NHS
Wiltshire
Clinical Commissioning Group

Annual Report and Accounts
2015/16

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Performance report

Overview

NHS Wiltshire Clinical Commissioning Group (CCG) is responsible for commissioning a broad range of healthcare for the population of Wiltshire. We are led by experienced local GPs drawn from across the county, who provide clear clinical leadership to the big decisions affecting the future of healthcare provision in Wiltshire, carefully tailored to meet the differing needs of people locally.

With Wiltshire GPs in the driving seat, supported by an experienced team of lay members, executives and managers, we make and implement clinically led decisions suited to local needs, and derive strategies and plans which address the future requirements of the people of Wiltshire.

In July 2015, our inaugural Clinical Chair, Dr Steve Rowlands retired, having made a huge contribution to the county over a long and successful career, and who was at the very forefront of the successful establishment and first 2 years of the CCG. Dr Peter Jenkins was elected as successor, and took on the mantle from 1 July 2015.

The main feature of our strategy is to deliver more services in a community setting, by which we mean wherever possible and practical, delivering services at or close to home given the large and rural nature of our geography. Consequently, key to our success is our relationship with Wiltshire Council who are responsible for the social care services with which we aim to integrate as seamlessly as possible.

Quality outcomes and patient experience is at the forefront of everything we do. We work closely with our providers (hospitals, community services, primary care, social care, mental health, ambulance and transport) – the organisations we commission (or buy) care from – to ensure that system wide we have a patient-centred culture and that we have the right early warning systems in place if anything should go wrong.

We have strong and constructive relationships with our key system partners and neighbouring Commissioning Groups, which are reaping rewards in terms of county wide transformation and delivery of services. This includes regular board to board meetings, as well as very senior regular meetings between the Chief Executives and Finance Directors across the system.

Already a very important element of what we do, in the next few months we will be working across our health system to collaboratively create a long term Sustainability and Transformation Plan in order to deliver an effective and sustainable model of healthcare for our future populations.

We make regular patient safety visits to a range of care providers and at each Governing Body meeting the safety and performance standards of our providers are reviewed and discussed, usually enhanced by a patient story from a member of the public.

Our vision remains that Health and Social Care services in Wiltshire should support and sustain independent healthy living based on three principles:

- People are encouraged and supported to take responsibility for, and to maintain/enhance their wellbeing
- Equitable access to a high quality and affordable system, which delivers the best outcome for the greatest numbers
- Care should be delivered in the most appropriate setting, wherever possible at, or close to home:
  - Where acute care is one-off or infrequent, there should be formal and rapid discharge
  - Where care is on-going (e.g. chronic conditions) the default setting of care should be primary care

We have made major strides in the past year in setting the conditions for success in this regard, most notably with the successful procurement and award of new long term contracts for both Adults' and Children's Community Health Services. These are both fundamental to the successful implementation of our strategic vision, and working with the new providers in the future offers us a genuine opportunity to deliver our aspirations. Both represent the culmination of extensive and significant effort on behalf of the CCG and our partners, and the outcome should provide the very bedrock foundation on which we can build the transformation of our system into our future vision.

Other initiatives which are already delivering well in very local settings are:

Multidisciplinary teams
We have established 20 Multidisciplinary teams across the county. These fully integrated patient centred local multi-disciplinary teams (comprising community nursing staff, therapists, mental health workers and social workers) based in our communities are a fundamental building block of our strategy. They build on the existing strength of primary care across the county, with the teams designed to wrap around primary care practices, being led and co-ordinated by our GPs.

Care co-ordinators county wide
We have also successfully recruited and established Care Co-ordinators county wide, delivering one of the CCG's very early aspirations. The coordinators, based in GP practices, help to reduce unnecessary admissions into hospital or care home. They act as a point of contact to bring together the medical and social care services that may be available to someone who needs just that little extra support to stay at home.

They are supported by the application of proven risk stratification tools, and we have established an improved, better integrated, co-ordination cell (the Simple Point of Access) to help mobilise the right services, at the right place and right time.

Partnership Better Care Fund actions
We have Implemented, in partnership with our Council colleagues, a range of Better Care Fund actions to avoid admissions and accelerate discharge, including streamlined access to care through a single number; step up care and crisis management in the community; improved discharge to "pull" patients out of acute into home and community based care; enhanced care at home including rapid access reablement.

Pathway re-designs
We have developed several clinically led pathway re-designs exemplified by GP led single pathway work on Gastroenterology, resulting in a clinically led pan-Wiltshire approach to resolve demand and capacity issues.

In furtherance of our vision of delivering better integrated out of hospital services, the CCG has also formulated a ground breaking primary care offer. This is a three year programme, designed to transform the commissioning, delivery and monitoring of enhanced services from our GP practices; it supports the development of locality working, and should support the sustainability of primary care at the same time as enhancing the quality of the services delivered from primary care.

Having taken responsibility for co-commissioning primary care alongside our colleagues from NHS England, we aim to continue to build on the excellent foundations of primary care in the county, and strengthen that by encouraging networking across primary care practices.

We have utilised the funding provided under the Transforming Care of Older People programme to encourage local innovation to improve support to the frail and elderly cohort of our population, and have a scheme live under this programme in every part of the county. Using this, we are encouraging empowerment of non GP clinicians to free up GP capacity, extended hours and provision of locally tailored support targeted to meet the specific needs of our largely rural, but each unique, communities, and are delivering localised plans to achieve this. We also have an aspiration to enhance primary care provision to include greater access to urgent care services without recourse to Accident & Emergency units.

In September 2015, our internal controls for risk and performance management gave us early indications that we were going to struggle to achieve our financial targets unless we took action. Accordingly, we created and implemented a Financial Recovery Plan, which thanks to the very hard work of our people and the co-operation of many of our system partners has succeeded in rectifying the potential problem. Crucially, the CCG will manage to maintain a very sound financial foundation on which we can build for the future.

The CCG is fortunate to share a common and county wide boundary with our Council colleagues, which greatly assists with our strong and equal partnership within the Health and Wellbeing Board. This enables the CCG to take a full role in the development and writing of the county wide Wiltshire Health and Wellbeing Strategy, guided by a strong and experienced clinical voice. Indeed the development of our own long term strategy was heavily guided by the Wiltshire Health and Wellbeing Strategy, and the CCG shares its plans and aspirations for change regularly with the Health and Wellbeing Board.

Our clinical leaders took part in a board development seminar along with other Health and Wellbeing Board members in order to further develop our board effectiveness, endeavours which were recognised by the recent Local Government Association Award for Most Effective Health and Well Being Board.

Furthermore, when Wiltshire Council participated in a health and social care services peer review, which included the effectiveness of the Health and Wellbeing Board, the CCG took a full and active role, including co-authoring the action plan to address all suggestions arising. Naturally, the CCG also co-authors along with Wiltshire Council colleagues the Health and Wellbeing Board Annual Report, and has assisted in the formulation of a performance review system to enable the Board to measure progress against the delivery of their strategy.

We believe that notwithstanding the many challenges we still face, we have made good progress over the last year. We have commissioned services that are already creating significant improvements to the NHS in Wiltshire, and have strong relationships and the correct plans in place, and already being delivered.

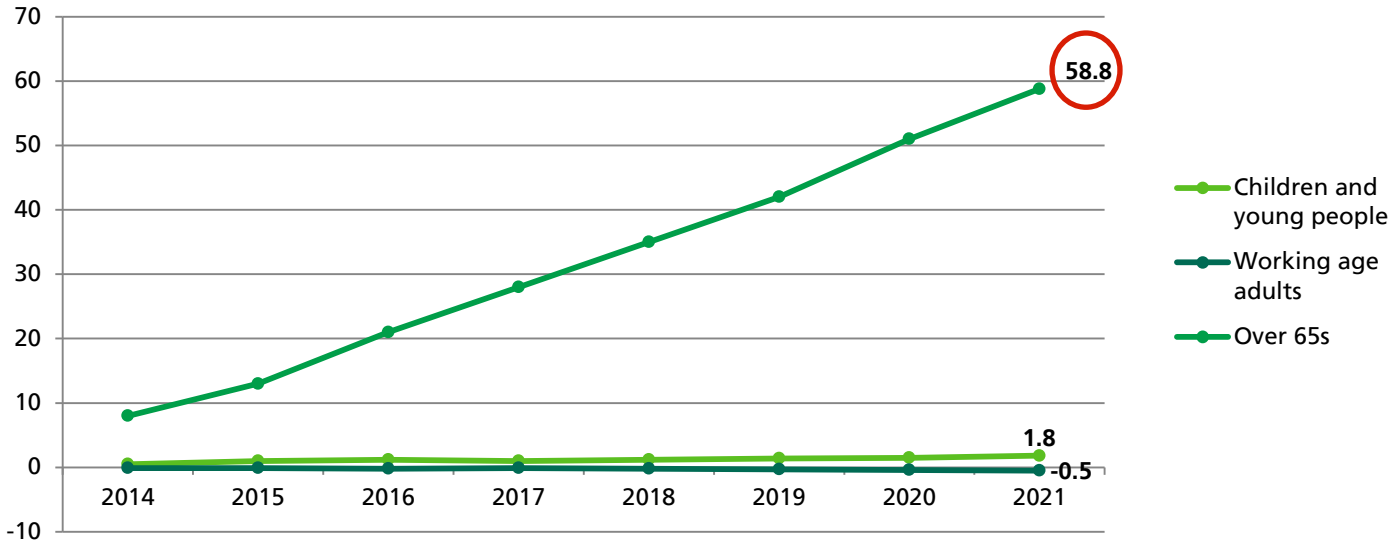
We look forward with a clear commitment to making further improvements and delivering our vision to improve the health and wellbeing outcomes for our communities. This will be central to development work, which has already commenced, in close partnership with our key system partners and neighbouring CCGs in our area on formulating a system wide Sustainability and Transformation Plan.

Our financial position

In the last annual report NHS Wiltshire CCG was starting to experience significant pressure on its financial position as a consequence of the increasing health needs of the population. As previously stated this was predicted as part of its financial and demand modelling which forecasted that as the population of Wiltshire increased as well as more people living longer the demand for healthcare would increase. In 2013 as part of our strategic planning we predicted that the health economy would have a financial gap of approximately £60m by 2021 before any additional money being allocated to the NHS.

As predicted the projected trend has become a reality and continues to focus the thinking and strategic direction in order to ensure that the finite resources are used in the most effective and economic way possible.

Cumulative increase in annual resource requirements (£m) to 2021 by age group based on population projections x 2014/15 updated average spend per head = £60.1m



What is being experienced locally is also being reflected on the national stage with the NHS predicted to be spending £32billion more by 2020/2021 compared to 2014/15. In response to this financial challenge, NHS England secured from the Treasury £10billion of extra funding to support the increased financial pressure on the promise that the NHS would transform to save the residual gap of £22billion. Obviously this is a huge challenge and one that Wiltshire CCG has risen to in line with its development of out of hospital services including the expansion of primary and community care.

Table summarising the split of Additional Funding to the NHS (Nationally and Locally)

Year	NHS £billion	Wiltshire CCG £m
2015/16	1.9	13.5
2016/17	3.7	31.4
2017/18	1.4	13.9
2018/19	0.5	14.0
2019/20	0.8	14.7
2020/21	1.6	25.5

The additional income for Wiltshire reflects the increase in the over 65s population as well as the rural aspect of the county and has reduced some of the financial challenge into future years. However, the demand that is being placed on Wiltshire's health services will still require the CCG to deliver significant transformation of its services in line with its strategic intent. It is predicted that the CCG will need to reduce expenditure over the next 5 years by a minimum of £40m and this is before any new unknown financial pressures as a result of new technology and new investment priorities.

Statement of purpose and activities of the CCG

The Governing Body are very satisfied with the CCG's performance and delivery over the last year, having agreed the strategic direction and overseen the early delivery of the plans. In particular, the culmination of the procurement process for the future of community services is a very significant achievement, and while the challenges of mobilisation lie ahead, the Governing Body are confident that the right platform is in place in order to deliver many of our aspirations for the future model of care set out in our strategy.

The contract was awarded to a new organisation called Wiltshire Health and Care, a joint venture between our three major acute providers, and accordingly we anticipate that we will be able to work closely with them, using our well established and robust relationships, in order to work together and make some fantastic changes which will deliver better services and outcomes for our population, while sustaining the overall viability of our health system. We want to better exploit the clinical expertise that exists within our acute hospitals, shape it more closely around our population clusters and thereby better utilise that expertise to support community and primary care. In short we want to provide a seamless service focussed on the individual within their own home, closely tailored to local needs. The manner in which our future community services provider is able to deliver will be key in all of this and we have specified our requirement for an effective integrator – that being a framework which performs a convening role and works intentionally and systemically to achieve improvements in health and wellbeing.

Performance is being regularly and carefully scrutinised utilising the rich depth of information presented in our fully integrated monthly performance report which brings together, in one place, data and metrics to give a coherent indication of the organisation's performance in key areas. This, together with a robust system for the identification and management of risks, and an internal staff appraisal system based on a system of cascaded objectives, forms the basis of our output based performance management regime – this is our performance management framework.

The Governing Body has continued to invest in board development. This has included follow up self-analysis and reflection following some specialist consultancy support last year, and an away day session to formulate new ideas about the internal structure of the CCG to even better equip us for the next important stage of our journey.

The rationale behind the restructure was that while the Governing Body recognised that there is great strength within the group structure on which the CCG was originally formed, there was a risk that we had inadvertently built in an element of inefficiency and a risk of duplication in our cross cutting functional work. This was unfortunate, given the fundamentally important nature of the transformation programmes in driving the change we aspire to deliver. We wanted to be able to put in place locality leads in order to help all our localities to deliver better provision, and achieve a more consistent approach in our dealings with acute providers. The CCG was also required to build capacity to deliver our elements of commissioning of primary care, without any additional resource, which also acted as an imperative for change.

Accordingly, we have internally re-organised in a manner which preserves the group structure from which we draw so much strength but which changes the emphasis of lead responsibility for our Commissioning Directors in order to provide increased focus and accountability for delivery. While being lead Director for a Group structure will remain a very important function within our structure, we will reconfigure our service redesign/commissioner capability into four key delivery areas, those being:

- Acute Commissioning
- Primary and Urgent Care
- Community Services and Joint Commissioning
- Joint Director of Integration

The key principles which underpinned this structure were:

- Improve the focus on localism and the delivery of locality plans
- Acceptance that some work is led at scale and pace on behalf of the whole of Wiltshire
- Clinical leads and managers are trusted and empowered to take their agenda forward, seeking assurance via the clinical executive; greater focus on performance and delivery with clear leadership in place
- An ability to better develop the people we have and manage talent within the organisation
- Empower and delegate to enable our localities the freedom to deliver
- Under an outcomes-focused framework work towards local budgets
- Reconfigure our resources to best support localities
- Supporting localities to connect with each other
- Enhancing clinical executive to be the engine room of the organisation
- The Better Care Plan will have an important interface with each of the key programme areas given the system wide nature of the work
- Staff working to help each other deliver on the priorities, programmes and projects that contribute to the success of the CCG.

We have also designed and implemented a bespoke training programme targeted at emerging GP future leaders which commenced in January 2016 and are about to implement revised processes and reporting frameworks to support our staff talent management and development, as well as succession planning.

Our Population

Wiltshire's population is predominantly rural and with a low population density, whose acute care needs are served by three principal providers. Whilst the population is generally healthy when compared with the England average, the increasing number of over 65s in Wiltshire will put increasing pressure on services and available resources.

Our five year strategy published in 2014 set out changes to how healthcare is delivered to take account of these structural pressures whilst making the best use of limited resources available for care. The strategy chimed strongly with the direction of travel set out in the Five Year Forward View.

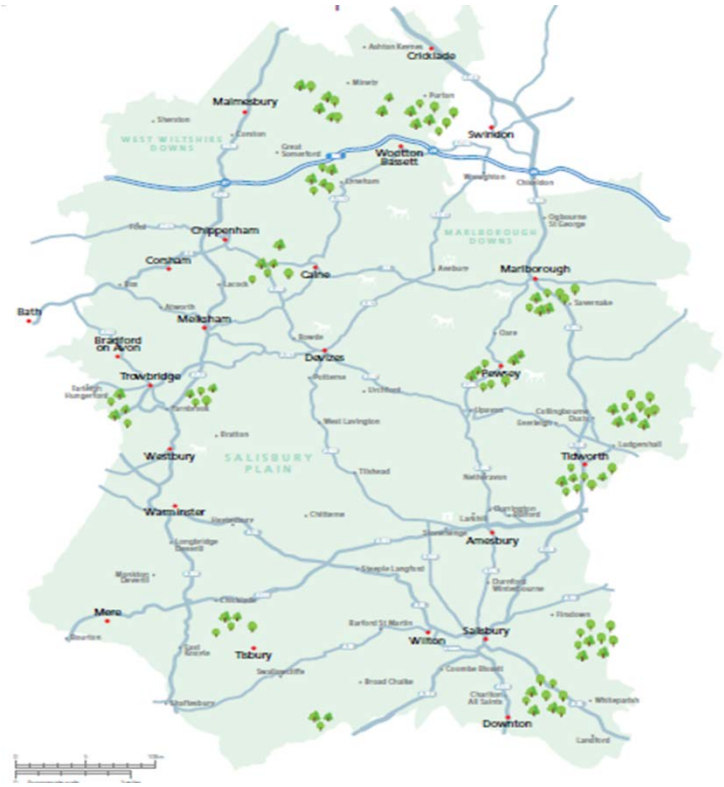
Wiltshire's geography

Wiltshire is a large, predominantly rural and generally prosperous County with a population of 484,400 in 2015.

Approximately 90% of the County is classified as rural:

- Almost half of the population live in towns and villages of fewer than 5,000 people
- A quarter live in villages of fewer than 1,000 people.

With 141 people per sq. km, Wiltshire has a lower population density than the South West of England overall. The rural nature of the County has implications for the planning and provision of health and social care services, particularly with a shift towards more provision of services in the community.



How the CCG is structured

The CCG is split into 3 localities covering the population of Wiltshire and each have their own Clinical Executive and reporting structure:

- NEW (North & East Wiltshire)
- Sarum (South Wiltshire)
- WWYKD (West Wiltshire, Yatton Keynell & Devizes)

Acute care for people that live in these localities is mainly provided by three principal NHS providers who each "face" the population in the localities. The locality structure helps to provide a strong local focus for healthcare commissioning and delivery in each of the three areas. However, the size and rurality of Wiltshire, together with the location of acute provision, which is split across three major acute providers increase the complexity of our system leadership role. Our three major acute providers each "face" a different principal commissioner, which makes both the commissioning process and implementation of change more complex.

The three main acute providers are:

- **Royal United Hospitals NHS Foundation Trust, Bath (RUH)** which faces Bath and North East Somerset.
- **Great Western Hospitals NHS Foundation Trust (GWH)** faces Swindon
- **Salisbury NHS Foundation Trust (SFT)** faces Dorset and Hampshire. It is a small district general hospital that also provides specialist services.

There are also five community hospitals in the NEW and WWYKD localities that provide a range of community based services as well as step up and step down community beds.

People's health in Wiltshire

The key characteristic of the population of Wiltshire is that people's health is generally better that the England average, with higher than average life expectancy.

The Public Health Outcomes Framework 2015 showing comparative life expectancy

Indicator	Period	Wiltshire		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
0.1i - Healthy life expectancy at birth (Male)	2012 - 14	-	66.6	65.1	63.4	55.0		70.5
0.1i - Healthy life expectancy at birth (Female)	2012 - 14	-	67.1	65.6	64.0	54.4		72.2
0.1ii - Life expectancy at birth (Male)	2012 - 14	-	80.9	80.2	79.5	74.7		83.3
0.1ii - Life expectancy at birth (Female)	2012 - 14	-	84.1	83.9	83.2	79.8		86.7
0.1ii - Life expectancy at 65 (Male)	2012 - 14	-	19.6	19.3	18.8	15.9		21.6
0.1ii - Life expectancy at 65 (Female)	2012 - 14	-	21.8	21.8	21.2	18.8		24.6

The Public Health Outcomes Framework also shows falling mortality rates and better than average comparative position on a range of key indicators.

Key indicators from the Public Health Outcomes Framework 2015 showing that Wiltshire's overall health position is favourable against the national average for England

Mortality	• Over the last 10 years, all-cause mortality rates have fallen • The early death rate from heart disease and stroke is better than the England average
Key indicators – many tend to be better than the England average. Some are similar to average	• Number of children classified as obese, better than the average for England • Levels of teenage pregnancy and breastfeeding are better than the England average • Estimated levels of adult 'healthy eating' and smoking are not significantly different than the England average
For some indicators, Wiltshire is worse than average	• The rate of road injuries and deaths is worse than the England average • Rates of sexually transmitted infections are worse than the England average

Whilst our population is relatively healthy, our five year strategy published in 2014 acknowledged that future approaches need to be tailored to the health needs of people in Wiltshire. The direction of travel in the strategy is similar to the Five Year Forward View and proposes measures around:

- Prevention
- Early intervention
- Developing the individual's personal responsibility for healthy lifestyle choices, health and wellbeing to keep them in health

This direction of travel will change the nature of care being delivered for people in Wiltshire in future years.

Wiltshire's changing population

Wiltshire population profile is different from the UK average, with:

- A lower proportion of Working Age adults
- A higher proportion of over 65s

This is particularly relevant to healthcare in Wiltshire because over 65s require greater level of health resources compared to other age related population groups.

Wiltshire has a higher proportion of over 65s compared to the UK average

Group	Population '000s		Population %	
	UK	Wiltshire	UK	Wiltshire
Children and young people	13,688	104.0	21.2%	21.5%
Adults of working age	39,502	282.4	61.2%	58.4%
Older people	11,407	96.8	17.7%	20.0%
	64,597	483.1	100.0%	100.0%

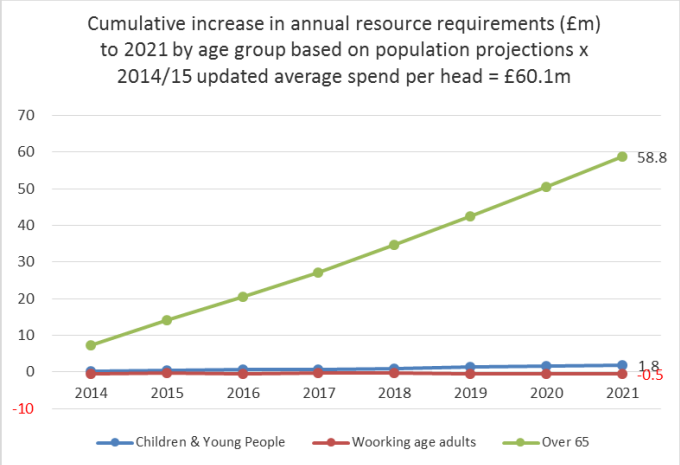
Wiltshire's population is also changing:

- The population is set to increase from 474,000 to 505,000 people (31,100/6.6%) between 2011 and 2021 according to ONS interim population projections
- Some 23% of the additional population will be over 65 years

These projections do not take account of military personnel changes which will add a further dynamic and potential pressure to our health and social care economy.

This change will have a profound impact on healthcare provision as the over 65 age group requires the highest level of healthcare resources compared to other age groups in the population. Previous analysis has shown the impact of population alone to be an additional cost of some £60m by 2021.

The increase in over 65s will materially increase healthcare costs in Wiltshire



The implications of an ageing population are profound as people live longer into older age, with:

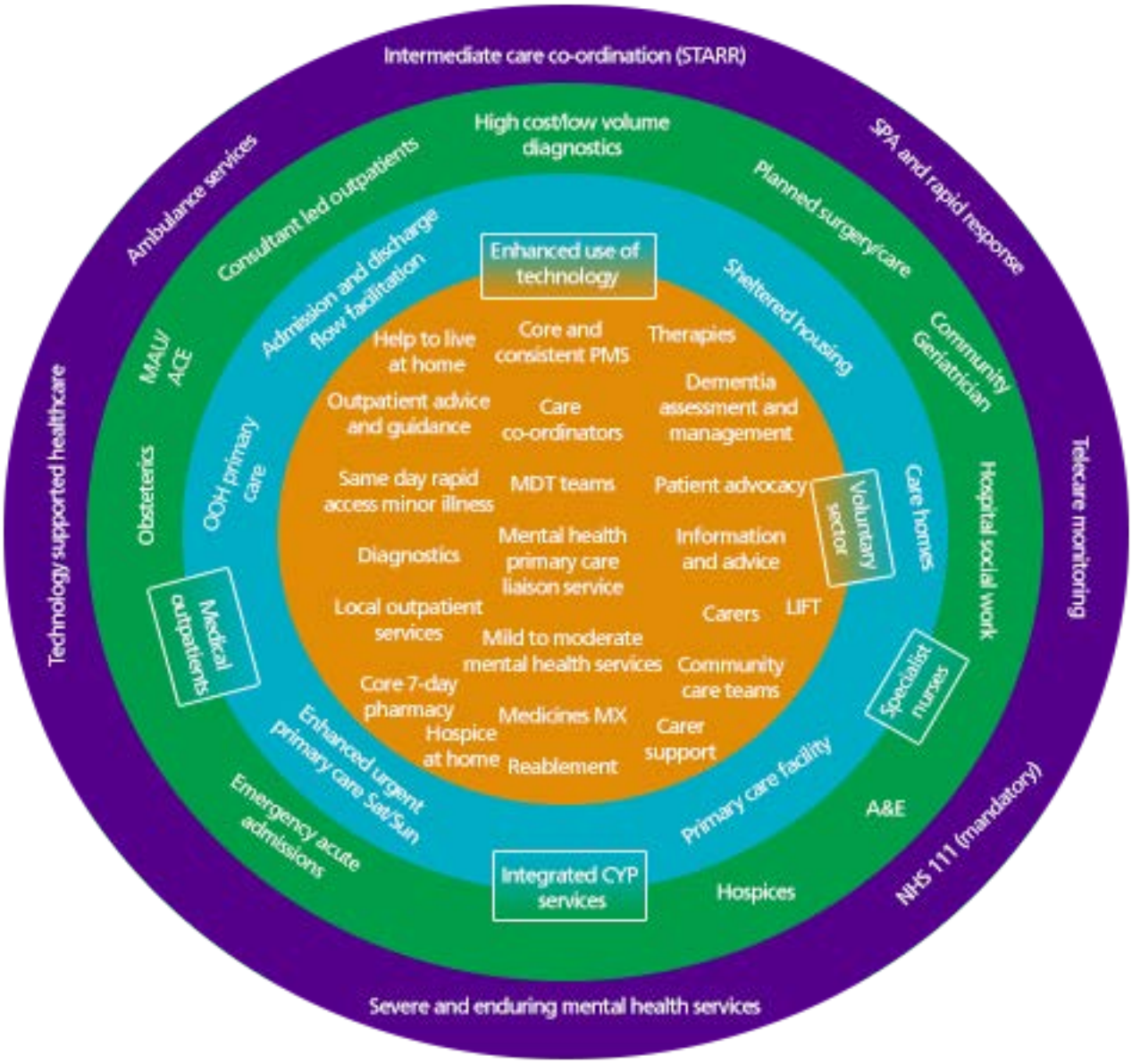
- An increased demand for health services
- A higher burden of chronic diseases
- Susceptibility to the negative impacts of social isolation

Wiltshire CCGs Five Year Strategy

Our five year strategy recognised these trends and set a direction of travel to change the way care is delivered to take account of both the health of people in Wiltshire and the way that the structure of the population is changing, particularly:

- Current services are too heavily focussed upon the acute sector and bed-based hospital services
- There is scope to develop further community and home based services as credible high quality alternatives to the current default of acute inpatient care
- Building further on joint work with Wiltshire Council through Integrated Teams to deliver more home based services

Our ambition is for a range of care services to be available for people in Wiltshire, tailored to their individual needs.



Our strategic vision is that Health and Social Care services in Wiltshire should support and sustain independent healthy living based on three principles where local primary and community care teams coordinate the delivery of holistic care to individuals in the community e.g. to address social isolation and loneliness.

- People encouraged and supported to take responsibility for, and to maintain/enhance their wellbeing.
- Equitable access to a high quality and affordable system, which delivers the best outcome for the greatest numbers.
- Care should be delivered in the most appropriate setting, wherever possible at, or close to home:
    - Where acute care is one-off or infrequent, there should be formal and rapid discharge.
    - Where care is on-going (e.g. chronic conditions) the default setting of care should be primary care.

Our model is based on achieving vertical and horizontal system integration, to enable our people to have the right care and support in place to help them live the life they want to the best of their ability. We are determined to take decisive steps to break down barriers in how care is provided, making out of hospital care a much larger component of what we do, and driving much better integration around the patient.

This vision is predicated on maintaining individuals' health care in the community via improved care planning, with care at or close to home becoming the future default option for primary and community care management of patients.

We are convinced that our strategy is absolutely the right approach for Wiltshire. Our Governing Body have re-affirmed their commitment to the future care model outlined in the strategy. We will drive forward our programme of transformation, continue to be bold regarding the pace of change and invest resources into key system innovations as we implement this change.

We have exploited every opportunity to invest in system change to support our ambitious approach, although it has been necessary to do this without any additional transformation funding.

Key issues and risks that could prevent delivery of objectives

The CCG has a robust and dynamic business risk process in place, which enables us to identify and report those key risks which erode our ability to deliver against our objectives.

Naturally, one of the paramount risks to delivery is the pressure on financial resources. Notwithstanding a relatively healthy financial allocation for Wiltshire for the financial year 2016/17, we are in no doubt that, when viewed in the context of our entire health system, if nothing changes there will be an increasing gap between the trends in demand and the resource available to service that demand. The CCG identified this issue very early and indeed our entire 5 year strategy, while primarily focussed on delivering better health outcomes for our population in an out of hospital model, also seeks to address this reality.

Looking to the future we are already essentially widening the scope of our strategic ambition, and have started to work on a system wide Sustainability and Transformation Plan, which includes our key partners and stakeholders from both the health sector within Wiltshire, but also neighbouring commissioning groups in Swindon and Bath & North East Somerset.

Supporting the CCG strategy to develop and enhance services closer to people's homes a number of strategies have been developed and started to be implemented throughout 2015/16. The key areas that have been focused on are Information Technology (IT) and estates.

