NHS
Swindon
Clinical Commissioning Group

Swindon Clinical Commissioning Group 2015/16 Annual Report and Accounts

Feedback to this document
We would very much like to hear your views on our annual report. To comment on it, get a copy in an alternative format, or get involved with helping NHS Swindon Clinical Commissioning Group (CCG) shape health services for the people of Swindon and Shrivenham please visit our website www.swindonccg.nhs.uk or call us on 01793 683700 or email enquiries@swindonccg.nhs.uk

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Part 1 – Performance Report

Performance Report

Overview

Statement from the Accountable Officer

Nicki Millin

Welcome to the third Annual Report and Accounts for NHS Swindon Clinical Commissioning Group (CCG). The last twelve months have seen the CCG continue to grow and develop into an organisation that is confident to face the challenges ahead and has the experience to make major decisions about the future healthcare in the local area.

Both nationally and locally the NHS continues to face significant challenges in terms of meeting the health needs of the increasing population, ensuring clinical and financial sustainability.

Performance

A more detailed analysis of the CCG's performance in 2015/16 can be found on pages 15 to 27.

Financial Review

CCGs have a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties were as follows:

- The CCG planned to achieve a surplus of £2,540,000. The actual surplus achieved for the year was £2,604,000. This improved from the surplus of £1,728,000 in 2014/15 and is in line with the 1% national requirement for CCGs.
- The CCG kept within its revenue resource limit of £256,189,000 by drawing down £253,585,000
- The CCG kept within its capital resource limit of £840,000 by making acquisitions totalling £833,000.
- The CCG kept within its revenue administration resource of £5,345,000 by spending £4,668,000. The revenue administration resource included £375,000 in respect of Quality Premium relating to 2014/15.
- The CCG achieved all targets under the Better Payments Practice Code.

Strategy

In 2014 the CCG developed its Five Year Strategic Plan 2014 – 2019 which set out the vision and ambitions for Swindon and Shrivenham health and healthcare services. Information on how the CCG is performing against the strategy can be viewed from page 7.

Risk Management

The CCG has continued its strong focus on risk management during 2015/16. To ensure that risk management is kept at the heart of the CCG it has governance structures and processes in place to actively identify, manage and monitor risks – see page 53.

Governance and the Governing Body

A formal document, called a Constitution, sets out the arrangements the CCG has made to ensure it meets its responsibilities for commissioning high quality services for the people of Swindon and Shrivenham. The CCG refreshed its Constitution during 2015/16.

Highlights of our year

Some highlights of 2015/16 have included:

- The new Swindon Health Centre
- The continuation of the SUCCESS scheme
- The review of Community Services
- Patient stories being shared at Governing Body meetings
- The review and continuation of the Community Navigator Project
- Joint Co-commissioning with NHS England

Looking ahead

Whilst acknowledging some of the successes of the past year, the CCG is also minded to look ahead and consider the challenges and opportunities in the year to come. The CCG has an Operational Plan which sets out the organisations plans for the coming year to improve health outcomes and the quality of health care services for the people of Swindon and Shrivenham. Further information about the CCG's future plans can be read on page 10.

On a personal note, I would like to take this opportunity to thank all those people working both for the CCG and with it for their continued support over the last twelve months. I am also grateful for the continued support of the 26 GP practices who are members of the organisation.

As with everything the CCG does, your voice is vital and I actively encourage you to get involved with the work of the organisation. If you are interested please email the Communications and Engagement Team communications@swindonccg.nhs.uk

Thank you for reading our report – I hope you find it informative and interesting.

Nicki Millin
Accountable Officer
25 May 2016

Purpose and activities of the CCG

Swindon CCG is responsible for planning and funding healthcare on behalf of local people in Swindon and Shrivenham.

CCGs are statutory NHS organisations made up of GP practices from the local area. The CCG is required to have a governing body which is made up of elected clinicians and lay (independent) members who "run" the CCG on behalf of the general practices and are responsible to the practices for doing a good job of planning healthcare services its patients require.

The CCG is a clinically led organisation made up of 26 GP practices who took the responsibility for commissioning (buying) health services on 1 April 2013. This means the CCG is responsible for discharging a range of duties on behalf of our population in line with the NHS Act 2006.

The CCG does not commission primary care services such as GP practices, dental care, pharmacy or optometry (opticians). This is done by NHS England through their local team, referred to as NHS England (South Central Team). NHS England also has the responsibility for commissioning specialised services such as organ transplant and specialist cardiac services. Our partners in Swindon Borough Council (SBC) have responsibility for commissioning public health services including health visiting and drug and alcohol services.

Our ambition

In 2014 the CCG developed its Five Year Strategic Plan 2014 – 2019 (this plan is available on our website) which set out the vision and ambitions for Swindon and Shrivenham health and healthcare services.

The vision for people in Swindon is enshrined in the Health & Wellbeing Strategy:

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

The CCG's mission is:

To optimise the health and wellbeing of the people of Swindon and Shrivenham

At the heart of the CCG's Five Year Strategic Plan are the following aims:

- To increase the life expectancy of people living in Swindon and Shrivenham;
- To reduce health inequalities within Swindon and Shrivenham;
- To increase our self-reliance and support self-care;
- To increase the support we offer to those with long term conditions;
- To reduce unnecessary emergency admissions and promote a shift from unplanned towards planned care;

- To promote the use of new technology and practice to improve the efficiency and productivity of local health services;
- To improve the patient's experience of local health services.

The CCG's ambitions by 2019 are to have achieved the following outcomes:

- Reducing the potential years of life lost in Swindon to 1,865 (13% improvement) thus increasing female life expectancy to above the English average
- Reducing the gap in life expectancy between the most and least advantaged of the male population to below eight years
- Meeting the specific health needs of the growing population from minority groups and also reducing the health inequalities experienced by those who provide informal care for others
- Shift an average of 1.5% of emergency admissions each year into planned care or one stop shop style care (ambulatory care)
- Reducing emergency hospitalisation or admission rates by 1.5% per annum
- Providing greater support to those with long term conditions so that at least 80% of those for whom the CCG cares feel supported
- Reducing the norm for medical length of stay by 10% by 2019
- Reducing the percentage of patients by 60% who are ready to leave hospital but are delayed leaving
- Increasing the number of patients who, when surveyed say their experience of local healthcare was neutral to positive to 90%

The Population We Serve

Below are the changes in the outline of the CCG's population as identified in the Joint Strategic Needs Assessment (JSNA) 2015/16.

The full JSNA along with a number of detailed needs assessments can be found on the Swindon JSNA website and are used to inform commissioning and developing strategies. http://www.swindonjsna.co.uk/

Some of the key facts highlighted in the 2015/16 JSNA summary provide context for some of the decision making in relation to the 2016/17 CCG Operational Plan include:

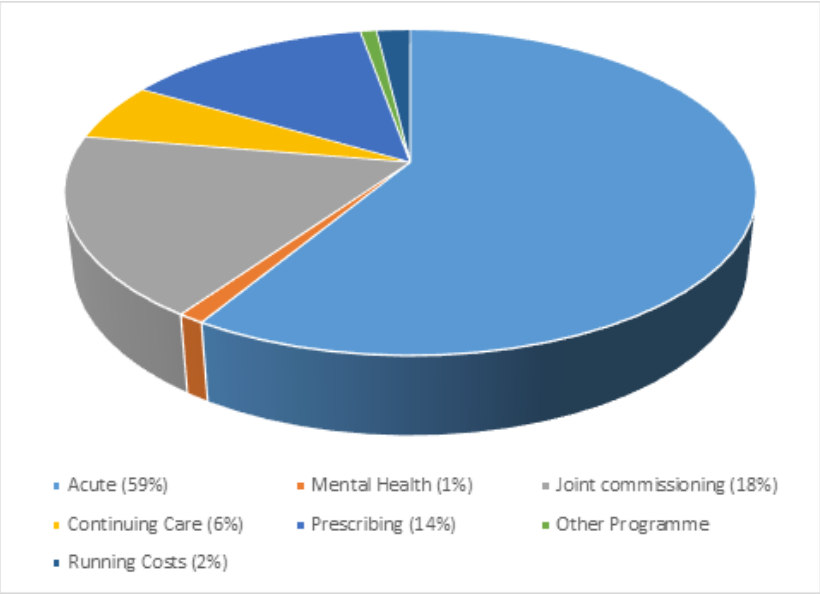
- SBC projections estimate that Swindon's population could increase by 14% from 2011 to 2021, and a further 10% from 2021 to 2031. Figures from mid-2014 for Swindon show that there were 48,604 under 18s (22.5%); 134.958 aged between 18 and 64 (62.5%) and 32,237 aged 65 or older (14.9%)
- In Swindon, in 2012-14, average life expectancy was 79.5 years for males and 83.0 years for females, which is similar to England but males in Swindon will spend 80.7% of their lives in good health, whereas women will only spend 75.8% in good health
- In the most deprived areas of Swindon, men die on average 9.0 years earlier and women 2.9 years earlier than those in the least deprived areas
- People with a learning disability are three times more likely than the general population to have a death classified as potentially avoidable through the provision of good quality healthcare.

CCG expenditure

The CCG commissions (buys) a full range of health services and jointly commissions integrated health and social care services with SBC. The major acute provider for Swindon CCG is Great Western Hospital NHS Foundation Trust (GWHFT) in Swindon and this contract represents 47% of our annual spend.

	£m
Great Western Hospital NHS Foundation Trust	119.3
Joint Commissioning with Swindon Borough Council	45.5
Oxford University Hospital NHS Foundation Trust	4.5
South Western Ambulance Service NHS Foundation Trust	6.6
Gloucestershire Hospitals NHS Foundation Trust	1.5
Private Hospital providers	5.8
Hospices	1.2
Other Acute providers <£1m	8.0
Private transport providers	1.6
Prescribing costs	33.5
Continuing Healthcare	14.6
Mental Health placements	2.6
Other programme spend	4.3
Running costs	4.6
	£253.6m

The pie chart below shows the percentage spend by area:



Future Plans

Looking to the future and considering our risks and challenges we face during 2016/17, we are working with our member practices and partners to plan for services which will benefit local patients and meet our priorities.

The CCG's 2016/17 Operational Plan sets out our plans for the coming year to improve health outcomes and the quality of health care services for the people of Swindon and Shrivenham. This Plan is driven by the needs of the local population and continues work started two years ago as part of the CCG's Five Year Strategy and more recently detailed in the Five Year Forward View.

Our view is that the most significant issues facing the local health and care economy are as follows:

- Delivery of the Five Year Forward View aspirations
- Securing sustainable finances and actively pursuing efficiencies whilst maintaining high quality, safe and effective services for people in Swindon
- Closing the health and wellbeing gap by focusing on inequalities within our community, reducing variation and shifting the balance in favour of prevention and self- care.
- Delivery of all core access and quality standards for our patients
- Concluding the community services re-design work to inform our future plans for the commissioning of community services across Swindon
- Finalising our strategy for primary care to support the system to gain stability through workforce, estate and at scale working.

More urgently our focus in 2016/17 will be on:

- Restoring and stabilising A&E 4 hour performance at GWHFT
- Actively managing emergency activity growth
- Ensuring delivery of Referral to Treatment Time (RTT) targets, taking into account the impact of NICE guidance
- Delivering aggregate financial balance across our health and care system
- Further strengthening integration with health system partners.

Details of our priorities for 2016/17 can be seen in our Operational Plan 2016/17 which can be found on our website: http://www.swindonccg.nhs.uk/

Key issues and risks

The CCG has governance structures and processes in place to actively identify, manage and monitor risks. The CCG maintains a risk register and a Board Assurance Framework to capture the individual risks facing the CCG in delivering on its objectives. Both are regularly reviewed and updated.

The CCG has a statutory responsibility for ensuring that the organisations from which it commissions services provide safe systems, safeguarding both children and vulnerable adults. The CCG has representation on both the Adults and Children's

Local Safeguarding Boards, promoting a partnership approach to the safeguarding agenda.

The Governing Body believes that the principal risks and uncertainties facing the CCG at the time of writing this report are as set out below, together with the actions taken to manage and mitigate them:

Area of Risk	Principal risk and uncertainty	Risk mitigation and management
People **The CCG's performance and development depends on its staff**	In order to remain compliant with regulations and to deliver against the CCG's strategic objectives the CCG needs to ensure that our people have the appropriate skills and are supported to allow them to perform.	Much of our major change activity within the CCG is organised via projects using a strong project management approach. Robust recruitment procedures apply to ensure new appointments are suitable for the role. Each person has regular meetings with their managers and annual appraisals to ensure that learning and development needs are met.
Key person dependency	The CCG is a lean organisation and is reliant on a small number of staff for its day to day activities.	Executive directors have deputies to provide cover and weekly executive meetings are held to ensure that absences are managed.
Provider performance **The performance of the providers from which the CCG commissions healthcare can affect the quality of care that patients receive, the CCG's financial strength and the ability of the CCG to achieve its strategic outcomes.**	Demand for healthcare services exceed the levels expected within activity plans. This would lead to an increase in the CCG's costs.	In order to manage exposure to changes in demand the CCG has modelled a range of scenarios and identified management actions that could be taken to mitigate their impact if they should arise. The CCG closely monitors the achievement of our annual plans through our governance structures so that any mitigating actions required can be taken in a timely way.

	Quality of patient care delivered by a provider impacts on the ability of the CCG to achieve its strategic objectives.	The CCG manages this risk by setting targets against which to benchmark and monitor each provider's performance. The CCG closely monitors these through our governance structures so that any mitigating actions required can be taken in a timely way.
Counterparty failure **Local health services are delivered by a small number of organisations.**	The lack of diversification in the local economy means that the CCG is dependent on a small number of organisations to provide patient care. Failure of one organisation could have a significant impact on the CCG's financial strength, quality of patient care and the CCG's ability to deliver its strategic objectives.	The CCG has formal contracts with its main providers and actively manages and monitors their performance through our governance structures. The CCG has developed a market strategy to develop and encourage diversification where it would be beneficial to patient outcomes and offers value for money to do so.
Legislation and regulation **A change in legislation may have a detrimental effect on the CCG's strategy and financial strength.**	The CCG is dependent on the Department of Health for its funding. Changes in funding would impact on the CCG's ability to be able to deliver its strategic objectives.	The CCG closely monitors legislative developments. Commitments under standard NHS contracts are for one year only. CCG allocations are now notified for a 3 year period.

Going Concern

The annual accounts of the CCG are prepared on the basis that the organisation is a 'going concern' and that there is no reason why it should not continue in operation on the same basis for the foreseeable future.

The CCG has been informed of its allocation for the forthcoming two financial years and has been given indicative allocations for the following three (2016/17-2020/21).

This has enabled it to work with its main providers to understand the size of the financial challenge facing the system over the medium term (as outlined in its medium term financial plan).

There is a significant financial challenge of circa £170m across health and social care, which the system has started to address through establishing the model of care it will work towards the Accountable Care Organisation - ACO (The basic concept of an ACO is that a group of providers agrees to take responsibility for all care for a given population for a defined period of time under a contractual arrangement with a commissioner). The CCG will describe how it will ensure financial sustainability in the 'STP' (Sustainability and Transformation Plan) it will be developing for June 2016.

During 2015/16 the CCG has operated within its cash limit, it has exceeded its surplus target at £2,604,000 and in doing so 80% of QIPP (QIPP stands for Quality, Innovation, Productivity and Prevention). It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS) was delivered.

The CCG appointed a permanent Accountable Officer in year and has reshaped its Executive Team to provide more senior oversight on Governance. It has strengthened its informatics, contracting and finance functions to improve its performance management of provider contracts and has undertaken a further review of the services provided by the South, Central and West Commissioning Support Unit (CSU). As a consequence of which, it has transferred communications, risk management and policy development in house in the latter part of 2015/16.

The CCG undertook a self-assessment of its financial controls and as a consequence agreed to establish a Finance Committee to provide greater scrutiny on the financial agenda facing the CCG; this has met formally once in the year. As a commissioning organisation, the area of greatest financial risk is over performance against provider contracts. The CCG has implemented weekly and monthly performance monitoring to enable risks to be highlighted promptly against key NHS constitutional and performance targets and the CCG to respond accordingly. The CCG has strengthened its Programme Management Office function; formal monthly meetings are now chaired by the Chief Financial Officer and the QIPP scorecard monitors performance during the year.

Performance Report

Performance Analysis

2015/16 Year End Performance Summary

Performance Area		Performance 2015/16	Performance 2014/115
CCG Assurance Framework The CCG has self- assessed itself against the CCG Assurance Framework since its introduction during 2015/16. This is a quarterly assessment and forms part of the assurance process with NHS England. Improvements have been made but not all have led to changes into the performance category assessment.			
Well led organisation	**Target – good or outstanding**	**Q1 –Limited assurance** **Q2 – Limited assurance** **Q3 - Good** **Q4 - Good**	**N/A**
The key driver of the improvement in the assessment was the permanent appointment of an Accountable Officer in September 2015. The post had been filled on an interim basis since May 2014, given the CCG's organisation size this is a key leadership post within the organisation. Over the year development sessions have been held with the Governing Body to develop the organisations wider leadership skills and the CCG has continued to actively engage with both staff through the Staff Partnership Forum and its membership and other stakeholder groups.			
Performance: delivery of commitments and improved outcomes	**Target – good or outstanding**	**Q1 – Limited assurance** **Q2 – Limited assurance** **Q3 – Limited assurance** **Q4 – Limited assurance**	**N/A**
This area of performance has been rated as "limited assurance", which means that improvements are required as the rating is below target levels. The CCG measures a range of metrics (NHS Constitution and NHS Outcome measures). The detailed information is included on pages 18 to 26. There has been improvements on last year's performance standards, notably around the 31 day Cancer for subsequent treatment for radiotherapy. The CCG and its main provider met all cancer standards in 2015/16 in comparison to the National picture where performance has been found to be more challenging. We continue to face a number of performance challenges as we move into 2016/17. Some of these are areas we have traditionally found challenging e.g. A&E 4 hour waits, Ambulance waits, Delayed transfer of care, Referral To Treatment (RTT) targets. We remain committed to meeting these from understanding of delivery data and working together with providers to help overcome any difficulties wherever possible. These are constantly reviewed and managed through our risk register.			

