	90.5%	90.4%	90.4%	89.8%
Threshold	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
52+ Weeks	4	4	27	20	14	6	4	4	4	2	2	1
Threshold	0	0	0	0	0	0	0	0	0	0	0	0

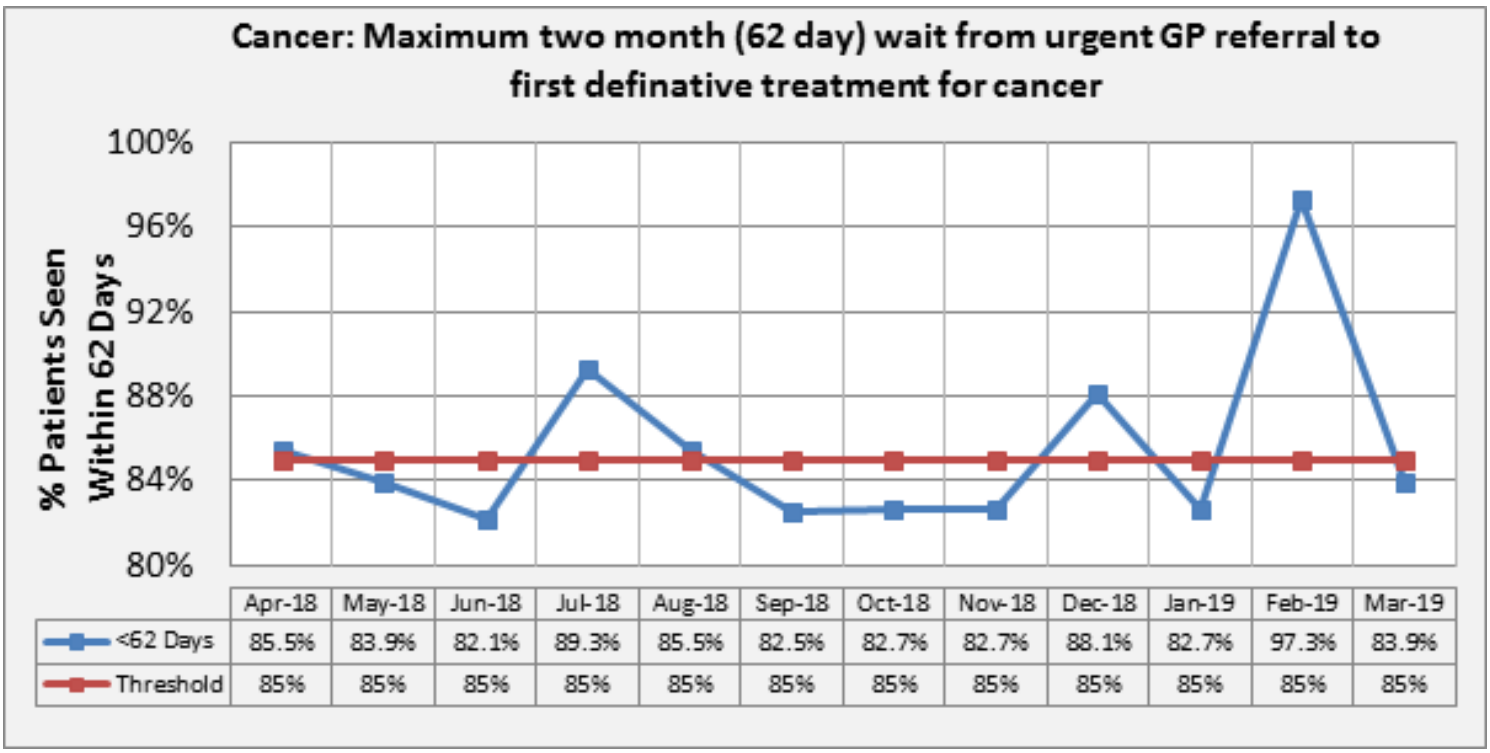
Performance Analysis



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
>6 Weeks	0.96%	0.35%	0.64%	0.70%	0.93%	0.50%	0.63%	0.79%	0.77%	1.20%	1.10%	0.90%
Threshold	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%

Are patients able to access treatment for cancer quickly (within 62 days of an urgent referral)?

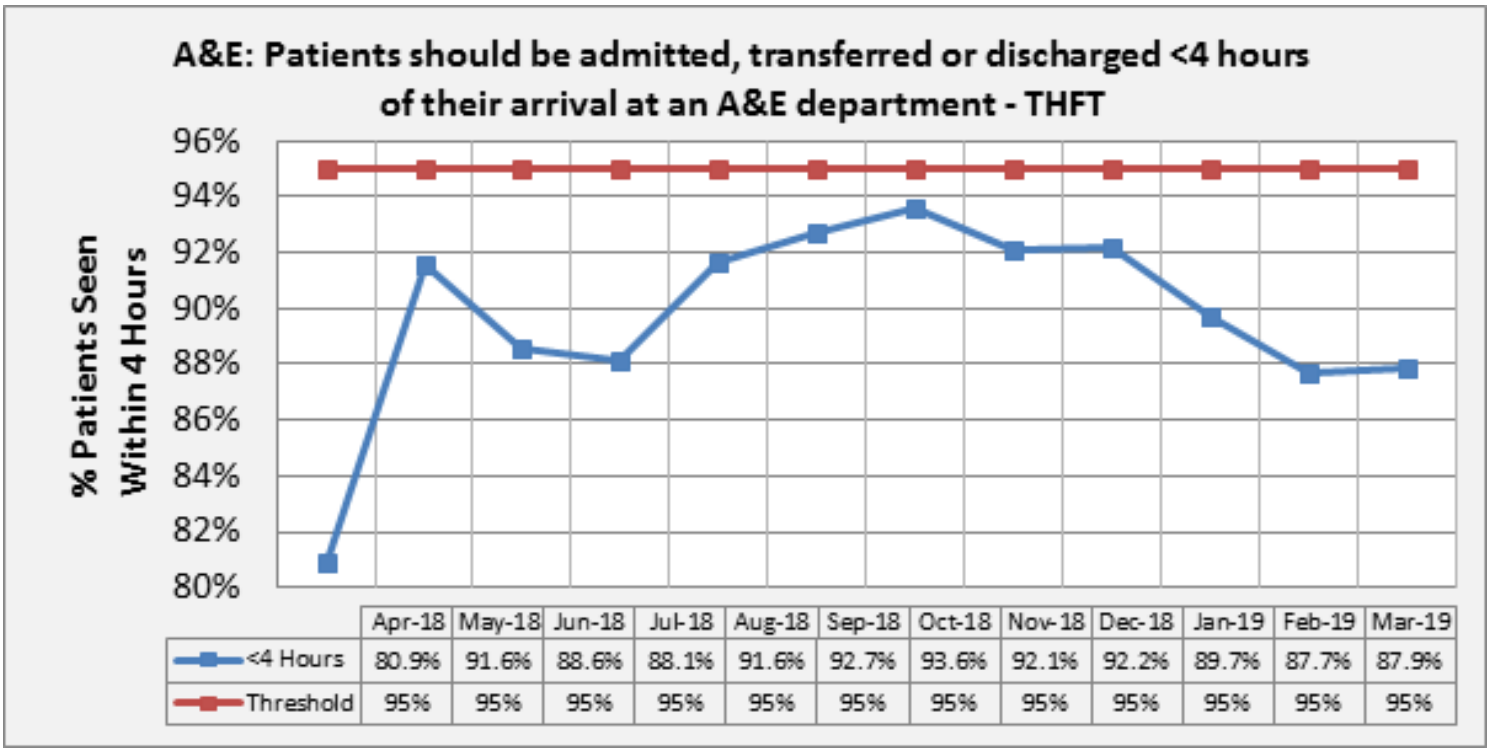
The majority of patients were assessed within two weeks of a referral and receive their first definitive treatment for cancer within 62 days of an urgent referral. We are working to improve this performance even further and would like to encourage patients not to cancel or rearrange their appointments when offered within two weeks. We saw an unusual hike in performance during February, this was due to lower numbers presenting, shorter month and less breaches.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<62 Days	85.5%	83.9%	82.1%	89.3%	85.5%	82.5%	82.7%	82.7%	88.1%	82.7%	97.3%	83.9%
Threshold	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Are patients treated quickly when accessing emergency care (are they are admitted, transferred or discharged from A&E within four hours)?

In 2018/19 87,116 people were seen in A&E, an increase of 633 from 2017/18. There was a rise of 1,151 people who were admitted as an emergency in 2018/19 which represents an increase of 5.5% from 2017/18. Our 2018/19 performance has consistently been the best in GM and in the upper quartile nationally.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
<4 Hours	80.9%	91.6%	88.6%	88.1%	91.6%	92.7%	93.6%	92.1%	92.2%	89.7%	87.7%	87.9%
Threshold	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Healthcare-Acquired Infections (HCAI)

National targets are set for Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-Diff) to achieve year-on-year reductions in HCAIs. In recent years Tameside and Glossop health and social care organisations have worked closely to reduce the number of people who acquire preventable HCAIs. We have done this by developing an integrated approach to improving quality in infection prevention practice and antibiotic stewardship with the aim of reducing the incidence of HCAIs.

The CCG has worked with Derbyshire County Council to secure appropriate resources to ensure the infection prevention service is delivered consistently across Tameside and Glossop and that appropriate provision is in place to ensure all cases are investigated, lessons learnt identified, and prevention work is acted upon.

In 2018/19 the CCG reported 70 cases of C-Diff against an annual plan of no more than 96 cases;

- In an acute setting there were 26 cases against a plan of 45 (18 were at T&G ICFT)
- In a non-acute setting there 44 against a plan of 51.

In 2018/19 the CCG reported 11 MRSA bacteraemia cases against an annual plan of no more than zero cases.

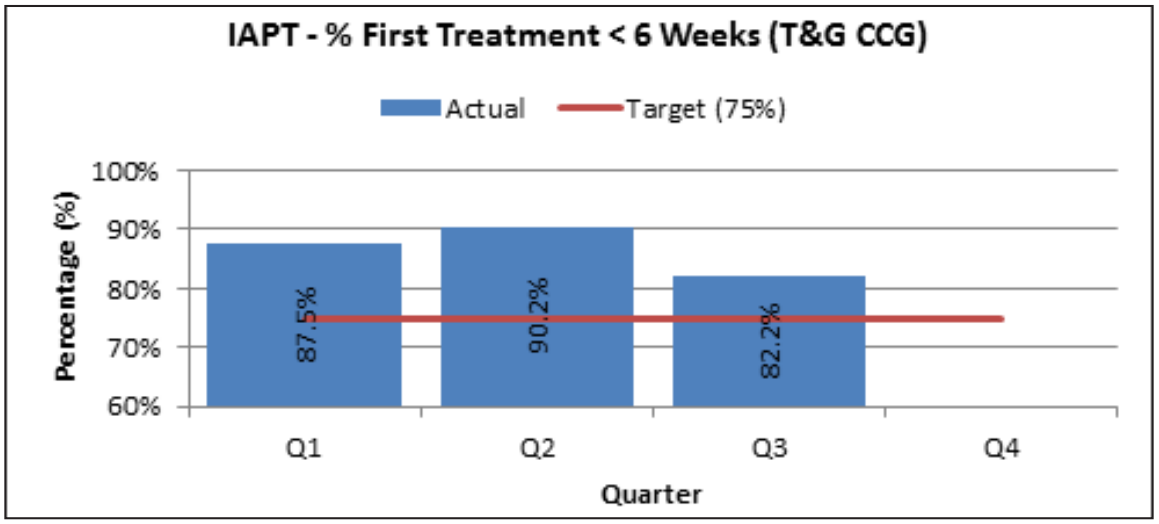
- 6 in the community
- 5 at T&G ICFT

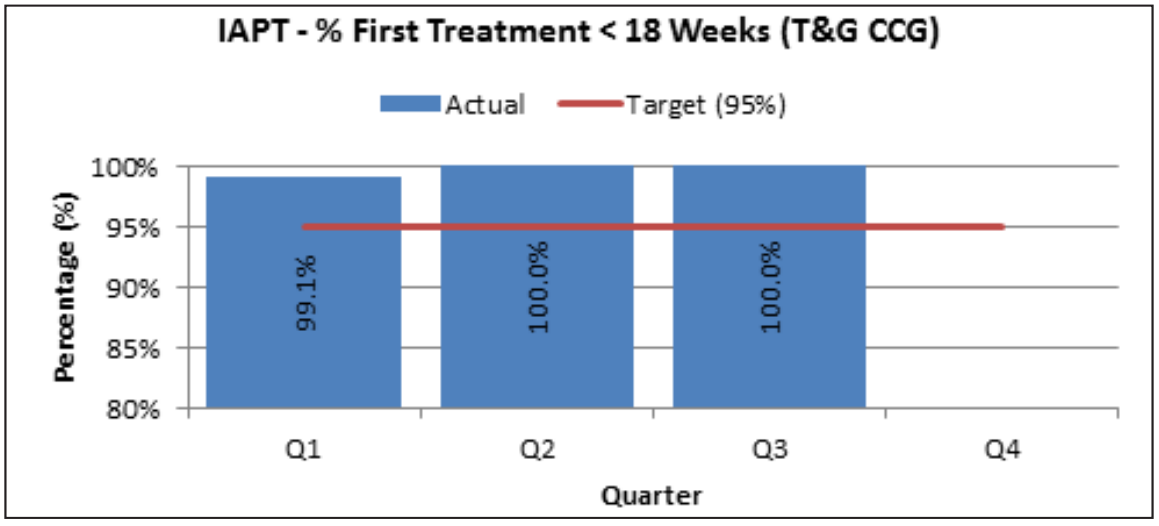
We will continue to strive for zero cases of MRSA and all cases are reviewed to identify how and why they occurred to ensure all learning informs future prevention.

Are people able to access support for their mental health quickly?

The local Healthy Minds service has been working hard to achieve the national Improving Access to Psychological Therapies (IAPT) targets.

More people are benefiting from access to the service and people's waiting time for psychological therapy has been reduced. By Quarter Three in 2018/9 82.2% of people were receiving a service within six weeks of referral (against the target of 75%) and 100% of people received a service within 18 weeks of referral (against a target of 95%).





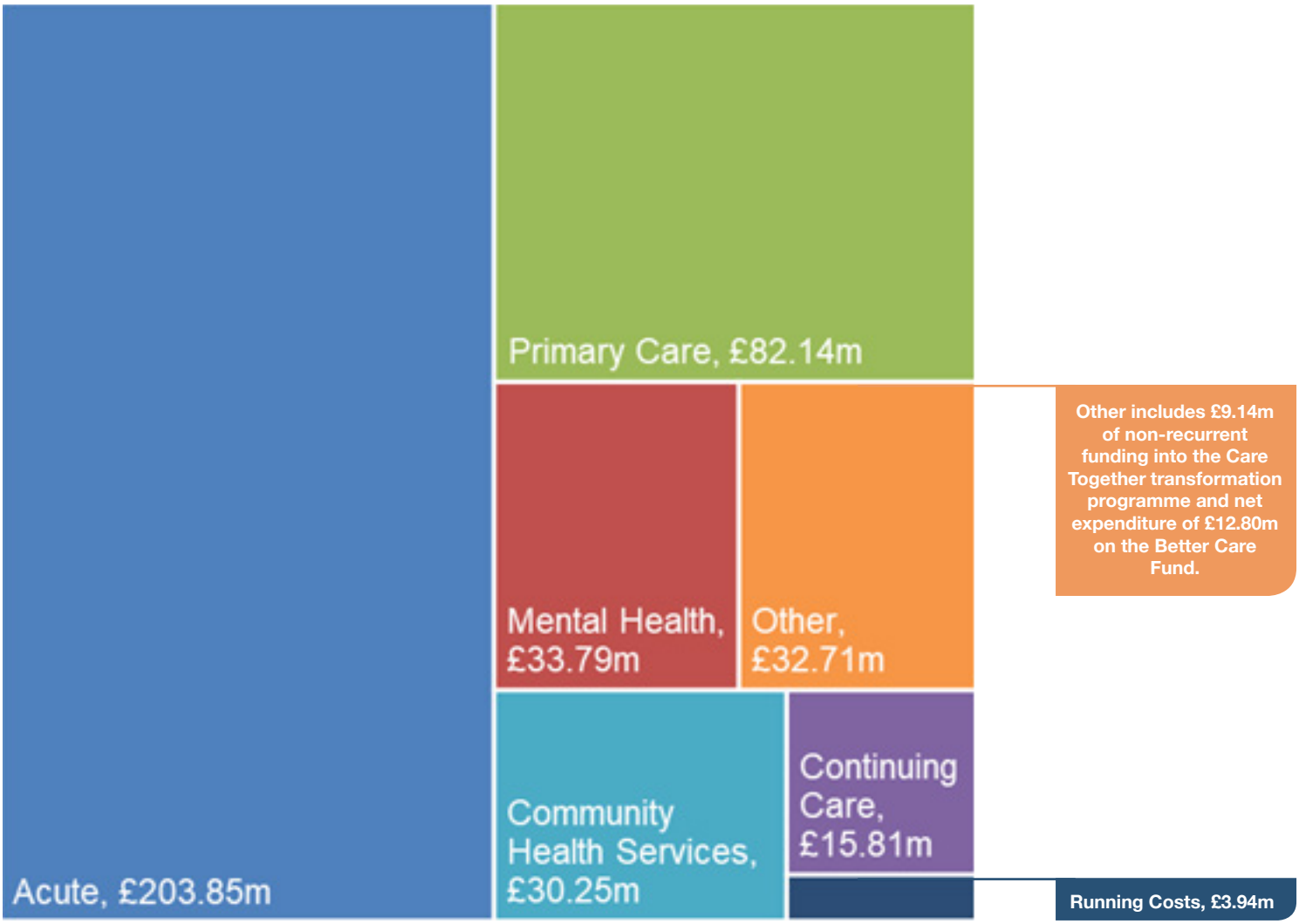
Performance Analysis

Financial

Tameside & Glossop CCG received an allocation of £402.49m in 2018-19 (up from £389.38m 2017-18).

The chart below provides a summary of how this money was spent:

Breakdown of £402.49m expenditure in 2018/19



A full set of audited financial statements are included within this report. These provide a comprehensive account of the CCG's financial position and performance in 2018-19.

