ANNUAL REPORT

2015-16

NHS
Wolverhampton
Clinical Commissioning Group

Contents

FOREWORD CHAIR AND ACCOUNTABLE OFFICER

In our third year as a CCG we've moved forward developing services that give local people the care and support they most want and need, at the right time and in the right place whilst at the same time getting a grip on our finances.

We've become more effective in what we do – and are seeing real results. For instance, learning from the implementation of an efficiency review group (ERG) helped us to identify services that needed to deliver better quality and effective care. It is with this pragmatic and measured approach we now look closely at every contract we have with service providers and every grant we make. This ensures we are investing in the right services and initiatives' for the people of Wolverhampton that take their wishes into account.

Concentrating on being as efficient as we can means we're now on a far better financial footing and, even in the tough economic climate facing the NHS nationally, we're in the fortunate position of being able to spend money on new initiatives and improvements.

We made greater savings than ever before through our quality, innovation, productivity and prevention (QIPP) programme. We still have a way to go, but we are now in a position where we can reinvest these savings in local services.

Getting our finances in hand has settled any concerns the CCG regulator, NHS England, previously had about our stability and we're now authorised 'without conditions', with every aspect of the CCG fully assured. This shows we're progressing year on year, and thanks to the hard work done in 2015-16, we have a firm base from which to push on. We've had the go-ahead to start co-commissioning and aim to be fully delegated within 12 months, giving us far more control over how we spend our NHS budget.

We believe that empowering primary care is the way to support a shift to community services that will minimise the need for hospital visits as well as reduce costs. Our detailed primary health care strategy approved by the CCG Governing Body in January 2016 is designed to make this a reality. It reflects the national policy set out in the NHS Five Year Forward View to move care 'closer to home' and more accessible to our communities. With our help our member GPs are developing new models of care based on suggestions in the Five Year Forward View. They are building on work done by the Wolverhampton Doctors Federation, which is currently made up of 29 practices with a strong commitment to deliver integrated care.

We're really proud that eight of our practices have come together as Wolverhampton Total Health Care and been chosen as one of 15 'rapid test sites' across England working with the National Association of Primary Care to develop and test the Primary Care Home model. This aims to redesign primary care around the health and social needs of local communities. This model is in line with our strategy and will encourage GPs to group together in sub-localities of 20-30,000 people and build community-level multi-disciplinary teams around their community. The other new model we hope to test is one of 'vertical integration', with several practices exploring how to work more closely with local hospitals.

We're already offering quicker and easier access to care in our community. From April 2016 Northern Doctors Urgent Care Ltd will run the new 24/7 urgent care centre at New Cross Hospital site where people can be treated for minor injuries and illnesses without needing to visit A&E or their GP. The Pharmacy First scheme, with accredited pharmacists across Wolverhampton, is another way to see a qualified health professional without an appointment.

The electronic prescription service introduced at 36 practices is a faster, more reliable and convenient way for patients to get their medication, picking it up direct from a pharmacy or dispensing appliance contractor of their choice without the need to make a special trip to their practice to collect the prescription.

The role of community pharmacists and optometrists in providing care closer to home continues to grow. The primary eye care assessment and referral service (PEARS) has really bedded in during 2015-16, with 28 local opticians now accredited to assess and manage minor eye conditions. Our feedback shows that 99% of people who use PEARS are very happy with it.

Our community rapid response team launched in January, made up of health and social care staff visit people with long-term conditions if they experience difficulties and keep them out of hospital unless it's really necessary. Nine out of 10 patients seen by the team are able to stay in their own home or nursing home.

Closer working has been a definite theme of the past year. GP community meetings support peer reviews to foster better communication between practices. Our system resilience group is tasked with making Wolverhampton's whole health and care system better able to cope. We're one of four CCGs funding the 'mental health crisis car', which paramedics and police can call to get someone seen quickly by a psychiatric nurse and receive appropriate support.

We want to work more closely, effectively and in partnership with the voluntary sector and have offered grants to help small local charities continue and expand activities that enable the elderly and people with long-term conditions to stay well and in their own homes.