A & E 4 hour waits

Four-hour performance has been very challenging in 2015/16 with year to date performance at 94.1%. The Emergency Care Intensive Support Team made a series of recommendations for improving system flow and the CCG issued a performance notice to Great Western Hospital. This led to the development of a four-hour remedial action plan which is being monitored by the Systems Resilience Group and an Urgent Care working group is also in place. An Urgent Care strategy has been prepared in light of NHS England's guidance for transforming urgent and emergency care services (August 2015) and the more recently published commissioning standards for integrated urgent care (Sept 2015). We now have a new Urgent Care Scorecard. We expect to have recovered the 4 hours target by July 2016 and sustain it for the remainder of the year. An Urgent Care Board is now in place to monitor and review the actions being taken to achieve the targets.

Ambulance waits

The CCG's year to date performance for Category A (Red 1) 8-minute response times in Swindon (as at month 10) is 80.1% against a target of 75%. Category A (Red 2) targets have a locally agreed target of 70% in 2015/16 which was agreed by commissioners, Monitor and NHS England. As at month 10, performance is reported as 77.6%.

However SWAST red 1 and red 2 delivery as a whole for 2016/17 will remain challenging and the CCG will continue to work with other Commissioners to ensure SWAST continue to work towards achievement of these indicators.

The CCG is working with eleven commissioning partners to agree improvement trajectories and deliver the plan for year one for ambulance responses and complete the Red 2 pilots.

18 Week Referral to Treatment

The 18 week referral to treatment target has been a difficult and challenging area of performance during 2015/16. Throughout 2015/16 the CCG has been working closely with Great Western Hospital to work through three main issues which have impacted on performance. In order to make improvements Great Western Hospital have also been supported by the Intensive Support Team to deliver an improved quality data set. Great Western Hospital ended the year with a significant improvement in performance and are on target to meet the standard of 92% by the end of May 2016.

Delayed Discharges of Care (DTOC)

The number of patients that have experienced a delay in the discharge from hospital has been challenging in 2015/16 and as a result has significantly impacted on GWHFT Accident & Emergency 4-hour standard. We have been working closely with Great Western Hospital, SEQOL and SBC to review patient flow and capacity across Swindon Health Economy. This has led to some improvement in QTR4 2015/16 and we expect performance to improve significantly in 16-17 in line with a number of projects and initiatives to ensure patients are discharged on time.

Performance Area		Performance 2015/16	Performance 2014/15
Financial management	**Target – good or outstanding**	**Q1 - Good Q2 - Good Q3 - Good Q4 - Good**	**N/A**
The CCG has achieved all financial targets for the year and as a result has maintained a good rating throughout the year. The CCG has achieved its target surplus of 1%, this is an improvement on 2014/15 where 0.5% was the target. The CCG's financial control environment has been rated as "satisfactory" by internal audit based on the reviews conducted during the year. The CCG has also delivered over 80% of its QIPP savings target (£3.8m)			
Planning	**Target – good or outstanding**	**Q1 - Good Q2 - Good Q3 - Good Q4 - Good**	**N/A**
The CCG has rated performance in this area as good. The operating plan and Better Care Fund plan were assured for 2015/16. The CCG is working closely with its local providers and fellow commissioners on the development of system transformation plans from 2017/18.			
Delegated functions	**Target – good or outstanding**	**Q1 - Good Q2 - Good Q3 - Good Q4 - Good**	**N/A**
The Joint Primary Care Co-commissioning Committee making progress. Planning commenced for full delegation in 2017/18			

How we measure performance

Securing high quality services for patients is the role of CCGs, assessment of this is primarily through the achievement of key performance and outcome indicators.

In developing local commissioning intentions and plans the CCG incorporates guidance and requirements issued by NHS England.

This guidance sets out a number of outcome, Constitution and general performance measures that the CCG is required to monitor and report. These measures are a mixture of annual, monthly and quarterly measures.

Performance against some of these measures can also trigger additional income for the CCG in the form of Quality Premiums. (The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities).

CCG Assurance Framework

NHS England has a statutory duty to make an annual assessment of each CCG's performance. This is supported by the CCG Assurance Framework. The framework considers the breadth of the CCG's responsibilities and looks to provide a rating across five areas and four assurance categories (outstanding, good, limited assurance, not assured):

	Areas monitored
A well led organisation	Leadership skills Governance arrangements Patient public engagement Partnership working Value for money Skills and capabilities Compliance with statutory duties
Performance: delivery of commitments and improved outcomes	Performance against range of measures
Financial management	Financial performance Financial controls Financial governance, resources and processes
Planning	Assured annual plan Performance against plan in year Assurance System Resilience Group plan Assured Better Care Fund plan Long term plan to implement a five year forward view
Delegated functions	Governance and management of potential conflicts of interest Procurement Expiry of contracts Availability of services Outcomes

The CCG has designed its governance structures and reporting processes to support these assurance requirements. The CCG meets quarterly with NHS England as part of assurance processes.

NHS Constitution measures

The CCG reports these measures monthly to the Governing Body.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.

CCGs are required in demonstrating compliance with the Constitution to report against certain constitution measures. The amount of quality premium that a CCG can receive is reduced where measures are not achieve or if quality or financial objectives are not met.

NHS outcome measures

The CCG reports these measures monthly to the Governing Body.

The Mandate to NHS England from the Department of Health is structured around the five domains of the NHS Outcomes Framework and, as such, progress against objectives in the Mandate are assessed using the NHS Outcomes Framework.

The NHS Outcomes Framework:

i. provides a national overview of how well the NHS is performing;
ii. is the primary accountability mechanism, in conjunction with the Mandate, between the Secretary of State for Health and NHS England; and
iii. drives up quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process. It is a set of 68 indicators which measure performance in the health and care system at a national level.

The Department of Health uses the framework to hold NHS England to account and is continually reviewing progress against the Mandate objectives. NHS England in turn monitor the performance of CCGs against the same measures.

The NHS Outcomes Framework was developed in December 2010, following public consultation, and has been updated every year to ensure that the most appropriate measures are included.

Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each domain, there is a small number of overarching indicators followed by a number of improvement areas. These improvement areas include both sub-indicators (for outcomes already covered by the overarching indicators but meriting independent emphasis), and complementary indicators (extending the coverage of the domain). The domains focus on improving health and reducing health inequalities, namely by:

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment and protecting them

NHS England, working with CCGs and others, determine how best to deliver improvements against the Mandate and how they do this is set out in the annual business plan.

NHS England has developed the CCG Outcomes Indicator Set (CCG OIS) 8 to support the NHS Outcomes Framework. The CCG OIS comprises NHS Outcomes Framework

indicators that can be measured at CCG level and additional indicators developed by NICE and HSCIC. These provide clear, comparative information to support clinical commissioning groups and Health and Wellbeing Boards to identify local priorities and demonstrate progress on improving outcomes, as well as delivering public transparency about local health services.

Outcome measures are assessed across five domains and seven outcome measures.

Quality premium measures

Quality premium measures are reported to Governing Body on a quarterly basis.
The quality premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. CCGs can receive a maximum of £5 per patient.

The targets set consider both national and local priorities, for 2015/16 these were:

- reducing potential years of lives lost through causes considered amenable to healthcare;
- urgent care and emergency care – Health and Wellbeing Boards were required to choose from a range or measures;
- mental health - Health and Wellbeing Boards were required to choose from a range or measures;
- improving antibiotic prescribing in primary and secondary care;
- two local measures based on local priorities.

CCGs do not receive quality premium:

- if it is considered not to have operated in a manner consistent with Managing Public Money during the year;
- if it ends the financial year with an adverse variance against its planned surplus or requires unplanned financial support;
- incurs a qualified audit report; or
- if there has been a serious quality failure.

Provider and system performance

Contract monitoring and achievement of performance measures are an integral part of the core business of the CCG. The CCG formalises its relationships through contracts with its providers, setting service key performance indicators (KPIs) and establishing performance obligations. These are monitored via regular reporting and contract meetings.

The CCG has a track record of issuing performance and contract notices to providers when key performance targets are not achieved. The Contract and Performance Management Group (CPMG) provides director oversight of all aspects of contract management, including quality, performance measures, activity and finance, as well as providing the opportunity to discuss the implementation of key strategic objectives and goals of both the CCG and provider organisation.

Operational performance

The CCG produces an annual Operational Plan which is approved by the Governing Body. The Governing Body receives a monthly Integrated Finance and Performance Report which monitors and reports on performance against this Operational Plan.

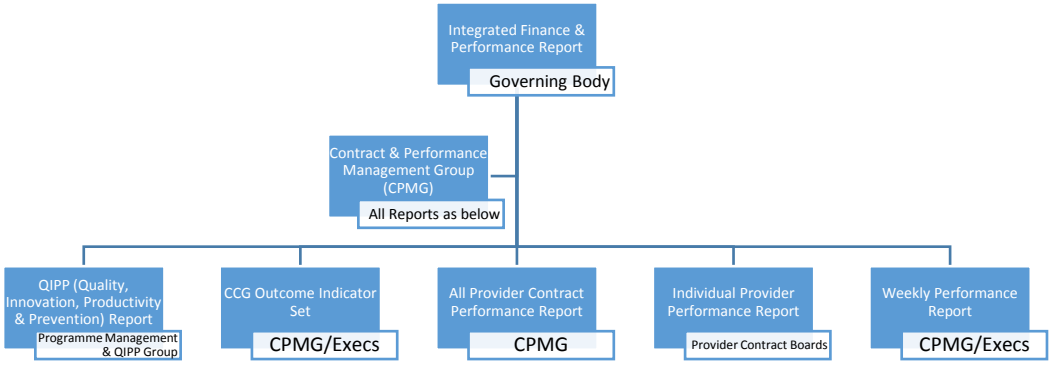


Figure 1 Performance monitoring

NHS Outcomes Framework 2015/16

at a glance

1 Preventing people from dying prematurely

Overarching Indicators

1a Potential years of life lost (PYLL) from causes considered amenable to healthcare
- i Adults ii Children and young people

1b Life expectancy at 75
- i Males ii Females

1c Neonatal mortality and stillbirths

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4*)
1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7*)
1.3 Under 75 mortality rate from liver disease (PHOF 4.6*)
1.4 Under 75 mortality rate from cancer (PHOF 4.5*)
- i One- and ii Five-year survival from all cancers
- iii One- and iv Five-year survival from breast, lung and colorectal cancer
- v *One- and vi Five-year survival from cancers diagnosed at stage 1&2* (PHOF 2.19**)

Reducing premature mortality in people with mental illness
1.5 i Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9*)
- ii *Excess under 75 mortality rate in adults with common mental illness*
- iii *Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services* (PHOF 4.10**)

Reducing mortality in children
1.6 i Infant mortality (PHOF 4.1*)
- ii Five year survival from all cancers in children

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicators

2 Health-related quality of life for people with long-term conditions (ASCOF 1A**)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions (ASCOF 1E** & PHOF 1.8*)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (ASCOF 1D**)

Enhancing quality of life for people with mental illness
2.5 i Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)
- ii *Health-related quality of life for people with mental illness* (ASCOF 1A** & PHOF 1.6**)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia (PHOF 4.16*)
- ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life* (ASCOF 2F**)

Improving quality of life for people with multiple long-term conditions
2.7 *Health-related quality of life for people with three or more long-term conditions* (ASCOF 1A**)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*)

Improvement Areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
- i *Physical health-related procedures*
- ii *Psychological therapies*
- iii *Recovery in quality of life for patients with mental illness*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *Survival from major trauma*

Improving recovery from stroke
3.4 *Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]*)
- ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]*)

Improving Dental Health
3.7 i *Decaying teeth* (PHOF 4.02**)
- ii *Tooth extractions in secondary care for children under 10*

4 Ensuring that people have a positive experience of care

Overarching Indicators

4a Patient experience of primary care
- i GP services
- ii GP Out-of-hours services
- iii NHS dental services

4b Patient experience of hospital care
4c *Friends and family test*
4d *Patient experience characterised as poor or worse*
- i. *Primary care*
- ii. *Hospital care*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 *Patient experience of community mental health services*

Improving children and young people's experience of healthcare
4.8 *Children and young people's experience of inpatient services*

Improving people's experience of integrated care
4.9 *People's experience of integrated care* (ASCOF 3E**)

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a *Deaths attributable to problems in healthcare*
5b *Severe harm attributable to problems in healthcare*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Deaths from venous thromboembolism (VTE) related events
5.2 Incidence of healthcare associated infection (HCAI)
- i MRSA
- ii C. difficile

5.3 *Proportion of patients with category 2, 3 and 4 pressure ulcers*
5.4 *Hip fractures from falls during hospital care*

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Improving the culture of safety reporting
5.6 Patient safety incidents reported

Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)

* Indicator is shared
** Indicator is complementary

Indicators in italics are in development

Detailed performance analysis
NHS Outcomes

Domain 1 - Preventing people from dying prematurely

Indicator (NHS OF) indicates this is also in the NHS Outcomes Framework)	Data source	Frequency of publication	Expected publication date(s) using the most recently available data	Date most recent data added -	Measure Type	12-13	13-14	14-15	% change between latest and previous reporting period	Improvement or deterioration
Potential Years Life Lost from causes considered amenable to healthcare (NHSOF 1.a.i and ii)	GP / PCMD	Annual	Jun-16	Oct-15	DSR	2002	2090	2135	2.2%	↓
Under 75 mortality rate from cardiovascular disease (NHSOF 1.1)	GP / PCMD	Annual	Jun-16	Oct-15	DSR	61	68	72	5.9%	↓
Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes	NDA	Annual	Mar-17	Oct-15	ISR	81				insufficent data to determine trend
Mortality within 30 days of hospital admission for stroke	SSNAP	Annual	Dec-16	Dec-15	SMR		1			insufficent data to determine trend
Under 75 mortality rate from respiratory disease (NHSOF 1.2)	GP / PCMD	Annual	Jun-16	Oct-15	DSR	33	27	33	22.2%	↓
Under 75 mortality rate from liver disease (NHSOF 1.3)	GP / PCMD	Annual	Jun-16	Oct-15	DSR	10	18	10	-44.4%	↑
Emergency admissions for alcohol related liver disease	GP / HES	Quarterly	Jun-16	Mar-16	DSR	21	17	20	7.7%	↓
Under 75 mortality rate from cancer (NHSOF 1.4)	GP / PCMD	Annual	Jun-16	Oct-15	DSR	121	121	124	2.5%	↓
One-year survival from all cancers (NHSOF 1.4.i)	ONS	Annual	Mar-17	Mar-16	%	67%	67.3%	67.7%	0.6%	↓
One-year survival from breast, lung and colorectal cancers (NHSOF 1.4.iii)	ONS	Annual	TBC	Mar-16	%	67.6%			0.9%	↓
People with severe mental illness who have received a list of physical checks	GP	Annual	Jun-16	Mar-16	%		42.3%	26.0%	-38.5%	↓
Antenatal assessments <13 weeks	UNIFY	Quarterly	TBC	Dec-15	%		86%	94%	18	↓
Maternal smoking at delivery	Omnibus	Quarterly	Jun-16	Mar-16	%		14%	13%	1.3	↓
Breast feeding prevalence at 6-8 weeks	UNIFY	Quarterly	NONE PLANNED	Dec-15	%		45%	46%	5	↑
Cancer: record of stage at diagnosis	CAS	Annual	Jun-16	Oct-15	%	56%	73.8%		18	↑
Cancer: early detection	CAS	Annual	Jun-16	Oct-15	%	45.2	49.5		-100.0%	↑
Lung cancer: record of stage at diagnosis	NLCA	Annual	Mar-17	Oct-15	%	94%				insufficent data to determine trend
Breast cancer: mortality	GP / PCMD	Annual	Jun-16	Oct-15	DSR	39.3	41.5	38.5	-7.2%	↑
Heart failure: 12 month all cause mortality	HES / PCMD	Annual	TBC	Mar-16	ISR	100	93.5		-6.9%	↑
Hip fracture: incidence	HES	Quarterly	Dec-16	Mar-16	DSR		511	457	3.0%	↓
Serious mental illness; smoking rates	GP	Annual	Jun-16	Mar-16	%			41		insufficent data to determine trend
Neonatal mortality and stillbirths (NHSOF 1.6.i)	ONS & CCG	Annual	Dec-16	Dec-15	rate per 1,000		6			insufficent data to determine trend
Low birth weight full-term babies (PHOF 2.01)	ONS & CCG	Annual	Dec-16	Dec-15	%		2.8	2.9	3.6%	↓

Domain 2 - Enhancing quality of life for people with long-term conditions

Indicator (NHS OF) indicates this is also in the NHS Outcomes Framework)	Data source	Frequency of publication	Expected publication date(s) using the most recently available data	Date most recent data added -	Measure Type	12-13	13-14	14-15	% change between latest and previous reporting period	Improvement or deterioration
CCGOIS Health-related quality of life for people with long-term conditions (NHSOF 2)	GPPS	Annual	Sep-16		Directly standardised average health status	0.76	0.76	0.74	-3.0%	↓
Proportion of people feeling supported to manage their condition (NHSOF 2.1)	GPPS	Annual	Sep-16	Oct-15	Directly standardised percentage	63.4	66.2	60.8	-8.2%	↓
People with COPD and Medical Research Council (MRC) Dyspnoea Scale ≥3 referred to a pulmonary rehabilitation programme	GP	Annual	Jun-16	Mar-16	%		12.9%	13.2%	2.3%	↑
People with diabetes diagnosed less than a year who are referred to structured education	NDA	Annual	Sep-17	Oct-15	%	13.8				↑
Unplanned hospitalisation for chronic ambulatory care sensitive conditions in adults (NHSOF 2.3.i)	HES / GP	Quarterly	Jun-16	Mar-16	DSR	902	857	893	2.4%	↓
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s (NHSOF 2.3.ii)	HES / GP	Quarterly	Jun-16	Mar-16	DSR	372	273	281	12.7%	↓
Complications associated with diabetes	NDA	Annual	Mar-17	Oct-15	ISR	81.2				insufficent data to determine trend
Access to community mental health services by people from black and minority ethnic groups	ONS / MHMDS	Annual	Sep-16	Oct-15	crude rates per 100,000 population	912.4	1094.0	1066.1	-2.6%	↑
Access to psychological therapies services by people from black and minority ethnic groups	ONS / IAPT	Annual	Dec-16	Dec-15	Rate per 100K	317	1750	1867	6.7%	↓
Recovery following talking therapies for people of all ages IAPT Reliable ***Recovery***	IAPT	TBC	Jun-16	Mar-16	%		62%	38.9%	2	↑
The percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable ***improvement*** following completion of treatment	IAPT	TBC	Jun-16	Mar-16	%		58%	52%	1	↑
The percentage of referrals to Improving Access to Psychological Therapies (IAPT) services which indicated a reliable ***deterioration*** following completion of treatment	IAPT	TBC	Jun-16	Mar-16	%		6%	8.5%	-1	↑
Health-related quality of life for carers (NHSOF 2.4)	GPPS	Annual	Sep-16	Oct-15	DSR	0.79	0.76	0.80	5.9%	↓
Health related quality of life for people with a long term mental health condition	GPPS	Annual	Sep-16	Dec-15	DSR		0.52	0.51	-0.6%	↓