The accounts confirm that the CCG met all of its statutory financial duties for the year; key highlights include:

- Managed within revenue resource limit of £402.49m, achieving operational financial balance.
- Delivered cumulative revenue surplus of £12.35m, in line with plan (up from £9.35m in 2017-18). The CCG is planning to 'draw down' £6.00m of this cumulative surplus in 2020-21, to meet obligations within the Integrated Commissioning Fund and to invest non-recurrently in improved services for the people of Tameside and Glossop.
- Managed within cash limits.
- Achieved the running costs target. Spending £3.94m against an allocation of £5.21m, with savings re-directed to the delivery of front line services.
- Met and exceeded all Better Payment Practice Code (BPPC) targets.
- Delivered the Mental Health Investment Standard. Demonstrating increased investment in mental health services of 6.8%, against recurrent programme growth of just 2.8%.
- Fully achieved the Targeted Efficiency Plan (QIPP target) of £19.80m within the financial year.

Sustainable Development

We recognise our responsibilities as a public sector body under the sustainability agenda. In support to this the Strategic Commission held a Green Summit in November 2018. This Summit was a 'Call to Action' for organisations and individuals from across a range of partners – businesses, public services, schools and voluntary and community groups. The event included presentations from leading experts, debate on key topics and facilitated work streams and culminated in Summit delegates making environmental pledges for themselves and their organisations, to have a positive impact on the environment and climate change. Following the Summit the Strategic Commission has been proactively taking action on the pledges:

1. **We will reduce the energy demand from heating, cooling, hot water and appliances across our corporate estate through better management and installation of appropriate retrofit measures.**
   A number of building audits have been carried out to see where improvements can be made as well as obtaining and analysing fine grained building data to determine whether we can improve settings and make savings. Low energy LED lighting has been installed across a number of our key sites. The new Headquarters building – Tameside One - has had solar panels installed which will assist in partially powering the building.
2. **We will continue our programme of tree planting in Tameside by planting 3500 trees across our green spaces in 2018/19. We will continue our partnership with City of Trees and will encourage all new developments to include high quality tree planting.**
   We have planted 4615 trees across Tameside since November 2018, in total across Tameside we have now planted 13,000 trees over the last 3 years. We continue to explore the opportunities to plant more trees across the borough in the future.

The CCG is also working with the Council on further environmental issues and have set up a Refill scheme to reduce single use plastic bottle usage amongst staff and residents. Businesses are also encouraged to think about plastics they use.

New cycling and walking routes are being developed which will give residents and staff members a cleaner, greener and safer option to enable them to leave the car at home and be more active.

A number of staff 'squads' have also been established which aim to drive innovation and transformation across systems to improve services and delivery. One has been set up to work on environmental issues:

- Transport Squad – work to include how we can encourage staff to travel sustainably to work or between meetings / installation of electric vehicle charging points etc.
- Carbon Literacy – how we can encourage the whole workforce to think and act more sustainably through carbon literacy training.

Improve Quality

The quality of health and social care services is core to how the CCG commission and monitor services for the public. It is what matters most to people and what motivates and unites the workforce. NHS England and the public rightly expect those responsible for commissioning services to ensure that those services provide the highest standards of safe, effective, responsive care.

The health and social care economy continues to face the combined challenges of rising demand, increased cost, advancing science, changing expectations, and tough economic circumstances. It is core to the CCGs functioning that we meet these challenges whilst continuously improving quality and safety. It is essential for the sustainability of our health and social care economy. We continue to develop a health and social care economy focused on continual learning and improvement.

In Tameside and Glossop the Clinical Commissioning Group (CCG) and local authority have come together as a Strategic Commission combining commissioning teams and budgets. With this arrangement comes a commitment and responsibility for securing continued high quality services for our local population.

We have a single shared view of high-quality, person-centred care for all, now and into the future. We know that to provide high-quality care we need high performing providers and commissioners working together and in partnership with, and for, local people and communities, to provide services that are:

- **Well-led:** they are open and collaborate internally and externally and are committed to learning and improvement
- **Use resources sustainably:** they use their resources responsibly and efficiently, providing fair access to all according to need, and promote an open and fair culture
- **Equitable for all:** they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity, or marital or civil partnership status
- **Safe:** people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned
- **Effective:** people's care and treatment achieve good outcomes, promote a good quality of life, and are based on the best available evidence.

And that people have a positive experience of using services that are:

- **Caring:** staff involve and treat people with compassion, dignity, and respect
- **Responsive and person-centred:** services respond to people's needs and choices and enable them to be equal partners in their care.

Securing and improving quality cannot be achieved by the Strategic Commission in isolation. We recognise that our patients' journeys cut across primary, secondary, specialist, and social care with services commissioned and delivered by multiple organisations and professions both within and outside the NHS. We appreciate the commitment of our partners to working with us to improve quality. We will continue to support and collaborate with provider organisations to improve the quality of services, whilst holding them to account for the standards of their service delivery.

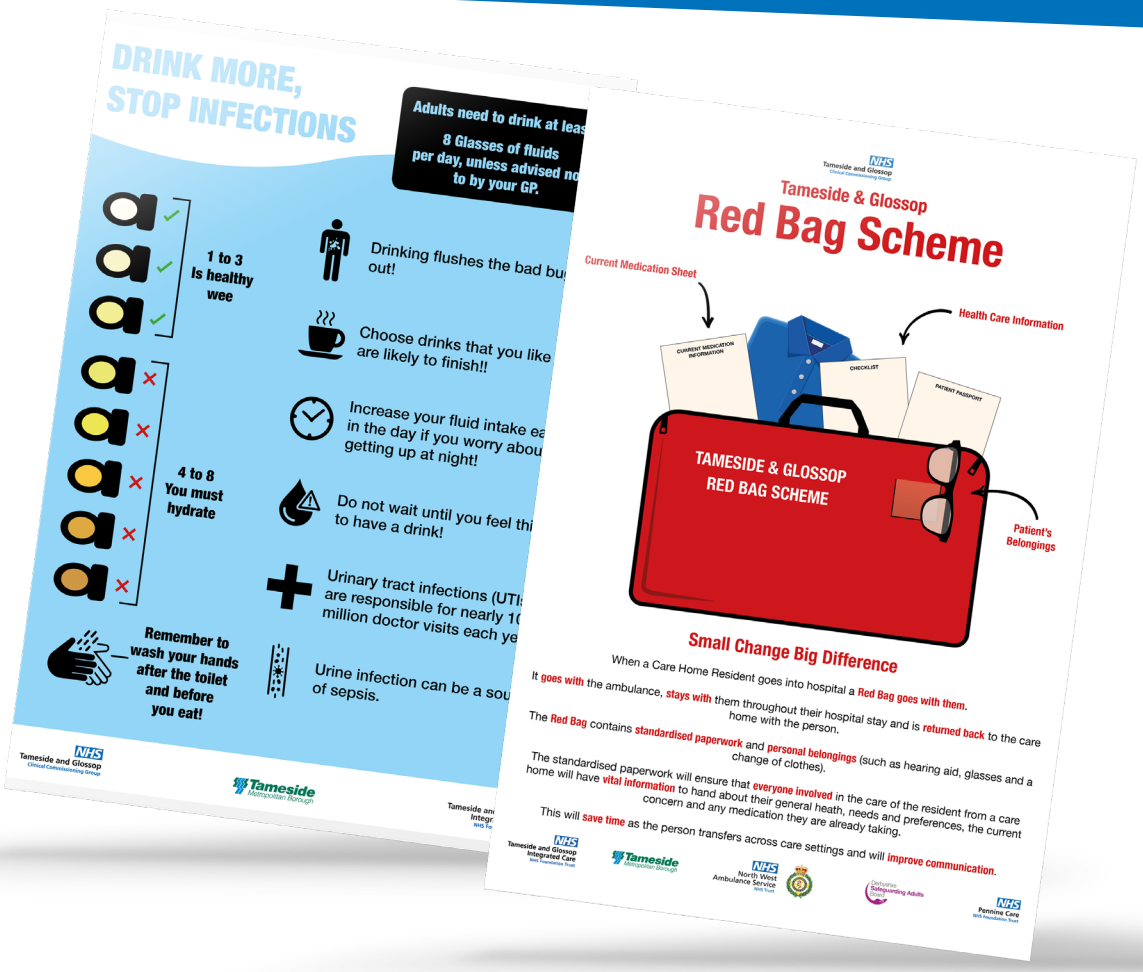
NHSE Quality Premium Scheme

The Quality Premium Scheme rewards Clinical Commissioning Groups (CCGs) for improvements in the quality of the services they commission. The scheme incentivises CCGs to improve patient health outcomes and reduce inequalities in health by improving access to services.

The 2018/19 scheme focused on a number of national and local quality areas; a health and care stakeholder group has worked across the locality to drive the delivery of the quality premium scheme.

- Cancers diagnosed at early stage
- Experience of making a GP appointment
- NHS Continuing Healthcare
- Mental Health: Equity of Access and outcomes in IAPT services
- Reducing gram negative blood stream infections across the whole health economy
- Reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care
- In addition the Strategic Commission had a local focus on increasing the numbers of people on the GP register for COPD.

CCGs are advised of their achievement in quarter 3 of the following financial year (therefore reported in Q3 2019/20).



Reducing gram negative bloodstream infections (GNBSIs)

Throughout 2018/19 a health and care stakeholder group has been working collaboratively to deliver the national ambition to achieve a 50% reduction in healthcare associated gram-negative bloodstream infections (GNBSIs) by March 2022.

National and local analysis indicates that 45 % of urinary tract infections are associated with a germ called E.coli when it gets into the bladder.

The group aim to reduce urinary tract infection in older people by improving a person's hydration and by encouraging and supporting people to wash their hands after going to the toilet. This ambition has been underpinned by a range of quality improvement initiatives including a hydration campaign aimed at older people, many of whom do not have health care involvement. The group achieved the expected 10% reduction in healthcare associated GNBSIs by March 2018.

The Red Bag Initiative

The Tameside & Glossop Red Bag Scheme is part of a National Drive to improve communication, safety and the persons experience as they transfer across care settings and has been implemented with effect from 19th September 2018.

A Red Bag is provided to all people who reside in a Care Home/Nursing Home when they need to be admitted to hospital. When a Care Home Resident goes into hospital the Red Bag goes with them throughout their journey.

Inside the Red Bag are personal belongings including a set of clothes and a Patient Passport with important information about the person and important documentation relevant to their care/clinical needs (Medication sheet, DNAR (original Copy) and Herbert Protocol etc.).

Reducing Health inequalities in people with Learning Disabilities

People with a learning disability have a right to good health, yet they still face many health inequalities, often resulting in worse health than the general population.

Our vision is for a future where health inequalities faced by people with learning disabilities is eliminated. These individuals will have access to the same quality of physical and mental healthcare as everybody else.

A health and care stakeholder group has been working collaboratively to deliver NHS England's ambition for 75% of people on GP Learning Disability Registers, from age 14 years, to have an Annual Health Check.

The group delivered a Greater Manchester 100 day challenge whereby a resource pack was developed for Primary Care services to support them to deliver good quality checks and health action plans.

Work will continue throughout 2019/20 to increase the number of people on the Learning Disability register and to increase the number of these over the age of 14 receiving a good quality health check and action plan with the aim to reduce health inequalities in this population.

Performance Analysis

Quality in Residential and Nursing Homes

A continuous improvement has been seen in CQC performance across Tameside and Glossop in the last year in residential and nursing homes. In February 2019, 73% of operational care and nursing homes in the locality were rated as “good” or “outstanding” this is an improvement of 18% since April 2018.

There is a strengthened support and improvement offer to care homes with assistance from the Quality Improvement Team, leadership and training support and specialist teams such as Infection Prevention & Control, Medicines Management, Safeguarding,Tissue Viability and End of Life.

The Quality Improvement Team

The Quality Improvement Team was established to support independent providers across the locality to improve the quality and safety of the services they provide. The team are working with providers using the Care Excellence/Provider Quality Improvement Programme (PQIP) that has been agreed as a GM model of choice.

The Team’s focus has been on working with the Residential and Nursing Home sector, with a particular focus on those homes rated “Inadequate or Requires Improvement” by the CQC. The ambition of the strategic commission , is that all homes will achieve good or outstanding ratings, therefore providing good quality care for the people who live in them.

Improving Leadership: Tameside and Glossop Buddy Scheme

The Buddy Scheme, launched November 2018, is a supportive arrangement between new and existing residential/nursing care home managers. The purpose of the scheme is to offer supervision and operational support to new managers who move into the Borough. The buddy scheme has assisted in ensuring we have effective, quality leadership to drive the continuous improvement journey.

Engaging people and communities in Tameside and Glossop

In 2018/19 NHS Tameside & Glossop Clinical Commissioning Group have:

- Facilitated over 30 thematic Tameside and/or Glossop engagement projects
- Received over 5,000 engagement contacts (excluding attendance at events / drop-ins)
- Delivered five Partnership Engagement Network (PEN) conferences attended by nearly 300 delegates
- Supported over 20 engagement projects at the Greater Manchester level
- Promoted over 30 national consultations where the topic was of relevance to and/or could have an impact on Tameside and/or Glossop
- Agreed and implemented a Tameside and Glossop Engagement Strategy (which was co-designed with the Partnership Engagement Network)
- Established the Partnership Engagement Network (PEN) family, a database of residents, patients and stakeholders who receive a monthly digest of all live engagement and consultation for them to access from one place.
- Undertook the first joint budget conversation exercise for NHS Tameside and Glossop Clinical Commissioning Group and Tameside Council
- Developed and implemented the first joint Equality Scheme of the Tameside and Glossop Strategic Commission (Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group) – One Equality Scheme.
- Achieved Green Star (including four out five domains at outstanding) in the public and patient participation Improvement and Assessment Framework (IAF)

NHS Tameside and Glossop Clinical Commissioning Group (T&G CCG) is committed to putting the voice of patients and our local communities at the heart of decisions about how we deliver local services.

Involving the public is key to successful public service delivery and results in better services more appropriately tailored to people’s needs.

Our commitment to ensuring that the public, stakeholders, partners, and the voluntary, community and faith sectors are central in shaping the way we commission and deliver the best possible outcomes for our population is set out in the Tameside & Glossop Engagement Strategy.

The success of how we do this is assessed by the extent to which:

- people have an opportunity to express their views, and feel confident their voices are heard
- people feel their opinions and ideas influence the commissioning, design and deliver of local services
- our services are better as a consequence of engagement and consultation
- high quality engagement is something that occurs routinely within our organisations, and is ongoing

The implementation of the Engagement Strategy is jointly facilitated by the Tameside & Glossop Strategic Commission (Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group) and the Tameside & Glossop Integrated Care NHS Foundation Trust (formerly Tameside Hospital) and guided by the Partnership Engagement Network (PEN). Members of PEN representing the voices of public and patient representatives across Tameside & Glossop were integral to the development of the Strategy.

The Engagement Strategy was officially launched at the PEN Conference in June 2018.

Senior Leaders launching the Engagement Strategy for Tameside & Glossop (left to right): Cathy Elliott (Non-Executive Director, Tameside & Glossop Integrated Care NHS Foundation Trust), Maggie Murdoch (Lay Member for Public & Patient Participation, Tameside & Glossop CCG), Dr Kate Hebden (GP Member for Primary Care, Tameside & Glossop CCG), Councillor Brenda Warrington (Executive Leader, Tameside Council), Jane McCall (Chair, Tameside & Glossop Integrated Care NHS Foundation Trust), Dr Alison Lea (Vice Chair, Tameside & Glossop CCG), Steven Pleasant (Chief Executive – Tameside Council / Chief Accountable Officer, Tameside & Glossop CCG)

Partnership Engagement Network (PEN)

The Partnership Engagement Network (PEN) continues to be one of the key ways in which we engage local people. PEN was established jointly by NHS Tameside & Glossop Clinical Commissioning Group, Tameside Metropolitan Borough Council and NHS Tameside & Glossop Integrated Foundation Trust in October 2017 as part of a multi-agency approach to provide the public and our partners with an identified and structured method to influence the work of public services and to proactively feed in issues and ideas.

The approach ensures that structures exist to have ongoing conversation with the public and stakeholders and creates forums for people and organisations to get their voices heard and gives the opportunity to hear about and contribute to the development of public sector programmes and work.

The key principles of the Partnership Engagement Network (PEN) are to:

- Engage in an ongoing conversation with the public, patients and other stakeholders
- Reach across the whole of the public and community sectors so that engagement doesn't happen in organisational silos
- Begin discussions early, enabling the public, patients and other stakeholders to be part of designing solutions.

PEN operates across two tiers:

- Strategic – engagement on approach, principles, cross-cutting issues and direction of travel. And a space to identify and join up key themes emerging from operational engagement activity.
- Operational – engagement on service plans, new and developing models, emerging ideas and commissioning approach. Operational engagement takes place at both the thematic (service based), or neighbourhood (place based) level.

Performance Analysis

The following diagrams outline the PEN approach in more detail.

