NHS
Wiltshire
Clinical Commissioning Group

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Annual Report and Accounts 2017/18

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Linda Prosser, Interim Chief Officer
22 May 2018

Overview

Accountable Officer statement

I'm pleased to present to you the Wiltshire Clinical Commissioning Group annual report and accounts for 2017/18.

The report provides information on our commissioning activity and performance from the last 12 months, as well as details of our financial performance and key areas of development. It also describes a clear record of achievement and improvement of which we can all be proud.

The challenges facing the nation's health and social care system has hardly left the headlines this year. As a nation we need to discuss how our health and social care system can work more effectively so it provides the best value from the precious resources available. That's often a challenge with the geography of Wiltshire, and through all of our discussions we have been keeping a keen eye on our ability to demonstrate value for patients. Value is much more than just cost, it also relates to the clinical quality of services and the way they meet our needs as individuals.

So in spite of the distraction and intense pressures, a lot of planning and hard work has carried on in the background. The Governing Body is determined to continue the programme of developments and service improvements despite the financial climate. Clear plans are being developed which will form the basis of our future, and can only be delivered with the support and energy of our staff.

As a result of the tremendous dedication and relentless drive for change that has taken place over the last 12 months, Wiltshire CCG has made some very notable achievements. We saw some of our best performance around cancer and mental health programmes.

We have also taken back full responsibility for commissioning primary care services. We want to continue building on the excellent foundations of primary care in the county. The retention and recruitment of GPs to Wiltshire continues to be a problem but a lot of work is underway to encourage wider collaboration and federated networks across GP practices, with positive results.

The BaNES, Swindon and Wiltshire Sustainability and Transformation Partnership (BSW STP) continues to focus on the shared opportunities and efficiencies across the wider geographical footprint. This means that many of our 'place based' plans and operational systems (our offer to expectant mothers, for example) will be the same, where relevant, across the whole of our three areas.

During 2017/18 we have had some changes within our leadership. Following Dr Peter Jenkins' retirement from the Chairmanship in June 2017, a comprehensive election process was held amongst our GP members and Dr Richard Sandford-Hill was elected to take up the post. Richard has been a voting member of the Governing Body since the inauguration of the CCG and continues to practice in Market Lavington, where he is Senior Partner.

The departure of our previous Interim Chief Officer, Tracey Cox, in June 2017 led to further changes to the leadership team on an interim basis. Tracey did a sterling job of overseeing both Wiltshire and Bath and North East Somerset CCGs for nine months before returning to BaNES full time. I was delighted to be asked to support Wiltshire CCG and took on the job of Interim Chief Officer in June 2017. Since then we have been working very closely with our system partners, sowing seeds for an ambitious, borderless integrated health and care system for Wiltshire.

It has been hard work, but extremely satisfying to oversee the emergence of governance structures and the seeds of proposals and operational plans taking shape as we develop an ambitious new system.

To do this, and get it right, will ultimately be the most challenging work for us to do in the coming year. Plans will become embedded and we will be in action mode. We are all very conscious of how we engage meaningfully and communicate effectively with the public and we will prioritise our engagement strategy in 2018/19. Everyone has a part to play and everyone's contribution, no matter how big or small, is vital to the process now and for the future.

In the event, though, we did and we continue to do all of the things listed above, but they turned out not to be the year's big story. In February we faced some of the most severe weather conditions for many years. It's rare to find ourselves in the position of a declared Major Incident caused by weather, but the Police took that decision, and a multi-agency command, control and co-ordination structure was established. Assistance was also sought from the Military through Central Government. Luckily we plan for exceptional circumstances and our planning paid off. The commitment of all hospital colleagues, provider colleagues, agencies, volunteers and our staff, who worked tirelessly over weekends and throughout the nights was incredible.

It's fair to say we hadn't then expected to go straight into another incident in which Wiltshire – specifically the City of Salisbury - has been the focus of international news. Once again, extraordinarily exceptional circumstances were managed through Major Incident command and control co-ordination, led at first by Wiltshire Police and then by Counter Terrorism. Members of CCG staff became important members of Gold Command, the Strategic Co-ordination Group, the Tactical Coordination Group and the Recovery Co-ordination Group, contributing expert advice, experience and action at all levels with dedication, effort and commitment.

At time of writing the work remains demanding and exhausting, and I'd like to put on record how immensely proud we are of our colleagues at Salisbury District Hospital. We all hope that public services in Wiltshire never again have to be tested to the degree they have been in the start to 2018.

It would be remiss of me not to also mention the ransomware attack in May 2017 which, whilst not directly targeted at the NHS, did affect a number of NHS organisations nationwide. In Wiltshire, we had an isolated case of one computer affected by the ransom ware, which was securely removed from use with no further impact to our IT infrastructure. The robust security measures we have in place were extremely effective in protecting our IT network and digital information during this time and are reflective of the importance we place on maintaining safe and secure technology systems.

The continued resilience, determination and commitment of our staff and the CCG's GP membership is to be applauded and we would like to thank them for their continued efforts.

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

Linda Prosser
Interim Chief Officer

Our financial position

During recent years the health service has seen continuing pressures which have arisen due to increased demand and complexity set against a backdrop of lower levels of growth funding. In Wiltshire we have responded to this challenge by seeking to transform services for quality and efficiency gains via our Quality Innovation Productivity and Prevention (QIPP) schemes. For 2017/18 this saw the CCG develop plans to address a £14.5m challenge.

This challenge does not subside as we move into 2018/19, with the CCG having a £15.8m challenge, however having delivered our financial requirements in previous years the CCG continues to be in a strong financial position going into 2018/19 with plans being developed to deliver against this target.

We are currently entering the third year of the comprehensive spending review period, during which the government committed an additional £7.6bn of funding to the NHS in response to NHS England's Five Year Forward View. Further to this, the 2017 autumn statement committed further additional funding to the NHS (£1.6bn) which will see further resources flow into provider and commissioner sustainability funds and directly into CCG allocations – for Wiltshire this will see an additional £4.8m being provided to commission services.

Split of additional funding to the NHS

Year	NHS England £billion	Other Department of Health £billion	Autumn 2017 additional resources £billion	Net change in overall health budgets £billion
2016/17	3.7	-1.7		2.0
2017/18	1.4	-0.6		0.8
2018/19	0.4	-0.1	1.6	1.9
2019/20	0.7	-0.5		0.2
2020/21	1.4	-0.3		1.1
Total	**7.6**	**-3.2**	**1.6**	**6.0**

For Wiltshire CCG these increases are reflected in the core financial allocations that are received. The table below summarises the core funding received for 2017/18 and 2018/19, including the impact of the additional autumn 2017 funding – it should be noted that these allocations do not include delegated primary care allocations or other non-recurrent funds received in year.

Core CCG funding allocations for 2017-19

Year	£m
2017/18 core allocation Adjustment for agreed in year transfers	585.6 -2.1
Updated 2018/19 starting point	583.5
Growth in allocation Share of additional autumn 2017 funding	14.0 5.0
2018/19 funding	602.5

The core financial allocations received are compared against a national funding formula and identify that in 2018/19 Wiltshire will be 2.17% below its target level of funding (down from -2.45% in 2017/18) – this is equivalent to a c£13.4m shortfall in funding against national models.

Despite these additional resources there are still substantial financial challenges facing the NHS. NHS England's Five Year Forward View highlighted a £30bn gap in NHS funding by 2020/21.

Whilst there is additional investment coming into the health system the NHS will still need to make efficiency savings in the region of £20bn by 2021 to remain financially sustainable.

More locally, the Strategic Transformation Partnership (STP) for Bath and North East Somerset, Swindon and Wiltshire is developing strategies to address this financial challenge locally. In 2018/19 the partnership, comprising health commissioners and providers and local authorities, has identified a financial challenge of c£110m – the Wiltshire CCG element of this is £15.8m.

We continue to work in collaboration with STP partners to develop plans to secure further efficiencies and improve service provision in as part of meeting this challenge.

Our county, our people and their health

County

3,485km²	90%	492,240
A large county	Classified as rural	Population in 2017

People

141	50%	25%
People per square kilometre - a low population density	Living in places with fewer than 5,000 people	Living in places with fewer than 1,000 people

Health

A generally healthy population when compared with the England average

More people are living longer

More people aged 65+ are putting additional pressure on local health services

People's health in Wiltshire

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

The Public Health Outcomes Framework May 2018 shows comparative measure of health life and life expectancy.

	Period	Local value (in years)	Change from prev
Healthy life expectancy at birth (Male)	2014 - 16	65.2	→
Healthy life expectancy at birth (Female)	2014 - 16	67.1	→
Life expectancy at birth (Male)	2014 - 16	81.0	→
Life expectancy at birth (Female)	2014 - 16	84.1	→
Life expectancy at 65 (Male)	2014 - 16	19.5	→
Life expectancy at 65 (Female)	2014 - 16	21.7	→

Life expectancy at birth and at age 65 is also significantly better than the England average and continues to increase year-on-year. Healthy life expectancy is more variable, but has not changed significantly and remains considerably higher than the England average for females. For males, current data is not significantly different to the national average. Closing the gap between healthy life expectancy and life expectancy will be a key challenge in the coming years.

The Public Health Outcomes Framework also shows falling premature mortality rates and these remain significantly better than the England average.

Key indicators from the Public Health Outcomes Framework (May 2018) show that Wiltshire's overall health position is favourable against the national average for England.

Mortality	Over the last 10 years, all age preventable mortality rates have fallen 16%
	The premature mortality rate from heart disease and stroke has fallen by around a third and remains significantly 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 are the lowest they have been and remain significantly lower than the England average
	Overall smoking prevalence is significantly better than the England average although it remains high in part of the population in routine and manual work
For some indicators, Wiltshire are worse than average	The rate of those killed or seriously injured on the roads is significantly worse than the England average
	The rate of admission to hospital for young people with deliberate injuries is also significantly worse than the England average

Whilst our population is relatively healthy, over the next few years we know that demand for NHS services in Wiltshire will continue to increase and that the funding available will, at best, stay the same. As the organisation responsible for designing and commissioning a range of healthcare services in Wiltshire, our five year plan (2014-2019) sets out how we can provide high quality, yet affordable changes to the shape of healthcare services for the local people in Wiltshire. This plan supports the NHS five year forward view and proposes measures around:

- Prevention
- Early intervention
- Developing the individual's personal responsibility for their health and wellbeing by making healthy lifestyle choices which keep them in good health.

A changing population

The population of Wiltshire is set to increase from 483,100 to 506,500 people (23,400/4.8%) between 2014 and 2022 according to ONS interim population projections 85% of the additional population will be over 65 years which increases from 96,900 to 116,800 (19,900/20.5%) over the same period.

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

This change to the Wiltshire population will have a profound impact on healthcare provision with an increased demand for health services (with the over 65s requiring the highest level of resources compared to other age groups) a higher burden of chronic diseases and susceptibility to the negative impacts of social isolation. 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.

Our future healthcare model is based on three principles:

Encourage and support Wiltshire residents to take on more responsibility for their health and wellbeing

Provide fair access to a high quality and affordable system of care for the greatest number of people

Provide less care in hospitals and more care at home or in the community

Wiltshire Clinical Commissioning Group structure

Wiltshire is split into three localities and each has their own clinical executive and reporting structure:

- NEW (North and East Wiltshire)
- West Wiltshire (West Wiltshire and Devizes)
- Sarum (South Wiltshire)

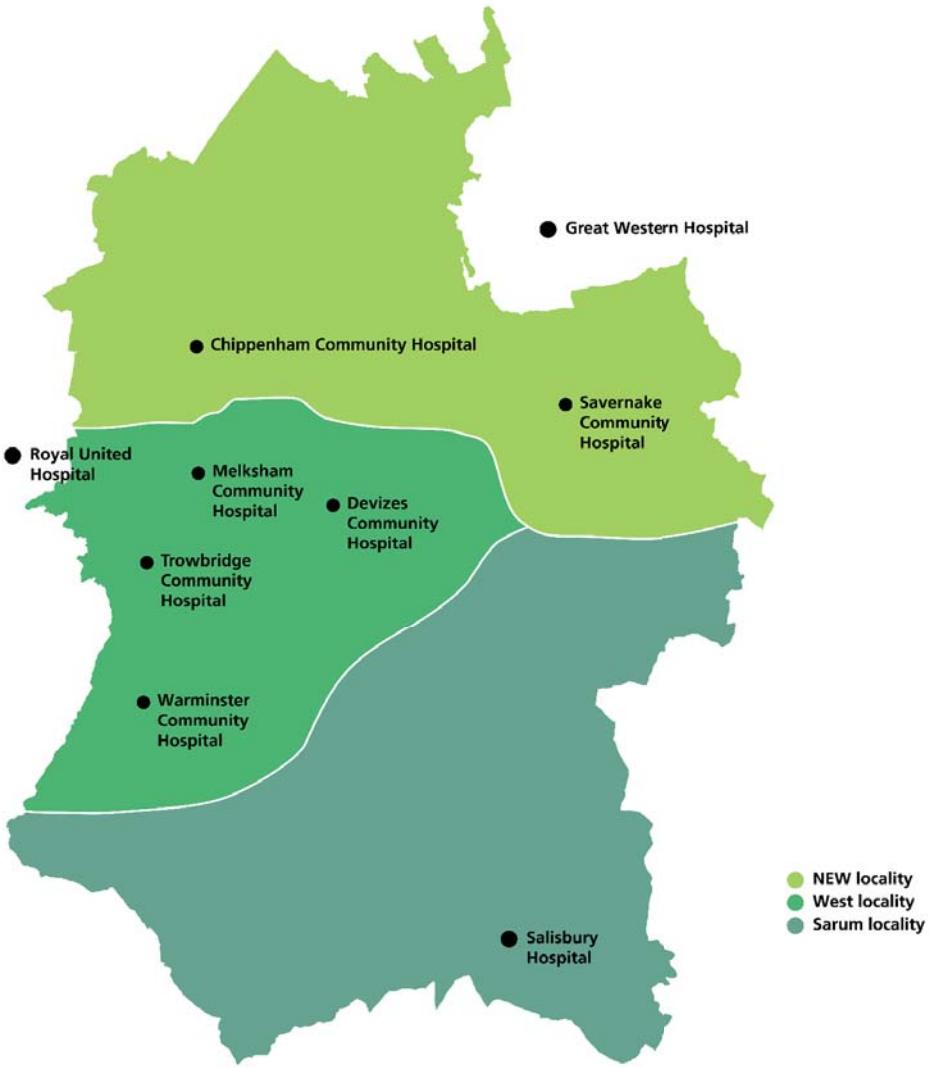
Acute care for people who live in these localities is mainly provided by three principal NHS providers.

Each provider 'faces' a different principal commissioner, which increases the complexity of both the commissioning process and implementation of change:

- Royal United Hospital NHS Foundation Trust, Bath - faces Bath and North East Somerset.
- Great Western Hospitals NHS Trust, Swindon - faces Swindon.
- Salisbury NHS Foundation Trust, Salisbury - faces Dorset and Hampshire. It is a district hospital that also provides specialist services.

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

Map showing localities, acute and community hospitals across Wiltshire



Statement of purpose and activities

Wiltshire CCG has been established for five years. It is a clinically-led statutory body that buys (commissions) and plans health services for the county of Wiltshire.

CCGs replaced Primary Care Trusts on 1 April 2013 following the 2012 Health and Social Care Act. Wiltshire CCG provides healthcare services for 490,000 people in the area.

As at 1 April 2018, the CCG is a membership organisation made up of 49 member GP practices, and is collectively responsible for honouring the NHS Wiltshire CCG constitution. Our constitution sets out our governing principles, rules and procedures to ensure integrity, honesty and accountability, and commits the CCG to taking decisions in an open and transparent way, placing the interests of patients and public at its heart. Our member practices can influence and inform decisions and provide feedback, so that we do not lose the local focus amongst the national and wider Wiltshire priorities. For a full list of the CCG's member practices, visit: http://www.wiltshireccg.nhs.uk/about-us

We listen to members of the public to involve them in the decisions we make. We also ensure they are involved in helping to improve the health services we buy for Wiltshire people.

People in Wiltshire generally live healthier and longer lives compared to the average for England, but this is not evenly spread across our county – we think this variation is unacceptable. We must reduce the gap between the health of the poorest and richest. Many factors play a part in creating the gap. The prosperity of an area is one factor. Lifestyle factors are another big reason why people may have more ill health. Based on current trends, obesity and heart disease will become an even more widespread problem in the next two years.

There is a difference of up to 20 years' life expectancy of people with mental health problems. We want everyone in Wiltshire to receive the same high quality of care, regardless of where they live, what health condition they have, or any other personal characteristic.

We also know that people who act as carers are at high risk of experiencing worse health outcomes, having their employment or education disrupted and becoming socially isolated, which in turn impacts on their role as a carer.

We were allocated £585.6m in 2017/18, which we converted into healthcare services for the Wiltshire population. We acquire these services from NHS providers, including acute hospitals, mental health services and community care providers, as well as independent providers such as Medvivo, which provides the GP Out of Hours service in the Wiltshire area.

A key part of our role as a commissioner is to work with our partner organisations – such as Salisbury Foundation Trust, Great Western Hospital Trust, Royal United Hospital Bath and Wiltshire Health and Care – to ensure that the care you receive is safe and of good quality. This collaborative working also ensures that the public monies we are responsible for are spent as effectively and efficiently as possible. These services include urgent care, care for long term conditions such as diabetes, mental health, cancer treatment, surgical procedures and maternity services.

There is a compelling need for change, driven by the changing needs of our local population – the services we have inherited were not designed to deliver care for the 21st Century. To help CCGs mark performance and achievements, last year NHS England introduced an Improvement and Assessment framework for CCGs (CCG IAF) and the framework covers indicators located in four domains, which are:

- Better health
- Better care
- Sustainability
- Leadership

* in 2018/19 a fifth indicator will be implemented, covering Public Engagement and Involvement.

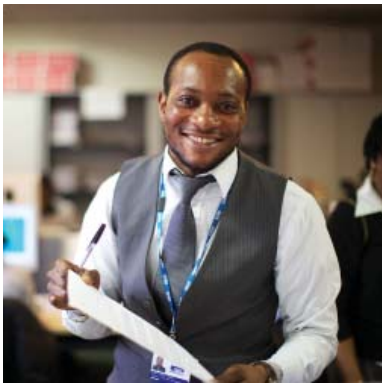
Wiltshire CCG has ended the financial year 2017/18 rated as 'Good' against all four indicators.

We are one third of the BaNES, Swindon and Wiltshire Sustainability and Transformation Partnership and developing plans across the wider geography has strengthened collaborative working. Our shared vision is to deliver health and care services that meet people's needs, enable people to live well in their communities, encourage people to improve their health and wellbeing, get the best out of modern technologies and address inequalities. We want to empower people to take greater responsibility for their own health, and make sure we have the right services in place to support them with this.

The CCG's overall performance is regularly monitored and carefully scrutinised through monthly performance reports and a robust system for the identification and management of risks, as well as an internal staff appraisal system based on a system of cascaded staff objectives.

The Governing Body invests in its own development, with seminars to discuss potential future organisational structures and how we see new models of healthcare for Wiltshire. We encourage all staff to seek continual personal development opportunities and have run the first full year of our bespoke training programme for future leaders for those in an earlier stage of their career. The programme combines structured action learning and academic content to develop outstanding healthcare leaders for the future.

Our headquarters are based at Southgate House in Devizes.



NHS Wiltshire CCG Strategic Objectives 2017/18

- To continue delivering a clinically led model providing an enhanced range of high quality and integrated patient services within the community providing 'wrap around' care at or close to home. E.g. high intensity care in the community and the development of urgent care treatment centres.
- Commission and transform appropriate services to meet the needs of the local population and implementing NHS England's Five Year Forward View focusing on urgent and emergency care, primary care, mental health and cancer services.
- Engage effectively with the local population to enable patients and carers to influence the services that we commission increasing our engagement with hard to reach groups.
- Enhance and assure the quality, safety and experience of services by ensuring effective mechanisms are in place to set quality standards, monitor performance, address concerns and embed a culture of continuous quality improvement.
- Achieve a sustainable (in terms of performance and finance) health and care economy across Wiltshire and the Sustainability and Transformation Partnership footprint optimising appropriate use of resources for the delivery of effective services to address the efficiency, quality and health and well-being gaps.
- Develop an effective and responsive clinically led commissioning organisation, working collaboratively with partner organisations and with Wiltshire Council increasing our focus on integrated commissioning and delivery of services.
- Encourage and support the Wiltshire population in managing and improving their health and wellbeing, wherever possible increasing the ability of people to manage their own care and to make their own choices.
- To support the resilience of primary care across Wiltshire through the implementation of our local GP Forward View Plan and delegated responsibilities of primary medical services.
- To work with partners to develop our vision for an Accountable Care System across Wiltshire.
- To ensure that the CCG workforce remains focussed and motivated by providing clear and consistent leadership, applying our objective and appraisal system, reacting appropriately to staff survey action points and feedback from the Staff Partnership Forum and investing in staff training, development and wellbeing.

Visit Wiltshire CCG website for more information: www.wiltshireccg.nhs.uk

Key issues and risks which could prevent delivery of our objectives

We have developed a robust business risk process, to ensure that there is a streamlined approach to assurance enabling the Governing Body and delegated committees to focus only on the strategic risks of the organisation. For assurance, see the full governance statement on page AR 15.

The process is supported by the Corporate Risk Register (see page AR 27) which documents all strategic and operational risks for the organisation. The Corporate Risk Register is reported regularly to the Governing Body and to the Audit and Assurance Committee.

We will face an increasingly challenging year in 2018/19 as the NHS continues to operate within a tight financial framework during a period of further change and movement towards greater integration with social care.

We are committed to minimising risks to which we are exposed, strategically and corporately. The overriding aim is to reduce the potential for loss of services due to adverse events, financial management or performance and quality management of commissioned services that could ultimately be of detriment to the Wiltshire population.

Our risks and uncertainties should be viewed against a back drop of a rising number of older people in the local population, health inequalities and a significant number of people living with long term conditions.

Key risks identified are:

- High levels of demand within urgent care and A&E with pressures impacting on system sustainability including primary care, discharge, patient care and performance against NHS Constitution targets.
- Recruitment and retention of appropriately trained staff across the health and social care system and impact on support to transformation agenda including the ongoing resilience of Primary Care.
- Challenges to partnership working, impacting on effective integration of service commissioning and delivery.
- Successful delivery of financial control total, impacting on service delivery and implementation of service changes within health economy.

Statement of going concern

The resources, principal risks and uncertainties and relationships that may affect the Clinical Commissioning Group's long-term value.

The CCG is allocated a sum of money each year to directly commission the healthcare services we are responsible for (known as programme allocations) and to also fund the costs of commissioning those budgets (known as running cost allocations). Approved budgetary resources are entrusted to our Directors in line with our scheme of delegation and our 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 also work closely with other commissioners and providers of healthcare, both within our Sustainability and Transformation Partnership and beyond, to ensure that Wiltshire has a high performing and resilient health system.

As part of preparing our financial statements the CCG has prepared them on a going concern basis – this establishes whether the CCG is viewed as being in a viable position to continue to operate for the foreseeable future. The key points of consideration are:

Area	Response
Whether the CCG has cash resources to meet its obligations.	The CCG operates within its annual cash limit and has continually achieved this.
The level of working capital balances, borrowings and outstanding debts.	These are monitored by the Audit and Assurance Committee and are not of a material level of concern. The CCG continues to demonstrate strong better payment performance. The CCG is unable to borrow funds.
The level of cost improvements required to deliver its financial position.	All NHS organisations require a level of efficiencies to be delivered. The CCG's challenge in the medium term is comparable with other organisations. In addition the CCG holds a contingency reserve to mitigate against emerging financial risks.
Previous financial performance.	The CCG has a history of achieving its financial performance targets.
Operating conditions and ability to respond to a change in legislation or local environment.	No issues identified.
Serious non-compliance with regulatory or statutory requirements	No issues identified.
Strength of governance and risk management.	Strong internal controls in place which are assessed by Internal Audit and reviewed regularly by the Audit and Assurance Committee.
How well it is expected to fare in the medium to long term.	The CCG is confident of being able to maintain its balanced financial position across the medium term.
Has the CCG been notified by a relevant national body of the intention for dissolution with transfer of services or function to another entity.	No notification of any intention has been received.

On the basis of the above assessment the CCG is considered to be a going concern.

Financial year 2017/18

This year has again been financially challenging for the NHS. The CCG has seen a continuing increase in demand for healthcare services and from the impact of Wiltshire's ageing population, exacerbated by pressures faced in the social care system. These factors have had a particular impact through the winter months, where demand has been extremely high across the health and social care system. In spite of additional pressures, the CCG planned and delivered its target of £57k surplus on its 2017/18 allocation, and delivered 83% of its planned savings during the year.

As set out in the 2017/18 NHS Planning Guidance, Clinical Commissioning Groups were required to hold a 0.5% 'risk' reserve uncommitted from the start of the year, created by setting aside the monies that we were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

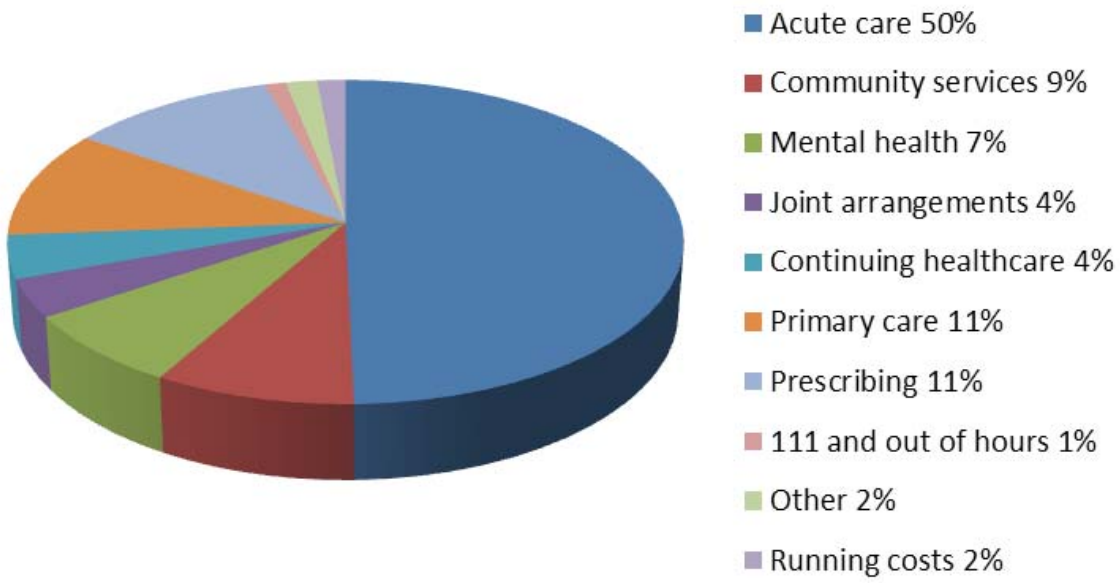
In the event, the national position across the provider sector has been such that NHS England has been unable to allow Clinical Commissioning Groups' 0.5% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Wiltshire Clinical Commissioning Group has released its 0.5% reserve to the bottom line, resulting in an additional surplus for the year of £2.9m. This additional surplus will be carried forward for drawdown in future years.

During 2017/18, savings arising from a reduction in Category M (generic drugs) prices were held centrally by NHS England. These savings have been returned to the CCG at the end of 2017/18 with the expectation that the CCG's reported in year surplus should increase in line with the value of the Category M savings. Category M savings are forecast to be £0.62m in 2017/18 and the CCG's reported financial surplus includes the impact of this saving.

Target Description	Target	Achievement
Planned Surplus against Resource Limit	£57k	£57k
Risk reserve released	£2.9m	£2.9m
Category M drugs savings	£0.6m	£0.6m
Total CCG surplus (including risk reserve and Category M drugs savings)	£3.6m	£3.6m
Revenue Cash Limit – balance in account	Below £587k	£29k
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%	99.6% 99.6%
Core Running Cost Allocation Performance	£10.6m	£9.9m

For 2017/18 we received funding of £656.9m, of which £10.6m related to the running costs of the Clinical Commissioning Group, with £646.9m being available to spend on health services. This includes £61.9m relating to commissioning of GP services, responsibility for which transferred to the CCG from NHS England in 2016/17. At the end of 2017/18 we had spent £653.4m, including running costs.

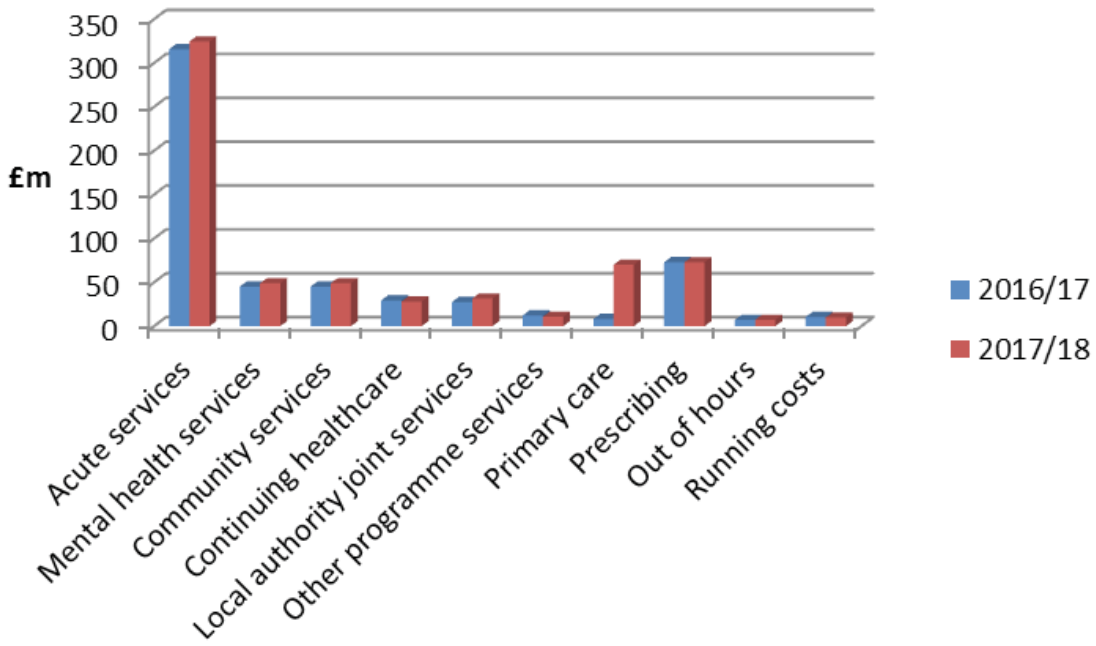
The split of this expenditure by programme area is shown in the chart below:



We achieved our running costs with 22.8% of our allocation paid to the South, Central and West Commissioning Support Unit for commissioning and back office functions support. The remaining 77.2% relates directly to the costs of running the Clinical Commissioning Group.

The graph below compares our expenditure, at programme level, with the prior financial year:

Comparison of 2016/17 and 2017/18 expenditure



Looking forward – 2018/19

The 2018/19 financial year is set to be just as challenging as 2017/18. The financial plan supports our aim to provide less care in hospitals and more care at home or in the community. We have set ourselves a savings target of £15.8m so that we can invest in transformed services in line with our five year strategic plan.

Our financial plan for 2018/19 is shown below with comparisons to the actual expenditure for 2017/18.

Programme area	2017/18 Actual £m	2018/19 Plan £m
Acute services	324.5	326.5
Mental health services	49.0	51.4
Community services	46.8	47.6
Community services non-recurrent support (VAT and property)	2.2	0.0
Continuing care services	28.2	29.4
Better Care Fund	31.6	31.6
Delegated primary care commissioning	60.7	61.9
Primary care services	89.6	92.4
Other programme services	10.8	22.1
Total - commissioning services	643.5	662.9
Running costs	9.9	10.3
Contingency	0.0	3.4
Total application of funds	653.4	676.6
Surplus/(Deficit)*	-3.5	-0.2

*2017/18 surplus includes risk reserve of £2.9m and Category M drugs savings of £0.6m which are limited to 2017/18.

In 2018/19, we will 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.
- **Mental health** – Clinical Commissioning Groups are required to increase their investment in mental health services. We will be investing in mental health to support parity of esteem.
- **Resilience** – in previous years we have received funding to support the resilience of the health system across times of high demand, particularly in the winter. This funding is now part of our recurrent resources and we will look to fund schemes that support the health systems at times of high demand.
- **Development of primary care services** – to work towards more resilience in primary care provision, and extending the hours of primary care availability.
- **Community services** – the CCG has identified and is investing in a number of schemes where community provision of services will be better for patients, allow treatment closer to home, and could prevent hospital admission, including Muscular Skeletal conditions, heart failure, and ophthalmology.
- **Better Care Fund** – In 2015/16 jointly with Wiltshire Council we formerly established a pooled budget for the Better Care Fund. As we moved into 2016/17 the partnership working arrangements were further strengthened through a revised s75 agreement, and in 2017/18 both the CCG and the Council invested significantly in this fund. In 2018/19 we will continue to operate this fund as a joint pool for health and social care, with the objective of supporting more people in the community and reducing the reliance on acute hospitals.

Performance Summary

Wiltshire CCG is measured against a number of national "NHS constitutional" performance standards, and despite ongoing periods of pressure on accident and emergency departments, including a very challenging winter period, has performed well overall.

The national standard for accident and emergency performance is 95% of patients being seen within 4 hours. The CCG is measured on performance at Salisbury Hospital Foundation Trust as the lead commissioner, regardless of whether the patient is a Wiltshire resident. Whilst the 95% standard has not been consistently met, the performance has been above 90% for all but two months of the 2017/18 year at Salisbury Foundation Trust. Underneath this performance measure, we should recognise that our GP services (including out of hours) and community teams have also been extremely busy, and their efforts to support patients outside of hospital settings has contributed hugely to the health system in Wiltshire achieving the performance that it has done.

Waiting times for planned (elective care) have not met national targets throughout the year, but have maintained strong performance in the context of the impact from increased urgent care activity. Both wait times for diagnostic and treatment have been marginally below their respective targets throughout for most of the year. The CCG has continued to work with hospitals to understand and put in place action plans, including redirecting patients to other providers, to deal with the issues that have arisen during the year; which have to a large extent been staffing issues. We have, unfortunately, continued to see a small number of our patients experience waits over 52 weeks. The vast majority of these patients were treated by non-local specialist providers which receive patients from a wide geography. In all cases where this happens, the CCG requests assurance that no harm to the patient's health took place through waiting for treatment.

The CCG achieved the 2 week cancer wait target for the majority of the year and has been above the 93% target every month since July. The 62 day target has been more challenging at times through the year, but concerted efforts by our hospitals have meant we are finishing the year having achieved the target for the final quarterly period.

The CCG has seen a significant improvement in the number of mixed sex accommodation breaches with the majority of the breaches occurring in the last two months and at a time where nationally it had been accepted that breaches may need to occur to maintain overall department safety. The quality team has worked closely with providers to agree actions to continue to sustain this improved position.

The CCG has also achieved against the target of number of C. Difficile and MRSA infections in 2017/18.

Nationally there is a target to have 67% of the expected prevalence of dementia diagnosed by GP practices. The CCG is not currently achieving this target, as the expected prevalence has increased at a faster rate than diagnoses are being recorded. The CCG is meeting the expected performance for Improving Access to Psychological Therapies and Early Intervention in Psychosis treatment.

Performance Analysis

Performance against key national targets

We are responsible for designing and commissioning a range of health services that will ultimately help to improve the health and wellbeing of Wiltshire people.

Key access and quality standards help to measure progress and success of commissioning activities and these measures are listed as part of the NHS Constitution.

The performance information shared within this report accurately reflects performance and financial performance during 2017/18 and is reflective of Wiltshire Clinical Commissioning Group's ratings on My NHS.