Domain 3 - Helping people to recover from episodes of ill health or following injury

Indicator (NHS OF) indicates this is also in the NHS Outcomes Framework)	Data source	Frequency of publication	Expected publication date(s) using the most recently available data	Date most recent data added -	Measure Type	12-13	13-14	14-15	% change between latest and previous reporting period	Improvement or deterioration
Emergency admissions for acute conditions that should not usually need hospital admission (NHSOF 3a)	HES / GP	Quarterly	Jun-16	Mar-16	DSR	1220	1161	1339	1.5%	↓
Patient reported outcome measures for elective procedures: hip replacement (NHSOF 3.1.i)	PROMS	Annual	Sep-17	Oct-15	EQ-5D™ Average Health Gain	0.41	0.45		9.2%	↑
Patient reported outcome measures for elective procedures: knee replacement (NHSOF 3.1.ii)	PROMS	Annual	Sep-17	Oct-15	AHG	0.29	0.32		11.5%	↑
Patient reported outcome measures for elective procedures: groin hernia (NHSOF 3.1.iii)	PROMS	Annual	Sep-17	Oct-15	AHG	0.07	0.10		42.9%	↑
Patient reported outcome measures for elective procedures: varicose veins (NHSOF 3.1.iv)	PROMS	Annual	Sep-17	Oct-15	AHG	*	0.08			↓
Emergency admissions for children with lower respiratory tract infections (NHSOF 3.2)	HES / GP	Quarterly	Jun-16	Mar-16	DSR	282	269	363	-5.3%	↓
People who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital	SSNAP	Annual	Dec-16	Dec-15	%		59%	40%	-32	↓
People who have had an acute stroke who receive thrombolysis	SSNAP	Annual	Dec-16	Dec-15	%		11.6%	9.6%	-2	↓
People with stroke who are discharged from hospital with a joint health and social care plan	SSNAP	Annual	Dec-16	Dec-15	%		98%	59%	-40	↓
People with stroke who are reviewed 6 months after leaving hospital	SSNAP	Annual	Dec-16	Dec-15	%		0%	1%	1	↑
Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit	SSNAP	Annual	Dec-16	Dec-15	%		81%	75%	-6	↓
Proportion of patients recovering to their previous levels of mobility/ walking ability at 30 days (NHSOF 3.5.i)	NHFD	Annual	Dec-16	Dec-15	%		33%	40%	7	↑
Proportion of patients recovering to their previous levels of mobility/ walking ability at 120 days (NHSOF 3.5.ii)	NHFD	Annual	Dec-16	Dec-15	%		52%	73%	21	↑
Hip fracture: collaborative ortho-geriatric care	NHFD	Annual	Dec-16	Dec-15	%		96%	95.4%	-1	↓
Hip fracture: timely surgery	NHFD	Annual	Dec-16	Dec-15	%		83%	86.6%	4	↑
Hip fracture: multifactorial falls risk assessment	NHFD	Annual	Dec-16	Dec-15	%		99%	100%	1	↑
Alcohol: admissions	HES / GP	Quarterly	Jun-16	Mar_16	DSR		79	90	1.2%	↓
Alcohol: readmissions	HES / GP	Quarterly	Jun-16	Mar_16	ISR		105	104	-0.8%	↑
Readmissions to Mental Health within 30 days of discharge	MHMDS	Quarterly	Jun-17	Mar_16	ISR		101	83	-26.0%	↑
Proportion of adults in contact with secondary mental health services in employment	MHMDS	Quarterly	Jun-17	Mar_16	%		7.9%	7.4%	9.0%	↓
Hip fracture: care process composite indicator	National Hip Fracture Database (NHFD)	Annual	Dec-16	Dec-15	%			77%		insufficent data to determine trend

NHS Constitution Standards

NHS Swindon CCG Delivery Dashboard		2015-16												
Performance Standard	**Standard**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	92.9%	88.8%	91.9%	92.7%	90.3%	84.2%	87.3%	80.0%	79.4%	79.0%	80.4%	71.3%	83.8%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	91.9%	94.2%	94.7%	93.5%	93.9%	91.8%	91.8%	88.8%	88.0%	85.2%	87.1%	84.8%	91.0%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	91.1%	91.2%	90.3%	89.3%	88.6%	90.1%	89.4%	87.1%	89.3%	89.0%	88.9%	90.3%	89.6%
Zero tolerance of over 52 week waiters (incomplete pathways)	0%	1	1	1	2	1	2	2	3	6	3	6	2	30
6.3 Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	94.1%	94.7%	95.5%	95.1%	95.3%	95.0%	95.4%	92.4%	93.2%	93.7%	95.2%	92.7%	94.5%
6.4 Maximum two-week wait for first outpatient appointment for patients referred urgently with symptomatic breast cancer	93%	96.2%	94.8%	99.2%	93.3%	95.2%	98.1%	95.5%	97.8%	95.5%	95.0%	94.7%	95.2%	96.0%
7.4 Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	100.0%	96.1%	94.1%	95.8%	93.7%	98.0%	94.7%	94.2%	95.5%	98.8%	97.7%	96.0%	96.3%
7.11.1 Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	89.5%	100.0%	100.0%	94.1%	100.0%	100.0%	96.7%	95.0%	100.0%	100.0%	100.0%	100.0%	97.7%
7.11 Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	100.0%	100.0%	100.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%
7.11 Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	95.0%	100.0%	100.0%	94.4%	95.8%	100.0%	95.7%	100.0%	93.1%	100.0%	81.8%	97.6%
8.4.1 Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer (Including rare cancers)	85%	83.9%	85.7%	80.6%	91.2%	86.7%	79.5%	87.5%	74.2%	92.3%	82.8%	81.5%	87.5%	84.2%
9.4 Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	91.7%	98.9%
62 Day PTL - Number of patients who have breached beyond 104 days	0	1	1	4	0	0	1	1	1	0	0	1	0	10
Percentage of patients waiting 6 weeks or more from referral for a diagnostic test	<1%	0.6%	0.3%	1.5%	1.3%	1.7%	1.3%	1.0%	0.8%	0.8%	0.6%	0.4%	2.0%	0.9%
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - ALL TYPES	95%	94.0%	95.7%	96.8%	97.3%	93.1%	91.7%	93.3%	89.3%	90.0%	81.6%	86.1%	84.3%	91.7%
A&E 12 hour waits	0	0	0	0	0	0	0	0	0	0	0	2	49	2
Mixed Sex Accommodation Breaches - Minimise breaches	0	0	0	0	0	0	0	0	2	0	19	0	76.9%	80.1%
Incidence of Healthcare Associated Infection - MRSA	0	1	1	1	1	0	0	0	2	0	0	0	64.8%	77.6%
Incidence of Healthcare Associated Infection - C.Difficile (SCCG)	<44	7	6	2	4	4	7	6	8	5	6	3	91.6%	96.9%
GWH Response rate for FFT (Friends & Family Test)	15%	16.3%	15.9%	13.7%	16.5%	12.0%	12.0%	5.0%	16.0%	7.0%	7.9%	10.3%	12.0%	12.0%
Estimated diagnosis rate for people with dementia against plan	66%	63.0%	60.4%	61.6%	62.1%	63.7%	62.7%	61.4%	63.1%	63.8%	63.4%	62.9%	62.4%	62.5%

Quality premiums measures

National/Local	QP %	Quality Premium		Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-15	Feb-15
National	10%	Reducing PYLL through causes considered amenable to healthcare	2014 published data is DSR 2,135	<1973	Data not yet available										
National/local	30%	Reducing NHS-responsible delayed transfers of care		<3100	287	291	180	260	284	250	156	302	332	229	213
National/local	30%	A defined improvement in coding patients attending A&E		90%	67.7%	68.7%	72.2%	75.3%	75.0%	84.6%	86.5%	87.5%	87.9%	85.8%	87.4%
National/local	30%	Reduction in the number of patients with A&E 4 hour breaches who have attended with a mental health need		95%	88.6%	79.3%	87.7%	93.0%	86.8%	83.1%	85.7%	71.8%	78.1%	56.7%	57.3%
National	10%	Improving antibiotic prescribing in primary & secondary care (there's approx a 2 month time lag on reporting)	prescribed in primary care by 1% (or greater) from each CCG's 2013/14 value {Indicator = (ITEMS/STAR-PU)}	<1.14	1.126	1.12	1.12	1.116	1.11	1.102	1.095	1.09	1.06	1.00	
National	10%		Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care	<14.46%	13.71%	13.70%	13.55%	13.47%	13.31%	13.10%	12.89%	12.80%	12.80%	12.69%	
National	10%		Part c) secondary care providers validating their total antibiotic prescription data	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE	TRUE
Local	10%	A reduction in the number of hospital admissions as a result of self harm (10 to 24 years)		<=296	28	23	25	13	17	18	32	31	20	22	26
Local	10%	**NI 135 Statutory Return Indicator: Carers receiving an assessment or review.** Carers receiving an assessment or review who receive a service or information & advice as a % of clients receiving community		>=30%	1.8%	3.0%	15.0%	33.2%	39.4%	51.1%	53.1%	57.3%	68.7%	72.0%	

Performance on other matters

Operational Performance

The following section of the report provides a review of our achievements against our 2015/16 Operational Plan.

Cancer

During 2015/16 the CCG worked with its key partners to:

- Focus on cancer pathways for the elderly;
- Expand the use of holistic needs assessment across tumour site, improving support to patients living with and beyond cancer;
- Sustain achievement of national cancer timed pathway standards;
- Move forward the Radiotherapy Business Case to full approval to enable services to be delivered in Swindon in the future;
- Participate in a Thames Valley audit of patients diagnosed with cancer following emergency presentation.

Community Navigator Project

During 2014/15 the CCG and SBC submitted a bid to the national Transformation Challenge Award (TCA) to expand the Community Navigator Team in 2015/16. Following approval by the Governing Body in January 2015 to continue the pilot for a second consecutive year, arrangements were made to commission the Health and Wellbeing Team at SBC to provide 14 Community Navigators for all 26 GP practices, emphasising the need to promote and enable self-care and management for those patients with long term conditions and to facilitate engagement with existing voluntary services available including Swindon Circles of Support.

The service was rolled out (following recruitment of the community navigators) between June and July 2015 and has been fully operational since late July with a full complement of staff in post. An evaluation of the service took place from July 2015 to December 2015 and the report can be viewed on the CCG's website: http://www.swindonccg.nhs.uk/index.php/list-of-events/governing-body-meetings/governing-body-papers/55-governing-body-papers-21-january-2016/file

COPD/Respiratory

In 2015, the CCG identified and published priority areas to deliver improvements to services for COPD patients within Swindon (COPD stands for chronic obstructive pulmonary disease. It includes the conditions emphysema and chronic bronchitis).

During the year The British Lung Foundation in partnership with the CCG and local providers re-formed the local Breathe Easy Support Group within Swindon. The main aim for the group is for patients to come together, support and learn more about living with a lung condition. The group will continue to become more established during this forthcoming year and publicise through other local organisations and patient services.

Dementia

Recognising increased demand and priority of dementia care, the CCG has worked with GPs to manage more routine diagnosis and management of those with dementia. Performance against the national diagnosis target has been challenging in recent years, however, the CCG has now secured a new model of care which will support ongoing delivery in the future.

The CCG is also ensuring that there is a minimum of two thirds diagnosis rates for people with dementia. Within the Dementia Strategy there is a model for specialised treatment and management of more chronic and specialist requirements. This is being delivered now via a Specialist Dementia Team in Avon and Wiltshire Mental Health Partnership NHS Trust (AWP).

Diabetes

The following activities took place in 2015/16:

Weekly foot ulcer clinics

During 2015/16 the CCG recognised that there was further potential to develop and optimise the care for patients presenting with diabetic foot problems to reduce minor and major amputation rates. Working closely with providers the CCG developed a robust foot ulcer pathway supported with new weekly foot attack clinics, with the aim to reduce minor and major amputations.

Diabetes UK event - Living with Diabetes Day in Swindon

In November 2015 the CCG participated in a free one day event for people with diabetes. Sessions included learning how to maintain a healthy diet and becoming more confident in managing diabetes day-to-day. Attendees had an opportunity to ask diabetes experts their questions and get practical up-to-date information on diabetes and meet other people with Type 2 diabetes.

Clinically led service review in the acute trust

A clinically-led service review took place at GWHFT in November 2015 and a comprehensive report detailing key recommendations that should be prioritised in 2016/17 was produced. The opportunity to move towards developing and adopting a community-led model of care that incorporates the whole system will be a priority for the CCG and providers. By delivering this model of patient care, this will not only manage patients appropriately with the right care provider and in the right setting at the right time, but also support primary care.

End of Life Care

The CCG with wide representation from local providers has been and will continue to work collaboratively with the South West Clinical Network End Of Life Workstream to review both the current local pathway for end of life (EOL) care and develop the aspirational pathway that will focus on the individual and their families' wishes in terms of advanced care planning, EOL care wishes, preferred place of care and death.

The roll out of a Treatment Escalation Plan (TEP) form from GWHFT into primary care and also the CCG led Advanced Care Plan document (ACP) has focused informed joint conversation and documentation with patients and their families as to wishes regarding treatment choice at EOL. This is fully aligned and endorsed by national

publications such as One Chance to Get it Right, What's Important to Me, The Ambitions for Palliative and End of Life Care and the recently published Transforming End of Life Care in Acute Hospitals.

The CCG funded extension of the local Hospice at Home service this year has for example generated local improvements in terms of speed of access, choice and quality results for those reaching the end of their life. The recent Care Quality Commission (CQC) inspection to the acute hospital locally has deemed the EOL care service as good, providing additional assurance that our approach will continue quality improvements.

Estates

The Swindon Health Centre

The NHS Swindon Health Centre project is a new, modern, Health Centre in Swindon in is the strategic development centre in the centre of town. It is a replacement for Carfax Street Health Centre.

The new health centre will be built over four levels which will include a pharmacy, two GP practices, dental, podiatry and a variety of community health services. The health centre will provide a full range of community and enhanced primary care services over four floors to over 22,000 registered patients, over 36,000 unregistered and a walk-in centre for the local population and the wider area. The project commenced in January 2016 and due to be completed during spring 2017.

Planning for local estate to meet the strategic growth

The CCG released the first iteration of the Swindon Estates Strategy in December 2015 and it will be finalised in June 2016. The strategy helps to support the delivery of the priorities set out in Swindon's Joint Health and Wellbeing Strategy. The strategy will help the CCG to identify further planning needs and to manage the strategic growth that Swindon and Shrivenham will see over the fourth-coming years. In conjunction with the strategy a Local Estates Forum is being set up with key stakeholders to help support the required development and changes in local estates.

The CCG is working collaboratively with SBC on some key strategic sites around Swindon and Shrivenham to develop local estates and 'Health Campus' to meet the strategic housing and population growth in Swindon and Shrivenham which is anticipated to be in excess of circa 63,000 over a five year period.

Medicines Management

The CCG wants to make sure patients make the best use of the medicines prescribed to them, reduce medicines waste and work with prescribers to choose clinically approved cost effective treatments. Here are some examples of what has been achieved over the past year:

- Good engagement from practices in performing detailed medication reviews in over 75s on more than 15 repeat medicines. Inappropriate polypharmacy (taking unnecessary medicines) has reduced. This has been a priority for the CCG as many hospital admissions result from problems with medicines;
- Care homes pharmacists continue to perform detailed medication reviews in frail elderly care home patients; all residents in nine nursing or care homes have had medication reviews with the specialist pharmacist alongside the regular GP;

- Continuing to promote shared decision making and provide prescribers with the available information to enable patients to make informed choices about their medicines;
- Continuing to work with GWHFT to jointly agree formulary decisions on medicines and prescribing guidelines;
- A non-prescription dressing scheme has been introduced for practice nurses. The process for having stock dressings available in practices is easier and more efficient, improving patient care;
- Having a dietician working with the pharmacists in the medicines optimisation team, ensuring the CCG is making best use of nutritional supplements across the CCG;
- Practices are working brilliantly with the CCG team who are helping to promote cost effective prescribing alongside agreed audits to improve the quality of prescribing;
- Over the last year, there has been a steady decline in the amounts of antibiotics prescribed overall (less inappropriate prescribing for viral infections) and also a reduction in those antibiotics most associated with causing adverse effects such as *clostridium difficile* infection;
- Continuing to use and develop IT initiatives to support prescribers to make safe, evidence based and cost effective prescribing decisions.

Paediatrics

Paediatric care demand has been significantly reduced across GWHFT during 2015/16 through alternative care provision within children's clinics in the community and the public accessing alternatives to the emergency department. The CCG continues to work in providing seamless transition across children's to adult services and increasing the local provision of care.

Planned Care (elective care)

During 2015/16 the key focus for planned care has been progress towards the sustainable specialty level delivery of the national 18 week Referral to Treatment (RTT) standard. This focus has translated into closer working with GWHFT to improve the accuracy of information reporting, and addressing specialties where performance needed to improve. The CCG anticipates that this work will continue into quarter one of 2016/17, whilst all specialties move towards a sustainable position of being able to deliver the 18 week RTT standard.

Mental Health and Learning Disabilities

The CCG has worked very closely with its provider to transform access to services in Swindon. This has resulted in improved access rates, and treatment times during 2015/16. This work has supported the management and reduction for out of area treatment for CCG patients in Swindon.

The Psychological Therapies service was nominated for national award this year and performance overall has improved in 2015/16.

SUCCESS/Primary Care Support Services

The Prime Ministers Challenge Fund wave 2: Improving Access to General Practice project has been in place during 2015/16 to provide increased access to primary care

services delivered at scale. It has provided additional services to support the increasing burden of delivering urgent demand within primary care, whilst enabling practices to treat and assess those patients who most benefit from continuity of care.