The estates strategy has focused on 2 key components the first being the redevelopment of the existing community hospitals and the second being the expansion of primary care and community care across the county in order to support the integration of out of hospital services and greater 7 day access.

Given the increases in the Wiltshire population the CCG has worked with primary care and community services to plan for new developments that will cater for the ever increasing health needs of the population. The priorities have been Devizes, Trowbridge and Chippenham where the localities have established a strategy of developing an urgent primary care hub which would see urgent on the day appointments across a number of practices within a locality being delivered from a centralised primary care hub. It is envisaged that the new Devizes Urgent Primary Care centre will open in 2018 replacing the old community hospital. The new developments will also facilitate joint provider working and establishing greater linkages with social workers and the third sector.

Linked to the estates strategy is the development of IT across the county. Although funding has been limited for new IT developments the CCG has pursued a number of priorities that have built on the standardisation of IT systems across out of hospital services. This has included the majority of in hours and out of hours primary care being on the same clinical system and the roll out of the same system is happening for all community services. This will allow GPs and community health workers to have access to a patients' record where consent has been given to support joint decision making and proactive care. Added on to this is the ability of the 3 acute hospitals and the mental health provider to be able to view this rich record of information to support clinicians in other settings to make better informed decisions.

For 2016/17 the CCG has been working on the continued enhancement of sharing information is actively promoting the use of the enhanced summary care record which is the national system that has been developed to share key patient information. This will see additional services such as ambulance and 111 to be able to key clinical information that could help in supporting clinical decision making. The CCG is also promoting the use of sharing of information with other agencies such as Wiltshire Council, police and fire under the Better Care Fund Single View project. Detailed work is being undertaken on the information governance agenda associated with this project given the sensitivities of sharing personal data.

The CCG commissions acute hospital activity from a number of providers; 3 local acute foundation Trusts and 10 other material providers. The CCG has good information on demand that it needs to address through commissioning activity but capacity within providers is not dedicated to any CCG. Therefore, we apply significant rigour in our approach to contracting in order to ensure that we have commissioned sufficient activity to serve our population and that the right capacity is in place across the provider landscape. Ensuring that there is enough capacity for the demands of the Wiltshire population is further complicated by patient choice, other CCGs changing demands or activity flows and workforce issues at individual providers. To mitigate this, the CCG works collectively with BANES and Swindon CCGs and our local providers to review demand and capacity and the impacts on delivery of NHS Constitutional Targets relating to waiting times.

We also recognise that the available workforce both now and into the future will be crucial. At the strategic level we participate along with partners from Wiltshire Council in a Wiltshire Institute of Health and Social Care to underpin the delivery of our care model, ensuring a workforce which is fit for purpose into the future. This is underpinned by a Wiltshire Workforce Action Group, which has membership from across the sector in the county and which is seeking to find new and innovative ways of improving the manner in which we recruit, retain, motivate and enable progression our people.

Statement of going concern

The resources, principal risks and uncertainties and relationships that may affect the CCG's long-term value

We are allocated resources to fund the costs of directly commissioned services that we are responsible for (programme allocations) and to fund the costs of commissioning those budgets (running cost allocations). Approved budgetary resources are devolved to the Directors and Groups in line with our matrix of responsibilities with each party operating in line with our scheme of delegation and the aims and ambitions.

We maintain risk registers, at a group / directorate and organisational level, to identify operational and financial risks that may affect our strategies and development. These issues are managed through application and review of mitigating actions and via the application of contingent reserves where applicable.

We work closely with other commissioners and providers of healthcare to ensure that Wiltshire has a high performing and resilient health system. 2015/16 has also seen a strengthening of our relationship with Wiltshire Council for social care and other services that support the local population. This has been reinforced by the continuation of the Better Care Programme.

Financial Year 2015/16

Financially 2015/16 has been a very challenging year as the impact of Wiltshire's population getting older and frailer becomes evident. Demand has also been seen in the under 18 population and the people of working age (18-65 year olds). The providers from which we commission services have seen demand increase compared to 2014/15 and demand significantly above the planned activity levels that reflect the CCG strategic direction. However, the CCG has made some significant impact in some areas in the urgent care sector. The over 65 year old population in Wiltshire has increased by 2.9% in 2015/16 compared to 2014/15, whereas, the number of over 65s being admitted to an acute hospital for urgent care has only risen by 0.1% on the same period.

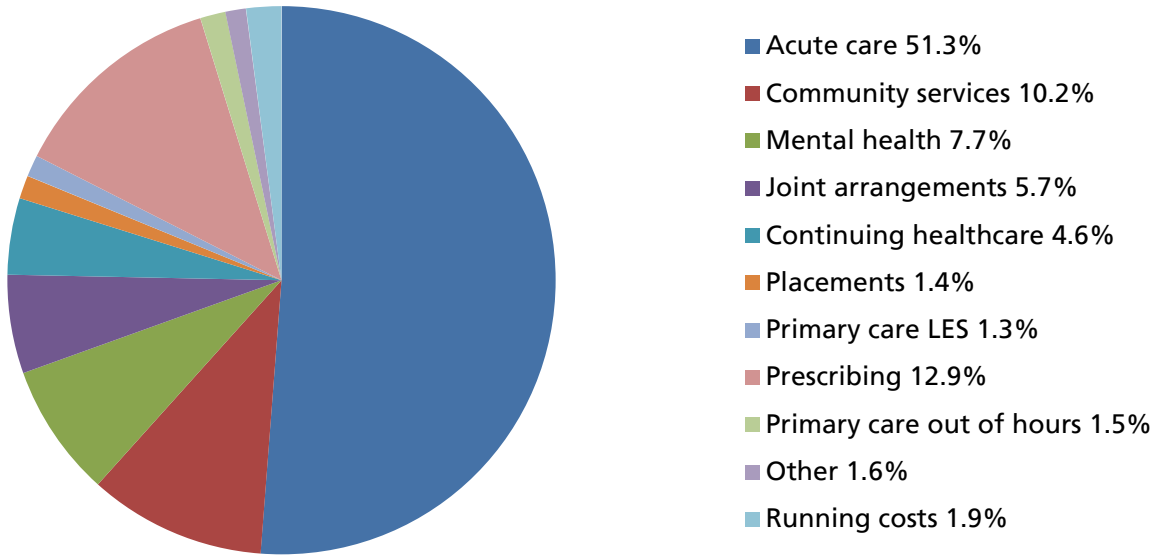
Given the challenges that have been experienced the CCG reported a movement in its anticipated year end surplus position earlier in the year. In response the CCG has produced, and successfully delivered, a financial recovery programme that has seen the CCG achieve a surplus of £5.5m which is in line with the planned target, as per NHS England business rules.

Target Description	Target	Achievement
Planned Surplus against Resource Limit	£5.5m	£5.5m
Revenue Cash Limit – balance in account	<£0.46m	£0.39m
Capital Resource Limit		
Achievement of the Better Payment Policy Code (payment of invoices within 30 days)	Number of Invoices paid within 30 days 95% Value of Invoices paid within 30 days 95%	99.2% 99.9%
Core Running Cost Allocation Performance	£11.5m	£10.4m

The CCG received funding of £560.1m of which £11.5m related to the running costs of the CCG (£1.1m of which was non recurrent quality premium funding). Against this total allocation the CCG has spent £554.6m and delivered a surplus of £5.5m which is in line with the NHS England business rule requirement of delivering a 1% surplus.

The split of this expenditure by programme area is shown in figure below:

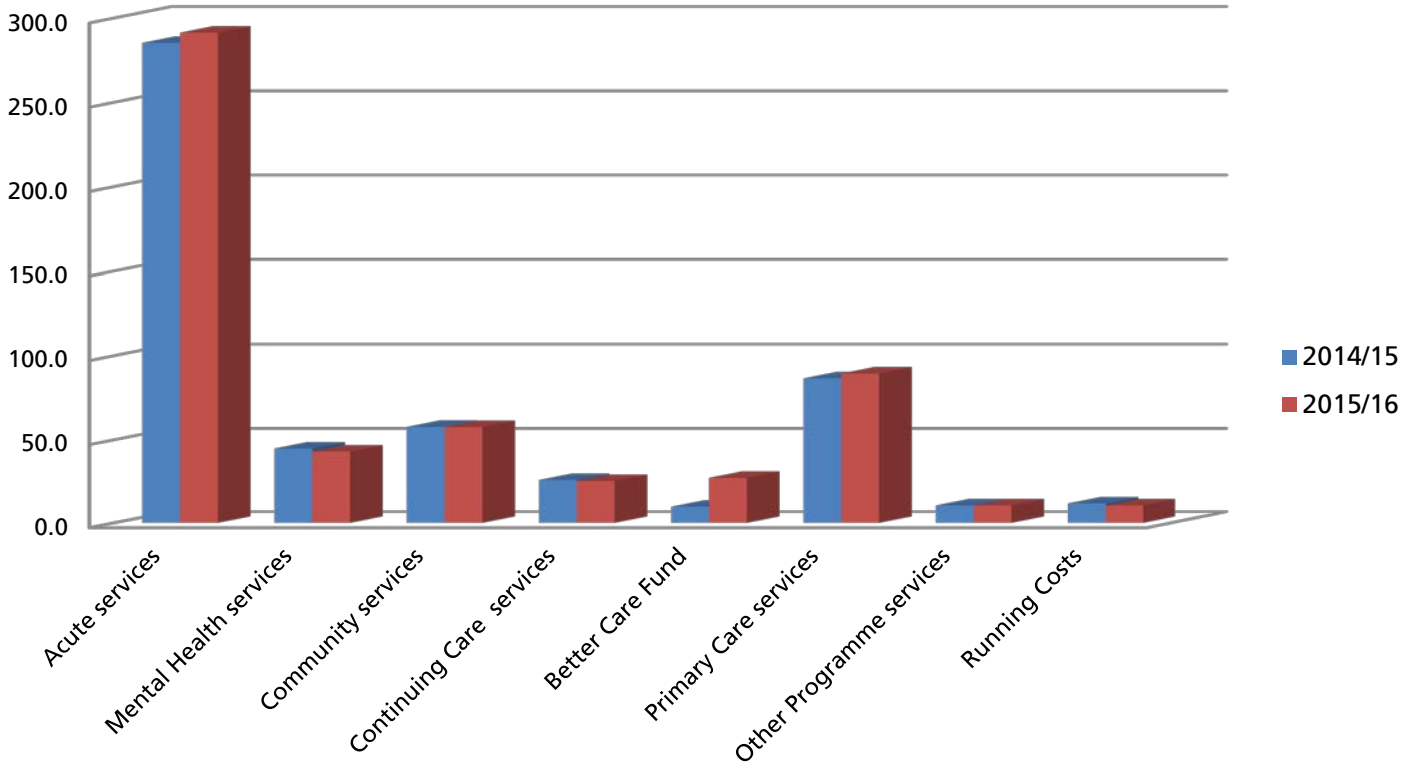
2015/16 Breakdown of Expenditue by Programme Area



The CCG achieved its running costs with 26.3% of its allocation paid to the South, Central and West Commissioning Support Unit for commissioning and back office functions support and 73.7% relating to direct CCG costs.

The graph below compares the CCG expenditure, at programme level, with the prior financial year. This positon shows that additional monies were spent in most areas with the inclusion of renal specialised services, which the CCG became responsible for in 2015/16.

Comparison of expenditure between 2014/15 and 2015/16 at programme level



Financial Year 2016/17

This financial year is set to be as challenging as the one we have just finished. The CCG has set itself a savings target of £13m in order to invest in transformed services in line with the CCG 5 year strategic plan. This includes the continuation of the Better Care Fund which will operate as a joint funding pool for health and social care with the objective of supporting more people in the community and to reduce the reliance on acute hospitals. The financial plan supports the endeavour of only sending patients to hospital when they are acutely ill and establish more community capacity across health and social care. Our financial plan for 2016/17 is shown below with comparisons to the actual expenditure for 2015/16.

Programme area	2015/16 Actual £'m	2016/17 Plan £'m
Acute services	291.3	299.7
Mental Health services	43.0	45.6
Community services	57.6	55.7
Continuing Care services	25.2	24.7
Better Care Fund	27.1	28.0
Primary Care services	89.4	91.0
Other Programme services	10.5	22.1
Total - Commissioning services	544.1	566.7
Running Costs	10.4	10.0
Contingency	0.0	2.9
Total application of funds	554.5	579.6
Surplus/(Deficit)	-5.5	-5.9

The CCG will continue to focus investment in the following areas:

- **Demographic and non-demographic growth** – which is designed to take account of activity and demand pressures resulting from changes in population, principally around the elderly
- **Call to action** – investment to pump prime services that will be developed through the implementation of our 5 year strategic/2 year operational plan and the Better Care Fund.
- **Local priorities –** we plan to invest in local priority areas that are not included in investments outlined above which helps ensure a local focus for investment priorities particularly within the three groups
- **Mental Health** – CCGs are required to increase its investment in mental health services. The CCG will be investing in mental health to support parity of esteem.
- **Winter Resilience** – the CCG in previous years has received funding to support the resilience of the health system across times of high demand particularly in the winter. This funding is now in the recurrent resources of the CCG. The CCG will look to fund schemes that support the health systems at times of high demand.

The challenges facing the CCG in 2016/17 will relate in the main to the management of demand and the complexity of clients needing to use NHS services. As the population of Wiltshire become older and more fragile the pressure on the current health system increases, therefore, it is imperative that new models of care and client self-responsibility are maximised to the full.

Performance summary

Overall the CCG has performed well over the past year, achieving some major milestones along the way, most notably the successful procurement of major community service provider contracts, and really bucking the national trend in largely containing growth in non-elective activity, particularly for the older population. Despite some difficult months when the financial forecast looked slightly alarming, Wiltshire CCG ends the year in a good financial position and achieves all financial and business rules targets.

In terms of quality and constitution targets there remains work to do, particularly with regard to Accident and Emergency performance at both Royal United Hospital NHS Foundation Trust, Bath and Great Western Hospitals NHS Foundation Trust, and although we have managed the enduring Referral To Treatment issue well, performance is still not where we would wish it to be. Trends for Mixed Sex Accommodation breaches and hospital acquired infections continue to be encouraging.

Performance Analysis

Performance against key national targets

The CCG has the responsibility for commissioning services for Wiltshire that will achieve outcomes that improve the health and wellbeing of the population. To measure the success of Wiltshire's commissioning, the CCG is required to performance manage against a large number of key access and quality standards. The CCG has made some progress against the achievement of these targets, however, there remain a number of challenges that will be tackled in 2016/17.

The NHS Constitution

We recognise our obligations to patients in Wiltshire as set out in the NHS Constitution. Our patients have a right:

- To non-emergency treatment starting within a maximum of 18 weeks from referral.
- To be treated within 52 weeks.
- To a diagnostic test with a maximum of 6 weeks
- To be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- To be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.
- To be treated with dignity and respect, including single sex accommodation.
- To a choice of a number of hospitals for elective care.
- To view their personal health record.
- To have complaints dealt with efficiently and investigated properly.

A summary of the performance achievement is shown in the table below:

Indicator	Achievement (Q1-3)
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	
Number of patients waiting more than 52 weeks	
Patients waiting 6 weeks or more for a diagnostic test	
A&E waits – SFT	
A&E waits – RUH	
A&E waits – GWH	
Cancer 2 week waits	
Cancer 31 days	
Cancer 62 days	
Ambulance calls red 1 response times	
Ambulance calls red 2 response times	
Mixed sex accommodation breaches	
Mental Health Care Programme Approach achievement	

Development and performance of the CCG for the period under review and in the future

Our Current Performance

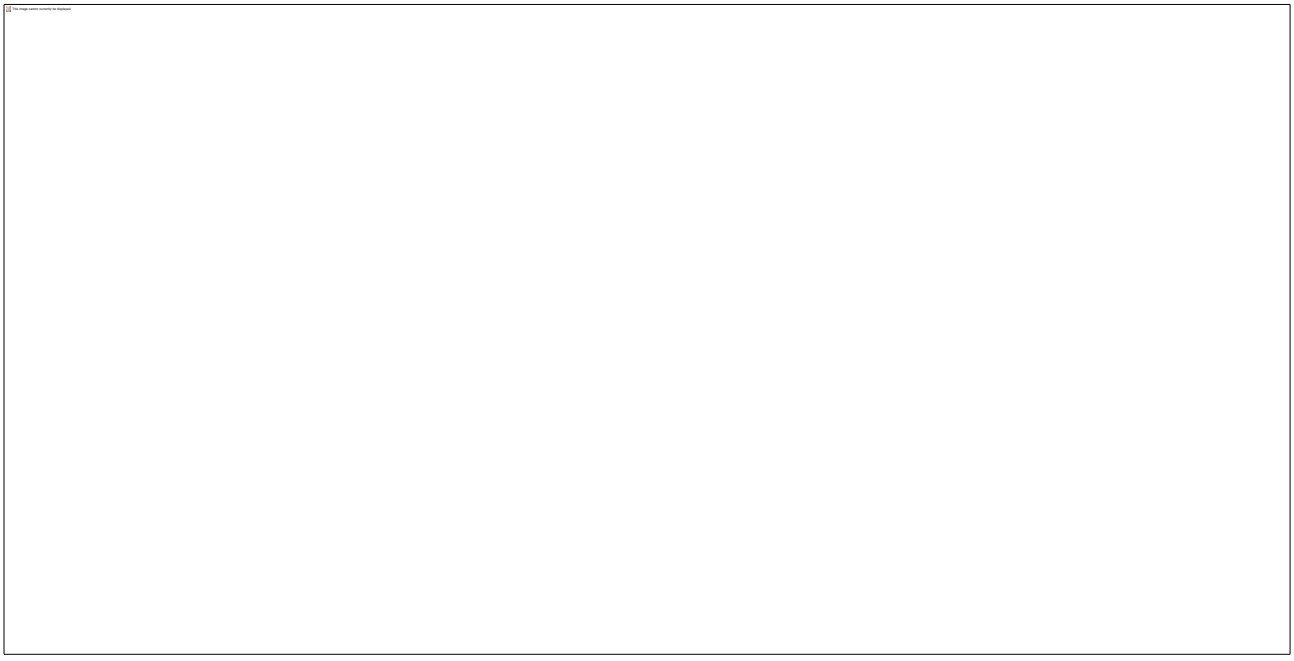
NHS Wiltshire CCG and its partners are continuing the transformational journey in a strong position in terms of the overall performance of the health and care system and in delivering against the pledges and rights our patients should expect as part of the NHS Constitution.

Referral-to-Treatment Times (RTT)

It has been a challenging year in relation to delivery of RTT performance for our main providers. Increasing pressure around non-elective care has impacted on elective performance delivery including increased waiting times. The CCG is working with our providers to ensure sustained delivery and through the pan-Wiltshire RTT Assurance group to provide focus on ongoing deliver, management of risk and sharing of best practice. We are also working with primary and secondary care clinicians to reduce preventable referrals to deliver reduced waiting times for patients. There have unfortunately been breaches patients who have waited more than 52 weeks.

Mixed Sex Accommodation (MSA)

At the beginning of 2015/16, it was identified by Salisbury NHS Foundation Trust that MSA breaches were not being identified and reported appropriately within one area of the Trust. Throughout the year, the CCG has worked with SFT to support the Trust with the development and implementation of a Remedial Action Plan. This plan has led to a reduction in breaches and embedded learning within the Trust. The CCG is applying the learning from SFT in the development of the plan with Great Western Hospitals NHS Foundation Trust to address their recent breaches.



Progress against agreed targets

Planned care

The programme of work covering planned care has been developed to ensure that patients receive services which provide benefits which are clinically sound, delivered in the right locations and which are also financially sustainable. There have been developments across a number of schemes as indicated below:

- Effective Planned Care – designed to ensure that patients are receiving appropriate care. This has involved the review and development of policies which set out which clinical priorities the CCG will consider funding. Following agreement by the CCG's Clinical Advisory Group the renewed policies are implemented. This has led to a reduction in planned care activity through a more effective use of the Prior Approval process. Further policies are being reviewed.

- Unplanned to Planned (Ambulatory Care) – this scheme aims to increase the number of patients who are assessed and treated through a ambulatory model rather than being admitted to a hospital bed. The benefits to patients are reduced admissions to hospital and reduced length of stay. All three acute providers serving Wiltshire now have ambulatory care units operational.

- Outpatient Follow Ups – to reduce preventable face to face follow ups in secondary care by introducing 'patient initiated follow-ups' (PIFU). PIFUs have been successfully introduced at SFT and all other acute and independent providers are developing similar models.

- Gastroenterology – a clinically led working group was developed to find solutions to ongoing demand and capacity issues impacting on waiting times for patients. The group developed a single upper GI referral form to address the operational issues. The form has been launched across Wiltshire in November 2015.

- Dermatology – A new integrated community model was piloted in conjunction with a GP practice and secondary care provider to provide care closer to patients' homes and reduce preventable referrals into secondary care. Opportunities to extend this model in 2016 are being explored.

- Musculo-skeletal physiotherapy – to reshape the way in which physiotherapy services are delivered in the community including the interface with secondary care. A new model of community physiotherapy has been developed and a pilot is underway in the community settings and was included in the tender for the adult community services. This model will involve the provision of alternative treatments including osteopathy and chiropractors. Community physios will also become more instrumental in the referral pathway to secondary care to reduce demand for acute services which provide little clinical benefit to the patients referred.

Unplanned care and care for frail older people

Another key area of focus for the CCG has been the improvements in the urgent care arena. Work to address the pressures of rising demand and an elderly population have been driven by two programme areas – Transforming Care of Older People and the Better Care Fund.

Transforming Care of Older People

This programme area which began in 14/15 has continued in 15/16 and provides investment in primary care led initiatives focussed at the over 75s which meet the following criteria:

- The CCG strategic vision;
- Improved care for vulnerable older people;
- Reduced avoidable admissions;
- Continuity of care for older people;
- Improved overall quality and productivity of services; &
- Greater integration of health & care services, in particular out of hospital care

19 schemes (predominantly locality-based) have been supported and funded since 2014 - subject to successful delivery of the agreed outcomes for patients aged over 75 years. These schemes cover every GP Practice across the whole of Wiltshire. Currently, there is evidence of local and clinically-led initiatives with some collaborative working across practices and engagement/alignment with the wider MDTs, reviewing and addressing the individual practice variation and learning from best practice.

Performance of each scheme is reviewed at the TCOP review panel which provides a robust framework for monitoring the investment made in primary care. A range of supporting measures has been in place for the schemes including a CCG-wide TCOP Learning Event co-hosted with LMC & Healthwatch. At this event clinician led presentations from five case studies across the CCG were presented to set out the outcomes from each scheme in order to share the learning. This event was attended by over 100 people, the majority being front line clinicians and colleagues from Social Care.

Year-end reports will be submitted by each scheme to this panel with the purpose to review in year performance and to determine those schemes which will continue into 2016/17 within the proposed Primary Care Offer, which will incorporate TCOP within its scope.

The Primary Care Offer is intended to establish a coherent contractual framework for all non-core GMS/PMS activity in Primary Care. As such, it will incorporate both a range of initiatives intended to deliver TCOP outcomes and also an enhanced metrics and monitoring framework to report on achievement.

The Better Care Fund

The CCG has maintained its commitment to health and social care integration through its ongoing contribution to the Better Care Fund. This collaboration is seen as crucial to improving the flow of patients across the local health and care system which in turn will support the reduction in unplanned hospital activity as well as the enhancement of the experience for patients, their families and their carers. Building on the firm foundations established last year, and the national recognition that the Wiltshire programme attracted, BCF schemes in 15/16 have focussed on:

- Intermediate Care – a new model of 70 cohorted intermediate care hospital beds have been launched and length of stay in these beds has been sustained which improves patient flow. A process of trusted assessment between providers has been initiated with dedicated community therapists working on an 'in reach basis' in the acute hospitals serving Wiltshire patients.

- Admission avoidance – focus has been maintained on the 'front doors' of acute hospitals by partner providers engaged in the BCF with the aim of preventing unnecessary admissions. A rise in the complexity and acuity of patients has been experienced.

- Step up care – a new model of step up beds has been introduced. The model provides an enhanced level of care to that delivered to patients in their own homes and prevents unnecessary admission to acute hospitals. Referrals can be made from a wider range of professionals who are supported by clear guidance. The scheme is well used and active management of the flow of patients through these beds is in place involving the use of the Choice Policy,) improved utilisation of the CHS service for self- funders, and enhanced access to packages of care.

- Urgent Care at Home – through the provision of services by the providers of adult community services and general practice out of hours, more patients in need of urgent care in their own home are better able to access the services they require over a seven day period.

- Community Geriatrics – close working with consultants at the three acute hospitals serving Wiltshire has led to enhancements in the provision of geriatric care in the community. There is now a Wiltshire wide commitment and infrastructure to support the concept of comprehensive geriatric assessment which will bring benefits to patients and the health and care system.

- Wiltshire Home First – a new service involving co-located health and social care providers and their partners in the voluntary sector is being piloted in the South of the county. Increased numbers of referrals of patients ready to leave Salisbury Foundation Trust are being received. The service is having a number of key benefits which include improved MDT working, changes to existing culture of integrated working and reducing dependency and increasing longer term independence of clients once we discharge them home. The potential rollout of this pilot service is under consideration by the CCG and Wiltshire Council.

- 72 hour pathway for end of life patients – the out of hors general practice provider continues to work in partnership with the hospices serving Wiltshire in order to provide an enhanced Urgent Care @ Home Service for patients at the end of their life. Initially Dorothy House and Prospect Hospice are providing an additional carer to the pool of staff available for the UC@H service. They are available twenty four hours a day, seven days a week and are providing care for palliative patients (patients within the last year of life).

Healthwatch has completed an evaluation of patient experience in relation to BCP initiatives and have found that overall patients are very satisfied with the services they are provided. The plan has outlined a number of areas of improvement which will be acted upon.

System Resilience

Partnership working to reduce unplanned admissions to hospital for patients has continued through the CCG's leadership of the Wiltshire System Resilience Group which has provided investment to the Operational Resilience and Capacity planning proposals. The CCG allocated the total amount received for Operational Capacity and Resilience Planning (ORCP), £2.732m to providers of services through the governance of the System Resilience Group.

The majority of the funding, £2.203m, was directed towards the three secondary care providers to support their operations in maintaining patient flow from initial assessment within the emergency department through to timely and appropriate discharge.

Examples of how this funding was used locally include:

- Additional clinical staff within emergency departments and assessment units to increase performance reduce length of stay for patients and increase early discharges;
- Additional clinical staff within diagnostic and pharmacy services to improve access and reduce delays;
- Additional therapy staff on wards to provide early supportive discharge to usual place of residence.

In addition, the remainder of the funding was targeted outside of secondary care to support:

- Provision of a Health Care Professional line to support clinical access to a GP advice line;
- Provision of additional Out of Hours capacity during public holidays to support a reduction in emergency department attendances;
- Development of a seven CCG wide Directory of Service team to maintain the list of services locally available to signpost patients accessing the NHS via the NHS 111 telephone helpline.

Investment has also been made for additional primary care / Out of Hours resilience to support the Easter 2016 period and the primary care paediatric pilot at Salisbury Walk In Centre from December 2015 designed to test a response to curb the growth experienced in this patient group across the county.

The CCG has become a member of the Severn and Wessex Urgent and Emergency Care Networks.

Long term conditions - Diabetes

The diabetes programme board has continued to work with stakeholders including Public Health and those in primary and secondary care to review the way diabetes care is provided in Wiltshire. The aim is to move services out of hospitals into locally based community settings.

To support this direction there has been a focus on early adopter schemes. Following the development of a Business case funding has been agreed for the programme of work which will be implemented in quarter 1 of 16/17. These schemes will enable diabetic consultants for secondary care to work with primary care in community settings. The benefits will be the upskilling of Primary Care enabling greater complexity of cases to be managed outside hospital and thus preventing exacerbation of a patient's condition. The programme has also focussed on the review and development of patient education involving proactive management by the individual of their condition using interventions such as healthy diet and regular exercise.

Prescribing savings through housekeeping

This programme area has driven efficiencies in costs associated with drugs prescribed in primary care and introduced new measures to enable the savings to be realised.

Review of patients receiving CHC fast track and LD funding

As part of its cost improvement programme the CCG has reviewed payments for patients in receipt of funding. Through detailed reviews and correct governance for fair decision making the CCG has been able to make savings and improve its overall financial position.

Dementia diagnosis
Our dementia diagnostic rates over the past 12 months have increased by 9.1%, to 65.5%, however, we are still 1.2% short of the national target of 66.7%. Our rate of increase has continued this year as last year to be significantly high and we have a clear plan to achieving the national target in the first half of the 2016 financial year.

Improving Access to Psychological Therapies (IAPT)
The CCG has undertaken a full review of the Wiltshire IAPT service during 2015/16, and designed and implemented a new service model with effect from 1 April 2016. The new model will have a number of patient care benefits, however, it is expected that there may be a short downturn in recovery rates so a remedial plan is in place to enable the achievement of the national target of 50% by October 2016.

End of life care
The End of Life Programme Board has continued to work collaboratively across the whole health system during the last year to deliver the strategic and operational objectives of improving the experience of patients, relatives and carers. Key areas of focus in year are:

- Electronic Patient care Co-ordination System (EPaCCs) - enables the sharing of important information about patients and their wishes at the end of life stage are available to many community services and further developments are planned.

- Medicines Management – confirmed list of palliative care drugs to be stocked by pharmacies has been confirmed with a service level agreement developed to support the roll out of the initiative.

- Education/Treatment Escalation Plan (TEP) – following the development of the TEP an education programme, supported by information accessible on the CCG internet page, is being delivered. This will ensure the use of the TEP which records the wishes of patients at the end of life stage. Training in Advanced Care Planning and Dementia training for GPs, Community Teams and Care Homes is in development for roll out in February/March. The implementation of the TEP is already reducing preventable admissions to hospital and ensuring the wishes of patients are adhered to. A formal evaluation of the form is being undertaken from April 2015.

- Dementia - The Dementia Delivery Strategy Board Action Plan has now been augmented and will link with the End of Life (EoL) Programme Board. This will ensure staff and family members are aware of when and how to communicate with patients about EoL.