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

A summary of our key constitutional performance indicators as at 31 March 2018 is shown in the table below:

Indicator	
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	90.2%
Number of patients waiting more than 52 weeks	13
Patients waiting six weeks or more for a diagnostic test	97.7%
A&E waits – Salisbury Foundation Trust	92.3%
Cancer – two week waits	93%
Breast Cancer – two week waits	93%
31 day treatment - from diagnosis to first definitive treatment	97.2%
62 day treatment - from urgent GP referral to first definitive treatment	83.1%
Ambulance response on scene (NO LONGER REPORTED)	
Ambulance conveyance response on scene (NO LONGER REPORTED)	
Category 1 Mean Response Duration (Mins) SWAST total	9.7
Category 1 90th Percentile Response Duration (Mins) SWAST total	17.7
Mixed sex accommodation breaches	41
Mental health care programme approach achievement (Q3 2017/18)	99%
A&E waits – Royal United Hospital*	82.6%
A&E waits – Great Western Hospital*	87.2%

* BaNES CCG and Swindon CCG are lead commissioners for RUH and GWH respectively. Wiltshire CCG works closely with both CCGs but does not have overall responsibility for these constitutional targets.

In 2016/17 a new CCG improvement and assessment framework (IAF) was introduced to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework draws together the NHS Constitution, performance and finance metrics, and transformational challenges, and will play an important part in the delivery of the Five Year Forward View.

The IAF consists of 54 indicators spread across the four* categories:

1. Better health
2. Better care
3. Sustainability
4. Leadership

*In 2018/19 a fifth category will be added, assessing Patient and Public Involvement and engagement (PPI).

For the 2017/18 Improvement and Assessment Framework review, our performance is shown in the table below. This is consistent with our ratings as shown on My NHS.

	Overall Performance 2017/18			
	Q1	Q2	Q3	Q4
Better Health	Good	Good	Good	Good
Better Care	Requires Improvement	Requires Improvement	Good	Good
Leadership	Good	Good	Good	Good
Sustainability	Good	Good	Good	Good

Detailed analysis of development and performance

NHS Constitution targets

The NHS Constitution sets out a number of key targets for NHS organisations. In 2017/18 performance against these targets has remained a significant challenge and the CCG has worked collaboratively with providers throughout the year to understand the causes of underperformance, to ensure realistic and achievable improvement plans are in place and to ensure a robust contractual process is followed.

Whilst there has been good performance in some areas, notably around cancer targets and mental health care, there are a number of targets where the desired improvement has not been seen, with particular pressure on ambulance response times.

The CCG is continuing to work closely with providers to identify opportunities for increasing capacity to reduce waiting times and to implement alternative services.

More detail regarding each of the key national standards follows. The data included in this report is taken from the latest available nationally published sources. For some indicators the national data is not available for March 2018 at the time of writing this report.

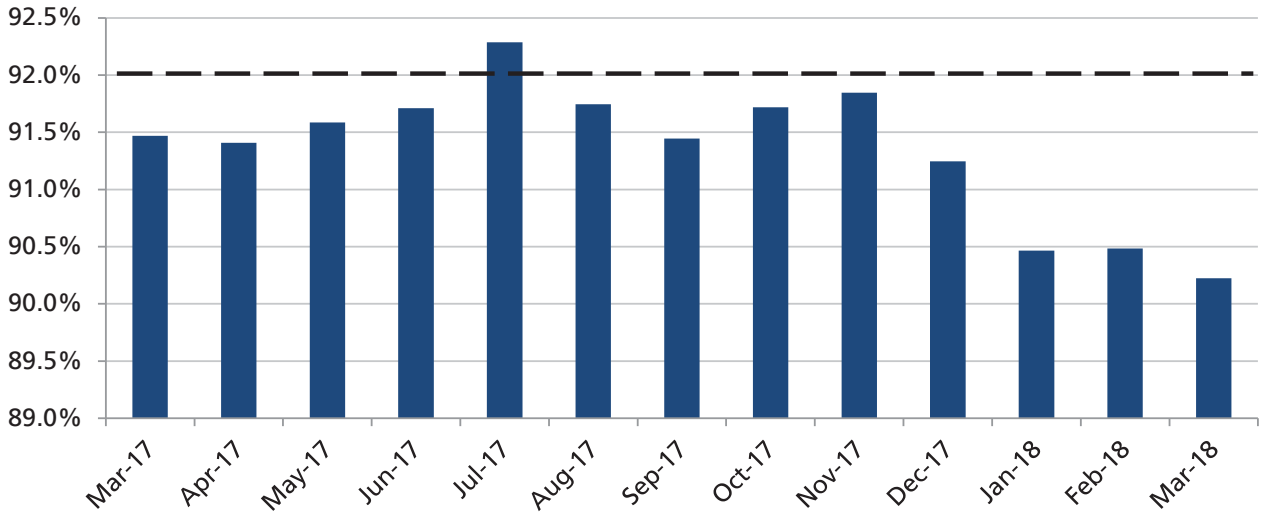
Performance against key targets

The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

As at end of February 2018, the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways is 90.5%.

Wiltshire CCG has developed an elective care plan to reduce waiting times for patients and to support recovery of the national Referral To Treatment performance target.

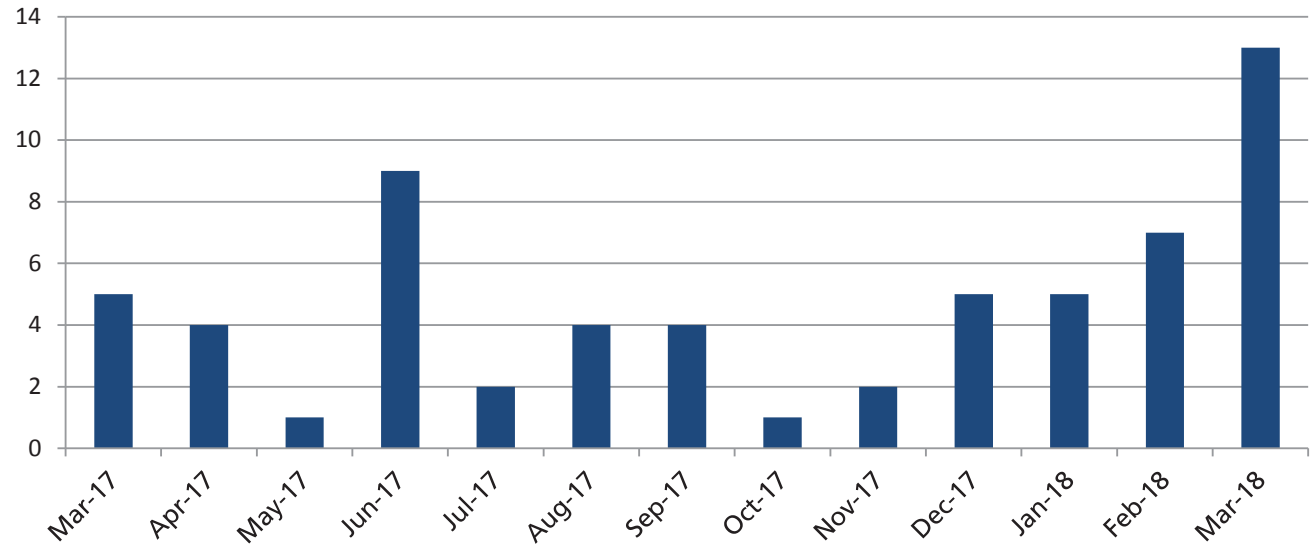
The chart below details delivery between March 2017 and March 2018.



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
%<18Wks	91.5%	91.4%	91.6%	91.7%	92.3%	91.7%	91.4%	91.7%	91.8%	91.2%	90.5%	90.5%	90.2%

We have seen an expected increase in cancer referrals combined with non-elective pressures, which has placed additional capacity constraints on elective care. To help mitigate this and to improve access for patients, our referral management centres have supported the re-direction of appropriate patients to the independent sector over the last 12 months. This work will continue in 2018/19 while acute providers reduce their waiting lists following the national directive to cancel all routine surgery in early 2018. More than 9,000 Wiltshire patients have had their elective surgery in the last 12 months as a result of this directive.

Number of patients waiting more than 52 weeks

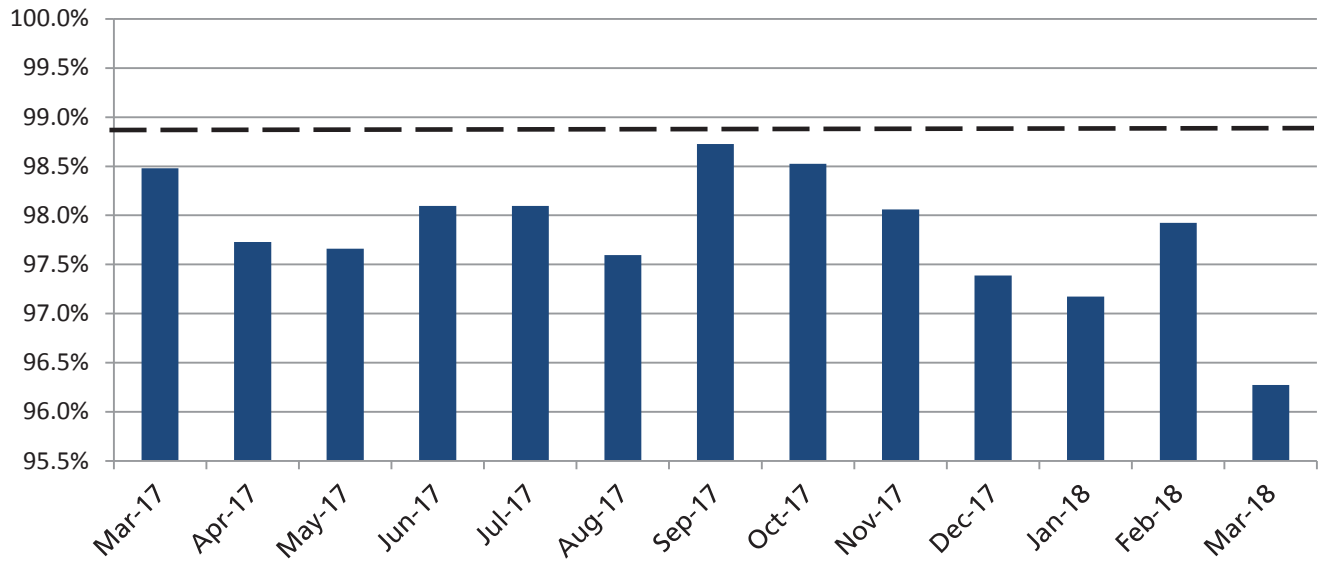


The national directive to cancel all routine surgery in early 2018 in response to winter pressures had an expected impact on the number of patients waiting more than 52 weeks for referral to treatment.

As at February 2018, there were 7 Wiltshire patients who had been on a waiting list for more than 52 weeks.

During the last 12 months, the majority of patients waiting over 52 weeks for referral have been at tertiary providers awaiting specialist treatment. All patients waiting over 46 weeks are now reported on a monthly basis and through our dedicated steering groups, we are actively monitoring waiting lists to try to reduce them as quickly as possible. During the last year, Wiltshire CCG has supported acute providers in transferring appropriate patients to other providers to help reduce waiting times.

Patients waiting 6 weeks or more for a diagnostic test



Wiltshire CCG did not deliver against the six week diagnostics target during 2017/18 due to challenges experienced across all three acute hospitals. Actions have been taken to mitigate these challenges and we are supporting each acute with a relevant recovery plan. Support will continue to be provided into 2018/19 and is evidenced in an improvement in results for February 2018.

A&E 4 hour waits

The A&E four-hour target measures the time a patient spends in A&E from arrival to transfer, admission or discharge. A&E waiting times are often used as a barometer for overall performance of the NHS and social care system. This is because A&E waiting times can be affected by changing activity and pressures in other services such as the ambulance service, primary care, community-based care and social services.

For example, patients cannot be admitted quickly from A&E to a hospital ward if hospitals are full because of delays in transferring patients to other NHS services, or in arranging required social care. It has been a matter of national headline news that A&E figures for periods during 2017/18 were the worst the NHS has witnessed for many years. The target A&E performance is 95%.

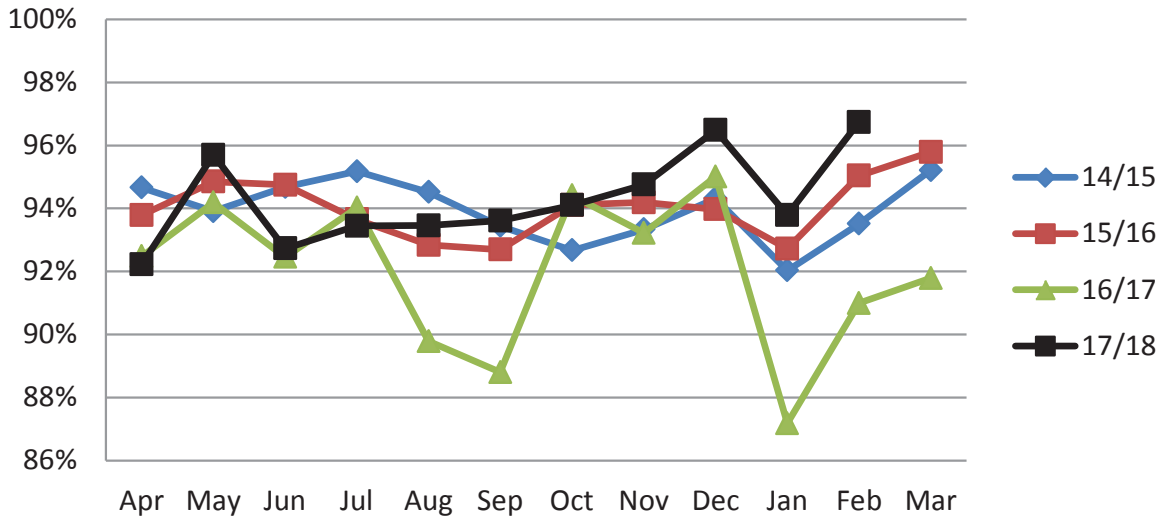
Provider performance based on the latest data available (April 2017 to February 2018) is shown below:

	February 2018	Average (April 2017 to February 2018)
Salisbury NHS Foundation Trust	90%	92.5%
Royal United Hospital Bath NHS Foundation Trust	74.4%	83.1%
Great Western Hospital NHS Foundation Trust	88.4%	87.4%

Wiltshire CCG participates in three A&E Delivery Boards, which enables a more collaborative focus on A&E performance of the wider urgent care system and for reviewing improvement plans for all providers.

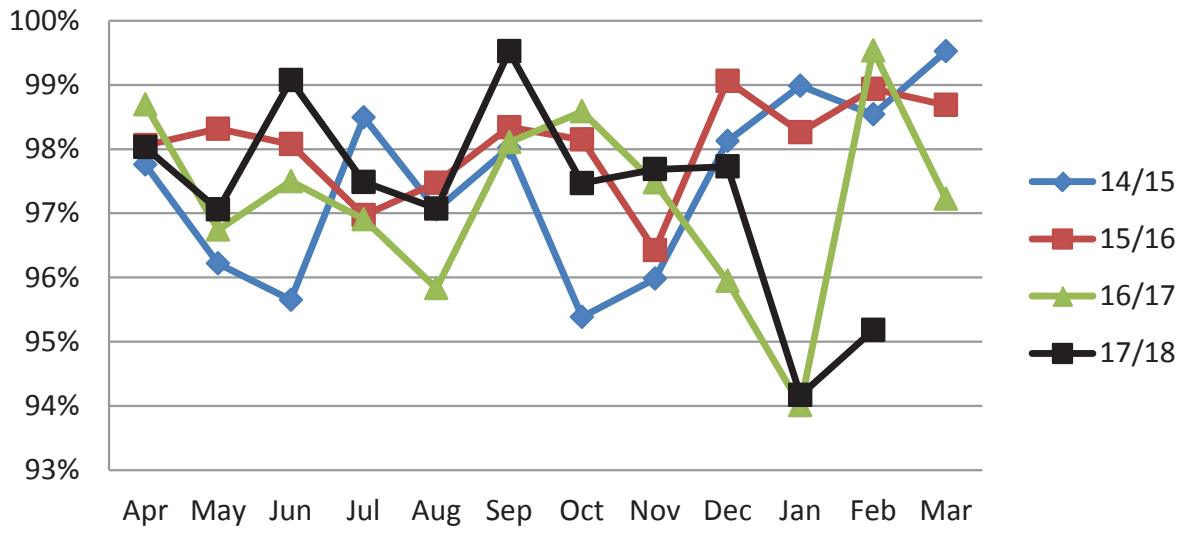
Cancer – Percentage of patients seen within two weeks (from urgent referral to first seen)

94.01% of Wiltshire patients were seen within two weeks from urgent referral between April 2017 and February 2018. The national standard is 93%.



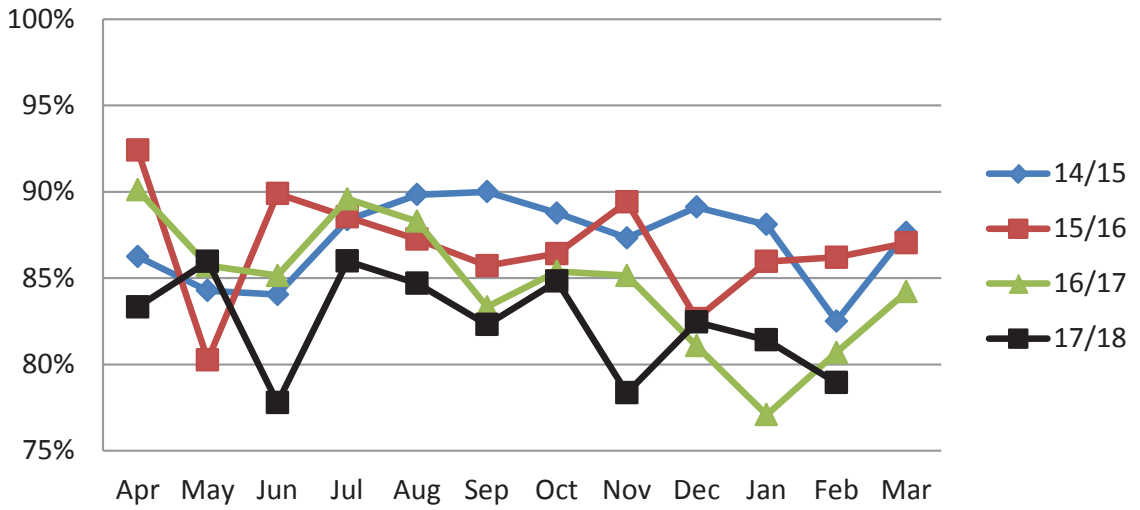
Cancer – Percentage of patients treated within 31 days

97.5% of Wiltshire patients were treated within 31 days between April 2017 and February 2018. The national standard is 96%.



Cancer – percentage of patients treated within 62 days (from urgent referral to first definitive treatment

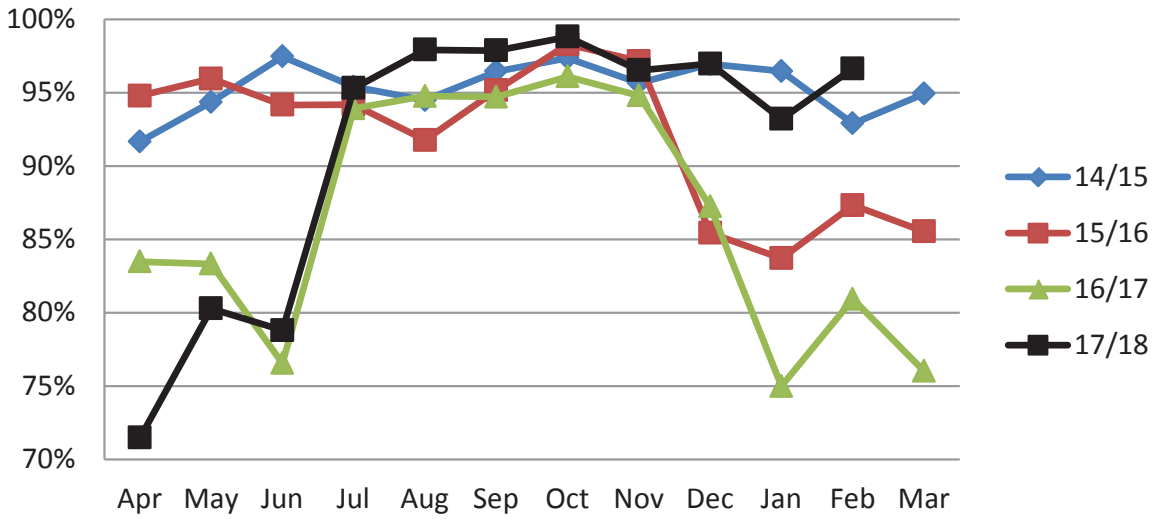
82.5% of Wiltshire patients were treated within 62 days between April 2017 and February 2018. This was below the national standard of 85%. Patients on the 62 day pathways often require more complex care, which is shared between local and tertiary specialist providers and contributes to delays in the pathway. During 2017/18 there was an increase of 6% of patients requiring treatment within 62 days compared to 2016/17.



Breast cancer – 2 week waits

90.75% of Wiltshire patients were seen within two weeks between April 2017 and February 2018. The national standard is 93%.

The reduction in performance between April and June is attributed to availability of staff and Wiltshire CCG supported the acute hospitals with their recovery plans during this time. The standard was met from July 2017 onwards.



Cancer targets

We continue to work closely with our providers to review cancer patient pathways and identify opportunities for improving referral to treatment times. Where referral to treatment falls outside of the national standard, we review individual patients' cases to identify opportunities for improvement for future patients.

Ambulance service

During 2017/18 the nationally mandated ambulance response time (ARP) was set up to improve ambulance response times to critically ill patients. It strives to make sure that the best, high quality, most appropriate response is provided for each patient first time. Key to this is the ability to send an appropriate vehicle with a skilled clinician to the patients most in need in a timely manner.

The new prioritisation system has four categories of call, which matches the range and complexity of problems for which people dial 999. The most serious prioritisation group (Category 1) has more than doubled in size, to ensure that people with life threatening problems get the fastest possible response. For other calls the ambulance service now aims to meet the needs of the patient, with the right response provided in the right timeframe for their needs.

The new categories are:

- Category 1: Calls from people with life-threatening injuries/illnesses
- Category 2: Emergency calls
- Category 3: Urgent calls
- Category 4: Less urgent calls

As a result the performance measures are different across the 2017/18 year.

		April 17 - Nov 17	Nov 17 - Mar 18
Previous 8min Response	Red 1 performance	62.53%	n/a
	Red 1 Target	75%	n/a
ARP Indicators	Mean Response Time	n/a	10.3 mins
	Mean Response Target	n/a	9.0 mins
	90th percentile response	n/a	19.2 mins
	90th percentile threshold	n/a	15.0 mins

To date the new response model has not delivered these anticipated improvements and SWASFT continue to work commissioners and regulators to understand the areas in service model that require improvement to consistently deliver the desired service.

Outcomes for calls were broadly similar to 2016/17 with a small increase in the number of calls that were managed without any conveyance to A&E or other locations.

	2016/17 SWAST	2017/18 SWAST
Calls that receive telephone advice (hear and treat)	11.5%	11.5%
Calls that receive a face-to-face response from the ambulance service, managed without need for transport to Type 1 and Type 2 A&E (see and treat)	36.5%	38.4%

Overall there has been an increase in Wiltshire incidents requiring an ambulance of 3% (69,607/67,361) against expected plan.

Mixed sex accommodation breaches

All NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall clinical best interest of the patient, or reflects personal or patient choice.

For all relevant providers commissioned by Wiltshire CCG, appropriate actions are taken in respect of their responsibilities under the mixed-sex accommodation guidance. We ensure that, at all times, patients receive appropriate care and that their privacy and dignity is not compromised.

The CCG is kept fully informed by all providers in respect of mixed-sex accommodation performance, with monthly reporting forming part of the standard NHS contract.

For the period April 2017 to February 2018 (the current data that is available), the number of reported breaches was 142 for Wiltshire CCG patients. This was lower compared to the same time period last year where there were 215 breaches reported.

Mental health care programme approach achievement

Our monthly performance report shows that for 2017/18 our Improving Access to Psychological Therapies (IAPT) services in Wiltshire have achieved the 19% target access rate (a figure set locally) and this trend is expected to improve.

Throughout 2018/19 we will continue to work closely with the service provider to ensure these service levels are maintained and opportunities for improvements are identified. We have also set an increased target for Wiltshire in line with meeting the national target access rate of 25% by 2020.

Performance of other matters

Primary Care

In November 2016, Wiltshire CCG made the decision to apply to take delegated responsibility of primary medical services from 1 April 2017. A memorandum of Understanding was agreed with NHS England that detailed the support available from NHSE to the transition process over the agreed period.

The opportunity offers the CCG and its membership various benefits including:

- The ability to expand its role within primary medical services commissioning without prejudice to practice entitlements, which are negotiated and set nationally.
- To increase its influence on the future strategy of primary care supporting General Practice sustainability.
- Potential to align wider health and social care planning developing a more integrated primary care based out of hospital service.
- To increase the ability to tackle variations in the quality of primary care, improving patient experience and new models of care.

Under delegated commissioning, Wiltshire CCG formed a Primary Care Commissioning Committee (PCCC) [see page AR 19]. The Committee functions as a corporate decision making body for the management of delegated functions. The first public meeting was held on 27 June 2017.

Wiltshire CCG continues to progress a safe and effective handover of delegated functions with an aim to fully complete the transition before July 2018.

Primary Care continued to experience significant pressures throughout 2017/18, particularly within workforce capacity – from GPs through to administration support staff. Wiltshire CCG worked closely with and supported its practices throughout the year, which has meant all practices are in a stronger position going into 2018/19 with no requirement for top-up locum support. A series of projects are also underway with practices to support them in further strengthening their resilience.

Urgent and Emergency Care

Integrated Urgent Care

In 2017/18 Wiltshire CCG carried out procurement for a local Integrated Urgent Care Service. This procurement will deliver more functionally Integrated Urgent Care Access, Treatment and Clinical Advice Service model by aligning existing service specifications for NHS 111 and the GP out of hours service with the national direction. This model will offer patients who require it, access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation.

The contract for this service was awarded in September 2017 to Medvivo Group Ltd, who are recognised as Outstanding by the Care Quality Commission and the new service will start in May 2018 following a period of mobilisation and testing. This will also bring a consistent urgent care service across BaNES, Swindon and Wiltshire.

There have also been additional schemes funded to support and increase out of hours primary care capacity and co-location of services during the Winter, Christmas and Easter periods These include; 'Hot Kidz' service, additional out of hours triage and visiting, extension of out of hours pharmacy over Easter and initiation of the Wiltshire integrated control centre.

Ongoing challenges and pressure in emergency departments over the last year has meant that all of our providers have struggled to meet the accident and emergency wait time target. We continue to support and work with providers to help them develop and implement remedial action plans to help improve performance and work in partnership with the wider system at each of the three local A&E delivery boards: Salisbury Foundation Trust; Royal United Hospital; and Great Western Hospital.

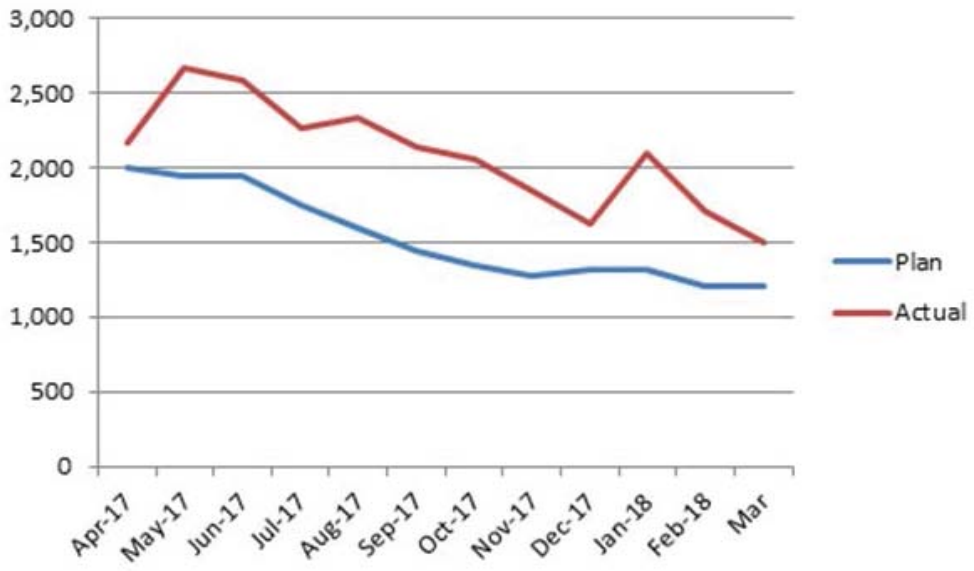
NHS 111 service

The performance target for the NHS 111 service is for 95% of non-emergency calls to be answered within 60 seconds. A combined Wiltshire and BaNES performance for 2017/18 against this target was 80%. A downward trend in performance has been observed from September 2017 to March 2018. A recovery action plan has been created and implemented by the provider and we are supporting them with this and reviewing performance regularly. From May there will be a change in service provider as the NHS 111 service will be delivered as part of the Integrated Urgent Care Service provided by Medvivo Group Ltd.

Better Care Fund

We have a well-established better care plan, which is supported by a strong section 75 agreement which allows funds be pooled between health and social care. The section 75 agreement has been scrutinised and re-drafted to ensure robust governance arrangements are in place. This was finalised at the Governing Body meeting in March 2018. The Better Care Plan is led by a jointly appointed (between Wiltshire Council and Clinical Commissioning Group) Portfolio Delivery Manager. The 2017/18 year has been a year of challenge as we progress the Adult Social Care Transformation and move towards greater levels of integration in both commissioning and service provision.

A key national measure in relation to the Better Care Fund is the number of days lost to delays, often referred to as Delayed Transfers of Care (or DTOCs).
The chart below shows progress against the national target of lost bed days set for Wiltshire.



Examples of successful improvements in outcomes delivered by the BCF

Focus area	Improved outcome
Patients being cared for in the right location	• The rate of avoidable admissions admitted to hospital continue to fall, however admissions generally are higher. We are maximising opportunities to manage cases and avoid admission to hospital. • Emergency admissions from care homes continue to reduce as the education and training we have offered homes continues to build confidence in homes. • Reduction in the number of deaths in hospital, currently 37.8% (lowest in region)
Longer term independence for our service users	• During the year the number of people being offered permanent placements to care homes is 20% less than target, this is demonstrating the impact of strategies to offer care at or close to home • The introduction of integrated discharge and Home First have led to challenges in achieving our target with respect to Wiltshire residents remaining independent 91 days post discharge. We are working with our providers to overcome these challenges and hope that 2018-19 will see performance return to sustainable levels. • Throughput and outputs in ICT remain strong

Higher level of patient and carer satisfaction	• We have seen improvements in the number of adult social care clients satisfied with the care and support they receive.

Going forward, our work facilitated by the better care fund focuses on seven areas, with a key theme of enhancing out of hospital capacity, for example through Intermediate Care, Urgent Care at Home and Wiltshire Integrated Discharge Service.

Forward developments facilitated by the Better Care Fund

Focus area	Actions underway
Intermediate care	• Our 70 cohorted intermediate care hospital beds were recommissioned 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
Admissions avoidance	• Focus has been maintained on the 'front doors' of acute hospitals by partner providers engaged in the better care fund with the aim of preventing unnecessary admissions • Our Urgent Care at Home service continues to deliver good levels of activity and outcomes.
Community geriatrics	• Close working with consultants at the three acute hospitals serving Wiltshire continues and has led to enhancements in the provision of geriatric care in the community
Wiltshire Home First	• Wiltshire is supporting the roll out of an integrated discharge service model across the county by our three acute providers in partnership with our community provider, adult social care and other key stakeholders. The model aims to identify patients earlier in the acute setting for discharge home under the care of an appropriate community resource. • The service has key benefits which include improved MDT working, changes to existing culture of integrated working, reducing dependency and increasing longer term independence of clients once they are able to go home.
72 hour pathway for end of life care	• The out of hours general practice provider continues to work in partnership with the hospices serving Wiltshire to provide an enhanced Urgent Care at 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 urgent care at home service. • They are available 24/7and are providing care for palliative patients (patients within the last year of life).

Improving patient flow and reducing delayed transfers of care

As part of the better care plan, reducing the amount of time people spend in hospital by discharging them quickly and ideally to their own place of residence is key. We believe that patients recover better and transition to independence more quickly in their own homes and our aim is to move patients from hospital as soon as they medically fit and ensure that no decisions around long term care are made in a hospital setting.

To do this we have put in place a number of initiatives:

- 70 cohorted ICT beds across nine locations. Providing active rehabilitation and support for patients between hospital and home
- The urgent care at home programme that supports patients flow through the system 24/7
- Social workers are now available seven days a week to support discharge at weekends.
- The integrated discharge programme and strategy which is in place across Wiltshire and has led to the development of integrated discharge teams in each of the three acute hospitals
- Consolidate and improve the performance of the Rehabilitation Support Workers programme in partnership with Wiltshire Health and Care. Rehabilitation support workers provide a full assessment and rehabilitation programme so that people discharged from an acute hospital, a community hospital or from an intermediate care bed will be helped to improve their health and wellbeing, reducing their long term dependency on care, avoiding readmission to hospital or admission to a care setting
- Enhanced discharge support through the 72 hour pathway for patients who are palliative or end of life

Referral to Treatment times and Elective Care

Wiltshire CCG has developed a strategic plan to support delivery of the elective care constitutional standards. This has included the expansion of our referral management services to support the referral process for patients, primary care and acute and independent providers.

Our priority remains to provide high quality elective care to patients and to improve access times. We have seen an 8% reduction in elective referrals during the past year. We have developed schemes including Optom triage of ophthalmology referrals to ensure that patients needing assessment and treatment are seen as quickly as possible. The CCG has been leading work across the Sustainability and Transformation Partnership (STP) footprint to transition away from paper referrals to use of the national electronic referral system (e-RS). This work will continue during 2018/19; however the CCG is ahead of national timeframes to move towards a paperless referral system. Our aim is to make the elective care pathway as seamless as possible for our patients.

Other specialty level clinical workstreams continue. These have included a review of the cardiology diagnostic pathway resulting in the implementation in 2018 of a community heart failure service; development of a musculo-skeletal interface service to help signpost and triage patients with musculo-skeletal problems as well as those with chronic pain – again due to go live in 2018/19; and the expansion of our community dermatology service to be Wiltshire-wide. We are also looking into options for improved delivery of audiology services across the county.

Cancer

BaNES, Swindon and Wiltshire STP is part of both the Thames Valley Cancer Alliance and Somerset, Wiltshire, Avon and Gloucester Cancer Alliance. Wiltshire CCG has taken the lead for BSW STP for the management of the national cancer transformation funding which has been made available to providers (RUH and SFT) to ensure all Wiltshire patients attending those acute trusts, regardless of geographical location, demography or tumour site feel their holistic needs are understood and they have access to appropriate support. This will be enabled by implementation of risk stratified pathways and supporting patients in self-management. (GWH falls within Thames Valley Alliance for transformation funding).

This will be achieved by:

- Improving holistic needs assessments and care planning.
- Digital patient portal for advice guidance and signposting to helpful resources.
- Additional cancer support workers.
- Support for Primary Care to improve the way that Cancer Care Reviews are conducted with patients.
- Improving patient access to health and wellbeing support.
- Development of metrics and information systems to measure progress and achievement.
- Improving early diagnosis of lung and colorectal cancers at stage one and two by streamlining referral pathways and diagnostic testing.

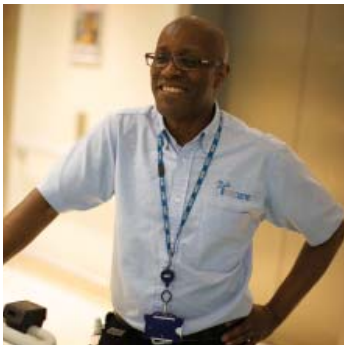
We are actively working in collaboration with formal and informal partnerships to align with national guidance and best practice.

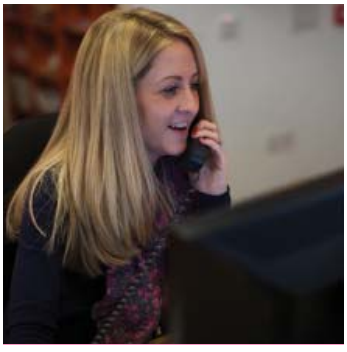
The CCG has also led a major pilot on behalf of the regional bowel cancer screening service, looking to achieved improved uptake of bowel screening among typically underrepresented groups; the lessons from which are being shared across the region.