The range of services include three core component parts, available to all GP practices:

- Urgent Care Clinic, operating at two neighbourhood centres from Monday to Friday, 8am to 8pm;
- Children's and Young Person Clinic, operating at two neighbourhood centres from Monday to Friday, 8am to 8pm;
- Daytime home visiting service.

During the year the infrastructure supporting this project has enabled online booking for services and the rapid transfer of a clinical précis of the patient's clinical records to and from the referring practice to support the delivery of urgent care.

Urgent Care

Urgent care services in Swindon have been under pressure during 2015/16 as it has been nationally. The CCG has worked closely with urgent care service providers to increase alternative care provision to the emergency department and introduced further services which provide care closer to home such as the Rapid Assessment Unit; SUCCESS home visiting and the extension of ambulatory care provision at the hospital. This has helped manage demand within the hospital and will be developed further within 2016 /17 to efficiently use all aspects of urgent care provision within Swindon.

Working with partners and integration

Effective collaboration is critical to support the achievement of our goals and delivery system-wide transformation. The CCG is committed to developing strong long-term partnerships with a range of stakeholders and actively participate in the work of a number partners to deliver the best possible outcomes for our local communities.

The partners we work with include: GP Member Practices, other CCGs, NHS England South Central Team, NHS providers (e.g. GWHFT, AWP, and SEQOL), SBC, Public Health (SBC), the Health and Wellbeing Board, community and voluntary sector organisations, Healthwatch Swindon, patients and the public.

By working closely with SBC, and integrating elements of health and social care commissioning and provision, the CCG has been able to improve efficiency and drive up the quality of care. By being more efficient the CCG can make savings to invest in alternative projects that will focus on preventing poor health, intervening earlier and supporting patients at home or in the community. Too often patients end up in hospital when they would be better treated in a community setting or could have avoided becoming ill be early intervention or better self-management. Avoiding hospital admissions and improving care closer to home are among our objectives that the organisation hopes to achieve through continued partnership working with SBC, healthcare providers and the voluntary and community sector.

Health and Wellbeing Strategy

The Swindon Health and Wellbeing Board and the CCG Governing Body both receive and sign off the joint commissioning intentions annually which will deliver the requirements of the health and wellbeing strategy. There is a Joint Commissioning Group in place which reviews progress against the delivery of the plans on a monthly basis, the minutes of this group are received and reviewed by both the Health and Wellbeing Board and the CCG Governing Body.

The CCG works very closely with Swindon Borough Council, the Clinical Chair is the Vice Chair of the Health and Wellbeing Board and the Accountable Officer and Executive Nurse are also voting members of the Board. In the last year the Health and Wellbeing Board has been a key stakeholder in signing off the CCG key priorities and plans, reviewing the Operating Plan and determining the Quality Premium Indicators for 2015/16. The CCG takes regular reports to the Board, key areas of discussion in the last year have been the Joint Commissioning Intentions, the Better Care Fund, the Review of Community Services in Swindon and the Mental Health Crisis Concordat. The Chair of the Health and Wellbeing Board is also a member of the newly convened Sustainability and Transformation Board and a paper on the draft plan has been taken to the Board for discussion. Information on the Swindon Health and Wellbeing Strategy be found here.

Emergency Preparedness Resilience and Response (EPRR) and Business Continuity

During 2015/16 significant progress has made to strengthen the EPRR arrangements in the CCG. The CCG has on secondment from GWHFT the Head of Resilience one day a week. With this additional support the CCG has: completed the CCG EPRR Assurance Return; co-ordinated the completion of individual 'departmental' Business Impact Analysis, a revised and more streamlined on-call pack; updating of the "Send Word Now" alerting software; completion of the Business Continuity Plan; and progressing the CCG Pandemic Flu Plan. Work has also progressed on reporting and managing system wide 'surge' pressures in urgent care.

Quality and Patient Safety

The CCG has put quality at the heart of everything it does. This focus has played an essential role in helping us to ensure that we commission safe, effective services which provide our patients with the best possible experience of the NHS.

Compassionate care is as important as the quality of treatment. The CCG works with its providers of care to ensure that patients, their families and carers are treated with compassion, respect and dignity, in a safe environment and protected from harm.

To ensure that the services the CCG commissions and the care provided to patients is safe and high quality it takes an active approach through a range of formal and informal reviews and discussions with providers, use of contractual levers, and through the implementation of quality improvement plans.

The CCG has worked closely with providers to ensure service delivery continually improves and that they have in place processes to drive this continual improvement, including the adoption and sharing of innovation.

The CCG reports against the NHS Outcomes Framework which is closely linked to the national and local quality agenda and consists of three main areas:

1. Patient Safety

- Safeguarding
- Infection prevention and control
- Serious incidents requiring investigation
- Sign up to Safety
- Responding to Care Quality Commission Inspections

2. Clinical Effectiveness

- Positive patient outcomes
- CQUINS
- Evidence-based practice
- Research-based practice
- Experience and competency based practice

3. Patient Experience

- Real time patient and carer experience, representing the diversity of the population
- National and local primary, community and secondary care patient and staff survey data
- Patient stories
- Engagement with local Healthwatch

Patient Safety

Safeguarding

Living a life that is free from harm and abuse is a fundamental right of every person. All of us need to act as good neighbours and citizens in looking out for one another and seeking to prevent harmful and abusive situations for children and adults at risk of harm and it is the responsibility of every NHS funded organisation and health care professional to ensure that people in vulnerable circumstances are not only safe, but also receive the highest possible standard of care. The CCG's Safeguarding Children and Adults at Risk policy sets out the organisation's role in ensuring this.

The CCG has statutory responsibilities for ensuring safe systems of care that safeguard children and adults at risk of abuse and neglect. During 2015/16 the CCG has continued to work in partnership with other commissioners and providers of health and social care services and other statutory and voluntary organisations to improve outcomes for adults at risk, children and young people. The CCG's Safeguarding Children and Adults at Risk Policy sets out the organisation's role in ensuring this.

In delivering its responsibilities to ensure effective safeguarding arrangements the CCG has adopted two overarching values:

- Safeguarding children, young people and adults at risk **is everyone's responsibility**.
- **The voice of the child or adult** is central and any intervention based upon a clear understanding and recognition of **a person centred approach.**

Safeguarding Declaration

The CCG recognises safeguarding as a high priority for the organisation. In order to achieve this it ensures it has arrangements in place to provide strong leadership, vision and direction for safeguarding. The CCG has a statutory duty to ensure that it makes arrangements to safeguard and promote the welfare of adults and children at risk of abuse and is central to quality of care as set out in the NHS Outcomes Framework 2014/15 (Dept. of Health, 2013), particularly Domain four: ensuring people have a positive experience of care and Domain five treating and caring for people in a safe environment and protecting them from avoidable harm.

The CCG is responsible for commissioning safe services through a robust commissioning process with clear commissioning standards that have been ratified by the Local Safeguarding Children's Board and the Local Safeguarding Adults Board. All contracted services have to demonstrate compliance to Section 11 of the Children Act 2004 (Duty to co-operate) and the Care Act section 42.

The following measures ensure that safeguarding and promoting the welfare of children and adults at risk is given priority and is discharged effectively across the whole local health community through commissioning arrangements:

- Executive level CCG membership of both the Safeguarding Children and Adult Boards ensures that safeguarding is at the forefront of service planning. The function of the Boards are to ensure that there are robust processes in place to learn lessons from cases where children or adults at risk have been seriously harmed through abuse or neglect. There is also consistent CCG representation on both Adult and Children Safeguarding Board subgroups;

- Senior CCG membership on the Health and Wellbeing Board;

- Close collaboration with SBC to assess and ensure the provision of coordinated, integrated services to meet the needs of the local population, including specialist services for vulnerable groups;

- Ensuring that safeguarding children and adult strategies and associated policies are in place and reflect national best practice guidance;

- All directors and staff (whether permanent, temporary, locum, agency volunteers or contractors) are required to adhere to the requirements of the CCG safeguarding policy and any associated procedures and guidelines;

- The CCG is represented at both local and serious case reviews to ensure outcomes are shared throughout the local heath economy;

- Ensuring that providers of services are held to account through regular reviews of safeguarding arrangements through quality scrutiny processes.

Reporting and Learning from Serious Incidents

Healthcare organisations strive to be as safe as possible for patients, staff and the public. Unfortunately, incidents do occur that impact on safety and some are so significant a heightened level of response is justified, commonly known as Serious Incidents (SI). These include unexpected or avoidable deaths, or serious harm to patients, staff or the public.

As part of its role in safeguarding and improving the health of its population, The CCG requires all commissioned provider organisations to report and escalate any incidents that meet that SI criteria as defined within the *Serious Incident Framework.* An organisation is deemed to have a strong, open learning culture if incidents are reported and investigated, ensuring learning and the implementation of associated actions are embedded in order to reduce the likelihood of reoccurrence.

The CCG's Serious Incident Review Panel meets on a bi-monthly basis to review the content of all root cause analysis (RCA) investigations submitted. The panel's aim is to scrutinise the quality of investigation and appropriateness of actions and work with providers to support learning outcomes. SI's are only closed when the panel is satisfied with the level of investigation completed and the robustness of the provider's action plan to reduce the likelihood of reoccurrence of similar incidents.

Serious Incident Reporting - trends and themes

During 2015/16, 96 serious incidents (SI) were reported to the CCG. The highest reported incident was related to pressure ulcers meeting serious incident criteria which accounted for 47 serious incidents. A quality improvement plan related to processes and procedures for pressure ulcer prevention and management was requested by the CCG as a result of this and continues to be monitored closely to ensure improvement is evidenced. During 2016/17 the CCG is working in collaboration with the West of England Academic Health Science Network and The Welsh Wound Innovation Centre to conduct a quality improvement project focused on improving wound care across Swindon.

There has also been a trend in treatment delays meeting SI criteria, with seven reported during 2015/16. NHS Swindon CCG are actively supporting providers through the Sign Up to Safety Quality Improvement work streams focused on improving sepsis management and the implementation of National Early Warning Score which both contribute to improving responses to the deteriorating patient through standardised processes and escalation procedures.

There have been seven SI's relating to self-inflicted harm meeting SI criteria. In line with identified learning from the RCA investigations, the CCG is working with providers to continuously improve service user risk assessment and the implementation of appropriate risk management plans/crisis plans. The CCG has monitored key actions relating to these key problems through the local Contract Quality Review Meeting for ongoing assurance in improvements in care.

Infection and Prevention Control (IP&C)

The CCG is a member of the Swindon wide Infection Prevention and Control Committee, led by Swindon Public Health Team. The aim of the committee is to ensure oversight and scrutiny of the national infection prevention and control agenda, ensuring all commissioner and provider organisations are able to evidence compliance to the Health and Social Care Act 2008, *Code of Practice of the prevention and control of infections and related guidance* (updated 2015) within local IP&C plans.

Mandatory Surveillance of Health Care Associated Infections (HCAI)

Healthcare associated infection (HCAI) surveillance data (including mandatory surveillance of MRSA blood stream infections and *clostridium difficile* infections) is monitored by the CCG in line with commissioner responsibilities as set out within the Code of Practice. Monthly validated data is published by Public Health England via the national HCAI data capture system. The data from Public Health England's national data capture system includes the total number of *clostridium difficile* infections reported within the Swindon population. This therefore reports cases of HCAI across all commissioned services within secondary and primary health care settings.

This data is also monitored jointly with commissioned provider services, via the Swindon wide IP&C committee and local provider quality review meetings. Risk factors for infection were gathered locally in order to better understand trends and outcomes.

During 2015/16, a total of seven MRSA bloodstream infections were reported within the CCG population, against a zero tolerance target. One case was reported within the hospital setting and six were acquired within the community setting (i.e. patient was admitted to hospital from home).

A total of 59 *clostridium difficile* infections were reported within the CCG population against an annual target of 44. No outbreaks of infection were reported within this number.

In order to continuously reduce the incidence avoidable infections, the CCG is working closely with provider services across health and social care in order to monitor IP&C standards and outcomes for patients. A key focus during 2015/16 was the monitoring of antibiotic prescribing within secondary and primary care settings, which has resulted in a reduction of the total usage of high risk antibiotics.

Learning from HCAI investigations

During 2015/16, post infection reviews for MRSA blood stream infections were completed for each reported case as per national guidance. Six cases were assessed as being unavoidable (using national guidance terms of reference), with one community case assessed as being potentially avoidable. Actions and lessons learned were discussed at the CCG's Commissioning for Quality meeting and the Swindon Infection Prevention and Control Committee.

All individual cases of reported *clostridium difficile* infection were reviewed in both the secondary and primary care settings during 2015/16.

A robust *clostridium difficile* infection rectification plan, incorporating all identified work streams implemented jointly by providers and commissioners aimed at reducing the incidence of healthcare associated infections across the whole health and social care economy in Swindon, is monitored by the IP&C committee.

Care Quality Commission (CQC) Inspections

During 2015/16 the CCG has continued to review all health provider organisation's compliance with CQC quality standards. This has included oversight of inspections carried out in primary care.

In addition, the CCG works collaboratively with SBC in order to review CQC reports for care homes and domiciliary care agencies in Swindon, thus ensuring all regulatory quality standards are monitored across the whole health and social care economy.

Both the CCG and SBC have ensured that any areas of non-compliance identified in CQC inspection reports have been addressed via relevant contractual quality review meetings and quality visits. Action plans have been submitted by the relevant organisation where required, with progress monitored in line with CQC recommendations and commissioner requirements. All inspection reports are publically available on the CQC website.

Research and Innovation

The CCG actively supports research and has a strong culture of leading innovation. Working directly with the Academic Health Science Network the CCG is engaging in a number of workstreams, including prompting research in practice and the use of evidence and evaluation toolkits.

Commissioning for Quality and Innovation (CQUINs)

Commissioning for Quality and Innovation schemes (CQUINS) were developed in partnership with providers. The aim being to make a proportion of health care providers income conditional on demonstrating improvements in quality and innovation in specified areas of care.

National CQUINs were set for health care providers in 2015/16. The agreement of local CQUINs in particular for acute and community providers were driven from key patient safety concerns, patient feedback and complaints and the need to align CQUINs with Quality, Innovation, Productivity and Prevention (QIPP) schemes. These centred on:

- Children in transition from paediatric to adult services
- Urgent care
- Diabetes care
- Cancer services
- Effective communication with primary care

Patient Experience

The CCG wants to ensure that it commissions the highest quality of care in the way patients need it. The integrated Patient Advice and Complaints Team support this

process. There are processes in place to capture concerns, comments, compliments and complaints about any of the NHS services which the CCG commissions for the population of Swindon and Shrivenham.

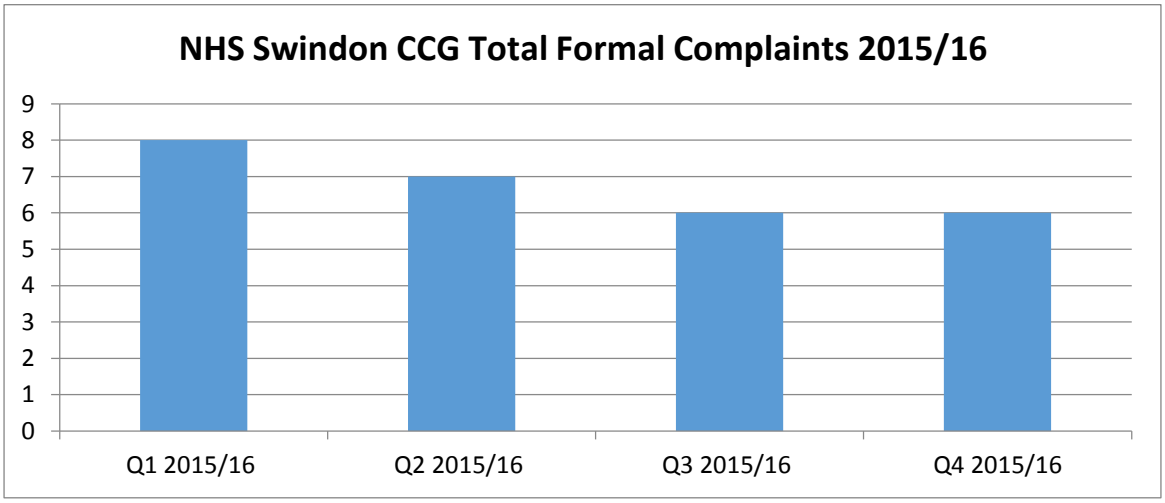
The CCG put patients at the heart of everything it does, so the Patient Advice and Complaints Team are there to listen, help and offer advice to patients, families and carers and to help resolve any issues. When someone makes a formal complaint, the team will support the person through the complaints process whilst their complaint is being investigated. If someone feels that their complaint has not been satisfactorily resolved it can then be referred to the Parliamentary and Health Service Ombudsman for an independent review.

During 2015/16, the CCG received a total 258 PALS concerns, comments, compliments and 27 formal complaints. Out of the 27 formal complaints, 13 were upheld and five were partially upheld by the CCG (66.6%). As of the 31 March 2016 four complaints remain open awaiting the CCG's final response. 100% of all complaints received were acknowledged within three working days. One complaint was referred to the Ombudsman for independent review and the CCG is currently awaiting the outcome decision.

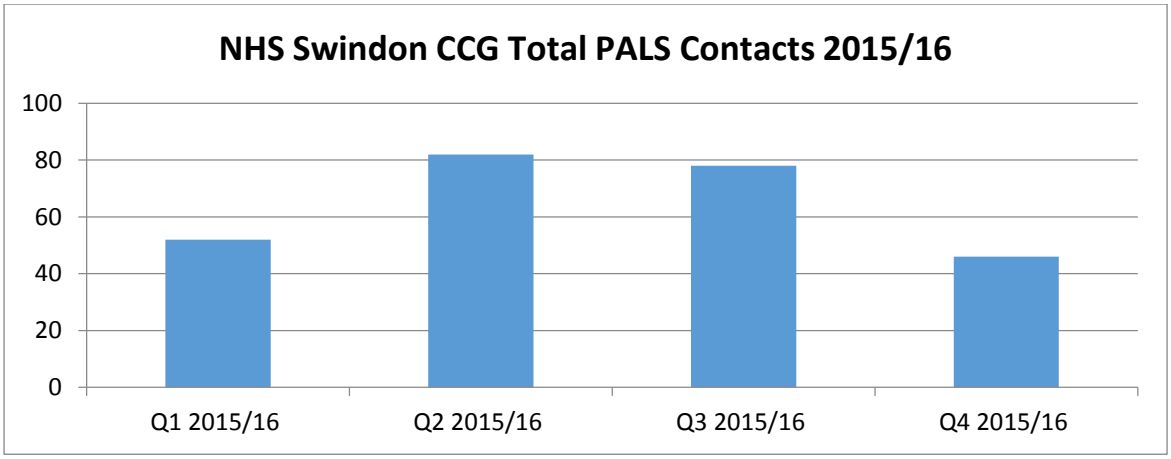
The top five themes have been:

- CCG financial issues/policy (29.6%)
- Clinical care (25.9%)
- Access and waiting (22.2%)
- Communication (18.5%)
- Behaviour and attitude of clinical and non-clinical staff (3.7%)

The graph below shows the total number of complaints received per quarter for the financial year 2015/16.