TAMESIDE AND GLOSSOP PARTNERSHIP ENGAGEMENT NETWORK

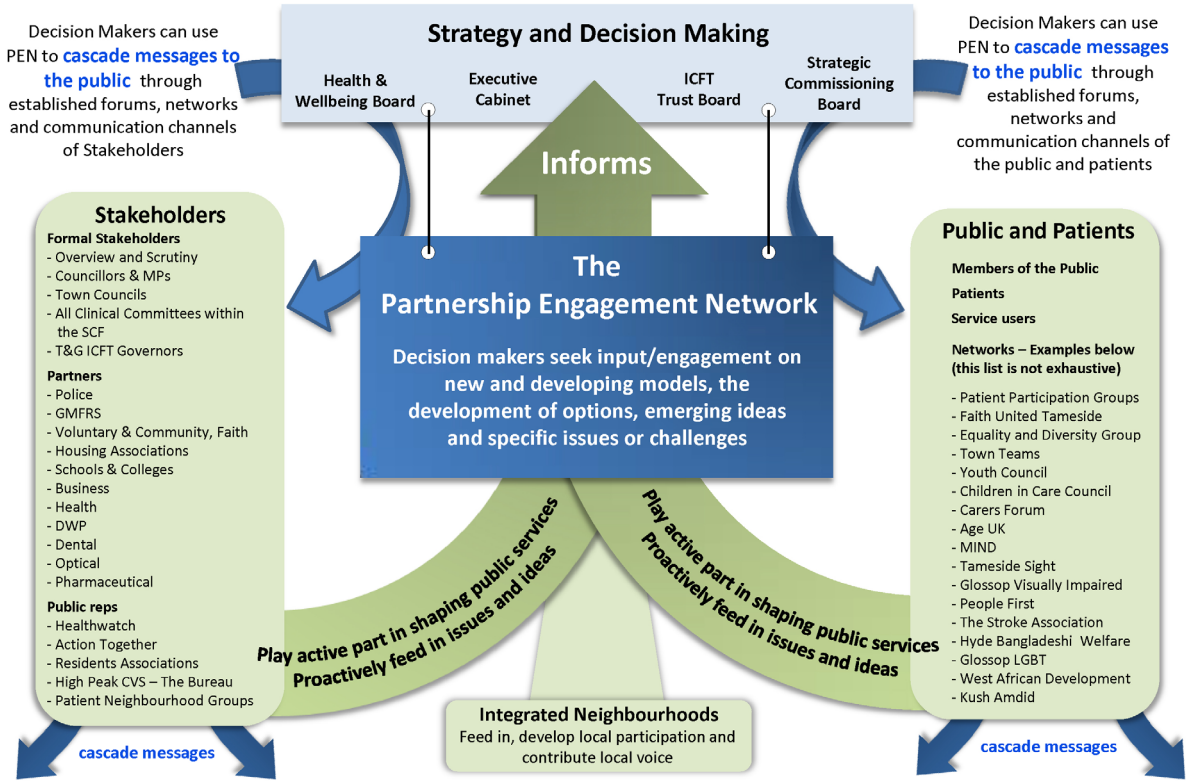
PEN Forum	PEN Conference	PEN Panel
When: Three times a year **Who:** A limited number of representatives from stakeholders (multi-agency) plus representatives of organisations or groups that represent the public and patients. **Purpose:** To undertake more detailed discussion around 'place shaping' and to explore key issues in greater depth. Participants would have subject specialism and capacity to provide advice on key issues. The forum will review forward plan of engagement and consultation activity, review the outputs from previous work and ensure the feedback loop is closed.	**When:** Three times a year **Who:** Up to one hundred and forty representatives from stakeholders (multi-agency) plus representatives of organisations or groups that represent the public. **Purpose:** To share best practice and learning, and to build relationships across the multi-agency partnership. Half day facilitated workshop, content will be a combination of public service led presentations seeking input on specific issues, along with some structured discussions around specific issues/challenges.	**When:** As required **Who:** Up to twenty individual members of the public and patients drawn from the existing Big Conversation membership plus other sources, e.g. T&G ICFT Membership **Purpose:** To be directly involved in the development of new models and options. People participating would depend upon the issue in question and the the twenty individuals would be refreshed on a regular basis. Opportunity to reach out to a much wider variety of people than would traditionally engage.

Public and Patients

For Public and Patients the Partnership Engagement Network is a space where they have genuine influence and can forge connections that enable them to progress their own agendas.

PEN provides the opportunity for collaboration around key, public service wide issues, that might result in specific partnerships working on areas of further integration.

TAMESIDE AND GLOSSOP PARTNERSHIP ENGAGEMENT NETWORK



Performance Analysis

Since its launch in October 2017 there have been five large conferences – details of which are summarised in the following table. Each of the conferences consists of key presentations and a number of facilitated workshops to gain input on the development of options, emerging ideas and specific issues and challenges currently facing Tameside & Glossop. Participants can select which workshops they choose to attend.

Conference	Presentations	Workshops
October 2017 (Over 60 delegates)	• Partnership Engagement Network Approach • Shared Priorities & Objectives • Care Together	• Integrated Neighbourhoods • Intermediate Care proposals • Patient voice in care and support planning • Mental Health • Preventing Homelessness Strategy • Air quality
February 2018 (Over 50 delegates)	• Patient Choice • Active Ageing • Partnership Engagement Network Update	• Patient Choice • Active Ageing Strategy • One Equality Scheme • Preventing hateful extremism and promoting social cohesion • Development of a new 'Compact' • Public Behaviour Change (Self Care Alliance)
June 2018 (Over 80 delegates)	• Improving Access to Primary Care • Partnership Engagement Network Update • What Matters to You	• Working Together to Tackle and Prevent Homelessness • Identifying & Supporting Ex-Service Personnel in the Armed Forces Covenant • Increasing Digital Skills and Employment • Prescribing of Over the Counter Medicine • Planning at End of Life • Improving Access to Primary Care
October 2018 (Over 70 delegates)	• Frailty • PEN update	• Frailty • Community Safety • Patient Centred Diagnosis Discussions in Long Term Conditions • Collaborative Practice in Primary Care • Tameside's Big Food Debate • Children's Emotional Health & Wellbeing
February 2019 (Over 70 delegates)	• Tameside & Glossop Strategic Commission Corporate Plan • Living Life Well	• Living Life Well (All Attendees) • PEN Development Session (All Attendees) • Loneliness • Greater Manchester Moving Local Delivery Pilot • Corporate Plan • Building a Social Movement around Community Wellbeing • Social Prescribing and Asset Based Community Development

In addition to the large scale conferences there have been five PEN Forums. The topics of the Forums were Palliative & End of Life Care, Age Friendly Tameside and MacMillan Recovery Services and include the two task and finish working groups to develop the joint Engagement Strategy

Full feedback reports are available for all events and are posted on the PEN pages of the website. Similarly, for all thematic engagement and consultation activity a short feedback report is posted on the Big Conversation pages of the website.

Members of the public are regularly encouraged to sign up to the PEN Family which they can do via a link on the website. Over 300 members who are currently signed up to the PEN Family receive monthly updates alerting them to relevant consultation and engagement opportunities at a local, regional and national level. Details of these updates are also posted on the website.

The website can be view at www.tameside.gov.uk/tamesideandglossopPEN

Engagement and consultation activity in 2018/19

Through 2018/19 a range of engagement and consultation activity has been undertaken.

In addition to those topics discussed as part of the Partnership Engagement Network (as outlined above) there have been other opportunities for the public to have their say on issues affecting Tameside & Glossop – at a local, regional and national level. These opportunities are promoted via the Big Conversation pages on the website and have included:

- Over 30 thematic Tameside and/or Glossop engagement projects
- Over 20 engagement projects at the Greater Manchester level
- Over 30 national consultations where the topic was of relevance to and/or could have an impact on Tameside and/or Glossop

Some key examples include:

Tameside & Glossop

- Urgent Care
- Care Home Contracts
- Ageing Well
- Shared Lives
- Over the Counter Medicines
- Homelessness Prevention
- Infant Feeding
- Maternity Services
- Digital Skills
- Housing Assistance Policy
- Budget Conversation
- Single Handed Care

Greater Manchester

- Working Carers
- Promoting social cohesion and preventing hateful extremism
- History Makers (make smoking history in Greater Manchester)
- Review of Greater Manchester Children's Hospital
- Greater Manchester Cardiology & Respiratory Services Redesign Projects
- Greater Manchester Culture Strategy
- Developing good jobs and growth: Greater Manchester's Local Industrial Strategy
- The Big Alcohol Conversation
- Developing a drug and alcohol strategy for Greater Manchester
- Greater Manchester's Plan for Homes, Jobs and the Environment
- Suicide Prevention

National

- Transforming the response to Domestic Abuse
- Integrated Communities Strategy Green Paper Consultation
- Proposed changes to the service specification for Tier 4 Child and Adolescent Mental Health Services
- Government's Draft Clean Air Strategy
- Reform of the Gender Recognition Act
- Evidence Based Interventions
- Contracting arrangements for Integrated Care Providers (ICPs)
- Gluten-free food on NHS prescription in England
- Sale of Energy Drinks to Children
- Calorie labelling for food and drink served outside the home
- Planning reform: supporting the high street and increasing the delivery of new homes
- Developing a patient safety strategy for the NHS

Once the results of each engagement / consultation exercise are available these are included as You Said, We Did style updates on the Big Conversation pages of the website.

Budget Conversation

2018/19 saw the first joint Budget Conversation exercise for Tameside & Glossop Strategic Commission (Tameside & Glossop CCG and Tameside Metropolitan Borough Council).

The total amount of money spent by both organisations combined is over £900 million a year. Although a significant sum of money that amount has reduced considerably over recent years due to cuts in funding from central Government, particularly for the Council. Council funding from central Government has been reduced by half in real terms since 2010. Over the next 5 years the Strategic Commission is expected to need to find £70 million of savings if we are to balance the budget. As such both organisations have to find new and innovate way to provide the services local people want.

Both Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group have to set a balanced budget for 2019/20. To prepare a balanced budget a number of considerations have to be taken into account. These include legal and statutory requirements place on us by Government, an understanding of the need for different services based on the analysis of existing service use, new ideas and opportunities including looking at what other areas are doing and the need to make savings while continuing to deliver for our community. In addition the views of local people are important in helping us understand your priorities and informing the budget setting.

Between 5 December and 29 January a conversation was undertaken with public, patients, partners, stakeholders, and voluntary & community groups across Tameside & Glossop to understand what they think the spending priorities should be for the Strategic Commission in addition to any ideas or suggestions for how we might deliver services more efficiently, save money or raise revenue.

Budget Conversation Key Headlines

A total of 731 engagements. This is based on:

- 501 survey responses
- 211 contacts at dedicated engagement, drop-in sessions and other meetings
- 17 E-mails
- 2 letters in local newspaper

Multiple channels used to communicate to the public and stakeholders, including:

- Websites and social media.
- Newspapers.
- Public sector partners.

In addition to promotion through written communications the Budget Conversation was also promoted in a number of other ways. These include via:

- Partnership Engagement Network – 300 members.
- Big Conversation website – 130 members.
- Purple Wi-Fi mailing list - 15,000 members
- Discussed at Patient Neighbourhood Groups and Tameside Strategic Neighbourhood Forums (49 engagements in total)
- Over 100 Budget Conversation social media posts (Facebook, Twitter, Instagram) reaching 90,000 followers.

Endeavoured to engage with people of all ages, ethnicities and circumstances. 5 dedicated engagement sessions and 6 drop-in sessions undertaken.

The Budget Conversation was also promoted via existing groups / networks. Information was sent directly to over 115 groups / networks.

85% of respondents to the Budget Conversation were residents of the area.

5% did not live in the area but work here. Remaining 10% have family in area, spend a lot of free time in area or are a member of a local charity or voluntary group.

Suggested spending priorities for the Tameside & Glossop Strategic Commission in 2019/20 and future years:

- Older people social care
- Education and schools
- Healthcare in general
- Children's social care
- Maintenance of roads and highways i.e. potholes
- Emergency Services: Police and Fire
- Mental Health services
- Transport infrastructure
- Littering or rubbish on the streets/Street Cleanliness
- Waste/recycling

Ideas or suggestions for how we might deliver services more efficiently, save money or raise revenue:

- Working practices and culture should be more efficient
- Increase fees or charges or fines
- Preventative early help investment to save money on service costs at later day,
- Encourage volunteering and community action
- Work with and support local businesses
- Utilise existing owned buildings better

A copy of the Budget Conversation report can be found at www.tamesideandglossopccg.org/Sites/NHSTGCCG/corporate/Agendaandreports130219.pdf (item 6b). Feedback can also be found at www.tamesideandglossopccg.org/get-involved/budget-conversation-2019-20-outcome.

One Equality Scheme (2018-2022)

One Equality Scheme 2018-22 is the first joint Equality Scheme of the Tameside & Glossop Strategic Commission (Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group). This was agreed by the CCG's Governing Body in May 2018 and the Council's Executive Cabinet in June 2018.

Under the terms of the Equality Act 2010, all public bodies are required to publish certain pieces of equality related information. Our joint Scheme ensures that both the Council and CCG fulfil our obligations - particularly to publish one or more specific and measurable equality objectives at no more than four years from the date of first publication.

The fourteen equality objectives of the Strategic Commission are set out below. A full copy of the scheme can be found at www.tamesideandglossopccg.org/corporate/equality-and-diversity/one-equality-scheme.

Reduce Inequalities & Improve Outcomes

1. Address key priority quality of life issues such as health inequalities, educational attainment, access to skills, training and employment opportunities, income levels, and health and wellbeing, across equality groups and the vulnerable and disadvantaged with a view to narrowing the gap.
2. Help people to continue to live independent lives, and assist the most vulnerable in our communities to access support and services that exist around this aim, through targeted interventions and tailored service provision. Work closely with partner organisations to most effectively facilitate this.
3. Aim to increase the level at which people believe that Tameside and Glossop is a place where people get on well together, amongst the population as a whole and by protected characteristic group. A key focus of this aim is to raise awareness and support the prevention of hate crime across the locality.

Meeting our obligations under the Equality Act 2010

4. Publish our equality objectives and ensure that they are published in a manner that is accessible .
5. Publish our workforce monitoring information by equality group (where known).
6. Undertake to produce and publish Equality Impact Assessments (EIAs) to support service delivery and commissioning decisions to be published with papers. These will help us to understand the impact of our policies and practices on persons sharing a relevant protected characteristic.

Equality Training, Development and Awareness

7. Ensure that employees are appropriately trained on equality legislation and their responsibilities under it - this includes Equality Act 2010, Equality Delivery System 2 (EDS2), Accessible Information Standard, Workforce Race Equality Scheme, Workforce Disability Equality Scheme and the requirements of the EDHR contract schedule. Staff are offered support and guidance through a range of methods and approaches such as briefing notes, training sessions and workshops.
8. Raise awareness and understanding of equality and diversity by working with partners (such as voluntary organisations, community groups and service providers) to ensure that the views of those from protected characteristic groups are represented and supported.

Consultation & Engagement

9. Engage (as early as possible to enable co-design and co-production processes) and consult with our communities through a broad range of methods and forums, such as surveys, events and customer feedback to ensure comprehensive and meaningful coverage. Ensure feedback is provided to participants following the engagement or consultation process.
10. Disaggregate the results of monitoring, surveys, feedback and consultation exercises by equality group (where appropriate and practical) to inform our understanding of the needs of different groups and individuals. When collecting demographic data as part of the engagement or consultation process ensure that respondents understand the importance of collecting this data and how it will be used.
11. Develop specifically tailored engagement and consultation activity where appropriate and when required for specific equality groups and disadvantaged / vulnerable people across Tameside and Glossop

Information, Intelligence & Need - Understanding Service Use & Access

12. Use a range of intelligence gathering, customer monitoring and insight tools, together with specific pieces of analysis, to inform both our understanding of residents, service users, service delivery and design, and to develop services that provide a varied, flexible and accessible offer.

Where possible, work with partner organisations to maximise the data available to provide deeper insight into understanding our local communities (whilst remaining mindful of data protection standards)

13. To encourage and promote the use of customer monitoring and disaggregation of data by equality group (where practical).
14. Use a variety of tailored communication methods to increase the accessibility and understanding of council and CCG services, that allows our different customers, residents and service users to make informed choices.

Safe and Sound Decision Making

Tameside & Glossop Strategic Commission continues to build on its approach to evidence-based decision making, ensuring that requirements are met in terms of equality and diversity, quality and consultation and engagement (including ongoing patient participation) when commissioners are proposing a change to the way in which a service is delivered.

When undertaking a change in service provision and/or a commissioned contract targeted work is required to ensure any decision to change that service or contract is done so is safe and sound and supported by an evidence base that has regard to the law and the impact on equalities, quality and the public, patients and service users. The ongoing work referred to above is the starting point but additional information gathering, analysis and impact assessment is required.

The approach has three elements and is designed to ensure there is an appropriate understanding of impact before any change is made. In order to do this it is appropriate to:

- Prepare an Equality Impact Assessment (EIA),
- Complete a Quality Impact Assessment (QIA),
- Undertaking a sufficient level of engagement and consultation consummate with the decision being taken.

PACT

PACT is an agreement between our voluntary, community, faith and social enterprise sector (VCFSE) and public-sector agencies.

PACT features three main principles:

- Involving community groups and charities in advising and delivering services
- Better communication to build partnership working
- Working together to secure investment

PACT was signed by Action Together, VSIG (Voluntary Sector Influencing Group), NHS Tameside and Glossop CCG, Tameside Council, Tameside and Glossop Integrated Care NHS Foundation Trust, Pennine Care NHS Foundation Trust, Greater Manchester Police, Active Tameside, Jigsaw Homes and Greater Manchester Fire and Rescue Service in January 2019.

PACT aims to give people a meaningful opportunity to be involved in decision-making and in setting priorities. It sets out commitments, including demonstrating that engagement was carried out at the earliest possible point in planning services, showing that feedback is listened to and shapes policy, and that there is VCFSE representation across all decision-making and governance partnerships.

Members of the Health & Wellbeing Board and the Voluntary Sector Influencing Group (VSIG) signing PACT

Other information

Tameside & Glossop CCG were awarded a 'green star' rating in the NHS England assessment for patient and community engagement for 2017/18. Feedback from NHS England stated that 'Tameside and Glossop CCG has an excellent approach to public and patient involvement and engagement…' and that 'The CCG is to be commended for its approach to public and patient involvement as a key priority…'

The first Tameside Strategic Commission (Tameside & Glossop CCG and Tameside Metropolitan Borough Council) wide Corporate Plan was agreed in early 2019. 'Our People Our Place Our Plan' outlines our aims and aspirations for the area, its people and how we commit to work for everyone, every day. The plan is structured by life course – Starting Well, Living Well and Ageing Well, underpinned by the idea of ensuring that Tameside & Glossop is a Great Place, and has a Vibrant Economy. Within each life course we have identified a set of goals that set out what we want to achieve for people in the area throughout their life.

The plan is supported by a list of our public service reform principles that define the ways of working we will take on to achieve those goals. The principles are Greater Manchester-wide idea that we have adopted locally and will redefine our relationship with residents – doing with, not to.
Further information can be found at www.tamesideandglossopccg.org/corporate/corporate-plan.

The Equality Delivery System 2 (EDS2) is a tool designed to help NHS organisations, in partnership with local stakeholders including patients, to review and improve their performance for people with characteristics protected by the Equality Act 2010 and to support them in meeting the Public Sector Equality Duty. In November 2018 the CCG held their annual EDS2 event where a diverse range of individuals and groups were represented.
The summary report for the event is available at www.tamesideandglossopccg.org/corporate/equality-and-diversity/equality-delivery-system-2.

The Strategic Commission continues to support our local GP practices to set up Patient Participation Groups (PPGs) and to help them guide and support individual PPGs. PPGs have been instrumental in providing ideas and feedback and bringing about changes for the benefit of other patients and carers within Tameside and Glossop.
Examples of the work of our PPGs can be found at www.tamesideandglossopccg.org/get-involved/patient-participation-groups.