Cancer standards performance is monitored on a monthly basis and areas of concern addressed with providers via the referral to treatment assurance meetings. Provision of diagnostic capacity is a national and cancer alliance priority, which we will continue to actively support.

Survival rates

Our cancer strategy 2016-2020 supports the national strategy and explains our approach to delivering this target by promoting early diagnosis to identify cancers earlier, when the benefit of treatment is greatest. Implementation of our cancer strategy will also support improvement in one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.





Children and young people

In January 2018 Wiltshire received its joint Ofsted and Care Quality Commission joint inspection to judge the effectiveness of the area in implementing the disability and special educational needs reforms as set out in the Children's and Families Act 2014. In their report inspectors praised effective partnerships and the ambition to deliver the very best outcomes for Wiltshire's children and young people with Special Educational Needs and/or Disabilities (SEND). In particular the effective partnerships across education, health and care were identified as a strength in Wiltshire.

The report highlights a number of areas of good practice in health services across Wiltshire, with the inspectors having seen clear evidence of integration between services and service changes as a result of feedback from parents, carers and young people, and the use of child focused outcomes. The report also highlights some key areas of development of which the CCG and Local Authority were already aware and are taking steps to address, namely through the development of a NICE-compliant autism-spectrum diagnosis pathway and the recruitment of a new Designated Clinical Officer for SEND.

Wiltshire Children's Community Healthcare Services

Joint commissioning across the Local Authority and CCG of children's community services continues, with multiple examples evidenced throughout the SEND inspection of the benefits for families of the integration of these services. Virgin Care has been undertaking a considerable transformation project throughout 2017/18 and we look forward to seeing further benefits of this endeavor in 2018/19. The transformation project has included:

- The movement of all services onto one electronic system that will enable sharing of clinical records between professional groups in the service. This has involved the electronic scanning of historical notes onto patient records, and the establishment of mobile working for community staff.
- Co-location of clinical teams into four principal 'hubs' across Wiltshire.
- Development of a Single Point of Access for all referrals into children's community health services.

Mental Health

Mental health service development is a key priority for us and our intention is to deliver the implementation plan for the Mental Health Five Year Forward View for all age groups, alongside access and quality standards. To do this we will increase baseline mental health spend to facilitate delivery of the Mental Health Investment Standard.

Our local transformation plan for children and young people's mental health and wellbeing has established a range of investments in community services that will reduce demand for costly hospital admissions for self-harm and mental health conditions for 11-18 year olds, with a planned reduction of 3.5% in 2017/18, increasing to 6.5% in 2020/21.

We work closely with our partners in the sustainability and transformation plan footprint so that our developments tie into the workstreams and project planning can be developed. This will ensure that mental health services operate at scale across Bath and North East Somerset, Swindon and Wiltshire to deliver system-wide pathways of care.

Psychological therapies

Our monthly performance report shows that services are delivering above the 19% access rate target and this improving trend is expected to continue. We also continue to achieve the 50% Improving Access to Psychological Therapies recovery rate target.

Reconfiguration of services is focused on delivering national institute for health and care excellence compliant improving access to psychological therapies services, enabling a more robust referral and treatment pathway. The service reconfiguration is also part of the response to the workforce challenge, which is nationally recognised and also felt in Wiltshire - and relates to high turnover and retention and recruitment of the workforce: particularly lower intensity therapists. These recruitment and retention issues have led to a reduced capacity of the service. We have introduced a centralised booking system for the eight standard courses in the pure improving access to psychological therapies service model.

Treatment for first episode of psychosis

Early intervention performance over the last year indicates that we expect to achieve or exceed the 50% referral to treatment target. The compliance rate ranged from 80% – 100% between July and December 2017. Service continues to exceed this target on a consistent basis.

We ring-fenced £104,000 parity of esteem funding in 2015/16 to work with Avon and Wiltshire Mental Health Partnership NHS Trust to develop the early intervention in psychosis service to meet national guidelines by enhancing workforce capacity and therapeutic skills.

With the introduction of the duty system and recruitment of two additional band five care co-ordinators to the team in 2016/17, the capacity of those with national institute for health and care excellence compliant skills and ability to deliver compliant interventions has increased. The team can deliver in excess of 1,800 Cognitive behavioural therapy sessions (over three years) and 1,280 hours are required to support their full caseload.

Individual placement support

The individual placement support service started on 1 April 2016 as part of a five year contract and we jointly commission this with Wiltshire Council. The service Memorandum of Understanding specifies delivery of a high fidelity individual placement support service exclusively to Avon and Wiltshire Mental Health Partnership Trust's Wiltshire Community Mental Health Team service users and Wiltshire Council Mental Health Social Care Teams. The centre for mental health provides individual placement support expertise and oversees the service implementation as part of a wider national evaluation of efficacy by the Department of Health. The individual Placement Support Service has been accepted as a centre of Excellence by the Centre for Mental Health.

The individual placement support service will continually review referral source and capacity to ensure the service evolves to manage demand and meet service delivery requirements. Service performance and development is monitored on a quarterly basis.

Children's Mental Health Services

Improving mental health services for children and young people continues to be a national priority and is providing a perhaps once in a lifetime opportunity to deliver large scale service transformation that should significantly enhance the life chances for children, young people and their families.

By 2020/21, the national aspiration is that significant expansion in access to high quality mental health care will result in at least 70,000 additional children and young people receiving treatment each year – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those children and young people with a diagnosable mental health condition. Based on local performance information, Wiltshire is on target to meet the 35% access target by 2020/21 and has exceeded the 30% target set for 2017/18.

To realise the national ambition for improvement (Future in Mind and Mental Health Five Year Forward View) the CCG has recently expanded, refreshed and republished its Local Transformation Plan for Children and Young People's Mental Health and Wellbeing. The plan details how the CCG is using additional funds to support Wiltshire's goals for change across the whole child and adolescent mental health system. This builds on progress made since the first publication of the Local Transformation Plan in 2015.

Some of our key achievements over the last twelve months have included:

- Significantly improving access to emotional wellbeing and mental health support by reducing waiting times and strengthening pathways for the most vulnerable children.
- Building closer partnerships between education and Children and Adolescent Mental Health Services (CAMHS) through our trailblazing Thrive Hub programme, expanding the number of secondary schools with CAMHS link workers from six to 12 as well as providing Wiltshire College with a dedicated CAMHS worker.
- Rolling out Youth Mental Health First Aid training to adults who work with and care for children, young people and families.
- Successfully re-commissioning a modern CAMHS Service across Swindon, Wiltshire and Bath and North East Somerset, to go live on 1 April 2018, with a much bigger focus on early intervention, improved access and reflective of the national THRIVE model (an updated model for CAMHS). More than 200 people including children, young people and parents/carers helped to shape the new service.

Eating disorders

We have enhanced our specialist community eating disorder service through a joint commissioning arrangement with Bath and North East Somerset and Swindon. We are the lead commissioner for the enhanced service across the sustainability and transformation plan footprint, which includes:

- A multi-disciplinary team in each base offering national institute for health and care excellence concordat treatment
- Eating disorder parenting groups in four of five bases
- Links with acute paediatrics at district general hospitals
- Time-limited home re-feeding via children and adolescent mental health services OSCA (Outreach Service for Children and Adolescents) teams
- Twice yearly Swindon, Wiltshire and Bath and North East Somerset eating disorder network meetings
- Teaching and training to partner agencies

Service developments that are in the process of being delivered include:

- Online referral forms
- Self-referral across the age range
- Enhanced involvement of families and young people in service development, implementation and monitoring
- Multi-dimensional outcome measurement and reporting
- Increase in capacity and standardisation of skill mix and expertise ensuring national institute for health and care excellence concordat treatment is available in all localities
- Multi-family therapy

Mental health access and quality standards

At each of the acute hospitals, the mental health liaison teams provide 24/7 cover and out of hours cover is provided by the local intensive teams. We commission the provision of two Wiltshire intensive teams (North and South) from Avon and Wiltshire Partnership who provide crisis interventions and home treatment around the clock. The Swindon and Wiltshire Control Room Triage service is to be extended to 24/7 coverage. This decision was based on the observed impact the service has achieved in appropriately reducing the number of section 136 detentions, and the improved conversion rate for section 136, and the motivation to continue to enhance the acute care pathway for local residents experiencing a mental health crisis.

People with Learning Disabilities

We continue to work with our partners in health and local government in Bath and North East Somerset, Swindon and Wiltshire to develop and improve services for people with learning disabilities and/or autism.

The key themes of this cross sector working include:

- Enhancing community provision by building on our track record of community solutions, which includes the rollout robust care pathways by March 2019.
- Further development the complex needs care pathways which includes the care programme approach, at risk of admission register, care and treatment reviews, intensive support service and blue light protocol by March 2019.
- Reducing the number of people in long term inpatient placements from 8 four before March 2019.
- Continuing to improve access so that by March 2019, 75% of people with learning disabilities who are registered with a GP receive an annual health check.

We have opened a brand new unit for people with learning disabilities and or autism who have complex care needs. The Daisy Unit is a bespoke home, currently registered as a hospital, situated on the Green Lane site in Devizes and was designed in partnership with architects experienced in developing buildings for people with learning disability and complex needs. Residents, carers, clinical and operational staff were also consulted in the design process. Operated by Avon and Wiltshire Mental Health Partnership NHS Trust, the Daisy provides a maximum of nine places, within five self-contained flats.

Transforming care partnership

We have developed a robust Transforming Care Partnership plan with our partners in Bath and North East Somerset and Swindon, that requires the delivery of improved levels of health action planning for people with learning disabilities and/or autism who have mental health and/or complex needs. The community focused plan aims to deliver assessment and treatment in a community setting and therefore avoiding, where possible, the need for patients to be treated in hospital.

Almost half of patients registered with a GP (44.8%) have received a health check in 2013/14 (most recent available data). The plan has an ambitious milestone for December 2017 to offer everyone, within the five groups across children's and adult services identified in the Transforming Care plan, a health action check. The number of patients having the health check will be monitored and remedial action taken where appropriate will help to ensure the 75% target is achieved by March 2019.

The transforming care partnership plan will focus on the key areas around improving not only mental health but also the wider learning disabilities health agenda, including:

- Workforce review to look at training needs of carers and support teams.
- Roll out of a consistent approach to positive behavioural support.
- Review of the Autism pathway focusing on post diagnostic support.
- Support for children and transition to adulthood.

Reducing premature mortality

The learning disabilities care pathway review was completed in 2017 and will be implemented as part of the Transforming Care agenda by 2019. A major focus of this review is about access to mainstream services for people with learning disabilities. The recommendations will be implemented through the transforming care plan action plan process, with the expectation that mortality rates will be in line with those of the general population by 2019. Consideration will be given to how to roll out changes within the current pathway that support people to access mainstream health services and where necessary using the skills and expertise of specialist learning disabilities teams to support reasonable adjustments and changes within Wiltshire health provision.

Diabetes

Across the sustainability and transformation partnership footprint, the National Diabetes Prevention Programme has been implemented Wiltshire wide providing free, nine month community-based behaviour change programmes to help people prevent the onset of Type 2 diabetes. The first of these programmes went live in September 2017 and a second round of proactive identification of patients will commence in 2018/19.

Wiltshire CCG has implemented virtual diabetes clinics in primary care during 2017/18, which sees diabetes consultants working with GPs and practice nurses to review case notes and provide expert guidance supporting primary care to better manage and more appropriately refer diabetes patients to community services, with resulting improvement in outcomes.

Wiltshire CCG also secured funding from NHS England as part of the National Transformation Programme and has commissioned additional structured education courses for patients across Wiltshire supported by diabetes nurse facilitators, empowering patients to feel more in control of their condition.

Obesity

Our vision for Wiltshire is that by 2020 the county will be a place where all individuals, families and communities are informed, enabled, motivated and empowered to achieve or maintain a healthy weight. Wiltshire CCG continues to collaborate with Wiltshire Council to tackle obesity across Wiltshire. The obesity strategy was finalised and ratified by the Governing Body and Wiltshire Council and an implementation plan was developed which supports the delivery of the strategic objectives.

A Healthy Weight for Life e-toolkit has recently been launched which provides resource, websites and services to support people in Wiltshire to achieve and maintain a healthy weight, and later this year an Early Years e-Toolkit will be developed.

End of Life care

Wiltshire CCG wants to make sure that patients, their families and carers have the best experience of services at the end of their lives and our End of Life Programme Board continues to work collaboratively with our service providers to develop a range of innovative services.

Wiltshire End of Life Care Strategy 2017-2020

Wiltshire's End of Life Care Strategy was formally ratified in July 2017 following feedback of multiple networks and facilitated public engagement sessions. The strategy sets out the local vision for end of life care which is personalised, well-co-ordinated and empowers patients to make informed choices about their care. Our vision is that all patients at end of life, together with those closest to them, are able to express their needs and wishes, and that as far as clinically appropriate and practically possible, these needs and wishes are met.

This refreshed strategy reinforces our commitment to improving and developing end of life care and support services. It adopts a community approach that integrates clinical, psychological, spiritual and social efforts in recognition that death, dying, loss and care take place in everyday life within the family and community. We will seek to raise awareness of death, dying, loss and care and provide a compassionate approach to end of life care which incorporates sustainable networks of care that adapt and are flexible depending on need and demand.

This strategy builds the significant progress and collaborative work with our providers to implement a range of innovative end of life care services. Partnership working has remained key for many years in delivering improvements across Wiltshire. Continuing to learn and enhance work in a joined-up manner across health, social care and the voluntary sector will be fundamental to our approach as we move forward.

This strategy also aligns with the aims of the Wiltshire Better Care Plan to provide more specialist care for the patient in their own home and community and take active steps to enhance the wellbeing and independence of the service user.

Wiltshire's End of Life Care Strategy is guided by the themes in the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020. This national framework for action sets out six 'ambitions' – principles for how care for those nearing death should be delivered at local level and eight principles which are the foundations to build and realise the ambitions. It has been developed in partnership with providers, service users and carers and it updates the End of Life Care Strategy 2014.

To ensure delivery of this strategy, an implementation plan was approved by the Health and Wellbeing Board in November 2017. This plan encompasses specific outcomes, activities and deadlines to help to ensure that momentum is maintained and that the right progress is achieved in a timely manner.

The most recent published data (2016/17) identifies that only 40% of deaths in Wiltshire took place in hospital, where the average for the South Central NHS region is 44% and the national average is 47%.

Enhanced discharge service with Dorothy House and Royal United Hospitals, Bath

Dorothy House Hospice Care continues to deliver a rapid discharge service in collaboration with the Royal United Hospitals Bath NHS Foundation Trust through the better care plan. The service provides up to 24 hour home care to support a rapid discharge to a patient's preferred place of care at the end of their life and to support earlier discharge for patients with complex needs. Carer visits are available with or without night support and the service has the flexibility to provide multiple day visits to patients at home enhancing quality impact of the care being provided under this scheme.

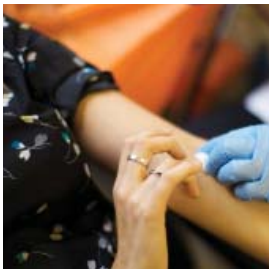
Collaboration with the community teams means the service is offering home as a realistic option for place of death and reducing inappropriate delays in discharge to preferred place of care at the end of life. From April to December 2017, 43 patients have been supported by the service, with 684 visits made to patients at home and more than 1,834 hours of care provided to patients at home.

The most recent published data (2016/17) shows that a quarter of deaths in Wiltshire were at home again exceeding the average figures for the South Central NHS region and nationally.

Information

Extensive information, advice and service detail is now available for those experiencing end of life care in Wiltshire through:
https://www.yourcareyoursupportwiltshire.org.uk/endoflifecare.

The published data can be explored at:
https://fingertips.phe.org.uk/profile/end-of-life/data#page/0/gid/1938132883/pat/46/par/E39000034/ati/153/are/E38000206



Sustainability Report

Background and accountability

NHS Wiltshire Clinical Commissioning Group 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 recognise the impact of commissioning and procurement decisions on the carbon footprint of the NHS and will work to minimise our use of scarce resources. The Chief Operating Officer is the Lead Director for sustainability but all staff have a part to play, through commissioning and day-to-day CCG operations.

Sustainability planning and partnerships

At the end of 2017/18, we were one of two tenants in Southgate House in Devizes. This property is owned by NHS Property Services who manage waste collection, energy and water provision. We have 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, we and NHS Property Services continue to discuss where appropriate investment may be made on sustainability projects to improve the facility. We continue to work in association with NHS Property Services and the other tenant, to assess risks, enhance our performance and reduce our environmental impact, including against carbon reduction and climate change adaptation objectives. This includes embedding social and environmental sustainability across CCG policy development, business planning and in commissioning to meet our obligations under the Climate Change Act 2008 and the Public Services (Social Value) Act 2012 and demonstrate our commitment as a socially responsible employer.

All health and social care organisations are working together across Bath and North East Somerset (BaNES), Swindon and Wiltshire on a five year sustainability and transformation partnership to improve our local population's health and wellbeing, to improve service quality and to deliver financial stability, with each organisation having their own plans and our BaNES, Swindon and Wiltshire Health and Wellbeing Strategies.

The emerging Sustainability and Transformation Partnership focuses on shared challenges and opportunities across the wider geographical footprint. This is 'place-based' planning that is not limited by organisational boundaries. The collective plan will drive greater efficiency and improvements in quality across the health and care system, reducing variation and refreshing patterns of clinical care with community based integrated care. For services to be sustainable, we also need to get better at preventing disease, not just treating it and encourage everyone to focus on being well and to manage their own care.

For more information about the Sustainability and Transformation Partnership visit: www.bswstp.nhs.uk

As a commissioning and contracting organisation, we 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, evidence of this commitment will need to be provided in part through contracting mechanisms.

Of our main providers Salisbury NHS Foundation Trust retained their score of 'Excellent' for Sustainable Development reporting for 2016/17, with Royal United Hospital NHS Foundation Trust, Bath also retaining their score of 'Good' for a third year. Both trusts have a Sustainability Development Management Plan in place and Royal United Hospital, Bath has a Healthy Travel Plan in place. Great Western Hospitals NHS Foundation Trust has a Healthy Travel Plan in place and has reclaimed their score for Sustainable Development reporting for 2016/17 as 'Good' recovering from a fall to 'Minimal' in the previous year. Avon and Wiltshire Mental Health Partnership NHS Trust remain at a rating of 'Poor'.

Working with a number of local GP practices, we are tackling the wastage of unused medicines that cost the NHS £2.7million every year in Wiltshire. Our aim is to ensure that patients are receiving the correct quantity of medication that they need in a timely manner, to help reduce the amount of prescription waste in our area. We have introduced our Prescription Ordering Direct service for Wiltshire patients, providing an easy way to order repeat prescriptions from home, removing the need to go in to the GP Surgery or pharmacy. A trained coordinator will discuss the patient's needs and ensure only the medication required is ordered. For more information about the Prescription Ordering Direct service visit: www.wiltshireccg.nhs.uk/your-health/local-health-services/prescription-ordering-direct

Sustainability policy

We continue to determine our vision for sustainability and responsibility for delivery, working with NHS Property Services and our partners in the delivery of healthcare for the growing population of Wiltshire. We will consider commissioning, general operations and travel and reflect actions in relevant plans as we work with partners and networks to facilitate integration.

Local sustainability arrangements

The CCG also considers 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 2017, 162 trees were saved (147 in 2016) demonstrating our drive to ensure that as much paper as possible is recycled. Staff are expected to use centralised printing facilities which are energy and ink efficient where it is necessary to print documents. We have access to and regularly use telephone conferencing equipment to reduce the need to travel to meetings. During 2017/18, NHS Property Services has reviewed the waste management arrangements to encourage additional waste recycling.

Southgate House benefits from a shower facility and staff are encouraged to cycle to work. The CCG runs a People's Group which organises events to drive a holistic approach to health and wellbeing and encourage staff to use the outside spaces on site for meetings and relaxation.

The CCG has undertaken an audit to identify disposable plastics being used by this organisation. Further work will be undertaken during 2018/19 to switch to alternative reusable or recyclable products, or challenge the use of the item.

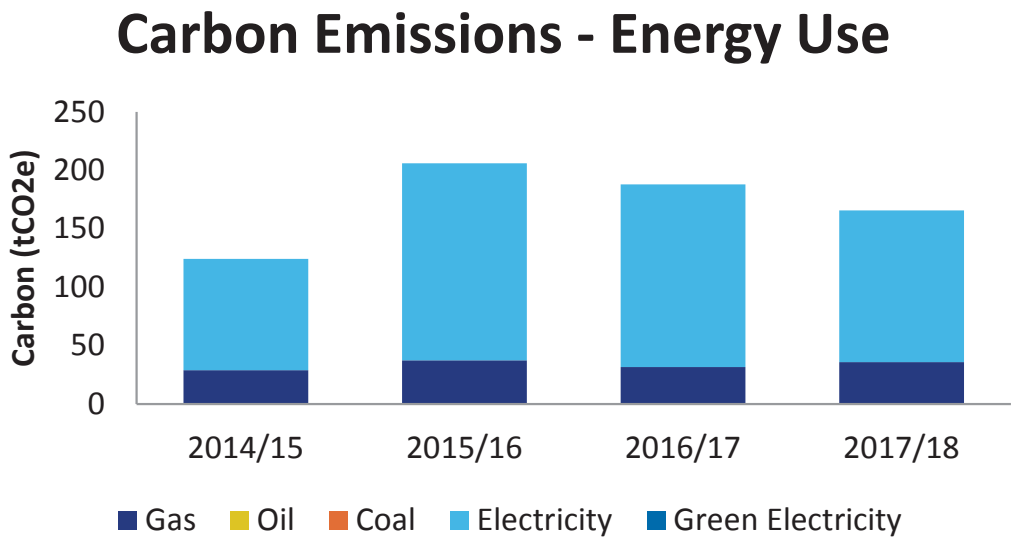
Performance and progress

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 its carbon footprint by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. We aim to meet this target by reducing our carbon emissions by 10% using 2007 as the baseline year.

Energy

We have spent £34,468 on energy in 2017/18, which is a 3.7% increase in cost on the reported spend for 2016/17. Electricity and gas usage is largely consistent with previous years and also reflects the increase in the CCG's proportional usage of Southgate House.

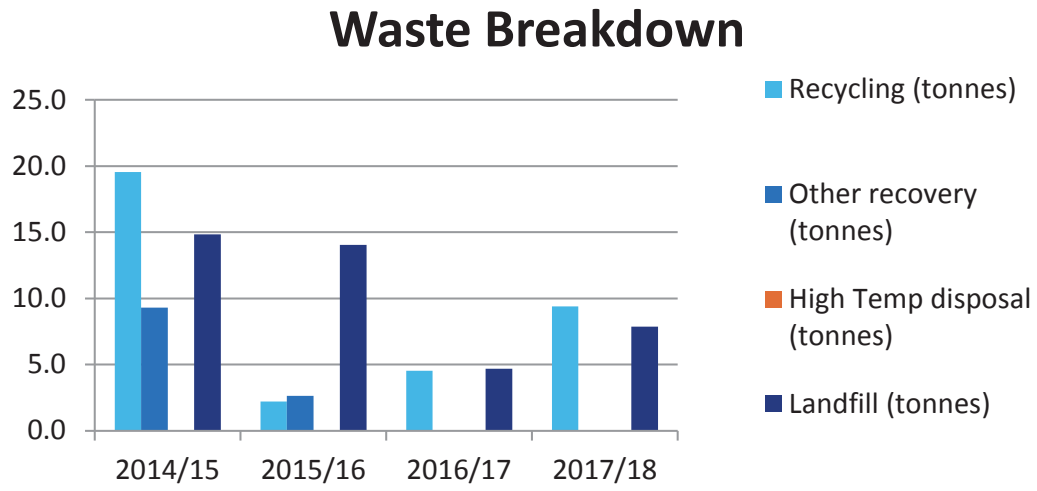
Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	138,402	179,167	151,697	170,326
	tCO2e	29	37	32	36
Oil	Use (kWh)	0	0	0	0
	tCO2e	0	0	0	0
Coal	Use (kWh)	0	0	0	0
	tCO2e	0	0	0	0
Electricity	Use (kWh)	153,840	293,077	302,489	290,998
	tCO2e	95	168	156	130
Green Electricity	Use (kWh)	0	0	0	0
	tCO2e	0	0	0	0
Total Energy CO2e		124	206	188	166
Total Energy Spend		£34,834	£34,704	£33,237	£34,468



Waste

All of our waste is office type waste and the percentage recycled during 2017/18 has improved compared to previous years. Our waste recycling is managed by NHS Property Services and we continue to work closely with them to identify further opportunities for improvement.

Waste		2014/15	2015/16	2016/17	2017/18
Recycling/ reuse	(tonnes)	20	2	5	9
	tCO2e	0.41	0.04	0.10	0.20
Other	(tonnes)	9	3	0	0
	tCO2e	0.20	0.05	0.00	0.00
Landfill	(tonnes)	15	14	5	8
	tCO2e	3.63	3.43	1.45	2.71
Total Waste (tonnes)		44	19	9	17
% Recycled or Re-used		45%	12%	49%	54%
Total Waste tCO2e		4.23	3.53	1.55	2.91



Water

Our water usage has increased during 2017/18 which was expected due to the increase of staff since 2016/17.

Water		2014/15	2015/16	2016/17	2017/18
Mains	m3	929	800	892	1,097
	tCO2e	0.85	0.73	0.81	1.00
Water & Sewage Spend		£4,004	£3,335	£3,682	£2,992

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 who use the services we commission. We support a culture for active travel to improve staff wellbeing and reduce sickness.

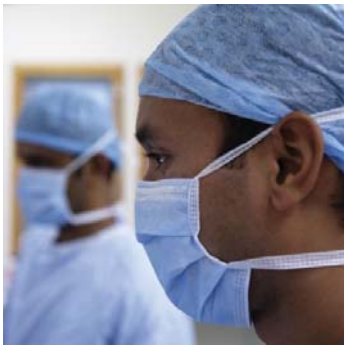
We encourage staff to travel less for business and have seen a corresponding reduction in business miles during 2017/18. Incidentally, there has been an expected increase in the use of telephone conferencing.

Category	Mode	2014/15	2015/16	2016/17	2017/18
Staff commute	miles	107,311	101,259	102,875	123,363
	tCO2e	39.43	36.62	37.18	43.96
Business Travel	miles	149,569	105,347	78,256	68,996
	tCO2e	54.98	38.10	28.28	25.13
Active and public transport	miles	21,190	12,622	16,849	32,003
	tCO2e	1.91	1.08	1.56	2.88
Owned Electric and PHEV mileage	miles	0	0	0	0
	tCO2e	0.00	0.00	0.00	0.00
Total cost of business travel	£	78,165.24	56,240.36	55,288.69	57,801.68

Emergency preparedness, resilience and response

We certify that NHS Wiltshire Clinical Commissioning Group has an Accountable Emergency Officer and complies with NHS England Core Standards for EPRR 2017. In October 2017, we provided assurance to NHS England about our compliance with the emergency preparedness resilience and response framework and to the Governing Body via the Audit and Assurance Committee in January 2018. As part of this assurance, we explained how we would address any gaps in our operational management arrangements which we had identified; we have also provided valuable support to NHS England and were actively involved in the assurance of healthcare providers.

We remain an active contributor to the Emergency Preparedness, Resilience and Response agenda through its involvement in the Wiltshire and Swindon Local Health Resilience Partnership (LHRP) and have been active in the development of plans to support the response by partner organisations to emergency situations.



Improving quality

Quality and patient safety report

Wiltshire's model of care aims to support and sustain healthy independent living and is underpinned by our strategic approach to commissioning high quality, safe and effective services. Central to service transformation is the focus on the person and their journey through the healthcare system. Whilst taking a long term approach to enable organisations to work together more effectively, we have maintained the three nationally accepted core elements of quality:

- Patient experience
- Patient safety
- Clinical effectiveness

Assurance that services meet the commissioned standards and these pillars of quality is gained through the triangulation of information from a variety of sources including national data sources, local reporting, quality visits to providers, clinical quality review meetings, patient feedback, other providers, clinical commissioning groups and regulators. Continuous improvement is supported and driven through quality schedules within national contracts which emphasis this and through the commissioning for quality and innovations framework.

During 2017/18, the above process and national publications, guidance and recommendations, have helped to shape quality and patient safety priorities.

Maternity

We continue to develop and implement a Local Maternity System across BaNES, Swindon and Wiltshire in alignment with the national maternity transformation programme "Better Births"; aimed at improving safety and increasing women's choice.

We are working collaboratively with all three maternity providers and user representatives to align policy and practice where possible to ensure safe births, positive experiences and equity for all women. We will apply the learning from national pilot sites that are modelling continuity of care in a locally appropriate way as it becomes available during 2018/19.

The commitment and ideas from staff provide the foundation of any transformation and we will ensure that their feedback informs and shapes our plan as it develops. Through embedding a continuous quality improvement approach, we will further develop the existing safety culture that is evidenced by transparent reporting and sharing of learning from serious incidents. We are committed to sharing and learning from each other when things go wrong as well as when celebrating success and this is being taken forward through our Safety Working Group, involving commissioners and providers across the system.

General Practice Nursing

In response to Health Education England General Practice Nursing Workforce Development Plan –Recognise, Rethink and Reform 2017, NHS England published General Practice – Developing confidence, capability and capacity: a ten point action plan for General Practice Nursing.

These documents have provided the framework for the development of our Wiltshire Practice Nurse Forum which offers professional development and support. Clinical updates have been provided on topics identified by the nurses and in addition professional areas such as peer appraisal and mentoring to facilitate the expansion of training placements in primary care. A key priority is raising the profile of practice nursing as an attractive career option.

Stroke Improvement Collaborative

The Quality Team has been monitoring provider stroke service performance since 2014. This has identified some key areas and indicators where services for Wiltshire patients appear to be under performing. In order to enable a Sustainability and Transformation Partnership wide (STP) wide view of the performance and quality issues regarding stroke delivery, the CCG Clinical Advisory Group recommended a collaborative quality improvement approach should be taken to service improvement. During late 2017, The CCG Quality Team therefore initiated and has been leading on an STP wide Stroke Quality Improvement Collaborative. The group has good engagement from all providers and commissioners across the STP footprint and has shared learning around areas of good practice, as well as developments and challenges and current research and national audit data have been reviewed.

The national NHS England lead for Stroke Services has been involved in this work and has provided advice and guidance.

The Collaborative Group has a number of ongoing key actions, including an audit which will take place across all providers. This will then inform the improvement work in 2018, which will initially take the format of a full pathway review. There are focused work streams in both the Ambulance Services and Primary Care to support this.

Patient Safety in Emergency Departments

Throughout 2017/18, the Quality Team has worked with providers to bring improved clarity to the reporting of patient safety in Emergency Departments. Each of the three Trusts has further developed their internal assurance processes and shares these with the CCG via contractual routes.

In October 2017, NHS Improvement mandated the use of the SHINE Emergency Department Patient Safety Checklist by Trusts who had not implemented the system or a similar, validated alternative. Great Western Hospital, with support from the Academic Health Science Network, adopted SHINE in 2016 following their CQC inspection. Salisbury Foundation Trust and the Royal United Hospital Trust Bath implemented SHINE in early 2018. The Trusts have not yet reached full compliance with the checklist, but are reporting on progress towards this. The Quality Team continues to support the Trusts with this process and with wider patient safety assurance.

In 2018/19, the Quality Team will lead a collaborative review of patient safety reporting and assurance by all Trusts; this will identify good practice, transfer learning and will improve consistency between Trusts which are currently operating disparate systems and cycles of reporting.
In addition to the above and to the mandatory review of cases which breach the 12 Hour 'Decision to Admit' or 'trolley' targets, the CCG has maintained focus on assurance regarding patients who are spending longer periods of time in the Emergency Department. A reporting mechanism has been developed to enable the Quality Team to understand the patient safety and experience impact for those patients experiencing waits in ED of over 16 hours (this is a combination of both the 4 hour and 12 hour targets). Setting up this report has highlighted some data anomalies which have taken time to resolve – this has been further exacerbated by two of the trusts going through IT system changes during 2017. It is anticipated that this will be resolved by April 2018.

The information below provides a summary in respect of patient experience, patient safety, clinical effectiveness, primary care services and safeguarding.

Complaints management

Documentation for our compliments, concerns and complaints policy is available at: www.wiltshireccg.nhs.uk

A status report on open complaints and the action taken to resolve them is shared with our Executive Directors on a weekly basis. A quarterly complaints and Patient Advice and Liaison Service (PALS) bulletin is published on the clinical commissioning group's intranet site, which ensures that all staff are aware of complaints and feedback regarding the services we commission. Trends identified through complaints are discussed with relevant commissioners and provider organisations as well as any commissioning or service delivery gaps so that remedial actions can be taken where required.

During 2017/18 our Lay Members continued to review a sample of complaint responses each quarter, and we used the feedback to improve or make changes to our processes. We also progressed with our 'complainant satisfaction survey' which is sent out to all complainants 6-8 weeks after the complaint has been responded to. The survey enables us to better understand what is working well and where areas of our complaints process could be improved, and make any changes as necessary.

The feedback channel for GPs, the 'Grumpy and Pleased' function, which enables GPs to provide feedback regarding the services we commission is also administered by the Complaints and PALS team. The feedback from GPs is used to identify themes and trends to be discussed with providers and commissioners where appropriate, with the aim of identifying and embedding improvement actions within provider organisations that leads to a better experience for our patients. This includes the collection of breaches of the Standard Hospital Contract which are then shared with the commissioning team and discussed with providers.

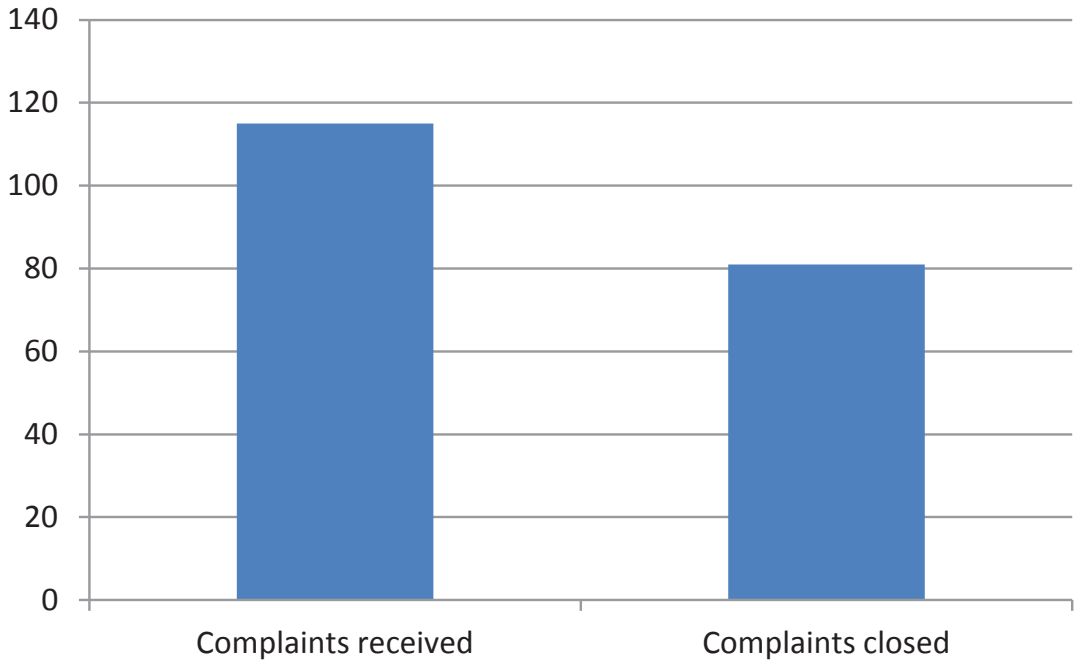
Formal Complaints - for April 2017– March 2018

	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	Total
NHS Wiltshire Clinical Commissioning Group	15	28	26	28	97
Member of Parliament	4	2	9	3	18
Total	19	30	35	31	115

The table above outlines the number of formal complaints received and those that have been sent to us through a Member of Parliament (MP).

Between April 2017 and March 2018, we have received 115 formal complaints, which is a 44% increase on the previous year. Of these, 70% (81) have been investigated and responded to and closed. For those complaints received via an MP's office, 89% (16) have been investigated and responded to.