The graph below shows the total number of PALS concerns, comments, compliments received per quarter for the financial year 2015/16.



Compliments

It is very rare for compliments about provider services to be made directly to the CCG (as these would normally be shared with the provider); however, the CCG received a total of 11 compliments for the year 2015/16. Some examples of the compliments received which made a difference to patients care include:

- NHS Carfax Health Enterprise Walk-in-Centre – a parent stated: *"Everyone in the centre was really helpful....the nurse who looked after my son was brilliant. When we left the walk in centre we felt reassured. Many thanks to the team at the walk in centre."*
- Arriva Transport – a patient reports: "*The driver looked very professional and was friendly; I knew I was in good hands. The driver advised me that she would be waiting for me, and would come into OPD at regular intervals to check how things were progressing. The return journey home was just as enjoyable, confident and capable driver too."*
- Great Western Hospital Midwifery and Health Visiting Service – new Mum reports of: *"The wonderful care and support that I have received."*
- The CCG's Continuing Healthcare Service – a family *stated: "During our dealings with them I found your [CCG CHC] team to be extremely helpful and courteous, especially the CHC Administrator with whom I had many conversations ... thank you once again for your team's diligence and care."*

During 2015/16 the 'quality walk about' visits and proactive face to face meetings with patients, families and service users who have shared their experience with the Patient Advice and Liaison Service (PALS) team has also enabled the CCG to hear first-hand about the personal journey that gives greater insight into the event, the experience and emotional impact of their care.

The quality monitoring of patient experience is presented to the Commissioning for Quality Committee, Integrated Governance Committee and Governing Body on a quarterly basis.

Sustainable Development

The CCG is required to report its progress in delivering against sustainable development indicators. The CCG continues to work with its building landlord who provides services for the CCG at their headquarters. The CCG continues to aim to strike the right balance between the three key areas of financial, social and environmental sustainability when making decisions. In doing so this enables the CCG to: save money, save resources and to benefit staff and patients.

Reducing our energy use

The CCG is a tenant in a serviced building – information on the landlord is available here and here.

Sustainability and commissioning

As a commissioner of services with a relatively small staff base the CCG's business processes will be the major contributor to its sustainability drive. The CCG therefore promotes sustainability in the way it commissions and procures services and goods.

The NHS Standard Contract asks providers to tale all reasonable steps to minimise adverse environmental impact. In line with the NHS Carbon Reduction Strategy, each provider must demonstrate its progress on climate change, mitigation and sustainable development, including performance against carbon reduction management plans, and must provide a summary of that progress in its annual report.

Governance

The Sustainability Lead for the CCG is Paul Bearman, Director of Corporate and Business Development.

Patient and Public Involvement

We are committed to ensuring we involve patients, carers and the public in everything we do to improve healthcare in Swindon and Shrivenham.

Under the terms of the Health and Social Care Act 2012 section 14Z2 of the Act, all NHS organisations must make arrangements to involve users, whether directly or through representatives (whether by being consulted or provided with information, or in other ways) in:

a) Planning of provision of services;
b) The development and consideration of proposals for changes in the way services are provided, and;
c) Decisions to be made affecting the operation of services.

During 2015/16, the Communications and Engagement team undertook a number of pieces of work which resulted in direct and indirect improvements to work programmes within the CCG, such improvements included changes to commissioning plans, increased support to new care interventions, and increased public engagement in partner and community events. These include:

- **Engagement in partner events:** the CCG took part in a greater range of partnership and public engagement events than in any year since its inception – these included groups focused on mental health, carer engagement, End of Life.
- **Patient reference groups:** the CCG convened patient reference groups on a number of topics including ophthalmology and diabetes. These groups act as advisory panels to both provider and commissioner colleagues on an ongoing and informal basis, allowing for there to be more regular patient involvement.
- **Development and launch of the Dying Well Community Charter (DWCC)** throughout 2015/16, the CCG has worked closely with its key local partners to develop a local DWCC. The Charter is a nationally led idea, but the ideas and commitments within it are ones that many local organisations will recognise as important and valid for our local community of Swindon. During national dying matters awareness week in 2015 and 2016, partners have worked together to develop local activities to raise public awareness of EOL care, and the importance of individual and family preparation and conversations for this.
- **The launch of an Advance Care Planning document:** this document supports people in considering and documenting their priorities and preferences for their future care – copies of this document can be accessed on the Prospect Hospice's website, and will be distributed through the health and public venues across Swindon including libraries and GP surgeries.
- **Launch of PPG guidance:** CCG representatives were able to join Healthwatch Swindon and NHS England to launch a guide to encourage patients and carers to get involved with their GP practice to improve the service quality and experience. The guide was developed in partnership with NHS England and supported by the CCG, National Association of Patient Participation and the Patient's Association. The guide offers information and advice to develop and support effective PPGs in GP practices and can be used whether a PPG is still being established, already fully developed or currently does not exist.
- **Freepost address:** the CCG invested in a freepost address, which has allowed it to receive a greater amount of public feedback, and will also encourage

people to take part in its patient surveys when it are carrying out evaluations throughout the year. The CCG can be contacted at: '**Freepost NHS Swindon CCG'**. Since setting this up, the CCG has received an increased number of public responses to its service evaluations, including the community navigator and the optometry pathway surveys.

- **Patient Feedback Card:** learning from other partner organisations demonstrated that the CCG could strengthen the amount and quality of patient feedback if it had feedback cards at the range of local events it attends. Following development with the PPI Forum, these patient feedback cards have now been printed and are being used in all engagement activities.
- **Review of Community Services engagement programme:** the Communications and Engagement team led an extensive programme of engagement on behalf of SBC and the CCG, to gather feedback on experiences of community health and social care services from the public, patients and carer groups. During the two month long programme of engagement approximately 400 people took part in the programme of events, providing a range of detailed feedback, concise and tailored opinions for improvement, and exciting ideas for future changes to services. Feedback from these events and the final report helped to inform the CCG's re-commissioning of community services in Swindon.
- **Public Website and intranet redevelopment**: During 2015/16, the CCG developed and launched a new website and membership intranet, in response to patient and member feedback regarding the usability and responsiveness of the existing sites. Both sites were developed with service user, membership and staff representatives and went live on the 29 February 2016. Both sites have been well received by both the public and staff.
- **Winter campaign and Newton Programme of work:** Before Christmas 2015 information about choosing the Right Health Services was given to six primary schools identified in areas for targeting as part of the winter campaign work and the Newton programme of work. The schools distributed the information in the children's book bags.

  As part of the Newton Programme of work the Communications and Engagement team have throughout 2015/16 worked with partners to develop targeted approaches to influence behaviour with particular segmented audiences to encourage the appropriate use of services in Swindon and Shrivenham. The objectives of the campaign are:
    - Increased awareness of the key Choose the Right Health Services messages;
    - Reduced attendances at Emergency Department (ED) for minor illness;
    - Reduced use of 999 phone calls and ambulance demand;
    - Increased uptake of self-care and alternative sources to ED e.g. pharmacies, Walk-in-Centre (Carfax), Urgent Care Centre (GWH site), Children's and Young Peoples Clinics, NHS 111 and out of hours GP services.

  Adverts were place in the local media encouraging people to use the right health services. Information about pharmacies that were open over the bank holiday period was shared widely. Partner organisations also helped promote winter messages via their social media channels and websites.

Equality and Diversity

Throughout 2015/16 the CCG has been committed to ensuring equality, diversity, inclusion, and human rights are central to the way the organisation commissions and delivers healthcare services and how it supports its staff. The CCG's aim is to reduce inequalities in health and health care for people in Swindon and Shrivenham.

As commissioners, the CCG must ensure it eliminates unlawful discrimination, advances the equality of opportunity and fosters good relations between different people when carrying out a public function.

During 2015/16 the CCG has taken key areas of work to promote equality and meet the needs of different groups, including the commencement of a gap analysis to review communication and contact with minority ethnic people, disabled people, transgender people, people of different ages, lesbian, gay and bisexual people, those with different religions and beliefs and those who are disadvantaged.

The CCG has discharged its duty to reduce inequalities acting in consultation and continues to strengthen the documentation process undertaken to both provide evidence of due consideration in day to day business and to capture any resulting actions required. The CCG has also published an annual Equality Report with key objectives in regards to equality (as per the NHS Equality Delivery System 2) and will pursue further actions to champion equality and inclusion across the health system in Swindon. The NHS Equality Delivery System 2 action plan has been progressed to further enhance progress and has been monitored for assurance.

The CCG's Equality and Diversity Strategy outlines its overall approach to equality, diversity and human rights in its capacity as an employer and a health commissioner has been published to reflect the above work and includes how the CCG:

- Maintains a governance structure aligned to equality and diversity;
- Ensures all staff have the necessary skills to commission services in line with the Equality Act 2010 and Public Sector Equality Duty under this act;
- Completes a systematic method of equality analyses/ equality impact assessments (EA/EIA) for people depending on their protected characteristic (e.g. age, disability, gender) to identify potential impacts on and outcomes for patients, equality analysis as an integral part of our intervention programme of work and redesign projects;
- Carries out EIAs in alignment with Quality Impact Assessments (QIAs) to ensure quality and equality are an integral part of our decision making and commissioning processes;
- Ensures that its communications and engagement activities are inclusive: reaching effectively people from all protected groups, including carers and seldom heard communities;
- Works with its statutory and voluntary sector partners to identify and tackle health inequalities;

- Ensures that its human resources policies are fair, transparent and in partnership with our staff and potential employees to improve working lives;
- Monitors complaints, comments and compliments by protected characteristic;
- Develops assurance mechanisms to satisfy ourselves that providers who are delivering services on its behalf (including South, Central and West CSU) are complying with the Equality Act 2010 as per 2015/16 contract requirements.

The CCG's Equality and Diversity Statement and the 2015/16 Equality Annual Report are available to read on the CCG's website.

Nicki Millin
Accountable Officer
25 May 2016

Part 2 – Accountability Report

Accountability Report
Corporate Governance Report

Members Report

A formal document, called a Constitution, sets out the arrangements the CCG has made to ensure it meets its responsibilities for commissioning high quality services for the people of Swindon and Shrivenham.

It describes the governing principles, rules and procedures which will ensure integrity, honesty and accountability. Also, it commits the CCG to taking decisions in an open and transparent way and places the interests of patients and public at its heart.

The Constitution can be downloaded at:
http://www.swindonccg.nhs.uk/index.php/about-us/download-our-plans-and-publications/20-constitution-april-2015/file

The CCG comprises 26 member practices with three localities in the geographical area of Swindon and Shrivenham, with a registered population of 231,277.

Practice	Population
Abbey Meads Medical Practice	18,376
Merchiston Surgery	14,187
North Swindon Practice	13,238
Carfax NHS Medical Centre	12,613
Taw Hill Medical Practice	12,472
Hawthorn Medical Practice	12,245
Ridgeway View Family Practice, Wroughton Health Centre	11,721
Moredon Medical Centre	11,215
Ridge Green Medical Centre	10,449
Ashington House Surgery	10,227
Westrop Surgery	10,150
Whalebridge Practice	9,840
Kingswood Surgery	9,686
Priory Road Medical Centre	8,485
Old Town Surgery	7,935
Eldene Surgery	7,772
Victoria Cross Surgery	7,396
Elm Tree Surgery	7,026
Lawn Medical Centre	7,018
Park Lane Practice	6,598
Great Western Surgery	5,659
Phoenix Surgery	4,879
Hermitage Surgery	4,380
Sparcells Surgery	3,572
Eldene Health Centre	2,453
Cornerstone Practice	1,685
	231,277

The CCG is led by an elected Clinical Chair, Dr Peter Crouch, and GP Partner at Taw Hill Medical Practice and supported by the elected Clinical Vice-Chair, Dr Peter Mack, Senior Partner at Moredon Health Centre. Dr Mack along with two other elected GP Governing Body members, Dr Sarah Bruen and Dr Philip Mayes who represented the

CCG's three localities during 2015/16. The Clinical Chair attends the weekly Executive Management Team meetings of the CCG.

All the GP and practice manager Governing Body members attend the Clinical Leadership Group (CLG) meetings which are held monthly. The Governing Body also includes an elected non-principal /salaried GP representative. During the year the CLG has provided a forum for active clinical debate, this has informed the decisions regarding priorities for the CCG. Throughout the year the CLG received and provided feedback to the CCG's member GP practices.

Membership engagement

During 2015/16 the CCG has continued to increase its focus and capacity, to ensure effective and continuous engagement with member GP practices. There is now an established CCG Primary Care Team in place, providing additional support to practices in the development of new projects, workforce planning and premises planning. The team is also able to ensure that practical support can be offered to membership practices where needed, such as in preparing and submitting national bids for transformation projects and as part of CQC compliance. This has enabled the CCG to work collaboratively with, and support our member GP practices.

The CCG has continued to send routine communication in a fortnightly newsletter, this has streamlined communication with practice managers and senior/managing partners. The newsletter is split into two sections, the first with messages from the CCG, the second with messages from other stakeholders in the health and social care system, with each article being highlighted as: for action, for information, for feedback, new service/project or service change.

In times of system escalation when urgent communication is needed, a real-time information system, Sendwordnow®, has also been introduced and this system will ensure that all practices are aware of any issues in the system that may affect their patients and onward referral.

The CCG has continued to host a quarterly Commissioning Forum to keep practices informed, and to allow them an opportunity to discuss key topics, the outcome and feedback from these sessions is discussed at the CLG and communicated via the newsletter. The structure of the CLG has continued to allow clinical representatives more time to engage with their localities and practices, with clear reporting of messages to and from CLG.

During 2016/17, the CCG is committed to continue working with local practices as part of its member practice development and engagement strategy. There are a number of key work stream within this:

Prime Minsters Challenge Fund wave 2 project

This has provided a range of additional services to increase capacity and access to primary care services. The CCG is committed to this scheme and is extremely keen for it to continue in 2016/17 based on evaluation to date. The CCG has seen a positive effect in the system from the additional capacity and access that the scheme has provided. At present the services will continue in April and May 2016 whilst an understanding of the national funding position becomes clearer. During 2015/16 it has

demonstrated how services can operate at scale to improve workforce constraints and access to services, as well as integrate with out of hours, primary care, community and acute services. However without additional funding the full access of the scheme may be reduced, the CCG is progressing discussions in this regard with NHSE.

Primary Care Workforce Development Project and Swindon Community Education Provider Network (CEPN)

There are significant workforce issues in primary care in Swindon, this is in part due to national pressures on workforce but also due to local factors affecting the ability to recruit and retain staff in an area of significant patient growth and increased workload.

In 2015/16 membership practices, supported by the CCG, prioritised ten workforce projects to implement in order to find practical solutions to improve the issues associated with primary care workforce in Swindon. The projects were intended to be deliverable within the next year and prioritised areas in which practices and CCG have control, rather than areas that require engagement and influence on national training programmes or contracts. Good progress has been made with the delivery of these projects and in 2016/17 this will develop into the work overseen by the Swindon Community Education Provider Network (CEPN). The Swindon CEPN will cover the Swindon and Shrivenham area. The initial priority for the CEPN will be to undertake a baseline assessment of workforce across all clinical professions in primary care, use this to develop a workforce needs assessment linked to local models of care and clinical pathways, and use this to agree actions to address the needs identified. It is expected that these will include (but not limited to) training networks and programmes, agreeing new models of care and the development of new skill mix models, and using resources at scale across organisational boundaries.

Primary Care Transformation Fund (PCTF)

Building on the Swindon Estates Strategy, the PCTF will aim to prioritise premises and technology developments to support new works of working to help deliver a wider range of services, to accelerate transformation and operating at scale. The CCG is working with local practices to collate and prioritise schemes to reflect individual and group priorities and aspirations, focusing on estate, technology and infrastructure changes over the next four years.

Joint Co-commissioning of primary medical services with NHS England

From 1 April 2015, the CCG adopted 'joint' co-commissioning arrangements with NHS England for primary medical services. Commissioning arrangements have been overseen by a Joint Primary Care Committee (JPCC), this is a meeting held quarterly in public. The JPCC is supported by a monthly operational group.

In 2015/16 the CCG has delivered a joint strategic work plan with NHSE focusing on key work streams that included strategy development, premises, workforce, and review of enhanced services, IT, performance and quality development. The aim of the plan was to ensure that as part of joint commissioning arrangements the representative leads for each area in NHSE and the CCG were clear about responsibilities and outcomes expected. The plan was also discussed as part of the co-commissioning working group set up between NHSE, Swindon, Bath and North East Somerset and Wiltshire CCGs, in order to ensure that tasks or outcomes could

be shared across the area, where appropriate, in order to reduce duplication and share learning.

Governing Body

The CCG has a constitution which outlines how the organisation will deliver its statutory duties and this was amended following the governance review in 2014/15 and the need for it to be up dated to reflect changes in the commissioning of primary care services and the role of NHS England. The CCG constitution has been widely consulted upon and can be accessed via its website: www.swindonccg.nhs.uk/our-constitution or telephone 01793 683700 for a printed copy.

The Governing Body is in place to ensure that the CCG has the appropriate arrangements in place to exercise its functions effectively, efficiently and economically. The Governing Body of the CCG throughout the year has an ongoing role in reviewing the CCG's governance arrangements to ensure that the CCG continues to reflect the principles of good governance.

Membership of the Governing Body is in line with statute and in addition is representative of the member GP practices through the elected locality clinicians. Further information on the roles of individual members of the Governing Body are covered in detail in the CCG's published constitution.

In summary, each member of the Governing Body shares responsibility as part of a team to ensure that the CCG performs its duties in accordance with the terms of the constitution. Each brings a unique perspective, informed by their expertise and experience.