Patient Neighbourhood Groups (PNGs) provide a forum for all Patient Participation Groups (PPGs) in the area to work together for the benefits of patients in the locality and in the wider Tameside and Glossop area. The PNGs ensure that patients can contribute to the commissioning of services, the delivery and development of GP services and the improvement of primary and secondary healthcare in Tameside and Glossop. PNGs also act as a conduit to other wider organisations, opening up opportunities for partnership working and two-way communication. The Strategic Commission provides ongoing support to Patient Neighbourhood Groups across Tameside and Glossop. Members of our local PNGs and PPGs are also participants in the Partnership Engagement Network (PEN).

Legislation and regulations

Through the approach outlined above and the full range of detailed activity that it is not possible to cover in this report NHS Tameside and Glossop Clinical Commissioning Group is confident that it meets the following relevant legislation and regulations:

- NHS Act 2006 – Section 242 and Section 244
- Health and Social Care Act 2012 – Section 14Z2
- NHS Constitution 2015 – Section 3a
- Gunning Principles
- HM Government (Cabinet Office) Consultation Principles 2016
- Equality Act 2010 – Section 149 and the Public Sector Equality Duty
- Brown Principles

Reducing health inequality

One Equality Scheme 2018-22 (www.tameside.gov.uk/TamesideMBC/media/policy/OneEqualityScheme2018-2022.pdf) is the first joint Equality Scheme of the Tameside & Glossop Strategic Commission (Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group). The single joint scheme sets out how the Council and CCG strive to reduce the impact of inequality and to improve the lives of the most vulnerable members of our community. The Scheme will ensure that our ethos towards equality and diversity is embedded in everything that we do and every service that we provide, an objective that is particularly important in this period of great structural change and financial challenge. In addition, we aim wherever possible to challenge discrimination and ensure that provision of services is not carried out in a way that is discriminatory. This can only be achieved through strong corporate ownership, effective partnership working and, above all, listening to what our residents and communities are telling us and responding accordingly and appropriately.

The Strategic Commission reviewed the needs of our local population through the data available including:

Tameside's and Derbyshire's Joint Strategic Needs Assessments (JSNA) (www.lifeintamesideandglossop.org).

- Topic specific JSNAs including those focusing upon
- Health Outcomes Framework data tool and Performance and Quality reporting
- Neighbourhood Risk Stratification Tools and Neighbourhood scorecards.

In Tameside and Glossop work to reduce health inequalities is a priority due to a large proportion of our health outcomes being significantly worse than the England average. Work to identify the relationships between deprivation, emergency hospital admissions, and premature mortality has led to a continued local commitment by the ICFT to incorporate a systematic approach to inequalities within their local transformation programmes.

We aim to reduce health inequalities and improve outcomes for residents through the following ambitions:

- Addressing key priority quality of life issues such as health inequalities, educational attainment, access to skills, training and employment opportunities, income levels, and health and wellbeing, across equality groups and the vulnerable and disadvantaged with a view to narrowing the gap.
- Helping people to continue to live independent lives, and assisting the most vulnerable in our communities to access support and services that exist, through targeted interventions and tailored service provision. Working closely with partner organisations to most effectively facilitate this.
- Aiming to increase the level at which people believe that Tameside and Glossop is a place where people get on well together, amongst the population as a whole and by protected characteristic group.

Health and wellbeing strategy

Tameside & Glossop CCG is an active member of both Tameside and Derbyshire Health and Wellbeing Boards. The Chair of the CCG is vice Chair of the Tameside Board and the Director of Public Health attends CCG Governing Body meetings held in public. Minutes of the Health and Wellbeing Board meetings are included on Governing Body agendas.

The focus of Tameside Health and Wellbeing Board is delivering a Health and Wellbeing Strategy to improve outcomes and reduce inequalities through every stage in people's lives. The strategic priorities of the Tameside Health and Wellbeing Board are to:

- Improve the health and wellbeing of local residents throughout life
- Give targeted support to those with poor health to enable their health to improve faster
- Focus on prevention and early intervention
- Develop cost effective solutions and innovative services through improved efficiency
- Emphasise local action and responsibility for everyone
- Deliver more joined up services that meet local need, and
- Enable and ensure public involvement in improving health and wellbeing.

The Strategic Commission has developed a new corporate plan and health and wellbeing strategy that reflects the priorities and guiding principles for our joint work in the area.

'Our People Our Place Our Plan' outlines our aims and aspirations for the area, its people and how we commit to work for everyone, every day.

The plan is structured by life course – Starting Well, Living Well and Ageing Well, underpinned by the idea of ensuring that Tameside & Glossop is a Great Place, and has a Vibrant Economy. Within each life course we have identified a set of goals that set out what we want to achieve for people in the area throughout their life.

The plan is supported by a list of our public service reform principles that define the ways of working we will take on to achieve those goals. The principles are Greater Manchester-wide idea that we have adopted locally and will redefine our relationship with residents – doing with, not to.

Accountability Report

Steven Pleasant
(Accountable Officer)

22 May 2019

The Commissioning Improvement Scheme (CIS) in place in 2018/19 has delivered significant support to the achievement of transformation, and CCG statutory duties, through our Locality Plan. The CIS saw a range of Invest to Save projects designed and piloted by each neighbourhood with a clear focus on outcomes for their respective population. This Invest to Save element of the scheme created a platform for the testing of new and innovative ways of working with a focus on bringing care closer to home. There has also been a recognition of improved relationships with a range of stakeholders and increased use of patient feedback to inform future planning.

The CIS model has also supported increased sharing of best practice, understanding of activity data, and exploring different ways of working by Neighbourhoods. It has also embedded a greater understanding of services available to patients across Neighbourhoods and how practices and/or patients can refer into these.

The transformation agenda has been wide ranging and delivered outcomes and ensured statutory duties of financial balance have been achieved. This is the work of all stakeholders across all parts the system, including the role of general practice at the heart of the neighbourhood.

The period of delivery of the Commissioning Improvement Scheme through Neighbourhoods, particularly since April 2018 has also supported the development of relationships across Neighbourhood practices. This provides a strong foundation on which to build the Primary Care Networks from 2019/20.

Some of the neighbourhood delivery successes are detailed below

Ashton	
Review A & E Frequent Attenders	Review of frequent attenders, analysing when the attendances are happening and discussing the attendance with the patient either by telephone or face to face. In addition, patients are being sent information about accessing out of hours care. Tameside and Glossop Integrated Care Foundation Trust (TGICFT) is working with A & E frequent attenders with mental health issues to reduce their A & E attendance and will be working with the practices to support this work.
Long Length of Stay Patients	For patients with over 7 and 21 days in TGICFT the registered GP will undertake in-reach at TGICFT to support discharge of patients where the patient is deemed to be medically fit but have been staying in the hospital. This work is supported by the Clinical Director for Ashton, who has been spending time on wards at TGICFT performing deep dives to challenge situations where patients medically fit. The aim is to determine if these patients can be more effectively, or appropriately, managed in the neighbourhood.
Denton	
Denton Diabetes 100 day challenge	Denton Diabetes Diverts (DDD) has been shortlisted for an HSJ Award. The NESTA 100 Day Challenge aimed to 'reduce the HbA1c by 0.2, and see an improvement in at least 1 lifestyle measure for 75% of people coded as pre diabetic. The Neighbourhood GP practices identified patients who attended an event and signed up to services to improve their lifestyle. Many patients reversed their pre-diabetes and continue to improve their lifestyle.
Care Home Ward Rounds	A service for patients in care/nursing homes which would involve the registered GP practice undertaking 'ward rounds' to any home they have patients in, to proactively review these patients/or undertake any acute visits. Positive feedback from Care Homes, staff undertaking the visits and CQC.
SlimPod	Obesity is a problem within Tameside & Glossop therefore we worked with a famous Harley Street weight loss specialist who through an 'app' helped tackle obesity in a completely innovative way. 100 residents of Denton and Droylsden signed up for this programme. 4 weeks into the project some amazing results were achieved. A number of people were able to loose 5kg or more which has improved their health and wellbeing.
Glossop	
Minor Injuries Service	This provides an opportunity for Glossop registered patients to receive a Minor Injury service within their GP Practice. All the Glossop Neighbourhood Practices will be offered the opportunity to opt in and deliver the scheme on behalf of their patients. Undertaking a Minor Injury Service in Glossop supports Glossopdale residents to access a level of high quality care in their Neighbourhoods and reduce the level of minor injuries activity attending A&E.
FeNO Machines and Testing Kits	Delivery of FeNO testing locally supports the earlier identification of asthma. It also enables Practices to ensure patients are placed on the most appropriate medication to control their condition at the time. Undertaking FeNO testing locally will ensure the numbers of patients attending hospital are kept to a minimum; therefore reducing admissions. The devices play a role in education too.

Hyde	
Asthma Champions	Delivery of long term health promotion and improvement, with Breath Champs training a team to provide support to children, parents, teachers and pupils to help improve management of asthma. These champions will deliver asthma awareness assemblies to Neighbourhood primary schools and will also run asthma parties. These parties provide a non-clinical environment to carry out asthma reviews and provide education and support to children, families and school staff. The project will work with school nursing, community pharmacy, paediatricians, Public Health and the Children's Community Nursing team.
Raising the profile of Children's and young people's mental health services	Support to all 6 secondary schools across the Neighbourhood, rolled out based on need and will improve local provision. This will increase the frequency of drop in sessions from 1 to 3, two hour sessions per week and provide access to on-site counsellors. This complements a series of events working alongside public health colleagues to raise awareness of what is available within the Neighbourhood to support individuals, empower people to look at alternative options to promote their own Health and Wellbeing and to identify anyone who may need some additional support or interventions. This collaboration includes working with Diversity Matters to ensure they are more accessible for the large Bangladeshi population in Hyde.
Alternatives to Prescribing	Community events have been held to raise awareness alternatives to medication for pain in a bid to reduce opioid prescribing and create a pain template. Practices have been aligned with care homes who are working to reduce hospital admissions.
Mental Health	The development of the mental health offer has grown for lower level mental and social issues. This offer is being co-ordinated to support healthy minds for a more all-round offer acknowledging the importance of the many issues people have in their lives which can contribute to the presentation of mental health issues. The pilot is a new wrap around model of care for those with unmet mental health issues such as dual diagnoses, learning difficulties and personality disorders who were previously not appropriate for the services available.
Self Care and Prevention	Population health is also being looked at with new ways to increase self-care and prevention treatment / intervention decay. Work is also ongoing to launch my COPD app.
Stalybridge	
Community Events/COPD Event	A number of Inter-generational events have taken place including Marvellous Mossley (for the Brownies etc and moderately frail patients); afternoon teas for moderately frail and we now have reading buddying at schools with our moderately frail patients. An event for COPD patients took place to support patients and inform them of the services available locally to help them manage their condition/lifestyle. Patients were able to sign up to local lifestyle services. As a result of the vent a Stalybridge COPD choir was formed which meets weekly.
Care Home Visiting Teams	A weekly/fortnightly proactive ward round (dependent on numbers of registered patients) has been introduced. This is aimed at reducing the need for acute visits to care home residents. The ward round are a Multi-disciplinary team approach to provide a visit to each home Monday to Friday providing a targeted health and wellbeing review of each resident. GP to have an identified team to access (either present at the ward round or virtually following the ward round) to include District Nurse, Social Worker, Be Well Advisor, Physiotherapy, Occupational Therapy, re-ablement, IUCT, Community Neuro, Extensivist Team, Care Home representative, Action Together to identify those care needs if not met may lead to residents needing inappropriate secondary care.
Coffee Mornings/Luncheon Club	Regular luncheon clubs with transport to and from the venues available to severely frail who can't get to the venues independently. There are also low level exercise sessions running at these venues (Live Active) following the coffee mornings/luncheon clubs and participants will be encouraged to join in or sign up to other community activities.

In addition, a number of workstreams have been delivered across all neighbourhoods.

These include Multi-morbidity MDTs taking place in all practices on a weekly/fortnightly basis where patients who are most 'at risk' of using health and social care services are discussed. The teams present ensure that further referrals to support the patients' holistic care are made and patients followed up. The 'my care my way' advanced care plan has been rolled out across the whole health economy as has the Rockwood frailty scoring system in a bid to using the same language across the primary and secondary care. NESTA 100 day challenge has continued to be a success. The involvement of the voluntary sector particular drove the excellent work to improve patient experience and embowing them in the pathway through a hospital admission with the relaunch of the ticket home document which is ongoing.

Member Practices

Our GP member practices are split across five geographical neighbourhoods: Ashton, Denton, Glossop, Hyde, and Stalybridge.

Ashton

- Albion Medical Practice
- Ashton GP Service
- Ashton Medical Group
- Gordon Street Medical Centre
- HT Practice
- West End Medical Centre
- Stamford House
- Waterloo Medical Centre

Denton

- Denton Medical Practice
- Droylsden Medical Practice
- Guide Bridge Medical Practice
- Market Street Medical Practice
- Medlock Vale Medical Practice
- Millgate Health Partnership

Glossop

- Cottage Lane Surgery
- Hadfield Medical Practice
- Howard Street Medical Practice
- Manor House Surgery
- Lambgates Surgery
- Simmondley Medical Centre

Hyde

- Awburn House Surgery
- The Brooke Surgery
- Clarendon Medical Centre
- Dukinfield Medical Centre
- Donneybrook Medical Centre
- Hattersley Health Centre
- Haughton Thornley Medical Centre
- The Smithy Surgery

Stalybridge

- Grosvenor Medical Centre
- King Street Medical Centre
- Lockside Medical Centre
- Millbrook Medical Practice
- Mossley Medical Practice
- The Pike Medical Practice
- Staveleigh Medical Centre
- St Andrew's House
- Town Hall Surgery.

Members Report

Composition of the Governing Body from 1 April 2018 to 31 March 2019 (unless otherwise stated)

Dr Alan Dow: Chair
Alan has been responsible for leading our Governing Body as well as playing a key role in overseeing governance, strategy and vision since NHS Tameside and Glossop formed as a shadow CCG 6 years ago. Alan has worked as a GP for nearly 30 years including 24 years in Gamesley, Glossop. His interests include cardiovascular disease and reducing health inequalities. He is also active in training new GPs.

Alan helped set-up the Strategic Commission; the first in the country, where GPs, lay members and councillors come together to make integrated funding decisions.

Steven Pleasant MBE: Accountable Officer
In September 2016 Steven was appointed as the Accountable Officer of NHS Tameside and Glossop Clinical Commissioning Group. This ensures single leadership with his dual role as Chief Executive of Tameside Metropolitan Borough Council.

Steven is the lead Chief Executive on behalf of the Greater Manchester Combined Authority for Health and Wellbeing and for Asylum, Refugees, and Migration. Steven acts as the lead Chief Executive for the North West for Adult Social Care Sector-Led Improvement.

He is the Chair of the North West Regional Asylum Steering Group, which governs the work of the North West Regional Strategic Migration Partnership, and has been honoured with an MBE in recognition of this work.

Steven is also the chair of iNetwork which has been successfully supporting public service improvement and transformation across the North West region for many years.

Kathy Roe: Chief Finance Officer
Kathy has worked across many NHS commissioning organisations in Greater Manchester over the last 33 years including Health Authorities, PCTs, a CCG, and now a combined role across Health and the Local Authority.

Having successfully managed her career up to Director level in 2011, she took up the role of Chief Finance Officer at Tameside and Glossop CCG from April 2013.

Kathy's determination to address the financial challenges across her locality, including the variation in care and outcomes achieved, was a key driver behind the inception of the local economy wide 'Care Together' vision in Tameside and Glossop - a strategy that would see the implementation of an Integrated Care Organisation at the local hospital and a single Strategic Commissioning Function across the CCG and Local Authority.

Kathy took up a system wide role as the Director of Finance across the full Council and CCG, including the Section 151 Officer role, from October 2017. She is focused on addressing the wider determinants of health in order to address the system wide challenges.

Kathy has led her finance team to many award successes over the years including CIMA's Public Sector Finance Team of the Year in 2010, PQ Magazine's Accounts Team of the Year in 2012, and HFMA's North West Finance Team of the Year in 2018. More recently, Kathy herself was awarded National Finance Director of the Year 2018 by HFMA in recognition of her trailblazing integration role.

Clinical Governing Body Members

Dr Kate Hebden: GP Member for Primary Care (shared role)
Kate has been working at Denton Medical Practice since soon after qualifying as a GP in 2006. She has a particular interest in women's health and improving quality in general practice.

Dr Vinny Khunger: GP Member for Primary Care (shared role)
Vinny is a GP at Guide Bridge Medical Practice having worked there since 2009. He is a GP trainer, appraiser and does occasional work for the General Medical Council (GMC). He has also served as CCG clinical lead for mental health and learning disabilities for the past 3 years

Dr Jamie Douglas: GP Member - Lead for Ageing Well
Jamie qualified in Medicine from the University of Manchester in 2004. He worked at a number of hospitals across Greater Manchester before undertaking his GP training in Tameside and Glossop between 2007 and 2010. Currently a GP at the Albion practice in Ashton, Jamie is also a GP appraiser for NHS England and an undergraduate tutor at the University of Manchester. He supports us by ensuring quality is at the heart of any decisions made.

Dr Christine Ahmed: GP Member – Starting Well (December 2018)
Dr Christine Ahmed has been a GP at Millbrook Medical Practice for the last 5 years as well as working with the Extensive Care Team across Tameside and Glossop for the last year. She enjoys teaching, having worked for the University of Manchester teaching undergraduates for the last 3 years and has a particular interest in dermatology.

Dr Alison Lea: GP Member – Lead for Starting Well (April – September 2018)
Ali is a practicing GP and has been working in Denton for 12 years. She is a GP Partner at the newly merged Millgate Healthcare Partnership. With significant expertise in medical education and having been part of CCG clinical leadership for 3 years, Ali was the Governing Body GP Lead for Starting Well until she left her role as Governing Body GP at the end of September 2019.

Professor Tim Hendra: Secondary Care Consultant
Tim worked as a consultant physician at the Royal Hospital in Chesterfield until retiring from clinical practice in May 2016. He remains an Honorary Professor at the Faculty of Health and Wellbeing of Sheffield Hallam University, and a Trustee of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

Previously Tim was Medical Director at the Mid-Yorkshire Hospitals NHS Trust (2008-12) and Deputy Medical Director at Sheffield Teaching Hospitals NHS Foundation Trust (2001-8).