The chart below outlines the number of complaints received and the number of complaints closed.

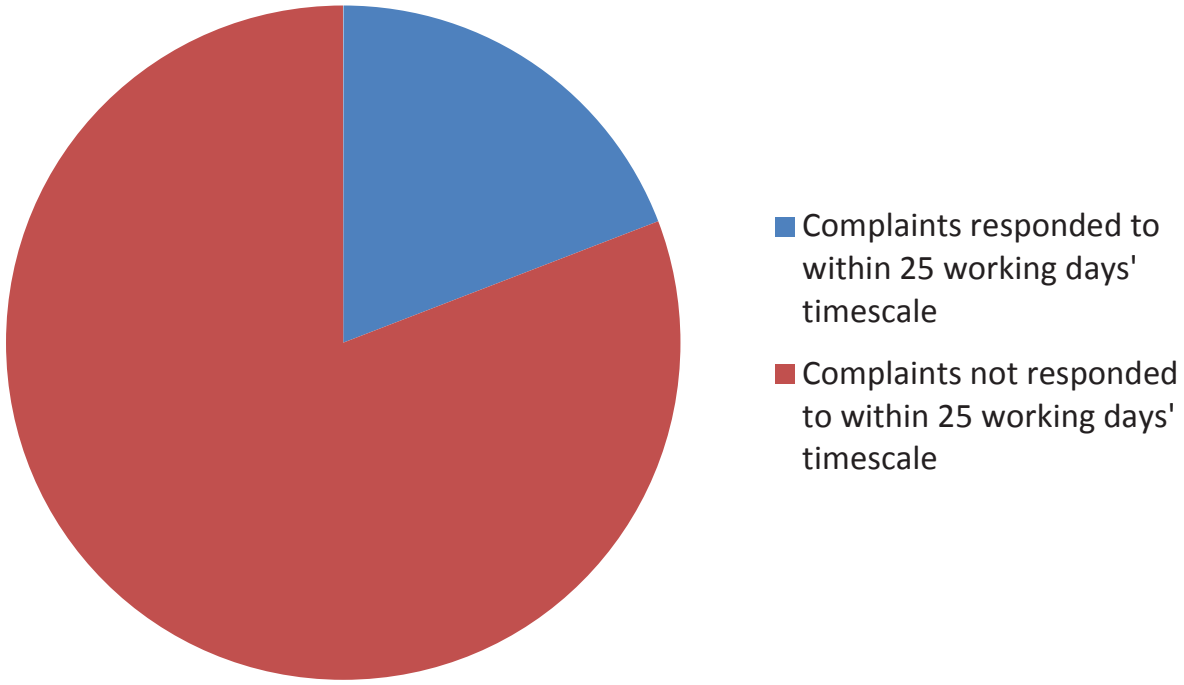


The Complaints and PALS team aims to acknowledge all complaints within three working days. Performance in 2017/18 demonstrates that this was achieved in 93% of cases (107). This is an improvement of 2% over the previous year 2016/17. Over the next 12 months, improving the performance around the three day working target is a key performance objective for us.

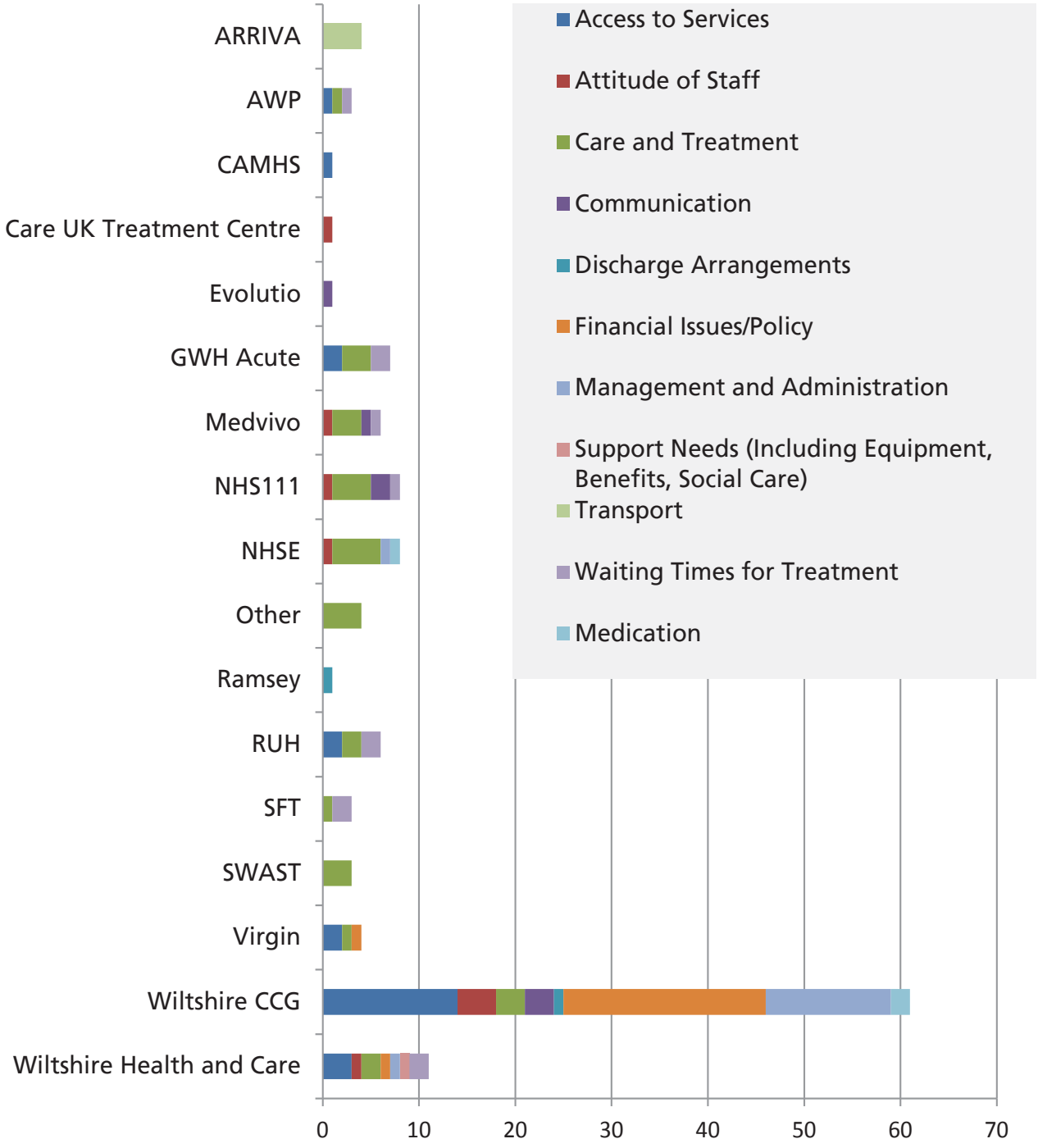
There is no set timescale for NHS Complaints (NHS Complaints Regulations 2009), however, in line with many other organisations we adopt a 25 working days timeframe as a reasonable guide to investigate and provide a response to the complainant; the timescale begins on receipt of consent. Where a complaint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

Of the 81 closed complaints, 6% (5) did not follow the full complaints process. Of these, 2.5% (2 cases) are reported as being referred to the provider concerned as it was already subject to an investigation. In 5 (4) of cases, the complainant chose not to return the consent form (a reminder letter is always sent).

The chart below identifies the complaints closed within 25 working days, and those which are not. Of all of the complaints received, 19% (22) were closed within 25 working days. It should be noted, that if additional information is required to ensure a complaint response is fully responded to, we write to the complainant to explain why there is a delay and when they can expect to receive a response. In cases where the complaint made is about a provider we commission services from, the CCG cannot respond to a complaint in full until we have received a response from the provider(s). We continue to work with both internal and external stakeholders to improve our complaint response times.

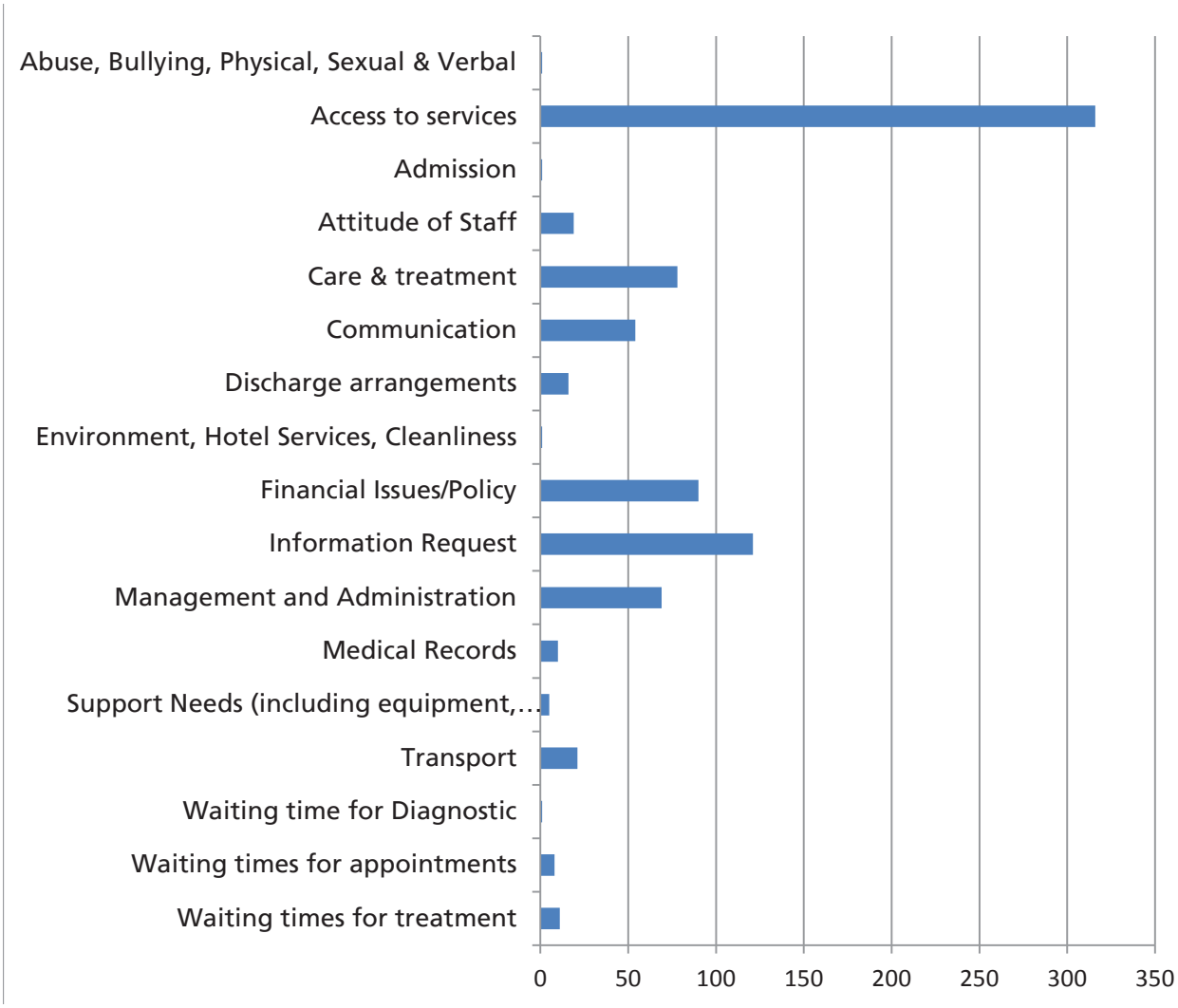


Complaints breakdown by Provider and Theme



PALS enquiries and concerns

The CCG received 826 PALS enquiries between April 2017 and March 2018; this includes 87 'Grumpies,' which is the GP feedback channel. This is an increase in PALS enquiries of 42% compared to 2016/17.

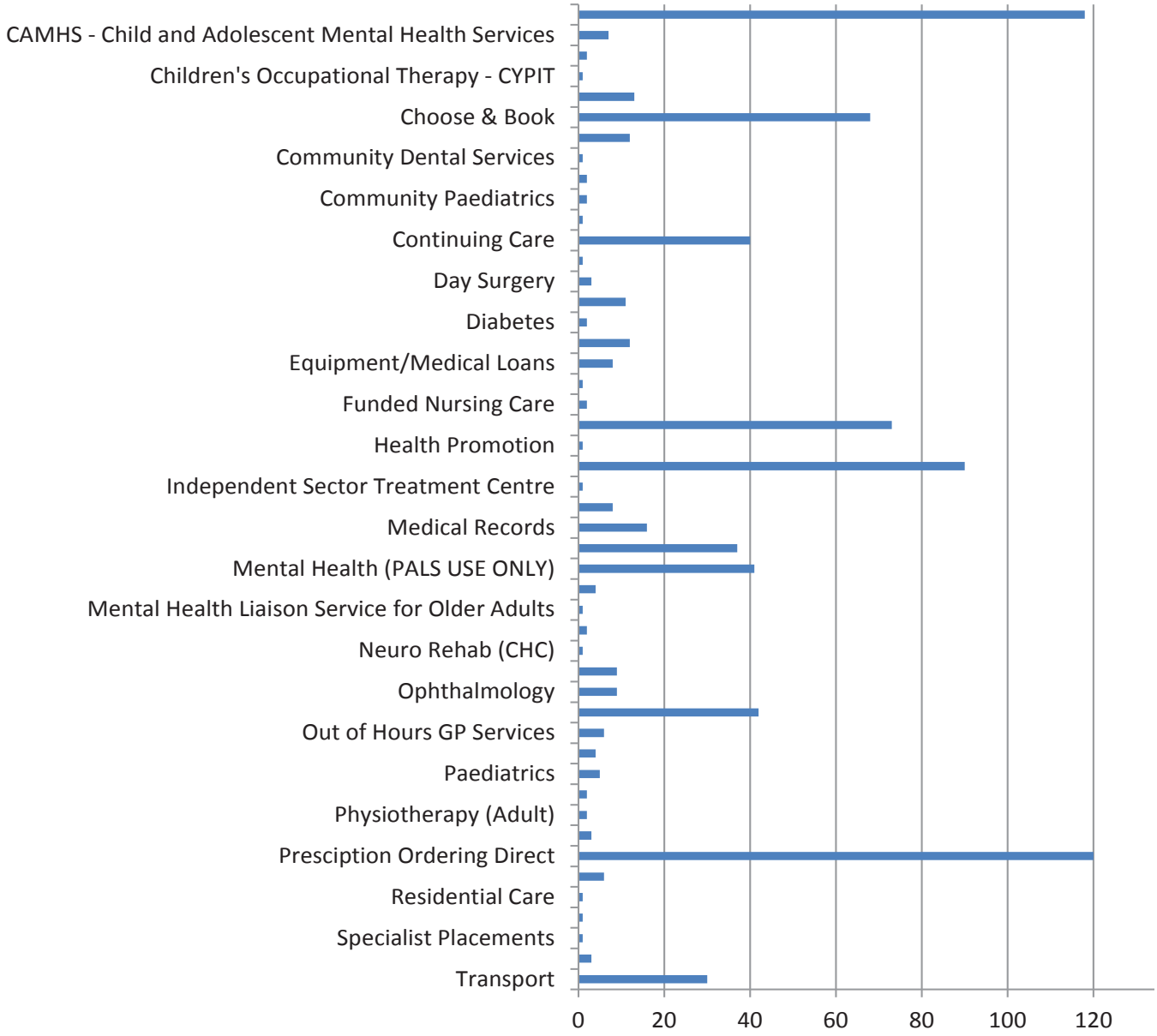


Of the PALS received, 95% (786) have been closed to the satisfaction of the person making the enquiry. Of the remaining 40 open cases, four relate to MP office enquiries and 11 are 'Grumpies' or GP feedback regarding commissioned services. The main themes captured through PALS relate to access to services, requests for information, financial issues and policy, management and administration, care and treatment and communication.

The table below outlines the PALS concerns received directly by the CCG, those that have been shared through a MP and those that relate to feedback received from GPs regarding commissioned services.

	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	Total
NHS Wiltshire Clinical Commissioning Group	98	171	260	171	700
Member of Parliament	4	12	11	12	39
GP feedback (Grumpy)	20	24	30	13	87
Total	122	207	301	196	826

Patient Advice and Liaison Service (PALS) by Service



Staff Experience

Good staff experience is an essential indicator of good patient experience. We hear directly from front line staff at our contract quality review meetings with providers and also during our quality visits to service providers. We also review providers' staff satisfaction surveys as well as the NHS England staff survey results to ensure our providers are supporting staff appropriately.

The health and wellbeing CQUIN, introduced during 2016 and continued in to 2017/18 encourages providers to improve their role as an employer in looking after the physical and mental health well-being of their employees. Providers are rewarded for introducing initiatives focused on staff mental health, physical activity and musculoskeletal problems.

Patient Safety

Safety within the context of the NHS means that people are protected from avoidable harm and abuse and when mistakes occur, we learn from them. Patient safety is primarily the responsibility of front line healthcare staff that must be enabled to report incidents to ensure appropriate action can be taken to mitigate impact and prevent future occurrences.

Management of serious incidents
Serious incidents requiring investigation within healthcare are rare, but we have systematic measures in place to respond to them. Guidance is included in all provider contracts for the reporting of serious incidents, which is aligned to the 2015 Serious Incident Framework. This aims to ensure that robust investigations are carried out, appropriate action is taken to protect patients, and learning is embedded in the provider organisation to minimise recurrence.

We are responsible for reviewing and supporting the closure of incidents for patients registered with a GP in Wiltshire and for holding providers to account for the quality of their investigations and implementation of actions to address organisational learning arising from serious incidents. We have reviewed our serious incidents policy to reflect and ensure compliance with recent revisions to the framework. As a consequence of delegated commissioning for Primary Care, the Quality Team has revised the policy and processes to include primary care and to provide practices with support and advice regarding incident reporting and investigation.

Service providers are required to notify us of a serious incident within two working days of it happening. We oversee and hold providers accountable for their reporting and investigations processes, including adhering to timescales, deadlines and the implementation of actions and learning.

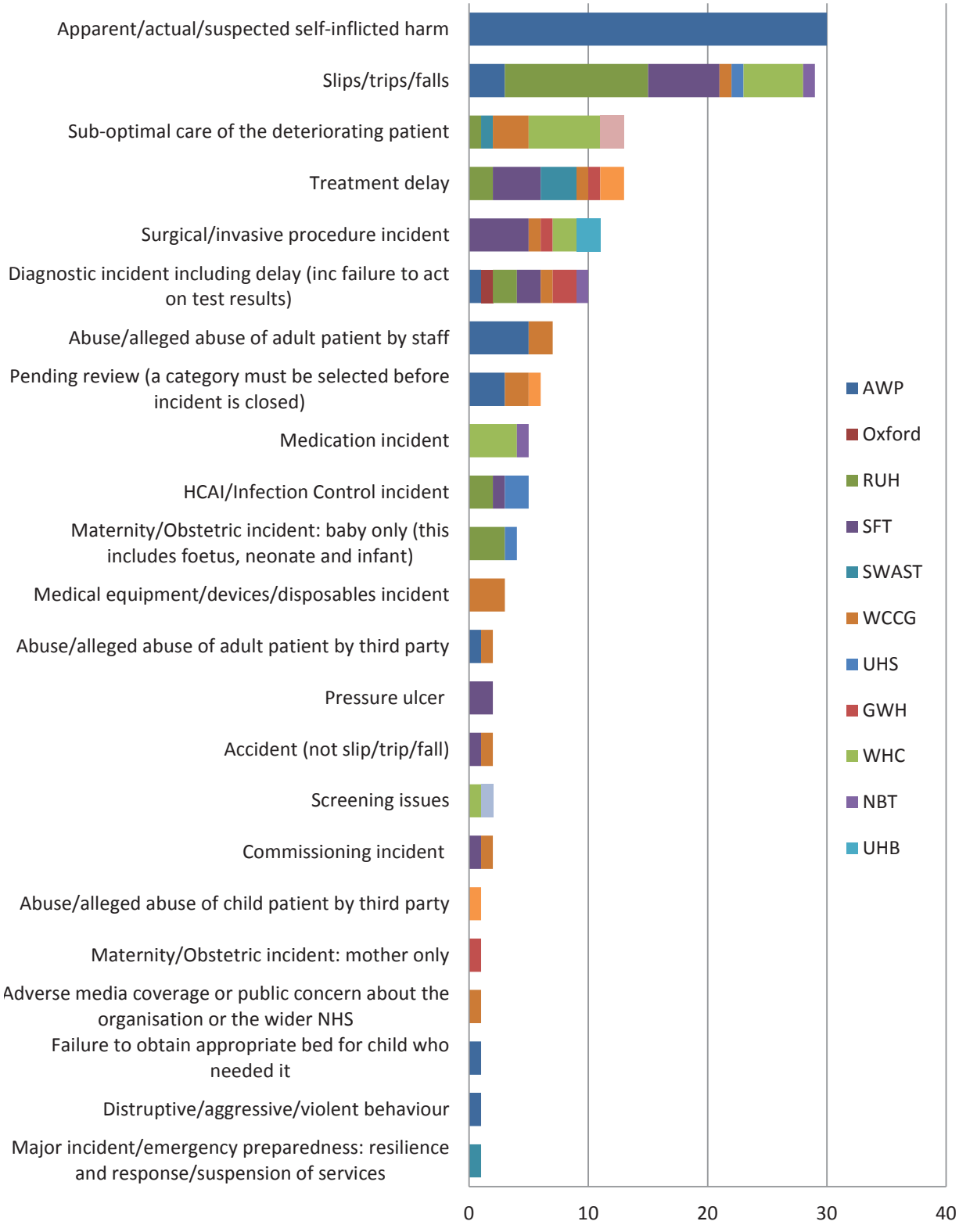
We hold fortnightly serious incident closure meetings to review the root cause analysis reports submitted by the providers and ensure actions are in place to mitigate the risk of the incident occurring again. We give feedback, provide support and continue to monitor closed incidents to ensure that appropriate action is taken to enable learning to be imbedded.

We log serious incidents for our commissioned providers of NHS funded care who do not have access to upload this information on to the Strategic Executive Information System (STEIS, NHS England's web-based serious incident management system) where it involves patients registered with a Wiltshire GP and/or we are the lead commissioners and/or the organisation is within Wiltshire.

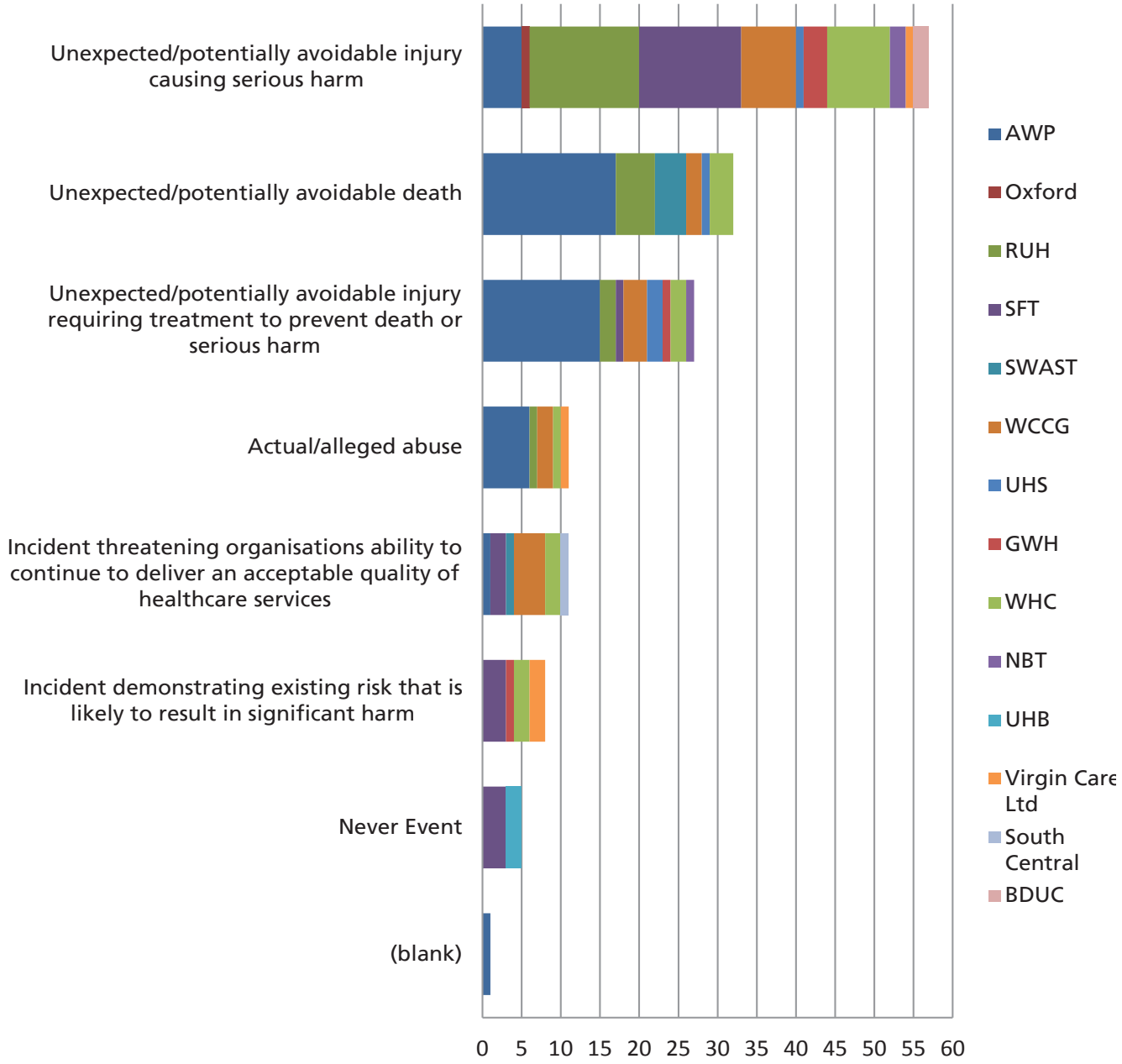
Serious incidents are logged against a 'Type of incident' and 'Reason for reporting'. The most common types of incident reported in 2017/18 were 'slips/trips/falls', and 'apparent/ actual/suspected self-inflicted harm'. The most common 'reasons for reporting' were 'unexpected/ potentially avoidable injury causing serious injury' and 'unexpected/ potentially avoidable death'.

For 2017/18, the list of provider reported serious incidents for Wiltshire patients is shown in the graphs below for type and reason.

Themes and Trends



These figures are correct as of 3 April 2018



These figures are correct as of 3 April 2018

Never Events

NHS England published the revised 'Never Events Policy and Framework' in January 2018, which supersedes the previous version published in March 2015, and acts as a guide for staff providing and commissioning NHS funded services who may be involved in identifying, investigating or managing never events.

A never event is defined as a particular type of serious incident that meets all of 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 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.

We are required to monitor the occurrence of never events within the services we commission and publicly report them on an annual basis.

During 2017/18 there were five never events involving Wiltshire patients; three of which have been fully investigated and closed. The action plans following the root cause analysis are monitored by the appropriate contract quality review meetings. The two open never events are currently being investigated and the CCG is due to receive the reports in May 2018.

The table below shows never events for Wiltshire patients since April 2013 to March 2018.

		Number of Wiltshire Patient(s) involved in a Never Event				
Provider	Category of Incident	2013/14	2014/15	2015/16	2016/17	2017/18
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	1	3
	Medication incident				1	
University Hospital Southampton	Surgical Error		1			
WCCG (British Pregnancy Advisory Service)	Surgical Error				1	
United Hospital Bristol	Surgical Error					2

These figures are correct as of 3 April 2018

Health care associated infections MRSA and Clostridium difficile 2016/17 targets set by Public Health England

The term 'heath care associated infection' covers a wide range of infections with the most well-known including those caused by Methicillin-Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C. difficile), norovirus and the flu virus. Health care associated infections pose a serious risk to patients, staff and visitors and can incur significant costs for the NHS and cause significant morbidity to those infected.

Reducing health care associated infections remain high on the Government's safety and quality agenda and in the general public's expectations for quality of care. Our quality team works with providers to gain assurance of their performance, and ensure their contribution to sustained improvement in infection prevention and control practices that reduce such infections and antimicrobial resistance. NHS England planning guidance, the national contract, sets a zero tolerance approach to MRSA bloodstream infections and every organisation is expected to achieve this.

During 2017/18, NHS England introduced the 2017 to 2019 Quality Premium scheme to reduce gram negative blood stream infections across the whole health economy by 50% by 2020, the aim for 2017/18 was to reduce the number of gram negative blood stream infections by 10% based on 2016 CCG data. E-coli infections represent 65% of all gram negative infections. NHS England has now begun to publish E-coli infection data in the same way that MRSA and C.difficile are already reported.

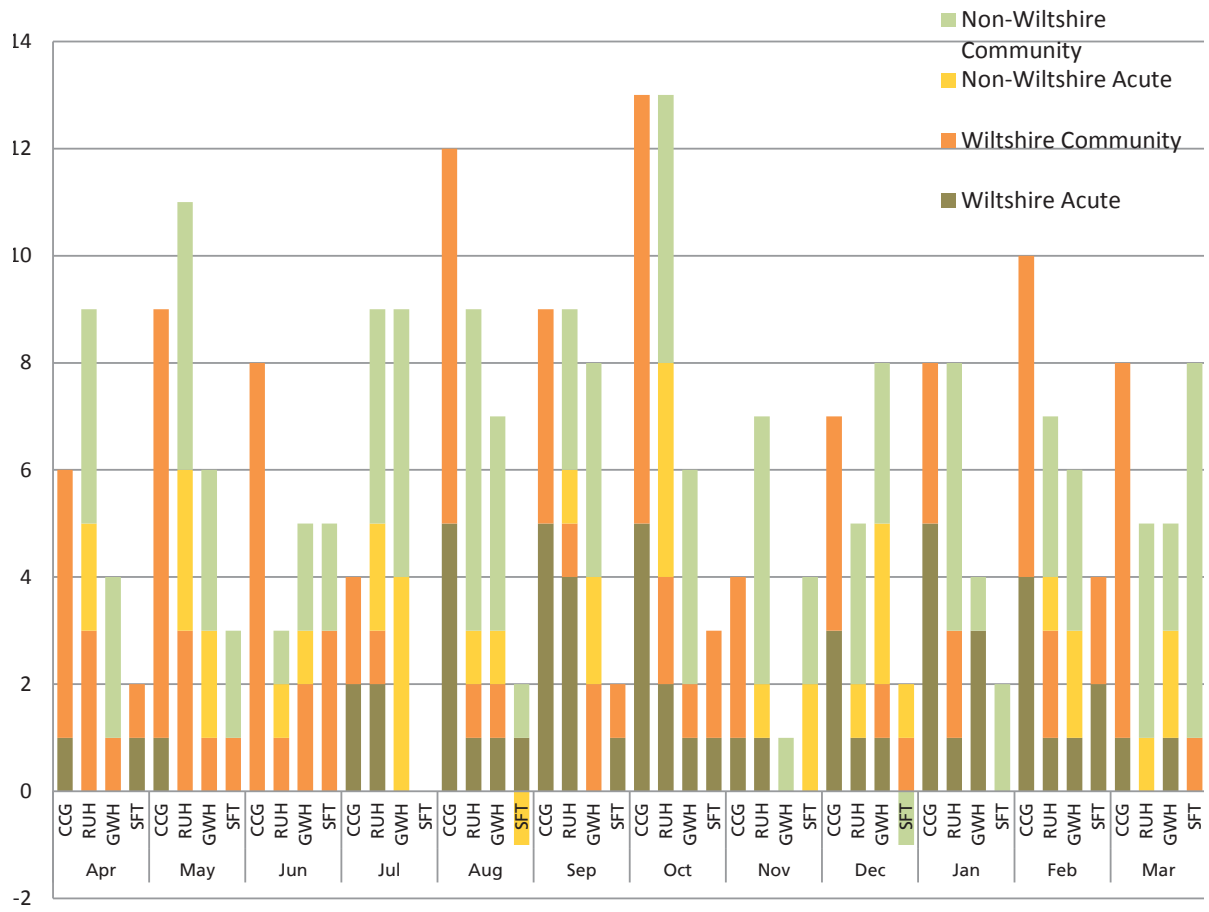
Recorded 2017/18 E-coli cases are at 233 (to the end of December 2017), 7 cases fewer than the same time period last year. Significant efforts have been made by the three acute providers to reduce the post admission 48 hour cases (meaning that they are likely to have been contracted within the healthcare setting) and support community and primary care in reducing pre-48 hour ('community acquired') cases. The work will continue across the STP during 2018/19 over which time the trajectory for a reduction of 10% on 2016/17 cases remains unchanged.

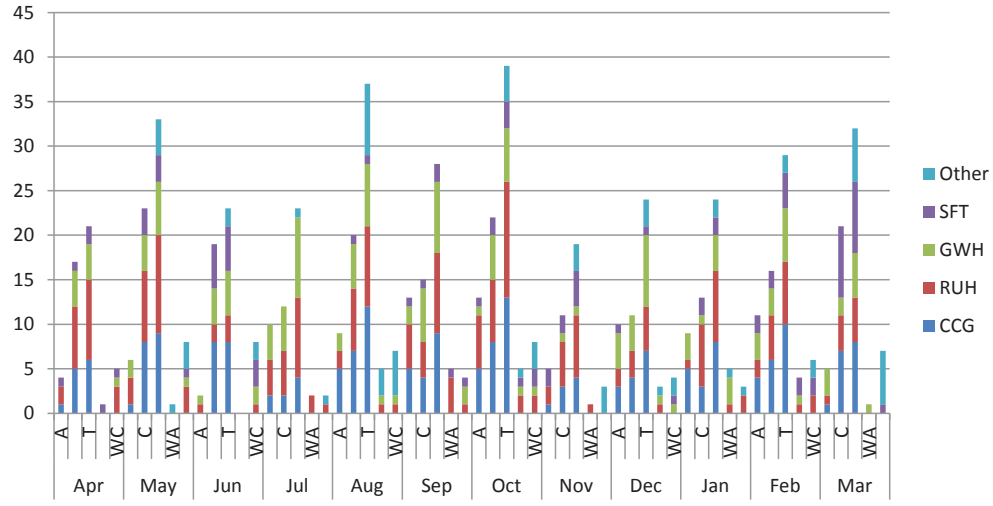
The NHS England MRSA threshold objectives for 2018/19 remain at the same levels as 2016/17. NHS England has issued new guidance on post infection reviews for MRSA blood stream infections. The new guidance has been modified so that formal reviews must only be undertaken for organisations with the highest rates of infection. Wiltshire CCG is not listed under the organisations that are required to undertake these reviews nor are any Wiltshire CCG providers. The NHS England CDI objectives for 2018/19 have slightly reduced and are as follows; GWH – 19, RUH – 21, SFT – 18. Alongside our local providers, we continue to collaborate and strive to reduce health care associated infections.

During 2017/18, there have been 90 cases of C.difficile bacteraemia (to the end of February 2018).The year end threshold for 2017/18 is 103 cases. This represents a considerable improvement from the previous years. This reduction in the upward trend has been positively influenced as a result of our recovery action plan which was implemented in 2015/16. The emerging trend in increasing numbers of cases attributable to community and primary care healthcare settings continued throughout 2017/18. The Quality Team continues to offer closer support to these settings to ensure the increasing trend is reversed as soon as possible. Actions to support Primary Care have been set out in the CCG's Infection Prevention and Control Strategy which was approved in September 2017.

C.Difficile Thresholds and Achievements

Provider	2014/15		2015/16		2016/17		2017/18	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
SFT	18	23	19	10	19	13	19	8*
RUH	37	29	22	18	22	45	22	30*
GWH	28	19	20	14	20	21	20	22*
Community Acquired	Unknown from early data		42	72	42	65	42	58*
Out of area Cases	Unknown from early data		0	14	0	5	0	7*
Total for Wiltshire (including out of area cases)	**140**	**106**	**103**	**128**	**103**	**100**	**103**	**90***





Key

A: (Acute) Total number of acute infections (appearing 48 or 72 hours after Trust admission depending on infection type) that occurred.