The Programme Board will be continuing for the next year and work streams for this important are of care have been drafted.

Community services and integrated care
Wiltshire CCG's vision for an out of hospital model of care which will bring clinical benefits to patients and a more financially stable platform remains. Providers led by primary care work in integrated teams with important contributions from community services, mental health and social care alongside the voluntary sector. To further the aims of the CCG the procurement of both adult and children's services was completed in this year. Mobilisation and contracting of the new providers is underway.

The contract for Children's services, awarded to Virgin Care, will begin on 1 April 2016. The contract for adult community services will begin on 1 July 2016. This contract was awarded to Wiltshire Health and Care which is a joint venture organisation formed by the three acute hospitals serving Wiltshire.

Quality and Patient Safety Report

Introduction

Improvement of quality and patient safety is central to what we do; ensuring that the services we commission provide high quality safe care to patients and their families and carers. During 2014/15 the Quality Team was strengthened to ensure robust monitoring and processes are in place to provide the Governing Body and public with assurances that commissioned care is safe, and of the highest possible quality. In 2015/16 the team structure was further amended to deliver improved collaboration and information sharing.

The three aspects of quality are enshrined in our approach in line with the international definition of quality, namely:

- Patient safety
- Patient experience
- Clinical effectiveness

Within this definition we have continued to strengthen our approach to the review of quality metrics and joined up working with performance and contracting colleagues so that we can be sure the outcome for patients promotes continuous improvement whilst maintaining safety and responsiveness to patient feedback.

In 2015/16 some seminal reports and recommendations have influenced the quality and safety agenda in England, most notably the Kirkup 'Report of the Morecambe Bay Investigation' (March 2015), the Mazars 'Independent review of deaths of people with a Learning Disability or mental Health problem in contract with Southern Health NHS Foundation Trust April 2011 to March 2015' (December 2015), the Carter 'Operational productivity and performance in English NHS acute hospital: Unwarranted variations' (February 2016). The Centre for Health and the Public Interest also published 'How safe are NHS patients in private hospitals? Learning from the Care Quality Commission' (November 2015).

Although the implementation of the recommendations from these reports remains work in progress, we are committed to commissioning safe, high quality services in all commissioned care settings. We are holding providers to account for the quality and safety of services with structured reports across providers using a range of indicators and metrics from a number of sources, which are regularly reported to our Governing Body.

The Five Year Forward View which was published in October 2014 laid out the ambitions and challenges in tackling the care and quality gap for the NHS. Subsequently, in December 2015, the six national NHS bodies issued 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21. This document addresses the task of closing the finance, health and wellbeing and quality gaps both on a local (Wiltshire) and system-wide (Wiltshire, Swindon and Bath and North East Somerset working collaboratively to meet the needs of the wider population) basis.

The guidance included the requirement to develop and implement plans to maintain and improve quality for patients and for an affordable plan to make improvements in quality, particularly for organisations in special measures. The guidance also set out the requirement for providers to participate in the annual publication of avoidable mortality rates at Trust level.

The Quality Team has already taken steps to progress these requirements and has, for example, been working throughout 2015/16 to embed the review and triangulation of mortality data, focusing on variation across the 7 day period and diagnosis groups for which mortality rates exceed expected levels. There is further information about mortality rates within this report. The team will build on the achievements in 2015/16 and continue work collaboratively to deliver the aims set out for 2016/17 and beyond.

The Report of Morecambe Bay Investigation was published in March 2015. Conducted by Dr Bill Kirkup, CBE, the report captures the independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013. The report included a range of conclusions and recommendations. In response to assurance requested by the CCG, providers of maternity services to Wiltshire patients have undertaken a review of their services against the findings of the report and have developed and implemented action plans in order to meet identified gaps.

In 2016/17 the Quality Team will be monitoring the progress on these action plans and working with colleagues across the CCG to action the vision set out in the National Maternity review; "Better Births", improving outcomes of maternity services in England, a Five Year Forward View for Maternity Care (March 2016). In 2015/16, the Quality Team strengthened the quality and safety reporting requirements for Maternity services, and funded a CQUIN (Commissioning for Quality and Innovation) scheme to reduce stillbirths. This scheme will be further extended in 2016/17 to support the role-out of the National Still Birth Care Bundle as set out in 'Saving Babies' Lives, A care bundle for reducing stillbirth (NHS England, March 2016).

In February 2016, Lord Carter of Coles published his Department of Health report; 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations'. This report identified significant and unwarranted variation in costs and practice which, if addressed could save the NHS £5bn. Of the savings, up to £2bn comes from the workforce budget, through:

- Better use of clinical staff
- Reducing agency spend and absenteeism
- Adopting good people management practices

The report looked at good practice in the NHS and elsewhere and developed the concept of a model hospital. Based on data on successful organisations, the report identified nine practices that are the key elements in developing a successful organisation. Values-based behavioural framework; Patient-centred organisation Structure improvements; Leadership strategy; Operational management process; Dashboards; Individual performance management system; Engagement and Colleague opinion survey. It also clearly identified the links between quality, efficiency, safety and performance.

Salisbury Hospitals NHS Foundation Trust was one of the 32 Trusts to engage with Lord Carter and his team. The Quality Team will continue to work with providers regarding the appropriate learning, actions and recommendations arising from this report.

In response to the preventable death of a patient with learning disabilities in July 2013, whilst in the care of Southern Health NHS Foundation Trust (a mental health service provider), NHS England commissioned an independent review from Mazars, an integrated international audit, tax and advisory firm. The Mazars Report (December 2015) reviewed all deaths of people in receipt of care from Mental Health and Learning Disability services in the Southern Health NHS Foundation Trust between April 2011 and March 2015.

The report focuses on the responsibilities as they impact on the Trust to report deaths and then to secure the right level of review, enquiry or investigation, while noting that the responsibility for investigating deaths lies with a number of organisations across the area and are referred to where appropriate. The scope of the review was to help secure:

- A shared view across all the key players of risks within Southern Health NHS Foundation Trust services, of improvement action required, and plans to deliver change.
- Advice to CCGs about Learning Disability commissioning, data management and analysis, and adverse events indicators

Following the publication of this report, assurance was sought from Avon and Wiltshire Mental Health Partnership (AWP) regarding their status on the number of deaths of a patient in receipt of a service, verses how many of these deaths had been investigated. AWP have been benchmarked against other mental health trusts, further work will be undertaken in 2016/17 to understand the reporting rates against national reporting levels. The Quality Team has worked extensively with co-commissioners and AWP to review the reporting of Serious Incidents and the identification and embedding of learning, and this work will continue in 2016/17.

Ensuring that people have a positive experience of care

A critical aspect of high-quality NHS treatment and care is the experience of patients, their relatives and friends. 'Ensuring that people have a positive experience of care' is a key part of the NHS Outcomes Framework.

As a CCG we are keen to learn from patient experiences. During 2015/16 we brought a number of patient stories to the Governing Body Meetings in public. The purpose of this was to ensure that members of the Governing Body were able to hear the concerns and experiences of people in Wiltshire and to ensure that commissioners work with providers to bring about change or improvement.

During 2015/16 members of the quality team joined a Healthwatch led 'Health and Social Care Forum' in which the three acute providers and AWP attend to discuss patient experience themes and trends and to share best practice and lessons learned across the region. The quality team are also accessing information and data from the inpatient experience toolkit to further support improvement initiatives related to patient experience.

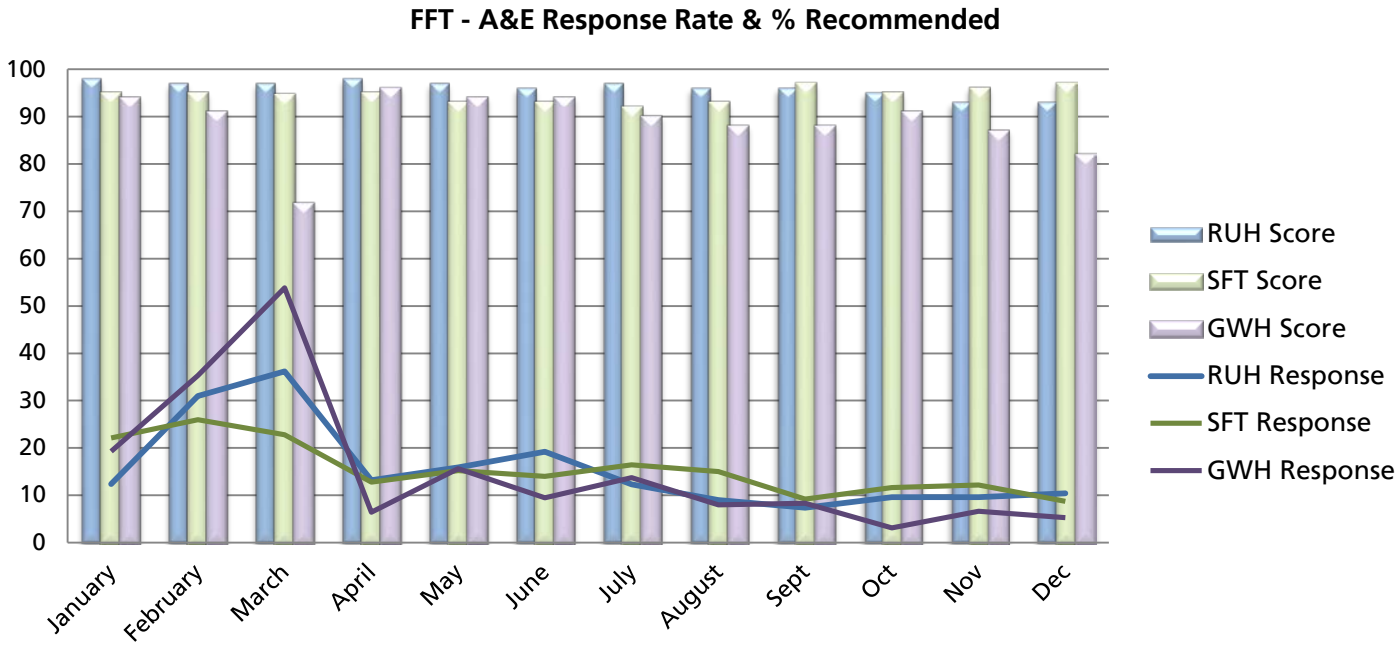
The 'Friends and Family' test

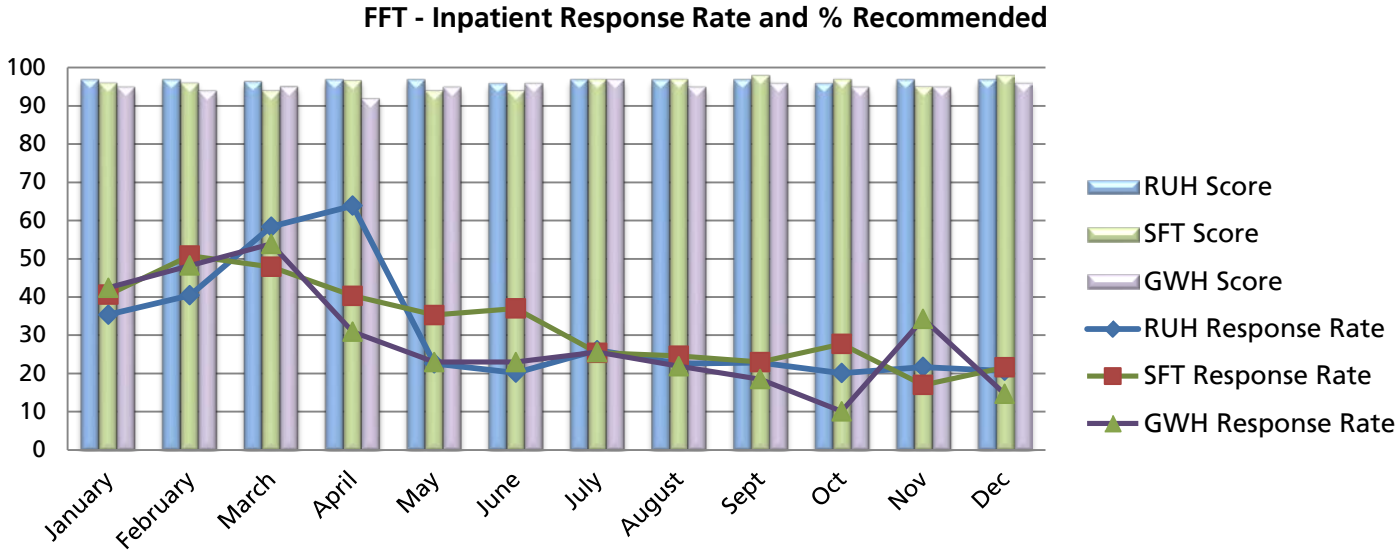
The NHS Friends and Family Test (FFT) is one of a range of tools available to CCGs to review patient experience within the services we commission. The FFT has been designed to add to, not replace, the current system of high level, comparable national surveys and local information derived from complaints, PALS, patient groups and individual surveys.

FFT guidance focused on making the FFT inclusive to all patient groups and provided expertise in developing and promoting methods to obtain feedback. The NHS Friends and Family Test has already provided local hospitals with feedback and is playing an active role in transforming the services. The table below shows the FFT response rates and recommended rates for A&E, inpatient and maternity services and illustrates the overall finding that the majority of patients surveyed reported a positive experience with an over 90% recommendation rate.

The overall response rate for all services is an area where ongoing improvements are needed and is recognised by our provider organisations.

Charts below include FFT data up to December 2015 as the latest available data when writing this report.





The CCG continues to monitor FFT and triangulate data with other key quality indicators such as complaints data. Improving response rates and recommended rates remains a priority.

Complaints Management

Principles for remedy

The Parliamentary and Health Service Ombudsman published revised Principles for Remedy in May 2010, setting out the following six principles that represent best practice.

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

The rich source of information that complaints and concerns data produces enables the CCG to review the themes and trends of complaints, and use this information to assess any commissioning gaps or improvements which need to be made to the services we commission. In October 2013 the Clwyd & Hart review of the NHS Hospitals complaints system, putting patients back in the picture was a humble reminder of the learning we can gain from actively managing complaints and speaking directly with families to listen to their stories along with other publications, such as 'My Expectations' have been developed by the Ombudsman and Healthwatch. This document is a user-led vision for raising concerns and complaints. The document defines what a good complaints process looks like and will be taken in to consideration when reviewing Complaints and PALS policies locally.

The Complaints and PALS team located within the CCG Quality Directorate, provide an effective link to performance and quality leads to help triangulate those themes and trends of concerns and complaints, back through the contract management process.

During 2015/16 the Complaints and PALS function undertook to review the CCG's Compliments, Concerns and Complaints Policy, as well as reviewing the CCG's complaints process. Work took place to embed the new process and policy within the CCG, and with external stakeholders such as provider organisations and MP offices. These documents are easily accessible on the CCG website.

A weekly status report on open complaints and the action being taken to close continues to be circulated to all CCG Executive Directors. In addition, a report regarding number of complaints, themes and trends is submitted to the Quality and Clinical Governance Committee. A quarterly complaints and PALS bulletin also is circulated to all CCG staff to ensure complaints and feedback regarding the services we commission is visible to all. As part of this, commissioning gaps and themes arising from complaints are discussed with relevant commissioners within the CCG, in order that discussions will take place with provider organisations.

NHS Wiltshire CCG for April – March 2015/16 – Formal Complaints

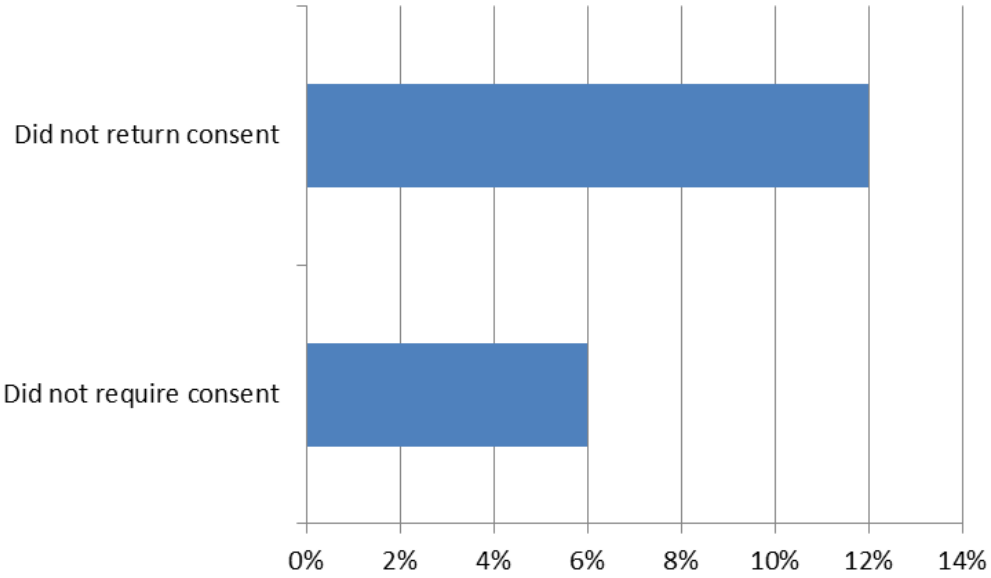
	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	Total
NHS Wiltshire Clinical Commissioning Group	21	23	18	12	74
Member of Parliament	3	0	4	3	10
Total	24	23	22	15	84

Between April 2015 and March 2016, 84 formal complaints were received by the CCG. Of these 84 complaints, 73% (61) have been closed. For those complaints received via an MP's office, 70% (7) have been closed.

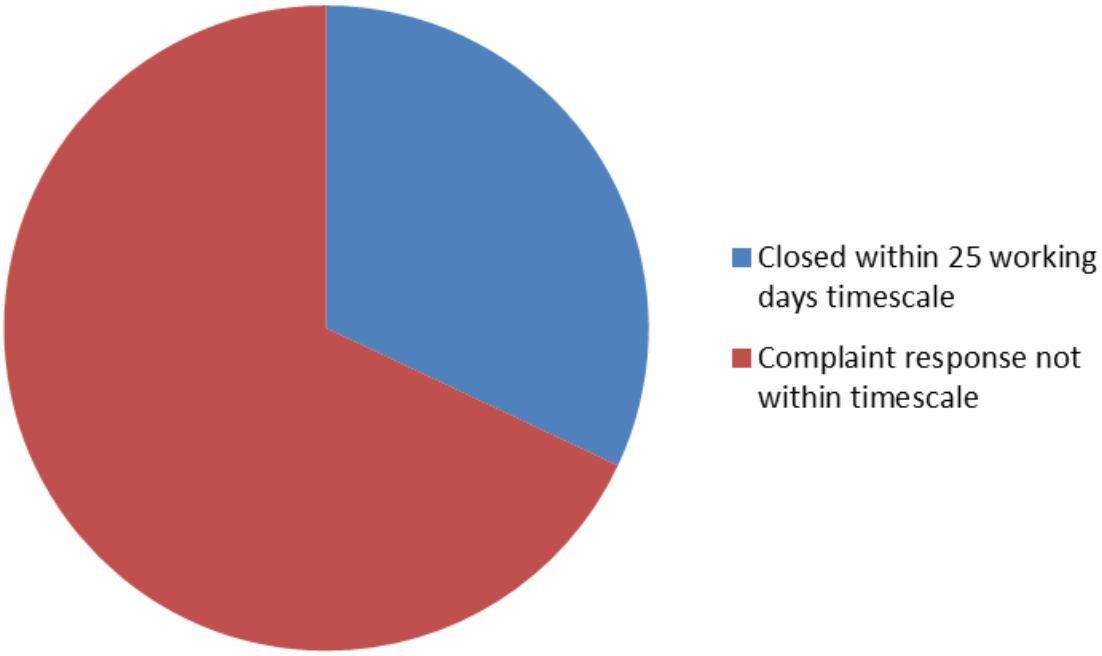
The Complaints and PALS Team aim to acknowledge all complaints within 3 working days. Performance in 2015/16 demonstrates that this was achieved in 95% of cases (80), Over the next 12 months, improving the performance around the 3 day working target is a key performance objective Complaints and PALS Department.

There is no set timescale for NHS Complaints (NHS Complaints Regulations 2009), however, the Complaints and PALS team adopt 25 days as a reasonable guide to investigate and provide a response to the complainant; the timescale begins on receipt of consent. Where a complaint received is complex in that it may require responses from a number of Organisations, the Complaints and PALS department may negotiate a longer response time, which is agreed with the complainant.

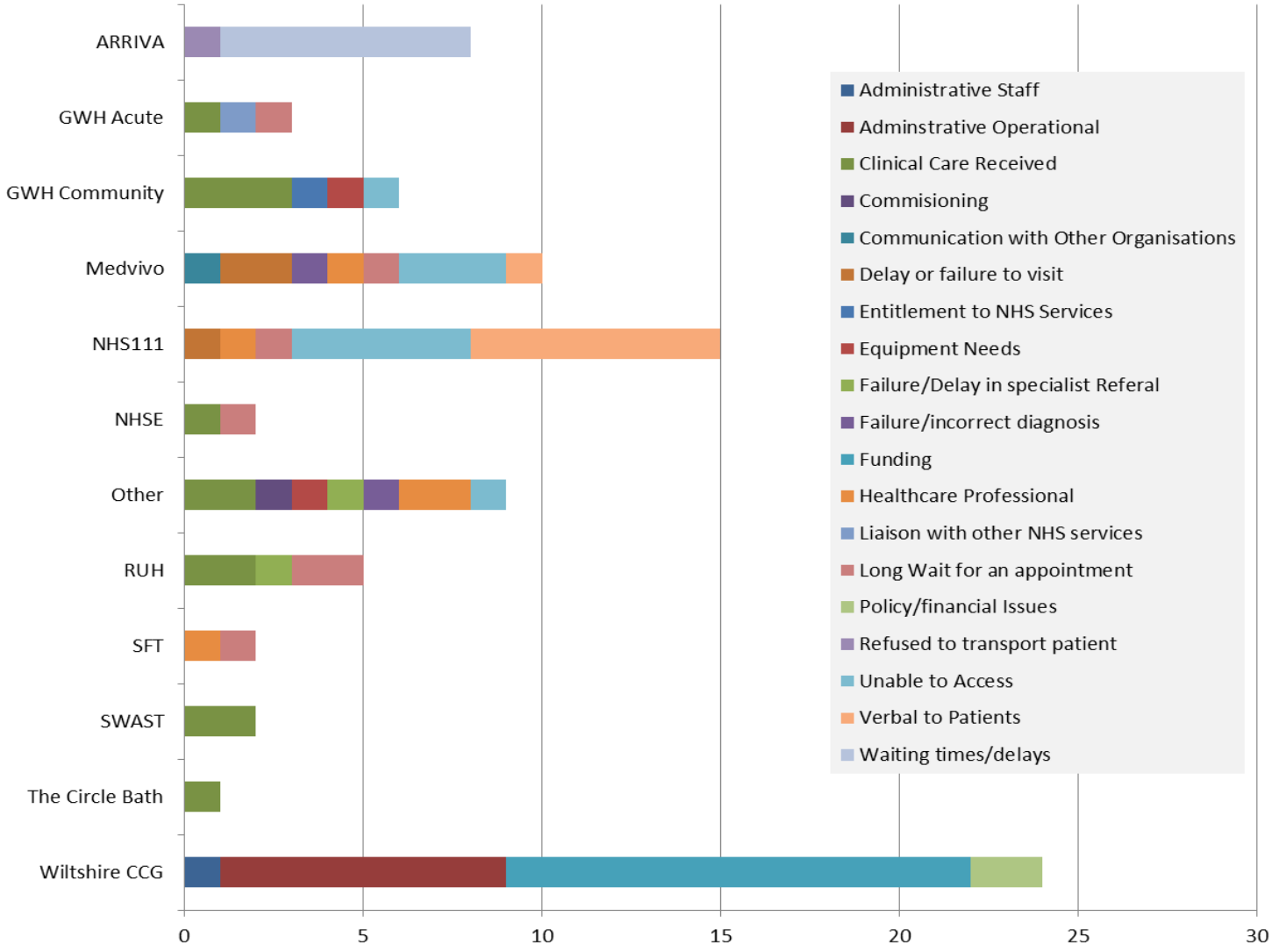
Of the 68 closed complaints, 18% (12) did not follow the full complaints process. 6% (4) of these cases are reported as not requiring consent and therefore would not have 'started the clock'. In 12% (8) of cases, the complainant failed to return the consent form despite a reminder letter.



The chart below identifies the complaints closed within 25 working days, and those which are not. Of all of the complaints received, 32% (18) were closed within the target of 25 working days. Over the next 12 months the CCG will continue to work with both internal and external stakeholders to improve complaint response times.



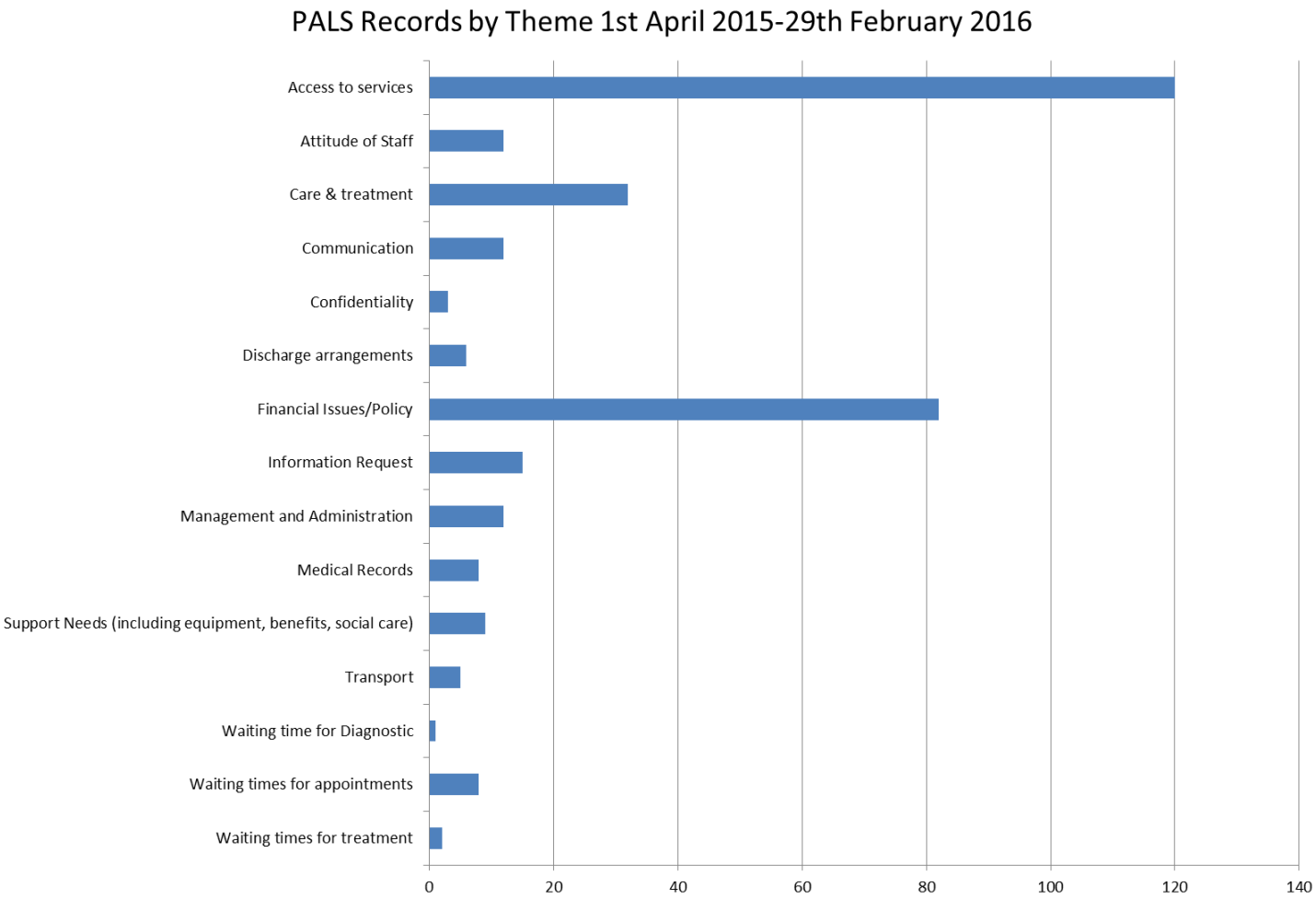
Complaints breakdown by Provider and Theme



	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	Total
NHS Wiltshire Clinical Commissioning Group	86	62	95	79	322
Member of Parliament	5	4	0	12	21
Total	91	66	95	91	343

Of the 327 PALS enquiries received between April 2015 and March 2016, 85% (277) have been closed to the satisfaction of the person making the enquiry. Of the remaining 21 open cases, 6 relate to MP office enquiries.

Patient Advice and Liaison Service (PALS) by Themes



The main themes captured through PALS relate to Information requests and access to services.

Patient safety

We continue to monitor improvements in patient safety through a variety of sources with a particular focus on local priorities and clinical risks. The publication of the revised Serious Incident Framework and Never Event List by NHS England in March 2015 aggregated a number of previously separate categories of reportable incidents and for some types of incidents, (for example, pressure ulcers), introduced the principle of aggregated investigations for multiple incidents.

The CCG has worked with providers to ensure that incidents continue to be appropriately identified and where relevant, has introduced alternative reporting mechanisms to ensure continued assurance for key areas. We have also used tools and systems available to us to ensure patient safety is as robustly and proactively monitored as possible, including the National Reporting and Learning System (NRLS) and the National Patient Safety Alerting System (NPSAS).

NHS England has published monthly data on their website showing providers compliance with the alerts and we have used this information as part of the Clinical Quality Review Meetings with contracted providers.