Dr Ashwin Ramachandra: GP Member and Vice Clinical Chair - Lead for Living Well
Ashwin is a senior GP partner having worked at Market Street Medical Practice in Droylsden for close to a decade. In addition to having a special interest in minor surgery and musculo-skeletal issues he has come up with successful and innovative methods to provide effective holistic care for his patients. He obtained the Masters in Business Administration from the Alliance Manchester Business School (University of Manchester) in 2016 and is now a GP trainer.

Clare Todd: Governing Body Nurse
Clare began her nursing career 25 years ago at Hope Hospital and Royal Manchester Children's Hospital before gaining extensive NHS experience in hospital, hospice, and community settings. She has worked closely with GPs as a community nurse and has significant experience working with local authorities across the North West.

As the CCG's Governing Body Nurse Clare has a key role in ensuring the safety and quality of the services commissioned by the CCG and uses her broad perspectives and knowledge of the healthcare system to support service redesign and a more integrated approach to care.

Dr Carmen Chan: Post-CCT Fellow Governing Body GP Member
Carmen graduated from the University of Manchester in 2012 and completed her foundation training in the East Midlands. She started her GP training in Tameside and Glossop in 2014 and worked at Tameside and Glossop Integrated Foundation Trust and at GP practices in Hyde and Stalybridge. She qualified as a GP in 2017 and is currently a salaried GP in Stalybridge.

Lay Members

David Swift: Lay Member for Governance and Deputy Chair (Lay)
Until his retirement in January 2014 David spent his whole career in the NHS and has forty years' experience in finance and governance across a range of organisations including those dealing with primary, secondary, and specialist care. David is a Chartered Internal Auditor by profession and was the Senior Internal Audit Manager for a number of CCGs including Tameside and Glossop.

Maggie Murdoch: Lay Member for Patient and Public Involvement
Maggie has worked with people living with dementia and their families in Tameside for the last seven years. During that time she also cared for her mum who had Alzheimer's disease and she is passionate about the need for improvement in this sector. She was a lay member (in her unpaid carer role) for the National Institute for Clinical Excellence sub-committee, writing the first set of guidelines on good practice in social care for people living with dementia. Maggie has, prior to this, worked for many years as a volunteer, a manager and a practitioner in the Voluntary, Community, and Education sectors.

Carol Prowse: Lay Member for Commissioning
Until recently Carol was Deputy Chairman and Senior Independent Director at Stockport NHS Foundation Trust where she was on the Board for nine years. She was a Non-Executive Director of the High Peak Dales Primary Care Trust prior to this. She has a great commitment to high quality health services being shaped around the needs of patients. Carol until recently was Chairman of the High Peak Theatre Trust, one of the UK's leading regional receiving theatres (Buxton Opera House) and thoroughly enjoys the opportunity to work, on a voluntary basis, with such a successful arts venue at the heart of the Community. Carol also works with the Kinder Choirs of the High Peak, one of the UKs leading choral organisations.

CCG Directors in Attendance at Governing Body Meetings (no voting rights)

Gill Gibson: Director of Quality and Safeguarding
Gill Gibson is the Director of Quality and Safeguarding. Gill has over thirty years' experience in the NHS having trained as a nurse and her career has spanned working in the fields of Learning Disability, Mental Health, community services, Paediatrics and child and adult safeguarding within both the acute and community sectors. Gill has a long history of working in and developing integrated services that span health and social care. Gill started working in Tameside & Glossop in 2007 as a locality manager of Health Visiting, School Nursing, and Therapy services. During this period she helped to integrate services for children with additional needs for which the team won a Nursing Times Child Health Award. In 2009 Gill became the Designated Nurse for Safeguarding Children and Adults and Deputy Director of Nursing and Quality in 2013. Gill has a passion for quality and patient safety and for involving patients and the public in decisions about their care.

Jessica Williams: Interim Director of Commissioning
Jessica joined NHS Tameside and Glossop CCG in September 2015 to drive health and social care integration as Programme Director for Care Together. This involved close working across partners to deliver significant improvements in population outcomes as well as improved clinical and financial sustainability. From September 2017, Jessica also took on responsibility for strategic commissioning across Tameside and Glossop including general practice, all acute services, mental health and the health estate. Jessica leads on the design and implementation of integrated models of care to drive up healthy life expectancy, reduce inequalities, and improve the overall experience of the health and social care system. Jessica joined the NHS in 1991 and has extensive experience at Director level in acute, mental health, and research organisations and also at the Greater Manchester Health and Social Care Partnership where she set up and led the Primary Care Transformation Team until joining Tameside and Glossop.

Members Report

CCG Committees

The committees of NHS Tameside and Glossop CCG are:

- Governing Body
- Audit Committee
- Finance and QIPP Assurance Group
- Primary Care Committee
- Quality and Performance Assurance Group
- Remuneration and Terms of Service Committee
- Strategic Commissioning Board.

Later in this report is the Remuneration Report which includes details of the membership of the CCG's Remuneration and Terms of Service Committee. The Annual Governance Statement includes the details and memberships of all of the committees of the Governing Body including for the Audit Committee.

Register of Interests

The details of company directorships and other significant interests can be found in the CCG's Register of Interests which is publically available on the Tameside and Glossop CCG's website: www.tamesideandglossopccg.org/corporate/register-of-interests

Personal data related incident

The CCG has no serious untoward incidents relating to data security breaches to report for the financial year 2018/19.

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

Tameside and Glossop Clinical Commissioning Group fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2019 is published on our website at www.tamesideandglossopccg.org/Sites/NHSTGCCG/downloads/YOUR-HEALTH/Safeguarding/Slavery-and-human-trafficking-statement-November-2017.pdf

Statement of Accountable Officer's Responsibilities

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

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

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

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

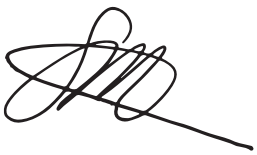
In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Assess the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern;
- 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; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the 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 Tameside and Glossop CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

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.



Steven Pleasant
(Accountable Officer)
22 May 2019

Governance Statement

Introduction and context

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG established a Strategic Commission with its partner organisation Tameside Metropolitan Borough Council in 2017/18. In 2017/18 the two statutory organisations formed a joint committee named the Strategic Commissioning Board (SCB). The SCB has decision-making authority over a pooled budget which has increased from £267m in 2017/18 to £931m in 2018/19.

During 2018/19 the Governing Body has reviewed its governance arrangements and has identified areas to change. Members have been consulted and agreed to support the engagement of a lead specifically for Mental Health to support the work of the Governing Body.

The following tables indicate attendance to the above committee and groups during 2018/19 and use the key below.

Governing Body table of attendance 2018/19

✓ Present / ✘ Absent / - Not in post at this time

Members	23 May 18	26 Sep 18	19 Dec 18	20 Mar 19
Dr Alan Dow (Chair)	✓	✓	✓	✘
Dr Christine Ahmed	-	-	✓	✓
Dr Carmen Chan	-	✓	✘	✓
Dr Jamie Douglas	✓	✓	✓	✘
Dr Kate Hebden / Dr Vinny Khunger	✓	✓	✓	✓
Prof Tim Hendra	✓	✓	✘	✓
Dr Alison Lea	✓	✓	-	-
Maggie Murdoch	✓	✘	✓	✓
Steven Pleasant	✓	✓	✓	✓
Carol Prowse	✓	✓	✓	✓
Ashwin Ramachandra	✓	✓	✓	✓
Kathy Roe	✓	✓	✓	✓
David Swift	✓	✘	✓	✓
Clare Todd	✘	✓	✓	✓

Audit Committee

The Audit Committee is a formal, statutory sub-committee of the CCG Governing Body. Its operation is governed by terms of reference which are kept under regular review, and formally approved by Governing Body.

The Committee has devised and implemented a work programme for the full financial year (Attachment B), and this serves to ensure that the full breadth of its responsibilities is addressed in a timely and comprehensive manner. This work programme can be summarised as covering:

- Governance and Risk
- Internal Audit reporting
- Anti-Fraud reporting
- External Audit Reporting
- Reports from the Chief Finance Officer
- Conflicts of Interest
- Information Governance/GDPR
- In-depth briefing on key topics.

The CCG has recognises the importance of having a clinical voice as an integral part of this key aspect of the assurance process, and committee members have performed this role with diligence and authority. The Audit Committee benefits significantly from the work of colleagues from our Internal Audit, Anti-Fraud, External Audit and IM&T Governance providers, and from officers of the CCG whose attendance at, and enthusiastic participation in, the meetings, is crucial to the effective completion of the work programme.

Audit Committee table of attendance 2018/19

✓ Present / ✘ Absent / - Not in post at this time

Members	23 May 18	22 Aug 18	14 Nov 18	20 Jan 19	20 Mar 19
David Swift (Chair)	✓	✓	✓	✓	✓
Dr Jamie Douglas	✓	✓	✓	✓	✘
Clare Todd	✘	✓	✓	✓	✓

Finance and Quality Innovation Productivity and Prevention (QIPP) Assurance Group

The Finance and QIPP Assurance Group is a sub-group of the CCG Governing Body, and an integral part of the assurance arrangements for the Strategic Commission. Its purpose is to provide a forum for the detailed examination and analysis of all finance related issues, and to provide assurance to the strategic levels of the local economy. The terms of reference for the Committee have been kept under regular review, with increased emphasis given to collaborative assurance at Strategic Commission and Health Economy levels. Our work has recently been significantly strengthened by the attendance and input of Councillor Fairfoull, the Council's Deputy Executive Leader, at the Finance and QIPP Assurance Group meetings.

(QIPP) Assurance Group table of attendance 2018/19

✓ Present / ✘ Absent / - Not in post at this time

Members	18 Apr 18	16 May 18	20 Jun 18	18 Jul 18	15 Aug 18	19 Sep 18	17 Oct 18	28 Nov 18	19 Dec 18	23 Jan 19	27 Feb 19	27 Mar 19
David Swift (Chair)	✓	✘	✓	✘	✓	✓	✓	✓	✓	✓	✓	✓
Dr Jamie Douglas or Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kathy Roe or Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jessica WIlliams or Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Greater Manchester Joint Commissioning Board

The Greater Manchester Joint Commissioning Board (GM JCB) is the forum for collective commissioning/decommissioning decision making. The first public meeting was held in December 2018 where the Terms of Reference were reviewed and approved. The JCB has oversight of commissioning undertaken on a GM footprint and provides strategic input into commissioning decisions made by commissioning organisations in GM.

GM Joint Commissioning Board table of attendance 2018/19

✓ Present / ✘ Absent / - Not in post at this time

Members	18 Dec 18	19 March 19
Dr Alan Dow	✓	✘
Steven Pleasant	✓	✓

Primary Care Committee

The Primary Care Committee has oversight of delegated responsibility from NHS England for the commissioning of primary medical services and also assurance for the delivery of the work streams of the Primary Care Investment Agreement with Greater Manchester Health and Social Care Partnership under the Primary Care Reform programme.

Primary Care Committee has overseen the implementation of the three practice merger, approved late in 2017/18 and approved the closure of a branch site of a practice, including full Equality Impact Assessment (EIA). The Primary Care Access Service (PCAS) was procured and launched in November; this is a single service model covering the full scope of the previous Extended Access, Out of Hours and Alternative to Transfer services. This is the first of this scale across Greater Manchester (GM) and as such has received interest from GM commissioner colleagues.

An Access Outcomes Framework (AOF) has been launched to support practices delivering primary medical services throughout core hours for our population; this includes scope for delivery on a neighbourhood basis.

Quality Assurance and Quality Improvement of primary medical services are overseen by the Primary Care Committee, managed via our Primary Care Delivery and Improvement Group and includes a comprehensive process following CQC inspection of practices, with a programme of support for practices rated as requires improvement or special measures.

Primary Care Committee table of attendance 2018/19

✓ **Present / ✘ Absent / - Not in post at this time**

Members	2 May 18	6 Jun 18	22 Jul 18	29 Aug 18	3 Oct 18	7 Nov 18	5 Dec 18	6 Feb 19	6 Mar 19
Carol Prowse (Chair)	✓	✘	✓	✓	✓	✓	✓	✓	✓
David Swift	✓	✓ (Chair)	✘	✓ (Chair)	✓	✓	✓	✓	✓
Maggie Murdoch	✓	✘	✓	✘	✓	✓	✓	✓	✓
Dr Alan Dow	✓	✓	✓	✓	✓	✓	✘	✓	✘
Dr Kate Hebden	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gill Gibson or Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jessica Williams	✓	✓	✓	✘	✓		✓	✓	✘
Tracey Simpson or Deputy	✘	✓	✓	✓	✓	✓	✓	✓	✓

Quality and Performance Assurance Group

As part of the integration of health and social care in Tameside and Glossop, and the development of the Strategic Commission, has meant that the Quality and Performance Assurance Group can scrutinise the quality and performance of all services we commission.

The amalgamation to review performance alongside quality of commissioned services as a group ensures that key matters, concerning performance and risk, including mitigating actions and decisions requested by the Governing Body and Strategic Commissioning Board within the Quality and Performance report and by separate reports by exception when necessary.

Quality and Performance Assurance Group table of attendance 2018/19

✓ Present / ✘ Absent / - Not in post at this time

Members	25 Jul 18	26 Sep 18	28 Nov 18	23 Jan 19	27 Mar 19
Clare Todd (Chair)	✓	✓	✓	✓	✓
TMBC Executive member (Deputy Chair) – Vacant	-	-	-	-	-
Dr Alison Lea / Christine Ahmed	✓	✓	✘	✓	✓
Ali Rehman	✓	✓	✓	✓	✓
Gill Gibson	✓	✓	✓	✘	✘
Jessica Williams	✓	✓	✘	✓	✘
Stephanie Butterworth or Deputy	✓	✓	✓	✘	✘
Debbie Watson or deputy	✓	✓	✓	✓	✓
Simon Brunet	✓	✘	✓	✘	✘
Healthwatch Representative	✓	✘	✘	✓	✓
Lynn Jackson	✓	✓	✓	✓	✓
Michelle Walsh	✘	✘	✓	✓	✓
Victoria Leonard	✘	✘	✓	✘	✘
Primary Care representatives	✓	✓	✘	✓	✓

Remuneration and Terms of Service Committee

The Remuneration Committee is a formal, statutory sub-committee of the CCG Governing Body. Its purpose is to make recommendations to the Governing Body regarding the remuneration, fees, and other allowances for employees, clinicians, and for people who provide services to the group other than those covered by the national arrangements under Agenda for Change.

Unlike the other Committees and Groups of the Governing Body, there is no specific pattern of meetings, as these are held as and when required, in line with the terms of reference. Key areas of our work in 2018/19 have been:

- Advice to Governing Body re pay uplifts for non-Agenda for Change Staff and Governing Body Members;
- Assessment and analysis of remuneration-related risks.

Remuneration and Terms of Service Committee table of attendance 2018/19

✓ **Present / ✘ Absent / - Not in post at this time**

Members	15 Nov 18	7 Mar 19
Maggie Murdoch (Chair)	✘	✓
Dr Jamie Douglas	✓	✘
Vinny Khunger	✘	✓
Steven Pleasant	✘	✘
Carol Prowse	✓	✓
Kathy Roe	✓	✓
David Swift	✓ (Chair)	✓

Strategic Commissioning Board

The Strategic Commissioning Board (SCB) is a joint committee between NHS Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council. The Strategic Commissioning Board has been established to make decisions on the design, on the commissioning, and on the overall delivery of health and care services including the oversight of their quality and performance.

Strategic Commissioning Board table of attendance 2018/19

✓ Present / ✘ Absent / - Not in post at this time

Members	17 Apr 18	23 May 18	20 Jun 18	25 Jul 18	29 Aug 18	19 Sep 18	24 Oct 18	28 Nov 18	12 Dec 18	23 Jan 19	13 Feb 19	27 Mar 19
Dr Alan Dow (Chair)	✓	✓	✓	✘	✓	✓	✓	✓	✓	✓	✓	✓
Dr Christine Ahmed	-	-	-	-	-	-	-	-	✓	✓	✓	✘
Cllr Warren Bray	-	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cllr Ged Cooney	✘	✘	✓	✓	✓	✘	✘	✓	✓	✘	✓	✓
Dr Jamie Douglas	✓	✓	✘	✓	✓	✘	✓	✘	✓	✘	✘	✓
Cllr Bill Fairfoull	✘	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cllr Leanne Feeley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✘	✓
Cllr Jim Fitzpatrick	✓	-	-	-	-	-	-	-	-	-	-	-
Cllr Allison Gwynne	✘	✘	✓	✓	✓	✓	✓	✘	✓	✘	✘	✓
Dr Vinny Khunger/ Dr Kate Hebden	✓	✓	✓	✘	✓	✓	✓	✓	✘	✓	✓	✓
Dr Alison Lea	✓	✓	✓	✓	✓ (Chair)	✓	✓	-	-	-	-	-
Steven Pleasant	✓	✓	✓	✘	✓	✓	✘	✓	✓	✓	✓	✓
Carol Prowse	✓	✓	✓	✓	✘	✓	✓	✘	✓	✘	✓	✓
Dr Ashwin Ramachandra	-	-	✘	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cllr Oliver Ryan	-	-	✓	✓	✓	✓	✓	✓	✓		✓	✓
Cllr David Sweeton	✓	-	-	-	-	-	-	-	-	-	-	-
Cllr Brenda Warrington	✓	✓	✓	✓	✘	✓	✓	✓	✓	✓	✓	✓

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

The CCG is committed to managing all forms of risk in order to ensure that the quality and performance of commissioned services are maintained and that the CCG's reputation, workforce, assets, and finances are protected. The CCG has an Integrated Risk Management Framework in place. This sets out the organisation's approach to risk management and acknowledges that the organisation 'has a statutory and regulatory obligation to ensure that systems of control are in place to minimise the impact of all types of risk which could negatively affect the proper functioning of NHS Tameside and Glossop Clinical Commissioning Group.' The CCG believes in and supports a systematic and consistent approach to risk management throughout the organisation and across all functions and activities. The Integrated Risk Management Framework enables the organisation to have a clear view of the risks affecting each area of its activity including how those risks are being managed, the likelihood of the risk occurring, and their potential impact on the successful achievement of the CCG's objectives.