Information about these committees is available via the CCG's website: http://www.swindonccg.nhs.uk/index.php/about-us/download-our-plans-and-publications/20-constitution-april-2015 or telephone 01793 683700 for a printed copy

We certify that NHS Swindon Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

Governing Body members and the committees they chair:

Title	Name	Committee Chair
Clinical Chair	Dr Peter Couch	Chair of Clinical Leadership Group
Clinical Vice-Chair	Dr Peter Mack	Chair of Commissioning for Quality
Accountable Officer (Until 30/4/2015)	Jan Stubbings	
Chief Finance Officer	Caroline Gregory	
Chief Operating Officer (with effect from 1/4/2015) & Acting Accountable Officer (with effect from 30/4/2015)	Nicki Millin	

Executive Director of Corporate and Business Development	Paul Bearman	
Executive Nurse	Gill May	
Locality GP Representative	Dr Peter Mack	
Locality GP Representative	Dr Eric Holliday	
Locality GP Representative	Dr Phillip Mayes	
Salaried GP Representative	Dr Liz Alden	
Secondary Care Doctor	Dr Tim Jobson	
Registered Nurse	Christine Perry	Chair of Integrated Governance Committee
Practice Manager	Angela Brunning	
Practice Manager	Sarah Francome	
Director of Public Health	Cherry Jones	
Director of Social Care	John Gilbert	
Lay Member (public and patient involvement) and Operational Chair of Governing Body	Paul Byrnes	Chair of PPI Forum
Lay Member (governance)	Ian James	Chair of the Audit Committee
Lay Member	Bill Fishlock	

Profiles of Governing Body Members can be viewed on the CCG's website: http://www.swindonccg.nhs.uk/index.php/about-us/meet-our-governing-body

Audit Committee

The Audit Committee meets on a bi-monthly basis and is chaired by the lay member for governance. The Committee is attended by fellow Lay Members and a GP member, the Chief Finance Officer, Head of Corporate Governance, security and counter fraud specialists and representatives from both internal and external audit.

The experience of Ian James and Bill Fishlock bring to the Audit Committee can be read here.

Register of Governing Body members' interests and personal relationships with outside bodies

It is the policy of the CCG that all staff and Governing Body members should at all times work in the best interests of the CCG, its membership and patients. In performing their duties, Governing Body members should not be influenced by desire for personal gain. Accordingly, the CCG has adopted rules to guide disclosure of potential conflicts of interest and the CCG's response that shall apply to those who work for the organisation. Attendance, apologies for absence, and declarations of interests and/ or conflicts of interests are formally recorded in the minutes of meetings.

A list of members' interests and personal relationships with outside bodies is provided on the CCG's website: http://www.swindonccg.nhs.uk/index.php/about-us/governance-and-compliance

Statement as to disclosure to auditors

At the time the report is approved we can confirm that each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Note: “Relevant audit information” means information needed by the CCG’s auditor in connection with preparing this report.

Note: Companies Act 2006 s418 refers (note: s418 (5) and (6) are not applicable). The signing of the statement cannot be delegated to an audit committee.

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).

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.
In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,

- Prepare the financial statements on a going concern basis.

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Nicki Millin
Accountable Officer
25 May 2016

Governance Statement

Introduction and context

Swindon CCG was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2015, the CCG was licensed without conditions.

Scope of responsibility

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

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

I was appointed as Acting Accountable Officer from the 1 May 2015 and permanently into the role from 1 September 2015. The Interim Accountable Officer was appointed on 22 June 2014 until 30 April 2015. For the period from 1 April to 30 April 2015 I was employed as the Chief Operating Officer.

Compliance with the UK Corporate Governance Code

The CCG is not required to comply with the UK Corporate Governance Code. However, it has reported on its Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code it considers to be relevant to the CCG and best practice through the Integrated Quality, Finance and Performance report presented to the Governing Body along with minutes of the Integrated Governance and Quality Assurance Committee (IGC) and the Audit Committee. The CCG complied with and applied the provisions as set out in the Code as follows:

<u>Leadership</u>

- The CCG is headed by an effective Governing Body, who are collectively responsible for its strategic aims and ensuring appropriate resources are available to ensure long-term success;
- The Governing Body meets regularly against a planned schedule and established agendas;
- The division of responsibilities is clear; the leadership of the Governing Body and its effectiveness is managed by the Clinical Chair and the Accountable Officer is accountable for the operational business;
- The Lay Governing Body Members challenge and scrutinise the performance of management in meeting goals and objectives and monitor CCG performance, including integrity of information and financial controls.

Effectiveness

- The Governing Body consists of individuals (including executive, clinical and independent Lay Governing Body Members) with a mix of expert knowledge, skills, experience and capability. Collectively, this ensures robust and balanced challenge and assurance;
- Under Authorisation Criteria, the Accountable Officer, Chief Finance Officer and the Clinical Chair were required to undertake competency assessments as part of their recruitment to their positions to ensure their ability for the role. Other directors and independent Lay Members are appointed via a rigorous recruitment process which follows best practice;
- Clinical members of the Governing Body are appointed via a selection and election process;
- The elections are conducted by an independent organisation;
- On appointment all Governing Body members are required to ensure that sufficient time is allocated to discharge their duties and responsibilities effectively and are provided with information in a timely manner to support this requirement;
- All Members receive development training and an annual appraisal with the Clinical Chair or the Accountable Officer.

Accountability

- Through the Annual Report and published Governing Body papers, the Governing Body presents a fair, balanced and understandable assessment of the CCG's position and prospects;
- The CCG has engaged internal and external auditors to provide scrutiny and challenge of the corporate reporting, risk management and internal control processes. Audit reports to date have recommended enhancements (where appropriate) to existing controls to further improve robust systems.

The Governing Body adheres to the "Nolan Principles" setting out the ways in which holders of public office behave in the discharge of their duties and as a guiding principle for decision making. The effectiveness of the main CCG committees are reviewed by the Governing Body when receiving reports and minutes of the committees.

NHS England undertake as part of the CCG Assurance Framework quarterly reviews of the CCG. The quarter three assurance discussion concluded that NHS England's provisional headline assurance rating for the CCG is 'good'. The one area of concern was the delivery of the NHS Constitution standards particularly in relation to Referral to Treatment Times for elective care and meeting the A&E four hour wait target.

Remuneration

- The Remuneration Committee oversees and provides assurance on senior management and Governing Body terms and conditions outside NHS Agenda for Change.

Relation with Shareholders

- Whilst the CCG does not have shareholders as a Public Sector organisation the Governing Body held a successful Annual General Meeting (AGM) to engage with its major stakeholders i.e. the general public, providers and patients;

- The Governing Body/CCG understands its responsibility to listen and engage with its stakeholders and actively seeks their opinion.

The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The CCG's constitution sets out the principles of good governance which it adheres to and delegates authority to members or employees participating in those joint arrangements to make decisions on its behalf through the following committees:

- **Governing Body** to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the group's principles of good governance. Reporting to the CCG Governing Body were ten subgroups that enable it to discharge its responsibilities and manage its performance, quality and risk effectively:
  - The Audit Committee
  - The Remuneration Committee
  - The Integrated Governance and Quality Assurance Committee
  - The Clinical Leadership Group
  - The Public and Patient Involvement Forum
  - Swindon and Shrivenham Commissioning Forum
  - Swindon Strategic System Resilience Group
  - Audit Panel
  - Finance Committee
  - Joint Primary Care Commissioning Group

The Governing Body has worked diligently to carry out its responsibilities as a statutory body. All meetings have been held in public. The agenda and papers are placed on the CCG's website in advance of the meetings and act as a public record of the decisions taken and performance to date.

Governing Body attendances 2015/16									
Name	**Title**	**23/04/2015**	**28/05/2015**	**25/06/2015**	**23/07/2015**	**24/09/2015**	**26/11/2015**	**21/01/2016**	**24/03/2016**
Present									
Paul Byrnes	Lay Member PPI (Chair from 1st September)					●	●	●	●
Ian James	Lay Member Governance (Chair from 1st April to 30th August)	●	●		●	●	●	●	●
William Fishlock	Lay Member	●	●	●	●	●	●	●	●
Peter Crouch	Clinical Chair	●	●		●	●	●	●	
Dr Peter Mack	Clinical Vice Chair and Locality Two Clinical Chair	●	●	●	●	●	●	●	●
Dr Philip Mayes	Locality Three Clinical Chair	●	●			●	●		●
Dr Tim Jobson	Secondary Care Doctor	●	●		●		●	●	●
Dr Liz Alden	Non Principal GP Representative	●	●	●	●	●	●	●	●
Dr Sarah Bruen	Locality One Clinical Chair	●	●	●	●	●	●	●	●
Sarah Francome	Practice Manager Representative	●			●	●	●	●	●
Christine Perry	Registered Nurse		●	●		●	●		●
Jan Stubbings	Interim Accountable Officer (until 30th April 15)								
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)	●	●	●	●		●	●	●
Paul Bearman	Executive Director of Corporate and Business Development	●	●	●	●	●	●	●	●
John Gilbert	Group Director Adult & Children's Services (SBC)	●	●	●	●	●	●		●
Caroline Gregory	Chief Financial Officer	●	●	●	●	●	●	●	●
Cherry Jones	Director of Public Health (SBC)	●	●	●			●	●	●
Gill May	Executive Nurse	●	●	●	●	●			●
In Attendance									
Dr Francis Campbell	GP Clinical Evidence Fellow	●	●						
Sue Wald	Head of Commissioning Children & Adults (SBC)			●				●	
Doug Bale	Adult Safeguarding Manager, SBC						●		
Nigel Langhorn	Swindon CCG Account Manager (SWC CSU)	●	●						
Frances Mayes	Senior Public Health Manager on behalf of Cherry Jones					●			
Yvonne Knight	Corporate & Information Governance/Risk Manager	●		●		●	●	●	●
Robin Butcher	Head of Communications and Engagement						●		
Kate Liddington	Associate Director for Primary Care Engagement & Development		●				●	●	
Sharren Pells	Associate Director for Quality						●		
Lisa Samak	Associate Director of Contracts, Planning & Performance						●		
Sally Smith	Communications and Engagement Officer				●		●		
Sheila Baxter	Mental Health Commissioning Lead							●	
Ruth Atkins	Assistant Head of Strategic Communications and Engagement CSW CSU (From 1st April to 31st December) and Head of Corporate Communications & Minute Taker (From 1st January)	●	●	●	●	●	●	●	●
David Renner	Quality Support Manager				●				
Chris Pike	Minute Taker	●	●	●	●	●	●		

Also supporting these are the Joint Commissioning Managers Group and the Health and Wellbeing Board which support the health and social care integration.

- **Audit Committee** which is accountable to the CCG's Governing Body and provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and regulations and directions in so far as they relate to finance. In particular, the committee will seek to provide assurance to the Governing Body than an appropriate system of internal control is in place to ensure that:
    - business is conducted in accordance with the law and proper standards;
    - public money is safeguarded and properly accounted for;
    - financial statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question;
    - affairs are managed to secure economic, efficient and effective use of resources;
    - reasonable steps are taken to prevent and detect fraud and other irregularities.

Highlights of work to date have included governance of CCG finances and resources, planning and monitoring of internal audit, external audit and NHS Protect reviews, follow up of Governance review recommendations and oversight of CCG Finance self-assessment.

Audit Committee attendances 2015/16								
Name	Title	21/04/2016	14/05/2015	27/05/2015	03/09/2015	12/11/2015	14/01/2016	10/03/2016
Present								
Ian James	Lay Member Governance (Chair)	•	•	•	•	•	•	•
William Fishlock	Lay Member	•	•	•	•	•	•	•
Paul Byrnes	Lay Member PPI		•		•		•	
Dr Peter Swinyard	GP Representative	•		•	•	•	•	•
In Attendance								
Liz Cave	Grant Thornton (External Audit)			•		•		•
Chris Hackett	Grant Thornton (External Audit from 1st November)					•	•	•
Chris Rockey	Grant Thornton (External Audit from 1st April to 30th September)		•	•	•			
Lynn Pamment	Price Waterhouse Coopers (Internal Audit from 1st April to 30th September)							
Lynne Barber	Price Waterhouse Coopers (Internal Audit from 1st November)					•	•	•
Natalie Tarr	Price Waterhouse Coopers (Internal Audit)		•		•	•	•	•
Tracey Spragg	TIAA (Counter Fraud)		•		•		•	
Paul Travers	Secure (Security Management)				•	•		
Barry Hards	Secure (Security Management) in attendance on behalf of Paul Travers							•
Jan Stubbings	Interim Accountable Officer (until 30th April 15)							
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)	•	•	•	•			
Caroline Gregory	Chief Finance Officer	•	•	•			•	•
Matthew Hawkins	Deputy Finance Officer in attendance on behalf of Caroline Gregory	•		•	•	•		
Paul Bearman	Executive Director of Corporate and Business Development	•	•	•	•	•	•	•
Yvonne Knight	Head of Governance				•	•	•	
Julia Dobson	Personnel Assistant to Chief Finance Officer (Secretary)	•	•	•	•	•		•
Note: Meetings held on the 21/04/15 and 27/05/15 were extraordinary to review the draft accounts and approve the final accounts								

- **Remuneration Committee** which is accountable to the CCG's Governing Body and makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for senior management and for people who provide services to the group.

Remuneration Committee attendances 2015/16			
Name	Title	28/05/2015	23/07/2015
Present			
William Fishlock	Lay Member (Chair)	•	•
Ian James	Lay Member Governance	•	•
Peter Crouch	Clinical Chair	•	•
Dr Tim Jobson	Secondary Care Doctor	•	•
Christine Perry	Registered Nurse	•	

Integrated Governance and Quality Assurance Committee (IGC)

The overarching aim of the Integrated Governance and Quality Assurance Committee (IGC) is to ensure that controls are in place and are operating efficiently and effectively to deliver the principal objectives of the Governing Body and to set in place processes to manage identified risks, minimising the exposure of Swindon Clinical Commissioning Group to corporate, financial and clinical risks.

It has established the following Sub-Committees to help discharge its duties and responsibilities: the Commissioning for Quality Sub-Committee; and the Information Governance Steering Group. The IGC also receives assurance from the Joint Safeguarding Adults & Children's Boards.

Key achievements during the year include reviewing and agreeing a suite of policies prior to formal adoption by the Governing Body for example: Health & Safety policies; Record Management policies; and Information Governance policies. The IGC also has a rolling schedule of assurance reports that it receives at each meeting. These reports cover a variety of issues that have been identified by the Committee as requiring extended discussion and analysis and which are often prompted by the rigorous

scrutiny of the Corporate Risk Register that the Committee undertakes at every meeting.

IGQAC attendances 2015/16							
Name	Title	14/05/2015	09/07/2015	10/09/2015	12/11/2015	14/01/2016	10/03/2016
Present							
Christine Perry	Registered Nurse (Chair)	•	•	•	•		•
Paul Byrnes	Lay Member PPI		•	•		•	•
Ian James	Lay Member Governance	•	•		•	•	•
Dr Sarah Bruen	Locality One Clinical Chair	•	•		•	•	
Dr Peter Mack	Clinical Vice Chair and Locality Two Clinical Chair				•	•	•
Dr Philip Mayes	Locality Three Clinical Chair			•		•	
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)		•				
Gill May	Executive Nurse		•	•	•	•	•
Paul Bearman	Executive Director of Corporate and Business Development	•		•	•	•	

- **Clinical Leadership Group (CLG):** to develop vision and strategy for ratification by Governing Body; the annual commissioning plan to reflect CCG commissioning priorities; internal engagement with members and opportunities for practices to take on leadership roles in service redesign. Highlights of the CLG have included discussions around development of co-commissioning, and key areas of work which may impact on the member practices. The October 2015 meeting was a workshop and no meeting was held in August 2015.

Clinical Leadership Group attendances 2015/16										
Name	Title	15/04/2015	13/05/2015	17/06/2015	22/07/2015	16/09/2015	11/11/2015	16/12/2015	27/01/2016	24/02/2016
Present										
Peter Crouch	Clinical Chair (Chair)	•		•	•	•			•	•
Paul Byrnes	Lay Member PPI						•	•	•	•
Ian James	Lay Member Governance	•	•	•				•	•	
Dr Peter Mack	Clinical Vice Chair and Locality Two Clinical Chair	•	•	•		•	•	•		•
Dr Philip Mayes	Locality Three Clinical Chair	•	•	•		•	•			•
Dr Sarah Bruen	Locality One Clinical Chair	•	•	•	•	•	•	•	•	
Dr Francis Campbell	GP Clinical Evidence Fellow			•	•	•	•	•	•	
Dr Caroline Ward	GP Clinical Evidence Fellow						•	•		
Dr Liz Alden	Non Principal GP Representative		•							
Sarah Francome	Practice Manager Representative	•	•	•	•	•	•	•	•	
Jan Stubbings	Interim Accountable Officer									
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)		•	•		•				•
Caroline Gregory	Chief Finance Officer		•	•	•	•	•		•	•
Gill May	Executive Nurse	•		•			•		•	•
Paul Bearman	Executive Director of Corporate and Business Development	•	•	•	•	•	•	•	•	•
Kate Liddington	Associate Director for Primary Care Engagement & Development	•	•	•		•		•	•	•
Anna Field	Associate Director – Planned Care and Cancer Commissioning	•	•		•	•	•		•	
Thomas Kearney	Associate Director- Urgent Care and Mental Health	•								

- **Swindon and Shrivenham Commissioning Forum:** to provide member practice engagement with the CCG.

- **The Public and Patient Involvement Forum**: to ensure that patients, public stakeholders and partners are meaningfully engaged in decision making at all levels. The forum provides assurance and recommendations to the Governing Body to ensure its communications and engagement strategy is being delivered. The forum also helps the Governing Body in fulfilling its responsibility to consult with the public on matters of material change. Meetings were cancelled in May and August.