Management of Serious Incidents

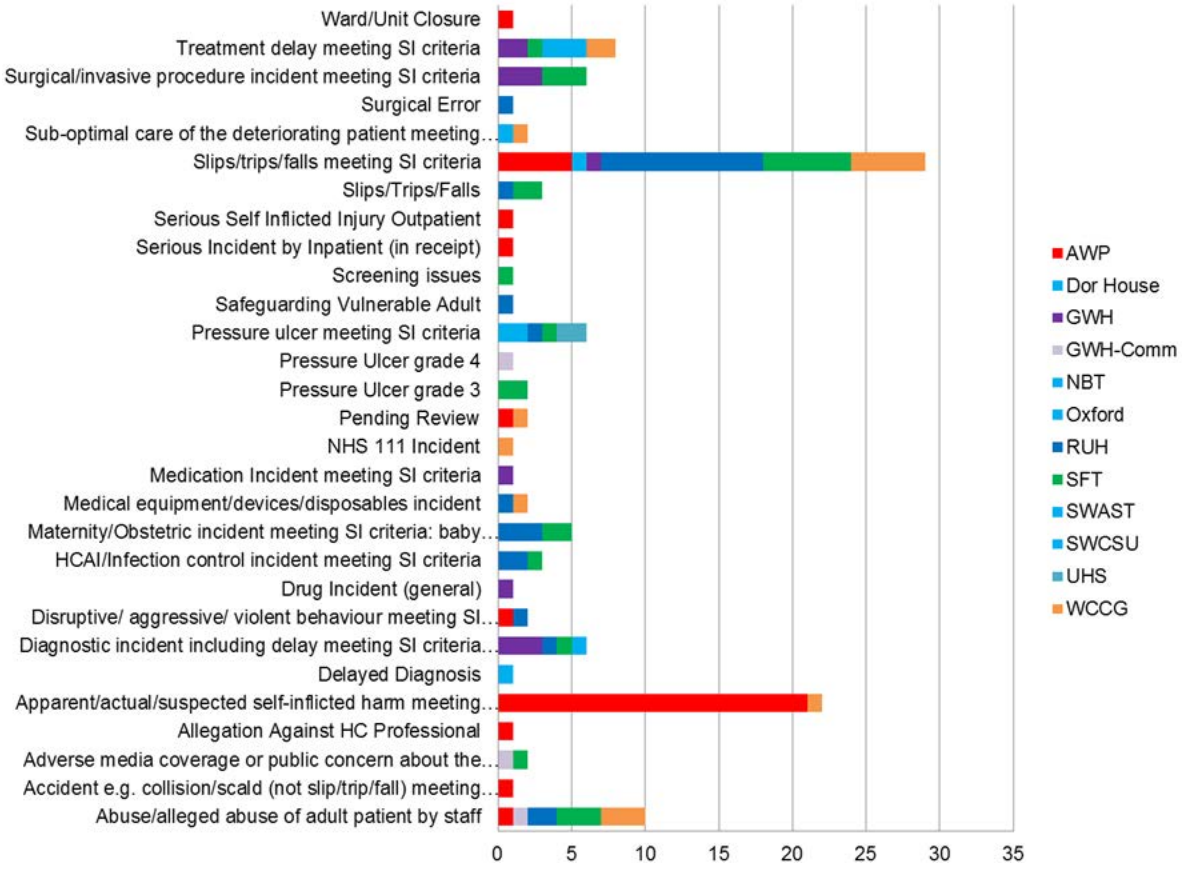
Serious Incidents (SIs) requiring investigation in healthcare are rare, but when they do occur, we have systematic measures in place to respond to them. Guidance is included in all provider contracts for the reporting of Serious Incidents, with the aim of ensuring that robust investigations are carried out, appropriate action is taken to protect patients, and learning from serious incidents is embedded in the provider organisation to minimise the risk of the incident happening again.

The responsibility for closing incidents sits with the CCG in whose commissioning area the patient to whom the incident occurred is registered with a GP. Therefore, NHS Wiltshire CGG has the responsibility to review and support closure of incidents for patients registered with a GP in Wiltshire. Furthermore, it is the CCG's role to hold providers to account for the quality of their investigations and implementation of actions to address organisational learning arising from serious incidents.

Following implementation of the revised framework, the CCG adjusted its internal processes to ensure compliance and is assured that providers have also reflected the revised framework within their processes. The CCG is currently reviewing its' SI Policy and process to ensure that amendments made following introduction of the revisions continue to deliver compliance against the framework.

Providers are required to notify the CCG of a Serious Incident within two working days. We oversee and hold providers accountable for their reporting and investigations processes, including adhering to timescales, deadlines and the implementation of actions and learning. We have established fortnightly Serious Incident (SI) Closure meetings to review the root cause analysis reports (RCAs) submitted by the providers. The SI closure meeting reviews the reports received from the providers and ensures that the root cause of the incident has been identified and that lessons have been learned and actions are in place to mitigate the risk of the incident occurring again. We give feedback to the provider requesting further information if necessary and support closure when assurance is received and continue to monitor closed incidents to ensure that the actions are completed.

The types of incidents that have been reported in 2015/16 are, falls resulting in a fracture, self-inflicted harm, treatment delays, surgical, diagnostic , grade 3 / 4 pressure ulcers, allegations against staff members and infection control. For 2015/16, the list of reported incidents by Providers is as detailed in the graph below:



Themes and Trends

(Please note, Due to changes in the categories in May 2015 under the new guidance, the above chart shows similar if not the same incident type with different wording for example 'Surgical Error' was prior to May 2105 and 'Surgical/invasive procedure incident meeting SI criteria' was post may 2015.)

Never Events

In March 2015 the revised 'Never Events Policy and Framework' was published by NHSE. The framework provides clarity for staff providing and commissioning NHS funded services who may be involved in identifying, investigating or managing Never Events.
The Framework defines Never Events as a particular type of serious incident that meet all the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not have to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- There is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
- Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

The Never Event list for 2015/16 has reduced from 14 to 25 this is due to the revision of the purpose and definition of a Never Event in the latest version of the Framework and that several of the Never Events have been merged for the purpose of simplification. It is anticipated that the Never Event list will be reviewed annually by NHS England.

CCGs are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis.

During 2015/16 there have been five Never Events involving Wiltshire patients: one has been fully investigated and four are still being investigated. The action plans following the root cause analysis will be monitored by the appropriate Contract Quality Review Meetings.

Provider	Category of Incident	No of Wiltshire Patient(s) involved in a Never Event for 2013/14	No of Wiltshire Patient(s) involved in a Never Event for 2014/15	No of Wiltshire Patient(s) involved in a Never Event for 2015/16 #
Great Western Hospitals NHS Foundation Trust	Surgical Error		1	1
	Retained Swabs	4		
	Diagnostic inc delay			1
Salisbury NHS Foundation Trust	Surgical Error		2	1
University Hospital Southampton	Surgical Error		1	

 # these figure are correct as of 1 April 2016

NHS Safety Thermometer

The NHS Safety Thermometer is a point prevalence tool to measure the incidence of harm occurring within inpatient healthcare providers. Harm Free care is captured monthly by providers and includes:

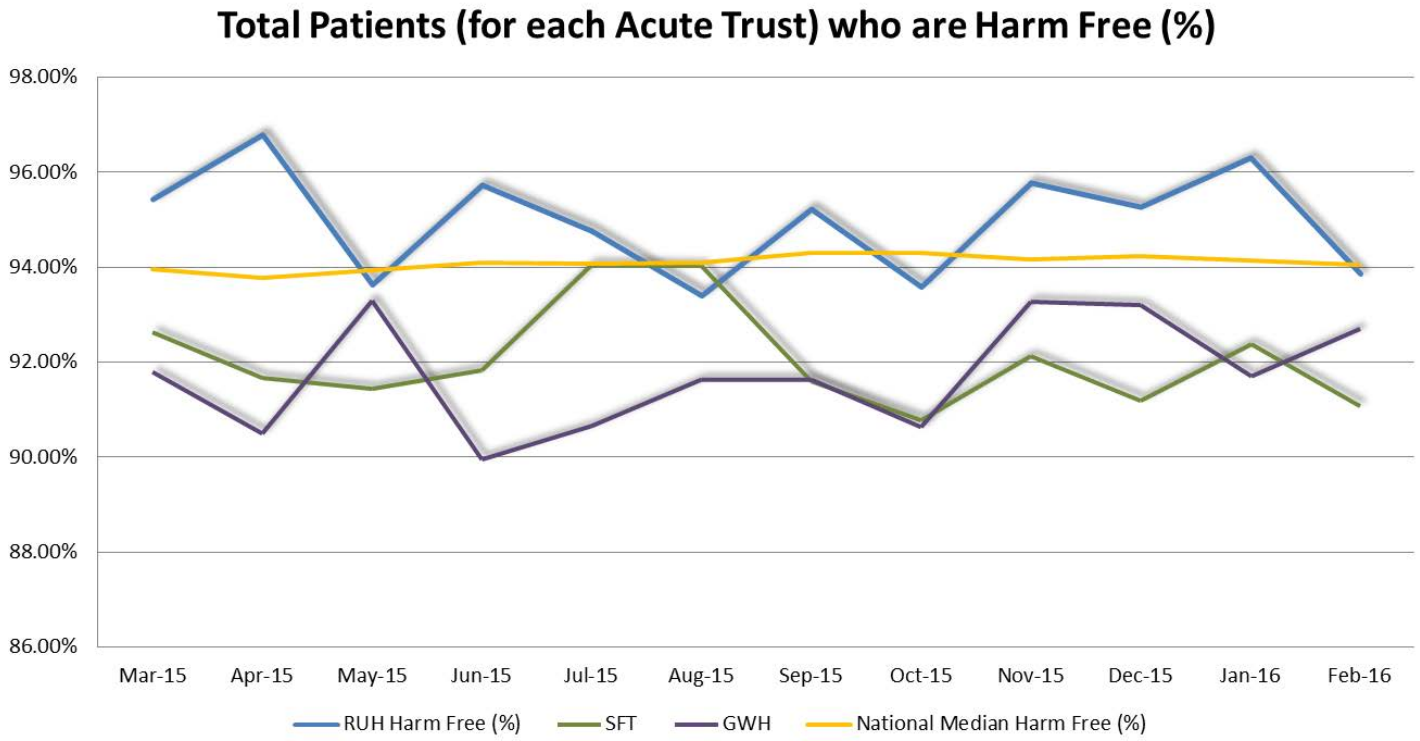
- Falls
- Pressure Ulcers
- Catheter Acquired Urinary Tract Infections (CAUTI)
- Venous Thromboembolism (VTE) (blood clots in limbs or chest)

These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400million. The programme supports the NHS to eliminate these four harms through one plan within and across organisations. It helps us in Wiltshire to consider complications from the patient's perspective, with the aim of every patient being 'harm free' as they move through the system. This moves away from the more usual approach of addressing these patient safety issues in silos.

The Safety Thermometer provides a 'temperature check' at any particular point in time and can be used alongside other measures of harm to measure progress. The table below shows the total number and % of patients who "received" harm by provider.

This data is gathered by the provider on a specific day each month. Data which is produced from this regarding harms should be triangulated against other sources of information and data regarding these key areas by the provider to establish if there are quality concerns requiring specific measures.

Pressure ulcers remain the most frequently reported harm across all three acute trusts. The table below shows the percentage of patients at each acute trust who received harm free care.



Health Care associated infections MRSA and Clostridium difficile 2014/15 targets set by PHE

The term Heath Care Associated Infection (HCAI) covers a wide range of infections. The most well-known include those caused by Methicillin-Resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile* (C. difficile). HCAIs pose a serious risk to patients, staff and visitors and can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

NHS England planning guidance for 2014/15, Everyone Counts: Planning for Patients 2014/15 to 2018/19 sets a zero tolerance approach to MRSA bloodstream infections. This means that each organisation is expected to achieve zero MRSA bloodstream infections.

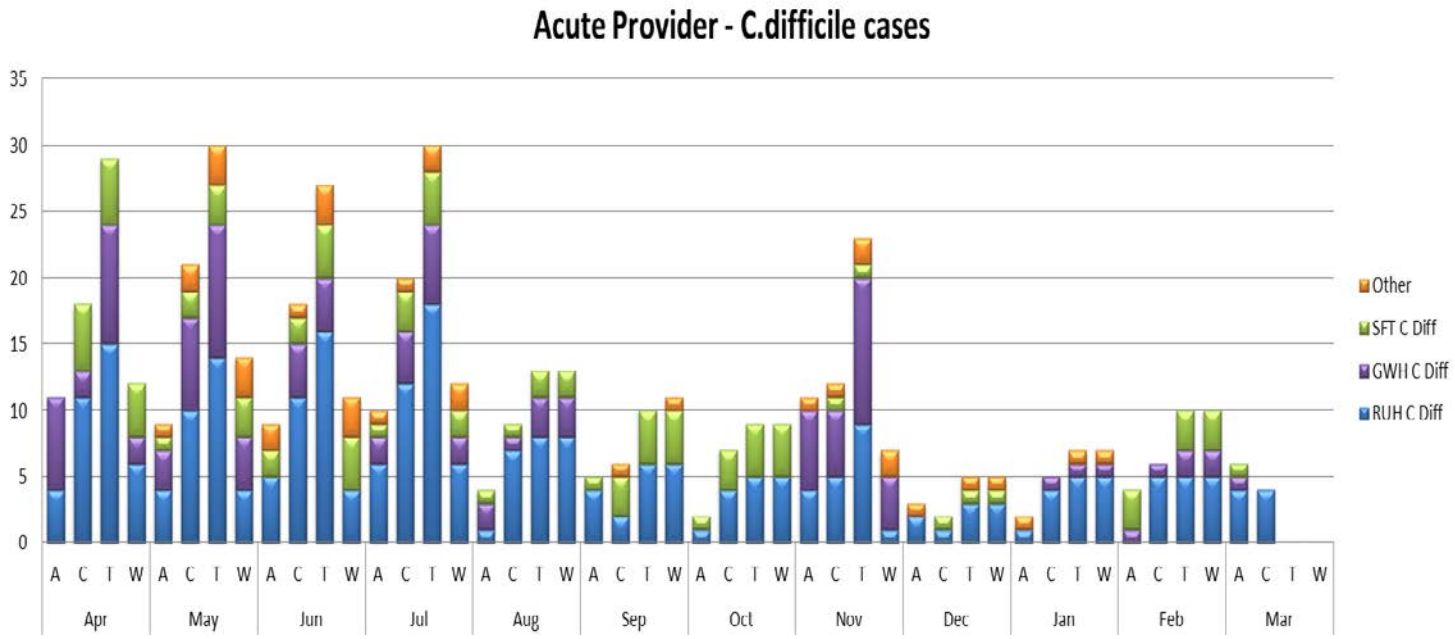
The NHS planning guidance explains that in the case of an MRSA bloodstream infection, a Post Infection Review must be undertaken to identify why an infection occurred and how future cases can be avoided. The Post Infection Review Guidance was updated in 2015 and re-published to help organisations conduct the reviews.

In March 2016 we received NHS England objectives for 2016/17 MRSA and *Clostridium difficile* ambitions. The targets for 16/17 remain at the same levels as for 2015/16. Alongside our local providers, we continue to strive to reduce HCAI.

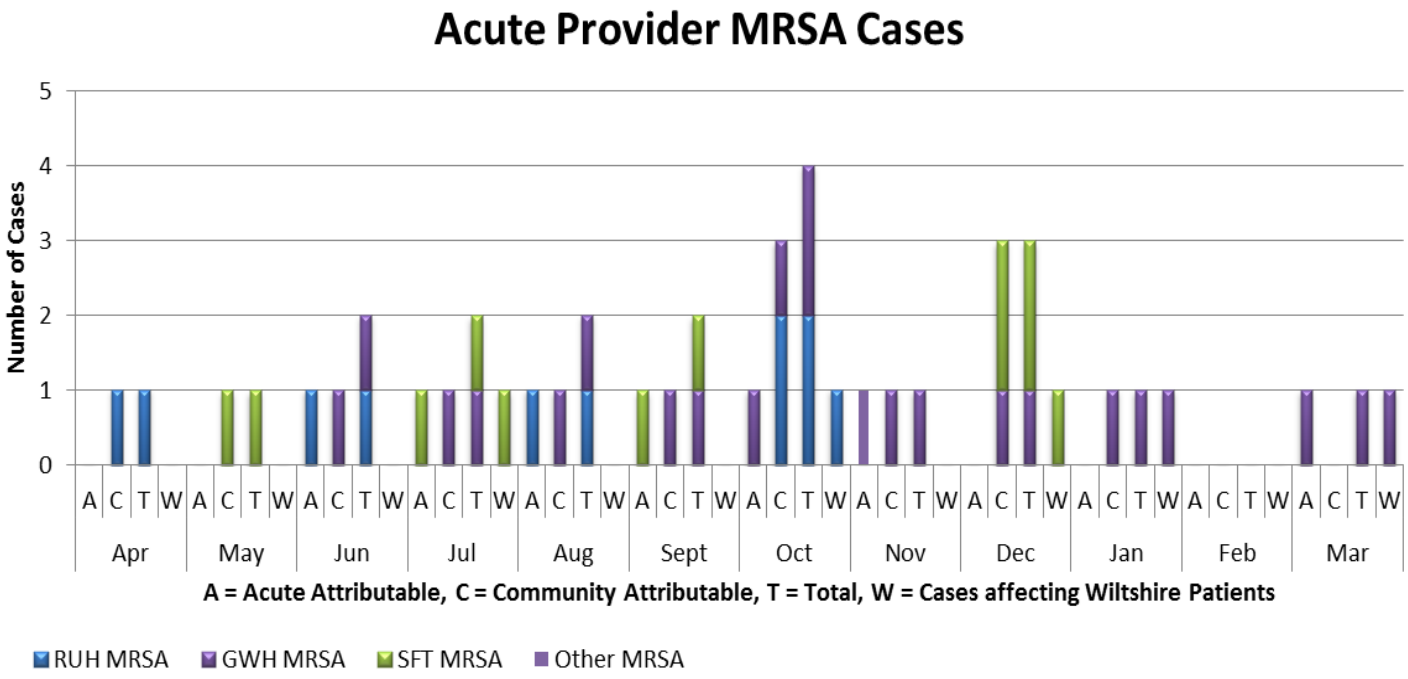
Provider	Clostridium *difficile*							
	2012/13 Target	2012/13 Actual	2013/14 Target	2013/14 Actual	2014/15 Target	2014/15 Actual	2015/16 Target	2015/16 Actual
SFT	25	25	21	21	18	23	19	10
RUH	31	27	29	37	37	29	22	18
GWH	21	30	20	23	28	19	20	14
Community Acquired							42	72
Total for Wiltshire (including 'out of area' cases)	139	160	127	133	140	106	103	128 (inc. 14 OOA)

In 2015/16 there were 128 cases of *c.Difficile* bacteraemia. The year-end threshold for 2015/16 was 103 cases. Although the threshold was breached, the number of cases is considerably fewer than previous forecast. This reduction in the upward trend has been positively influenced as a result of the CCG's recovery action plan which was implemented when it became apparent in September 2015 that c.diff cases were increasing.

The CCG undertook a range of critical friend visits to providers to offer support and advice. Whilst the acute Trusts were challenged in achieving their thresholds for 15/16, the predominant factor causing Wiltshire CCG's target to be breached is the rise in cases identified as community attributable. The action plan included work to address this.



During 2014/15 there were 3 cases of post 48 hour MRSA bacteraemia and 4 cases of pre 48 hour MRSA bacteraemia. In 2015/16 there have been 14 cases of pre 48 hour (Community Attributable) MRSA bacteraemia and 6 cases of post 48 hour (Acute Trust attributable) MRSA bacteraemia. Of these cases, only 5 were for Wiltshire patients, which represents an improvement of 2 cases from the previous year. The graph below displays the full detail for 15/16.



Mortality indicators

The Hospital Standardised Mortality Ratio (HSMR) is one of the most commonly used measures of overall mortality for trusts. It looks at those conditions which account for the vast majority of deaths in hospital (80%). The Summary Hospital-level Mortality indicator (SHMI) is for non-specialist acute trusts and covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital. NHS Choices publish against SHMI thresholds for NHS Trusts providing hospital care.

In March 2015, Dr. Foster Intelligence published mortality data for English Acute Trusts in February 2015 and in March 2016 published mortality statistics relating to the annual period July 2014 to June 2015. Although quarterly updates are available, full statistics are published six months after the period ends to allow time for capture of data relating to post-discharge deaths and to carry out complex analysis. After reviewing this data in conjunction with the providers' own mortality reports, it was confirmed that GWH and RUH are evidenced as performing at or better than expected rates for both mortality indicators for the period of data published. Since October 2015, SFT has flagged in some mortality indicators at higher than expected levels and clinical input from the CCG, has been participating in the working group set up by the Trust to address identified issues.

The chart illustrates provider mortality benchmarking over the previous four years:

Indicator (July to June - 12 months)	2011/12	2012/13	2013/14	2014/15	Trend	Performance
Royal United Hospitals						
SHMI Overall Trust Mortality ratio	95.9	101.1	95.06	97.02		
SHMI by Acute Hospital Site	95.9	101.1	95.08	96.97		
HSMR Overall Trust Mortality Ratio	99.4	100.1	94.22	104.5		
HSMR; by Acute Hospital Site	99	100.1	94.26	104.8		
Deaths in Low Risk Conditions	1.4	1.32	0.67	0.94		
HSMR Weekday	Data Not Available		98.34	104.2		
HSMR Weekend			105.5	106.9		
Great Western Hospitals						
SHMI Overall Trust Mortality ratio	102	96.42	97.67	92.18		
SHMI by Acute Hospital Site	103	99.81	100.1	94.38		
HSMR Overall Trust Mortality Ratio	103	99.31	100.1	86.4		
HSMR; by Acute Hospital Site	104	101.1	99.27	87.13		
Deaths in Low Risk Conditions	0.7	0.67	0.46	0.77		
HSMR Weekday	Data Not Available		103.4	83.38		
HSMR Weekend			114.8	97.17		
Salisbury Foundation Trust						
SHMI Overall Trust Mortality ratio	108	105.8	101	108.6		
SHMI by Acute Hospital Site	104	101.2	97.08	104.5		
HSMR Overall Trust Mortality Ratio	105	114.8	100.4	109.4		
HSMR; by Acute Hospital Site	103	111.4	97.67	106.1		
Deaths in Low Risk Conditions	0.4	0.74	0.87	0.69		
HSMR Weekday	Data Not Available		106.7	107.6		
HSMR Weekend			116.5	111.2		

In 2016, NHS England announced its intention to review the way in which clinical mortality reviews are carried out and to bring about national standardisation this process. A 'league table' of provider performance against mortality indicators will also be developed. The CCG will participate in this work in conjunction with providers.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking up to 2.5% of providers' income to the achievement of quality improvement goals. The guidance on the national CQUIN goals for 2015/16 is set out in Commissioning for Quality and Innovation (CQUIN) Guidance for 2015/16. For the acute and mental health trusts, there were a range of nationally mandated CQUIN goals for 15/16 in addition to several local schemes agreed by the CCG that aligned to local quality concerns or improvement priorities.

CQUIN schemes were also agreed with NHS 111, patient transport, the ambulance service, private hospital providers and hospice services.

The nationally mandated CQUINs sought to incentivise quality and efficiency and support the Five Year Forward View by rewarding transformation across care pathways that cut across different providers.

The CCG has continued to assess CQUIN achievement against the criteria set out in the CQUIN schemes and to set jointly agreed stretch targets.

Some of the outcomes from the CQUIN schemes for 15/16 have been an improvement in the recognition and treatment of Sepsis and of Acute Kidney Injury in acute trusts. CQUINs have also supported work to:

- reduce the number of admissions from the Emergency Department
- increase the number of mothers who chose to breast feed their babies
- reduce stillbirths
- make improvements for children transitioning into adult services
- deliver enhanced training to paramedics to avoid attendances to the Emergency Department
- improved the parity of treatment for physical health issues for people with mental health conditions

CQUINs have also focussed on improved transparency of incident reporting and learning in private providers.

The Clinical Advisory Group (CAG)

The Clinical Advisory Group (CAG) ensures that the CCG has an assurance process in place to support the decision making for health care interventions that may be commissioned for the local population, and to enable their prioritisation in a climate where resources are limited.

Meeting bi-monthly, the CAG is a sub-committee of the Quality and Clinical Governance Committee (QCGC) and is responsible for the clinical decision making process within the CCG and provides a forum for the assessment, forward planning and review of NICE technical and clinical guidance. The CAG encourages partnership working with providers of health care to deliver evidence-based, high quality health outcomes for the population of Wiltshire when planning and commissioning future services.

During 15/16, membership of the CAG and its terms of reference have been strengthened. The group is chaired by the CCG medical lead with regular attendance by medical representatives from primary and secondary care. The group has advised on policies for Exceptions and Prior Approvals, and Medicines Management prior to decision making by the QCGC which has led to the publication of improved information to support public and primary care decision making.

Previously identified as an exemplar in the review and consideration of NICE guidance in commissioning activity by Sir Andrew Dillon, Chief Executive of NICE, Wiltshire CCG has strengthened its' Commissioning Policy for NICE Guidance. In 16/17, the CCG intends to work collaboratively with providers and neighbouring commissioners to prioritise implementation of guidance which is supportive of strategic objectives.

The CAG has revised the monitoring process for thorough reviews of provider audits and NICE compliance statements. This further strengthens assurance across Wiltshire and enables triangulation of information to facilitate identification of targeted audits. To gain assurance, these audits of NICE guidance or care pathways will be carried out to address concerns arising at an individual provider level, and across multiple providers where the issue is identified as affecting patients Wiltshire-wide. Where appropriate, pathways will be audited across primary, community and secondary care.

The CAG will then make recommendations and share learning within the CCG and with the providers as appropriate to ensure that commissioning intelligence is shared and that quality improvement plans are put in place and monitored accordingly.

Safeguarding Children and Adults

NHS Wiltshire CCG has a statutory responsibility to have robust governance arrangements in place that ensure that the organisations from which we commission services provide a safe effective system that safeguards children and adults at risk of abuse or neglect.

In 2015/16 NHS Wiltshire has further strengthened the contractual standards and reporting mechanisms that monitor the safeguarding arrangements of providers. Evidence of continuous improvement and compliance in safeguarding outcomes for commissioned services are achieved through the use of specific contractual arrangements and metrics with provider organisations. This includes having in place:

- Key Performance Indicators (KPIs)
- quality schedules
- systems to embed learning from Serious Case Review
- incidents and complaints
- comprehensive single and multiagency safeguarding policies
- procedures to seek assurance that the health providers have effective and appropriate systems in place in their organisations for discharging their responsibilities in respect of safeguarding, including:
    - Safeguarding training and supervision strategy and framework
    - Recognising and reporting safeguarding issues.
    - A clear line of accountability for safeguarding within each organisation.
    - Ensuring effective arrangements for information sharing.
    - Securing the expertise of named doctors and nurses for safeguarding children and a paediatrician for unexpected deaths in childhood.
    - Having a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

NHS Wiltshire CCG are represented at a senior level by the Director of Quality and designated safeguarding professionals on the Local Safeguarding Children Board (LSCB) and are fully engaged and represented at a senior level on local Safeguarding Adults Board (SAB), working in partnership with local authorities to fulfil their safeguarding responsibilities. The CCG membership extends to the core business conducted through the safeguarding board sub groups.

NHS Wiltshire CCG works with the Safeguarding Boards, statutory agencies and its provider organisations to ensure the effectiveness of multi-agency arrangements to safeguard and promote the wellbeing of children, young people and adults at risk from harm or abuse.

Deprivation of Liberty Safeguards (DoLS)

In March 2014, the Supreme Court handed down a judgment regarding Deprivation of Liberty Safeguards (DoLS). DoLS is a statutory framework which allows health and/or social care to be delivered to someone who may lack capacity to consent to arrangements made to provide their care or treatment. The criteria for DoLS has been clarified by the Judgement, however, the threshold has been significantly lowered which has led to a 10 fold increase in applications. Since this law came into effect, the Local Authority, NHS Wiltshire CCG and its providers have been scoping the impact of the ruling and reviewing all relevant resources and processes.

Following this ruling, people in receipt of health or social care in their own homes may be considered to be deprived of their liberty, however, the normal DoLS framework does not apply to these individuals and instead, it is necessary to make an application to legally deprive someone of their liberty through the Court of Protection. CCGs are now considered responsible for the administration and resourcing of all applications made to the Court of Protection on behalf of health funded patients in settings outside of hospitals and care homes. No clear guidance to this affect has yet been published, however, NHS Wiltshire CCG has commenced work to scope and review all patients who may now require Court of Protection applications. The majority of this group are those who are in receipt of Continuing Healthcare funding. Following this work, a process to administer these applications will be developed during 2016/17.

Prevent

Prevent is part of the Government's counter-terrorism strategy *CONTEST*, which is led by the Home Office. The Department of Health and the health sector are considered to be key partners in working to protect vulnerable individuals from being drawn into terrorist-related activities. The health sector is required, by the *Prevent* agenda to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals at risk of radicalisation and by making safety a shared endeavour.

Prevent has been included in the NHS Standard Contract since 2014/15 and includes requirements for provider and CCGs to develop Prevent policies and procedures and a WRAP training delivery plan. WRAP is the nationally accredited training programme used to deliver the *Prevent* strategy. The Counter-Terrorism and Security Act which came into force 1 July 2015 has made the *Prevent* programme statutory.

During 2015/16, NHS Wiltshire CCG has developed a draft *Prevent* policy and distributed awareness raising information to all CCG employees. The CCG is also working with providers to establish a trajectory for achieving compliance with their statutory duty to deliver both *Prevent* awareness and WRAP training.

Sustainability Report

Background

As our world is impacted upon by business and agriculture choices and by peoples' lifestyles, sustainability becomes increasingly important. As part of the 2013 authorisation process, CCGs have self-certified compliance to the statement:

"*We declare that at the point of authorisation our CCG will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner*".

NHS Wiltshire CCG acknowledges the responsibility to our patients, local communities and the environment to take steps to lessen our impact and the impact of the decisions we make and the contracts we put in place for healthcare. We will strive to minimise our carbon footprint and adhere to Sustainable Development principles.

Sustainability Planning

NHS Wiltshire CCG is one of three tenants in Southgate House in Devizes. This property is owned by NHS Property Services who manage waste collection, energy usage and water usage. NHS Wiltshire CCG has worked with NHS Property Services to establish an appropriate method to apportion waste and utility usage between the tenants on the basis of percentage occupancy.