The Integrated Risk Management Framework describes risk management within the CCG as being 'a proactive, systematic process of risk identification, analysis, treatment, and evaluation of potential and actual risks.' Its primary purpose is to enable individuals, Committees, and the Governing Body to deal competently with all key risks. As such the CCG applies a uniform approach to assessing all risks that is based on the Risk Management System in the Australian/New Zealand Risk Management model (AS/NZS 4360:1999).

The Governing Body recognises that robust risk management and assurance is an integral part of its governance responsibilities and that good management practice should be part of the CCG's culture. The Governing Body is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices, and business plans rather than being viewed or practised separately, and that the responsibility for the implementation of risk management is accepted at all levels of the organisation.

The Governing Body aims to take all reasonable steps in the management of risk towards the overall objective of protecting staff and publicly-funded resources and assets by recognising, preparing for, or avoiding events or inactions which could have a negative impact by making the organisation more effective, and by meeting national objectives and the local corporate, commissioning, and financial governance core objectives. The purpose of the Integrated Risk Management Framework is to encourage a culture whereby risk management is viewed by the CCG and its staff as an integral part of the CCG's activity, to ensure that structures and processes are in place to support the assessment and management of risks throughout the CCG, and to assure the public, patients, their carers and representatives, staff, and partner organisations including provider organisations that the CCG is committed to managing risk appropriately.

The CCG is committed to the effective and efficient management of risk and ensures that robust risk management systems and procedures are implemented. The purpose of such systems and procedures is to identify, evaluate, control, and eliminate or reduce to an acceptable level all risks that may adversely affect the quality of commissioned patient care, the commissioning of and access to high quality services, the health and safety of employees and visitors, and the ability to meet financial and contractual arrangements. It is recognised that some risks cannot be eliminated and in these instances action is taken to minimise risk within available resources and as is reasonably practicable.

A risk management system is in place which ensures that risks are identified and captured within a risk register. At this stage the CCG's appetite to this newly-identified risk is established. This risk register in turn informs the Governing Body Assurance Framework which is formally reviewed by the Audit Committee and the Governing Body. Risk management is embedded in the activity of the CCG as, for example, the Governing Body's meeting agenda is informed by the strategic objectives of the organisation and the associated risks to their achievement as detailed within the Assurance Framework. The Assurance Framework has been incorporated into the Governing Body meeting agendas as a standing item. The management of individual risks within the risk register is owned by individual officers and the action planning process is regularly monitored on the Governing Body's behalf by the Audit Committee.

The organisation has robust counter-fraud arrangements in place. The CCG commissions a Counter-Fraud service which reports regularly to the Audit Committee. There are also regular staff and service communications with the aim of reducing the likelihood of the CCG being the victim of fraud as well as mandatory training for staff. The CCG has in place arrangements to involve the public in the design of services, and undertakes a proactive role in consulting with patients and public stakeholders. The organisation has effective relationships with the local Healthwatch groups and with local authority Scrutiny Committees. Public stakeholders are involved in managing the risks which impact upon them; for example the Engagement Strategy provides for patient and public involvement from the beginning of any new service proposal or service re-design and the Strategic Commissioning Board would not support any commissioning proposal that was not accompanied by the relevant impact assessments.

The CCG is fully engaged with public views and opinions and has undertaken two wide-reaching public consultations during the year.

The Audit Committee receives regular reports detailing all serious incidents affecting the CCG and uses such data to inform its review of the Operational Risk Register and its assessment as to whether or not the mitigations and controls in place are appropriate.

There are control measures in place to ensure that the organisation complies with all of its obligations under equality, diversity, and human rights legislation.

The CCG ensures that all of its providers of health services are fully compliant with the Care Quality Commission's 'essential standards of quality and safety' where applicable.

Governance Statement

Capacity to Handle Risk

The responsibility for the management of risk across the CCG resides with the Governing Body and, as Accountable Officer, I am accountable overall for risk management within the organisation and therefore I provide the necessary leadership in this area.

The Audit Committee has responsibility on behalf of the Governing Body for overseeing risk management in operation. The following officers were specifically responsible during 2018/19 for risk issues within their own defined area of responsibility: the Chief Finance Officer, the interim Director of Commissioning, and the Director of Quality and Safeguarding. These directors ensured that staff undertook mandatory training in Health and Safety, Fire Safety Awareness, Information Governance, Manual Handling, Safeguarding Adults, Safeguarding Children, Equality and Diversity, Managing Conflicts of Interest, and Fraud Awareness as appropriate. These officers ensure that risk is managed within their directorates in accordance with the requirements of the organisation's Integrated Risk Management Framework. The CCG also seeks to learn from good practice in risk management, and maintains contacts with other organisations both inside and outside the NHS (including other CCGs, the Greater Manchester Health and Social Care Partnership, NHS England, NHS Resolution, and local authorities) in order to achieve this.

The CCG's directors use the most current performance information to inform their assessment of the risks within their areas of responsibility. The Governing Body continues to routinely receive a comprehensive performance and quality report which sets out achievement against its NHS Constitutional and statutory obligations. The Governing Body enjoys a significant degree of scrutiny of this performance and quality data and this is triangulated with other key messages including those from the financial reporting.

The CCG's staff are supported in the management of risk by the Director of Finance. This includes discussions to evaluate the impact and likelihood scores in the context of the CCG's Integrated Risk Management Framework to ensure consistency across the Operational Risk Register.

During 2018/19 the Governing Body has regularly received the Governing Body Assurance Framework at its meetings to facilitate the discussion as to whether or not the CCG's current risks are being appropriately monitored and controlled.

Risk Assessment

The Governing Body Assurance Framework and Operational Risk Register reflect the CCG's risk profile. They contain the strategic and operational risks identified by the CCG, they describe the controls in place, and they indicate the strength and quality of assurances available on how well the risks are being managed.

These documents support the Governing Body (via the Audit Committee with regards to the Operational Risk Register) in making a declaration on the effectiveness of the CCG's system of internal control in this Annual Governance Statement.

The following sections describe how the CCG identifies, evaluates, and controls risk:

- **Establishing the context:** The CCG's activities are defined and the underlying goals and objectives are identified. These CCG objectives form a framework for the Governing Body Assurance Framework and the assessment of the principal risks associated with these forms the basis of the Operational Risk Register.
- **Risk appetite:** The CCG's risk appetite is the amount of risk which the CCG judges to be tolerable and justifiable. It is the amount of risk that the CCG is prepared to accept, tolerate, or be exposed to at any point in time. Definitions of the limits of the risk appetite are determined on the Governing Body's behalf by the Audit Committee.
- **Risk Assessment:** The CCG applies a five by five matrix (of likelihood and impact ratings) for assessing its risks and assesses controlled risk and risk appetite in the same terms. The CCG has adopted a hierarchical matrix approach to risk appetite and this recognises that risks occur at different levels in the organisation. An effective escalation procedure is in place to ensure that these risks are escalated to senior managers quickly.

The following steps are in place when identifying and assessing risks:

- risk identification (either prospective or reactive)
- risk analysis (separating the minor, acceptable risks from the major risks and providing data to assist in the evaluation and management of risks)
- the evaluation and ranking of risks (an assessment of risk is made using the five by five matrix based on the consequences should the risk occur and also the likelihood of the risk actually happening)
- review (each responsible officer ensures that their areas of risk are being actively managed and are reviewed and updated on a regular basis)
- and treatment (the actions taken to reduce the risk to an acceptable level and therefore bring it within the CCG's risk appetite).

The CCG identified two new risks during 2018/19 which related to the following areas:

- risk of challenge to plans for procurement of Home Oxygen Service contract extension
- risk of disruption to the NHS if no deal is reached for Brexit

The CCG experienced no externally reportable lapses in data security during the year.

This risk will continue to be managed by the responsible directors with oversight by the Audit Committee on behalf of the Governing Body via the Operational Risk Register review process and the Governing Body Assurance Framework. Although it was reduced to low risk by the end of the financial year.

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 Governing Body Assurance Framework has been developed in order to provide effective and focused management of the principal risks to meeting the CCG's strategic objectives and to provide control of the supporting processes. It provides a structure for the evidence to support the validity of this governance statement. The framework is based on the principal strategic objectives of the organisation and identifies the major risks that are present and which, if not addressed, could adversely affect the achievement of those objectives. It goes on to detail the key controls that are in place to address these risks together with the assurances and their sources available to the Governing Body. This process enables the Governing Body to identify where there are gaps in assurance or gaps in control. No significant gaps in assurance or control have been present within the Governing Body Assurance Framework during 2018/19. The reviews of the Operational Risk Register by the Audit Committee have assured the Governing Body that actions are embedded. This view is further supported by the review of the Governing Body Assurance Framework conducted by the CCG's Internal Auditors during 2018/19.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) 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 has instructed its internal auditors to carry out the annual audit of the arrangement for the management of conflicts of interest. The following table sets out the scope areas considered and the compliance levels attained.

	Scope Area	Compliance Level	RAG rating
1	Governance arrangements	Fully compliant	●
2	Declarations of interests and gifts and hospitality	Fully compliant	●
3	Register of interests, gifts and hospitality and procurement decisions	Fully compliant	●
4	Decision making processes and contract monitoring	Fully compliant	●
5	Reporting concerns and identifying and managing breaches / non-compliance	Fully compliant	●

Data Quality

The Governing Body is presented with different types of data from a number of sources. Much of the data is provided to the CCG by specialist analysts at the Greater Manchester Shared Services (formerly the North West Commissioning Support Unit).

The Governing Body also receives information in a narrative form such as the assurance reports from its formal committees.

A key element of the CCG's system of internal control is the Governing Body's effectiveness in triangulating these different information sources to arrive at effective and informed decision-making.

The Governing Body has supported the development of improved performance and quality reporting. The changes have been focused upon expanding the scope of the report's content and were not driven by any concerns regarding the quality or accuracy of the data being received. No significant internal control issues have been identified in this area.

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. The CCG is pleased to report that it has submitted a self-assessment for the Data Security and Protection Toolkit (DSPT)..

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

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

Business Critical Models

There is an appropriate framework and operating environment in place to provide quality assurance of the CCG's business critical models. No significant internal control issues have been identified in this respect as the CCG uses only those models prescribed by NHS England.

Third party assurances

The CCG's Audit Committee receives a programme of audits of third party suppliers to provide assurance of these arrangements. No significant issues have been identified through these audits

Control Issues

There are no significant control issues currently facing the CCG.

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

The CCG has applied value for money principles in order to ensure that the outcomes and outputs achieved reflect the 3Es (economy, efficiency, and effectiveness) while ensuring the best possible level of quality and safety in commissioned services for our population. The Governing Body and its committees are mindful of these requirements in their deliberations and decisions, and have received assurance from internal and external auditors, and also via the Governing Body Assurance Framework and Operational Risk Register, accordingly.

During 2018/19 the CCG achieved its targets for delivering a financial surplus and for Quality, Innovation, Productivity, and Performance (QIPP) (an efficiency measurement) despite the very challenging context. This evidences how the CCG has delivered value for money for its public. The CCG has been instrumental in developing a constructive and transparent financial culture within the locality whereby the CCG, Tameside Metropolitan Borough Council, and Tameside and Glossop Integrated Care NHS Foundation Trust work together to ensure that costs are removed from the economy rather than being 'shunted around' to the detriment of any one organisation.

The CCG has in place a structured approach to the identification and monitoring of QIPP plans. This approach has been reviewed in year by Mersey Internal Audit Agency (our Internal Auditors) and for this review the CCG received an audit opinion of 'high assurance'.

The progress made against the QIPP programme has routinely been reported through to the Governing Body via the Finance & QIPP Assurance Group minutes.

Delegation of functions

The CCG operates a scheme of delegation which sets out the powers reserved by the GP membership and those delegated to other components of the CCG's decision-making architecture. This scheme of delegation is overseen by the Audit Committee on behalf of the Governing Body and the membership and is open to scrutiny by both Internal Audit and External Audit colleagues.

The most significant area of delegation for the CCG is, as described above, to the Strategic Commissioning Board. There is routine reporting from the Strategic Commissioning Board to the Governing Body to provide feedback and assurance.

There are reviews undertaken by the CCG's Executive Support Manager of the minutes and reports to ensure that the Strategic Commissioning Board is operating within the terms of its delegation.

Counter fraud arrangements

The CCG has made the following arrangements regarding its managing of counter fraud:

- •An accredited Counter Fraud Specialist is contracted from TIAA to undertake counter-fraud work proportionate to the identified risks
- The CCG's Audit Committee receives a report against each of the Standards for Commissioners at least annually. There is the commitment to provide executive support and direction for a proportionate proactive work plan should this report identify any risks to the organisation
- The Audit Committee oversees the CCG's self-assessment exercise in respect of the Self-Reporting Tool to the NHS Counter-Fraud Authority
- The Lay Member with responsibility for Governance is proactively and demonstrably responsible for tackling fraud, bribery, and corruption
- The CCG has in place a Whistleblowing Policy which is in line with the joint guidance received from NHS England and NHS Improvement
- The CCG would take appropriate action regarding any quality recommendations from the NHS Counter-Fraud Authority

Head of Internal Audit Opinion

In accordance with Public Sector Internal Audit Standards, the Head 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, which was agreed with management and approved by the Audit Committee in March 2018.

Our overall opinion for the period 1st April 2018 to 31st March 2019 is:

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.

Our opinion covers the period 1st April 2018 to 31st March 2019 inclusive, and is underpinned by the work conducted through the risk based internal audit plan.

Assurance Framework

The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Governing Body and clearly reflects the risks discussed by the Governing Body.

Conflicts of Interest

As required by NHS England's Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (June 2017), an audit of conflicts of interest was completed following the prescribed framework issued by NHS England. The CCG was fully compliant in all scoped areas.

Primary Medical Care Commissioning and Contracting Arrangements

The Primary Medical Care Commissioning and Contracting Internal Audit Framework for Delegated CCGs was issued in August 2018. NHSE require an Internal audit of delegated CCGs primary medical care commissioning arrangements. The purpose of this is to provide information to CCG's that they are discharging NHSE's statutory primary medical care functions effectively, and in turn to provide aggregate assurance to NHSE and facilitate NHSE's engagement with CCGs to support improvement.

The 2018/19 Primary Medical Care Commissioning and Contracting review focused upon Governance and provided Substantial Assurance (assurance rating provided as per the NHSE guidance).

Risk Based Reviews

We issued:

1 high assurance opinions	QIPP
5 substantial assurance opinions	Continuing Healthcare Strategic Commission Financial Systems & Reporting Data Security & Prevention Toolkit Performance Management
0 moderate assurance opinions	N/A
0 limited assurance opinions	N/A
0 no assurance opinions	N/A

We raised no critical and one high risk recommendation in respect of the above assignments. The high risk recommendation was in relation to the review of Continuing Healthcare.

Steve Connor
(Head of Internal Audit, MIAA)
March 2019

Governance Statement Review

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

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

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

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

- The Governing Body
- The Audit Committee
- The Quality and Performance Assurance Group
- Our Internal Auditors (Mersey Internal Audit Agency)

Conclusion

The consultations of each of these are that no significant control issues have been identified.

Steven Pleasant
(Accountable Officer)
22 May 2019

Remuneration

Remuneration Report

The Remuneration Committee's remit is to make recommendations to the Governing Body on determinations about the remuneration, fees, and other allowances for employees, clinicians and for the people that provide services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

The Committee is responsible for:

- Making recommendations to the Governing Body on any proposed remuneration and terms of service for clinical Governing Body members taking into account any national or local guidance as appropriate so as to ensure that the individual is fairly rewarded for their contribution to the CCG whilst having proper regard to the CCG's circumstances and performance.
- Advising the Governing Body on appropriate remuneration and terms of service for the Chief Operating Officer, Directors, and any other senior employees who report to the Chief Operating Officer in accordance with relevant national pay frameworks or any other guidance as appropriate. This will include all aspects of salary (including any performance related elements and bonuses), provisions for other benefits, and any other contractual terms.
- Advising and overseeing appropriate contractual arrangements for staff and clinicians including proper calculations and scrutiny of termination payments, excluding ill health and normal retirement, and taking into account such national guidance as is appropriate.
- Approving the design of and determining targets for any performance-related pay schemes, and approving the total annual payments made under such schemes.
- Determining any ad-hoc arrangements relating to pension arrangements for any Executive Directors and any other Senior Managers.
- Considering and, if appropriate, approving proposals presented by the Chief Operating Officer or by the Chair of the Governing Body for the setting of remuneration and conditions of service for other employees and officers.
- Reviewing plans produced by the Chair or the Chief Operating Officer which set out appropriate succession planning for clinical posts and senior officers, taking into account the challenges and opportunities facing the CCG and the skills and expertise required of the Governing Body in the future.
- Ensuring that all provisions regarding the disclosure of remuneration, including pensions, are fulfilled.
- Ensuring that remuneration and terms and conditions of engagement for all staff are set out in writing in a contract of employment or engagement.

For each member of the Governing Body and other Senior Managers who have served during the financial year 2018/19, the details regarding service contract, remuneration and pension benefits are shown in the tables on the following pages.

Presumption of disclosure

Information about named individuals will be given in all circumstances and all disclosures in the Remuneration Report will be consistent with the identifiable information of those individuals in the Financial Statements.

Remuneration and Terms of Service Committee Report

For the period from 1 April 2018 to 31 March 2019, details of the membership of the Remuneration Committee were as follows:

- Steven Pleasant, Accountable Officer
- Kathy Roe, Chief Finance Officer and CCG Deputy Accountable Officer
- Steven Pleasant, Accountable Officer
- Jamie Douglas, Governing Body GP member
- Vinny Khunger, Governing Body GP member
- Maggie Murdoch, Lay Member
- Carole Prowse, Lay Member
- David Swift, Lay Member and Deputy Chair (Lay)

The Remuneration and Terms of Service Committee follow national guidance issued by the Department of Health and Social Care to determine the remuneration and terms and conditions of senior managers using the national Very Senior Managers pay framework (VSM). The Remuneration and Terms of Service Committee is also responsible for the remuneration of the clinical members.

The policy on the duration of senior manager contracts is in line with the CCG's Approved Standing Orders.

The performance of VSMs is assessed through the CCG's Personal Development Review system in line with NHS policy. Remuneration is not performance-related. Termination of contracts, and any relevant payments, would be calculated on an individual basis taking into account circumstances of termination, notice periods, length of service, and salary. All calculations would be in line with statutory and NHS terms and conditions.