PPI Forum attendances 2015/16								
Name	Title	23/04/2015	25/06/2015	23/07/2015	24/09/2015	22/10/2015	21/01/2016	25/02/2016
Present								
Paul Byrnes	Lay Member PPI (Chair from 1st September)		•		•		•	•
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)		•			•		
Ian James	Lay Member Governance (Chair from 1st April to 30th August)	•		•	•	•	•	•
xxx	Member of the public		•			•	•	•
xxx	Member of the public	•	•	•	•	•	•	•
xxx	Member of the public	•	•	•	•	•		
xxx	Member of the public	•		•	•	•		•
xxx	Member of the public		•		•	•		•
xxx	Member of the Public							
xxx	Homeground PPG	•	•	•		•	•	•
xxx	Member of the public and Ridgeway View PPG	•	•	•				•
xxx	Chair of Breathe Easy Group		•			•		
xxx	Manager Healthwatch Swindon		•			•		
Sarah Francome	Practice Manager Representative	•		•	•	•	•	
xxx	RNIB Representative	•		•	•	•		•
xxx	Strategic Development Manager VAS	•			•	•		
xxx	Health Locality Lead SBC	•						
xxx	Public Health Programme Coordinator SBC	•	•			•		•
xxx	Healthwatch, Swindon	•	•					
xxx	Service Development Manager, British Lung Foundation							•
xxx	Deputy CEO, Swindon Carers Centre							•
Gill May	Executive Nurse	•	•	•	•		•	•
Ruth Atkins	Assistant Head of Strategic Communications and Engagement CSW CSU (From 1st April to 31st December) and Head of Corporate Communications & Minute Taker (From 1st January)	•	•	•	•	•	•	•
Robin Butcher	Head of Communications and Engagement	•	•	•		•	•	
Sally Smith	Communications and Engagement Officer		•	•	•	•	•	•
Kristina Clay	Quality Improvement Lead		•	•				
Teresa Wallace	Facilities Manager	•	•					
In Attendance								
Tess Green	Attain Commissioning, GWH		•			•		
Mary O'Donohue	Project Manager		•			•		
Lynette Glass	Quality Lead for Projects		•		•			
Chris Pike	Note Taker	•	•	•	•			

The **Swindon Strategic System Resilience Group** (SRG) brings together partner organisations with a common aim: to improve the health and health care experience of the people of Swindon and Shrivenham, and from the catchment area of North Wiltshire within the resources made available. The SRG meets monthly with the aim of providing a strategic, delivery and monitoring forum for health and social care partners to ensure operational resilience, cancer standards and referral to treatment requirements are achieved for the local health and social care systems.

The Governing Body also supported the formation of three further Committees during 2015/16:

- **Joint Primary Care Committee:** to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the group's principles of good governance in relation to primary care. This responsibility is held jointly with NHS England. Meetings held on the 12 December and 19 February were exceptional.

The Governing Body of the CCG and the Joint Primary Care Commissioning Group meet in public and make available their papers, agenda and minutes on the website.

Joint Primary Care Committee attendances 2015/16						
Name	Title	01/07/2015	07/10/2015	12/12/2015	06/01/2016	19/02/2016
Present						
Paul Byrnes	Lay Member PPI (Chair from 1st September)		●	●	●	●
Ian James	Lay Member Governance (Chair from 1st April to 30th August)	●		●	●	●
Peter Crouch	Clinical Chair	●	●		●	●
Dr Peter Mack	Clinical Vice Chair and Locality Two Clinical Chair (deputising for Peter Crouch in December)			●		
Dr Gareth Bryant	Wiltshire & Swindon LMC Executive Representative			●	●	
Dr Sarah Bruen	Locality One Clinical Chair	●			●	
Valerie Vaughan	Executive Healthwatch Representative	●			●	
Sarah Francome	Practice Manager Representative	●			●	
Debra Elliott	Director of Commissioning, NHS England	●	●	●	●	●
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)	●	●	●	●	●
Nikki Holmes	Head of Primary Care, NHS England	●	●		●	●
Caroline Gregory	Chief Finance Officer	●				
Gill May	Executive Nurse	●	●	●	●	
Cherry Jones	Director of Public Health, SBC	●			●	
Kate Liddington	Associate Director for Primary Care Engagement & Development	●	●		●	●
Rosi Shepherd	Assistant Director of Nursing, NHS England	●		●	●	
Geoff Shone	Assistant Head of Finance, NHS England (1st July to 30th September)	●				
Tracey Strachan	Assistant Head of Finance, NHS England (From 1st October)				●	
Sue Carvell	Primary Care Manager		●			●

- **Finance Committee**: to provide advice and support to the Governing Body, and to the Accountable Officer, in scrutinising and monitoring the delivery of key financial targets and priorities as outlined in the CCG's Strategic and Operational plans. It will ensure that any risks associated with achieving these priorities and targets are being reported properly through to the Governing Body and will test the robustness of any mitigating actions. Highlights of the work-to-date include Financial Performance Reviews, QIPP, key financial risks (including contract agreements), financial planning for 2016/17, and review of financial planning guidance and development of plans.

Finance Committee attendances 2015/16		
Name	Title	25/02/2015
Present		
William Fishlock	Lay Member (Chair)	●
Ian James	Lay Member Governance (Chair from 1st April to 30th August)	●
Dr Tim Jobson	Secondary Care Doctor	●
Paul Bearman	Executive Director of Corporate and Business Development	●
Caroline Gregory	Chief Finance Officer	●
Nicki Millin	Chief Operating Officer (1st to 30th April), Acting Accountable Officer (1st May to 30th August), Accountable Officer (From 1st September)	

- **Audit Panel**: this panel provides advice and support to the Governing Body, on the appointment of the CCG's external auditor. It will ensure that any risks associated with achieving this are being reported promptly to the Governing Body and will test the robustness of any mitigating actions. The Audit Panel should advise the CCG on the purchase on non-audit services from the auditor such as consultancy, advice and project management. The terms of reference for this panel were

approved at the March 2015 Governing Body meeting and they have not therefore met formally during 2015/16.

The Clinical Commissioning Group Risk Management Framework

The CCG recognises that risk management is an intrinsic part of the organisation's operation. The CCG is committed to active management of risk within the commissioning process and the services it commissions. The CCG's policy is to minimise or remove risks wherever possible to service users, staff, and members of the public and other stakeholders. This embraces all types of risk – clinical, financial, corporate, operational and reputational.

This is enabled and supported by a comprehensive system of internal controls aligned to management systems, corporate planning, clinician-led commissioning and strategy development. The Governing Body recognises the pervasive nature of risk and considers effective risk management to be an integral part of good management practice. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk and to apply sound governance arrangements

The CCG's approach to managing risk is outlined in its Risk Management Strategy which explains how risks are identified, evaluated, scored and monitored within the organisation.

Risk management is the responsibility of everyone in the organisation. The review and maintenance of an effective risk management system involves all staff and, as appropriate, key stakeholders and is applied to all systems and processes, corporate and financial.

The Governing Body is responsible for the performance of the organisation and needs to be simultaneously entrepreneurial in driving the business forward whilst keeping it under prudent control. It needs to strike a balance between controls, assurance and strategy, risk-taking and delivery. It held a specific workshop in February 2016 to develop and review its appetite for risk; this was facilitated by the CCG's Internal Audit as part of their programme for 2015/16.

The Audit Committee is responsible for commissioning internal audits to provide assurance to the Governing Body on the robustness and effectiveness of risk management within the CCG.

The Accountable Officer is accountable to the Governing Body for the safe management of risk within the organisation – this responsibility is delegated to the Chief Financial Officer on a day to day basis.

The Chief Financial Officer has overall responsibility for the management of risk within the CCG.

Senior managers and project managers are empowered to manage the risks within their areas and to escalate risks appropriately. All staff members and contractors working for the CCG have a responsibility for following the approved risk management

strategy and are required to report risk to their managers for assessment and subsequent risk scoring using the approved risk matrix.

The CCG is committed to maintaining a sound system of internal control including risk management. By doing this, the organisation aims to ensure that they are able to maintain a safe environment for patients through the services it commissions, staff and visitors, minimise financial loss to the organisation and demonstrate to the public that it is a safe, effective and efficient organisation.

Risk assessment and management process

Risk assessment and management are an intrinsic part of the CCGs operation. The CCG's risk register is a live document that is subject to regular reviews by a number of entities including:

- The CCG's Governing Body
- The Integrated Governance Committee
- The Audit Committee

The Executive Management Team

The Governing Body and Audit Committee regularly consider whether the sources of assurance that it has for managing and mitigating risks remain effective and sufficiently robust. The CCG has developed a risk matrix which is used for all risks, both clinical and non-clinical within the organisation.
Each risk includes:

- Description and cause of risk
- Current controls and assurances
- Proposed actions with target dates
- Latest and next review date
- Risk owner and responsible director
- Link to the appropriate strategic risk in the Governing Body Assurance Framework (GBAF)

The CCG has a Quality and Equality Impact Assessment (QEIA) process in place which provides the framework to ensure compliance with its statutory obligations and to identify any risks to the organisation. Impacts are also assessed through the cover sheets for all reports that are presented to the Governing Body and other committees of the CCG to ensure it is integral to planning and implementation. The CCG has an active framework for patient and public engagement and actively attends through its member representation on the Health and Wellbeing Board. A network of patient participation groups and regular events seek the views of patients and the public.

The CCG proactively links its priorities to the NHS Outcomes Framework, this is clearly documented at the organisation's quality committee where all risks assigned to patient quality are measured.

All identified risks are recorded on the CCG's Risk Register. Where risks cannot be managed within the specific area of responsibility then these are escalated to the next level of governance to be managed appropriately.

The full Corporate Risk Register is reviewed monthly by the Executive Management Team and bi-monthly by the Integrated Governance and Quality Assurance Committee. The highest scoring risks are reported monthly to the Governing Body along with the strategic risks contained within the GBAF. The GBAF is a key source of evidence that links strategic objectives to risks and assurances and is one of the main tools the CCG uses in discharging its overall responsibility for internal control. During 2015/16, the CCG requested an independent review of the soundness of its GBAF which was conducted by the South Central and West CSU. This concluded that:

- The strategic aims and objectives were clearly documented;
- It was helpful to see measures highlighted in framework and used to monitor objectives;
- The framework should be condensed to exclude reporting frequency, data feed and contract management link as not clear what value these provide;
- The Risk Management Strategy needs to be tailored more to the CCG and include commissioning focused descriptors;
- A report be produced to the Integrated Governance Committee on how CCG should embed and respond to good Governance Institute guidance.

The GBAF also allows the CCG to determine where to make the most efficient use of its resources and to address identified issues in order to improve the quality and safety of care. It is the role of the Governing Body to focus on those risks and events which may compromise the achievement of the CCG's strategic objectives and support an organisational culture which allows the organisation to anticipate and respond appropriately to adverse events.

The CCG actively deters risks through the adoption of robust counter fraud and security management methodology. The CCG has a contract with TIAA to provide counter fraud management and Secure UK to provide security management. The CCG RAG rated itself as 'amber' against the national standards for counter fraud and anticipates applying the same process to Security Management in 2016/17.

The CCG's Audit Committee critically reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities which supports the achievement of the organisation's objectives. It reviewed its terms of reference during the year and also undertook a self-assessment against areas of best practice and is now compliant in all areas that it 'must' and 'should' do.

The top three strategic risks identified during 2015/16 were:

1. Delivery of the NHS Constitution Targets focused particularly on RTT within 18 weeks and the 4 hour A&E target
2. Managing demand for urgent care and specifically emergency admissions
3. Not achieving financial balance and the failure to deliver the QIPP programme

The Governing Body were kept informed at each meeting on progress against mitigating actions to ensure these risks did not materialise or the impact of these was minimised in year. The first risk was not fully mitigated in year and although significant progress was made towards delivering these two constitutional targets, neither were achieved by the end of the financial year. Remedial action plans anticipate RTT performance to be on track by the end of June 2016 and a sustainable performance on A&E 4 hour target by end of July 2016.

The Clinical Commissioning Group Internal Control Framework

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

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

The CCG's system of internal control has been in place for the year ended 31 March 2016 and up to the date of approval of the Annual Report and Accounts.

The CCG recognises the importance of a robust governance framework and has continued to strengthen this by formalising arrangements for the adoption of policies by producing a Policy on the Development, Approval and Management of Policies which was approved by the Governing Body. This included clarification on the decision-making role of the sub-committees of the Governing Body.

It has reviewed its financial controls using the NHSE self-assessment template and addressed areas requiring improvement by building additional capacity in its contracting team and finance team to focus on the management of acute and non-acute contracts in year. It has raised the visibility of Swindon's performance against NHS Constitution, outcome, finance and activity targets through the generation of weekly performance reports and monthly provider reports. This also recommended the formation of a Finance Committee who met formally for the first time in February 2016.

It continued to follow up the recommendations of the Governance Review which was undertaken in 2014/15 with progress being monitored through the Audit Committee. In 2015/16 all recommendations have been implemented.

The CCG's Audit Committee continued to provide oversight and scrutiny on the internal control environment which they derive through reviews undertaken against areas deemed high risk by internal audit, counter fraud and security management.

Information Governance

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. It has established an Information Governance Management Framework and is

developing information governance processes and procedures in line with the Information Governance Toolkit.

Progress against these are monitored through the Information Governance Steering Group, chaired by the Senior Information Risk Owner (SIRO). All CCG staff are mandated to complete a suite of IG training modules annually and we have developed a staff Information Governance Handbook, thereby ensuring that they are aware of their IG responsibilities. There are processes in place for incident reporting and investigation of serious incidents.

The CCG continues to develop information risk assessment and management procedures to ensure a fully embedded information risk culture throughout the organisation. During 2015/16 the CCG had no incidents involving data loss or confidentiality breaches. Through the annual self-assessment of compliance against this toolkit, the CCG improved its rating in a number of areas from level '2' to '3' and maintained an overall score of '2', showing continuous improvement.

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.

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

External Audit are required to give a value for money conclusion on whether:

- In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for tax payers and local people.

External Audit have provided the CCG with an unqualified audit opinion for 2015/16 as there are no significant issues to report in relation to these areas.

The CCG continues to benchmark services to ensure it is delivering value for money. It has embarked on an ambitious programme of work in response to the Five Year Forward View; the first step of which is to ensure it can demonstrate value for money through integration across acute and community services. It served notice on its current community services provider SEQOL in February 2016 and is retendering during 2016/17.

The CCG undertook a further review in year to consider whether the remaining services it was sub-contracting for the South Central and West CSU were providing value for money. As a consequence it decided to transfer Communications and Risk Management in house during the latter part of the year.

The CCG has well developed systems and processes for managing its resources. The annual operational financial plan was approved by the Governing Body and is monitored closely throughout the year. The Chief Finance Officer has worked closely

with key stakeholders to ensure resources are not over committed in year and financial targets are achieved. The annual plan clearly described the level of reserves available to fund ad-hoc pressures in year and the Governing Body were cited on financial risks which could impact on the organisation during the year.

The CCG set itself a challenging target to deliver £4.8m of efficiencies across a range of QIPP schemes and ensured that the Governing Body was kept updated on progress against these. Where concerns were identified, the CCG responded and put in place mitigating actions. The CCG has started to see the benefits of strengthening its Project Management Office (PMO) during 2014/15 to ensure more scrutiny and rigour was applied to developing QIPP and has reported financial success rates at 90% compared to target.

The CCG continues to review its running costs to ensure it delivers value for money and has achieved a 10% reduction in costs in line with the reduction in its national allocation; NHSE required each CCG to reduce its costs by 10% in 2015/16.

Feedback from delegation chains regarding business, use of resources and responses to risk

Where the CCG uses service organisations to carry out services on its behalf it receives assurance about the control procedures in the service organisation through the following mechanisms:

- The CCG sub-contracts the provision of a number of its corporate services to the South Central and West Commissioning Support Unit (SCWSU). The CCG reviews the performance of this service level agreement monthly and in addition, the Audit Committee reviews the findings from the Service Audit Report (SAR) which the CSU commissions from Deloitte to assess the reasonableness of the controls it has in place. The SAR report for the period April to September 2015, highlighted actions which had still not been addressed in contract management and HR. Those relating to HR can be actioned by the CCG and the CCG has addressed those relating to contract management through strengthening its performance management of providers in year.
- The CCG has a pooled budget arrangement with SBC for the provision of community, mental health, continuing health care and children's services. Specific services within this arrangement predominately relating to the management of out of hospital care are managed through the Better Care Fund. This is formalised through a Section 75 agreement and performance is reviewed in year through the Joint Commissioning Governing Body who report up to the CCG's Governing Body.

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

Capacity to Handle Risk

Leadership of risk management is provided by the Governing Body which is committed to ensuring that an effective risk management system is operating throughout the CCG.

It is the role of the Governing Body to focus on those risks and events which may compromise the achievement of the CCG's strategic objectives and support an organisational culture which allows the organisation to anticipate and respond appropriately to adverse events.

A specific development session was held with Governing Body Members and Internal Audit to consider risk appetite, review specific objectives and corporate risk register.
All staff receive training on the identification of fraud within the CCG.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

This review is informed by the work of the internal auditors, the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports. Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and IGQAC.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

- sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control;
- there are adequate and effective governance, risk management and control processes to enable the related risks to be managed and objectives to be met based on the risk appetite and the internal audit plan agreed;
- The adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control has been assessed as 'Satisfactory'.

In giving this opinion, it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

This assessment was based on the following:

- the number and priority of high recommendations is the lower compared to the previous year. There was one more medium recommendation and fewer low risk recommendations than in the prior year;

- they did not issue any high risk rated reports and there were no individual high risk ratings;
- there was good progress in following up on recommendations raised with none being identified where no action had been taken;
- the core finance review was assessed as a low risk overall.

Data Quality

Regular reports are presented to the Governing Body to provide assurance on all CCG business and include, but are not limited to: strategic planning, patient safety and quality of clinical care, organisation development, performance management and the achievement of national and local NHS targets, financial management reports, patient engagement, stakeholder engagement, emergency planning, compliance with the NHS Constitution and identified risks and actions.

Substantial improvements have been made in relation to the quality of the information and data analysis provided to the Governing Body, its committees and Programme Boards following the decision in 2014/15 to repatriate services from the CSU.

Business Critical Models

The CCG has identified all its business critical models and information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

Data Security

I can confirm that the CCG has not had any lapses in data security for the period April 2015 to the end of March 2016. The CCG has submitted a satisfactory level of compliance with the Information Governance Toolkit assessment.

Discharge of Statutory Functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with extensive expert input, to ensure compliance with the all relevant legislation. That advice also informed the matters reserved for Governing Body's decisions and adherence to the scheme of delegation as outlined in the NHS Constitution.