As Southgate House is an old building, the CCG and NHS Property Services have discussed where some capital investment may be made on sustainability projects to improve the facility. We intend to continue to work on a Sustainability Site Plan during 2016/17, in association with NHS Property Services and the other tenants, to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

NHS Wiltshire CCG is also considering how our day-to-day operations can have a stronger focus on sustainability. We already have central waste arrangements, rather than waste bins at each desk, with both confidential and non-confidential paper waste being collected by a shredding contractor for recycling. In 2015, 182 trees were saved (347 in 2014).

During 2015/16, NHS Property Services has replaced the hot water boiler with a more energy efficient model. Southgate House benefits from a shower facility and staff are encouraged to cycle to work. The CCG has access to and regularly uses telephone conferencing equipment to reduce the need to travel to meetings and now has access to limited video conferencing facilities. Staff are expected to use centralised printing facilities which are energy and ink efficient.

The CCG will be looking at further operational initiatives for sustainability during 2016/17 and working with NHS Property Services, we will ensure that the CCG meets its obligations under the Climate Change Act 2008 and the Public Services (Social Value) Act 2012 and demonstrate our commitment as a socially responsible employer.

The largest impact that the CCG can make is through sustainable commissioning. The CCG is committed to commissioning health care to be provided in a way that supports the UK sustainable development agenda and contributes to environmental improvements, regeneration and reducing health inequalities.

As part of the NHS Wiltshire CCG Five Year Strategic Plan (2014 – 2019), we aspire to create a model within which, when care is needed it can be delivered closer to home, creating a system built around individuals and local communities. Key to achieving this is multi-disciplinary teams based in small community based clusters to provide integrated and accessible care. Current services are being redesigned so that investment can be freed up to develop the necessary infrastructure and services out of hospital to deliver this localised healthcare vision.

Sustainability Policy

NHS Wiltshire CCG is determining its vision for sustainability and its responsibilities for delivery, working with NHS Property Services and our partners in the delivery of healthcare for the growing population of Wiltshire. The Policy will consider commissioning, general operations and travel and actions will be reflected in a Sustainable Development Management Plan (SDMP).

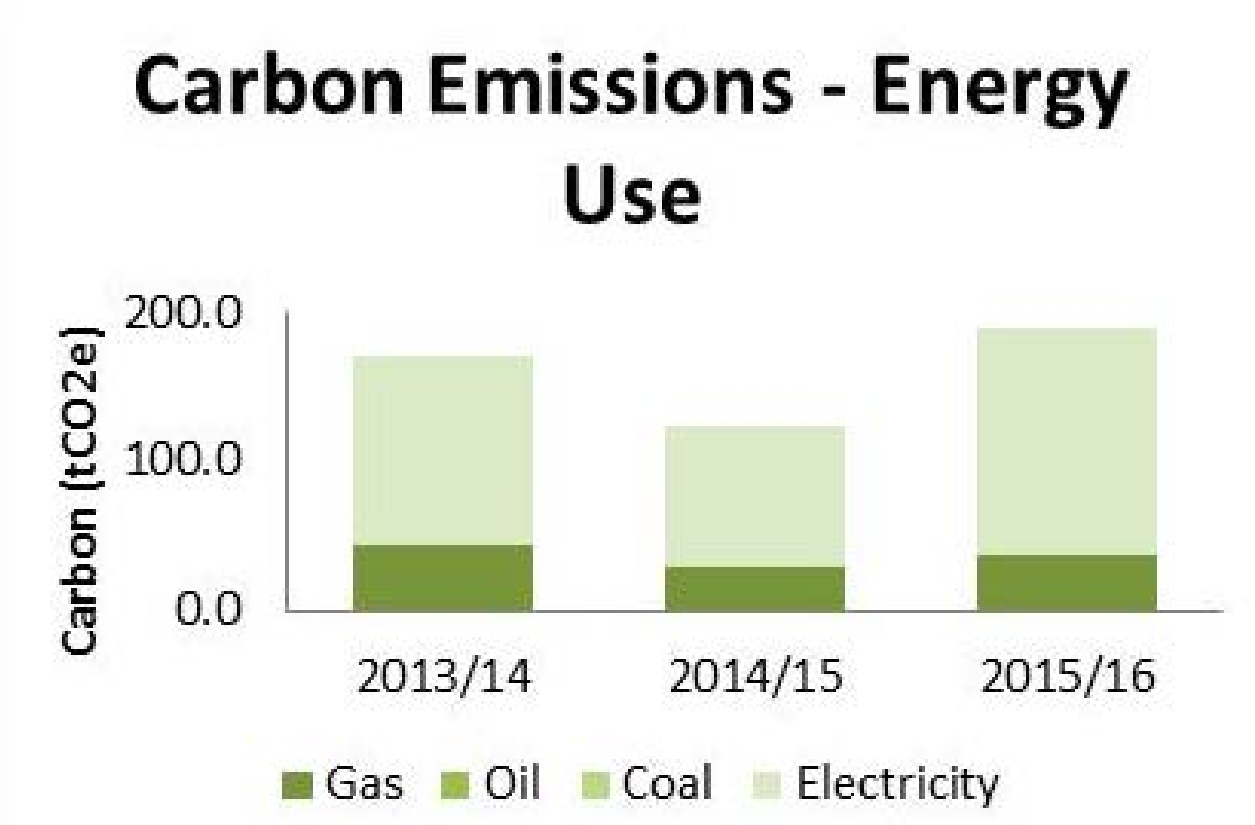
Performance and progress

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions by 10% using 2007 as the baseline year. Here's how we have done:

Energy

NHS Wiltshire CCG has spent £37,404 on energy in 2015/16 which is a 35.1% increase on 2014/15.

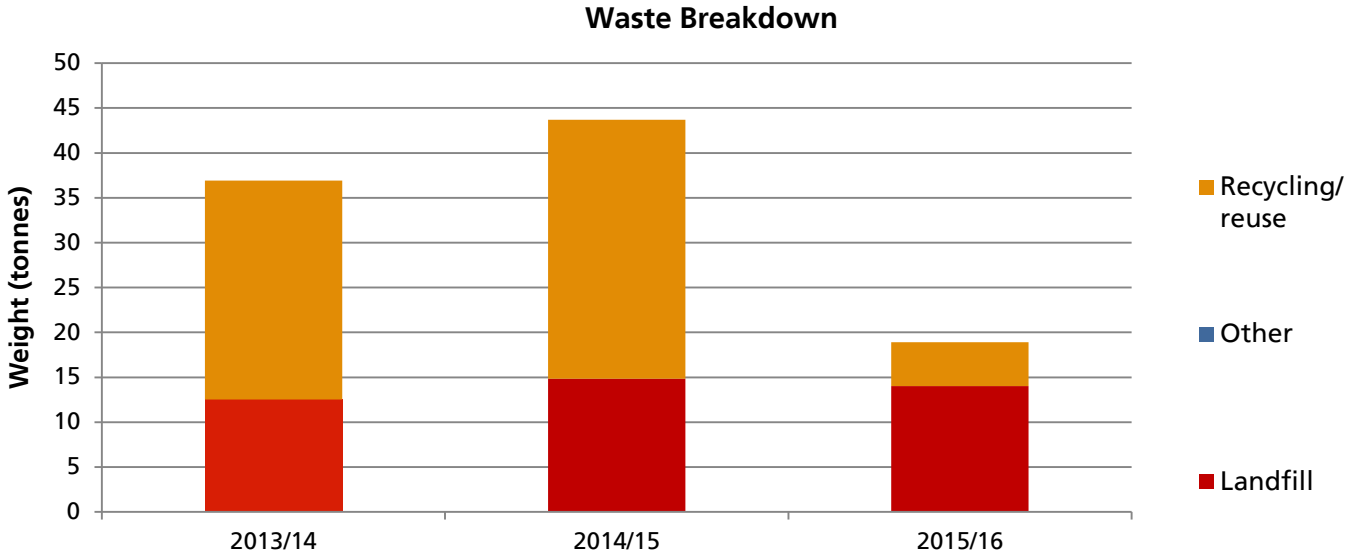
Resource		2013/14	2014/15	2015/16
Gas	Use (kWh)	202,066	138,402	175,145
	$tC0_2e$	42.9	29.0	36.7
Oil	Use (kWh)	0	0	0
	$tC0_2e$	0	0	0
Coal	Use (kWh)	0	0	0
	$tC0_2e$	0	0	0
Electricity	Use (kWh)	228,150	153,840	266,523
	$tC0_2e$	127.7	95.3	153.2
Total energy $C0_2e$		170.6	124.3	190.0
Total energy spend (£)		27,684	34,834	37,404



Waste

All of the CCG waste is office type waste. The amount of waste sent to landfill in 2015/16 is consistent with the previous two years. The data appears to show an overall reduction in waste with a large reduction in the amount of waste sent for recycling. As our waste recycling is managed by NHS Property Services we will be investigating this figure with them.

Waste		2013/14	2014/15	2015/16
Recycling/ reuse	(tonnes)	24	29	5
	tCO_2e	0.512295	0.605829	0.10206
Other	(tonnes)	0	0	0
	tCO_2e	0	0	0
Landfill	(tonnes)	13	15	14
	tCO_2e	3.065732	3.625449	3.432114
Total Waste (tonnes)		36.938	43.682	18.902
% Recycled or Re-used		0.660431	0.660432	0.257116
Total Waste tCO_2e		3.578027	4.231278	3.534174



Water

The water usage for NHS Wiltshire CCG has decreased by approximately 30% in 2015/16. The CCG needs to investigate the reasons behind this decrease as there is likely to be a timing issue between 2014/15 and 2015/16 rather than an actual decrease with actual usage being broadly similar in each year.

Water		2013/14	2014/15	2015/16
Mains	m^3	756	929	650
	tCO_2e	1	1	1
Water & Sewage Spend		£ 3,259	£ 4,004	£ 2,456

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff, through our providers and to the patients and public that use the services we commission. We support a culture for active travel to improve staff wellbeing and reduce sickness.

The CCG is encouraging staff to travel less for business and has seen a corresponding reduction in miles during 2015/16.

Category		2013/14	2014/15	2015/16
Business Travel	km	234,249	264927.4	184660.4
	tCO_2e	7	10	5
Staff commute	km	150,787	172699.6	160316.5
	tCO_2e	35	39.42906	36.02472

Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

Of our main providers Great Western Hospitals NHS Foundation Trust retained their score of 'Good' for sustainable development based on their 2014/15 return. Salisbury NHS Foundation Trust managed to improve their score to 'Excellent' but Royal United Hospital NHS Foundation Trust, Bath saw a decline in their score of 'Good' and Avon & Wiltshire Mental Health Partnership NHS Trust saw a decline to 'Poor'.

External Audit

The cost of work performed by our external auditors, KPMG, in 2015/16 was £67,500 plus VAT.

Disclosure of "serious untoward incidents"

The CCG has not had any data losses or confidentiality breaches that have been categorised as Serious Untoward Incidents.

Setting of charges for information

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

Emergency preparedness and response

We certify that NHS Wiltshire Clinical Commissioning Group has an Accountable Emergency Officer and complies with NHS England Core Standards for EPRR 2015. In September 2015, the CCG provided assurance to NHS England about our compliance with the EPRR Framework.

As part of this assurance we identified how we would address any gaps in our operational management arrangements which we had identified. As part of the assurance process we also provided valuable support to NHS England and were actively involved in the assurance of healthcare providers.

The CCG remains an active contributor to the EPRR agenda through its involvement in the Wiltshire and Swindon Local Health Resilience Partnership and has been involved in exercises to test the inter-operability of LHRP plans between partner organisations.

Equality Report

Understanding the demographic profile of Wiltshire

The population of Wiltshire based on 2015 data is approximately 485,770 people. There are 106 self-declared ethnicities in Wiltshire. The Black and Minority Ethnic (BME) population make up 4.7% of this population within which the Moroccan community is considered to be the largest outside London. There are also significant African-Caribbean, Polish, Slovakian, Chinese, Bangladeshi, Filipino, Indian and Pakistani communities in Wiltshire. There is recognised large gypsy and traveller population. For 97.5% of Wiltshire residents the main language is English with Polish as the main language spoken after English.

The majority of Wiltshire's residents reported that they were Christian (64%) or had no religion (26%). The largest other religions are Muslim (0.4%) and Buddhism (0.3%).

Wiltshire has a near equal population split between males and females with children (0-15 years) being approximately 18% of the population and the older population (65 years plus) being over 20% of the population.

Using the nationally established statistic that 5-7% of the population is lesbian, gay or bisexual, approximately 23,850 Wiltshire residents are expected to have these sexual orientations.

The Gender Identity Research and Education Society (GIRES) criteria suggests that approximately 3,200 people within Wiltshire would experience some degree of gender variance, the majority of which would continue to live in their birth gender.

Our decision making processes

We are committed to ensuring that the organisation values diversity and promotes equality and inclusivity in all aspects of our business. Individual members of the Governing Body will bring different perspectives, drawn from their different professions, roles, backgrounds and experience, and ensure that we consider the full impact of the decisions made.

We conduct and publish Equality Impact Assessments (EIAs) on all policies and proposals for approval, critically assessing the impact on protected groups and identifying opportunities to promote equality at the start of projects and programmes.

The Governing Body holds meetings in public in various premises around Wiltshire and we ensure that these premises are accessible to the disabled.

Promoting the Public Sector Equality Duty (PSED)

We have an Equality & Diversity Strategy in place and carry out Equality Impact Assessments on all policies and decisions presented to the Governing Body. We engage with and consult the public on our plans and major commissioning decisions. We hold healthcare providers to account with regard to the Public Sector Equality Duties. All our staff are required to undertake Equality and Diversity training.

We have an Equality and Diversity Strategy which has identified the following equality objectives for our first four years of operation:

- To improve the quality of information available about prevalence of health conditions in different communities with specific protected characteristics;
- To embed equality and diversity considerations into communications, engagement and consultation;
- To actively identify key services issues for service users to support specific actions to be implemented based on evidence to improve service user outcomes;
- To focus on developing our leadership and capacity to ensure that we continue to comply with the PSED and use EDS to improve performance and ongoing compliance.

We work closely with Wiltshire Council to determine the demographics of our shared population and the health needs and health inequalities therein. We are also strongly engaged with Healthwatch Wiltshire to support our consultation and engagement with the public, ensuring that a voice is given to the public throughout the decision making processes and that harder to reach populations are considered and included. We have a Communications and Engagement Strategy in place that clearly recognises the value of interaction with different communities with specific protected characteristics and this is reflected in our CCG Constitution.

We hold healthcare service providers to account to ensure that they comply with the Equality Act 2010 and associated PSED. We hold regular quality review meetings with providers which include the discussion of survey information showing patients' experience of treatment and care outcomes and results of the Friends and Family Test (FFT).

These meetings also consider the report from the Patient Advice & Liaison Service (PALS) as the impartial service looking into concerns, problems and complaints in regard to patients' care and treatment. We also require providers to meet the legislative requirements as part of the procurement process for new or revised contracts.

The CCG Workforce

Information is collected regarding our workforce with reference to the protected characteristics. As at 31 March 2016 we had 123 staff. The majority of workforce within the CCG is female (76.4%) and the majority of the workforce has declared an ethnic group of 'White-British' (96.5%). 16.3% of the workforce of the CCG are aged 60 years and over. Although we are monitoring the staff information, the PSED exempts us from publication of detailed information as we have fewer than 150 staff.

We have in place a number of workforce related policies that support and protect staff from discrimination, harassment, bullying and victimisation. We require all staff to undertake mandatory Equality and Diversity training.

Delivering equality

We recognise that inequality exists, that it can be difficult to identify and fully consider the impact that some decisions may have on different communities with specific protected characteristics and that there may be barriers to equality. However, we will strive to critically assess our operations on an ongoing basis to tackle these issues.

The CCG has self-assessed against the NHS Equality Delivery System (EDS2), with the assistance of our stakeholders, to inform plans to continue to improve the imbedding of equality and diversity processes into everything we do. The assessment has found that, for our CCG, evidence shows that the majority of people in six to eight protected groups fare as well as people overall. In this we are achieving our duties.

Breakdown of number of employees of each gender who were on the Governing Body and details of numbers of each gender employed as a Very Senior Manager (VSM)

	Female Headcount	Male Headcount	Total
Governing Body	5	8	13
Very Senior Manager(VSM)	0	0	0
All other Employees	89	21	110
Total Employees	94	29	123

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 our potential or current employees with any of protected characteristics specified in the Equality Act 2010 and to support our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

The CCG publishes their employee profile by each of the nine protected characteristics, this helps the organisation to identify and address areas of under-representation in a systematic manner as and when opportunities arise.

We certify that we have complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

Deborah Fielding
Accountable Officer
May 2016

Accountability report

Corporate Governance Report
Members' Report
Member Practices
North and East Wiltshire (NEW)

- Beversbrook Medical Centre - Calne
- Box Surgery
- Cricklade Surgery, also Ashton Keynes Surgery
- Hathaway Medical Centre - Chippenham
- Malmesbury Primary Care Centre
- New Court Surgery – Wotton Bassett
- Northlands Surgery - Calne
- Old School House Surgery – Great Bedwyn
- Patford House Partnership, also Sutton Benger Surgery - Calne
- Pewsey Surgery
- Purton Surgery, also Green Gable Surgery, Cricklade
- Ramsbury Surgery, also Wanborough Surgery
- Rowden Medical Partnership - Chippenham
- The Lodge Surgery - Chippenham
- The Marlborough Medical Practice
- The Porch Surgery - Corsham
- The Sprays Surgery - Burbage
- The Tolsey Surgery - Sherston
- Tinkers Lane Surgery – Wotton Bassett

Sarum

- Avon Valley Practice - Upavon
- Barcroft Medical Practice - Amesbury
- Cross Plains Surgery - Shrewton
- Downton Surgery
- Endless Street Surgery - Salisbury
- Harcourt Medical Centre - Salisbury
- Hindon Surgery
- Mere Surgery
- Orchard Partnership - Wilton:
    - Cherry Orchard
    - Old Orchard
    - Spring Orchard
    - Till Orchard
- Silton Surgery
- Sixpenny Handley - Salisbury & Chalke Valley Surgery – Broad Chalke
- St Ann Street Surgery - Salisbury
- The Bourne Valley Practice - Ludgershall
- The Castle Practice - Tidworth
- Three Swans Surgery - Salisbury
- Tisbury Surgery
- Whiteparish Surgery
- Wilton Health Centre
- Salisbury Medical Practice

West Wiltshire, Yatton Keynell and Devizes (WWYKD)

- Adcroft Surgery - Trowbridge
- Bradford on Avon & Melksham Health Partnership
- Bradford Road Medical Centre - Trowbridge
- Courtyard Surgery – West Lavington
- Giffords Surgery - Melksham
- Jubilee Field Surgery – Yatton Keynell
- Lovemead Group Practice - Trowbridge
- Market Lavington Surgery
- Smallbrook Surgery - Warminster
- Southbroom Surgery - Devizes
- Spa Medical Centre - Melksham
- St James' Surgery - Devizes
- The Avenue Surgery - Warminster
- The Lansdowne Surgery - Devizes
- Westbury Group Practice (White Horse Health Centre)
- Widbrook Medical Practice - Trowbridge

Governing Body 15/16

The CCG's Governing Body has overall responsibility for the formulation and implementation of strategy, policy and the performance of the CCG. The Governing Body meets on a monthly basis (every other month in public) and is chaired by Dr Peter Jenkins.

At 31 March 2016, voting membership of the Governing Body comprised the Chair, the Accountable Officer, the Chief Financial Officer, two Lay Members (one of whom leads on Audit and Governance matters and the other on Public and Patient Involvement) who bring an external view to the organisation, along with six GPs (the Chair and Vice Chair of each Locality Group), a registered nurse and a secondary care doctor. The Governing Body met 12 times during the period 1 April 2015 to 31 March 2016. The details of the Governing Body membership at 31 March 2016 can be seen below:

Dr Peter Jenkins	GP Chair
Deborah Fielding	Accountable Officer
Simon Truelove	Chief Financial Officer
Christine Reid	Lay Member: Patient and Public Involvement
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Dr Simon Burrell	GP Chair, North and East Wiltshire
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Toby Davies	GP Chair, Sarum
Dr Chet Sheth	GP Vice Chair, Sarum
Dr Richard Sandford-Hill	GP Chair, WWYKD
Dr Lindsay Kinlin	GP Vice Chair, WWYKD
Mary Monnington	Registered Nurse Member
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
David Noyes	Director of Planning, Performance and Corporate Services
Dina McAlpine	Director of Quality
Jo Cullen	Director of Primary Care and Urgent Care/Group Director – WWYKD
Mark Harris	Director of Acute Commissioning/Group Director – Sarum
Ted Wilson	Director of Community and Joint Specialist Commissioning/Group Director – North and East Wiltshire
Dr Helen Osborn	GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
James Roach	Director of Integration
Maggie Rae	Corporate Director, Wiltshire Council
Chris Graves	Chair, Healthwatch, Wiltshire
Diana Hargreaves	Board Administrator, CCG
Non-members who always attend (no voting rights)	
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO
Sarah MacLennan	Associate Director, Communications and Engagement

The CCG's committee structure comprises five formal sub-committees of the Governing Body:

- Finance and Performance Committee
- Quality and Clinical Governance Committee
- Remuneration Committee
- Audit and Assurance Committee
- Primary Care Joint Commissioning Committee.

In addition, the CCG has established a committee for each of the three Locality Groups: North and East Wiltshire (NEW), Sarum and West Wiltshire, Yatton Keynell and Devizes (WWYKD).

The Audit and Assurance Committee ensures that governance arrangements of the CCG are in place, well designed and appropriately applied. The Committee ensures that robust, effective financial management systems are in place and being followed and that as a CCG we appropriately manage risk. The Committee meets bi-monthly and its members are listed below:

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid	Vice Chair, Lay Member: Patient and Public Involvement
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Simon Truelove	Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Natalie Tarr / Lynne Baber	Internal audit, Price Waterhouse Cooper
Duncan Laird / Jonathan Brown	External audit, KPMG UK LLP
Tracey Spragg	Counter Fraud Specialist
Paul Travers	Security Management Specialist
Steve Perkins	Deputy Chief Financial Officer
Susannah Long	Governance and Risk Manager
Diana Hargreaves	Board Administrator

You can read more about our Governance procedures and details of membership of the other sub-committees in the Governance Statement. There are more details about all our Governing Body members in the Governing Body and Senior Management Profiles section.

Governing Body and Senior Management Profiles

Dr Peter Jenkins - GP Chair

Peter qualified from St Mary's Hospital, London, in 1975 and has been a GP in Avon Valley Practice for more than 30 years. Until recently he was a GP Trainer and GP Tutor for Salisbury and GP Appraiser. Previously, he was a Board Member and Clinical Governance Lead for South Wiltshire Primary Care Trust (PCT) until March 2013. Before taking up his post as Chair of the CCG, Peter was the Medical Adviser and named GP for safeguarding children for the CCG.

Declared Interests	Member of the following committees
• Family connection to Lansdowne Surgery, Devizes • Locum GP	• Governing Body (Chair) • Finance and Performance Committee (Chair) • Remuneration Committee

Deborah Fielding – Accountable Officer

Deborah's extensive experience includes Deputy CEO at NHS Havering as well as seven years in a commissioning role as Director of Strategy and Transformation in Essex.

Declared Interests	Member of the following committees
• Director of own management company Solutions for Integrated Healthcare (dormant from April 2013) • Volunteer for the Wilderness Foundation Youth Charity	• Governing Body • Finance and Performance Committee • Remuneration Committee

Simon Truelove - Chief Financial Officer / Senior Information Risk Officer
Simon has worked as an accountant and Director of Finance for a number of NHS provider and commissioning organisations since 1990 and is a member of the Chartered Institute of the Public Finance and Accountancy.

Declared Interests	Member of the following committees
• Married to the Deputy Chief Executive of the Royal United Hospital NHS Foundation Trust, Bath	• Governing Body • Finance and Performance Committee • Audit and Assurance Committee • Remuneration Committee

Christine Reid - Lay Member, Patient and Public Involvement
Christine served as a councillor in Wiltshire until 1998 during which time she held many health related roles. She also served on the national Local Government Association as lead member for rural local authorities and was awarded the OBE for this work. Christine has an ongoing interest in mental health services, carer services, delivering the Equality and Diversity agenda, and working with stakeholders.

Declared Interests	Member of the following committees
• Mental Health Act Associate AWP • Trustee of Warrington Homes Limited	• Governing Body • Finance and Performance Committee • Audit and Assurance Committee – Vice Chair • Remuneration Committee – Vice Chair • Quality and Clinical Governance Committee

Peter Lucas - Lay Member, Audit, Governance and Vice Chair
Peter's background is in industry, commercial and investment banking and local community activities. His involvement in the NHS began as chair of the Patient Partnership Group of his local GP practice before holding a number of roles with health authorities in the South West.

Declared Interests	Member of the following committees
• None	• Governing Body – Vice Chair • Finance and Performance Committee – Vice Chair • Audit and Assurance Committee - Chair • Remuneration Committee - Chair

Dr Helen Osborn - GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
Helen qualified in 1988 from the University of London. She is a GP and senior partner at Courtyard Surgery in West Lavington, near Devizes. Her clinical interests are all aspects of family medicine, family planning, care of the elderly and palliative care.

Declared Interests	Member of the following committees
• Owner and GP Partner in Courtyard Surgery Practice, West Lavington • Staff grade elector – CASH service Devizes and Melksham • Employed by Sirona Health & Care to provide contraceptive services	• Governing Body • Quality and Clinical Governance Committee • Finance and Performance Committee

Dr Simon Burrell - GP Chair, NEW
Simon qualified in Bristol in 1979 and worked in several hospitals in Bristol and Bath for some years in various specialties, but particularly in obstetrics. He joined the partnership in Corsham in 1985.

Declared Interests	Member of the following committees
• Partner in Porch Surgery, Corsham • Porch Surgery likely to become part of a wider North Wiltshire GP provider organisation • Director of Wilcare – no longer an active organisation • Trustee of Corsham Link	• Governing Body • Finance and Performance Committee

Dr Toby Davies - GP Chair, Sarum
Toby qualified in 1985 at Birmingham University and completed his GP training in Devon after working in Australia. Since 1994 he has been a partner at the Castle Practice in Ludgershall, Wiltshire, and his specialisms include asthma, cardiology and minor surgery.

Declared Interests	Member of the following committees
• Senior Partner in Castle Practice, Lugershall • Sole Director of Morley Manor which is registered with Company House to provide medical services. • Castle Practice is a shareholder in WilcoDoc which runs Salisbury Walk-in Centre	• Governing Body • Finance and Performance Committee

Dr Richard Sandford-Hill - GP Chair, WWYKD
Richard qualified from St. George's Hospital Medical School in 1988. In 1994, after completing his General Practice training in West Dorset, Richard became a partner in the Market Lavington Surgery, where he has been a senior partner since 2006. Richard's specific clinical interests include minor surgery and palliative care.

Declared Interests	Member of the following committees
• GP, Market Lavington Surgery	• Governing Body • Finance and Performance • Remuneration Committee • Quality and Clinical Governance Committee

Dr Anna Collings - GP Vice Chair, NEW
Anna was born and brought up in Wiltshire and is passionate about local services. Anna graduated in London in 1992 and previously worked as a locality chair in Swindon, now practicing in the village where she was brought up.

Declared Interests	Member of the following committees
• GP Partner, Pewsey Surgery • Possible that Pewsey Surgery may become part of a federation of practices wishing to bid for healthcare services	• Governing Body • Audit and Assurance Committee

Dr Chet Sheth - GP Vice Chair, Sarum
Chet qualified in 2003 at Imperial College in London. He has worked in several hospitals prior to joining St Ann's Street Surgery in Salisbury in 2009. His clinical interests include all aspects of family medicine, elderly and palliative care.

Declared Interests	Member of the following committees
• GP Partner, St. Ann Street Surgery • Shareholder of Wilcodoc, which runs Salisbury Walk-in Centre • Director of Arden's Health Informatics Limited • In discussions with other GPs and providers about forming a provider arm looking at the Community Services contract	• Governing Body • Finance Committee

Dr Lindsay Kinlin – GP Vice Chair, WWYKD
Lindsay qualified in 1998 and has a specialist interest in chronic disease management. She is a partner of The Avenue Surgery in Warminster.

Declared Interests	Member of the following committees
• The Avenue Surgery is a Member of the Wessex Primary Healthcare Alliance (GP Federation) • Director of Wylye Vale Health Limited • Director of Redmedical Limited • Committee Member for The Friends of Warminster Hospital	• None

Mary Monnington - Registered Nurse Member
Mary qualified as a nurse in 1972 and has worked in a range of nursing posts. In 1978 she migrated to Australia to work at the Alfred Hospital. Upon her return to the UK, she completed postgraduate degrees in economics and nursing and has held a number of senior nursing posts across the south west.

Declared Interests	Member of the following committees
• Owner of Mary Monnington Associates – sole trader at present • Council Member UK Council of Caldicott Guardians • Registrant / Panel member - Nursing & Midwifery Council • Nurse Member Dorset CCG	• Governing Body • Quality and Clinical Governance Committee - Chair

Dr Mark Smithies - Secondary Care Doctor
Mark qualified in 1981 at the University of London. Prior to becoming Director of Intensive Care at the University Hospital of Wales, in Cardiff, he was a consultant in Intensive Care at Guys Hospital in London.

Declared Interests	Member of the following committees
• Voluntary Board Member and Trustee of Salisbury based charity "Health Care Sudan" • Editor of a current awareness journal "Intensive Care Monitor" that reviews the world's published literature in the field of Critical Care • Financial and close family relationship with 'Plus Guidance' internet start-up company	• Governing Body • Finance and Performance Committee • Audit and Assurance Committee • Remuneration Committee • Quality and Clinical Governance Committee – Vice Chair

Jo Cullen – Director of Primary Care and Urgent Care/Group Director – WWYKD
Jo has worked for the NHS for over 30 years, qualifying as a Registered Nurse from Guy's Hospital in London in 1986, and graduating from University of Bath in 1991. She has worked clinically in the RUH; in a GP practice in Bath on a Department of Health funded mental health project, and since 1996 worked for Wiltshire across previous predecessor NHS organisations. Jo was Head of Primary Care since 2009, managing the contracts for GPs, dentists, pharmacists and opticians and led the procurement of the Walk-in Centre, Out of Hours and Single Point of Access and NHS 111 for Wiltshire.