Name and Title	2018/2019					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Executive Governing Body Members						
* S Pleasant Chief Operating Officer/Accountable Officer	0	0	0	0	0	0
** K Roe Chief Finance Officer	110-115	0	0	0	27.5-30	135-140
Other Senior Managers						
Jessica Williams Interim Director of Commissioning	110-115	0	0	0	12.5-15	120-125
Gill Gibson – Director of Quality & Safeguarding	95-100	0	0	0	87.5-90	185-190
Clinical Governing Body Members						
A Dow Chair	110-115					110-115
T Hendra GB Secondary Care Consultant	5-10					5-10
J Douglas GB GP Member – Ageing Well	55-60					55-60
A Lea GP Member – Starting Well Until 30.9.18	25-30					25-30
C Todd Governing Body Nurse	15-20					15-20
*** V Khunger GB GP member Primary care development.	25-30					25-30
*** K Hebden GB GP member – Primary care development	25-30					25-30
C Chan Post CCT Fellow GB GP Member From 4.6.18	40-45					40-45
A Ramachandra GB GP Member	55-60					55-60
C Ahmed GB GP Member From 1.12.18	15-20					15-20

Remuneration

Name and Title	2018/2019					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Governing Body Lay Members						
D Swift Lay Member, Audit Chair & Deputy Chair (Lay)	5-10					5-10
C Prowse Lay Member	5-10					5-10
M Murdoch Lay member	5-10					5-10

* S Pleasant: The Accountable Officer is paid a salary of £173,690 by Tameside MBC, with no recharge to the CCG

** K Roe: The Chief Finance Officer has also been appointed as the Section151 Officer for Tameside MBC. No recharge of the salary detailed in the table above, is made to Tameside MBC, however, in addition to this salary, an amount of £8,000 per annum is paid by Tameside MBC.

*** V Khunger/K Hebden: This role is shared between 2 GB GP Members

KPMG under the terms of the audit, have audited the above figures showing senior managers' pension entitlements.

Senior Manager Remuneration (including salary and pension entitlements) Prior year

Name and Title	2017/2018					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Executive Governing Body Members						
S Pleasant Chief Operating Officer/Accountable Officer	0	0	0	0	0	0
K Roe Chief Finance Officer	105-110	0	0	0	17.5-20	120-125
Other Senior Managers						
C Watson Director of Commissioning Until 30 Sept 17	40-45				62.5-65	105-110
Jessica Williams Interim Director of Commissioning From 1st Oct 17	50-55				12.5-15	60-65
Gill Gibson – Director of Quality & Safeguarding From 1st May 17	80-85				40-42.5	125-130
M Walsh Interim Director of Nursing & Quality 1st Apr 17 - 30th Apr 17	5-10				0	5-10

Remuneration

Name and Title	2017/2018					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Clinical Governing Body Members						
A Dow Chair	135-140					135-140
T Hendra GB Secondary Care Consultant	5-10					5-10
J Douglas GB GP Member – Ageing Well	55-60					55-60
C Greenhough GP Member – Living well (Clinical Vice Chair)	40-45					40-45
A Lea GP Member – Starting Well	55-60					55-60
C Todd Governing Body Nurse	15-20					15-20
V Khunger GB GP member Primary care development. 1.1.18	25-30					25-30
K Hebden GB GP member – Primary care development From 1 Jan 18	5-10					5-10
Governing Body Lay Members						
C Poole Lay Member 1st Apr 17 – 30th Apr 17	0-5					0-5
D Swift Lay Member, Audit chair & deputy chair (Lay)	5-10					5-10
C Prowse Lay Member	5-10					5-10
J Farley Lay Member 1 Aug 17 – 30 Sep 17	0-5					0-5
M Murdoch Lay Member From 19 Mar 18	0-5					0-5

KPMG under the terms of the audit, have audited the above figures showing senior managers' pension entitlements.

Pension benefits as of 31 March 2019

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2018	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2019	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Governing Body Executive Members								
K Roe – Chief Finance Officer	0-2.5	0	45-50	110-115	738	106	859	0
Governing Body Executive Members								
G Gibson – Director of Nursing & Quality	2.5-5	7.5-10	30-35	70-75	481	126	620	0
J Williams – Interim Director of Commissioning	0-2.5	0	30-35	75-80	545	70	629	0

KPMG under the terms of the audit, have audited the above figures showing senior managers' pension entitlements.

Inflation is assumed to be 3% for figures relating to 2017/18 in the above tables.

Remuneration

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

Compensation on early retirement of for loss of office

Nil for 2018/19

Payments to past members

Nil for 2018/19

Pay multiples

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

The banded remuneration of the highest paid member in NHS Tameside & Glossop CCG in the financial year 2018/19 was £187.5k-£190k (2017/18: £182.5k-185k). This was 4.5 times (2017/18: 4.4) the median remuneration of the workforce, which was £41.7k (2017/18: £41.7k).

In 2018/19, nil employees received remuneration in excess of the highest-paid member.

Remuneration ranged from £190k to £4k (2017/2018: £184k to £7k).

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.

Number of Senior Managers

The number of senior managers employed by the CCG as at 31st March 2019, is detailed in the table below. The equivalent information is shown as at 31St March 2018 for comparison purposes.

	31st March 2019		31st March 2018	
	Number	Full-time Equivalent (FTE)	Number	Full-time Equivalent (FTE)
Band 7	24	23.39	20	19.26
Band 8a	11	10.8	11	11
Band 8b	8	7.8	6	5.8
Band 8c	8	7.6	8	8
Band 8d	1	1	2	1.6
VSM	3	3	3	3
Total	**55**	**53.59**	**50**	**48.66**

The above table does not include Non-Officer Governing Body Members.

Employee Benefits

	March 2019			March 2018		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£000	£000	£000	£000	£000	£000
Salaries & Wages	3,834	262	4,096	3,649	443	4,092
Social security costs	412	21	433	387	16	403
Employer contributions to pensions	524	24	548	485	15	500
Apprenticeship Levy	7	0	7	5	0	5
Termination benefits	46	0	46	0	0	0
Recovery in respect of employee benefits	(373)	0	(373)	(280)	0	(280)
Total	**4,450**	**307**	**4,757**	**4,246**	**474**	**4,720**

Staff Report

Average Number of People Employed

	April 2018 - March 2019			April 2017 - March 2018		
	Permanent Employees FTE	Other FTE	Total FTE	Permanent Employees FTE	Other FTE	Total FTE
Total CCG	80.49	4.89	85.38	78.0	5.00	83.00

Staff Composition – Average (April 2018- March 2019)

Level	Male		Female	
	AVG Number	AVG FTE	AVG Number	AVG FTE
Governing Body Members and Clinical Leads	9.25	2.65	9.67	3.37
Senior Managers	16.58	16.58	40.33	38.93
Other	4.58	4.58	28.25	26.15
Total	30.41	23.81	78.25	68.45

Staff Composition – Average (April 2017 – March 2018)

Level	Male		Female	
	AVG Number	AVG FTE	AVG Number	AVG FTE
Governing Body Members and Clinical Leads	10.6	2.5	7.5	2.4
Senior Managers	13.6	12.9	40.0	37.8
Other	2.1	2.1	26.1	24.8
Total	26.3	17.5	73.6	65.00

Sickness absence data 2018/19

AVG FTE	Adjusted FTE sick days	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Annual Sick Days per FTE
92.14	1029	33,631.52	998.27	10.83

Responsibilities Towards Staff Members with Disabilities

We have legal responsibilities towards disabled employees as defined in the Equality Act 2010. Protection against discrimination due to disability is now covered by the Act. Whilst the Act aims to streamline and harmonise all discrimination legislation, due to the additional barriers faced by disabled people, it does allow disabled people to be treated more favourably than their non-disabled colleagues. It is crucial to acknowledge and understand the reasons for this legislation in order to remove the barriers that continue to deny disabled people equality of outcome in work and more broadly.

The Equality Act 2010 defines a disabled person as: "... someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."

All our employee-related policies adhere to the social model of disability so that reasonable adjustments to working conditions, policies, and practices may be requested. This aims to ensure disabled people have the opportunity to obtain and remain in employment with the CCG and to support people who may become disabled while in employment. Appropriate adjustments may be made to the working environment (including equipment), terms and conditions of employment (such as working hours), and the duties of posts (such as reallocating duties to other team members).

We will ensure a consistent, equitable, and sustainable approach to making reasonable adjustments is taken throughout the organisation. We undertake to monitor the number and proportion of CCG employees who identify as disabled and to report on this annually as part of our workforce monitoring. This will also include the experiences of those applying for employment with the organisation.

We will encourage disabled employees to self-identify themselves as having impairment or long-term health condition as experience shows that many people do not do so for a number of reasons. We will aim to adopt and implement good practice and standards which support us to meet the aims of our Equality and Diversity Policy, beginning with the Two Ticks Disability Equality symbol and assurance framework.

Other Employee Matters

The CCG is committed to equality of opportunity for all employees and is committed to employment practices, policies and procedures which ensure that no employee, or potential employee, receives less favourable treatment on the grounds of sex, race, ethnic or national origin, sexual orientation, marriage and civil partnership, religion or belief, age, pregnancy and maternity, trade union membership, disability, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation, or any other personal characteristic. Diversity is viewed positively and, in recognising that everyone is different, the unique contribution that each individual's experience, knowledge, and skills can make is valued equally. The promotion of equality and diversity is actively pursued through policies and ensures that employees receive fair, equitable and consistent treatment. It also ensures that employees, and potential employees, are not subject to direct or indirect discrimination.

The CCG's employment policies are taken to the Strategic Commission's Employee Consultation Group where they are reviewed by management, staff, and Union representatives.

The CCG has in place robust policies and procedures regarding health and safety practices in the workplace.

The CCG applies the Agenda for Change salary management framework for its staff. To supplement and support this the CCG has in place processes for staff personal development including annual reviews.

Expenditure on Consultancy

The CCG had no expenditure on consultancy services during 2018/19

Off-payroll Engagements

Table 1: Off-Payroll Engagements Longer than Six Months
The CCG has no off-payroll engagements as at 31 March 2019 for more than £245 per day and that lasted longer than six months.

Table 2: New Off-Payroll Engagements
The CCG had no new off-payroll engagements that reached six months in duration, between 1 April 2018 and 31 March 2019, where costs exceeded £245 per day.

Table 3: Off-Payroll Engagements / Senior Official Engagements
The CCG had no off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019.

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole Numbers Only	£s	Whole Numbers Only	£s	Whole Numbers Only	£s	Whole Numbers Only	£s
Less than £10,000								
£10,000 - £25,000								
£25,001 - £50,000	1	£45,553			1	£45,553		
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Totals	1	£45,553	0	0	1	£45,553	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change. Exit costs in this note are accounted for in full in the year of departure. Where NHS Tameside & Glossop CCG has agreed early retirements, the additional costs are met by NHS Tameside & Glossop CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

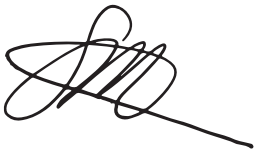
Table 2: Analysis of Other Departures

The CCG had no Voluntary redundancies including early retirement contractual costs, Mutually Agreed Resignations (MARS) contractual costs, early retirements in the efficiency of the service contractual costs, exit payments following Employment Tribunals or court orders, or non-contractual payments requiring HMT approval.

Parliamentary Accountability and Audit Report

Tameside and Glossop CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report.

An audit certificate and report is also included as an appendix to this in this Annual Report



Steven Pleasant
(Accountable Officer)
22 May 2019

Annual Accounts

Steven Pleasant
(Accountable Officer)

22 May 2019

FOREWORD TO THE ACCOUNTS

NHS Tameside and Glossop Clinical Commissioning Group

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

These accounts for the year ended 31 March 2019 have been prepared by NHS Tameside and Glossop 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 NHS Clinical Commissioning Groups to prepare their Annual Report and Annual Accounts in accordance with Directions issued by NHS England.

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The Primary Statements:

Notes to the Accounts

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

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(3,423)	(771)
Other operating income	2	(16)	(2,966)
Total operating income		**(3,439)**	**(3,737)**
Staff costs	4	5,129	5,000
Purchase of goods and services	5	400,264	387,552
Depreciation and impairment charges	5	21	22
Provision expense	5	28	146
Other Operating Expenditure	5	483	398
Total operating expenditure		**405,925**	**393,118**
Net Operating Expenditure		**402,486**	**389,381**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**402,486**	**389,381**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**402,486**	**389,381**
Comprehensive Expenditure for the year		**402,486**	**389,381**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	13	21	42
Total non-current assets		21	42
Current assets:			
Trade and other receivables	17	2,592	2,874
Cash and cash equivalents	20	171	9
Total current assets		**2,763**	2,883
Total current assets		**2,763**	2,883
Total assets		**2,784**	2,925
Current liabilities			
Trade and other payables	23	(24,486)	(19,549)
Provisions	30	(277)	(389)
Total current liabilities		**(24,763)**	(19,938)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(21,979)**	(17,013)
Assets less Liabilities		**(21,979)**	(17,013)
Financed by Taxpayers' Equity			
General fund		(21,979)	(17,013)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(21,979)**	(17,013)

The notes on pages 7 to 33 form part of this statement

The financial statements on pages 3 to 6 were approved by the Governing Body on 22/05/2019 and signed on its behalf by:

Stephen Pleasant
Chief Accountable Officer

31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(17,013)	0	0	**(17,013)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	0			**0**
Impact of applying IFRS 15 to Opening Balances	0			**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(17,013)**	**0**	**0**	**(17,013)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(402,486)			**(402,486)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(402,486)**	**0**	**0**	**(402,486)**
Net funding	397,520	0	0	**397,520**
Balance at 31 March 2019	**(21,979)**	**0**	**0**	**(21,979)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(16,082)	0	0	**(16,082)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(16,082)**	**0**	**0**	**(16,082)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(389,381)			(389,381)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(389,381)**	**0**	**0**	**(389,381)**
Net funding	388,450	0	0	388,450
Balance at 31 March 2018	**(17,013)**	**0**	**0**	**(17,013)**

The notes on pages 7 to 33 form part of this statement

Statement of Cash Flows for the year ended
31 March 2019

	Note	**2018-19** **£'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(402,486)	(389,381)
Depreciation and amortisation	5	21	22
(Increase)/decrease in trade & other receivables	17	282	91
Increase/(decrease) in trade & other payables	23	4,937	593
Provisions utilised	30	(140)	(42)
Increase/(decrease) in provisions	30	28	146
Net Cash Inflow (Outflow) from Operating Activities		**(397,358)**	(388,571)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) before Financing		**(397,358)**	(388,571)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		397,520	388,450
Net Cash Inflow (Outflow) from Financing Activities		**397,520**	388,450
Net Increase (Decrease) in Cash & Cash Equivalents	20	**162**	(121)
Cash & Cash Equivalents at the Beginning of the Financial Year		**9**	130
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**171**	9

The notes on pages 7 to 33 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis ***[despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014].***

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

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

1.2 Accounting Convention

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

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

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

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

1.4 Pooled Budgets

The NHS Clinical Commissioning Group has entered into a pooled budget arrangement with Tameside Metropolitan Borough Council and Derbyshire County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled to provide integrated health and care services across the Local Authorities and the NHS. Note 35 provides details of the income and expenditure.

The pool is hosted by Tameside Metropolitan Borough Council. The NHS Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 Operating Segments

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

Notes to the financial statements

1.6 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the NHS Clinical Commissioning Group will not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less;
• The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date;
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the NHS Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application;
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

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

1.70 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

1.9.1 **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.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Subsequent Expenditure**

Notes to the financial statements

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.

1.1 **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 NHS Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the NHS 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 NHS Clinical Commissioning Group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

1.11 **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.

Notes to the financial statements

1.12 **The NHS 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 NHS 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.

1.13 **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 NHS Clinical Commissioning Group's cash management.

1.14 **Provisions**

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

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

• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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

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

1.15 **Clinical Negligence Costs**

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

1.16 **Non-clinical Risk Pooling**

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

1.17 **Contingent liabilities and contingent assets**

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Value Added Tax**

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

1.19 **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 NHS Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

Notes to the financial statements

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

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

The calculation of running costs has been undertaken in accordance with NHS England national guidance and definitions. However the application of the rules for each organisation involves an application of professional judgement to particular circumstances

1.33.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Due to the NHS England deadline for the submission of the accounts, actual information is not available for the full 12 months for some material expenditure such as prescribing expenditure and Continuing Healthcare expenditure. The NHS Clinical Commissioning Group therefore estimates one or two months of expenditure in some areas using historical information, embedded systems, and other available information sources.

NHS England has set performance targets in respect of non-frontline expenditure (administration expenditure). NHS Clinical Commissioning Groups therefore categorise revenue income and expenditure as either “administration” or “programme”. This involves an application of professional judgement.

Amounts included in provisions include an element of uncertainty around both the amount and timing of the likely liability occurring. They are also frequently, but not necessarily, one-off or unusual items for which there are fewer comparisons.

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

The Department of Health and Social Care Group Accounting Manual does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the Government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The NHS Clinical Commissioning Group has a limited number of operating leases which would require re-consideration on the adoption of IFRS 16. The impact on the financial statements is not considered likely to be material to the NHS Clinical Commissioning Group.