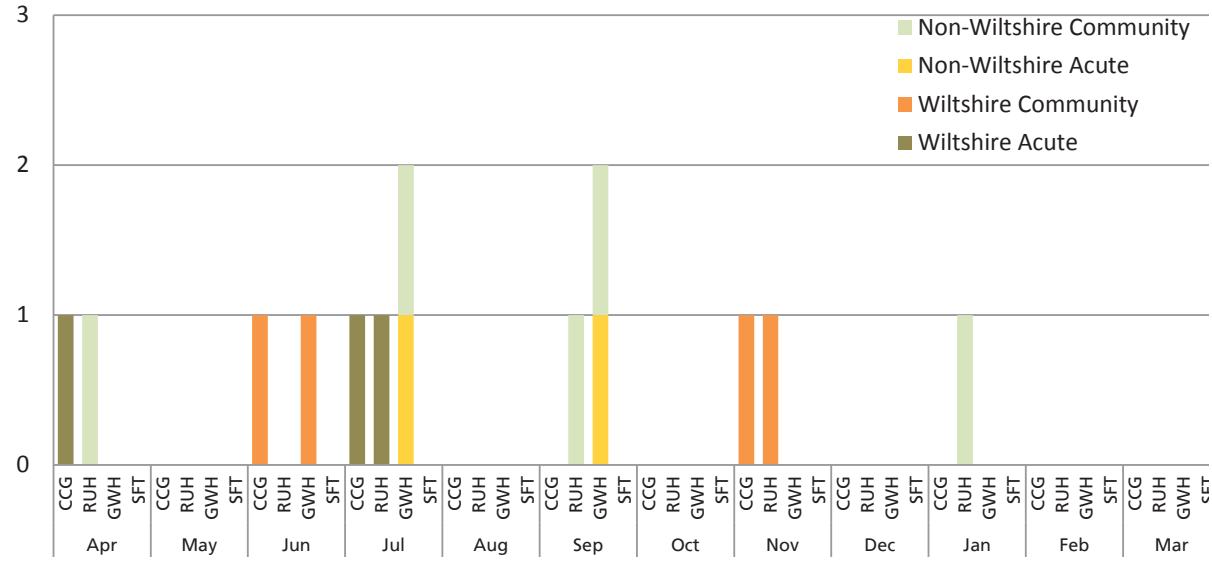
C: (Community) Total number of non-acute infections (appearing within 48 or 72 hours of Trust admission depending on infection type) that occurred.

T: (Total) Total number of infections, either for Wiltshire CCG or the whole of the named Trust.

WA: (Wiltshire Apportioned Acute) Total number of acute infections that occurred on Wiltshire CCG patients at the Trusts.

WC: (Wiltshire Apportioned Community) Total number of non-acute infections that occurred on Wiltshire CCG patients at the Trusts.

During 2016/17 there were 7 cases in total across all providers, of methicillin-resistant Staphylococcus aureus (MRSA). There were 2 recorded cases of post 48 hour MRSA bacteraemia and 5 recorded cases of pre 48 hour MRSA bacteraemia. In 2017/18 there have been 2* cases of pre 48 hour (Community Attributable) MRSA bacteraemia and 2* cases of post 48 hour (Acute Trust attributable) MRSA bacteraemia for Wiltshire patients, which represents a significant decrease from the previous years. The graph below displays the full detail for 2017/18*



(* - denotes figures calculated to the end of February 2018; 11 months).

Mortality indicators

The Hospital Standardised Mortality Ratio (HSMR) is one of the most commonly used measures of overall mortality for trusts, which looks at conditions accounting for 80% of deaths in hospital. The summary hospital-level mortality indicator 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 these thresholds for NHS Trusts providing hospital care. The mortality data is analysed to review performance for patients admitted during week days, weekends, and for 'low risk' diagnosis groups.

In January 2018, Dr. Foster Intelligence published mortality statistics for English acute trusts for the period July 2016 to June 2017. Although quarterly reports and recently, monthly updates are available, full statistics are published between six and nine months after the period ends to allow time for capture of data relating to post-discharge deaths and to carry out complex analysis.

The following chart illustrates provider mortality benchmarking over the previous five years. In line with the general national trend, this chart demonstrates a trend of rising mortality ratios across all Trusts. All three Trusts are participating in the NHS England national programme to standardise mortality reviews and learning from deaths. A 'league table' of provider performance against mortality indicators will also be developed and published by NHS England. We will collaborate in this work in support of quality and safety improvement.

Key:

Within expected range ↔

Lower than expected range ↓

Higher than expected range ↑

Indicator (July to June- 12 months)	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	Trend	Performance
Royal United Hospitals								
SHMI Overall Trust Mortality ratio	95.92	101.1	95.06	97.02	100.9	103.1		↔
SHMI by Acute Hospital Site	95.87	101.1	95.08	96.97	98.52	105.6		↑
HSMR Overall Trust Mortality Ratio	99.38	100.1	94.22	104.5	107.4	91.27		↔
HSMR; by Acute Hospital Site	99.04	100.1	94.26	104.8	107.6	111.5		↑
Deaths in Low Risk Conditions	1.4	1.32	0.67	0.94	0.58	0.719		↔
HSMR Weekday	Data Not Available		98.34	104.2	106.3	109.9		↔
HSMR Weekend			105.5	106.9	115.1	120.8		↑
Salisbury Foundation Trust								
SHMI Overall Trust Mortality ratio	107.8	105.8	101	108.6	103.2	106.1		↔
SHMI by Acute Hospital Site	103.5	101.2	97.08	104.5	110.4	114.3		↑
HSMR Overall Trust Mortality Ratio	105	114.8	100.4	109.4	118.9	87.86		↑
HSMR; by Acute Hospital Site	103.2	111.4	97.67	106.1	115.1	112.7		↑
Deaths in Low Risk Conditions	0.4	0.74	0.87	0.69	0.35	0.381		↔
HSMR Weekday	Data Not Available		106.7	107.6	119.7	112.9		↔
HSMR Weekend			116.5	111.2	120.7	125.7		↔
Great Western Hospitals								
SHMI Overall Trust Mortality ratio	102.3	96.42	97.67	92.18	95.4	96.63		↔
SHMI by Acute Hospital Site	103.5	99.81	100.1	94.38	99.22	98.33		↔
HSMR Overall Trust Mortality Ratio	103.5	99.31	100.1	86.4	99.99	98.45		↑
HSMR; by Acute Hospital Site	103.5	101.1	99.27	87.13	100.9	97.87		↔
Deaths in Low Risk Conditions	0.7	0.67	0.46	0.77	0.68	0.46		↔
HSMR Weekday	Data Not Available		103.4	83.38	97.02	96.72		↔
HSMR Weekend			114.8	97.17	113	105.9		↔

Data and contractual reporting by Salisbury Foundation Trust has confirmed that despite being above expected level, HSMR continues to decline and the absolute rate and numbers are stable. The Trust Mortality Group and Medical Director have reviewed the palliative care coding and Chelsea comorbidity coding. They identified that the new end of life care process was not coded in line with palliative care and this had resulted in elevated mortality figures. This has now been rectified so the new process is now coded as per palliative care. Additionally, Salisbury Foundation Trust has developed a gap analysis in reference to the National Guidance on Learning from Deaths. Learning points along with improvement actions are set out within the Trusts' routine and contractual quality reporting. In October 2017, a bereavement survey started to be offered to relatives and carers along with the opportunity for an open discussion with the clinical team if they have any concerns or queries.

The Royal United Hospital has recorded a 'higher than expected' Mortality rate for more than 12 months. For five of the last 12 months, the HSMR rate has been recorded at summary level as 'Significantly Higher than Expected'. In line with contractual reporting requirements, the Trust has provided commissioners with assurance regarding their plans and actions to review mortality data. At the time of writing this report, the Trust is further developing these plans in response to Commissioner requests for further detail clarification and assurance.

For Great Western Hospital the July 2017 Dr Foster data gives a final HSMR figure for the year 2016/17 of 98.39, this is slightly higher than 2015/16 but is still within the nationally expected range. The HSMR figure for April 2017 to October 2017 is 98.99, with the HSMR figure for October being 84.96; both these figures are provisional, although neither is expected to change significantly when the data is next updated. The rolling 12 month HSMR for November 2016 to October 2017 is 99.56. The Standardised Hospital Mortality Indicator (SHMI) for the rolling 12 month period of July 2016 to June 2017 is 96.65, with the confidence limits 92.14 to 101.33 giving the Trust an 'As Expected' rating.

The SHMI for this period is lower (better) than the nationally expected value of 100, and is similar to the previous 12 month period (January 2016 to December 2016). This is showing a similar trend to the HSMR figures.

For all Trusts, there is a variation between weekday and weekend mortality benchmarking data. During 2018/19, the Quality Team will work with the Trusts and through the Mortality Review Collaborative to further understand this disparity and to facilitate actions to reduce this unwarranted variation.

The Academic Health Science Network is facilitating a Mortality Review Collaborative. Each of the three acute trusts is participating in the group. Significant progress continues to be made by the Trusts on implementing the Royal College of Physicians (RCP) structured case record review process. All trusts have now received their Structured Case Record Review training. Data on the number of reviews completed by Trusts is now being shared across the group with the most prevalent theme relating to early recognition of End of Life, both inside and outside the hospital setting, as well as timely senior reviews once in hospital.

The West of England AHSN is now working with partners across the region to scope whether the ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment) for end of life care planning should be adopted across the region.

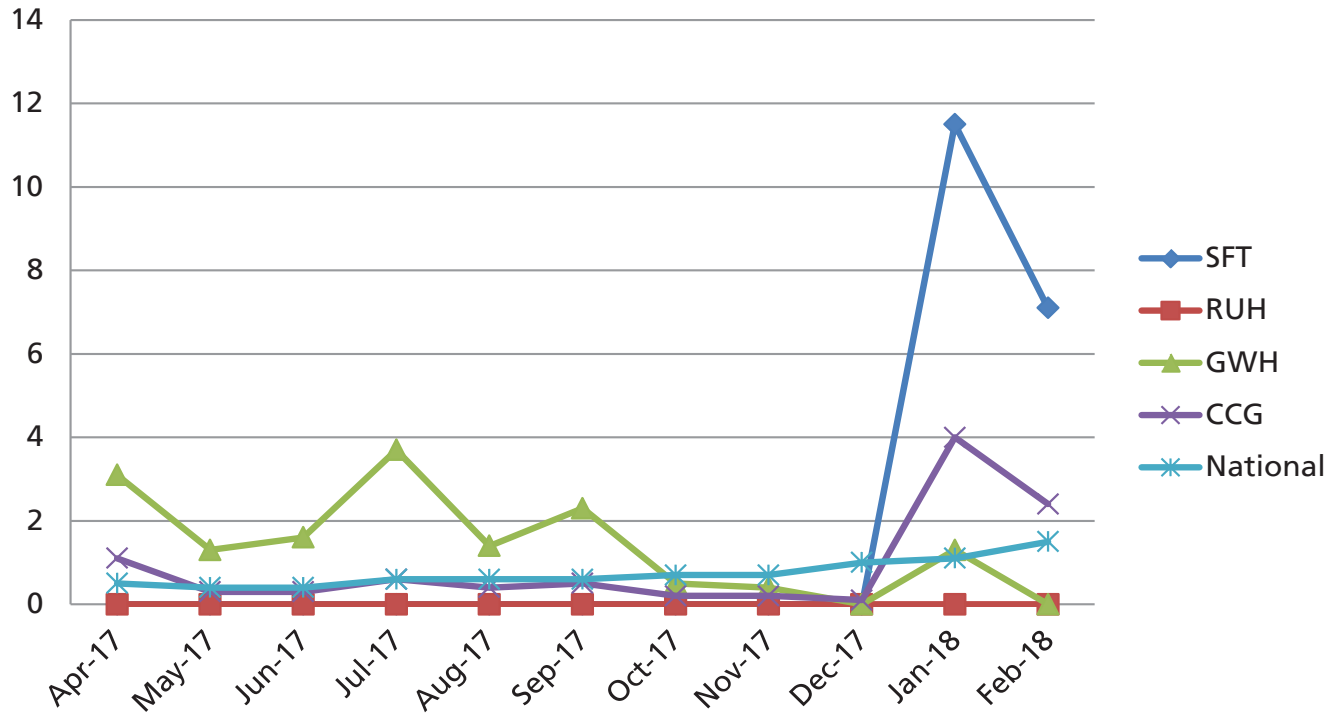
Mixed sex accommodation breaches

All NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall clinical best interest of the patient, or reflects personal or patient choice.
For all relevant providers commissioned by Wiltshire CCG, we can confirm that all take appropriate actions in respect of their responsibilities under the mixed-sex accommodation guidance. We ensure that, at all times, patients receive appropriate care and that their privacy and dignity is not compromised.

The CCG is kept fully informed by all providers in respect of mixed-sex accommodation performance, with monthly reporting forming part of the standard NHS contract.

For April 17 to February 18 (the current data that is available), the number of reported breaches was 142 for Wiltshire CCG patients. This was lower compared to the same time period last year where there were 215 breaches reported.

The chart below demonstrates that larger number of breaches occur during times of high demand, linked with increased winter pressures. We have received assurances from the Trusts regarding mitigations in place for these patients, and they have provided the learning from the original remedial action plans. There have been no complaints from patients in relation to either providers, relating to breaches of Mixed Sex Accommodation.



Suicide Prevention

During 2017/18, we undertook a deep dive into the number of suicides and self-inflicted harm reported by Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) as a serious incident. The deep dive was presented to the CCG's Quality and Clinical Governance Committee in January 2018 and identified that the number of serious incidents related to suicide has increased in 2017 to-date, with the most frequently seen 'means of suicide' changing from overdose, to hanging/ ligature. It is however not possible to determine whether the increase in suicides reported through STEIS is a sustained trend.

What can be concluded however is that further work is required to improve the quality and timeliness of risk assessment and contemporaneous review of risk to include effective communication and record keeping. Furthermore, management and involvement of carers and family, which should be addressed and has been identified as part of the AWP Suicide Prevention Strategy. AWP have been engaged with this piece of work and attended the Quality and Clinical Governance Committee where this work was presented.

The AWP overall suicide rate (2012-14, NCISH) has been identified as 8.6 per 10,000 under mental health care, compared to 7.3 nationally. However, looking at Wiltshire specifically (PHE data), the rate of suicide is 9.0 compared to an England average of 10.1. The CCG will continue to work with AWP throughout 2018/19 to monitor the actions identified within the AWP suicide prevention strategy.

Clinical Effectiveness

The Clinical Advisory Group

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

The group is chaired by our Clinical Chair with regular attendance by medical representatives from the clinical executive group. This group has advised on policies for exceptions and prior approvals, and medicines management prior to decision making by the Quality and Clinical Governance Committee which has led to the publication of improved information to support public and primary care decision making.

The Clinical Advisory Group ensures adherence to the monitoring process for thorough reviews of both national and provider audits and the National Institute for Health and Care Excellence compliance statements. This further strengthens assurance across Wiltshire and enables triangulation of information to facilitate identification of targeted audits.

During 2017/18 the CAG was re-launched to widen the organisational understanding and engagement with the group. This has proved to be successful and provided a firm foundation for the future work of the group and will support the development of collaborative approaches to audit, clinical policy development and pathway redesign at STP level.

Commissioning for quality and innovation

The commissioning for quality and innovation payment framework enables commissioners to reward excellence, by linking up to 2.5% of providers' income to the achievement of quality improvement goals. During 2017/18, the guidance from NHS England outlined that for 2017-19, Commissioners should implement the national schemes, which could not be amended. The guidance on the national schemes for 2017/18 is set out in the CQUIN Indicator Specification Information on CQUIN 2017/18 – 2018/19 and aims to incentivise quality and efficiency and support the five year forward view by rewarding transformation across care pathways that cut across different providers. The schemes also focused on prioritising STP engagement and delivering financial balance across local health economies. With that in mind, 0.5% of the national scheme was available to support engagement with STPs and another 0.5% was linked to a providers' risk reserve. The remaining 1.5% of the available CQUIN monies was allocated to the national schemes.

During quarter 3 2017/18, we have adopted an STP approach across all commissioners to evaluating provider CQUIN submissions. This ensures that there is parity in the decisions made across the co-commissioned providers in BaNES, Swindon and Wiltshire. We have done this by collaborating with colleagues in BaNES and Swindon CCGs to jointly assess achievement against the criteria set out by NHS England.

Where the nationally set schemes are not relevant to some of our providers, we have worked in collaboration with those providers to implement local schemes, which will help to improve the quality and patient safety of the services provided.

Quality Premium

The quality premium scheme rewards Clinical Commissioning Groups for improvements in the quality of the services they commission, incentivises improved patient health outcomes, reduced inequalities in health outcomes and improved access to services.

These include delivery of the NHS Constitution commitments on referral to treatment times, accident and emergency, ambulance and cancer waiting times; adhering to quality regulatory standards, and delivering financial balance. The quality premium scheme will view Clinical Commissioning Group performance in the planning submissions round on the national and local priorities, as well as on the fundamentals of commissioning to recognised standards.

A two year scheme was put in place at the beginning of 2017/18 and the quality premium paid to Clinical Commissioning Groups in 2018/19 and 2019/20 reflects the quality of the health services commissioned by them in 2017/18 and 2018/19. The QP award is based on measures that cover a combination of national and local priorities, and on delivery of the gateway tests, as described below.

There are five national measures and in total these are worth 85% of the quality premium. These measures are:

1. Early Cancer Diagnosis 17%
2. GP Access and Experience 17%
3. Continuing Healthcare 17%
4. Mental Health 17%
5. Bloodstream Infections 17%

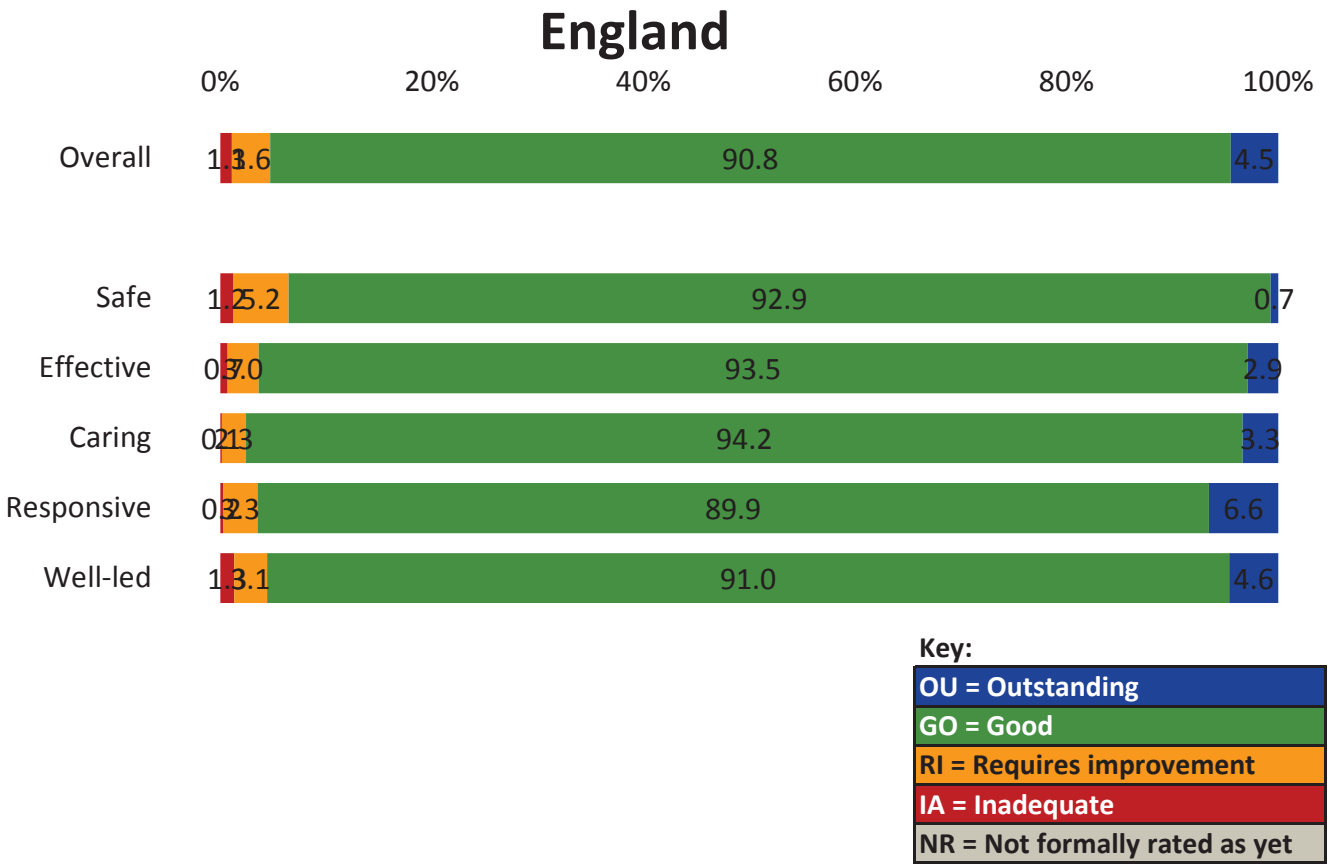
The local selected indicator by the CCG for 2017/18 is the percentage of pregnant women vaccinated for flu and this has the weighting of 15%.

Data in support of quality premium achievement is variously reported across multiple systems and date ranges. At the end of 2017/18, the CCG is able to report full achievement of the Blood Stream Infection scheme, the percentage of women vaccinated for flu and the second component of the CHC indicator; 'Full CHC Assessment'. This represents a strong performance and in improvement in achievement from 2016/17.

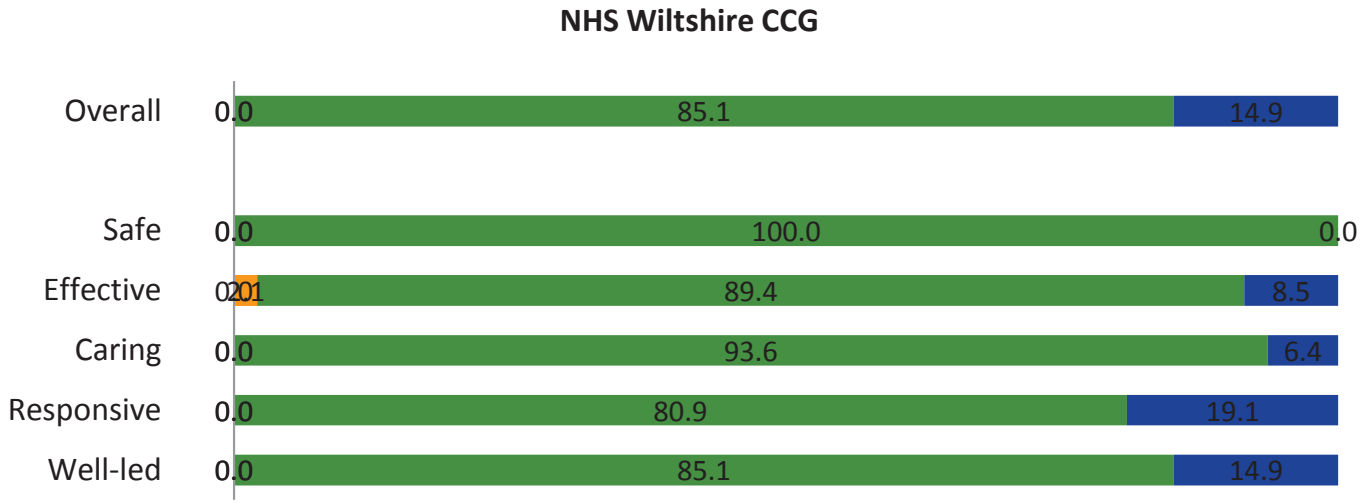
Primary Care

At the time of writing this report, forty five of the forty nine Wiltshire GP practices had received Care Quality Commission inspections under the revised inspection regime. There are currently four practices that have 'not yet been inspected' following practice mergers, although all practices prior to merger were assessed as delivering safe care by CQC. Wiltshire practices have worked hard to deliver these inspection outcomes and are performing above national average levels for being rated as 'Good' or 'Outstanding', although no practice is "outstanding" in the safety domain. There are currently no practices rated in a domain or overall as 'Inadequate'. The rating of 'Requires Improvement' at domain level is only for one practice with none having an overall rating of 'Requires Improvement'. The breakdown of results is as below. The CCG continues to support practices with inspection preparation and the further development of a continuous improvement quality and safety culture.

The chart below highlights the current (January 2018) national average CQC inspection results. These statistics are the most recent data available.



The chart below demonstrates the strong performance of primary care in Wiltshire against national average inspection results (January 2018 results).



The Quality Directorate works collaboratively within the Clinical Commissioning Group on joint work streams where appropriate e.g. Quality Premium.

Safeguarding children and adults

We have a statutory responsibility to have robust governance arrangements that ensures our provider organisations have an effective system that safeguards children and adults at risk of abuse or neglect.

In 2017/18, we strengthened the contractual standards and reporting mechanisms which enable robust monitoring of providers' safeguarding arrangements to gain assurance of compliance and support continuous improvement in safeguarding.

The safeguarding elements of the contract require providers to provide assurance regarding the following:

- numbers of staff trained to the relevant level in adult safeguarding
- recognition and reporting safeguarding concerns
- clear lines 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
- leadership for safeguarding adults and the Mental Capacity Act 2005
- relevant single and multiagency safeguarding policies and procedures

Additional areas which support contractual monitoring include key performance indicators, quality schedules, monitoring of investigations into serious incidents and complaints and review of systems to embed learning from serious case reviews.

We are represented at an Executive level by the Director of Nursing and Quality and designated safeguarding professionals on the local safeguarding children and adults boards working in partnership with local authorities to fulfil our safeguarding responsibilities. Our membership extends to the core business conducted through the safeguarding board sub groups.

We also work with the safeguarding boards, statutory agencies and 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

In March 2014, the Supreme Court handed down a judgment regarding Deprivation of Liberty Safeguards, which is a statutory framework that 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 deprivation of liberty safeguards has been clarified by the Judgement, however, the threshold has been significantly lowered which has led to a ten-fold increase in applications. The impact of this continues to be monitored and new case law reviewed and shared with providers to inform best practice.

PREVENT

PREVENT is one part of the UK four strand counter-terrorism strategy CONTEST. It is a multi-agency approach which aims to disrupt the radicalisation process and reduce the UK terrorism threat by identifying and supporting individuals who may be vulnerable and at risk before they are radicalised. The PREVENT strategy contains statutory duties for health which we are committed to supporting.

We are represented at the Contest Board and are engaged and represented at a senior level on local associated subgroups and channel panels as required.

Prevent has been included in the NHS Standard Contract since 2014/15 and this requirement has been monitored via the Adult Safeguarding Schedule with the metrics incorporated into the quality dashboard.

Human Trafficking and Modern Slavery Act 2015

The Modern Slavery Act received Royal Assent on 26 March 2015. The Act consolidates slavery and trafficking offenses and introduces tougher penalties and sentencing rules and introduces measures to enhance the protection of victims of slavery and trafficking.

We are committed to supporting the implementation of this legislation and are represented at the Anti-Slavery Strategic Partnership board and are engaged and represented at a senior level on local associated subgroups working to develop local mechanisms and responses.

Domestic Violence and Abuse NICE Guidance 2016

We are represented and are active participants at the domestic abuse joint community safety partnership and safeguarding board subgroup. We are also monitoring the application of new legislation and national guidance such as domestic violence and abuse national institute for health and care excellence guidance 2016 and the new offence of coercion and control under the serious crime act 2015.

Child Sexual and Criminal Exploitation

Child Sexual Exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them. Children or young people may be tricked into believing they're in a loving, consensual relationship. They might be invited to parties and given drugs and alcohol. They may also be groomed online. Some children and young people are trafficked into or within the UK for the purpose of sexual exploitation. Sexual exploitation and criminal exploitation can also happen to young people in gangs.

The national focus on safeguarding has remained high over the past year. In this reporting period nationally there have been: a review of local safeguarding children's boards' role and functions and national reviews follow investigations into Child Sexual Exploitation in Rotherham, Greater Manchester, Oxford and Bristol.

The Independent Inquiry into Child Sexual Abuse (IICSA) has been commissioned with national initiatives to investigate whether public bodies have taken seriously, their duty to protect children from sexual abuse and to identify, if there have been any organisational failures to protect.

Engaging people and communities

Wiltshire CCG is committed to placing patients and the public at the heart of everything we do. In doing so, the CCG seeks to respond to the needs and wishes of the public and ensure that public, patient and carer voices are at the centre of healthcare services – from planning to delivery, and in the way involvement is reported and communicated.

We have a duty under the National Health Service Act 2006 (as amended) to engage, involve and consult patients and the public – for CCGs this duty is outlined in section 14Z2 of the Act and guidance from the Department of Health, National Institute for Clinical Excellence and the Care Quality Commission give further direction on how to meet all the requirements of the Act.

During 2017/18 we have been able to establish engagement working in partnership as a health and social care system. In doing so we have worked with a range of organisations to maintain a dialogue with communities through a period of intense change and challenge. We have been able to hold discussions around the county, the outputs of which will provide a basis for decisions about how services are developed in 2018/19 and by future health and social care systems, as well as informing continuous quality improvement.

Each of the 18 community areas in Wiltshire has an Area Board with devolved executive functions, and a local Health and Wellbeing Board. Some local Health and Wellbeing Boards are more developed than others, but during the course of 2017/18 have been attended by CCG Executives and commissioners, councillors, professionals, local voluntary organisations and service users and carers. They are used as forums for engaging on priorities and service changes, for example, events to set local Joint Strategic Needs priorities, and events focussing on adult health and social care transformation.

To carry out our engagement function we use a range of methods, sometimes in partnership with other statutory, voluntary and public sector agencies across the county, to ensure we are continuously listening to, and building stronger relationships with the communities we serve, using their views and experiences to inform our commissioning processes. For instance, Healthwatch Wiltshire continues to be an active participant in our work and is represented at the CCG Governing Body, the Health and Wellbeing Board and Health Select Committee.

Over the year 2017/18 colleagues from Wiltshire CCG and Wiltshire Council have forged a productive relationship through a Voluntary and Community Sector Strategic Engagement Group, working with organisations including Age UK and the Centre for Independent Living, to enable a continual dialogue which constructively challenges the health and social care system and helps us to make decisions based on a representative, public view.

Examples of activities involving older people, their families and carers include but are not restricted to:

- The co-design, use and effectiveness of a toolkit to support patients, their carers and families living with diabetes.
- Feedback to support improvements to the county-wide continence service.
- A substantial piece of system-wide engagement with patients, carers and the public to inform a revised End of Life Strategy for Wiltshire people.
- Facilitated discussions with service users to co-produce elements of the new Integrated Urgent Care service (launching in May 2018).
- Discussion with older people's groups to help inform the CCG's strategy for GP Extended Access.
- A public survey to support the system's eligibility criteria for Non-Emergency Patient Transport Service
- Workshops to explain the overnight closure of the county's two Minor Injuries Units.
- Joint working and facilitation with Patient Participation Groups to support practice population's understanding of merging GP practices and dispersal of practice lists.
- Collaborative engagement, workshops and listening events with providers, LMS and community midwives to gather people's feedback on the county's maternity service.
- Joint engagement with Wiltshire YouthWatch and young service users on the refresh of the Child and Adolescent Mental Health Service.
- Co-production work with Wiltshire Seniors for the Prescription Ordering Direct service.
- The recent Carers Strategy was co-produced with carers and the action plan is monitored by the Wiltshire Carers Action Group and the Wiltshire Carer Involvement Group (which is comprised almost wholly of carers).
- Participation in public meetings and debates about community health services and our community health estate.

In addition we held our annual Stakeholder Assembly in June 2017, bringing together 80 regular delegates, drawn from groups across the county who represent geographical areas, the voluntary sector and charities, service users, patients, carers, elected members and members of the public. The June 2017 meeting updated delegates on progress with the BSW Sustainability and Transformation Partnership, allowing the opportunity for questions and answers and providing feedback to help define a number of key priorities.

Since its inauguration in 2016/17, our Patient Participation Group Forum has gone from strength to strength. During 2017/18 we met twice, working through a continually evolving work plan and allowing groups to share their experiences of best practice amongst PPGs.

Further improvement

The CCG is working to further improve and strengthen our engagement and work began in early 2018 to develop a patient and public engagement committee (PPEC) as a sub-committee of the governing body. Our intention is that the PPEC will oversee the quality and effectiveness of engagement and develop a robust engagement structure to ensure decision making is a collaborative effort that brings together the expertise of commissioners, clinicians, communities and individuals.

We are aware that we need to improve the information we provide online (via our websites, for instance) which represents involvement activity underway, coming up or already taken. Public and Patient involvement will become a fifth performance indicator added to the NHS England Assurance Framework and NHSE feedback in December 2017 indicates that our online information often does not fully represent the involvement activity we are undertaking. We are therefore taking steps to address this, including more comprehensive information on our website about how patients and the public can become involved with the work we do. This will help us strengthen even further the important connections between public and community engagement and our local strategies and priorities, by making the information explicit, clearly described and linked with appropriate action.

We are also in the process of providing more evidence of how involvement has made a difference to services, plans and policies, and people's health and wellbeing, and this information will be shared via our website, social media channels and promotional material, so that the feedback loop is closed.

Our ambition is to ensure members of the public (or of a community or voluntary group) find it easy to identify how to take action or follow through on opportunities.

Healthwatch Wiltshire

In 2017/18 the Council and Wiltshire CCG began the re-tendering process for Healthwatch services and for user-led engagement services. A shared strategy for co-production will ensue once the new provider has been decided.

Other types of communication

The CCG also uses a wide range of communication channels to ensure patients and the public are kept informed of its work. These channels include:

- A monthly newsletter
- A quarterly PPG Newsletter
- Twitter
- Facebook
- Webpages
- Media briefings
- MP briefings
- Public health campaigns – local and national initiatives
- Paid-for advertising
- Leaflets and posters

Use of these channels has increased steadily over the previous years.

Between 1 April 2017 and 31 March 2018 we used a range of different communication channels to engage with the public and our stakeholders.

We have led **7** local Health Campaigns, and supported **19** nationwide Public Health Campaigns to help promote key health messages to the public

85,633 Number of times people visited our website

7,271 Number of people who visited our website

320 subscribers received our monthly newsletter

Quarterly Patient Participation Group newsletter sent to **49** GP Practices

35 press releases shared with local media

15 paid-for adverts in local press

17 Briefings with local MPs

30 public meetings attended

Twitter

2,347 Followers	1,809 Tweets
694,715 Number of times our tweets were seen	6,358 Number of likes, retweets and clicks

Facebook

196 Followers	549 Posts
133,552 Number of times our posts were seen	3,623 Number of likes, shares, reactions and clicks

Pinterest

10 Boards 139 Pins

Equality report

Understanding the demographic profile of Wiltshire

The population of Wiltshire based on the Joint Strategic Needs Assessment is approximately 488,400 people. Wiltshire has a near equal population split between males and females, with children and young people (0-19 years) accounting for approximately 23% of the population and the older population (65 years plus) for more than 21%.

According to Wiltshire Council's Corporate Equality Plan 2017, Wiltshire's minority ethnic population has changed from a largely Asian or Asian British grouping recorded in the 2001 census to an Eastern European grouping where Polish migrants feature prominently. For 2.5% of Wiltshire residents aged three years and over, their first language is not English.

The majority of Wiltshire's residents reported that they are Christian (64%) or had no religion (26%). The largest other religions are Muslim (0.4%) and Buddhism (0.3%). (Wiltshire Census 2011).

Based on the nationally established statistic that 5-7% of the population is lesbian, gay or bisexual, approximately 29,300 Wiltshire residents are expected to have these sexual orientations.

The Gender Identity Research and Education Society criteria suggests that approximately 3,900 people within Wiltshire would experience some degree of gender variance, the majority of which would continue to live with their birth gender.

Our decision making processes

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

We conduct Equality Impact Assessments on all policies and proposals for approval by the Governing Body, 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 and the CCG premises are accessible to the disabled.

Promoting the Public Sector Equality Duty

We have an Equality and 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 with the public on our plans and major commissioning decisions. We hold healthcare providers to account with regard to the Public Sector Equality Duties.

Our staff are required to complete Equality and Diversity training and a representative from each Directorate receives a higher level of training, to be able to act as an Equality and Diversity Lead - enabling them to support their colleagues.