Declared Interests	Member of the following committees
• None	• Governing Body • Finance and Performance Committee

Mark Harris – Director of Acute Commissioning/Group Director – Sarum
Mark has worked for 21 years in commissioning organisations throughout the south in Surrey, Hampshire, London and Berkshire. Over that time Mark has led the commissioning of acute, mental health, community and ambulance services in a variety of roles.

Declared Interests	Member of the following committees
• Occasional consultancy work through companies that support the pharmaceutical industry with customer insight, understanding NHS policy and business development	• Governing Body • Finance and Performance Committee

Ted Wilson - Group Director – NEW
Ted has worked for the NHS for over 30 years in a range of strategic management and planning roles at a senior level. His previous positions include Director of Operations for Shropshire Community Health NHS Trust, Joint Director of Service Delivery at NHS Swindon and Swindon Borough Council as well as a great deal of NHS experience in Wales which culminated in a Chief Executive position of a Local Health Board (LHB) in Merthyr.

Declared Interests	Member of the following committees
• Great Western Hospitals NHS Foundation Trust Governor on behalf of NHS Wiltshire CCG • Previously employed by predecessor to SEQOL	• Governing Body • Finance and Performance Committee

David Noyes - Director of Planning, Performance & Corporate Services
David retired from the Royal Navy in March 2013, after 28 years' service, to join the Clinical Commissioning Group. David joined the Royal Navy in 1985 and spent the majority of his early career at sea, including spells of active duty in the Gulf and during the Bosnia conflict. David was promoted to Commander in 2001, then Captain in 2009, and worked in a variety of strategic planning and support roles in the MOD and Fleet HQ. In early 2011 he was selected to be Deputy Commander of the UK Support Headquarters (Afghanistan) deploying to Helmand for a 6 month tour of duty in late 2011/early 2012.

Declared Interests	Member of the following committees
• None	• Governing Body • Finance and Performance Committee • Audit and Assurance Committee • Remuneration Committee

James Roach - Director of Integration
James has worked in the NHS for the last 12 years. He entered the NHS via the NHS Graduate Management Scheme. James has extensive experience at Director level in both provider and commissioning organisations, more recently as a Chief Operating Officer in a CCG and then Accountable Officer of a large CCG.

Declared Interests	Member of the following committees
• Joint appointment with Wiltshire Council	• Governing Body • Finance and Performance Committee

Dina McAlpine – Director of Quality / Caldicott Guardian
Dina qualified as an RGN in 1993 having studied at Charing Cross Hospital, London. She initially worked in plastic and reconstructive surgery before specialising in adult intensive care in London. Upon moving to the West Country she continued to work in intensive care nursing.

Dina then left working in the NHS to commence work as a senior manager within the health and social sector. She later joined Wiltshire Primary Care Trust, working as a service improvement commissioner, focusing on older people and long term conditions. She then became associate director responsible for continuing healthcare and later took on responsibility for specialist placements.

In 2014 Dina became Assistant Director of Quality and Patient Safety. In July 2015, Dina became our Director of Quality and is also our Caldicott Guardian.

Declared Interests	Member of the following committees
• None	• Governing Body • Finance and Performance Committee • Quality and Clinical Governance Committee

Statement as to Disclosure to Auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

- So far as the Member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware

  and

- That the member has taken all the steps that they ought to have taken as a Member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

I confirm that, as far as I am aware, there is no relevant audit information of which the auditors are unaware, and that I have taken steps to make myself aware of any relevant audit information and to establish that the auditors are aware of that information.

I confirm that the annual report and accounts as a whole are fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgements required for determining that they are fair, balanced and understandable.

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.

Deborah Fielding
Accountable Officer
May 2016

Governance Statement by the Chief Officer as the Accountable Officer of NHS Wiltshire Clinical Commissioning Group

Introduction and context

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

As at 1 April 2015, the clinical commissioning group was licensed without conditions.
The Governing Body of the CCG is made up of six practicing GP members elected by member practices, four Lay Members, a clinical Chair and two senior executives.

Governing Body meetings are held in public every two months, in varying locations around Wiltshire to promote public access, and the public are invited to raise questions or comment on agenda items in advance of the meeting.

Scope of responsibility

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

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

Compliance with the UK Corporate Governance Code

As a public sector body, we are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the clinical commissioning group.

Corporate Governance Code

The CCG Governing Body determines to ensure that the organisation inspires confidence and trust avoiding any potential situations of undue bias or influence in decision-making and protecting the NHS, the CCG and individuals involved from any appearance of impropriety. All employees and appointees of the CCG will reflect the seven principles of public life set out by the Nolan Committee:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

The Governing Body engenders a culture of openness and transparency in business transactions ensuring that:

- the interests of patients remain paramount at all times;
- all are impartial and honest in the conduct of their official business;
- public funds entrusted to the CCG are used to the best advantage, always ensuring value for money;
- there is no abuse of official positions for personal gain or benefit;
- no advantage to private or other interests is sought in the course of official duties.

It is the policy of the CCG to identify, minimise, control and where possible, eliminate any risks that may have an adverse impact on patients, staff and the organisation. The Accountable Officer carries ultimate responsibility for all risks within the control of the organisation. The CCG risk management strategy and policy describe the responsibilities for risk management from the organisational responsibility of the Governing Body, through all clinicians, managers and staff ensuring commitment to the principles of risk management.

During 2015/16, we have attended and participated in a number of Area Board meetings, patient participation groups, health and social care forums and voluntary sector events throughout the county. We also organised our own stakeholder meeting in November 2015, attended by over 70 delegates made up of representatives from partner organisations, the voluntary sector, service users, patients, carers, elected members and the public. With the current NHS landscape one of challenge, this half day meeting informed our key stakeholders of the challenges we face on a local and national level and collectively we discussed our plans for the way forward.

This Governance Statement is intended to demonstrate the clinical commissioning group's compliance with the principles set out in Code.

For the financial year ended 31 March 2016, and up to the date of signing this statement, we complied with the provisions set out in the Code and applied the principles of the Code.

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 Constitution states that, at all times it will observe the generally accepted principles of good governance in the way it conducts its business. This includes:

- the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
- 'The Good Governance Standard for Public Services';
- the standards of behaviour published by the Committee on Standards in Public Life *(1995)* known as the 'Nolan Principles'
- the seven key principles of the NHS Constitution;
- the Equality Act 2010.

The Governing Body of the CCG has, throughout each year, an on-going role in reviewing the CCG governance arrangements to ensure that the CCG continues to reflect the principles of good governance.

Committee structure

The CCG's committee structure comprises five formal sub-committees of the Governing Body:

- Finance and Performance Committee
- Quality and Clinical Governance Committee
- Remuneration Committee
- Audit and Assurance Committee
- Primary Care Joint Commissioning Committee.

In addition, the CCG has established a committee for each of the three Locality Groups: North and East Wiltshire (NEW), Sarum and West Wiltshire, Yatton Keynell and Devizes (WWYKD).

Governing body

The Governing Body has been responsible for:

- ensuring delivery of the CCG strategic aims and focus on the organisation's purpose and on outcomes for patients and the population;
- creating a culture of openness, transparency and learning; values and behaviours which support continuous improvements in clinical effectiveness, safety and experience of the services they commission;
- monitoring management of significant risk and seeking assurance that management decisions balance performance within appropriate limits;
- taking informed, transparent decisions;
- engaging stakeholders and making accountability real.

The Wiltshire GP practices form the Council of Members for the CCG. The Governing Body is made up of six practicing GP members elected by member practices, Chair, Accountable Officer, Chief Financial Officer, Registered Nurse Member, Secondary Care Doctor Member, Lay Member for Stakeholder Engagement and Patient and Public Involvement Engagement and Lay Member for Audit and Assurance – thirteen in total.

The following Governing Body Members are In Attendance:

- Director of Planning, Performance and Corporate Services
- Director of Primary Care and Urgent Care/Group Director WWYKD
- Director of Acute Commissioning/Group Director Sarum
- Director of Community and Joint Specialist Commissioning/Group Director NEW
- Director of Quality
- Integration Director
- GP Medical Advisor
- Corporate Director, Wiltshire Council
- Chair, Healthwatch Wiltshire
- Board Administrator

Non-members who always attend:

- Associate Director, Communications and Engagement
- Associate Director, Performance, Corporate Services and Head of PMO

Membership at 31 March 2016

Dr Peter Jenkins	GP Chair
Deborah Fielding	Accountable Officer
Simon Truelove	Chief Financial Officer
Christine Reid	Lay Member: Patient and Public Involvement
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Dr Simon Burrell	GP Chair, North and East Wiltshire
Dr Toby Davies	GP Chair, Sarum
Dr Richard Sandford-Hill	GP Chair, WWYKD
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Chet Sheth	GP Vice Chair, Sarum
Dr Lindsay Kinlin	GP Vice Chair, WWYKD
Mary Monnington	Registered Nurse Member
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
David Noyes	Director of Planning, Performance and Corporate Services
Dina McAlpine	Director of Quality
Jo Cullen	Director of Primary Care and Urgent Care/Group Director – WWYKD
Mark Harris	Director of Acute Commissioning/Group Director – Sarum
Ted Wilson	Director of Community and Joint Specialist Commissioning/Group Director – North and East Wiltshire
Dr Helen Osborn	GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
James Roach	Director of Integration
Maggie Rae	Corporate Director, Wiltshire Council
Chris Graves	Chair, Healthwatch, Wiltshire
Diana Hargreaves	Board Administrator, CCG
Non-members who always attend (no voting rights)	
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO
Sarah MacLennan	Associate Director, Communications and Engagement

Remuneration and Terms of Service Committee

This Committee advises the CCG Governing Body about appropriate remuneration, the appointment, termination and terms and conditions of the Accountable Officer, Executive Directors, Clinical Leads and other senior managers with locally determined contracts described by the NHS Very Senior Managers Pay Framework.

The Committee monitors, evaluates and confirms the satisfactory performance of these posts and ensures contractual arrangements taking account of national guidance where appropriate.

Membership at 31 March 2016

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid	Vice Chair, Lay Member: Patient and Public Involvement
Dr Richard Sandford-Hill	GP Chair, WWYKD
Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Dr Peter Jenkins	GP Chair CCG
Deborah Fielding	Accountable Officer
David Noyes	Director of Planning, Performance and Corporate Services
Simon Truelove	Chief Financial Officer
HR Business Partner	CSW-CSU
Diana Hargreaves	Board Administrator

Audit and Assurance Committee

The role of this Committee is to consider the adequacy and effective operation of the internal control systems that underpin the delivery of the organisation's objectives. This non-executive Committee includes a clinical GP executive member with executive directors in attendance.

The Committee reviews the establishment, maintenance and adequacy of the system of integrated governance, internal controls and risk management, across the whole of the organisation's activities (financial, non-financial, clinical, non-clinical, and information). This includes advising the Governing Body on internal and external audit services, counter fraud services and local security management services.

The Committee monitors compliance with and waiver of the financial policies and scheme of delegation, reviews every decision to suspend the scheme of delegation, reviews the schedule of losses and compensations and reviews the annual financial statements prior to submission to the Governing Body. During 2015/16, the Vice Chair of the Governing Body has chaired the Committee.

Membership at 31 March 2016

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid	Vice Chair, Lay Member: Patient and Public Involvement
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Simon Truelove	Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Natalie Tarr / Lynne Baber	Internal audit, Price Waterhouse Cooper
Duncan Laird / Jonathan Brown	External audit, KPMG UK LLP
Tracey Spragg	Counter Fraud Specialist
Paul Travers	Security Management Specialist
Steve Perkins	Deputy Chief Financial Officer
Susannah Long	Governance and Risk Manager
Diana Hargreaves	Board Administrator

Quality and Clinical Governance Committee

This Committee considers and advises the Governing Body on service quality issues, performance managing service and clinical issues with particular reference to action plans emerging from Serious Incidents Requiring Investigation (SIRI), Serious Case Reviews (SCR) and Care Quality Commission (CQC) inspections.

The Committee provides assurance to the Governing Body regarding organisational learning and the fulfilment of its statutory responsibilities, implementing plans to drive continuous improvement, including the focus on patient feedback and a direct relationship with commissioning decisions. During 2015/16, the Registered Nurse Lay Member of the CCG has chaired the Committee.

Membership at 31 March 2016

Mary Monnington	Chair, Registered Nurse Member
Dr Mark Smithies	Vice Chair, Secondary Care Doctor
Dina McAlpine	Director of Quality
Dr Richard Sandford-Hill	GP Chair, WWYKD
Christine Reid	Lay Member: Patient and Public Involvement
Susannah Long	Governance and Risk Manager
Dr Helen Osborn	Named GP for Safeguarding Children
In attendance (no voting rights)	
Sophia Swatton (from March 2016)	Associate Director of Quality
Kate Purser (yet to attend)	Associate Director of CHC and Adult Safeguarding
Deborah Haynes (from January 2016)	Public Health Consultant, Wiltshire Council
Nadine Fox	Head of Medicines Management
Emily Shepherd	Quality Lead
Louise French	Quality Lead
Emma Higgins	Quality Lead
Lynn Franklin	Adult Safeguarding Lead
Dr Fiona Finlay	Designated Doctor, Safeguarding Children
James Dunne	Designated Nurse, Safeguarding Children
Lena Pheby	Designated Nurse, Looked After Children
Dr Stuart Murray	Designated Doctor, Looked After Children
Danela Adams	Team Administrator

Finance and Performance Committee

The Committee monitors the financial performance of the CCG against the approved detailed financial plans and seeks assurance that robust plans are in place to ensure financial risks are managed. The Committee has considered and assessed new investment decisions and made recommendations to the Governing Body and officers of the CCG in line with the Scheme of Delegation. During 2015/16, the Committee was chaired by the CCG Chair.

Membership at 31 March 2016

Dr Peter Jenkins	Chair, GP Chair
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Deborah Fielding	Accountable Officer
Simon Truelove	Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Dina McAlpine	Director of Quality
Christine Reid	Lay Member: Patient and Public Involvement
Dr Mark Smithies	
Jo Cullen	Director of Primary and Urgent Care/Group Director – WWYKD
Mark Harris	Director of Acute Commissioning/Group Director – Sarum
Ted Wilson	Director of Community and Joint Specialist Commissioning/Group Director – North and East Wiltshire
Dr Simon Burrell	GP Chair, North and East Wiltshire
Dr Helen Osborn	GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
Dr Toby Davies	GP Chair, Sarum
Dr Richard Sandford-Hill	GP Chair, WWYKD
James Roach	Integration Director
In attendance (no voting rights)	
Steve Perkins	Deputy Chief Financial Officer
John Dudgeon	Head of Information
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO
Diana Hargreaves	Board Administrator

Locality Group Committees

The CCG has established a Committee for each of the three Locality Groups namely North and East Wiltshire, Sarum, and West Wiltshire, Yatton Keynell and Devizes. The Locality Group Committees were responsible for the following functions delegated to them:

- ensuring good governance within the Groups;
- developing and agreeing strategic direction for the Groups (and therefore for the CCG), taking account of national directives;
- commissioning services under the scheme of delegation;
- engaging with local stakeholders;
- maintaining risk registers and escalating risks where appropriate.

Membership

Membership of the Governing Body and Committees was arranged to ensure that discussions were comprehensive. Members of the Committees were conscious of the responsibility placed on them. Records show that there were seven Governing Body meetings held during 2015/16 including the Annual General Meeting. Attendance at these meetings was as follows:

The CCG continues to work collaboratively with Wiltshire Council to transform the delivery of health and social care for the people of Wiltshire. The CCG has attended joint Committees including the Joint Commissioning Board and the Health and Wellbeing Board.

Governing body voting members – attendance 2015/16

Name	Position	May 2015	Jul 2015	Sep 2015	Sep 2015 (AGM)	Oct 2015	Nov 2015	Jan 2016	Mar 2016
Dr Simon Burrell	GP Chair, NEW								
Dr Anna Collings	GP Vice Chair, NEW								
Dr Toby Davies	GP Chair, Sarum								
Deborah Fielding	Accountable Officer								
Dr Peter Jenkins	GP Chair								
Dr Lindsay Kinlin	GP Vice Chair, WWYKD								
Peter Lucas	Lay member and Vice Chair								
Mary Monnington	Registered Nurse Member								
Steve Perkins	Deputy Chief Financial Officer								
Christine Reid	Lay Member								
Dr Steve Rowlands	GP Chair								
Dr Richard Sandford- Hill	GP Chair, WWYKD								
Dr Chet Smith	GP Vice Chair, Sarum								
Dr Mark Smithies	Secondary Care Doctor								
Simon Truelove	Chief Finance Officer								

Key

	In attendance
	Did not attend
	Not attending (see below)

Steve Perkins, Deputy Chief Finance Officer, attended in place of Simon Truelove, Chief Finance Officer

Dr Peter Jenkins replaced Dr Stephen Rowlands as GP Chair from Jul 2015 meeting

Governing Body Performance 2015/16

The Governing Body has continued to devote time to reflect on their own performance and to invest time in their development. The Governing Body held an away day during 2015/16 to reflect on their performance, examine their effectiveness and consider plans for the future. The Governing Body also scrutinised the structure of the organisation, realigned portfolios and redesigned the CCG staffing structure to facilitate the transformation agenda.

In order to drive ahead with the ambitious transformation agenda, the CCG has now implemented, in alternate months, a formalised Out of Hospital Programme Board and a Planned Care Programme Board, each comprising our clinical leaders and executive team in order to drive forward on those key programmes of work which will deliver the CCG strategic aspirations.

The CCG continues to undertake monthly performance monitoring with a disciplined approach to project performance monitoring. Transparency of performance is evidenced by the Integrated Performance Report being published on the CCG website each month.

Highlights of committee reports

Sustainable Transformation Plan

NHS Bath & North East Somerset CCG, NHS Swindon CCG and NHS Wiltshire CCG (BSW) have committed to work together to develop a Sustainability and Transformation Plan (STP) which will accelerate our joint delivery of the objectives of the *Five Year Forward View.* We will jointly develop a vision which will guide the development of the plan, supported by a mission that will directly address health and wellbeing, quality and finance.

The STP will be developed on a whole system basis with commissioners, providers and local authorities working together to develop the right plan, irrespective of organisation boundaries. The combined total population across BSW is in the region of one million people with a joint health commissioning budget in excess of £960million, excluding social care and public health budgets. It is clear that short, medium and longer term delivery of the STP is fundamental to achieving the objectives of the *Five Year Forward View* and that this requires commitment to changing the models of care and working across organisational boundaries to achieve the required scale of change.

The STP will be built on wide engagement of key stakeholders, including patients, service users and carers, and working in partnership with organisations such as HealthWatch. In order to ensure that the programme can achieve transformation at scale a change network of Clinical Leaders will be established. The Clinical Network will be a key agent for change, supported by the programme director, and consistently engaged with regarding key messages and developments to be disseminated.

For larger scale requirements concerning centres of excellence for services such as trauma, cancers, specialised services etc., we will have arrangements that ensure we engage across neighbouring STP footprints enabling change at scale while supporting local ownership and sustained delivery. Every effort will be made to ensure these components and pathways are aligned with the new models developed for Urgent and Planned care.

To achieve our goals we have appointed a single leader for development of the STP and will put in place strong, robust governance including a single group across BSW that will lead development and implementation of our the overarching STP.

Children's Community Health Services
Children's Community Health Services in Wiltshire have been delivered by five separate organisations where a single provider could lead to more equitable support across the county and easier access to services. The re-commissioning of children's community health services has been undertaken as a joint commissioning project with Wiltshire Council and NHS England. The range and complexity of these services means that there has been a need to engage with a large number and range of stakeholders including the people who currently use or may need to use services in the future. Following completion of the tendering process, Virgin Care Services have been formally awarded the contract. The CCG and Wiltshire Council are working with Virgin Care Services on the mobilisation of the contract which will come in to force on 1 April 2016.

Adult Community Services
The Adult Community Services (ACS) procurement began in 2014/15 using a competitive dialogue process, incorporating Pre-Qualification Questionnaire (PQQ), Invitation to Submit Outline Proposals (ISOP) and Call for Final Tenders (CFT) stages. Following completion of the tendering process, Wiltshire Health and Care was awarded the contract which will come into force on 1 July 2016. The organisation is a joint venture between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust. The Board of Wiltshire Health & Care will include GP provider representatives to ensure a strong primary care voice and lay membership to represent patient and public views. The CCG is working with Wiltshire Health & Care on the mobilisation of the contract.

Joint Obesity Strategy
At the heart of the strategy is the reduction in the human and financial cost of obesity to individuals, families, communities, public services and the wider economy. We aim to achieve this by working collaboratively across health services, Council services, schools, workplaces, communities and with individuals to maximise opportunities to be physically active and eat a healthy diet.

An obesity summit consultation event held in July 2015, brought together a wide range of professionals including school nursing and health visiting, public health and protection, environmental health, leisure services, oral health promoters, library services, military health, general practitioners, pharmacies, education, fire services, representatives from academia and third sector organisations to identify the key priorities for tackling obesity in Wiltshire. This consultation event informed the strategy and how it will be taken forward.

The strategy examines delivery of services for people living in Wiltshire; addressing variation in access; ensuring communities are engaged in maintaining a healthy weight and ensuring a greater focus on prevention and early intervention. Five strategic targets have been set and will be measures for our success.

The Clinical Commissioning Group Risk Management Framework

The Governing Body has formally adopted a Risk Management Strategy, originally approved prior to Authorisation but reviewed annually and most recently revised in October 2015. This sets out the CCG strategic direction for the management of risk including the definition of risk, risk management objectives, roles and responsibilities, the process, risk appetite, training, communication and monitoring.

A key element of the Strategy is the Board Assurance Framework (BAF) The BAF outlines systems in place to manage the organisation's strategic objectives and control the risks to these objectives, detailing where assurances on the effectiveness of these controls has been obtained, where there are gaps in control or assurance and any actions required to strengthen assurance or control.

At the year-end the BAF identifies that controls to manage risks to the organisations objectives could be improved by:

- implementing further mechanisms to limit contract over or under performance of provider organisations; and
- identifying and planning out duplications of roles/tasks carried out by staff across the health system.

At the year-end the BAF confirms that assurances of listed controls are in place.

All risks are recorded on the CCG Risk Register. During 2015/16 the structure of the six directorate risk registers was changed moving three locality risk registers to risk registers associated with acute commissioning, primary & urgent care commissioning, and community & joint commissioning. This new structure takes an approach that precludes duplication, encourages communication and focuses attention on identification of risks that threaten the objectives of the CCG. The risk register is not a static record but a tool that allows risks to be explored, prioritised for treatment and management actions to be programmed and monitored. Directors provide the ownership and leadership for their teams to identify, share and address risks taking a CCG wide approach.

On a two monthly cycle the CCG Risk Register is presented to the Executive Team for discussion. The most prominent risks are determined and presented to the Audit and Assurance Committee for consideration. Of these, ten risks are escalated to the Governing Body in public session to confirm the extent to which the CCG objectives are threatened and monitor progress, holding directors to account as appropriate.

Risk appetite refers to the level of risk that the organisation is willing to tolerate when controlling risks, as the risks arise or when embarking on projects. The Governing Body acknowledges that risk is a component of change and improvement and, therefore, does not consider the absence of risk to be a necessarily positive position. The CCG will, where necessary, tolerate risks where action is not cost effective or reasonably practicable. The CCG will not normally accept risks with a score of between 15 and 25 using a 5 by 5 Risk Matrix, with plans being put in place to ameliorate the risk.

The CCG provides leadership and commitment from the top with the Governing Body supporting a culture of risk awareness and personal, professional and corporate responsibility and accountability. This is supported by a clear framework within which risks are identified, reported, analysed, managed and monitored. Staff Representatives of Employee Safety assist with risk assessment in their area contributing their specific local knowledge and providing local leadership for risk management. Good practice is shared and independent assurance is provided by external experts in Security, Counter Fraud, and Health & Safety. All staff are encouraged to report incidents using the existing paper based system and by contacting the Governance & Risk Manager.

Each staff member has objectives set and is provided with appropriate training (both mandatory and specialist) to ensure they have the correct knowledge and skills to meet their objectives, and identify and prevent risk.

The CCG and the members of the Governing Body are committed to ensuring that the organisation values diversity and promotes equality and inclusivity in all aspects of our business considering the full impact of the decisions made. The CCG conducts and publishes Equality Impact Assessments (EIAs) on all policies and proposals critically assessing the impact on protected groups and identifying opportunities to promote equality.

The CCG holds healthcare service providers to account at the regular Clinical Quality Review meetings, to ensure that they comply with the Equality Act 2010 and associated Public Sector Equality Duty. The CCG also requires providers to meet the legislative requirements as part of the procurement process for new or revised contracts.

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

The CCG has a robust recruitment process and has in place a number of workforce related policies that support and protect staff from discrimination, harassment, bullying and victimisation. All staff are required to undertake mandatory Equality and Diversity training.

The CCG informs, engages and consults public stakeholders with regards to changes to health services that may impact upon the public. The CCG uses a variety of methods to do this including posters, leaflets and other publicity materials as well as public meetings, workshops and presentations. The public are consulted on proposals from the very earliest stage and their comments are fed back to decision makers so that improvements can be made. Decisions are taken by the Governing Body in public.

The CCG held a Stakeholder Assembly on 5 November 2015. This is a bi-annual opportunity to engage with key stakeholders about strategic matters affecting the NHS both nationally and locally, and the impact on the CCG's current and future plans. This year delegates discussed the delivery of safe and sustainable health services within a challenging financial environment which included consideration of prescribing, information sharing and prevention/self-responsibility. The next meeting will be held in June 2016; stakeholders will be updated on the progress made on matters discussed at the November meeting and their feedback sought on more recent plans and strategies.

Risk Assessment

Risk to the CCG strategic objectives is identified through a number of mechanisms including, but not limited to, the following:

- business decision making and project planning;
- strategy and policy development;
- External/Internal Audit findings and other scrutiny;
- concerns and complaints;
- risk assessment process;
- Serious Incident Requiring Investigation (SIRI) and adverse event processes.

Identified risks are recorded on the CCG risk register, controls are identified, further mitigating actions are programmed and progress is monitored. The risk profile of the CCG is considered by the Governing Body and action against the ten key risks is closely monitored.

During 2015/16 the NHS has seen activity continuously over agreed activity plans. Over-performance on contracts adversely effects the financial position of the CCG resulting in greater QIPP requirements. The CCG has implemented actions associated with the Better Care Fund, QIPP projects and ongoing projects which have the potential to reduce activity levels and promote treatment of patients in the right place at the right time. However, continued activity pressures have resulted in the CCG reducing its achievement against the planned surplus position. During 2015/16, NHS Wiltshire CCG restructured to ensure that appropriate staffing resources are in place to deliver against both the QIPP and transformation agenda.

In addition there have been periods of escalation in urgent care threatening to destabilise the health and social care system. Performance management systems are now firmly in place to monitor activity and for system wide escalation.

The year has presented challenges in meeting some of the NHS Constitutional targets. The CCG has created monitoring arrangements including the Referral To Treatment (RTT) Assurance Group to ensure increased scrutiny of provider actions to mitigate risk. The CCG attends and supports meetings within the providers and receives reports as part of the Wiltshire SRG.

The local health and social care system continues to recognise a lack of staff with difficulties for recruitment, national staff shortages and a competitive local market. The CCG is working with partner organisations to identify potential solutions to meet demand for services and provide safe high quality care both now and in the future. The Workforce Action Group was founded in September 2015 and is working on various projects including:

- Identifying and removing role duplication;
- Shared coaching register;
- Staff training passport; and
- Rotation and placements in different settings.

The Wiltshire Health Institute of Health & Social Care has been established and a Health & Social Care workforce strategy is under development.

The ambulance service within Wiltshire is routinely failing to meet the target response times. The increased response times has the potential to adversely affect clinical outcomes for Wiltshire patients. The CCG continues to work closely with the South Western Ambulance Service NHS Foundation Trust. The Dispatch on Disposition national pilot adjusting the triage window has shown positive benefits which have been incorporated into the Ambulance Response Programme (ARP) locally. Effectiveness is being monitored by the CCG.

The CCG has in place sound governance arrangements with established committees reporting to the Governing Body. A register of Declarations of Interest is maintained to ensure transparency of interests when making decisions for both members of the Governing Body and staff. Risks are recorded on the CCG risk register, discussed and mitigating actions planned. Both the Board Assurance Framework and the CCG risk register are reported to the Governing Body at each meeting. Each month, Governing Body members receive the Integrated Performance Report examining quality, financial and access, and project performance.

On a quarterly basis, the CCG discusses its performance with NHS England Area Team. The CCG retains its licence without conditions.

The Clinical Commissioning Group Internal Control Framework

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

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

The risk and control framework encompasses the key assurance systems including planning, performance monitoring, audit, management policies, external assessment and risk management. The operation, scrutiny and reporting of these systems facilitates internal control.

The CCG has identified initiatives in the CCG Operating Plan. The initiatives have been developed into projects by the CCG Locality Groups who are responsible for the delivery of target outputs. Internal control is supported by the Programme Management Office (PMO) tracking progress of delivery through meetings with project managers and escalation of any concerns through the project governance structure which includes the Clinical Executive, Finance & Performance Committee, and the Governing Body. All initiatives require agreement on clear planned milestones and outputs that must be delivered and has an embedded project risk register. An Equality Impact Assessment (EIA) is completed for each project and the impact on privacy of individuals is also considered. This project framework enables progress to be monitored and successful delivery evidenced.

On a monthly basis, the CCG produces an Integrated Performance Report monitoring quality, financial performance and access, and project management. The document is aligned to the NHS England CCG Assurance Framework and supports the quarterly NHS England Area Team assurance discussions. The Integrated Performance Report is presented to the Governing Body and published on the CCG website to inform stakeholders.

The CCG Audit and Assurance Committee oversees the internal control framework on behalf of the Governing Body, satisfying itself that appropriate processes are in place to provide the required assurance. The Committee reviews the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (financial, non-financial, clinical, non-clinical and information) that supports the achievements of the organisation's objectives.