2 Other Operating Revenue

	2018-19 Total	2017-18 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	-
Non-patient care services to other bodies	**485**	491
Other Contract income	**2,565**	-
Recoveries in respect of employee benefits	**373**	280
Total Income from sale of goods and services	**3,423**	**771**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**16**	20
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**-**	2,946
Total Other operating income	**16**	**2,966**
Total Operating Income	**3,439**	**3,737**

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	306	-	-	-	-	1,968	-
Non NHS	-	179	-	-	-	-	597	373
Total	**-**	**485**	**-**	**-**	**-**	**-**	**2,565**	**373**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	485	-	-	-	-	2,565	373
Over time	-	-	-	-	-	-	-	-
Total	**-**	**485**	**-**	**-**	**-**	**-**	**2,565**	**373**

4. Employee benefits and staff numbers

4.1.1 Employee benefits **Total** **2018-19**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,834**	**262**	**4,096**
Social security costs	**411**	**21**	**432**
Employer Contributions to NHS Pension scheme	**524**	**24**	**548**
Apprenticeship Levy	**7**	**-**	**7**
Termination benefits	**46**	**-**	**46**
Gross employee benefits expenditure	4,822	307	5,129
Less recoveries in respect of employee benefits (note 4.1.2)	**(373)**	**-**	**(373)**
Total - Net admin employee benefits including capitalised costs	4,449	307	4,756
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,449	307	4,756

4.1.1 Employee benefits **Total** **2017-18**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,649**	**443**	**4,092**
Social security costs	**387**	**16**	**403**
Employer Contributions to NHS Pension scheme	**485**	**15**	**500**
Apprenticeship Levy	**5**	**-**	**5**
Gross employee benefits expenditure	4,526	474	5,000
Less recoveries in respect of employee benefits (note 4.1.2)	**(280)**	**-**	**(280)**
Total - Net admin employee benefits including capitalised costs	4,246	474	4,720
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,246	474	4,720

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2018-19 Total £'000	2017-18 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(299)**	**-**	**(299)**	**(224)**
Social security costs	**(33)**	**-**	**(33)**	**(26)**
Employer contributions to the NHS Pension Scheme	**(41)**	**-**	**(41)**	**(30)**
Total recoveries in respect of employee benefits	(373)	-	(373)	(280)

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**80.49**	**4.89**	**85.38**	**77.95**	**5.38**	**83.33**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	45,553	-	-	1	45,553
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**45,553**	**-**	**-**	**1**	**45,553**

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	1	11,153	1	11,153
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	1	76,814	-	-	1	76,814
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**76,814**	**1**	**11,153**	**2**	**87,966**

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	1	11,153
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**1**	**11,153**

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

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

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

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

4.5 Pension costs

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

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

The NHS Clinical Commissioning Group makes alternative pension arrangements for those staff not eligible to join the NHS Pension scheme. The NHS Clinical Commissioning Group uses the government-backed workplace pension scheme National Employment Savings Trust (NEST).This a defined contribution workplace pension scheme in the United Kingdom. It was set up to facilitate automatic enrolment as part of the Government's workplace pension reforms under the Pensions Act 2008.

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2018-19, employers' contributions of £548k were payable to the NHS Pensions Scheme (2017-18: £500k) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	671	637
Services from foundation trusts	228,126	240,160
Services from other NHS trusts	14,249	12,926
Purchase of healthcare from non-NHS bodies	50,018	31,857
Purchase of social care	19,261	14,753
Prescribing costs	42,849	44,545
GPMS/APMS and PCTMS	36,821	35,257
Supplies and services – clinical	8	9
Supplies and services – general	1,148	810
Establishment	1,257	701
Transport	85	1,151
Premises	5,139	4,146
Audit fees	45	45
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	10	-
Other professional fees	490	459
Legal fees	-	85
Education, training and conferences	87	11
Total Purchase of goods and services	**400,264**	**387,552**
Depreciation and impairment charges		
Depreciation	21	22
Total Depreciation and impairment charges	**21**	**22**
Provision expense		
Provisions	28	146
Total Provision expense	**28**	**146**
Other Operating Expenditure		
Chair and Non Executive Members	472	387
Clinical negligence	6	6
Expected credit loss on receivables	-	5
Non cash apprenticeship training grants	-	-
Other expenditure	5	-
Total Other Operating Expenditure	**483**	**398**
Total operating expenditure	**400,796**	**388,118**

6.1 Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10290	110560	10938	87780
Total Non-NHS Trade Invoices paid within target	10166	110108	10871	87031
Percentage of Non-NHS Trade invoices paid within target	**98.79%**	**99.59%**	**99.39%**	**99.15%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2646	245681	2562	257770
Total NHS Trade Invoices Paid within target	2644	245670	2558	257713
Percentage of NHS Trade Invoices paid within target	**99.92%**	**100.00%**	**99.84%**	**99.98%**

7 Income Generation Activities

The NHS Clinical Commissioning Group has no Income generation Activities in 2018/19 (£Nil for 2017/18)

8. Investment revenue

The NHS Clinical Commissioning Group has no Investment Income in 2018/19 (£Nil for 2017/18)

9. Other gains and losses

The NHS Clinical Commissioning Group has no other gains and losses to report in 2018/19 (£Nil for 2017/18)

10. Finance costs

The NHS Clinical Commissioning Group has no Finance costs to report in 2018/19 (£Nil for 2017/18)

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

The NHS Clinical Commissioning Group has no Net gain or losses on transfer absorption to report in 2018/19 (£Nil for 2017/18)

12. Operating Leases

12.1 As lessee

[Where the NHS Clinical Commissioning Group is a lessee, include a general description of significant leasing arrangements, including:
(a) *basis on which contingent rent is determined*
(b) *terms of renewal, purchase options or escalation clauses and*
(c) *restrictions imposed by lease arrangements]*

12.1.1 Payments recognised as an Expense

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	-	5,087	(1)	**5,086**	-	4,051	(10)	**4,041**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**5,087**	**(1)**	**5,086**	**-**	**4,051**	**(10)**	**4,041**

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

13 Property, plant and equipment

2018-19	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2018	-	-	-	-	-	-	106	5	111
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**106**	**5**	**111**
Depreciation 01 April 2018	-	-	-	-	-	-	64	5	69
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	21	-	21
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**85**	**5**	**90**
Net Book Value at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**21**	**-**	**21**
Purchased	-	-	-	-	-	-	21	-	21
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**21**	**-**	**21**
Asset financing:									
Owned	-	-	-	-	-	-	21	-	21
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**21**	**-**	**21**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2018	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The NHS Clinical Commissioning Group has no Additions to assets under construction, or property valuation to report for 2018/19 (£Nil for 2017/18).

13.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	2	10
Furniture & fittings	0	0

14 Intangible non-current assets

The NHS Clinical Commissioning Group has no Intangible non current assets to report for 2018/19 (£Nil for 2017/18)

15 Investment property

The NHS Clinical Commissioning Group has no Investment property to report for 2018/19 (£Nil for 2017/18)

16 Inventories

The NHS Clinical Commissioning Group has no inventories for 2018/19 (£Nil for 2017/18)

17.1 Trade and other receivables

	Current 2018-19 £'000	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS receivables: Revenue	726	-	251	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	1,232	-	1,614	-
NHS accrued income	452	-	614	-
Non-NHS and Other WGA receivables: Revenue	38	-	99	-
Non-NHS and Other WGA prepayments	104	-	159	-
Non-NHS and Other WGA accrued income	17	-	40	-
VAT	25	-	89	-
Other receivables and accruals	(2)	-	7	-
Total Trade & other receivables	**2,592**	**-**	**2,874**	**-**
Total current and non current	**2,592**		**2,874**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	**2018-19 Non DHSC Group Bodies £'000**	**2017-18 DHSC Group Bodies £'000**	**2017-18 Non DHSC Group Bodies £'000**
By up to three months	199	7	11	35
By three to six months	-	-	34	8
By more than six months	34	-	45	40
Total	**233**	**7**	**90**	**83**

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

	Trade and other receivables - NHSE bodies	**Trade and other receivables - other DHSC group bodies**	**Trade and other receivables - external**	**Other financial assets**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Classification under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost	9	151	852	1	**1,013**
Total at 31st March 2018	**9**	**151**	**852**	**1**	**1,013**
Classification under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	9	151	852	1	**1,013**
Total at 1st April 2018	9	151	852	1	**1,013**

18 Other financial assets

The NHS Clinical Commissioning Group has no other financial assets, or expected credit losses on financial assets, to report in 2018/19 (£Nil 2017/18)

19 Other current assets

The NHS Clinical Commissioning Group has no other current assets to report in 2018/19 (£Nil 2017/18)

20 Cash and cash equivalents

	2018-19	2017-18
	£'000	£'000
Balance at 01 April 2018	9	130
Net change in year	162	(121)
Balance at 31 March 2019	**171**	**9**
Made up of:		
Cash with the Government Banking Service	171	8
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**171**	**9**
Balance at 31 March 2019	**171**	**9**

21 Non-current assets held for sale

The NHS Clinical Commissioning Group, does not hold any Non current assets for sale as at 31st March 2019

22 Analysis of impairments and reversals

The NHS Clinical Commissioning Group has no impairments or revaluations to report in 2018/19 (£Nil 2017/18)

23 Trade and other payables	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS payables: Revenue	1,923	-	638	-
NHS accruals	2,215	-	2,110	-
NHS deferred income	-	-	47	-
Non-NHS and Other WGA payables: Revenue	2,547	-	770	-
Non-NHS and Other WGA accruals	15,421	-	12,918	-
Non-NHS and Other WGA deferred income	-	-	12	-
Social security costs	68	-	63	-
Tax	64	-	55	-
Other payables and accruals	2,248	-	2,936	-
Total Trade & Other Payables	**24,486**	**-**	**19,549**	**-**
Total current and non-current	**24,486**		**19,549**	

Other payables include £325k outstanding pension contributions at 31 March 2019

23.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Other borrowings (including finance lease obligations)	Other financial liabilities	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Liabilities held at Amortised cost	72	2,931	16,368	-	-	**19,371**
Total at 31st March 2018	**72**	**2,931**	**16,368**	**-**	**-**	**19,371**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities measured at amortised cost	72	2,931	16,368	-	-	**19,371**
Total at 1st April 2018	72	2,931	16,368	-	-	**19,371**

24 Other financial liabilities

The NHS Clinical Commisioning Group has no other financial liabilities to report in 2018/19 (£Nil 2017/18)

25 Other liabilities

The NHS Clinical Commisioning Group has no other liabilities to report in 2018/19 (£Nil 2017/18)

26 Borrowings

The NHS Clinical Commisioning Group had no borrowings to report in 2018/19 (£Nil 2017/18)

27 Private finance initiative, LIFT and other service concession arrangements

The NHS Clinical Commisioning Group had no Private finance initiative, LIFT and other service concession arrangements to report in 2018/19 (£Nil 2017/18)

28 Finance lease obligations

The NHS Clinical Commissioning Group has no Finance lease obligations to report in 2018/19 (£Nil in 2017/18)

29 Finance lease receivables

The NHS Clinical Commissioning Group has no Finance lease receivables to report in 2018/19 (£Nil in 2017/18)

30 Provisions

	Current 2018-19 £'000	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
Continuing care	281	-	273	-
Other	(4)	-	116	-
Total	**277**	**-**	**389**	**-**
Total current and non-current	**277**		**389**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2018	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**273**	**116**	**389**
Arising during the year	-	-	-	-	-	-	-	28	-	**28**
Utilised during the year	-	-	-	-	-	-	-	(20)	(120)	**(140)**
Balance at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**281**	**(4)**	**277**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	281	(4)	**277**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**281**	**(4)**	**277**

The other provisions relate to the over utilisation of the delapidations provision for the Clinical Commissioning Group's former Trust HQ.

31 Contingencies

The NHS Clinical Commissioning Group has no contingencies held as at 31st March 2019.

32 Commitments

The NHS Clinical Commissioning Group has no other commitments to report as at 31st March 2019.

33 Financial instruments

33.1 Financial risk management

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

As NHS Tameside and Glossop 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 NHS 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 NHS Clinical Commissioning Group in undertaking its activities.

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The NHS 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 NHS Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

As the majority of the NHS Clinical Commissioning Group's revenue comes parliamentary funding, the NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

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

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Trade and other receivables with NHSE bodies	505		505
Trade and other receivables with other DHSC group bodies	689		689
Trade and other receivables with external bodies	38		38
Other financial assets	(2)		(2)
Cash and cash equivalents	171		171
Total at 31 March 2019	**1,401**	**-**	**1,401**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Trade and other payables with NHSE bodies	216		**216**
Trade and other payables with other DHSC group bodies	14,076		**14,076**
Trade and other payables with external bodies	7,815		**7,815**
Other financial liabilities	2,248		**2,248**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2019	**24,355**	**-**	**24,355**

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning Healthcare	405,925	(3,439)	**402,486**	2,784	(24,763)	**(21,979)**
Total	**405,925**	**(3,439)**	**402,486**	**2,784**	**(24,763)**	**(21,979)**

34.1 Reconciliation between Operating Segments and SoCNE

	2018-19 £'000
Total net expenditure reported for operating segments	402,486
Reconciling items:	None
Total net expenditure per the Statement of Comprehensive Net Expenditure	402,486

34.2 Reconciliation between Operating Segments and SoFP

	2018-19 £'000
Total assets reported for operating segments	2,784
Reconciling items:	None
Total assets per Statement of Financial Position	**2,784**

	2018-19 £'000
Total liabilities reported for operating segments	(24,763)
Reconciling items:	None
Total liabilities per Statement of Financial Position	**(24,762)**

35 Joint arrangements - interests in joint operations

Budgets are pooled under section 75 of the NHS Act 2006 for the provision of joint services. The NHS Clinical Commissioning Group has entered into three pooled arrangements. Two pooled arrangements are in relation to the Better Care Fund with Derbyshire County Council and Tameside Metropolitan Borough Council. The Better Care Fund is a programme spanning both the NHS and Local Government which seeks to join-up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. The Better Care Fund has been created to improve the lives of some of the most vulnerable people in our society and providing them with integrated health and social care services, resulting in an improved experience and better quality of life.
The third pooled arrangement is the section 75 element of the Integrated Commissioning Fund held between NHS Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council. The NHS Clinical Commissioning Group remains Lead Commissioner for its own element of the spend in the pool so the accounting remains the responsibility of the NHS Clinical Commissioning Group. Contributions between entities are detailed in the tables below:

35.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2018-19				Amounts recognised in Entities books ONLY 2017-18			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets**	**Liabilities**	**Income**	**Expenditure**	**Assets**	**Liabilities**	**Income**	**Expenditure**
			£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Better care Fund	Tameside MBC	0	0	0	4927	15896	0	0	4629	15597
Better care Fund	Derbyshire CC	0	0	0	464	2292	0	0	456	2252

36 NHS Lift investments

The NHS Clinical Commissioning Group has no NHS Lift investment to report in 2018/19 (£Nil 2017/18)

37 Related party transactions

Details of 2018/19 related party transactions with individuals are as follows:

Senior Manager	Relationship	payment made to	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr A Dow	GP Principal	Cottage Lane Surgery	321	0	0	0
Dr A Lea	GP Partner	Millgate Surgery	2,595	0	0	0
Dr A Ramachandra	GP Partner	Market Street Medical Practice	740	0	0	0
Dr C Chan	Salaried GP	Grosvenor Medical Centre	698	0	0	0
Dr C Ahmed	GP Partner	Mossley Medical Practice	303	0	0	0
Dr J Douglas	Salaried GP	Albion Medical Practice	1,155	0	0	0
Dr K Hebden	GP Partner	Denton Medical Practice	932			
	Member	Orbit Healthcare Ltd	125	0	0	0
Dr V Khunger	Salaried GP	Guide Bridge Medical Practice	560	0	0	0
Mr S Pleasant	Chief Executive	Tameside Metropolitan Borough Council	41,264	0	0	0

The Department of Health and Social Care is regarded as a related party. During the year, the NHS Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department of Health and Social Care is regarded as the Parent Department. The entities with material transactions comprise:

Tameside and Glossop Integrated Care NHS Foundation Trust
Manchester University NHS Foundation Trust (formerly Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust)
Pennine Care NHS Foundation Trust
NHS Pensions Agency
NHS England

Details of 2017/18 related party transactions with individuals are as follows:

Senior Manager			Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr A Dow	GP Principal	Cottage Lane Surgery	288	0	0	0
Dr A Lea	GP Partner	Millgate, formerly Churchgate Surgery	1,853			
Dr C Greenhough	Director	Go to Doc	2,822	502		
Dr J Douglas	Salaried GP	Albion Medical Practice	1,245	0		
Mr S Pleasant	Chief Executive	Tameside Metropolitan Borough Council	17,138	5,597	187	

38 Events after the end of the reporting period

The NHS Clinical Commissioning group has no events after the reporting period, to report.

39 Third party assets

The NHS Clinical Commissioning group has no third party assets to report.

40 Financial performance targets

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

	2018-19 Target	**2018-19 Performance**	2017-18 Target	2017-18 Performance
Expenditure not to exceed income	408,924	405,924	395,296	393,118
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	405,486	402,486	391,559	389,381
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	5,209	3,944	5,197	3,469

41 Analysis of charitable reserves

The NHS Clinical Commissioning Group has no charitable reserves at the reporting date 31st March 2019

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Admin			Programme			Total		2018-19
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	1,935	79	**2,014**	1,900	183	**2,082**	3,834	262	**4,096**
Social security costs	205	3	**208**	206	18	**224**	411	21	**432**
Employer contributions to the NHS Pension Scheme	262	5	**267**	262	19	**281**	524	24	**548**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship Levy	7	-	**7**	-	-	**-**	7	-	**7**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	46	-	**46**	46	-	**46**
Gross employee benefits expenditure	**2,409**	**87**	**2,496**	**2,413**	**220**	**2,633**	**4,822**	**307**	**5,129**
Less recoveries in respect of employee benefits (note 4.1.2)	(193)	-	**(193)**	(180)	-	**(180)**	(373)	-	**(373)**
Total - Net admin employee benefits including capitalised costs	**2,216**	**87**	**2,303**	**2,233**	**220**	**2,453**	**4,449**	**307**	**4,756**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**2,216**	**87**	**2,303**	**2,233**	**220**	**2,453**	**4,449**	**307**	**4,756**

4.1.1 Employee benefits

	Admin			Programme			Total		2017-18
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	1,977	117	**2,094**	1,672	326	**1,998**	3,649	443	**4,092**
Social security costs	208	2	**210**	178	15	**193**	387	16	**403**
Employer contributions to the NHS Pension Scheme	258	2	**260**	227	13	**240**	485	15	**500**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Apprenticeship Levy	5	-	**5**	-	-		5		**5**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**2,449**	**121**	**2,569**	**2,077**	**354**	**2,431**	**4,526**	**474**	**5,000**
Less recoveries in respect of employee benefits (note 4.1.2)	(192)	-	**(192)**	(88)	-	**(88)**	(280)	-	**(280)**
Total - Net admin employee benefits including capitalised costs	**2,257**	**121**	**2,377**	**1,989**	**354**	**2,343**	**4,246**	**474**	**4,720**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**2,257**	**121**	**2,377**	**1,989**	**354**	**2,343**	**4,246**	**474**	**4,720**

Losses and special payments

Losses

The total number of the NHS Clinical Commissioning Group's losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	-	-	1	5
Total	**-**	**-**	**1**	**5**

Special payments

	Total Number of Cases 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Compensation payments	1	0	-	-
Ex Gratia Payments	1	5	-	-
Total	**2**	**5**	**-**	**-**