Our Equality and Diversity strategy, updated in 2015, identified the following objectives for April 2015 – March 2018:

- Develop a fresh strategy and action plan for promoting equality, diversity, Human Rights, inclusion and reduction in health equalities including implementation of the revised Equality Delivery System.
- Increase awareness of the importance of promoting equality/reducing health inequalities within the Clinical Commissioning Group and across member practices.
- Improve quality of and accessibility to demographic profile of Wiltshire by protected characteristics and identify variations in health needs to enable staff to undertake meaningful equality impact analysis on the work as it develops.
- Support staff to put equality/reduction in health inequalities at the heart of the commissioning cycle.

We work closely with Wiltshire Council to determine the demographics of our shared population and the associated health needs and health inequalities. We work with Healthwatch Wiltshire to support our public consultation and engagement, ensuring that a voice is given to the public throughout our decision making processes and that harder to reach populations are considered and included. Our Communications and Engagement Strategy clearly recognises the value of interaction with different communities with specific protected characteristics and this is reflected in our Constitution. We take steps to ensure that our Black and Ethnic Minority community is encouraged to participate in our patient survey. We consider health inequalities when commissioning services and build this into our plans and strategies and is acknowledged in our Five Year Strategic Plan and Operational Plan: http://www.wiltshireccg.nhs.uk/publications

This can be demonstrated by the End of Life Strategy which shows the demographic information that has been used to help inform our decisions and the Carers Strategy where the importance of the Equality Act is stated: http://www.wiltshireccg.nhs.uk/publications

We hold healthcare service providers to account to ensure that they comply with the Equality Act 2010 and associated Public Sector Equality Duty. 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. These meetings also consider the report from the Patient Advice and Liaison Service as the impartial service looking into concerns, problems and complaints with 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.

Our workforce

Information is collected regarding our workforce with reference to the protected characteristics. As at 31 March 2018 we had 149 staff employed to carry out the functions of the CCG, of which 79.2% is female.
White-British has been declared by 82% of our workforce and 9.5% of our workforce is aged 60 years and over. While we are monitoring the staff information, the Public Sector Equality Duty 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. The Staff Partnership Forum takes an active part in the review of these policies representing the views of staff.

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. We self-assessed against the NHS Equality Delivery System (EDS2) with assistance from our stakeholders during 2015/16 which found that, for Wiltshire Clinical Commissioning Group evidence shows that the majority of people in six to eight protected groups fare as well as people overall.

We conducted a review of our performance against the EDS2 framework in March 2017 and again in February 2018 giving an overall grade of 'Achieving'. Detail of our assessment can be found at www.wiltshireccg.nhs.uk/about-us/equality-and-diversity

We continue to engage our patients and stakeholders when we are developing commissioning strategies, including:

- Holding meetings throughout the year to give local people the opportunity to share their views and be involved in the development of our plans.
- Creating member lists of patients and carers to help us review and look at different services and patient pathways.
- Working closely with Healthwatch Wiltshire on specific projects.
- Considering the impact on people with protected characteristics identified by the Equality Act 2010, when redesigning services.

Diversity breakdown by gender

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 as at 31 March 2018			
	Female Headcount	Male Headcount	Total
Governing Body	6	8	14
Very Senior Manager	0	0	0
All other Employees	112	23	135
Total Employees	**118**	**31**	**149**

Disabled employees

We have developed an integrated approach to delivering workforce equality meaning that we do not have a separate policy for disabled employees, or for any other protected characteristics. Equalities issues are incorporated in policies covering all aspects of employee management ranging from recruitment to performance to discipline.

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

We publish our employee profile by each of the nine protected characteristics, which helps 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).

Health and wellbeing strategy

During 2017/18 we have been a key contributor to the delivery of the Wiltshire Health and Wellbeing Strategy. The CCG remains a full and active member of the Health and Wellbeing Board and, as such, consults on matters relating to the health needs of the Wiltshire population and plays an active role in developing joint health and wellbeing priorities with Wiltshire Council.

Our own strategic approach, through our five year plan, operational planning and work as part of the BaNES, Swindon and Wiltshire Sustainability Transformation Partnership plan are aligned to the direction set out in the Wiltshire Health and Well Being Strategy and intelligence gained from the Wiltshire Joint Strategic Needs Assessment.

Some specific examples of how Wiltshire CCG has contributed to the delivery of the joint Health and Well Being Strategy in 2017/18 include:

Integrated Urgent Care

Mobilisation of the Integrated Urgent Care service combining NHS 111, GP out of hours service and an integrated Clinical Assessment Service (known as the hub) from 1 May 2018, will see improvements within the management of urgent care. With these services provided by Medvivo, the intention is to increase the clinical interventions being provided by the clinical assessment service to patients calling NHS 111, with the aim of managing their urgent care needs closer to home rather than in hospital.

GP Improved Access

Wiltshire CCG will be commissioning Improved Access to GP services from April 2018 to ensure all people living in Wiltshire have increased access to GP services across the county by October 2018.

Integrated Discharge and System Flow

During 2017, agreement was reached across Wiltshire to use a consistent approach and language in relation to discharge pathways. This 'Homefirst' approach is being embedded across all areas and is increasingly used in planning and modeling demand and capacity. It focuses on reducing unnecessary assessment and specification of onward care in inpatient settings, promoting the place of residence as the default location.

As part of the Wiltshire system-wide winter preparedness plan, a Wiltshire Integrated Command Centre (section 7) was set up in December. This command centre has an overview of the available health and social care capacity in the system over a 72 hour period. It is locally based, owned and recognised including:

- Community hospital beds
- Community teams
- Urgent care at home
- Intermediate care beds in care homes
- Winter pressure beds (NHS and Local Authority) in care homes

Carer Strategy and Support

In December 2017, Carer Support Wiltshire was awarded a new joint contract to support carers in Wiltshire. This new contract will begin on 1 April 2018 and will aim to provide services and support for all carers, including young carers, parent carers, those juggling work with caring and an aging population living longer and looking after loved ones. The young carer service will also begin from 1 April 2018. Carer Support Wiltshire will work with Wiltshire Council, Youth Action Wiltshire, and other organisations to ensure all young carers are identified and properly supported.

Integrated Community Equipment and Support service (ICESS)

This service continues to be a jointly commissioned and governed service for Health and Social Care in Wiltshire and is constituted as a S75 partnership between Wiltshire CCG and Wiltshire Council. Like any community equipment contract, it has a vital role in enabling people to remain in their own homes and links with other community based services delivered by health and social care by providing:

- community and home based products and equipment
- aids and adaptions for the home
- continence products
- home improvements and handyperson service
- pressure area care (e.g. chairs and mattresses)

This is a particularly strong area of collaboration and joint working between the CCG and Wiltshire Council. The joint team is to begin a re-procurement exercise and is also working with Swindon and BaNES CCGs to explore opportunities for a sustainability and transformation partnership wide service.

Improving Access to Psychological Therapies

In 2017 Wiltshire expanded its Improving Access to Psychological Therapies service to specifically include older people with long term conditions. Around 40% of people with depression and anxiety disorders also have a long term condition, while around 30% of people with a long term condition and 70% with medically unexplained symptoms also have mental health comorbidities. These services aim to ensure that people with these conditions have the same access to NICE-recommended psychological therapies as others. They will bring together mental and physical health providers so they can work in a coordinated way to achieve the best outcomes for all people, irrespective of their diagnosis.

Dementia

Wiltshire CCG contributed to the development of the Wiltshire Dementia Strategy and continues to work in collaboration with Wiltshire Council in the delivery and monitoring of the strategy. Service development is led by a joint commissioner and funding is place for:

- Dementia Adviser Service - Wiltshire CCG jointly fund this service with Wiltshire Council, the contract, following a tender process was awarded to a local dementia Charity There are nine Dementia Advisors and a Service Manager throughout the county. The service provides confidential advice and up to date information that can help people to understand more about dementia, what might happen in the future and to make informed decisions about care, treatment and support.
- Community Service for People Living with Dementia - Wiltshire CCG contributes to the overall funding of a variety of community services provided across Wiltshire. Groups include movement and music for the mind, day clubs, art groups, dementia cafes, carer support groups and training.

Children and Adolescent Mental Health Services

The implementation of our transformation plans for child and adolescent mental health services has enabled young people to access a range of mental health services and professionals more quickly and in ways which suit them.

Accountability report

Linda Prosser, Interim Chief Officer
22 May 2018

Corporate Governance Report

Members Report

Governing Body and Senior Management Profiles as at 31 March 2018

Dr Richard Sandford-Hill
Clinical Chair (from October 2017)

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.

Member of the following committees:

- Governing Body (Chair from October 2017)
- Finance and Performance Committee (Chair from October 2017)
- Remuneration Committee
- Quality and Clinical Governance Committee
- Primary Care Commissioning Committee

Linda Prosser
Interim Chief Officer (from June 2017)

Linda Prosser trained as a Physiotherapist and worked in the UK and overseas before developing her career in NHS Management. Initially managing services in the Acute sector, then community services; Linda moved in to commissioning almost 15 years ago. The challenge of working with and through partners to use a limited budget to achieve the best patient and population health outcomes has proved highly rewarding. Since 2013 Linda has been the NHS England Director of Commissioning for the Southwest. Since June 2017 she has been seconded to Wiltshire CCG as interim Chief Officer.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Remuneration Committee
- Joint Commissioning Board (Joint Chair with Wiltshire Council)

Mark Harris
Chief Operating Officer

Mark has worked for 25 years in NHS commissioning organisations throughout the south; in Wiltshire, Surrey, Hampshire, South West London and Berkshire. Over that time Mark has led the commissioning of acute, mental health, community and ambulance services in a variety of roles. Throughout those roles Mark has been responsible for improving service performance and delivering change programmes and projects.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Audit and Assurance Committee
- Quality and Clinical Governance Committee
- Joint Commissioning Board

Steve Perkins
Chief Financial Officer and Senior Information Risk Officer

Steve has worked for the NHS since 2003 and is a qualified accountant. Having completed his MSc at the University of Southampton, he joined the NHS as a graduate National Financial Management Trainee and has gone on to gain experience of NHS finances across a number of organisations. Steve joined the CCG in 2013 and is a member of the Chartered Institute of Management Accountants.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Audit and Assurance Committee
- Remuneration Committee
- Primary Care Commissioning Committee
- Joint Commissioning Board

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.

Member of the following committees:

- Governing Body - Vice Chair
- Finance and Performance Committee - Vice Chair
- Audit and Assurance Committee - Chair
- Remuneration Committee - Chair

Christine Reid, OBE
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.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Audit and Assurance Committee – Vice Chair
- Remuneration Committee – Vice Chair
- Quality and Clinical Governance Committee
- Primary Care Commissioning 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.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Audit and Assurance Committee
- Remuneration Committee
- Quality and Clinical Governance Committee – Chair from September 2017
- Primary Care Commissioning Committee – Vice Chair

Dr Helen Osborn
GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions

Helen qualified in 1988 from St. Mary's Hospital 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.

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee

Dr Andrew Girdher
GP Chair, North and East Wiltshire

Andrew is a GP Partner at Box Surgery and is the Chair of the North and East Wiltshire locality group. He has first-hand knowledge of what works in Primary Care and has an extensive understanding of population-based services.

Andrew is the CCG lead for Diabetes in Wiltshire, the GP Federation in North Wiltshire and is also the Sustainability and Transformation Partnership lead for Primary Care. He is an established trainer and a GP Appraiser. He represents Wiltshire CCG at the Royal United Hospital in Bath for the Clinical Commissioning Reference Board.

Member of the following committees:

- Governing Body
- Renumeration Committee
- Finance and Performance Committee (shared attendance with Dr Anna Collings)
- Quality and Clinical Governance Committee (shared attendance with Dr Anna Collings)
- Primary Care Commissioning 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.

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee

Dr Catrinel Wright
GP Interim Chair, West Wiltshire (from October 2017)

Catrinel qualified in 1996 and worked in a variety of hospitals in England and Scotland before completing GP training in West Sussex. Her interest in quality improvement has led her to become a GP Specialist Advisor for the Care Quality Commission and more recently, a GP Appraiser for NHS England. Catrinel's clinical special interests are Dermatology and Minor Surgery.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Quality and Clinical Governance Committee
- Primary Care Commissioning Committee

Dr Anna Collings
GP Vice Chair, North and East Wiltshire

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.

Member of the following committees:

- Governing Body
- Audit and Assurance Committee
- Finance and Performance Committee (shared attendance with Dr Andrew Girdher)
- Quality and Clinical Governance Committee (shared attendance with Dr Andrew Girdher)

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.

Member of the following committee:

- Governing Body

Dr Lindsay Kinlin
GP Interim Vice Chair, West Wiltshire (from October 2017)

Lindsay qualified from Southampton University in 1998. She has been a partner at The Avenue Surgery in Warminster since 2011. Her clinical interests are in improving the quality of life for patients with long term conditions and complex co-morbidities, by simplifying and improving care processes across the different care organisations.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Quality and Clinical Governance Committee

Ted Wilson
Director of Community Services and Joint Commissioning/Group Director – North and East Wiltshire

Ted has worked for the NHS for over 36 years in a range of senior health care commissioning and provider roles. 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 substantial NHS experience in Wales which included Chief Officer for the Vale of Glamorgan Local Health Group and Chief Executive for Merthyr Tydfil Local Health Board.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Joint Commissioning Board

Lucy Baker
Acting Director of Acute Commissioning and Acting Group Director – Sarum

Lucy initially trained and worked as a journalist, specialising in health reporting. She joined the NHS 19 years ago and has 16 years' experience of working in senior operational roles across both planned and urgent care services within acute hospitals. She has been heavily involved in service redesign and the development of patient-centric pathways to improve access times and experience.

Lucy joined Wiltshire CCG three years ago and became Deputy Director of Acute Commissioning in September 2015. She is now Acting Director of Acute Commissioning. Lucy has completed her masters in strategy, change and leadership at the University of Bristol and is the Sustainability and Transformation Partnership lead for elective demand management and maternity.

Member of the following committees:

- Governing Body
- Finance and Performance Committee

Jo Cullen
Director of Primary Care and Urgent Care/Group Director – West Wiltshire

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 at the Royal United Hospital, Bath; in a GP practice in Bath on a Department of Health funded mental health project, and since 1996 worked in Wiltshire across previous predecessor NHS organisations, always with a focus on primary care.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Primary Care Commissioning Committee
- Joint Commissioning Board

Dina McAlpine
Registered Nurse and Director of Nursing and Quality (from October 2017) and Caldicott Guardian

Dina qualified as a Registered Nurse 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.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Remuneration Committee (from October 2017)
- Quality and Clinical Governance Committee
- Primary Care Commissioning Committee
- Joint Commissioning Board

Sue Shelbourn-Barrow
Director of Transformation and Integration (from August 2017)

Sue has worked for 24 years in NHS, Local government and third sector in national, regional corporate roles across the south and local roles in Wiltshire, Hampshire, Portsmouth, Southampton and Isle of Wight, Berkshire and London. Over that time Sue has led numerous national and regional programmes in strategic and operational roles within health and social care.

Sue has held various voluntary posts including Chair of a registered charity and successfully led and launched a national staff support service. Throughout those roles Sue has been responsible for service redesign at scale, engagement and consultation and improving service performance and delivering change programmes and projects.

Member of the following committees:

- Governing Body
- Finance and Performance Committee
- Joint Commissioning Board

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 that would be relevant for the purposes of their audit report; and,

- That the member has taken all the steps that they ought to have taken as a Member in order to make him or herself aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Register of Interests

Visit www.wiltshireccg.nhs.uk to review the latest Register of Declarations of Interest.

Member Practices

The member practices are formed into three groups:
North and East Wiltshire (NEW)
Sarum
West Wiltshire (West)

Details of the member practices are available on the Wiltshire CCG website:
http://www.wiltshireccg.nhs.uk/wp-content/uploads/2013/03/Wiltshire-CCG-GP-list-1-2.pdf

Governing Body 2017/18

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 Richard Sandford-Hill.

At 31 March 2018, voting membership of the Governing Body comprised the Chair, the Interim Chief Officer, the Chief Financial Officer, the Chief Operating 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 16 times (seven in public) during the period 1 April 2017 to 31 March 2018.

The details of the Governing Body membership during 2017/18 is shown below:

Dr Peter Jenkins	GP Chair of the CCG (until September 2017)
Dr Richard Sandford-Hill	GP Chair, West Wiltshire and Devizes (until September 2017) and Clinical Chair of the CCG (from October 2017)
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Tracey Cox	Interim Accountable Officer (until May 2017)
Linda Prosser	Interim Chief Officer (from June 2017)
Steve Perkins	Chief Financial Officer
Mark Harris	Chief Operating Officer
Christine Reid	Lay Member: Patient and Public Involvement
Dr Mark Smithies	Secondary Care Doctor
Dr Andrew Girdher	GP Chair, North and East Wiltshire
Dr Toby Davies	GP Chair, Sarum
Dr Catrinel Wright	GP Vice Chair, West (until September 2017) Interim GP Chair of West (from October 2017)
Dr Chet Sheth	GP Vice Chair, Sarum
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Lindsay Kinlin	GP Interim Vice Chair, West (from October 2017)
Jill Crook	Registered Nurse Member (until August 2017)
Dina McAlpine	Registered Nurse / Director of Nursing and Quality (voting Member from October 2017)

In attendance (no voting rights)	
David Noyes	Director of Planning, Performance and Corporate Services (until June 2017)
Ted Wilson	Director of Community and Joint Specialist Commissioning/Group Director – North and East Wiltshire
Lucy Baker	Acting Director of Acute Commissioning/Interim Group Director - Sarum
Jo Cullen	Director of Community and Joint Specialist Commissioning / Group Director - North and East Wiltshire
Dr Helen Osborn	GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
Sue Shelbourn Barrow	Director of Integration and Transformation (from August 2017)
Frances Chinemana	Public Health, Wiltshire Council (until May 2017)
Tracey Daszkiewicz	Acting Director of Public Health (until December 2017) Director of Public Health and Public Protection (from January 2018)

Chris Graves	Chair, Healthwatch, Wiltshire
Sharon Woolley	Board Administrator
Non-members who always attend (no voting rights)	
Sarah MacLennan	Associate Director, Communications and Engagement

CCG Committees

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

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

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

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 and governance systems are in place and are being followed, and that as a CCG we appropriately manage risk. The Committee meets bi-monthly and its members for the year are listed below:

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid, OBE	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)	
Steve Perkins	Chief Financial Officer
Mark Harris	Chief Operating Officer
David Noyes	Director of Planning, Performance and Corporate Services (until June 2017)
Natalie Tarr/Lynne Baber	Internal audit, Price Waterhouse Cooper
Duncan Laird/Jonathan Brown	External audit, KPMG UK LLP (until May 2017)
Peter Barber / Katie Whybray	External audit, Grant Thornton
Lorraine Bennett	Counter Fraud Specialist, TIAA
Will Smith	Security Management Specialist, TIAA
Sujata McNab	Deputy Chief Financial Officer
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO (from July 2017)
Susannah Long	Governance and Risk Manager
Sharon Woolley	Board Administrator

You can read more about our Governance procedures and details of membership of the other sub-committees in the Governance Statement on page AR 14. There are more details about all our Governing Body members in the Governing Body and Senior Management Profiles section commencing on page AR 2.

Personal data related incidents

We have not had any data losses or confidentiality breaches that have been categorised as serious untoward incidents.

Modern Slavery Act

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

Statement of Accountable Officer's responsibilities

The National Health Service Act 2006 (as amended) 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 Interim Chief Officer to be the Accountable Officer of Wiltshire Clinical Commissioning Group.

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction.

The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

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

I also confirm that:

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

Linda Prosser
Interim Chief Officer
22 May 2018

Governance statement

Introduction and context

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

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

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

Scope of responsibility

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

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

Governance arrangements and effectiveness

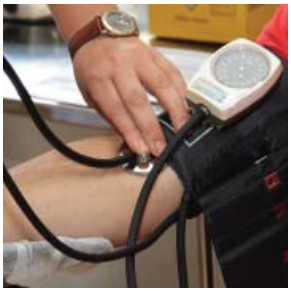
The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The Clinical Commissioning Group Constitution states that, at all times we will observe the generally accepted principles of good governance in the way we conduct our 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

Our Governing Body has, throughout each year, an ongoing role in reviewing our governance arrangements to ensure that we continue to reflect the principles of good governance.

The Governing Body is made up of six practicing GP members elected by member practices, two Lay Members, a Secondary Care Doctor, a clinical Chair and three senior executives one of whom is also our Registered Nurse Member. Governing Body meetings are held in public every two months and the public are invited to raise questions or comment on agenda items in advance of the meeting.



Committee structure

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

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

There is also a committee for each of the three locality groups: North and East Wiltshire (NEW), Sarum, and West Wiltshire and Devizes (West); to ensure that our members are empowered to contribute to the progress of the CCG.

In addition, with our local authority partner Wiltshire Council, the CCG attends the Health and Wellbeing Board to contribute to a shared leadership for a strategic approach to the health and wellbeing of our communities, and the Joint Commissioning Board to provide oversight to the Better Care Plan and section 75 agreement.

Governing Body

The Governing Body has been responsible for:

- Ensuring delivery of the Clinical Commissioning Group's 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 Clinical Commissioning Group. The Governing Body is made up of six practicing GP members (elected by member practices), Chair, Accountable Officer, Chief Financial Officer, Chief Operating Officer, Registered Nurse Member (Director of Nursing and Quality), Secondary Care Doctor Member, Lay Member for Patient and Public Involvement and Lay Member for Audit and Assurance – fourteen in total.

The following Governing Body Members are in attendance:

- Director of Primary Care and Urgent Care / Group Director West
- Interim Director of Acute Commissioning / Interim Group Director Sarum
- Director of Community and Joint Specialist Commissioning/Group Director NEW
- Director of Integration and Transformation
- GP Medical Advisor
- Public Health and Public Protection 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 Project Management Office

Membership at 31 March 2018:

Dr Richard Sandford-Hill	Clinical Chair of the CCG (from October 2017)
Linda Prosser	Interim Chief Officer (from June 2017)
Mark Harris	Chief Operating Officer
Steve Perkins	Chief Financial Officer
Christine Reid, OBE	Lay Member: Patient and Public Involvement
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Dr Andrew Girdher	GP Chair, North and East Wiltshire (from May 2016)
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Toby Davies	GP Chair, Sarum
Dr Chet Sheth	GP Vice Chair, Sarum
Dr Catrinel Wright	GP Interim Chair of West (from October 2017)
Dr Lindsay Kinlin	GP Interim Vice Chair, West (from October 2017)
Dr Mark Smithies	Secondary Care Doctor
Dina McAlpine	Registered Nurse / Director of Nursing and Quality (voting Member from October 2017)
Dr Lindsay Kinlin	GP Vice Chair, West Wiltshire, and Devizes (until January 2017)
Dr Catrinel Wright	GP Vice Chair, West Wiltshire, and Devizes (from February 2017)
Mary Monnington	Registered Nurse Member (until May 2016)
Jill Crook	Registered Nurse Member (from May 2016)
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Jo Cullen	Director of Primary Care and Urgent Care/ Group Director – West Wiltshire and Devizes
Lucy Baker	Acting Director of Acute Commissioning/ Acting 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
Sue Shelbourn Barrow	Director of Integration and Transformation (from August 2017)
Tracy Daszkiewicz	Director of Public Health and Public Protection (from January 2018)
Chris Graves	Chair, Healthwatch, Wiltshire
Sharon Woolley	Board Administrator (from August 2016)

Membership

Membership of the Governing Body and Committees was arranged to ensure that discussions were comprehensive. Members of the Committees were aware of the responsibility placed on them. Records show that there were seven Governing Body meetings held during 2017/18 including the Annual General Meeting. Attendance at these meetings was as follows:

Name	Position	May 2017	June 2017 AGM	July 2017	Sept 2017	Nov 2017	Jan 2018	Mar 2018
Dr Anna Collings	GP Co-Chair, NEW							
Tracey Cox	Interim Accountable Officer (until May 2017)			n/a	n/a	n/a	n/a	n/a
Jill Crook	Registered Nurse Member (until August 2017)				n/a	n/a	n/a	n/a
Dr Toby Davies	GP Chair, Sarum							
Dr Andrew Girdher	GP Co-Chair, NEW							
Mark Harris	Chief Operating Officer							
Dr Peter Jenkins	GP Chair (until September 2017)					n/a	n/a	n/a
Dr Lindsay Kinlin	GP Interim Vice Chair, West (from October 2017 to March 2018)	n/a	n/a	n/a	n/a			
Peter Lucas	Lay Member and Vice Chair							
Dina McAlpine	Registered Nurse/ Director of Nursing and Quality (voting member from October 2017)	n/a	n/a	n/a	n/a			
Steve Perkins	Chief Finance Officer							
Linda Prosser	Interim Chief Officer (from June 2017)	n/a	n/a					
Christine Reid, OBE	Lay Member							
Dr Richard Sandford-Hill	GP Chair, West (until September 2017) Clinical Chair of the CCG (from October 2017)							
Dr Chet Sheth	GP Vice Chair, Sarum							
Dr Mark Smithies	Secondary Care Doctor							
Dr Catrinel Wright	GP Vice Chair, West (until October 2017) Interim GP Chair of West (from October 2017 to March 2018)							

	In attendance
	Did not attend
n/a	Not attending (see below)

Tracey Cox was Interim Accountable Officer from September 2016 to May 2017
Linda Prosser was appointed as Interim Chief Officer from June 2017
Jill Crook resigned from the Registered Nurse role in August 2017
Dina McAlpine appointed as the Registered Nurse Member in October 2017 and became Voting Member
Dr Lindsay Kinlin appointed as Interim Vice Chair of West in October 2017
Dr Catrinel Wright appointed as Interim Chair of West October 2017
Dr Peter Jenkins resigned from the role as Chair of the CCG in September 2017
Dr Richard Sandford-Hill appointed as Chair of the CCG in October 2017

We continue to work collaboratively with Wiltshire Council to transform the delivery of health and social care for the people of Wiltshire and have attended joint committees including the Joint Commissioning Board and the Health and Wellbeing Board.

Remuneration Committee

This committee advises the 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 2018:

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid, OBE	Vice Chair, Lay Member: Patient and Public Involvement
Dr Richard Sandford-Hill	Clinical Chair of the CCG (from October 2017)
Dr Mark Smithies	Secondary Care Doctor
Dr Andrew Girdher	GP Chair, North and North East Wiltshire (Committee Member from October 2017)
Dina McAlpine	Registered Nurse / Director or Nursing and Quality (from October 2017)
Linda Prosser	Interim Chief Officer (from June 2017)
Steve Perkins	Chief Financial Officer
In attendance (no voting rights)	
HR Business Partner	SCWCSU Consult HR
Sharon Woolley	Board Administrator (from August 2016)

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 2017/18, the Vice Chair of the Governing Body has chaired the Committee.

Membership at 31 March 2018:

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid, OBE	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)	
Steve Perkins	Chief Financial Officer
Mark Harris	Chief Operating Officer
Rosie Fisher/Lynne Baber	Internal audit, Price Waterhouse Cooper
Peter Barber/ Katie Whybray	External audit, Grant Thornton
Lorraine Bennett	Counter Fraud Specialist, TIAA
Will Smith	Security Management Specialist, TIAA
Sujata McNab	Deputy Chief Financial Officer
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO (from July 2017)
Susannah Long	Governance and Risk Manager
Sharon Woolley	Board Administrator

Primary Care Commissioning Committee

The committee carries out the functions relating to the commissioning of primary medical services. The CCG has operated under full delegation of Primary Care from 1 April 2017. During 2017/18, the committee was chaired by the lay member for patient and public involvement.

The Primary Care Commissioning Committee undertakes the following activities:

- General Medical Services, Personal Medical Services and Alternative Provider Medical Services contracts (including the design of Primary Medical Services and Alternative Provider Medical Services contracts, monitoring of contracts, taking contractual action such as issuing branch/ remedial notices, and removing a contract).
- Newly designed enhanced services (Local Enhanced Services and Directed Enhanced Services).
- Design of local incentive schemes as an alternative to the quality outcomes framework.
- Decision making on whether to establish new GP practices in an area.
- Approving practice mergers.
- Making decisions on 'discretionary' payment (e.g, returner/retainer schemes).

Membership at 31 March 2018:

Christine Reid, OBE	Chair, Lay Member: Patient and Public Involvement
Dr Mark Smithies	Vice Chair, Secondary Care Doctor
Debra Elliot	Director of Commissioning, NHS England
Dr Richard Sandford-Hill	Clinical Chair of the CCG (from October 2017)
Linda Prosser	Interim Chief Officer (from June 2017)
Dr Toby Davies	GP Chair, Sarum
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Andrew Girdher	GP Chair, North and East Wiltshire
Dr Catrinel Wright	GP Interim Chair, West (from October 2017)
In attendance (no voting rights)	
Jo Cullen	Director of Primary and Urgent Care/ Group Director – West Wiltshire and Devizes
Steve Perkins	Chief Financial Officer
Dina McAlpine	Director of Nursing and Quality / Registered Nurse (from October 2017)
Sujata McNab	Deputy Chief Financial Officer
Dr Helen Osborn	GP Medical Advisor
Nikki Holmes	Head of Primary Care, NHS England
Baroness Jane Scott	Leader, Wiltshire Council
Chris Graves	Chair of Healthwatch Wiltshire
Victoria Stanley	Commissioning Manager/ Locality Lead
Tracey Strachan	Associate Director of Out of Hospital Care
Sharon Woolley	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, serious case reviews and care quality commission 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 2017/18, the Registered Nurse and the Secondary Care Doctor have chaired the Committee.

Membership at 31 March 2018:

Dr Mark Smithies	Chair, Secondary Care Doctor (from September 2017)
Dr Richard Sandford-Hill	Vice Chair, Clinical Chair of the CCG (from October 2017)
Dina McAlpine	Registered Nurse / Director of Nursing and Quality (from October 2017)
Christine Reid, OBE	Lay Member: Patient and Public Involvement
Dr Andrew Girdher	GP Chair, North East Wiltshire
Dr Catrinel Wright	GP Interim Chair, West (from October 2017)
Dr Toby Davies	GP Chair, Sarum
Linda Prosser	Interim Chief Officer (from June 2017)
Mark Harris	Chief Operating Officer
In attendance (no voting rights)	
Dr Helen Osborn	Named GP for Safeguarding Children
Alison West	Associate Director of Quality
James Dunne	Associate Director Safeguarding Continuing Healthcare and Specialist Placements (from July 2017)
Nadine Fox	Head of Medicines Management
Emily Shepherd	Quality Lead
Emma Higgins	Quality Lead
Lynn Franklin	Adult Safeguarding Lead
Dr Fiona Finlay	Designated Doctor, Safeguarding Children
Lena Pheby	Designated Nurse, Looked After Children
Deborah Haynes	Public Health Consultant, Wiltshire Council
Susannah Long	Governance and Risk Manager
Sharon Woolley	Board Administrator

Finance and Performance Committee

The committee monitors the financial performance of the Clinical Commissioning Group 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 Clinical Commissioning Group in line with the scheme of delegation. During 2017/18, the committee was chaired by the Clinical Chair of the CCG or the Vice Chair, the Lay Member of Audit and Governance.

Membership at 31 March 2018:

Dr Richard Sandford-Hill	Chair, Clinical Chair of the CCG (from October 2017)
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Steve Perkins	Chief Financial Officer
Linda Prosser	Interim Chief Officer (from June 2017)
Christine Reid, OBE	Lay Member: Patient and Public Involvement
Dr Mark Smithies	Secondary Care Doctor
Mark Harris	Chief Operating Officer
Dr Andrew Girdher	GP Chair, North and East Wiltshire
Dr Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Catrinel Wright	GP Interim Chair, West (from October 2017)
Dr Toby Davies	GP Chair, Sarum
In attendance (no voting rights)	
Sujata McNab	Deputy Chief Financial Officer
John Dudgeon	Associate Director of Information
Dina McAlpine	Director of Nursing and Quality / Registered Nurse (from October 2017)
Jo Cullen	Head of Medicines Management
	Director of Primary and Urgent Care/Group Director – West Wiltshire and Devizes
Ted Wilson	Director of Community and Joint Specialist Commissioning/Group Director – North and East Wiltshire
Lucy Baker	Acting Director of Acute Commissioning/Acting Group Director – Sarum
Sue Shelbourn Barrow	Director of Integration and Transformation (from August 2017)
Rob Hayday	Associate Director, Performance, Corporate Services and Head of Project Management Office
Dr Helen Osborn	GP Medical Advisor
Sharon Woolley	Board Administrator

Locality group committees

We have established a committee for each of the three locality groups - which were responsible for the following functions delegated to them:

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

Governing Body Performance 2017/18

The Governing Body has continued to devote time to reflect on their own performance and to invest time in their development.

To continue to drive the transformation agenda, in alternate months, we hold a formalised out of hospital programme board and a planned care programme board, each comprising our clinical leaders (drawn from our membership) and executive team.

We continue to complete monthly performance monitoring with a disciplined approach to project performance monitoring. Transparency of performance is evidenced by our publishing of integrated performance reports on our website each month.

The CCG is progressing with the integration agenda working closely with Wiltshire Council.

Highlights of committee reports

Delegated Commissioning of Primary Care

From 1 April 2017 delegated responsibility for primary medical services moved to the CCG from NHS England (NHSE). A Memorandum of Understanding was agreed with NHSE that detailed the support available for the transition over a 12 month period. There are 49 work areas to transfer identified in the Delegation Agreement and a plan is in place with relevant risk assessments to manage these transfers.

Delegated Commissioning offers the CCG and its membership the ability to:

- Expand its role within primary medical services commissioning.
- Increase its local influence on the future strategy of primary care and hold more power to drive the development of the GP Forward View and its associated funding streams, supporting General Practice sustainability.
- Align incentives with wider health and social care planning, improving the potential to develop an integrated primary care based out of hospital service.
- Increase the ability to tackle variations in the quality in primary care, improving patient experience and new models of care.

The CCG Primary Care Commissioning Committee (PCCC) functions as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers for the commissioning of primary care.

NHS RightCare Programme

NHS RightCare is leading the work to address unwarranted variation in outcomes from treatment across England. Wiltshire CCG is participating in Wave 2 of the Right Care Programme, using national benchmark intelligence and evidence, has agreed four priority areas:

- Gastrointestinal
- Musculoskeletal
- Circulatory Disease
- Trauma and injuries

The CCG will be using information to identify the areas for change in the prioritised areas.

Wiltshire End of Life Strategy for Adults 2017 to 2020

Wiltshire CCG wants to ensure that the highest quality end of life care services are available through integrated services, which are personalised, well co-ordinated and empower patients to make informed choices about their care.

The refreshed strategy adopts a community approach to end of life care that integrates clinical, psychological, spiritual and social efforts in recognition that death, dying, loss and care take place in everyday life. National and local guidelines and policies, best practice models, feedback from patients and insights from health and social care professionals also influenced the strategy development. The recommendations from the National Palliative and End of Life Care Partnership ambitions framework, which builds on the 2008 Department of Health (DH) Strategy for End of Life Care, has been reflected in this updated document.

Carers in Wiltshire Joint Strategy 2017-2023

The Carers in Wiltshire Joint Strategy 2017-2023 builds on previous strategies to increase awareness of and support given to carers, parent carers and young carers. It takes into account changes in our statutory duties due to the implementation of the Care Act 2014 and the Children and Families Act 2014. This strategy is for all carers, including young carers and parent carers, who help another person (adult, young person or child) in their day to day life, who could not always manage without that support or requires more care and support than others. This is not the same as someone who provides care professionally or through a voluntary organisation.

Five outcomes now sit at the heart of the strategy:

- Carers have improved physical health, mental health and wellbeing.
- Carers are empowered to make choices about their caring role and to access appropriate support and services for themselves and the people they care for.
- Carers have the best financial situation possible, and are less worried about money.
- Carers' needs, and the value of carers, are better understood in Wiltshire.
- Carers influence services.

Integrated Urgent Care Service

The CCG has been working with Bath and North East Somerset (BaNES) CCG and Swindon CCG to redesign services for NHS111 and out-of-hours services to provide an innovative new service that dovetails with existing primary care services with clear, clinically-led and local urgent care services. Medvivo has been awarded a five year contract to provide integrated urgent care services across BaNES CCG, Swindon CCG and Wiltshire CCG, from 1 May 2018. This has the opportunity to transform the provision of urgent care and will help to ensure everyone has access to the same high quality, personalised and responsive service.