The Committee utilises the work of an effective internal audit control function, which provides appropriate independent assurance, and reviews the work and findings of the External Auditor appointed by the Audit Commission, considering implications and the CCG response. Please see the section on Significant Control Issues. The Committee ensures compliance with the Secretary of State's directions on counter fraud by overseeing the effective operation of the Counter Fraud Service, including policies and plans. The Local Security Management Service is contracted to undertake assessments of healthcare Providers' security arrangements which is support by the NHS contract. The Committee receives reports from both Counter Fraud and the Local Security Management Service.

The Audit and Assurance Committee seeks reports and assurances from Directors and managers, as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control. The Committee also seeks assurance from External Audit to benchmark the CCG.

Information Governance

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

The CCG places high importance on protecting patient, staff and corporate information and has in place an information governance management framework. Please see the section on Data Security.

The CCG has self-assessed against the requirements of the Information Governance Toolkit and has received positive assurance from Internal Audit on this programme. The CCG has a trained Senior Information Risk Owner and a trained Caldicott Guardian in place with deputies in support of these roles. The CCG also has trained Information Asset Owners and Information Asset Administrators in place.

A suite of Information Governance policies, including Information Security, is in operation and all staff are required to undertake training in Information Governance and records management on an annual basis. The CCG Staff Handbook contains a comprehensive information governance section with further information available on the CCG staff intranet. An assessment of information assets and flows has been undertaken with risks to data security identified and managed. A reporting and investigation framework is in place for incidents and near misses supported by Information Governance expertise provided by NHS South, Central and West Commissioning Support Unit. The CCG demonstrates a strong information risk culture.

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

NHS Wiltshire CCG is required to work within the financial resources available and return a surplus. QIPP initiatives have been identified to improve health care provision while using resources more efficiently in line with the vision and values of the CCG. This work is supported by an embedded framework for project management supported by the Project Management Office (PMO). Project workbooks identify required outcomes and potential risks before the expenditure of resources.

As part of the Internal Audit programme, it was noted that the Medicines Management Team meets with prescribers at each of the CCG Practices to discuss prescribing approaches, procedural changes and issues they are facing. This provides an opportunity to assist with challenges faced by each practice and relay best prescribing practice. The CCG are on average incurring costs per patient
10% below the national average cost.

External Audit, as part of the Annual Accounts process for 2014/15, have satisfied themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

The Head of Integration Delivery at NHS England, recently visited NHS Wiltshire to gain an understanding of the Better Care Fund. It was found that we are making good progress in developing better integrated health and care services for local people with the BCF performing well and well developed plans for 2016/17.

The Health and Wellbeing Board is seen as effective with strong leadership across the system and a shared focus.

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

As Accountable Officer, I lead on determining the strategic approach to risk with the governance framework arranged and managed by the Director of Planning, Performance and Corporate Services. Leadership for risk management is provided by the Executive Directors with support from key individuals including the Governance and Risk Manager and NHS South, Central and West Commissioning Support Unit.

From training at Corporate Induction onwards, all staff are encouraged to report risks and adverse events, and share good practice. The Representatives of Employee Safety meet on a regular basis to share issues and good practice. Commissioning Managers and members of the Quality team work with contracted provider organisations to discuss the appropriate management of contractual and patient safety risks.

The Senior Information Risk Officer is focused on reducing the likelihood and impact of information governance related risks with the assistance of the CCG Information Asset Owners and Information Asset Administrators. The Audit and Assurance Committee review the risk register and discuss risk issues at each meeting, where appropriate calling on directors, senior managers and GP representatives to attend the meeting to discuss specific risk issues.

Review of Effectiveness

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

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls, to 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 and Assurance Committee and Quality and Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The effectiveness of the system of internal control has been tested and challenged by the following means:

- The Accountable Officer and Chief Finance Officer have met with the Chief Executives and Directors of Finance from the local acute trusts. The Lay Members are meeting with Lay Members from the other CCGs within this Area Team geography and have shared issues including internal control arrangements.
- The Audit and Assurance Committee has reviewed the terms of reference for the Committee. The Audit and Assurance Committee has also received presentations from CCG Directors discussing their risk management arrangements and key risks.
- The Quality and Clinical Governance Committee has invited Quality leads from Provider organisations to present the key issues as they are seen by their organisation as triangulation to the Clinical Quality Review meetings and performance data. The Committee has also reviewed Care Quality Commission reports regarding Provider organisations.
- Internal Audit has undertaken audits across the CCG. Audit reports have been presented to and discussed by the Audit and Assurance Committee with actions to address recommendations noted and progress against actions monitored.
- The Health and Safety arrangements have been assessed by NHS South, Central and West Commissioning Support Unit who has been supportive of the progress made.

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:

We are satisfied 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. 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.

Opinion
Our opinion is as follows:

Satisfactory	Generally satisfactory with some improvements required	**Significant improvement required**	Unsatisfactory
There are significant weaknesses and non-compliance in the framework of governance, risk management and control which put the achievement of organisational objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of governance, risk management and control.			

Opinion basis

Our opinion is based on:

- All audits undertaken during the year.
- Any follow up action taken in respect of audits from previous periods.
- The effects of any significant changes in the organisation's objectives or systems.
- Any limitations which may have been placed on the scope or resources of internal audit.
- What proportion of the organisation's audit needs have been covered to date.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

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

- To date we have completed 11 internal audit reviews in the 2015/16 internal audit plan (1 of which is at draft report) for the year ended 31 March 2016. Our work to date has identified 11 Low, 26 medium, 8 high and 2 critical risk rated findings.
- The Better Care Fund review, which is currently in draft, has been assigned an overall classification of critical risk. Findings related to lack of overall agreed governance, disputes with the Council around the treatment of non-allocated funds, payment for performance funds and full impact of the care act funds within the BCF finance schedule. There were also weaknesses in controls around evidencing approval of funds and that expenditure related to the BCF.
- The overall classification for the Human Resources objectives setting and appraisals review was high risk. Findings related to limited compliance with regard to employees setting objectives and undertaking appraisals, managers not being held to account for this non-compliance and training in respect of objectives and appraisals not being mandatory.
- The overall classification for the Contract Performance review was high risk. Findings related to a lack of detail within the Service Level Agreement (SLA) in respect of the provider performance management process, SLAs not being signed timely, inadequate representation at contract meetings and insufficient evidence of meeting minutes.
- We identified one high risk finding in our review of Procurement, which related to there not being a contracts register in place which details all contracts in operation with third party service providers.
- There are 10 recommendations from the prior year relating to Communications, Clinical Governance, Corporate Governance, Core Financial Systems and Performance Management that are still outstanding. Within these are 1 high, 7 medium and 2 low risk rated findings.

Significant Control Issues

During the year, Internal Audit issued the following audit reports which identified governance, risk management and/or control issues which were significant to the organisation:

Internal Audit reports during the year have identified two critical (significant) control issues relating to the Better Care Fund. Findings related to some weaknesses in the controls and processes to manage the Fund. Although these were mainly at the administering body of the Fund, there is a consequential impact on the CCG as a result. These weaknesses included, amongst others, failure to produce monthly accruals thus potentially understating expenditure in monthly financial reporting, and not clearly identifying who is managing each BCF scheme.

No other significant control issues were identified by Internal Audit, however, the CCG recognises the following control issues:

- Financial Position – Whilst operating within available resources, early in 2015/16, the CCG identified that it would not be able to achieve the 1% financial surplus, as required by NHS England. Following the implementation of a financial recovery plan, the CCG

- Performance against NHS Constitution Targets – The CCG is currently forecasting a mixed performance against NHS Constitution targets. While most targets will be met, there are a small number which the CCG believes it will not achieve. These include the number of patients waiting more than 52 weeks, breaches of mixed-sex accommodation, the maximum 4 hour A&E wait, and C Difficile infections.

The HOIA has identified the need for significant improvement which the CCG has responded to. The three areas of improvement relate to the Better Care Fund (BCF), the setting and monitoring of staff objectives and appraisals and contract management. All of these areas have seen significant improvement before the start of the new financial year including a new business agreement for the BCF, a new cutting edge appraisal system and the revisions following the CCG reorganisation which has strengthened the CCG involvement in contracting as well as agreeing new working arrangements with the Commissioning Support Unit.

Internal Audit also recognises that significant progress has been made with the closure of outstanding recommendations. As at the 17 May 2016 Audit and Assurance Committee, of the 51 total recommendations, 35 have now been implemented, including all those from the 13/14 audit programme. Of the 16 remaining in progress/not due, 4 relate to 14/15 and 12 to 15/16.

Data Quality

Data is provided to the Governing Body as part of the Integrated Performance Report. The integration of performance data facilitates the overall validation of information provided.

Business Critical Models

The CCG has in place an appropriate and proportionate approach to providing quality assurance of business critical models, in line with the recommendations of the Macpherson Report.

Data Security

The CCG has self-assessed against the Information Governance Toolkit and Internal Audit has reviewed our self-assessment process and elements of our submission to provide assurance to the Governing Body. The CCG has determined compliance at level 2 of the toolkit which is deemed to be satisfactory.

During 2015/16, there have been twenty-four recorded breaches of data security; of these one has been attributed to the acts or omissions of NHS Wiltshire CCG staff. The incident attributed to the CCG was an e-mail sent to an insecure email account. The breach was dealt with internally with staff involved directed to the appropriate guidance and training materials. After investigation the breach was marked as a level 0. No breaches were of a level requiring a report to the Information Commissioners Office.

NHS Wiltshire CCG has not had any data security incidents deemed to be Serious Untoward Incidents during 2015/16.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. Legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the 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 legislation 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. Directors have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

The CCG Constitution has been reviewed during 2015/16.

The CCG has mechanisms in place with Internal Audit, External Audit and NHS England to scrutinise the execution of statutory functions and confirm that the CCG is legally compliant.

Conclusion

During 2015/16, two significant internal control issues have been identified relating to the Better Care Fund. Findings related to some weaknesses in the controls and processes to manage the Fund. Although these were mainly at the administering body of the Fund, there is a consequential impact on the CCG as a result. These weaknesses included, amongst others, failure to produce monthly accruals thus potentially understating expenditure in monthly financial reporting, and not clearly identifying who is managing each BCF scheme.

Deborah Fielding
Accountable Officer
May 2016

Remuneration and Staff Report

Each CCG has a Remuneration and Terms of Service Committee, the role of which is to determine and approve the remuneration package for Very Senior Managers (VSMs). In 2015/16, the CCG Remuneration Committee met on two occasions.

Membership of the Remuneration and Terms of Service Committee is made up of the following members:

Name	Role	Member type	Additional information	Number of meetings attended in 2015/16
Peter Lucas	Lay member	Voting	Chair of committee	1
Christine Reid	Lay member	Voting	Vice Chair of committee	2
Dr Mark Smithies	Secondary Care Doctor	Voting		2
Dr Richard Sandford-Hill	GP Chair, WWYKD	Voting		2
Dr Steve Rowlands (to July 2015)	CCG Chair	Non voting		1
Dr Peter Jenkins (from July 2015)	CCG Chair	Non voting		0
Deborah Fielding	Accountable Officer	Non voting		1
David Noyes	Director of Planning, Performance and Corporate Services	Non voting		2
Simon Truelove	Chief Financial Officer	Non voting		0
HR Business Partner	NHS South, Central and West CSU	Non voting		2
Diana Hargreaves	CCG Board Administrator	Non voting		2

Remuneration Report – Senior Managers

This table shows the remuneration awarded to the CCG's senior managers. Senior managers are defined as

"those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This disclosure is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements.

Salaries and Allowances

The figures reported in this table relate to those individuals who hold or have held office as a senior manager of the CCG (members of the Governing Body) during 2015/16.

Salary

This is the remuneration payable in respect of the period that the senior manager has held office.

Pension Related Benefits
The figures shown under "All Pension Related Benefits" in the table below are a calculation of the change in an individual's accrued pension benefit between the beginning and the end of the financial year.

This is based on the following mandated national formula: [(20 x PE) + LSE] - [(20 x PB) + LSB] less the employee's pension contributions where:

- PE and LSE are the accrued pension and lump sum values at the end of the pension input period, and
- PB and LSB are the accrued pension and lump sum values as at the beginning of the input period, adjusted for inflation.

The impact of this formula is to show the individual's increase in pension during the year, spread over an average period of twenty years (an estimate of how long that pension would be paid for in retirement).

Total
This is the sum of the salary and pension related benefits. However, this is not the actual cash paid by the CCG during the year.

The Department of Health has mandated that CCGs must identify senior managers who are paid more than £142,500 per annum (annualising part time managers) and outline the steps that have been taken to determine that this remuneration is reasonable.

The CCG has identified that the Chair and one senior manager (the Director of Integration) receive remuneration greater than £142,500 per annum on a pro rata basis.
The CCG has satisfied itself that the remuneration for these posts is reasonable.

The remuneration of the Chair has been agreed by the CCG's remuneration committee. The post of Chair requires specialist clinical leadership skills, and the CCG believes that the remuneration of the Chair is in line with that of a senior partner within a GP practice, someone who would bring those skills to the post. The remuneration is also in line with that offered by other CCGs to their GP Chairs.

The Director of Integration post is a joint role between the CCG and Wiltshire Council. This post requires the officer to work within two different public sector bodies (the CCG and the Council), and requires a specialist to oversee the integration of care pathways between those organisations. It is an interim appointment, specifically focussed on achieving this objective, and is funded by the Better Care Fund, which both the CCG and the Council contribute to.

As an interim appointment, the Director is not a member of either the NHS or local government pension scheme, and does not receive holiday or sick pay. The CCG believes that the remuneration for this post reflects the complexity and high profile nature of this role along with the lack of benefits and is therefore reasonable.

Name and Title	Salary (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Steve Rowlands, GP Chair (to July 2015)	35-40		35-40
Dr Peter Jenkins, GP Chair (from July 2015) GP Medical Advisor, Safeguarding (children) and Clinical Exceptions (to July 2015)	65-70		65-70
Deborah Fielding, Accountable Officer	115-120		115-120
Simon Truelove, Chief Financial Officer	100-105	22.5-25	120-125
Christine Reid, Lay Member, Patient and Public Involvement	5-10		5-10
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	15-20		15-20
Dr Simon Burrell (1), GP Chair, NEW Group	60-65		60-65
Dr Toby Davies (2), GP Chair, Sarum Group	45-50		45-50
Dr Richard Sandford-Hill (3), GP Chair, WWYKD Group	65-70		65-70
Dr Anna Collings, GP Vice Chair, NEW Group	35-40	42.5-45	80-85
Dr Lindsay Kinlin (4), GP Vice Chair, WWYKD Group	30-35		30-35
Dr Chet Sheth (5), GP Vice Chair, Sarum Group	45-50		45-50
Mary Monnington, Registered Nurse Member	10-15		10-15
Dr Mark Smithies, Secondary Care Doctor	5-10		5-10
David Noyes, Director of Planning, Performance and Corporate Services	95-100	22.5-25	120-125
Jo Cullen, Director of Primary and Urgent Care	90-95	17.5-20	105-110
Mark Harris, Director of Acute Commissioning	95-100	15-17.5	115-120
Ted Wilson, Director of Community Services and Joint Commissioning	95-100	7.5-10	105-110
Dina McAlpine, Director of Quality	75-80	72.5-75	145-150
James Roach (6), Director of Integration	180-185		180-185

Notes

- No senior manager has received any taxable benefits during 2015/16.
- No senior manager has received any form of performance related pay during 2015/16.
- The costs for Dr Simon Burrell were recharged by The Porch Surgery, Corsham.
- The costs for Dr Toby Davies were paid via an agency – Morley Manor Ltd
- The costs for Dr Richard Sandford-Hill were paid via an agency – Sandford-Hill Medical Services
- The costs for Dr Lindsay Kinlin were recharged by The Avenue Surgery, Warminster.
- The costs for Dr Chet Sheth were paid via an agency - CS Medical Consultancy
- The costs for James Roach are met by the Better Care Fund, which is hosted by Wiltshire Council. The CCG contributed £27.073m to the Fund in 2015-16.

Salaries and Allowances 2014/15

The figures reported in this table relate to those individuals who held office as a senior manager of the CCG during 2014/15.

Name and Title	Salary (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Steve Rowlands, GP Chair	60-65		60-65
Deborah Fielding, Accountable Officer	115-120		115-120
Simon Truelove, Chief Financial Officer	100-105	0-2.5	100-105
Christine Reid, Lay Member, Patient and Public Involvement	5-10		5-10
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	15-20		15-20
Dr Simon Burrell (1), GP Chair, NEW Group	65-70		65-70
Dr Helen Osborn (2), GP Chair, WWYKD Group	65-70		65-70
Dr Toby Davies (3), GP Chair, Sarum Group	45-50		45-50
Dr Anna Collings, GP Vice Chair, NEW Group	35-40	55-57.5	90-95
Dr Debbie Beale (4), GP Vice Chair, WWYKD Group to 6/11/14	25-30		25-30
Dr Richard Sandford-Hill (5), GP Vice Chair, WWYKD Group from 6/11/14	20-25		20-25
Dr Celia Grummitt (6), GP Vice Chair, Sarum Group to 23/9/14	30-35		30-35
Dr Chet Sheth (7), Gp Vice Chair, Sarum Group from 23/9/14	20-25		20-25
Mary Monnington, Registered Nurse Member	10-15		10-15
Dr Mark Smithies, Secondary Care Doctor	5-10		5-10
David Noyes, Director of Planning, Performance and Corporate Services	100-105	20-22.5	120-125
Jo Cullen, Group Director – WWYKD Group	85-90	22.5-25	110-115
Mark Harris, Group Director – Sarum Group	100-105	32.5-35	135-140
Ted Wilson, Group Director – NEW Group	100-105	0	100-105
Jacqui Chidgey-Clark, Director of Quality and Patient Safety to 15/3/15	95-100	0	95-100
Dina McAlpine, Interim Director of Quality and Patient Safety from 15/3/15	0-5	25-27.5	25-30
Lynn Talbot (8), Interim Director of Community Transformation	110-115		110-115
Dr Peter Jenkins, GP Medical Advisor, Safeguarding (children) and Clinical Exceptions	60-65		60-65
James Roach (9), Director of Integration	75-80		75-80

Notes

- No senior manager has received any taxable benefits or any form of performance related pay during 2014/15.
- The costs for Dr Simon Burrell were recharged by The Porch Surgery, Corsham.
- The costs for Dr Helen Osborn were recharged by Courtyard Surgery, Market Lavington.
- The costs for Dr Toby Davies were paid via an agency – Morley Manor Ltd
- The costs for Dr Debbie Beale were recharged by White Horse Health Centre, Westbury.
- The costs for Dr Richard Sandford-Hill were recharged by Market Lavington Surgery
- The costs for Dr Celia Grummitt were paid via an agency - Rainbow 2 Ltd
- The costs for Dr Chet Sheth were paid via an agency - CS Medical Consultancy
- The costs for Lynn Talbot were paid via an agency - McLaren Perry Ltd
- The costs for James Roach were recharged by Wiltshire Council.

Pension Statement

This table discloses the pension entitlements at the end of the financial year for senior managers, in accordance with the government's Financial Reporting Manual (FReM). The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. 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.

On 12 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.

Name and Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Simon Truelove, Chief Financial Officer	0-2.5	0	20-25	65-70	357	381	19	0
Dr Anna Collings, GP Vice Chair, NEW Group	0-2.5	0-2.5	10-15	20-25	123	151	27	0
David Noyes, Director of Planning, Performance and Corporate Services	0-2.5	0	5-10	0	37	56	19	0
Jo Cullen, Director of Primary and Urgent Care	0-2.5	2.5-5	20-25	65-70	390	422	28	0
Mark Harris, Director of Acute Commissioning	0-2.5	0	25-30	80-85	405	423	13	0
Ted Wilson, Director of Community Services and Joint Commissioning	0-2.5	2.5-5	40-45	125-130	851	888	27	0
Dina McAlpine, Director of Quality	2-2.5	5-7.5	10-15	40-45	184	243	57	0

- Deborah Fielding and Dr Peter Jenkins are not members of the NHS Pension Scheme, and the CCG does not make any contributions towards a pension.
- Dr Steve Rowlands was in receipt of his NHS Pension, so the CCG does not contribute towards a pension. There are no disclosures to be made.
- Christine Reid, Peter Lucas, Mary Monnington and Dr Mark Smithies do not receive pensionable remuneration.
- With the exception of Dr Anna Collings, payments to the GP members reported in the salaries and allowances table are made either via their practices or to agencies. As the CCG is not contributing directly to the GP's pension, there are no disclosures to be made.

Name and Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2015 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2015 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Simon Truelove, Chief Financial Officer	0-2.5	0-2.5	20-25	65-70	329	357	19	0
Dr Anna Collings, GP Vice Chair, NEW Group	2.5-5	7.5-10	5-10	20-25	80	123	41	0
David Noyes, Director of Planning, Performance and Corporate Services	0-2.5	0	0-5	0	17	37	19	0
Jo Cullen, Group Director – WWYKD Group	0-2.5	2.5-5	20-25	60-65	343	390	37	0
Mark Harris, Group Director – Sarum Group	0-2.5	5-7.5	25-30	80-85	355	405	40	0
Ted Wilson, Group Director – NEW Group	0-2.5	0-2.5	40-45	120-125	795	851	34	0
Jacqui Chidgey-Clark, Director of Quality and Patient Safety to 15/3/15	0-2.5	0-2.5	25-30	85-90	524	557	18	0
Dina McAlpine, Interim Director of Quality and Patient Safety from 15/3/15	0-2.5	0-2.5	10-15	30-35	151	184	1	0

- Deborah Fielding and Dr Peter Jenkins are not members of the NHS Pension Scheme, and the CCG does not make any contributions towards a pension. Therefore, there are no disclosures to be made.
- Dr Steve Rowlands was in receipt of his NHS Pension, so the CCG does not contribute towards a pension. There are no disclosures to be made.
- Christine Reid, Peter Lucas, Mary Monnington and Dr Mark Smithies do not receive pensionable remuneration.
- With the exception of Dr Anna Collings, payments to the GP members reported in the salaries and allowances table are made either via their practices or to agencies. As the CCG is not contributing directly to the GP's pension, there are no disclosures to be made.

This disclosure is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements.

Staff report and fair pay disclosure

Pay Multiples

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. This disclosure is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements.

The banded remuneration of the highest paid director in NHS Wiltshire CCG in the financial year 2015/16 was £160,000 to £165,000 (2014/15, £185,000 to £190,000) on a whole time equivalent basis. This was 4.10 times the median remuneration of the workforce (2014/15, 4.95 times), which was £39,632 (2014/15, £37,921). The ratio has decreased this year due to a change in the method of remuneration of the specialist director appointed by the local authority to oversee the integration of care pathways between the CCG and the local authority. This role is fully funded by the Better Care Fund, which is hosted by Wiltshire Council. The median wage has also increased.

In 2014/15, an alternative calculation of the pay multiple excluded the specialist director role mentioned above. This produced a banded remuneration for the highest paid director of £160,000 to £165,000 on a whole time equivalent basis and the pay ratio was 4.29 times the median remuneration of the workforce of £37,921. For 2015/16, the banded remuneration of the highest paid director is £160,000 to £165,000 and the pay ratio is 4.10, a reduction on 2014/15, due to an increase in the median wage.

In 2015/16, 0 employees received remuneration in excess of the highest-paid director. Whole time equivalent remuneration ranged from £17,179 to £162,500.
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.
This calculation has been audited by the CCG's external auditor.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The real increase in CETV reflects the increase in CETV which is 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 benefits accrued as a result of their purchasing additional years of pension service at their own cost)) and uses common market valuation factors for the start and end of the period.

CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Pension Liabilities

Note 5.5 of the annual accounts (contained within Appendix 2) provide further information on the relevant pension schemes used by the CCG.

Pension obligations

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

Staff report

Average staff numbers are detailed in Note 4.2 of the Annual Accounts. Further information about staffing is available in the Equality section of this report.

Accessible leadership and responding to staff (Employee consultation)

NHS Wiltshire CCG is a medium sized employer of 123 staff. The workforce is made up of employees from a wide variety of professional groups, in many cases in small numbers and a large proportion of employees sit within the management delivery team.

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

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

The CCG has an organisational development plan which sets out how the organisation and individuals within it will progress to full capability. This is a two year programme and substantial progress has been made. The CCG has adopted a policy of visible and accessible leadership, with senior management engaging with staff.

Managers hold regular one-to-one meetings with their individual staff members and a robust objective-led appraisal system is in place to allow all staff to work towards clearly defined personal objectives, emanating from the Accountable Officer down, and to ensure that all staff are contributing to the organisation's objectives and priorities. Staff are supported with learning, training and development opportunities for everyone to help them be the best they can be in order to meet their personal work objectives.

Staff Survey

The CCG recently undertook an annual Staff Engagement Survey and the resulting analysis and Survey Report was carefully considered by the Executive Management Team. The results of the survey will be used to develop an action plan with broad staff involvement in order to tackle any areas of improvement identified through the survey.

Sickness absence data

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 Governing Body on a quarterly basis as part of the workforce reporting mechanism.

NHS Wiltshire CCG Staff sickness absence (April 2015 to March 2016) is detailed below:

Total WTE Days Available	38,166.53
Total WTE Days Sickness	731.41
% FTE Days Sickness	1.92%

The data presented in the Annual Accounts (note 5.3) covers the calendar year 2015. There were no ill-health retirements during this period (2014/15: Nil).

	2015/16 Number	2014/15 Number
Total days lost	641	668
Total staff years	106	104
Average working days lost	6	6

Communication with our staff

NHS Wiltshire CCG consists of 123 members of staff drawn from a wide variety of professional groups, including clinicians, managers and executive directors.

We communicate with our staff through a number of channels, and employees are encouraged to engage so that the process becomes an open, two-way conversation, so that they can feel supported, informed and valued.

Executive Team Meetings are held once a week and these are attended by our Directors. Relevant news, issues and information is then cascaded to staff within each of the separate directorates / locality groups, through weekly team meetings. These messages are reiterated complimented with additional news (including information about development opportunities, news from the wider health community and social activities) in our fortnightly newsletter '14 Days' which is managed and issued by the Communications Team and to which staff are encouraged to contribute. 14 Days is accessible at all times to staff via the intranet, so archived editions are available.

Quarterly 'Meet and Greet' sessions are hosted by the CCG Chair and Chief Executive, at which staff are presented with updates on the CCG's business and are encouraged to share their views and ask questions.

We have also introduced 'Directors Corner', open-door events which take place once a month as drop-in sessions whereby members of staff can talk face to face, separately or in small groups to members of the Executive Team, who host the sessions on a rotational basis. In addition, 'Comments please' boxes are located around the building to encourage staff to feedback comments on any subject (anonymously if they wish).

Both our intranet and internet sites have been upgraded. In its current form the intranet acts as a resource for key information, forms and documents to support staff in their day to day working.

We currently hold an annual staff survey; the results of which are reported to the CCG's Governing Body before being shared with staff more widely. The results are used to engage our staff in creating key objectives for the organisation, so that we are able to test how staff are feeling, to allow us to see where gaps might be and where improvements can be made.

Managers hold regular one-to-one meetings with staff helping staff to work towards clearly defined personal objectives which are supported with learning, training and development opportunities.

Staff Policies

The CCG has a number of policies related to human resources. The review process involves the Staff Partnership Forum and, in some cases, staff consultation.

Disabled Employees and Equal Opportunities

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.

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

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

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

- http://www.wiltshireccg.nhs.uk/publications/equality-and-diversity/information-and-resources
- http://www.nhsemployers.org/EMPLOYMENTPOLICYANDPRACTICE/EQUALITYANDDIVERSITY/Pages/Home.aspx

The Equality and Diversity Strategy has been reviewed and was approved by the Governing Body in May 2015 for the period April 2015 to March 2018. The strategy clearly shows the progress that has been made and the actions that will be taken to promote equality and diversity.

This is strongly linked to reduction of health inequalities and tangible improvements in patient experiences and outcomes. We are being assisted in this process by South, Central and West Commissioning Support Unit (CSU) who provide expertise to take this work forward and further our use of the Equality Delivery System Framework. Our aim remains to integrate equalities (including health inequalities, inclusion and Human Rights) issues in every stage of the commissioning cycle.

We are always keen to hear from members of the public and employees across the nine protected characteristics on how we can improve patient outcomes and experiences of our services and how we can improve the skills and working conditions for our workforce.

Expenditure on Consultancy

Off Payroll Engagements

Under Treasury guidance PES (2013) 09, all public sector organisations are required to disclose information about high paid off-payroll appointments. Payments to GP practices for the services of employees and GPs are deemed to be "off-payroll" engagements, and are subject to these disclosure requirements:

i) Off-payroll engagements as at 31 March 2016, for more than £220 per day and that last longer than 6 months, are as follows:

	Number
Number of existing engagements as of 31 March 2016	19
Of which, the number that have existed:	
• for less than one year at the time of reporting	1
• for between one and two years at the time of reporting	4
• for between two and three years at the time of reporting	14
• for between three and four years at time of reporting	0
• for four years or more at the time of reporting	0

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

ii) New off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than 6 months, are as follows:

	Number
Number of new engagements between 1 April 2015 and 31 March 2016.	1
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
• assurance has been received	0
• assurance has not been received	0
• engagements terminated as a result of assurance not being received, or ended before assurance received	0

iii) Off payroll engagements of board members and or senior officials with significant financial responsibility between 1 April 2015 and 31st March 2016, are as follows.

	Number
Number of off-payroll engagements of board members and senior officials with significant financial responsibility during the year	5
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	21

Off Payroll Engagements 2014/15 restated
Following clarification that payments to GP practices for the services of employees and GPs are deemed to be "off-payroll" engagements, and are subject to these disclosure requirements, the disclosures for 2014/15 have been restated:

i) Off-payroll engagements as at 31 March 2015, for more than £220 per day and that last longer than 6 months, are as follows:

	Number
Number of existing engagements as of 31 March 2015	25
Of which, the number that have existed:	
• for less than one year at the time of reporting	6
• for between one and two years at the time of reporting	19
• for between two and three years at the time of reporting	0
• for between three and four years at time of reporting	0
• for four years or more at the time of reporting	0

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

ii) New off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than 6 months, are as follows:

	Number
Number of new engagements between 1 April 2014 and 31 March 2015.	6
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
• assurance has been received	0
• assurance has not been received	0
• engagements terminated as a result of assurance not being received, or ended before assurance received	0

iii) Off payroll engagements of board members and or senior officials with significant financial responsibility between 1 April 2014 and 31st March 2015, are as follows.