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

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

Conclusion

Whilst no significant internal control issues have been identified, the CCG has an ethos of continual improvement and will seek to review, enhance and further improve its governance, processes and procedures during the next 12 months where appropriate. I can report that there are no significant internal control issues for the financial year 2015/16 and for the period up to the date of consideration of this report by the Audit Committee.

The Interim Accountable Officer resigned on 30 April 2015 and from the 1 May 2015, I have to the best of my knowledge and belief properly discharged the responsibilities expected as Accountable Officer.

Nicki Millin
Accountable Officer
25 May 2016

Accountability Report
Remuneration and Staff Report

Remuneration Report

The Remuneration Committee determines and approves the remuneration package for executive senior managers. Senior managers are those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. They influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. The pay and terms and conditions of other managers and staff members' are covered by Agenda for Change. The Remuneration Committee is responsible for approving the Remuneration Policy of the CCG, which determines payment to GPs (as Governing Body members and clinical leads) and practice managers (as Governing Body members).

Membership of the Remuneration Committee can be read on page 57.

Remuneration is designed to consider and agree fair reward based on each individual's contribution to the organisation's success taking into account the need to recruit, retain and motivate skilled and experienced professionals. This is not withstanding the need to be mindful of paying more than is necessary in order to ensure value for money in the use of public resources and the CCG's running cost allowance.

Senior managers' remuneration is set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them. This ensures a fair and transparent process via bodies that are independent of the senior managers whose pay is being set. Pay relating to GPs and practice managers working for the CCG is set out in the CCG's Remuneration Policy. No individual is involved in deciding his or her own remuneration. The framework and processed followed for determining pay is in accordance with:

- Clinical Commissioning Groups: Remuneration Guidance for Accountable Officers and Chief Finance Officer;
- CCG Remuneration Policy for Executive Senior Managers who are on permanent NHS contracts.

The length of contract and terms for and conditions for staff are set out in the Agenda for Change, NHS Terms and Conditions of Service Handbook. GPs and practice managers are appointed for a set period as detailed in the CCG's constitution which is approved by member GP Practices and are as follows:

	Term of office	Notice period
Clinical Chair	4 years (No maximum term)	6 months
Clinical Vice Chair	4 years (No maximum term)	6 months
Lay Members	4 years (No maximum term)	3 months
Registered Nurse	4 years (No maximum term)	3 months
Secondary Care Doctor	4 years (No maximum term)	3 months

Locality Chairs	2 years initially and then 4 years (no maximum term)	3 months
Practice Manager representative	4 years (No maximum term)	3 months
Accountable Officer	Permanent	6 months
Executive Nurse	Permanent	3 months
Chief Financial Officer	Permanent	3 months
Executive Director Business and Corporate development	Permanent	3 months

There was no early termination of contracts during the year.

Salaries and allowances of senior managers and directors 2015/16 (Audited)

	Job Title	Total Salary and fees (bands of £5,000)	Pension Related benefits (bands of £2,500)	Total (bands of £5,000)
Directors emoluments & compensation				
Nicki Millin	Accountable Officer (with effect from 1 May 2015) ❶	115-120	185.0-187.5	305-310
Caroline Gregory	Chief Financial Officer	100-105	15.0-17.5	115-120
Paul Bearman	Executive Director of Corporate and Business Development	95-100	10.0-12.5	110-115
Gill May	Executive Nurse	85-90	2.5-5.0	90-95
Jan Stubbings	Interim Accountable Officer (to 31 April 2015) ❷	0-5	0	0-5
Salaries and allowances of senior officers				
Dr Peter Crouch	Clinical Chair	70-75	15.0-17.5	85-90
Dr Peter Mack	Clinical Vice Chair / Locality GP Chair	25-30	0	25-30
Dr Elizabeth Alden	Salaried GP Representative	15-20	2.5-5.0	15-20
Dr Sarah Bruen ❸	Locality GP Chair	10-15	0-2.5	10-15
Dr Philip Mayes	Locality GP Chair	10-15	0-2.5	10-15
Sarah Francome	Practice Manager Representative	10-15	0-2.5	10-15
Ian James	Lay Member	10-15	0	10-15
Dr Timothy Jobson	Secondary Care Doctor	10-15	0	10-15
Christine Perry	Registered Nurse	10-15	0	10-15
Paul Byrnes❹	Lay Member	5-10	0	5-10
Bill Fishlock	Lay Member	5-10	0	5-10

❶Nicki Millin was appointed Acting Accountable Officer from 1 May 2015, with the role becoming permanent from 1 September 2015. The high level of pension related benefits for the year reflect the value of the increase in pension entitlement that has arisen from the salary increase gained from this new role. Being a member of a defined benefit pension scheme the pension benefits earned from a pay award reflect the length of membership in the scheme.

❷ Jan Stubbings left the CCG following the appointment of Nicki Millin as Accountable Officer on 31 April 2015.

❸ Dr Sarah Bruen joined the Governing Body following election from 1 April 2015.

❹ Paul Byrnes was appointed from 1 September 2015.

Salaries and allowances of senior managers and directors 2014/15

	Job Title	Total salary and fees (bands of £5,000)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
Directors emoluments & compensation				
Tony Ranzetta	Accountable Officer (to 30 November)❶	100-105	-	100-105
Jan Stubbings	Interim Accountable Officer (from 1 June 2014) ❷	120-125	-	120-125
Caroline Gregory	Chief Financial Officer	100-105	(0-2.5)	100-105
Paul Bearman	Executive Director Business and Corporate development	95 -100	12.5-15.0	110-115
Nicki Millin	Chief Operating Officer (from 1 September 2014)	45-50	30.0-32.5	75-80
Salaries and allowances of senior officers				
Dr Peter Crouch	Clinical Chair❸	65-70	-	65-70
Dr Peter Mack	Clinical Vice Chair / Locality GP Chair	25-30	2.5-5.0	30-35
Gill May	Executive Nurse	85-90	27.5-30.0	120-125
Dr Liz Alden	Salaried GP Representative	15-20	0-2.5	20-25
Michael Barnes	Non Clinical Vice Chair and Lay member - PPI	10-15	-	10-15
Angela Brunning	Practice manager	5-10	-	5-10
Sarah Francome	Practice manager	5-10	5.0-7.5	10-15
Dr Eric Holliday	Locality GP Chair	10-15	0-2.5	10-15
Dr Ian James	Lay member - Governance	10-15	-	10-15
Dr Philip Mayes	Locality GP Chair	10-15	(2.5-5.0)	5-10
Dr Tim Jobson	Secondary Care Doctor	10-15	-	10-15
Christine Perry	Registered Nurse	10-15	-	10-15
Bill Fishlock	Lay member	5 -10		5-10

❶Following a period of sustained absence, Tony Ranzetta retired on ill health grounds on 30 November 2014. Any relating pension augmentation costs have been met centrally by the NHS Pensions scheme. Under the rules of the scheme an employee retiring on the grounds of ill health is entitled to be paid at their full rate of pay during their notice period. In accordance with his contract of employment Tony Ranzetta received a payment equivalent to six months full pay during December 2014 of £61k, this has been included within the amounts for total salary and fees disclosed above. See note 4.3 'Staff sickness, absence and ill health retirement' in the Financial Statements for more details. During 2015/16 NHS Pensions have confirmed that they incurred costs of £60,116 to augment his pension following ill health retirement. These costs are not borne by the CCG.

❷Jan Stubbings was appointed to the role of Interim Accountable Officer during June 2014 on an interim basis to cover the role whilst Tony Ranzetta was absent. Following his retirement she continued in the role whilst a permanent replacement is being recruited - working on a part time basis. Total salary and fees include consultancy fees paid to carry out a governance review which was in addition to the interim accountable officer role.

❸ Dr Crouch made a retrospective application to join the NHS Pension scheme from 1 March 2015.

Directors, senior officers and other staff members of the CCG are entitled to a base salary, but the CCG does not operate any bonus schemes or other arrangements that would constitute a benefit in kind. Although the CCG does not operate any such arrangements it has taken on a legacy car lease relating to one staff member recruited from within the NHS in year. The staff member is not a director or senior officer.

Staff members are also entitled to join the NHS Pension Scheme. Amounts paid to a GP's practice are disclosed within the Related Parties note for GPs who served on the Governing Body during the year.

The amount included in respect of pension related benefits is calculated as the value of increase in pension entitlement over the year in excess of inflation; plus the change in the value of lump sum over the year in excess of inflation; less the employee's contributions.

Amounts included as total salary and fees excludes employer national insurance contributions.

Off payroll engagements

NHS bodies are required to include disclosures about their off payroll engagements. Off payroll engagements as of 31 March, for more than £220 per day and that last longer than six months:

	31 March 2016 Number	31 March 2015 Number
Number of existing engagements as of 31 March	-	2
Of which, the number that have existed:		
For less than one year at the time of reporting	-	2

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

	31 March 2016	31 March 2015
Number of new engagements, or those that reached six months duration during the year	-	2
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	-	1
Number for whom assurance has been requested and received	-	1

Number of off payroll engagements of Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	-	1
Number of individuals that have been deemed “board members, and or senior officers with significant financial responsibility” during the financial year. This figure includes both off payroll and on payroll arrangements	20	20

Multiple pay

(Audited)

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

The banded remuneration of the highest paid director in the CCG in the financial year 2015/16 was £115,000 - £120,000 (2014/15: £100,000 -105,000). This was 2.9 times (2014/15: 2.7 times) the median remuneration of the workforce, which was £40,650 (2014/15: £37,554). The remuneration of the highest paid director is calculated on an annualised full time equivalent basis and so may be different to the amount actually paid if they work part time. Please refer to note 4 ‘Employee benefits and staff numbers’ in the Financial Statements for more details on staff movements and costs.

In 2015/16, nil employees (2014/15: nil) received remuneration in excess of the highest-paid director. Remuneration ranged from £15,000 to £118,000 (2014-2015: from £15,000 to £100,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The increase in the remuneration of the highest paid director in the year represents a new appointment during the year.

Pension entitlements 2015/16

(Audited)

Name	Title	Real increase in pension at retirement age (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at retirement age at 31 March 2016 (bands of £5,000)	Lump sum at retirement age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent transfer value at 31 March 2016	Cash equivalent transfer value at 31 March 2015	Real increase in cash equivalent transfer value
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Caroline Gregory	Chief Financial Officer	0-2.5	-	25-30	75-80	459	436	17
Paul Bearman	Executive Director Corporate	0-2.5	2.5-5.0	10-15	30-35	238	208	28
Nicki Millin	Accountable Officer	7.5-10.0	25.0-27.5	40-45	125-130	746	578	161
Gill May	Executive Nurse	0-2.5	0-2.5	35-40	110-115	714	685	21
Dr Peter Crouch	Clinical Chair	0-2.5	-	0-5	-	12	-	12
Dr Peter Mack	Clinical Vice Chair / Locality GP Chair	0-2.5	0-2.5	5-10	15-20	128	123	3
Dr Liz Alden	Salaried GP Representative	0-2.5	-	10-15	40-45	172	167	3
Dr Philip Mayes	Locality GP Chair	0-2.5	0-2.5	5-10	15-20	122	119	2
Sarah Francome	Practice Manager Representative	0-2.5	0-2.5	5-10	15-20	117	114	2
Dr Sarah Bruen❶	Locality GP Chair	0-2.5	-	0-5	10-15	78	77	2

❶ Dr Sarah Bruen joined the Governing Body following election from 1 April 2015.

Pension entitlements 2014/15

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash equivalent transfer value at 31 March 2015	Cash equivalent transfer value at 31 March 2014	Real increase in cash equivalent transfer value
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Tony Ranzetta❶	Accountable Officer (to 30 November)	-	-	-	-	-	531	-
Caroline Gregory	Chief Financial Officer	0-2.5	0-2.5	25-30	75-80	436	405	21
Paul Bearman	Executive Director Corporate	5.0-7.5	2.5-5.0	5-10	25-30	208	171	32
Nicki Millin	Chief Operating Officer (from 1 September)	2.5-5.0	7.5-10.0	30-35	95-100	578	504	61
Gill May	Executive Nurse	0-2.5	5.0-7.5	35-40	105-110	685	615	53
Dr Peter Crouch❷	Clinical Chair	0-2.5	0-2.5	0-5	0-5	-	-	-
Dr Peter Mack	Clinical Vice Chair/ Locality GP Chair	0-2.5	0-2.5	5-10	15-20	123	100	20
Dr Liz Alden	Salaried GP Representative	0-2.5	0-2.5	10-15	40-45	167	153	10
Dr Eric Holiday	Locality GP Chair	0-2.5	0-2.5	0-5	10-15	60	56	3
Dr Philip Mayes	Locality GP Chair	0-2.5	0-2.5	5-10	15-20	119	113	3
Sarah Francome	Practice Manager Representative	0-2.5	5-7.5	0-5	15-20	114	70	42

❶ Tony Ranzetta retired on ill health grounds during the year, as a result no information has been provided by NHS Pensions regarding any changes to his pension within year. See note 4.3 'Staff sickness, absence and ill health retirement' in the Financial Statements included in Appendix 2 for more details. During 2015/16 NHS Pensions have confirmed that they incurred costs of £60,116 to augment his pension following ill health retirement. These costs are not borne by the CCG.

❷ Dr Crouch has made a retrospective application to join the NHS Pension scheme from 1 March 2015. CETV data is unavailable but has been estimated at £nil on the basis of one month's membership. Any accrued pension relating to one month's service has been estimated at less than £2,500 and any lump sum benefit as being less than £5,000.

As lay members do not receive pensionable remuneration, there are no entries in respect of pensions for lay members.

Pension entitlements have been calculated by NHS Pensions based on an individual's notional whole time pay. As not all members of the Governing Body work for the CCG on a full time basis the pension entitlements disclosed may not represent the benefits that the individual may ultimately receive.

Only GP members of the Governing Body directly employed by the CCG are included in the notes above. Any pension related to their role as a GP is excluded from the figures above. Information has only been disclosed where it has been provided by NHS Pensions.

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 members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figure 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.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated."

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 period. A figure of 1.2% has been used as an approximation of the inflation rate in year. (2014/15: 2.7%)

Staff Report

As of 31 March 2016 the CCG had 72 employees, including Governing Body members. The workforce is made up of employees from a wide range of professional groups.

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

The CCG recognises all of the trade unions outlined in the national Agenda for Change Terms and Conditions handbook who have members employed within the organisation.

During 2015/16 the CCG established a new Staff Partnership Forum (SPF), consisting of a staff representative for each major area of the organisation, and one or more executive directors plus an HR specialist. The Forum meets on a monthly basis and is actively communicated and consulted with on a wide range of staffing-related and organisational issues. The programme during this year has included new HR Policy development, action planning following the publication of the Annual Staff Survey report and staff well-being initiatives.

The CCG has HR policy development support and advice from the South, Central & West Commissioning Support Unit (CSU). New or revised HR Policies are formally reviewed by the Executive Management Team and by staff and the SPF who have the opportunity to comment and feedback, before being ratified and adopted by the CCG's Integrated Governance Committee prior to publication and adoption. All HR Policies and supporting guidance are accessible and available to all staff through the dedicated Swindon CCG HR Portal which is provided by the CSU.

The CCG has an Organisational Development (OD) Plan which sets out how the organisation and individuals within it will progress to full capability. The OD Plan will be reviewed and refreshed in 2016/17 in light of the anticipated changes in the CCG's operating environment in the coming months.

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

- Monthly staff briefing sessions – the Accountable Officer (supported by other Executive Directors and the Clinical Chair) holds monthly briefing sessions for all staff, including CSU staff. These briefings cover all aspects of the CCG's business including financial and performance positions, policies and procedures and developments. The monthly staff briefing is complemented by the publication of written notes;
- The establishment of a CCG intranet which holds information on all monthly staff briefings, policies, procedures and other information;
- The production of a monthly electronic newsletter for staff;
- The CCG executive team meet with senior managers regularly;
- Regular attendance at the Staff Partnership Forum by one or more Executive Directors.

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

Number of senior managers by band

The CCG has categorised members of the Governing Body as being senior managers and their salaries are included on page 73.

Staff survey

In May 2015 the CCG published a report of its first Staff Engagement Survey. 61 questions were asked which aimed to capture employees' honest and open feedback on a range of issues affecting the CCG and its staff, including job satisfaction, leadership and accountability and team working.

Just over 77% of staff responded to the survey – far higher than the national average of 42% for the NHS Staff Survey – demonstrating a high level of engagement amongst CCG staff.

The resulting analysis and the Survey Report were considered by the Executive Management team and the outputs were used to develop an action plan with direct staff involvement through the SPF. Over the last year the SPF has been addressing areas of potential improvement identified through the survey. The second annual Staff Survey has recently been launched to follow up and measure on-going progress.

Disabled employees

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

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

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

Sickness absence data

Details of the level of sickness absence are given in note 4.3 in the Financial Statements. The organisation has an approved policy and associated procedure to help with the management of sickness absence.

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

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to the CCG's Integrated Governance Committee on a quarterly basis as part of the workforce reporting mechanism. This committee includes both lay members and executive directors of the CCG.

Staff sickness, absence and ill health retirements in 2015/16

Name		AvFTE	Adjusted FTE sick days	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Annual Sick Days per FTE
NHS Swindon CCG		54	313	19,597	509	5.8

Source: HSCIC – Sickness Absence Publication – based on data from the ESR Data Warehouse.
Period covered: January to December 2015.

ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year. Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

There may be inconsistencies between these data and the statutory basis for accounts, in terms of the organisation against which staff are reported for a particular month.

There were no ill-health retirements during 2015/16.

CCG Diversity breakdown – gender

Gender Breakdown			
	Female Headcount	**Male Headcount**	**Total**
Governing Body Members	9	8	17
All other CCG Employees	40	20	60
Total	49	28	77

Expenditure on consultancy

The CCG has spent £25k on consultancy during the year (2014/15: £29k). Consultants were engaged to support analysis and benchmarking activities.

Off payroll engagements

See page 75.

Nicki Millin
Accountable Officer
25 May 2016

Part 3 – Financial Statements

Part 3 – Audit Opinion

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SWINDON CCG

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

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

- the analysis of staff numbers on page 82.

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

Respective responsibilities of the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on regularity

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

Opinion on other matters

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the CCG under section 24 of the Act; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of Swindon CCG in accordance with the requirements of the Act and the Code of Audit Practice.

{Signature to be inserted}

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

Hartwell House
Victoria Street
Bristol BS1 6FT

25 May 2016

Part 3 – Primary Statements and notes to the Accounts