UK Corporate Governance Code

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

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.

Corporate Governance Code

The Governing Body aims 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 Clinical Commissioning Group and individuals involved from any appearance of impropriety. All of our employees and appointees 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 Clinical Commissioning Group 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

The CCG, with input from its Audit and Assurance Committee, has strengthened the arrangements for managing potential conflicts of interests updating the Standards of Business Conduct Policy in line with the NHS England 'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017' (June 2017). The CCG continues to publish its Declaration of Interests Register, Register of Procurement Decisions and Register of Gifts, Hospitality and Sponsorship here: http://www.wiltshireccg.nhs.uk/governance

It is our policy 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 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.

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

During 2017/18 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.

Discharge of Statutory Functions

In light of the Harris Review, Wiltshire 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.

We have mechanisms in place with Internal Audit, External Audit and NHS England to scrutinise the execution of statutory functions and confirm that the Clinical Commissioning Group is legally compliant.

NHS Pension Scheme

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 in to 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.

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 and approved by the Governing Body in November 2017. This sets out the 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. The CCG Risk Management Strategy can be accessed at: www.wiltshireccg.nhs.uk/about-us/risk-management

A key element of the strategy is the Board Assurance Framework (BAF) which 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 Board Assurance Framework identifies that controls to manage risks to the organisation's objectives could be improved by:

- Finalising the Governing Body agreed Section 75 incorporating the Joint Employment Protocol and governance arrangements for a joint post with Wiltshire Council.
- Facilitating an appropriate delegation agreement and staffing resource to support full delegation of Primary Care commissioning.
- Planning engagement opportunities for the Sustainable Transformation Partnership (STP).
- Finalising 'Action cards' and clarifying interdependencies with the Commissioning Support Unit and with NHS Property Services to support business continuity arrangements.
- Accessing and implementing NHS guidance regarding the General Data Protection Regulations when available.

At the year-end the board assurance framework identifies that assurances of listed controls are in place.
Risks are recorded on the risk register. 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 an organisation wide approach.

Every two months the 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 Clinical Commissioning Group objectives are threatened and monitor progress, holding directors to account as appropriate. The Board Assurance Framework and Risk Register can be accessed on the Wiltshire CCG website as papers from the Governing Body: http://www.wiltshireccg.nhs.uk/governance/governing-body-meetings-in-public

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. We will, where necessary, tolerate risks where action is not cost effective or reasonably practicable and this is noted on the risk register. We do 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 manage the risk.

We provide 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 (RoES) assist with risk assessments in their areas 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, information governance and health and safety. All staff are encouraged to report adverse events and discuss these with the Governance and Risk Manager.

The CCG requires that staff members have objectives set and are 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. We carry out equality impact assessments on all policies and proposals critically assessing the impact on protected groups and identifying opportunities to promote equality.

We hold 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. Providers are also required to meet the legislative requirements as part of the procurement process for new or revised contracts.

Control measures are in place to ensure that we comply with the required public sector equality duty set out in the Equality Act 2010. We have has a robust recruitment process and 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.

Engaging people and communities

Wiltshire CCG is committed to placing patients and the public at the heart of everything we do. In doing so, the CCG seeks to respond to the needs and wishes of the public and ensure that public, patient and carer voices are at the centre of healthcare services – from planning to delivery, and in the way involvement is reported and communicated. In turn this supports public stakeholders to manage the type of risks which might impact them in some way.

We have a duty under the National Health Service Act 2006 (as amended) to engage, involve and consult patients and the public – for CCGs this duty is outlined in section 14Z2 of the Act and guidance from the Department of Health, National Institute for Clinical Excellence and the Care Quality Commission give further direction on how to meet all the requirements of the Act.

Over the year 2017/18 colleagues from Wiltshire CCG and Wiltshire Council have forged a productive relationship through a Voluntary and Community Sector Strategic Engagement Group, working with organisations including Age UK and the Centre for Independent Living, to enable a continual dialogue which constructively challenges the health and social care system, enables people to highlight risks and helps us to make decisions based on a representative, public view.

Examples of activities involving older people, their families and carers include but are not restricted to:

- The co-design, use and effectiveness of a toolkit to support patients, their carers and families living with diabetes.
- Feedback to support improvements to the county-wide continence service.
- A substantial piece of system-wide engagement with patients, carers and the public to inform a revised End of Life Strategy for Wiltshire people.
- Facilitated discussions with service users to co-produce elements of the new Integrated Urgent Care service (launching in May 2018).
- Discussion with older people's groups to help inform the CCG's strategy for GP Extended Access.
- A public survey to support the system's eligibility criteria for Non-Emergency Patient Transport Service.
- Workshops to explain the overnight closure of the county's two Minor Injuries Units.
- Joint working and facilitation with Patient Participation Groups to support practice population's understanding of merging GP practices and dispersal of practice lists.
- Collaborative engagement, workshops and listening events with providers, LMS and community midwives to gather people's feedback on the county's maternity service
- Joint engagement with Wiltshire Youthwatch and young service users on the refresh of the Children and Adolescent Mental Health Service.
- Co-production work with Wiltshire Seniors Forum for the Prescription Ordering Direct service.
- The recent Carers Strategy was co-produced with carers and the action plan is monitored by the Wiltshire Carers Action Group and the Wiltshire Carer Involvement Group (which is comprised almost wholly of carers).
- Participation in public meetings and debates about community health services and our community health estate.

To carry out our engagement function we use a range of methods to ensure we are continuously listening to, and building stronger relationships and using people's views and experiences to inform our commissioning processes. For instance, Healthwatch Wiltshire continues to be an active participant in our work and is represented at the CCG Governing Body, the Health and Wellbeing Board and Health Select Committee.

Engaging with our staff

We communicate with our staff through a number of channels and encourage all staff to engage so that the process becomes an open, two-way conversation, helping them to 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 and through regular team meetings. These messages are reiterated and complimented with additional news (including information about development opportunities, news from the wider health community and social activities) in our fortnightly staff 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.

News and updates are also posted to our intranet on a daily basis, creating a useful news archive for reference and a regular news feed. Our intranet acts as a resource for key information, forms and documents to support staff in their day to day working. The intranet has benefited from rebranding and restructuring at the end 2017, to enhance user experience and create a 'go to' place for staff.

Monthly staff meetings are hosted by the Executive Team at which staff are presented with updates on the Clinical Commissioning Group's business and are encouraged to share their views and ask questions.

We run an annual staff survey; the results of which are reported to the Governing Body before being shared with staff more widely. The results are used to engage our staff in creating key objectives for the organisation and provide insight into understanding how staff are feeling. The results also allow us to see where initiatives work well and where there might be opportunities for improvements to be made.

Our Staff Partnership Forum is made up of staff representatives from across the CCG and meets on a monthly basis. The Forum provides a regular and effective means of joint discussion between Wiltshire CCG Senior Managers and all staff on issues of mutual interest or concern.

We also have a People's Group, which is made up of staff from across the CCG and Commissioning Support Unit based in Southgate House. This group meets regularly to arrange fun health and social events to promote wellbeing and a good work/life balance.

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.

We also complete a six-monthly comprehensive workforce report which is formally discussed at the Governing Body meetings. The report includes a range of workforce related data, including that covered within the Workforce Race Equality Standard.

Risk Assessment

Risk to our 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
- Health and Safety compliance audit
- concerns and complaints
- risk assessment process
- Serious incidents and adverse event processes

Identified risks are recorded on the risk register, controls are identified, further mitigating actions are programmed and progress is monitored. The risk profile of the Clinical Commissioning Group is considered by the Governing Body and action against the ten key risks is closely monitored. Strategic risks identified and managed by the CCG during 2017/18 are detailed below.

During the last year, the NHS again saw high levels of demand and pressure within the health system. Accident and Emergency departments have been unable to consistently achieve their targets such as the four hour wait and the 12 hour trolley wait times, which impacts on patient experience and in some cases patient safety. Acute hospitals have struggled to maintain normal levels of elective care throughput. Throughout this period of sustained system escalation the CCG has been participating in the system wide endeavour to find solutions. The CCG has awarded a contract for Integrated Urgent Care providing improved arrangements for NHS111 and out-of-hours services.

The NHS continues to recognise a lack of appropriately skilled staff across the health and social care system. Locally this is due to difficulties in recruitment, national staff shortages, transformation of model of care and a competitive local market. Each organisation continues to monitor key workforce gaps and take remedial action. Workforce is a work stream within the Sustainability and Transformation Plan. The CCG has various initiatives underway including apprenticeship schemes, training and development for general practice staff and production of materials for career fairs. The CCG is involved with the recruitment promotion website 'Proud to Care Wiltshire' and has linked in with the Local Authority recruitment initiative.

During 2017/18, the CCG identified that Mental Health GP Lead representation at the Mental Health Exceptions Panel is causing mental health exceptions referrals to breach the 40 day review period, leaving the CCG liable and vulnerable to challenge and having a potentially detrimental effect on the patients concerned. The role of clinical leads and expectations regarding the Panel is being clarified. The CCG is also reviewing the process and looking for improvements to increase resilience.

The CCG commissioned an internal audit into the management of children's continuing healthcare (CHC). This helped the CCG to establish that there is potentially a lack of compliance with the Children's CHC national framework with key stages in the process.

Delegation of assessment to the contracted provider has resulted in an unacceptable degree of 'distance' between commissioners and the appropriate provision of packages of care for the patient. The CCG CHC team is reviewing existing packages of care and the children's CHC process is under review.

We have sound governance arrangements with Chairs of the established committees reporting to the Governing Body in public session and sharing committee minutes for noting. 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 risk register, discussed and mitigating actions planned. The board assurance framework and our 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. The integrated performance report can be accessed at: www.wiltshireccg.nhs.uk/publications

On a quarterly basis, we discuss our overall performance with the NHS England Area Team. Wiltshire Clinical Commissioning Group retains its licence without conditions.

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 Chief Operating Officer. Leadership for risk management is provided by the executive directors with support from the Governance and Risk Manager and key individuals from the 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 information asset owners and administrators with audit and awareness sessions completed. 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.

Other sources of assurance

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.

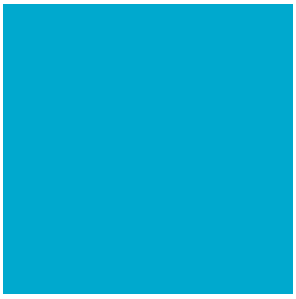
Internal control is supported by the Programme Management Office tracking progress of delivery of projects through directorate dashboards, meetings with project managers and escalation of any concerns through the project governance structure which includes the Clinical Executive, Finance and Performance 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 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.

Each month we produce an integrated performance report monitoring quality, financial performance and access, and project management. The document is aligned to the NHS England Clinical Commissioning Group Assurance Framework, supports the quarterly NHS England Area Team assurance discussions, is presented to the Governing Body and published on www.wiltshireccg.nhs.uk to inform stakeholders.

The 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 uses the work of an effective internal audit control function, which provides appropriate independent assurance, and reviews the work and findings of the external auditor, newly contracted for the year 2017/18, considering implications and our response. Please see the section on Significant Control Issues on page AR 35. The Internal Audit contract has been reviewed during 2017/18 with a new contract starting in 2018/19. The committee ensures compliance with the Secretary of State's directions on counter fraud by overseeing the effective operation of the local counter fraud service, including policies and plans. The local security management service is contracted to undertake assessments of healthcare Providers' security arrangements which is supported by the NHS contract. The Committee receives reports from both Counter Fraud and the Local Security Management Service. Both Counter Fraud and Local Security Management Services contracts have been reviewed and put out for tender during 2017/18 with new contracts commencing in 2018/19.

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 Auditors meet regularly with the CCG Lay Members. The Committee also seeks assurance from external audit to benchmark the CCG.



Annual audit of conflicts of interest management

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

This audit was undertaken in December 2017 giving an outcome of low risk and making recommendations to further improve compliance with the guidance. The audit found that the CCG has a good approach to identifying and managing conflicts of interest with 9 of the 12 areas found as partially implemented or not implemented in the 2016/17 audit now in place. It has been recommended that the CCG improves the management of sponsorships to ensure consistent handling in line with the guidance and that further arrangements are made to ensure consideration of potential conflicts of interest at lesser committees and groups.

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.

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 has self-assessed against the Information Governance Toolkit. The CCG has determined compliance with the toolkit of 77% which is deemed to be satisfactory. Eight of the attainment levels scored at level 3, sixteen at level 2 and four were deemed not relevant. The CCG successfully retained the Toolkit score and a new Toolkit is expected to be launched in April 2018.

We place high importance on protecting patient, staff and corporate information and have in place an information governance management framework.

We have a trained Senior Information Risk Owner and a trained Caldicott Guardian in place. We also benefit from trained Information Asset Owners and Information Asset Administrators. A suite of Information Governance policies, including Information Security, is in operation and all staff are required to complete training in Information Governance on an annual basis. Our staff handbook contains a comprehensive information governance section with further information available on the 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. We demonstrate a strong information risk culture.

Data Security

During 2017/18, there were twenty-five recorded breaches of data security; of these three have been attributed to the acts or omissions of our clinical commissioning group staff. The three incidents included an e-mail with attachments sent to the wrong recipient, Patient prescription found on the photocopier and two payslips found in the photocopying room. All breaches were dealt with internally and, where applicable, staff involved directed to the appropriate guidance and training materials. After investigation the breaches were marked as 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 2017/18.

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 2013 Macpherson Report.

Third party assurances

The CCG uses the standard NHS contract for provider services which requires levels of information governance arrangements. The CCG also receives assurance from the Security Management Service following their assessment of provider organisations.

Control Issues

The CCG has highlighted as a significant control issue the meeting of NHS Constitutional targets which is both a reputational issue for the NHS but also clearly affects the health outcomes of patients.

Wiltshire CCG continues to undertake pre-referral outsourcing of elective referrals to reduce demand on secondary care with continuation of the pathway for 2018/19. To improve access times, acute providers have been funded to outsource clinically appropriate patients from their over 18 week backlog. Dedicated Referral to Treatment (RTT) steering groups manage risk, escalating to Contract Review Meetings as required. To support demand management and a paperless system, a mandated ERS and Referral Management Centre pathway is in place across all non-cancer specialities.

The CCG is actively involved in the three Local Delivery Boards for the three local acute hospitals. An Integrated Control Centre has been set up to co-ordinate the management of high levels of activity and draw together the actions and intelligence to support the system. The CCG is actively involved in operational management of flow alongside partner organisations.

Quality assurance arrangements for patients experiencing A&E waits are reviewed at Contract Quality Review Meetings. The CCG is actively involved in monitoring patient safety processes in A&E departments during periods of high demand.

The CCG has also identified control issues regarding the management of Children's CHC services. These control issues may impact on the provision of appropriate and timely care to the detriment of our patients and may also damage the reputation of the CCG. The issue is discussed as part of the Head of Internal Audit Opinion on page AR 37.

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

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. Project workbooks identify required outcomes and potential risks before the expenditure of resources.

Financial controls remain in place throughout the year facilitating the early identification of potential financial issues and pressures in the health system which would prompt early management arrangements and, where necessary, financial recovery planning. The Finance and Performance Committee meets on a monthly basis during periods of financial pressure (usually bi-monthly).

The CCG is set an annual limit for running costs, which we are not supposed to breach. Costs are monitored as per the budget monitoring procedures. All spend is subject to the controls laid out in the Scheme of Delegation and Prime Financial Policies. These controls are designed to ensure that the CCG achieves value for money in its expenditure.

External Audit, as part of the Annual Accounts process for 2016/17, have satisfied themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Delegation of functions

The CCG manages the Better Care Fund jointly with Wiltshire Council with a jointly appointed Director managing this area. The Health and Wellbeing Board, which oversees the work of the fund, is seen as effective with strong leadership across the system and a shared focus. The Better Care Fund was audited by the CCG's internal audit contractor during 2016/17 to provide assurance.

Counter fraud arrangements

NHS Wiltshire CCG is committed to reducing fraud, bribery and corruption in the NHS and supports the rigorous investigation of any such suspicion or allegation. It will seek the appropriate disciplinary, regulatory, civil and criminal sanctions against those responsible for such actions and where possible will attempt to recover losses.

The Chief Financial Officer is responsible for ensuring an adequate Counter Fraud provision is in place, with a fully accredited and qualified person nominated to act as NHS Wiltshire CCG's Local Counter Fraud Specialist (LCFS). With the appointed LCFS, the CCG has considered how bribery and corruption may affect the organisation and proportionate procedures have been put in place to mitigate the risks. A programme of Counter Fraud work is agreed and approval by the Audit and Assurance Committee. All reports of fraud and corruption are taken seriously and thoroughly investigated. Appropriate action is taken where any recommendations are made to improve controls. The LCFS attends and reports to the Audit and Assurance Committee at least three times a year including a report against the Standards for Commissioners.

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:

Generally satisfactory with some improvements required

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.

Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

Basis of opinion

Our opinion is based on:

- All audits undertaken during the year;
- Any follow up action taken in respect of audits from previous periods;
- Any significant recommendations not accepted by management and the resulting risks;
- 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.

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

- As at the end of February 2018, we have completed all of the planned 9 internal audit reviews in the 2017/18 internal audit plan. Our work to date has identified 5 high, 12 medium and 8 low risk findings;
- We issued 2 high risk reports, these were children's continuing healthcare and business continuity, with 5 high risk findings raised in total. The findings raised have a significant impact on operational performance and regulation within the areas reviewed but not to the wider strategic objectives of the CCG. The issues raised are isolated to this area.
- There is one low risk recommendation from the prior year relating to clinical leadership that is still outstanding.

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

Area of Audit	Level of Assurance Given
Children's Continuing Healthcare	High risk – Limited assurance
Community Contracts	Low risk – Reasonable assurance
Continuing Healthcare	Medium risk – Limited assurance
Core Finance	Low risk – Reasonable assurance
Delegated Primary Care Commissioning	Low risk – Reasonable assurance
Corporate Governance – Conflicts of Interest	Low risk – Reasonable assurance
Business Continuity Planning	High risk – Limited assurance

Two high risk reports were issued. The risks in both reports are thought to be isolated to these areas and not systemic across other areas of the CCG.

The first was on children's continuing healthcare. We found:

- No policy or supporting procedures in place in the CCG regarding children's CHC.
- The Complex Needs Panel has no clearly defined terms of reference; panel minutes do not provide a clear audit trail and current membership is not compliant with national guidance.
- The CCG do not have KPIs in place to monitor Virgin Care's performance.

In response to these findings the CCG is developing a localised policy for the commissioning of children's continuing care and reviewing the panel meetings to consider:

a) Splitting meetings formally between decision making for eligibility for continuing care and subsequent development of care packages;

b) The list of attendees and ensure all necessary roles (CCG and Local Authority) are included with appropriate clinical input into panel.

Formal terms of reference will be developed and robust minutes will be taken documenting discussions, decisions and agreed actions for each case discussed.

A set of KPIs will be developed with the provider that will give assurance that individual packages of care are being delivered in accordance with the framework and the Service Level Agreement.

The provider will be expected to submit an annual report showing performance throughout the year.

The second was on business continuity (BC) planning. We found:

- The BC plan does not include details of how the services will continue in the event of disruption. Action cards have not been created to provide this guidance, and there is an assumption that managers and staff will be able to continue without any formal plans.
- The CCG has not provided Property Services with their requirements for property in the event of disruption affecting Southgate House, and it is not clear what the responsibility of Property Services would be in the event of a loss of workplace.

In response to these findings all directorates of the CCG will:

a) create action cards for their critical activities based on the output of the BIA that has been created. This should include a detailed list of actions required to ensure continued delivery during an incident.

b) review the contents of the BC plan and sections relating to policy and planning

c) from the BIA output, determine requirements for facilities at alternative locations, and agree with NHS Property Services how this will be provided.

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

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

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, Quality and Clinical Governance Committee and Internal Audit 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 received reports from the Security Management Service and the Counter Fraud Service. The Audit and Assurance Committee has also explored risk management arrangements and key risks with CCG Directors.
- 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.
- The Governing Body sub-committees terms of reference have been reviewed identifying and rectifying any differences between these and the updated Scheme of Reservation and Delegation.

Conclusion

The CCG has identified compliance with the NHS Constitutional Targets as a significant control issue.

During the year, Internal Audit issued no audit reports which identified governance, risk management and/or control issues which were significant to the organisation.

Internal Audit also recognises that significant progress has been made with the closure of outstanding recommendations.

Linda Prosser
Interim Chief Officer
22 May 2018

Remuneration and Staff Report

Remuneration Committee

This Committee advises the Clinical Commissioning Group (CGG) 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.

During 2017/18, the Committee met once.

Membership of the Remuneration Committee is made up of the following members:

Name	Role	Member type	Additional information	Meetings attended 2017/18
Peter Lucas	Lay member	Voting	Chair of committee	1
Christine Reid, OBE	Lay member	Voting	Vice Chair of committee	1
Dr Mark Smithies	Secondary Care Doctor	Voting	-	1
Dr Richard Sandford-Hill	GP Chair, West Wiltshire Group (until September 2017), CCG Chair (from October 2017)	Voting	-	1
Dr Peter Jenkins	CCG Chair (until September 2017)	Voting	-	1
Dr Andrew Girdher	GP Chair, North and East Wiltshire Group	Voting	Committee member from October 2017	0
Linda Prosser	Interim Accountable Officer	Voting	Interim Accountable Officer from June 2017	1
Steve Perkins	Chief Financial Officer	Voting		1
Dina McAlpine	Registered Nurse/Director of Nursing and Quality	Voting	Committee member from October 2017	0
HR Business Partner	NHS South, Central and West CSU	Non-voting	-	1
Sharon Woolley	CCG Board Administrator	Non-voting	-	1

Policy on the remuneration of senior managers

Remuneration is designed to fairly reward based on each individual's contribution to the organisation's success, taking into account the need to recruit, retain and motivate skilled and experienced professionals. This is not withstanding the need to be mindful of paying more than is necessary in order to ensure value for money in the use of public resources and the CCG's running costs allocation. Remuneration is determined by the Remuneration Committee based on available national guidance, comparisons with other CCGs and with due regard for national pay awards for wider NHS staff. In order to guide remuneration, the committee have derived and agreed a set of remuneration principles, which guide their decision making.

There is no performance related remuneration.

Very Senior Managers (VSM) have personalised contracts, which differ from the standard 'Agenda for Change' NHS contracts. The CCG's VSM's are the Accountable Officer, the Chief Financial Officer, the Chief Operating Officer and the Registered Nurse/Director of Nursing and Quality. These contracts were approved by the Remuneration and Terms of Service Committee.

Other directors are on permanent NHS contracts; however see below for details around two temporary appointments covering specific requirements. The remuneration, length of contract, notice period and compensation for early termination are in line with Agenda for Change, NHS terms and conditions of service handbook.

During 2017/18, the CCG did not have a permanent Accountable Officer in post. The Accountable Officer of Bath and North East Somerset CCG (BaNES CCG) Tracey Cox, carried out the role for both Wiltshire CCG and BANES CCG until the end of June 2017. As the Accountable Officer was employed by BANES CCG, Wiltshire CCG was recharged a proportion of their remuneration costs to reflect the time spent working in Wiltshire. This arrangement was reviewed and approved by the Remuneration Committee.

From July 2017 onwards, a senior officer from NHS England, Linda Prosser, was seconded to the CCG to carry out the role of Accountable Officer on a full time basis. NHS England recharges their remuneration costs to the CCG regularly. As with the previous interim appointment, this arrangement was reviewed and approved by the Remuneration Committee. This is the situation at 31 March 2018.

Due to the ongoing absence of a permanent Accountable Officer, as at 31 March 2018, the CCG has two senior managers on temporary contracts – the Chief Operating Officer and the Acting Director of Acute Commissioning. These are in place to provide sufficient capacity at Executive level during the time when the AO post is vacant.

The GP members of the governing body are appointed on fixed term contracts, which are generally three years in length. There are six GP governing body members, two from each of the CCG localities – Sarum, North and East Wiltshire and West Wiltshire. These members are elected to the governing body by the member practices within each locality.

Remuneration greater than £150,000 per annum

The Department of Health has mandated that CCGs must identify senior managers who are paid more than £150,000 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 no senior manager received remuneration greater than £150,000 per annum on a pro rata basis, during 2017/18.

Senior manager remuneration

The following 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."

The CCG's Accountable Officer has defined senior managers at Wiltshire CCG to be the voting members of the CCG Governing Body (as they control the strategic activities of the organisation) and the members of the CCG's Executive Management Team (as they direct the day-to-day operations).

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

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 2017/18.

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 following table 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.

Salaries and Allowances 2017/18

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to the nearest £100 (5)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Peter Jenkins (1), CCG Chair (to September 2017)	40-45	100	0	40-45
Dr Richard Sandford-Hill, GP Chair, West Wiltshire Group (to September 2017) CCG Chair (from October 2017)	55-60	0	0-2.5	60-65
Tracey Cox (2), Acting Accountable Officer (to June 2017)	10-15	100	0	10-15
Linda Prosser (3), Interim Accountable Officer (from June 2017)	95-100	300	0	95-100
Steve Perkins, Chief Financial Officer	110-115	100	57.5-60	165-170
Mark Harris, Chief Operating Officer	105-110	100	40-42.5	145-150
Christine Reid, OBE Lay Member, Patient and Public Involvement	10-15	100	0	10-15
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	15-20	300	0	15-20
Dr Toby Davies, GP Chair, Sarum Group	40-45	0	0	40-45
Dr Andrew Girdher, GP Co-Chair, NEW Group	50-55	0	5-7.5	55-60
Dr Anna Collings, GP Co-Chair, NEW Group	35-40	0	10-12.5	50-55
Dr Catrinel Wright, Interim GP Chair, West Wiltshire Group (from October 2017)	25-30	0	27.5-30	50-55
Dr Lindsay Kinlin, Interim GP Vice Chair, West Wiltshire Group (from October 2017)	0-5	0	0	0-5
Dr Chet Sheth, GP Vice Chair, Sarum Group	35-40	0	5-7.5	40-45
Jill Crook, Registered Nurse Member (to August 2017)	0-5	0	0	0-5
Dr Mark Smithies (4), Secondary Care Doctor	25-30	0	0	25-30

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to the nearest £100 (5)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
David Noyes, Director of Planning, Performance and Corporate Services (to June 2017)	25-30	0	15-17.5	40-45
Jo Cullen, Director of Primary and Urgent Care	95-100	1,300	45-47.5	145-150
Lucy Baker, Acting Director of Acute Commissioning	85-90	300	42.5-45	130-135
Ted Wilson, Director of Community Services and Joint Commissioning	100-105	200	15-17.5	115-120
Dina McAlpine, Registered Nurse Member (from October 2017)/ Director of Nursing and Quality	95-100	0	72.5-75	165-170
Sue Shelbourn Barrow Director of Transformation and Integration (from August 2017)	45-50	0	0-2.5	50-55

Notes

1. The remuneration paid to Dr Peter Jenkins in 2017-18 includes pay relating to work undertaken in the previous year. This was remunerated in the band £5,000 - £10,000.
2. Tracey Cox is the appointed Accountable Officer for Bath and North East Somerset (BANES) CCG, and split her time between Wiltshire and BANES. The costs for the work she undertakes at Wiltshire CCG are recharged by BANES CCG. Her full salary for the financial year was in the band £110,000 - £115,000.
3. Linda Prosser is a senior officer from NHS England. She is seconded to the CCG to fill the Accountable Officer post, and her costs are recharged to the CCG in full by NHS England.
4. The remuneration paid to Dr Mark Smithies in 2017-18 includes pay relating to work undertaken in previous years. This was remunerated in the band £5,000 - £10,000.
5. Taxable expense payments refer to where senior managers are reimbursed for mileage at a rate above the 45p/mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on mileage payments. This applies to all senior managers except for Jo Cullen – the taxable benefit reported is the value (for taxation purposes) of the lease car that was used during 2017/18.

No senior manager has received any form of performance related pay during 2017/18.

Salaries and Allowances 2016/17

This table has been restated to include taxable expense payments. No other entries in the table are impacted by this restatement.

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to the nearest £100 (4)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Peter Jenkins, GP Chair	70-75	200	0	70-75
Deborah Fielding, Chief Officer (to 7th July 2016)	35-40	300	0	35-40
Tracey Cox (1), Acting Accountable Officer (from 26th September 2016)	35-40	100	32.5-35	70-75
Simon Truelove, Chief Financial Officer (to 30th June 2016) Interim Accountable Officer (from 1st July 2016 to 25th September 2016)	55-60	100	117.5-120	175-180
Steve Perkins, Chief Financial Officer (acting CFO from 1st July 2016, permanent from 19th October 2016)	80-85	100	87.5-90	170-175
Mark Harris, Director of Acute Commissioning (to 9th October 2016) Chief Operating Officer (from 10th October 2016)	100-105	100	42.5-45	145-150
Christine Reid, Lay Member, Patient and Public Involvement	15-20	100	0	15-20
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	15-20	400	0	15-20
Dr Simon Burrell (2), GP Chair, NEW Group (to 31st May 2016)	5-10	0	0	5-10
Dr Toby Davies, GP Chair, Sarum Group	40-45	0	0	40-45
Dr Richard Sandford-Hill, GP Chair, West Wiltshire Group	50-55	0	152.5-155	200-205
Dr Andrew Girdher, GP Co-Chair, NEW Group (from 1st August 2016)	30-35	0	2.5-5	30-35
Dr Anna Collings, GP Vice Chair, NEW Group (to 31st May 2016) GP Co-Chair, NEW Group (from 1st June 2016)	40-45	0	10-12.5	50-55

Name and title	Salary (bands of £5,000)	Expense payments (taxable) to the nearest £100 (4)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Lindsay Kinlin, GP Vice Chair, West Wiltshire Group (to 31st January 2017)	20-25	0	110-112.5	130-135
Dr Catrinel Wright, GP Vice Chair, West Wiltshire Group (from 1st February 2017)	0-5	0	0-2.5	5-10
Dr Chet Sheth, GP Vice Chair, Sarum Group	35-40	0	7.5-10	40-45
Jill Crook, Registered Nurse Member	10-15	0	0	10-15
Dr Mark Smithies, Secondary Care Doctor	20-25	0	0	20-25
David Noyes, Director of Planning, Performance and Corporate Services	100-105	100	22.5-25	125-130
Jo Cullen, Director of Primary and Urgent Care	90-95	2000	32.5-35	125-130
Lucy Baker, Acting Director of Acute Commissioning (from 10th October 2016)	35-40	100	65-67.5	105-110
Ted Wilson, Director of Community Services and Joint Commissioning	100-105	300	22.5-25	120-125
Dina McAlpine, Director of Quality	80-85	200	47.5-50	130-135
James Roach (3), Director of Integration (to 28th February 2017)	165-170	0	0	165-170

Notes

1. Tracey Cox is the appointed Accountable Officer for Bath and North East Somerset (BANES) CCG, and split her time between Wiltshire and BANES. The costs for the work she undertakes at Wiltshire CCG are recharged by BANES CCG.
2. The costs for Dr Simon Burrell were recharged by The Porch Surgery, Corsham.
3. The costs for James Roach were met by the Better Care Fund, which is hosted by Wiltshire Council. The CCG contributed £27.970m into the Fund in 2016/17.
4. (4) Taxable expense payments refer to where senior managers are reimbursed for mileage at a rate above the 45p/mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on mileage payments. This applies to all senior managers except for Jo Cullen – the taxable benefit reported is the value (for taxation purposes) of the lease car that was used during 2017/18.

No senior manager has received any form of performance related pay during 2016/17.

Pension benefits

Pension benefits as at 31 March 2018

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.

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

Name and Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Tracey Cox, Acting Accountable Officer	0	0	40-45	100-105	640	671	3	0
Linda Prosser, Interim Accountable Officer	0-5	10-12.5	35-40	105-110	620	755	98	0
Steve Perkins, Chief Financial Officer	2.5-5	2.5-5	20-25	45-50	194	245	49	0
David Noyes, Director of Planning, Performance and Corporate Services	0-2.5	0	7.5-10	0	78	93	14	0
Jo Cullen, Director of Primary and Urgent Care	2.5-5	5-7.5	25-30	80-85	472	551	75	0
Mark Harris, Chief Operating Officer Acting Accountable Officer and Director of Acute Commissioning	2.5-5	0-2.5	30-35	85-90	466	533	62	0

Name and Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Ted Wilson, Director of Community Services and Joint Commissioning	0-2.5	2.5-5	45-50	135-140	950	1034	74	0
Dina McAlpine, Director of Quality	2.5-5	5-7.5	20-25	50-55	289	370	78	0
Lucy Baker, Acting Director of Acute Commissioning	2.5-5	2.5-5	20-25	55-60	280	333	50	0
Sue Shelbourn-Barrow, Director of Transformation and Integration	0-2.5	0-2.5	10-15	40-45	257	275	9	0
Dr Richard Sandford-Hill, CCG Chair and GP Chair (WWYKD Group)	0-2.5	0-2.5	5-10	25-30	163	174	9	0
Dr Andrew Girdher, GP Co-Chair (NEW Group)	0-2.5	0	0-5	5-10	73	81	8	0
Dr Anna Collings, GP Vice Chair and GP Co-Chair (NEW Group)	0-2.5	0	10-15	20-25	152	167	13	0
Dr Catrinel Wright, GP Vice Chair (WWYKD Group)	0-2.5	2.5-5	5-10	15-20	89	114	24	0
Dr Chet Sheth, GP Vice Chair (Sarum Group)	0-2.5	0	5-10	20-25	105	114	7	0

- Dr Peter Jenkins, Dr Toby Davies and Dr Lindsay Kinlin have opted out of the NHS Pension Scheme, and the CCG does not make any contributions towards a pension. Therefore, there are no disclosures to be made.
- Christine Reid, Peter Lucas, Jill Crook and Dr Mark Smithies do not receive pensionable remuneration.
- The GP members of the Governing Body are now remunerated via payroll, and are eligible to join the NHS Pension Scheme. The entries in the table above relate to their time working for the CCG, and do not reflect their work as GPs in the Wiltshire community.
- Where senior managers have been in post for only part of the year, the real increases reported in this table reflect the period of time they were in that role. For 2017-18, this applies to Tracey Cox, Linda Prosser and Sue Shelbourn - Barrow.

Pension benefits as at 31 March 2017

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 2017 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Tracey Cox, Acting Accountable Officer	0-2.5	2.5-5	40-45	110-115	549	640	29	0
Simon Truelove, Chief Financial Officer and Interim Accountable Officer	5-7.5	10-12.5	25-30	75-80	381	473	92	0
Steve Perkins, Chief Financial Officer	2.5-5	7.5-10	15-20	40-45	126	194	51	0
David Noyes, Director of Planning, Performance and Corporate Services	0-2.5	0	5-10	0	56	78	22	0
Jo Cullen, Director of Primary and Urgent Care	0-2.5	5-7.5	25-30	75-80	422	472	50	0
Mark Harris, Chief Operating Officer and Director of Acute Commissioning	2.5-5	2.5-5	30-35	80-85	423	466	43	0
Ted Wilson, Director of Community Services and Joint Commissioning	0-2.5	2.5-5	40-45	130-135	888	950	62	0
Dina McAlpine, Director of Quality	2.5-5	2.5-5	15-20	40-45	243	289	46	0

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 2017 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Lucy Baker, Acting Director of Acute Commissioning	2.5-5	5-7.5	20-25	50-55	201	280	37	0
Dr Richard Sandford-Hill, GP Chair (WWYKD Group)	5-7.5	20-22.5	5-10	20-25	38	163	125	0
Dr Andrew Girdher, GP Co-Chair (NEW Group)	0-2.5	0	0-5	5-10	65	73	5	0
Dr Anna Collings, GP Vice Chair and GP Co-Chair (NEW Group)	0-2.5	0-2.5	5-10	20-25	151	152	1	0
Dr Lindsay Kinlin, GP Vice Chair (WWYKD Group)	2.5-5	13.5-15	5-10	20-25	19	83	53	0
Dr Catrinel Wright, GP Vice Chair (WWYKD Group)	0-2.5	0	5-10	15-20	83	89	1	0
Dr Chet Sheth, GP Vice Chair (Sarum Group)	0-2.5	0	7.5-10	20-25	98	105	8	0

- Deborah Fielding, Dr Peter Jenkins, Dr Simon Burrell and Dr Toby Davies 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.
- Christine Reid, Peter Lucas, Mary Monnington, Jill Crook and Dr Mark Smithies do not receive pensionable remuneration.
- The GP members of the Governing Body are now remunerated via payroll, and are eligible to join the NHS Pension Scheme. The entries in the table above relate to their time working for the CCG, and do not reflect their work as GPs in the Wiltshire community.
- Where senior managers have been in post for only part of the year, the real increases reported in this table reflect the period of time they were in that role.