	Number
Number of off-payroll engagements of board members and senior officials with significant financial responsibility during the year	4
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	24

Exit packages disclosure

During 2015-16 there was 1 agreed departure, value £104,939 (2014-15; 3 departures, value £50,349), which has been paid in accordance with standard NHS terms and conditions. This was accounted for and paid during 2015-16. Details are reported in Note 4 of the financial statements.

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension scheme. Ill-health retirement costs are met by the NHS Pension scheme and are not included. During 2015-16, the CCG has not agreed any early retirements.

Deborah Fielding
Accountable Officer
May 2016

Financial statements NHS Wiltshire CCG 2015/16

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Statement of Comprehensive Net Expenditure for the year ended 31-March-2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	6,160	5,810
Operating Expenses	5	551,579	529,130
Other operating revenue	3	(3,204)	(3,054)
Net operating expenditure before interest		**554,535**	**531,886**
Investment Revenue		0	0
Other (gains)/losses		0	0
Finance costs		0	0
Net operating expenditure for the financial year		**554,535**	**531,886**
Net (gain)/loss on transfers by absorption		0	0
Total Net Expenditure for the year		**554,535**	**531,886**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	5,845	5,786
Operating Expenses	5	4,682	6,072
Other operating revenue	3	(116)	(188)
Net administration costs before interest		**10,411**	**11,670**
Programme Income and Expenditure			
Employee benefits	4.1.1	315	24
Operating Expenses	5	546,897	523,058
Other operating revenue	3	(3,088)	(2,866)
Net programme expenditure before interest		**544,124**	**520,216**

Other Comprehensive Net Expenditure	2015-16 £000	2014-15 £000
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Movements in other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net gain/(loss) on assets held for sale	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Share of (profit)/loss of associates and joint ventures	0	0
Reclassification Adjustments		
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**554,535**	**531,886**

The notes on pages 5 to 20 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	8	310	0
Intangible assets	9	34	0
Investment property		0	0
Trade and other receivables	11	0	0
Other financial assets		0	0
Total non-current assets		344	0
Current assets:			
Inventories		0	0
Trade and other receivables	11	2,832	4,548
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	12	327	46
Total current assets		**3,159**	4,594
Non-current assets held for sale		0	0
Total current assets		**3,159**	4,594
Total assets		**3,503**	4,594
Current liabilities			
Trade and other payables	13	(29,619)	(30,946)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	15	(73)	(71)
Total current liabilities		**(29,692)**	(31,017)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(26,189)**	(26,423)
Non-current liabilities			
Trade and other payables	13	0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	15	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(26,189)**	(26,423)
Financed by Taxpayers' Equity			
General fund		(26,189)	(26,423)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(26,189)**	(26,423)

The notes on pages 5 to 20 form part of this statement

The financial statements on pages 1 to 20 were approved by the Governing Body on 24 May 2016 and signed on its behalf by

Accountable Officer
Deborah Fielding

Statement of Changes In Taxpayers Equity for the year ended 31-March-2016

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(26,423)	0	0	**(26,423)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted CCG balance at 1 April 2015	**(26,423)**	**0**	**0**	**(26,423)**
Changes in CCG taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(554,535)			(554,535)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised CCG Expenditure for the Financial Year	**(554,535)**	**0**	**0**	**(554,535)**
Net funding	554,769	0	0	554,769
Balance at 31 March 2016	**(26,189)**	**0**	**0**	**(26,189)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(23,443)**	**0**	**0**	**(23,443)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted CCG balance at 1 April 2014	**(23,443)**	**0**	**0**	**(23,443)**
Changes in CCG taxpayers' equity for 2014-15				
Net operating costs for the financial year	(531,886)			(531,886)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised CCG Expenditure for the Financial Year	**(531,886)**	**0**	**0**	**(531,886)**
Net funding	528,906	0	0	528,906
Balance at 31 March 2015	**(26,423)**	**0**	**0**	**(26,423)**

The notes on pages 5 to 20 form part of this statement

Statement of Cash Flows for the year ended 31-March-2016

	Note	**2015-16 £000**	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(554,535)	(531,886)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	11	1,718	(2,177)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	(1,673)	5,321
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	15	(7)	(5)
Increase/(decrease) in provisions	15	9	(92)
Net Cash Inflow (Outflow) from Operating Activities		**(554,488)**	(528,839)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(554,488)**	(528,839)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		554,769	528,906
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**554,769**	528,906
Net Increase (Decrease) in Cash & Cash Equivalents	12	**281**	67
Cash & Cash Equivalents at the Beginning of the Financial Year		**46**	(21)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**327**	46

The notes on pages 5 to 20 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

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

1.2 **Pooled Budgets**

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

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

The CCG's judgement is that the Better Care Fund meets the requirements of a "jointly controlled operation. "

1.3 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.3.1 **Critical Judgements in Applying Accounting Policies**

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

- The main critical judgement made by the CCG is that the Better Care Fund is a "Jointly controlled operation". The CCG therefore has accounted for the Better Care Fund in accordance with accounting policy 1.2

1.3.2 **Key Sources of Estimation Uncertainty**

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

- the CCG makes an estimate of non-contract activity (healthcare performed by NHS and private providers with which the CCG does not have a contract) which has not been billed by the year-end. This estimate is based on information received from providers during the period when the accounts are prepared, along with past experience. The estimate could therefore be higher or lower than calculated once actual invoices are received from providers. The non contract activity accrual is included within the payables balance in the SOFP.
- the provision for continuing healthcare claims is an estimate, and is based on outstanding claims, periods of care and weekly fees. By its nature, the provision could be higher or lower, depending on the specific cases that pass the eligibility criteria for continuing healthcare funding, but is calculated at a point in time, using the information available.

- the CCG accrues expenditure with the Prescription Pricing Division (PPD) of the NHS BSA at the year end, representing an estimate of prescribing costs for the year still to be reimbursed. The accrual is based on the Prescribing Monitoring Document (PMD) issued by the PPD, which forecasts the likely spend to be incurred by the CCG, and takes into account payments already made. The accrual is recorded within Non NHS accruals in note 13.

1.4 **Revenue**

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

1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**

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

1.5.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.6 **Other Expenses**

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

Notes to the financial statements

1.7 **Property, Plant & Equipment**

1.7.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.7.2 **Valuation**

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use. This includes IT equipment.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.7.3 **Subsequent Expenditure**

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

1.8 **Intangible Assets**

1.8.1 **Recognition**

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

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

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

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

1.8.2 **Measurement**

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 **Depreciation, Amortisation & Impairments**

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

Depreciation and amortisation are charged in the first quarter after the month of acquisition. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.10 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. The CCG does not hold any finance leases. All expenditure on operating leases is charged in the year that the expenditure occurs.

1.11 **Cash & Cash Equivalents**

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

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

Notes to the financial statements

1.12 **Provisions**

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **Continuing healthcare risk pooling**

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

1.16 **Contingencies**

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

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

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

1.17 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

The CCG only has "loans and receivables" as financial assets.

1.17.1 **Loans & Receivables**

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

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

Given that loans and receivables are expected to be paid in under a year, their amortised cost equates to their initial value.

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

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

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

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

1.18 **Financial Liabilities**

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

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

The CCG only holds "Other Financial Liabilities".

1.18.1 **Other Financial Liabilities**

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

1.19 **Value Added Tax**

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

1.20 **Foreign Currencies**

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

1.21 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them. At 31st March 2016, no third party assets were held by the CCG.

Notes to the financial statements

1.22 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

1.23 **Research & Development**

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2 Financial performance targets

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

	2015-16 Target £000	2015-16 Performance £000	2015-16 Variance £000	Target achieved?
Expenditure not to exceed income	563,275	557,740	-5,535	Yes
Capital resource use does not exceed the amount specified in Directions	350	344	-6	Yes
Revenue resource use does not exceed the amount specified in Directions	560,069	554,535	-5,534	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	2,900	2,900	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	11,510	10,411	-1,099	Yes

NHS England set the CCG a Revenue Resource Limit of £560,069,000 for 2015-16, and the CCG achieved an underspend of £5,534,000 against this target.
The CCG was set a Capital Resource Limit of £350,000 for 2015-16, and underspent this target by £6,000.
The target for administration costs was set at £11,510,000, and the CCG achieved an underspend of £1,099,000.

Performance in 2014-15 was as follows:

	2014-15 Target £000	2014-15 Performance £000	2014-15 Variance £000	Target achieved?
Expenditure not to exceed income	538,029	534,940	-3,089	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	534,975	531,886	-3,089	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	2,700	2,700	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	12,072	11,670	-402	Yes

NHS England set a Revenue Resource Limit of £534,975,000 for 2014/15, and the CCG achieved an underspend of £3,089,000 against this target.
The CCG also underspent by £402,000 on administration costs, against the target spend of no more than £12,072,000 in 2014/15.

3 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	46	23	23	60
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	2,213	88	2,125	2,390
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	945	5	940	604
Total other operating revenue	**3,204**	**116**	**3,088**	**3,054**

3.1 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	3,204	116	3,088	3,054
From sale of goods	0	0	0	0
Total	**3,204**	**116**	**8,534**	**3,054**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2015-16	Total			Admin			Programme	
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	5,167	4,065	1,102	4,864	3,988	876	303	77	226
Social security costs	359	359	0	355	355	0	4	4	0
Employer Contributions to NHS Pension scheme	530	530	0	522	522	0	8	8	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	104	104	0	104	104	0	0	0	0
Gross employee benefits expenditure	**6,160**	**5,058**	**1,102**	**5,845**	**4,969**	**876**	**315**	**89**	**226**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,160**	**5,058**	**1,102**	**5,845**	**4,969**	**876**	**315**	**89**	**226**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**6,160**	**5,058**	**1,102**	**5,845**	**4,969**	**876**	**315**	**89**	**226**

4.1.1 Employee benefits	2014-15	Total			Admin			Programme	
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	4,872	4,221	651	4,851	4,210	641	21	11	10
Social security costs	371	371	0	370	370	0	1	1	0
Employer Contributions to NHS Pension scheme	539	539	0	537	537	0	2	2	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	28	28	0	28	28	0	0	0	0
Gross employee benefits expenditure	**5,810**	**5,159**	**651**	**5,786**	**5,145**	**641**	**24**	**14**	**10**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**5,810**	**5,159**	**651**	**5,786**	**5,145**	**641**	**24**	**14**	**10**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**5,810**	**5,159**	**651**	**5,786**	**5,145**	**641**	**24**	**14**	**10**

4.1.2 Recoveries in respect of employee benefits

The CCG has made no recoveries from other organisations in respect of employee benefits.

4.2 Average number of people employed

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**112**	**97**	**15**	117

None of those employed have been engaged on capital projects.

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	641	668
Total Staff Years	106	104
Average working Days Lost	**6**	**6**

No members of staff have retired early on ill health grounds (2014-15; 0).

4.4 Pension costs

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

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

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

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

4.4.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2015-16, employers' contributions of £530k were payable to the NHS Pensions Scheme (2014-15: £539k) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

4.4 Exit packages agreed in the financial year

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	1	11,541	1	11,541
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	104,239	0	0	1	104,239
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**1**	**104,239**	**1**	**11,541**	**2**	**115,780**

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	1,872	1	1,872
£10,001 to £25,000	0	0	1	14,892	1	14,892
£25,001 to £50,000	0	0	1	33,585	1	33,585
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**3**	**50,349**	**3**	**50,349**

	2015-16 Departures where special payments have been made		2014-15 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2015-16 Other agreed departures		2014-15 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	1	28,181
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	11,541	2	22,168
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**1**	**11541**	**3**	**50349**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures has been recognised in 2015-16.

Redundancy and other departure costs have been paid in accordance with the provisions of the standard NHS contract terms and conditions.

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

Where the CCG has agreed early retirements, the additional costs are met by the CCGs and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. The CCG has not agreed any early or ill-health retirements in 2015-16 (2014-15, none)

No non-contractual payments have been made to individuals during 2015-16 (2014-15, none)

The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. During 2015-16, no exit payments have been made to senior managers.

5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	5,264	4,949	315	4,924
Executive governing body members	896	896	0	886
Total gross employee benefits	**6,160**	**5,845**	**315**	**5,810**
Other costs				
Services from other CCGs and NHS England	4,052	2,771	1,281	4,442
Services from foundation trusts (1)	319,300	0	319,300	266,874
Services from other NHS trusts	43,493	0	43,493	91,508
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies (2)	100,717	0	100,717	84,594
Chair and Non Executive Members	517	517	0	524
Supplies and services – clinical	441	0	441	723
Supplies and services – general	273	216	57	284
Consultancy services	391	292	99	1,040
Establishment	444	251	192	745
Transport	4	4	0	8
Premises	378	304	75	357
Impairments and reversals of receivables	(16)	(16)	0	16
Inventories written down	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	81	81	0	108
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	74,023	0	74,023	71,202
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	3,059	0	3,059	3,051
Other professional fees excl. audit	226	226	0	203
Grants to other public bodies	2,900	0	2,900	2,700
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	0	0	0	10
Education and training	34	34	(0)	82
Change in discount rate	0	0	0	0
Provisions	9	0	9	(93)
Funding to group bodies		0	0	0
CHC Risk Pool contributions (3)	1,250	0	1,250	751
Other expenditure	2	0	2	1
Total other costs	**551,579**	**4,682**	**546,897**	**529,130**
Total operating expenses	**557,739**	**10,527**	**547,212**	**534,940**

(1) The main reasons for the increase in expenditure with Foundation Trusts are:
- spend with Royal United Hospitals Bath NHS FT was for the full year in 15/16, but only a part year in 14/15 (November to March). The Trust became a Foundation Trust on 1st November 2014.
- spend with Oxford University Hospitals NHS FT was for a part year in 15/16 (October to March). In 14/15, all spend was recorded against services from other NHS Trusts

(2) The increase in spend with Non NHS bodies reflects the spending on the Better Care Fund which is hosted by Wiltshire Council. The pooling arrangement means that the CCG accounts reflect expenditure incurred by the Council on behalf of the Fund.

(3) The CHC Risk pool contribution is set by NHS England, and reflects the CCG's contribution towards the fund used to settle continuing healthcare claims relating to periods before 1 April 2013. This expenditure is in line with accounting policy 1.15.

6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 **Number**	2014-15 **£000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,707	86,596	8,920	71,390
Total Non-NHS Trade Invoices paid within target	11,614	86,043	8,802	70,765
Percentage of Non-NHS Trade invoices paid within target	**99.21%**	**99.36%**	**98.68%**	**99.12%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,848	363,527	3,841	358,735
Total NHS Trade Invoices Paid within target	3,821	363,441	3,801	357,875
Percentage of NHS Trade Invoices paid within target	**99.30%**	**99.98%**	**98.96%**	**99.76%**

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

in 2015-16, the CCG did not make any interest payments relating to the late payment of commercial debts (2014-15; nil)

7. Operating Leases

7.1 As lessee

NHS Wiltshire CCG occupies and pays rent on Southgate House, Devizes, a property owned by NHS Property Services Ltd. It also pays a vacancy charge on Westbury Hospital, which is also owned by NHS Property Services Ltd. There is no signed lease in place, even though the nature of the transactions undertaken conveys the right for the CCG to use the property. Under paragraph 9 of IFRIC 4, these arrangements are a lease, and as such, they are accounted for in accordance with IAS17.

7.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2015-16 Total £000
Payments recognised as an expense				
Minimum lease payments	0	356	4	**360**
Contingent rents	0	0	0	**0**
Sub-lease payments	0	0	0	**0**
Total	**0**	**356**	**4**	**360**

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangements on Southgate House or Westbury Hospital.

	Land £000	Buildings £000	Other £000	2014-15 Total £000
Payments recognised as an expense				
Minimum lease payments	0	332	7	**340**
Contingent rents	0	0	0	**0**
Sub-lease payments	0	0	0	**0**
Total	**0**	**332**	**7**	**340**

7.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2015-16 Total £000
Payable:				
No later than one year	0	0	4	**4**
Between one and five years	0	0	3	**3**
After five years	0	0	0	**0**
Total	**0**	**0**	**7**	**7**

	Land £000	Buildings £000	Other £000	2014-15 Total £000
Payable:				
No later than one year	0	0	5	**5**
Between one and five years	0	0	4	**4**
After five years	0	0	0	**0**
Total	**0**	**0**	**9**	**9**

7.2 As lessor

The CCG has not acted as a lessor in either 2015-16 or 2014-15.

8 Property, plant and equipment

2015-16	Information technology £000	Total £000
Cost or valuation at 01-April-2015	0	0
Addition of assets under construction and payments on account		0
Additions purchased	310	310
Cost/Valuation At 31-March-2016	**310**	**310**
Depreciation 01-April-2015	0	0
Depreciation at 31-March-2016	**0**	**0**
Net Book Value at 31-March-2016	**310**	**310**
Purchased	310	310
Donated	0	0
Government Granted	0	0
Total at 31-March-2016	**310**	**310**
Asset financing:		
Owned	310	310
Total at 31-March-2016	**310**	**310**

The CCG did not have any property, plant and equipment in 2014/15.

No depreciation was charged in 2015/16. The assets were only purchased in March 2016, and it is the CCG's policy to depreciate in the first quarter following purchase.

8.1 Economic lives

The economic life of the information technology is 5 years.

9. Intangible non-current assets

2015-16	Computer Software: Purchased £000	Total £000
Cost or valuation at 01-April-2015	0	0
Additions purchased	34	34
Cost / Valuation At 31-March-2016	**34**	**34**
Amortisation 01-April-2015	0	0
Amortisation At 31-March-2016	**0**	**0**
Net Book Value at 31-March-2016	**34**	**34**
Purchased	34	34
Donated	0	0
Government Granted	0	0
Total at 31-March-2016	**34**	**34**

The CCG did not have any intangible non-current assets in 2014/15.

No amortisation was charged in 2015/16. The assets were only purchased in March 2016, and it is the CCG's policy to depreciate in the first quarter following purchase.

9.1 Economic lives

The economic life of the purchased computer software is 5 years.

10. Inventories

As at 31 March 2016, the CCG does not hold any inventory (2014-15, nil)

11 Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000 RESTATED	Non-current 2014-15 £000
NHS receivables: Revenue	790	0	2,429	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	0	0	166	0
NHS accrued income	416	0	128	0
Non-NHS receivables: Revenue	584	0	995	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	167	0	65	0
Non-NHS accrued income	833	0	738	0
Provision for the impairment of receivables	0	0	(16)	0
VAT	42	0	43	0
Other receivables	0	0	0	0
Total Trade & other receivables	**2,832**	**0**	**4,548**	**0**
Total current and non current	**2,832**		**4,548**	
Included above:				
Prepaid pensions contributions	0		0	

The majority of the CCG's income is from other NHS organisations and local authorities. As such, no credit scoring is considered to be necessary.

11.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	225	110
By three to six months	287	0
By more than six months	464	0
Total	**976**	**110**

£667k of the amount above has subsequently been recovered post the statement of financial position date.

11.2 Provision for impairment of receivables	**2015-16 £000**	2014-15 £000
Balance at 01-April-2015	(16)	0
Amounts written off during the year	0	0
Amounts recovered during the year	16	0
(Increase) decrease in receivables impaired	0	(16)
Transfer (to) from other public sector body	0	0
Balance at 31-March-2016	**0**	**(16)**

No receivables have been impaired at 31 March 2016

12 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	46	(21)
Net change in year	281	67
Balance at 31-March-2016	**327**	**46**
Made up of:		
Cash with the Government Banking Service	327	46
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial	**327**	**46**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**327**	**46**

The CCG holds no money on behalf of patients.

13 Trade and other payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	5,246	0	8,203	0
NHS payables: capital	0	0	0	0
NHS accruals	2,116	0	144	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	2,747	0	2,569	0
Non-NHS payables: capital	344	0	0	0
Non-NHS accruals	18,778	0	19,436	0
Non-NHS deferred income	0	0	0	0
Social security costs	56	0	54	0
VAT	0	0	0	0
Tax	62	0	63	0
Payments received on account	0	0	0	0
Other payables	270	0	477	0
Total Trade & Other Payables	**29,619**	**0**	**30,946**	**0**
Total current and non-current	**29,619**		**30,946**	

Other payables include £82,000 outstanding pension contributions at 31 March 2016 (£82,000 at 31 March 2015)

14. Borrowings

On both 31 March 2015 and 31 March 2016, the CCG had no bank overdraft or loans.

15 Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	73	0	71	0
Other	0	0	0	0
Total	**73**	**0**	**71**	**0**
Total current and non-current	**73**		**71**	

	Continuing Care £000s	**Other £000s**	**Total £000s**
Balance at 01-April-2015	**71**	**0**	**71**
Arising during the year	73	0	73
Utilised during the year	(7)	0	(7)
Reversed unused	(64)	0	(64)
Unwinding of discount	0	0	0
Change in discount rate	0	0	0
Transfer (to) from other public sector body	0	0	0
Balance at 31-March-2016	**73**	**0**	**73**
Expected timing of cash flows:			
Within one year	73	0	73
Between one and five years	0	0	0
After five years	0	0	0
Balance at 31-March-2016	**73**	**0**	**73**

Continuing Care - This provision relates to existing retrospective applications which may be eligible for Continuing Healthcare (CHC) funding, but which have not yet been agreed by the CHC panel. The liability has been estimated based on claims received, periods covered and estimated weekly costs.

Under the Accounts Direction by NHS England, issued on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS CHC claims relating to periods of care before Wiltshire CCG was established (1st April 2013).

The total value of legacy NHS CHC provisions accounted for by NHS England on behalf of Wiltshire CCG at 31 March 2016 is £2,582k (31/3/2015, £2,741k).

From 2014-15, all CCGs contribute funds to a risk-sharing pool to be used by NHS England for legacy payments. During 2015-16, Wiltshire CCG contributed £1,250k (2014-15, £751k). Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority(NHS LA) and the probabilities provided by them. There are currently no claims lodged with the NHS LA.

There is a requirement for NHS bodies to note the value of provisions carried in the books of the NHS Litigation Authority in regard to ELS (Existing Liabilities Scheme) and CNST (Clinical Negligence Scheme for Trusts) claims as at 31 March 2016.

The provision for ELS claims is nil, and for CNST claims is £119k. This does not represent expenditure by the CCG.

16 Contingencies

The CCG has no contingent assets or liabilities at 31 March 2016 (2014-15, nil)

17 Commitments

17.1 Capital commitments

The CCG has no capital commitments at 31 March 2016 (31 March 2015, £nil).

17.2 Other financial commitments

The CCG has no non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) at 31 March 2016 (31 March 2015, £nil).

18 Financial instruments

18.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is limited to cash management and is subject to review by internal audit.

18.1.1 Currency risk

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

18.1.2 Interest rate risk

The CCG receives capital resource from NHS England to fund capital expenditure and has no powers to borrow. The CCG draws down cash to cover expenditure as the need arises, and does not need to borrow to finance its business. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of the CCG's revenue comes from parliamentary funding, Wiltshire CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note, note 11.

18.1.3 Liquidity risk

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

18 Financial instruments cont'd

18.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,206	0	1,206
· Non-NHS	0	1,416	0	1,416
Cash at bank and in hand	0	327	0	327
Other financial assets	0	0	0	0
Total at 31 March 2016	**0**	**2,949**	**0**	**2,949**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,429	0	2,429
· Non-NHS	0	996	0	996
Cash at bank and in hand	0	46	0	46
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**3,471**	**0**	**3,471**

18.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,362	7,362
· Non-NHS	0	22,139	22,139
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	**0**	**29,501**	**29,501**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	8,347	8,347
· Non-NHS	0	22,483	22,483
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**30,830**	**30,830**

19 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare	557,739	(3,204)	**554,535**	3,503	(29,692)	**(26,189)**
Total	**557,739**	**(3,204)**	**554,535**	**3,503**	**(29,692)**	**(26,189)**

Reconciliation between Operating Segments and SoCNE

	31-Mar-16 £'000
Total net expenditure reported for operating segments	554,535
Reconciling items:	0
Total net expenditure per the Statement of Comprehensive Net Expenditure	554,535

Reconciliation between Operating Segments and SoFP

	31-Mar-16 £'000
Total assets reported for operating segments	3,503
Reconciling items:	0
Total assets per Statement of Financial Position	**3,503**

	31-Mar-16 £'000
Total liabilities reported for operating segments	(29,692)
Reconciling items:	0
Total liabilities per Statement of Financial Position	**(29,692)**

20 Pooled budgets

Wiltshire CCG and Wiltshire Council have pooled budgets in the Better Care Fund.

The Better Care Fund was established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve National Conditions and Local Objectives, through the establishment of a Better Care Plan. The Plan is based on the overriding principle of care closer to home with health care led by local GPs. The Plan is based on four priorities:
- "I will be supported to live healthily"
- "I will be supported to live independently"
- "I will be kept safe from avoidable harm"
- "I will be listened to and involved".

The CCG and the Council have contributed funds into a pooled budget and have developed a number of schemes based on Plan priorities. The Better Care Fund pooled budget is a jointly controlled operation, as all spending decisions are approved by a Joint Commissioning Board, made up of representatives from the CCG and the Council - both parties have to agree on spending commitments. The Better Care Fund is therefore accounted for as a jointly controlled operation, in line with the CCG's accounting policy, 1.2.

Wiltshire Council are the host of the Better Care Fund. This means that the Council holds all monies contributed to the Fund by the CCG and the Council. It appoints the Pool Manager, and is responsible for the administration of the pooled budget.

In 2015/16, Wiltshire CCG contributed £27,073,000 to the Better Care Fund, and Wiltshire Council contributed £4,842,000.

BETTER CARE FUND INCOME AND EXPENDITURE 2015/16

	£000
INCOME	31,915
EXPENDITURE	31,915
Net surplus/(deficit)	NIL

At 31 March 2016, the Better Care Fund held no payables or receivables balances, and its cash balance was £nil.

Wiltshire CCG's share of the income and expenditure handled by the pooled budget in the financial year was:

	2015-16 £000
Income	27,073
Expenditure	(27,073)

There was no comparable pool in 2014-15

21 Related party transactions

Details of related party transactions with individuals are as follows:

Name of related party	Nature of relationship	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
The Porch Surgery	Dr Simon Burrell, GP Chair NEW Group, is a partner within this practice.	341	0	9	0
Pewsey Surgery	Dr Anna Collings, GP Vice Chair NEW Group, is a partner within this practice.	132	0	2	0
The Castle Practice	Dr Toby Davies, GP Chair Sarum Group, is a senior partner of this practice.	148	0	13	0
Morley Manor Ltd	Dr Toby Davies, GP Chair Sarum Group, is a director of Morley Manor Ltd.	50	0	0	0
The Avenue Surgery	Dr Lindsay Kinlin, GP Vice Chair Sarum Group, is a partner wihin this practice.	405	0	26	0
Market Lavington Surgery	Dr Richard Sandford-Hill, GP Vice Chair WWYKD Group, is a partner of this practice.	118	0	2	0
Sandford-Hill Medical Services Ltd	Dr Richard Sandford-Hill, GP Chair WWYKD Group, is a director of Sandford-Hill Medical Services Ltd.	66	0	0	0
Salisbury Walk In Centre	The practice which Dr Toby Davies, GP Chair Sarum Group, belongs to, is a shareholder in Wilcodoc Ltd which runs Salisbury Walk In Centre. The practice which Dr Peter Jenkins, GP Medical Advisor, is a partner in, is a shareholder in Wilcodoc Ltd which runs Salisbury Walk In Centre Dr Chet Sheth is a director of Wilcodoc Ltd, which runs Salisbury Walk In Centre	939	0	0	3
St Ann Street Surgery	Dr Chet Sheth, GP Vice Chair Sarum Group, is a partner of this practice.	393	0	8	0
CS Medical Consultancy Services Ltd	Dr Chet Sheth, GP Vice Chair Sarum Group, is a director of this company.	50	0	0	0
Ardens Health Informatics	Dr Chet Sheth is a director of Ardens Health Informatics.	35	0	0	0
Royal United Hospitals NHS Foundation Trust	Simon Truelove, Chief Financial Officer, is married to the Director of Finance of the Trust	88,027	379	1,443	36
Wiltshire Council	James Roach, Director of Integration, is jointly employed with Wiltshire Council.	10,050	1,149	821	553

GP practices within the area have joined other professionals in the CCG in order to plan, design and pay for services. Under these arrangements, some services are designed to be delivered in a primary care setting. This involves paying GP practices for the delivery of these services.
A GP is also paid by the CCG for taking a lead role on clinical services. All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. Material transactions are disclosed appropriately in the accounts.

The Department of Health is considered to be a related party. During 2015-16, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities include:
- NHS England
- Salisbury NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Royal United Hospitals NHS Foundation Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South Western Ambulance Service NHS Foundation Trust

In addition, the CCG has had a number of material transactions with other central government and local government bodies. The majority of these transactions have been with Wiltshire Council.

22 Events after the end of the reporting period

There have been no events after the end of the reporting that require disclosure in this note, or adjustments to the accounts for 2015-16.
The accounts were authorised for issue by Simon Truelove, Chief Financial Officer, on 24 May 2016

23 Losses and special payments

23.1 Losses

The total number of NHS Wiltshire CCG's losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	1	(16)	1	15
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**1**	**(16)**	**1**	**15**

23.2 Special payments

	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	1	2	1	1
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	3	50
Total	**1**	**2**	**4**	**51**

24 Third party assets

The CCG does not hold any assets on behalf of third parties (2014-15, nil)

Independent auditor's report to the members of the governing body of Wiltshire CCG

We have audited the financial statements of Wiltshire CCG for the year ended 31 March 2016 in the Financial Statements Section on pages 1 to 20 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of Wiltshire CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body 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 set out on page 59, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for 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 under the Local Audit and Accountability Act 2014 ('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 Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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
- 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 criterion 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 this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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 the CCG as at 31 March 2016 and of its net operating expenditure for the year then ended

  and

- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England

  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 reflect compliance with guidance issued by the NHS Commissioning Board

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency

  or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014

  or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014

  or

- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Certificate

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

Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
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