Cash equivalent transfer values

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation on early retirement or for loss of office

The Clinical Commissioning Group has made no compensation payments on early retirement or for loss of office.

Payments to past directors

The Clinical Commissioning Group has made no payments to past directors during 2017/18.

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. The median remuneration is the mid-point of the range of remuneration paid by the CCG (i.e. from the lowest to highest paid). The calculation is based on the full-time equivalent staff of the CCG as at 31st March 2018 on an annualised basis (this means identifying the full time equivalent of the remuneration of part-time staff). This disclosure is audited by the external auditor and is covered by the audit opinion issued on the CCG's financial statements.

The banded remuneration of the highest paid director in Wiltshire CCG in the financial year 2017/18 was £140,000 to £145,000 (2016/17: £160,000 - £165,000). This is calculated on a whole-time equivalent (WTE) basis. This was 3.51 times (2016/17: 3.93 times) the median remuneration of the workforce, which was £40,428 (2015/16: £41,373). This has changed due to a reduction in the remuneration paid to the CCG chair (on a WTE basis) and an increase in the number of lower banded staff due to the expansion of the Prescription Ordering Department, and Referral Support Services.

In 2017/18, 1 employee received remuneration in excess of the highest-paid member on a whole time equivalent basis (2016/17; 0). Remuneration ranged from £16,968 to £143,363 on a WTE basis (2016/2017: £16,800 to £162,500).

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

Staff Report

Number of senior managers

The CCG defines a senior manager as those persons in senior positions having authority or responsibility for directing or controlling major activities within the CCG. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual parts of the organisation.

At 31 March 2018, the number of senior managers by Agenda for Change band was:

Agenda for Change Band	No. of senior managers
Very Senior Manager	4
Band 9	2

The CCG also has one GP Chair, six GP Governing Body members and four other Governing Body members with contracts outside the Agenda for Change bands.

Staff composition

The gender composition of staff at 31 March 2018 is:

	Males	Females
Directors and Senior Managers	9	9
Other employees	22	109

Wiltshire CCG does not have any staff acting as relevant union officials, therefore there is no working time spent on supporting this facility or on trade union activities.

Staff numbers, staff costs and sickness absence.

The disclosures on staff numbers, staff costs and sickness absence are audited by the external auditors and are covered by the audit opinion issued on the CCG's financial statements.

Staff numbers

The average number of people employed by the CCG during 2017/18 on a Whole Time Equivalent basis was 111 (2016/17; 110).

	Permanently employed	Other
	91	20
Analysed as:		
Administration	77	16
Medical	0	3
Nursing	9	1
Scientific & Technical	5	0

Staff costs

Total expenditure on employee benefits during 2017/18:

2017/18	Total (£'000)	Permanent Employees (£'000)	Other (£'000)
Salaries and wages	5,548	4,999	549
Social Security costs	523	523	0
Employer contributions to NHS Pension Scheme	630	630	0
Apprenticeship Levy	12	12	0
Gross Employee Benefits Expeniture	6,713	6,164	549
Less: Recoveries in respect of employee benefits	(93)	(93)	0
Net employee benefits expenditure	6,620	6,071	549

The equivalent spend in 2016/17 is detailed below:

2016/17	Total (£'000)	Permanent Employees (£'000)	Other (£'000)
Salaries and wages	5,105	4,438	667
Social Security costs	471	471	0
Employer contributions to NHS Pension Scheme	572	572	0
Termination Benefits	11	11	0
Total	6,159	5,492	667

Sickness absence data

The CCG has an approved sickness policy and associated procedures 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 policy and further reinforced by provision of HR support and training sessions for line managers on the effective management of sickness absence.

Managers ensure the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to the CCG's Governing Body on a quarterly basis, as part of the workforce reporting mechanism.

The NHS reports sickness absence data on a calendar year bases. The details below represent sickness absence for 2017:

	2017	2016
Total days lost	469	354
Total staff years	119	105
Average working days lost	4	3.4

Staff policies

The CCG has a number of policies related to human resources and keeps these under regular review. 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 the protected characteristics specified in the Equality Act 2010 and to support our employees to maximise their performance including making any reasonable adjustments that may be required, on a case by case basis.

Expenditure on consultancy

During 2017/18, the CCG has spent £347,000 on consultancy (2016/17, £312,000).

Off-payroll engagements

The Treasury requires public sector bodies to report arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements).

Table 1: Off-payroll engagements longer than six months

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

	Number
Number of existing engagements as of 31 March 2018	**0**
Of which, the number that have existed:	
• for less than one year at the time of reporting	0
• for between one and two years at the time of reporting	0
• for between 2 and 3 years at the time of reporting	0
• for between 3 and 4 years at the time of reporting	0
• for 4 or more years at the time of reporting	0

Table 2: New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**1**
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35 (see note below)	1
Number engaged directly (via PSC) and are on the payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

The engagement referred to above is for the CCG's Interim Accountable Officer, Linda Prosser. Linda is seconded to the CCG from NHS England, and is on the payroll of that organisation.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (see note below)	2
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	22

The two off-payroll engagements referred to above relate to the people employed as the CCG's Interim Accountable Officer during 2017/18, Tracey Cox and Linda Prosser. Both were seconded to the CCG and are on the payroll of their employing organisations (NHS Bath and North East Somerset CCG, and NHS England, respectively).

Exit packages, including special (non-contractual) payments

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

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	0	0	1	833	1	833	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 –£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	0	0	1	Agrees to table below	1	833	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of Agenda for Change terms and conditions. Exit costs in this note are accounted for in full in the year of departure. Where Wiltshire CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. There have been no early retirements during 2017/18. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements (Number)	Total Value of agreements (£000s)
	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice*	1	1
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
Total		

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number above will not necessarily match the total numbers in table 1 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under "non-contracted payments requiring HMT approval" below.

**includes any non-contractual severance payment made following judicial mediation, and relating to non-contractual payments in lieu of notice.

0 non-contractual payments (£0) were made to individuals where the payment value was more than 12 months' of their annual salary.

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

Financial statements

Linda Prosser, Interim Chief Officer
22 May 2018

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	3	(1,461)	(1,592)
Other operating income	3	(1,086)	(497)
Total operating income		**(2,547)**	**(2,089)**
Staff costs	5.1	6,713	6,159
Purchase of goods and services	6	647,994	570,552
Depreciation and impairment charges	6	3	332
Provision expense	6	469	705
Other Operating Expenditure	6	775	1,017
Total operating expenditure		**655,954**	**578,765**
Net Operating Expenditure		**653,407**	**576,676**
Finance income		0	0
Finance expense		0	0
Net expenditure for the year		**653,407**	**576,676**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**653,407**	**576,676**
Other Comprehensive Expenditure			
Comprehensive Expenditure for the year ended 31 March 2018		**653,407**	**576,676**

[a] This balance is made up of the following expenditure categories in note 6:
Services from other CCGs and NHS England, Services from Foundation Trusts, Services from other NHS trusts, Services from other WGA bodies, Purchase of Healthcare from non-NHS bodies, Purchase of Social Care, Supplies and Services - Clinical, Supplies and Services - General, Consultancy Services, Establishment, Transport, Premises, Audit fees, Prescribing costs, GPMS/APMS and PCTMS, Other Professional fees, Legal fees and Education and Training.
[b] This balance is made up of the following expenditure categories in note 6:
Chair and Non Executive Members, Impairments and Reversals of Receivables, Grants to other bodies, Clinical Negligence, and Other Expenditure.

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	9	0	0
Intangible assets	10	9	12
Total non-current assets		9	12
Current assets:			
Inventories		0	0
Trade and other receivables	13	4,280	2,920
Cash and cash equivalents	14	29	85
Total current assets		**4,309**	3,005
Total assets		**4,318**	3,017
Current liabilities			
Trade and other payables	15	(41,911)	(31,257)
Borrowings		0	0
Provisions	17	(1,037)	(778)
Total current liabilities		**(42,948)**	(32,035)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(38,630)**	(29,018)
Assets less Liabilities		**(38,630)**	(29,018)
Financed by Taxpayers' Equity			
General fund		(38,630)	(29,018)
Total taxpayers' equity:		**(38,630)**	(29,018)

The notes on pages FS 12 to FS 35 form part of this statement.

The financial statements on pages FS 2 to FS 35 were approved by the Governing Body on 22 May 2018 and signed on its behalf by:

Linda Prosser, Interim Chief Officer

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

Changes in Taxpayers' Equity for 2017-18

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2017	(29,018)	0	0	**(29,018)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(29,018)**	**0**	**0**	**(29,018)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(653,407)			(653,407)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(653,407)**	**0**	**0**	**(653,407)**
Net funding	643,795	0	0	643,795
Balance at 31 March 2018	**(38,630)**	**0**	**0**	**(38,630)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2016	**(26,189)**	**0**	**0**	**(26,189)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(26,189)**	**0**	**0**	**(26,189)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(576,676)			(576,676)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(576,676)**	**0**	**0**	**(576,676)**
Net funding	573,847	0	0	573,847
Balance at 31 March 2017	**(29,018)**	**0**	**0**	**(29,018)**

The notes on pages FS 12 to FS 35 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(653,407)	(576,676)
Depreciation and amortisation	6	3	67
Impairments and reversals	6	0	265
(Increase)/decrease in trade & other receivables	13	(1,360)	(88)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	15	10,654	1,982
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	17	(210)	0
Increase/(decrease) in provisions	17	469	705
Net Cash Inflow (Outflow) from Operating Activities		**(643,851)**	(573,745)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(344)
Net Cash Inflow (Outflow) from Investing Activities		**0**	(344)
Net Cash Inflow (Outflow) before Financing		**(643,851)**	(574,089)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		643,795	573,847
Net Cash Inflow (Outflow) from Financing Activities		**643,795**	573,847
Net Increase (Decrease) in Cash & Cash Equivalents	14	**(56)**	(242)
Cash & Cash Equivalents at the Beginning of the Financial Year		**85**	327
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**29**	85

The notes on pages FS 12 to FS 35 form part of this statement.

Notes to the financial statements

1. Accounting policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Going concern

These accounts have been prepared on the going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

1.2. Accounting convention

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

1.3. 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 clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly;
- The clinical commissioning group's share of the expenses jointly incurred; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "joint venture", the CCG must recognise its investment in its own group accounts using the equity method in IAS 28 (unless exempted from doing so under that standard. In its own separate financial statements, the CCG would account for the joint venture in line with paragraph 10 of IAS 27.

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

1.4. Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make 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.

1.4.1. 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". This is based on the fact that, although both the CCG and the Council manage schemes independently, each scheme is approved by the Fund's commissioning board (which is composed of both Council and CCG officers). The commissioning board also manages the day-to-day administration of the Fund. Based on these governance arrangements, the CCG has accounted for the Better Care Fund in accordance with accounting policy 1.3.

1.4.2. 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 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, taking into account payments already made. The accrual is recorded in Non NHS accruals.
- 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 activity data. The estimate could be therefore be higher of lower than calculated once actual invoices are received from providers. The non-contract activity accrual is included within the payables balance on the Statement of Financial Position (SOFP).

1.5. 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.

1.6. Employee Benefits

1.6.1. 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.

1.6.2. 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.

However, on the grounds of materiality, the CCG has opted not to follow this accounting standard and, in its financial statements, treats those employees as if they were members of the NHS Pension Scheme.

1.7. Other expenses

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

1.8. Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.9. Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

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

1.10. 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.

1.11. 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.

1.12. 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. This risk pooling finished in 2016-17. Any claims received by the CCG relating to periods before 31 March 2013 are assessed and if the claimant is found to be eligible, the costs are met from the risk pool.

1.13. 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.

1.14. 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 holds “loans and receivables” as financial assets.

1.14.1. Loans and Receivables

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

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

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

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

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

1.15. Financial Liabilities

Financial liabilities are recognised on the SOFP 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.
The CCG only holds "Other Financial Liabilities".

1.15.1. 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.

1.16. 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.

1.17. 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).

1.18. Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The DH Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to Government FReM (Financial Reporting Manual) adoption and early adoption is not therefore permitted.

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

Of these, IFRS 9 and IFRS 15 could have been applied to NHS financial statements in 2017-18. The CCG has considered the application of the Standards as revised and has concluded that they would not have a material impact on the accounts for 2017-18, were they applied in that year.

2. Financial performance targets

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

	2017-18 Target £000	2017-18 Performance £000	2017-18 Variance £000	Target achieved?
Expenditure not to exceed income	659,545	655,954	(3,591)	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	656,998	653,407	(3,591)	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	61,940	60,715	(1,225)	YES
Revenue administration resource use does not exceed the amount specified in Directions	10,623	9,910	(713)	YES

NHS England set the CCG a Revenue Resource Limit of £656,998,000 for 2017-18, and the CCG achieved an underspend of £3,591,000 against this target.

The CCG did not have a Capital Resource Limit in 2017-18.

The CCG assumed delegated responsibility for Primary Care in 2017-18, and is required not to spend more than its allocation for this service. The allocation was £61,940,000, and there was an underspend of £1,225,000.

The target for administration costs was set at £10,623,000 and the CCG achieved an underspend of £713,000.

Performance in 2016-17 was as follows:

	2016-17 Target £000	2016-17 Performance £000	2016-17 Variance £000	Target achieved?
Expenditure not to exceed income	590,360	578,765	(11,595)	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	588,271	576,676	(11,595)	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	0	0	0	YES
Revenue administration resource use does not exceed the amount specified in Directions	10,615	10,580	(35)	YES

NHS England set the CCG a Revenue Resource Limit of £588,271,000 for 2016-17, and the CCG achieved an underspend of £11,595,000 against this target.

The CCG did not have a Capital Resource Limit in 2016/17.

The target for administration costs was set at £10,615,000 and the CCG achieved an underspend of £35,000.

3. Other Operating Revenue

	2017-18 Total £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	93	0
Non-patient care services to other bodies	1,461	1,592
Other revenue	993	497
Total other operating revenue	**2,547**	**2,089**

4. Revenue

	2017-18 Total £'000	2016-17 Total £'000
From rendering of services	2,547	2,089
From sale of goods	**0**	**0**
Total	**2,547**	**2,089**

5. Employee benefits

5.1.1. Employee benefits

	2017-18 Total £'000	Total Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	5,548	4,999	549
Social security costs	523	523	0
Employer Contributions to NHS Pension scheme	630	630	0
Apprenticeship Levy	12	12	0
Gross employee benefits expenditure	**6,713**	**6,164**	**549**
Less recoveries in respect of employee benefits	(93)	(93)	0
Total - Net admin employee benefits including capitalised costs	**6,621**	**6,071**	**549**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,621**	**6,071**	**549**

	2016-17 Total £'000	Total Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	5,104	4,438	666
Social security costs	472	472	0
Employer Contributions to NHS Pension scheme	572	572	0
Termination benefits	11	11	0
Gross employee benefits expenditure	**6,159**	**5,493**	**666**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,159**	**5,493**	**666**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,159**	**5,493**	**666**

Further details on employee benefits can be found in the Accountability section of the Annual Report.

5.2. Pension costs

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

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

5.2.1. Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

5.5.2. Full actuarial (funding) valuation

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

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

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

For 2017-18, employers' contributions of £647,238 were payable to the NHS Pensions Scheme (2016-17: £600,303) at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 5.1.

6. Operating expenses

	2017-18 Total £'000	2016-17 Total £'000
Gross employee benefits		
Employee benefits excluding governing body members	6,171	5,281
Executive governing body members	542	878
Total gross employee benefits	**6,713**	**6,159**
Other costs		
Services from other CCGs and NHS England	4,316	3,800
Services from foundation trusts	295,398	298,726
Services from other NHS trusts	46,894	42,523
Services from other WGA bodies [a]	45,275	31,179
Purchase of healthcare from non-NHS bodies	92,720	96,224
Purchase of social care [b]	16,209	14,311
Chair and Non Executive Members	473	503
Supplies and services – clinical	955	716
Supplies and services – general	1,189	595
Consultancy services	347	312
Establishment	1,502	914
Transport	2,759	2,430
Premises [c]	1,551	824
Impairments and reversals of receivables	16	514
Depreciation	0	62
Amortisation	3	5
Impairments and reversals of property, plant and equipment	0	248
Impairments and reversals of intangible assets	0	17
Audit fees [d]	60	81
Prescribing costs	72,463	73,124
GPMS/APMS and PCTMS [e]	66,024	4,141
Other professional fees excl. audit [f]	52	49
Legal fees [g]	225	49
Grants to Other bodies	255	0
Clinical negligence	1	1
Education and training	55	53
Provisions	469	705
CHC Risk Pool contributions	0	500
Other expenditure	30	0
Total other costs	**649,241**	**572,606**
Total operating expenses	**655,954**	**578,765**

[a] The increase in expenditure is due to Wiltshire Health and Care being paid for a full 12 month period for the Community Service contract in 2017-18, compared to 9 months in 2016-17. This equates to approximately £12m, with the rest of the increase due to other one-off payments.

[b] Expenditure on the purchase of social care is a new disclosure for 2017-18. Previously, this expenditure was included within Purchase of healthcare from Non NHS bodies (the prior value of this category has been restated). The expenditure reflects schemes that are included within the Better Care Fund.

[c] Expenditure on Premises has increased due to the CCG taking on responsibility for rental and service charges on void and partly utilised NHS properties within Wiltshire from 1st July 2017.

[d] In accordance with SI 2008 no. 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations, where a CCG contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed. The CCG's contract with it's external auditors, Grant Thornton LLP, does contain a limitation of liability clause, with the absolute liability of both parties being capped at £2 million. This is in line with the standard Consultancy One (the procurement framework used to award the external audit contract) approach and the external auditor's standard terms and conditions.
The external audit fee for 2017-18 was £50k, plus £10k irrecoverable VAT (2016-17: £67.5k plus £13.5k irrecoverable VAT).

[e] This category of expenditure relates to primary care. This has increased in 2017-18 because the CCG assumed delegated responsibility for primary care from NHS England on 1st April 2017.

[f] This expenditure includes £52k for the provision of Internal Audit services (2016-17: £49k). The prior year value has been restated due to the new legal fees disclosure, and reclassifying some expenditure to Supplies and Services - General.

[g] Expenditure on legal fees is a new disclosure for 2017-18. In previous years, this was included within Other Professional Fees. The prior year values have been restated to reflect these new categories.

7. Better Payment Practice Code

Measure of compliance	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,907	125,265	8,337	108,860
Total Non-NHS Trade Invoices paid within target	7,869	124,805	8,305	108,686
Percentage of Non-NHS Trade invoices paid within target	**99.52%**	**99.63%**	**99.62%**	**99.84%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,831	344,170	3,569	318,847
Total NHS Trade Invoices Paid within target	3,826	344,165	3,557	318,779
Percentage of NHS Trade Invoices paid within target	**99.87%**	**100.00%**	**99.66%**	**99.98%**

8. Operating Leases

8.1. As lessee

NHS Wiltshire CCG occupies and pays rent on Southgate House, Devizes, a property 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.

Reported lease payments on buildings have increased in 2017-18. From July 2017, the CCG became responsible for paying rental charges on vacant and partly-used space within NHS properties in Wiltshire that transferred to NHS Property Services Ltd. The CCG has accounted for these charges but is in discussion with NHS Property Services about their validity.

Other lease costs relates to photocopiers, and a lease car. The lease car arrangement finished during 2017-18.

8.1.1. Payments recognised as an Expense

	2017-18				2016-17			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	Land £'000	Buildings £'000	Other £'000	**Total £'000**
Payments recognised as an expense								
Minimum lease payments	0	725	1	**726**	0	548	3	**551**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**725**	**1**	**726**	**0**	**548**	**3**	**551**

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.

8.1.2. Future minimum lease payments

	2017-18				2016-17			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	Land £'000	Buildings £'000	Other £'000	**Total £'000**
Payable:								
No later than one year	0	0	1	**1**	0	0	1	**1**
Between one and five years	0	0	1	**1**	0	0	1	**1**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**2**	**2**	**0**	**0**	**2**	**2**

8.2. As lessor

The CCG has not acted as a lessor in either 2017-18 or 2016-17.

9. Property, plant and equipment

The CCG held no property, plant and equipment during 2017-18.

10. Intangible non-current assets

The CCG holds a small value balance of purchased computer software.

The net book value of these assets at 31st March 2018 was £9k (31/03/17; £12k).

Amortisation of £3k was charged during 2017/18.

There is no balance on the Revaluation Reserve in respect of intangible assets.

10.1. Economic lives

The economic life of the purchased computer software is 3 years.

11. Analysis of impairments and reversals

11.1. Analysis of impairments and reversals: property, plant and equipment

There has been no impairment or impairment reversal to property, plant and equipment in 2017-18.

In 2016-17, an impairment of £248,000 was charged to the statement of comprehensive net expenditure due to loss or damage resulting from normal operations.

11.2. Analysis of impairments and reversals: Intangible assets

There has been no impairment or impairment reversal to intangible assets in 2017-18.

In 2016-17, an impairment of £17,000 was charged to the statement of comprehensive net expenditure due to over-specification of assets.

11.3. Analysis of impairments and reversals: totals

As per notes 11.1 and 11.2, the CCG has reported no impairments in 2017-18.

In 2016-17, a total impairment of £265,000 was charged to the statement of comprehensive net expenditure. This impairment was charged to the Department of Health and Social Care's departmental expenditure limit.

12. Inventories

As at 31 March 2018, the CCG does not hold any inventory (31/03/2017; £nil).

13. Trade and other receivables

	Current 2017-18 £'000	Current 2016-17 £'000
NHS receivables: Revenue	326	52
NHS receivables: Capital	0	0
NHS prepayments	1,287	909
NHS accrued income	699	281
Non-NHS and Other WGA receivables: Revenue	663	1,285
Non-NHS and Other WGA receivables: Capital	0	0
Non-NHS and Other WGA prepayments	729	517
Non-NHS and Other WGA accrued income	1,012	390
Provision for the impairment of receivables	(530)	(514)
VAT	94	0
Total Trade & other receivables	**4,280**	**2,920**
Total current and non current	**4,280**	**2,920**

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.

13.1. Receivables past their due date but not impaired

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	22	34	192
By three to six months	159	45	3
By more than six months	0	27	0
Total	**181**	**106**	**195**

£34k of the amount above has subsequently been recovered post the statement of financial position date.

13.2. Provision for impairment of receivables

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	(514)	0
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	0
(Increase) decrease in receivables impaired	0	(16)	(514)
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**0**	**(530)**	**(514)**

Balances with NHS organisations are no considered for impairment. Generally, invoices are impaired when they are more than 6 months overdue but this is applied after the background to each invoice is considered.

	2017-18	2016-17
	%	%
Receivables are provided against at the following rates:		
NHS debt	0%	0%
Specific invoices	100%	100%

14. Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	85	327
Net change in year	(56)	(242)
Balance at 31 March 2018	**29**	**85**
Made up of:		
Cash with the Government Banking Service	29	85
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in Statement of Financial Position	**29**	**85**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**29**	**85**

15. Trade and other payables

	Current 2017-18 £'000	Current 2016-17 £'000
Interest payable	0	0
NHS payables: revenue	2,889	4,849
NHS payables: capital	0	0
NHS accruals [a]	6,896	2,591
NHS deferred income	0	0
Non-NHS and Other WGA payables: Revenue	3,913	3,950
Non-NHS and Other WGA payables: Capital	0	0
Non-NHS and Other WGA accruals [b]	26,979	19,402
Non-NHS and Other WGA deferred income	0	0
Social security costs	85	76
VAT	0	84
Tax	74	70
Payments received on account	0	0
Other payables and accruals [c]	1,075	235
Total Trade & Other Payables	**41,911**	**31,257**
Total current and non-current	**41,911**	**31,257**

[a] The increase in NHS accruals can be attributed as follows:
- £1m due to increased partially completed spells accruals.
- £2.9m due to the value of invoices and accrual statements received in April (relating to the prior year) being higher than the corresponding period in 2016-17

[b] The increase in Non-NHS and other WGA accruals can be mainly attributed as follows:
- £4.7m related to primary care (as the CCG took on delegated responsibility for primary care from 1st April 2017)
- £1.6m related to year end balances with independent healthcare providers for performance and non-contractual activity being higher in 2017-18 than the previous year.

[c] Other payables includes £779,000 outstanding pension contributions at 31 March 2018 (31/03/2017; £91,000). This includes £679,000 relating to pensions for primary care staff (GPs and staff in their practices) which the CCG pays across to NHS Pensions on their behalf. This became the CCG's responsibility due to the delegation of responsibility for primary care.

16. Borrowings

On both 31 March 2018 and 31 March 2017, the CCG had no bank overdraft or loans.

17. Provisions

	Current 2017-18 £'000	Current 2016-17 £'000
Continuing care	330	78
Other	707	700
Total	**1,037**	**778**
Total current and non-current	**1,037**	**778**

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2017	**78**	**700**	**778**
Arising during the year	271	217	488
Utilised during the year	0	(210)	(210)
Reversed unused	(19)	0	(19)
Balance at 31 March 2018	**330**	**707**	**1,037**
Expected timing of cash flows:			
Within one year	330	707	1,037
Between one and five years	0	0	0
After five years	0	0	0
Balance at 31 March 2018	**330**	**707**	**1,037**

Other Provisions

Following professional advice, this provision is an estimate of tax and national insurance that the CCG may be liable to pay as the result of a review by HMRC into payments made to 'office holders' (including governing body members) of the CCG, in particular those remunerated under 'off-payroll' arrangements. It also includes an amount in respect of expected fees due to our advisers, PriceWaterhouse Coopers LLP, who are liaising with HMRC on the CCG's behalf. This review commenced in March 2017, and was still ongoing at 31 March 2018.

£210k of the provision has been utilised so far. £191k is a payment on account to HMRC (to reduce any interest charges), and the balance reflects fees paid to our advisers.

The liability has been estimated using the national insurance and tax rates in place for the financial years 2013/14 to 2016/17, and applying these to the payments made to those officers in that period. Although the CCG has made a payment on account in the year, it was felt to be prudent to restore the provision to its original value.

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, estimated weekly costs and the eligibility success rate of other claims.

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).

These claims are accounted for by NHS England on behalf of Wiltshire CCG as contingent liabilities. The value at 31 March 2017 is £2,797k (31/3/2017; £2,582k).

From 2014-15, all CCGs contributed funds to a risk-sharing pool to be used by NHS England for legacy payments. During 2016-17, Wiltshire CCG contributed £500,000 but this was the final year that the scheme operated, so no contribution was made in 2017-18.

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 2018.

The provision for ELS claims is nil (31/3/2017; £nil), and for CNST claims is £53k (31/3/2017; £138k). This does not represent expenditure by the CCG.

18. Contingencies

The CCG has no contingent assets or liabilities at 31 March 2018 (31/3/2017; £nil)

19. Commitments

19.1. Capital commitments

The CCG has no capital commitments at 31 March 2018 (31/3/2017; £nil).

19.2. 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 2018 (31/3/2017; £nil).

20. Financial instruments

20.1. 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.

20.1.1. 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.

20.1.2. 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.

20.1.3. 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 12.

20.1.3. 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.

20.2. Financial assets

The CCG only holds Loans and Receivables as financial assets

	Loans and Receivables 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0
Receivables:		
· NHS	1,025	1,025
· Non-NHS	1,676	1,676
Cash at bank and in hand	29	29
Other financial assets	0	0
Total at 31 March 2018	**2,730**	**2,730**

	Loans and Receivables 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0
Receivables:		
· NHS	333	333
· Non-NHS	1,675	1,675
Cash at bank and in hand	85	85
Other financial assets	0	0
Total at 31 March 2017	**2,093**	**2,093**

20.3. Financial liabilities

The CCG only carries liabilities classified as "Other Financial Liabilities".

	Other 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0
Payables:		
· NHS	9,785	9,451
· Non-NHS	31,967	32,301
Private finance initiative, LIFT and finance lease obligations	0	0
Other borrowings	0	0
Other financial liabilities	0	0
Total at 31 March 2018	**41,752**	**41,752**

	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0
Payables:		
· NHS	7,440	7,440
· Non-NHS	23,587	23,587
Private finance initiative, LIFT and finance lease obligations	0	0
Other borrowings	0	0
Other financial liabilities	0	0
Total at 31 March 2017	**31,027**	**31,027**

21. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Purchase of Healthcare	655,954	(2,547)	653,407	4,318	(42,948)	(38,630)
Total	**655,954**	**(2,547)**	**653,407**	**4,318**	**(42,948)**	**(38,630)**

21.1. Reconciliation between Operating Segments and SoCNE

	2017-18 £'000
Total net expenditure reported for operating segments	653,407
Reconciling items:	0
Total net expenditure per the Statement of Comprehensive Net Expenditure	653,407

21.2. Reconciliation between Operating Segments and SoFP

	2017-18 £'000
Total assets reported for operating segments	4,318
Reconciling items:	0
Total assets per Statement of Financial Position	4,318

	2017-18 £'000
Total liabilities reported for operating segments	(42,948)
Reconciling items:	0
Total liabilities per Statement of Financial Position	(42,948)

22. Pooled budgets

Wiltshire CCG and Wiltshire Council have pooled budgets in the Better Care Fund, covered by a signed S75 agreement.

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, note 1.3. The agreement between the CCG and the Council outlines how surpluses and deficits on the funds will be apportioned between the partners.

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 2017-18, Wiltshire CCG contributed £31,603,000 to the Better Care Fund, and Wiltshire Council contributed £13,626,000.

Better Care Fund income and expenditure	2017-18 £'000	2016-17 £'000
Income	45,229	32,930
Expenditure	(42,169)	-32,289
Net surplus/(deficit)	3,060	641

At 31 March 2018, the Better Care Fund had no outstanding receivables or payables.

At 31 March 2017, the Better Care Fund had the following balances which were allocated to members in line with the signed agreement:

	£'000
Receivables	60
Cash	690
Payables	(112)

		£'000
Wiltshire CCG share	Receivables	30
	Cash	345
	Payables	(56)

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

	2017-18 £'000	2016-17 £'000
Income	31,603	27,970
Expenditure	(31,603)	(27,651)
Net surplus/(deficit)	0	319

Although the pooled budget is showing an underspend for the year, as per the CCG's agreement with Wiltshire Council, this is wholly attributable to the Council.

23. 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
Whiteparish Surgery	The wife of Dr Peter Jenkins, CCG Chair for part of the year, is a practice manager at this surgery.	1,857	0	24	0
Market Lavington Surgery	Dr Richard Sandford-Hill, current CCG chair and former GP Chair West Wiltshire Group, is a partner of this practice.	1,622	0	33	0
The Castle Practice	Dr Toby Davies, GP Chair Sarum Group, is a senior partner of this practice.	2,923	0	48	0
Solstice Health Ltd	The practice which Dr Toby Davies, GP Chair Sarum Group, belongs to, is a member of Solstice Health Ltd.	264	0	0	0
Box Surgery	Dr Andrew Girdher, GP Co- Chair NEW Group, is a partner within this practice.	1,872	0	28	0
Kennet and Avon Medical Partnership (result of a merger between Marlborough Surgery and Pewsey Surgery)	Dr Anna Collings, GP Co-chair NEW Group, is a partner within this practice.	5,237	0	113	0
Great Western Hospitals NHS Foundation Trust	Dr Anna Collings was a member of the Trust's governing body during the year.	58,145	25	681	470
The Avenue Surgery	Dr Lindsay Kinlin, GP Vice Chair West Wiltshire Group for part of the year, is a partner wihin this practice.	4,904	0	107	0
Lovemead Group Practice	Dr Catrinel Wright, GP Chair West Wiltshire Group for part of the year, is a partner of this practice.	4,304	0	71	0
Salisbury Walk In Centre/ Wilcodoc Ltd	The practice which Dr Toby Davies, GP Chair Sarum Group, belongs to, 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.	945	0	40	0

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
Three Chequers Medical Practice (result of a merger between St Ann Street Surgery, Three Swans Surgery and Endless Street Surgery)	Dr Chet Sheth, GP Vice Chair Sarum Group is a partner of this practice.	9,042	0	196	0
Ardens Health Informatics	Dr Chet Sheth is a director of Ardens Health Informatics.	141	0	0	0
Wiltshire Council	Sue Shelbourn-Barrow, Director of Transformation and Integration, manages the Better Care Fund, which is a pooled budget with Wiltshire Council.	29,054	7,882	2,075	469
NHS Bath and North East Somerset CCG	Tracey Cox, Acting Accountable Officer for part of the year, is also the Accountable Officer of this CCG.	26	27	22	4
NHS England	Linda Prosser, Interim Accountable Officer, is on secondment from NHS England.	738	3,983	338	105

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 2017-18, 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.

23. Related party transactions cont

The 2016-17 disclosure is below:

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 for part of the year, is a partner within this practice.	316	0	0	1
Pewsey Surgery	Dr Anna Collings, GP Vice Chair NEW Group, is a partner within this practice.	153	0	0	2
The Castle Practice	Dr Toby Davies, GP Chair Sarum Group, is a senior partner of this practice.	234	0	0	1
Solstice Health Ltd	The practice which Dr Toby Davies, GP Chair Sarum Group, belongs to, is a member of Solstice Health Ltd.	93	0	0	0
Box Surgery	Dr Andrew Girdher, GP Co- Chair NEW Group for part of the year, is a partner within this practice.	170	0	0	0
The Avenue Surgery	Dr Lindsay Kinlin, GP Vice Chair West Wiltshire Group for part of the year, is a partner wihin this practice.	451	0	0	3
Market Lavington Surgery	Dr Richard Sandford-Hill, GP Chair West Wiltshire Group, is a partner of this practice.	249	0	0	1
Lovemead Group Practice	Dr Catrinel Wright, GP Vice Chair West Wiltshire Group for part of the year, is a member of this practice.	303	0	0	1
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. Dr Chet Sheth is a director of Wilcodoc Ltd, which runs Salisbury Walk In Centre	865	0	0	0
St Ann Street Surgery	Dr Chet Sheth, GP Vice Chair Sarum Group, is a partner of this practice.	488	0	1	0

Wilcodoc Ltd	Dr Chet Sheth, GP Vice Chair Sarum Group, is a director of this company. The practice which Dr Toby Davies belongs to is a shareholder in this company.	0	0	4	0
Ardens Health Informatics	Dr Chet Sheth is a director of Ardens Health Informatics.	0	0	166	0
Royal United Hospitals NHS Foundation Trust	Simon Truelove, Chief Financial Officer and Interim Accountable Officer for the part of the year, is married to the Director of Finance of the Trust	92,086	39	1,227	648
Wiltshire Council	James Roach, Director of Integration, is jointly employed with Wiltshire Council.	13,477	1,136	2,209	1,467
NHS Bath and North East Somerset CCG	Tracey Cox, Interim Accountable Officer, is also the Accountable Officer of this CCG.	41	0	8	3

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.

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The Department of Health is considered to be a related party. During 2016-17, 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.

24. Events after the end of the reporting period

The accounts were authorised for issue by Steve Perkins, Chief Financial Officer, on 18 May 2018.

25. Third party assets

The CCG does not hold any assets on behalf of third parties (2016-17; £nil)

26. Losses and Special Payments

26.1. Losses

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

	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	4	16	4	779
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	**4**	**16**	**4**	**779**

26.2. Special payments

	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	1	2	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**1**	**2**	**0**	**0**

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

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Wilshire CCG for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Who we are reporting to

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

Conclusions relating to going concern

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

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

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages PR 1- FS 35, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the CCG's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012 ; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity required by the Code of Audit Practice

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

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

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

As explained more fully in the Statement of Accountable Officer's responsibilities [79 - 101], the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

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

The Audit and Assurance Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.
We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

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

Signature

Peter Barber
Engagement Lead
for and on behalf of Grant Thornton UK LLP

2 Glass Wharf
Bristol
BS2 0EL
Date

Note: The opinion only reflects the information contained within this annual report. Where hyperlinks feature with the report, the opinion does not cover the information contained within them.