We want people to be as involved in their own health and wellbeing as possible, including shaping local services. This year saw us name our first Patient Champion of the Year. Marlene Lambeth, who received the award for her efforts as a patient representative on various health projects, organiser of community events and chair of her local patient participation group.

Through the Changing Our Lives charity we've been listening to young people with physical health needs and learning difficulties and in November some of them took over senior CCG roles for the day – including ours, to get a real feel for what we do. This is really helping us understand their needs and involve them in redesigning local services such as Wolverhampton's child and adolescent mental health service.

During 2015-16 other patient groups have required particular attention. Our work with the Refugee and Migrant Centre in Wolverhampton is helping people newly arrived in the city to understand the best way to use local health services.

We've also focussed on improving the transfers from hospital back into the community, ensuring that patients are assessed and discharged without unnecessary delay. We continue to work to address the challenges in putting the right care packages in place so that people can return home safely, especially as the local authority faces further cuts to its social care budget.

Much of our work during 2015-16 highlights the real benefits of strengthening relationships between local organisations. Public health colleagues have involved us in shaping their services in line with what we're doing. Currently they are talking to as many local people as possible as part of a healthy lifestyle survey, which should give a true picture of the local issues that health and social care services in Wolverhampton must address to enable the local population to live longer and healthier lives.

The progress we have made throughout the past year with our partner organisations will give us a much firmer platform on which to go forward, together.

CCG Chair Dr Dan De Rosa and Accountable Officer Dr Helen Hibbs

PERFORMANCE REPORT

About us

Wolverhampton Clinical Commissioning Group (WCCG) was set up under the Health and Social Care Act 2012. We were fully authorised by NHS England in October 2013 and have a budget of £341.742 million to buy healthcare services for people living in Wolverhampton. We are a clinically led organisation, comprising 46 GP practices, and we provide healthcare services for the 262,000 patients who are registered with a GP in Wolverhampton.

Our local population

Wolverhampton is located in the Black Country in the West Midlands. It currently has a population of 252,987 which is estimated to grow to 260,200 by 2021. Wolverhampton is a diverse city and 35 per cent of our population belongs to black minority ethnic (BME) communities.

As a city the number of over-65 years old has increased in line with the national picture and will continue to do so over the next 10 years. The average age of our residents is 39. The city also has the third highest unemployment rate of all of the English local authorities.

Social and community issues

People in Wolverhampton are living longer but still have a shorter life expectancy than the national average. The average life expectancy for Wolverhampton residents is below national average at 77.5 years for men and 82 years for women.

The number of births has been steadily increasing; meaning the number of under-16 year olds is higher than the national average. Since three quarters of these births are in the most deprived areas this has led to 30.2 per cent of children living in poverty.

There is also a consistent life expectancy gap between those living in the most deprived and those in the least deprived areas. This is approximately eight years for men and six for women.

Local priorities include reducing infant mortality, reducing obesity across the life course and reducing alcohol-related liver disease and associated mortality. Alcohol-related deaths and infant deaths are the main reasons why life expectancy has not improved or has only improved in line with the national average.

Our structure and commissioning activities

We are responsible for commissioning (or buying and monitoring) healthcare services as described in the 2006 National Health Service Act and as amended by the 2012 Health and Social Care Act. These health services include:

- Health services that meet the reasonable needs of all patients registered with our member practices, as well as people living in Wolverhampton who are not registered with any GP practice

- Emergency care
- Paying for prescriptions issued by our member practices.

To meet those needs, we commission a wide range of services including:

- Acute or hospital services
- Community services
- Prescribing
- Mental health services
- Ambulance services
- Continuing care
- Nursing home care.

NHS England commissions dentists, pharmacies and opticians and has, until 1 April 2015, commissioned all GP services. Recently, however, we have carefully assessed the approach we take to the commissioning of primary care and have decided to move towards a 'joint commissioning' model with NHS England, with a view to taking over full responsibility for commissioning GP services in the future. We are already working with NHS England and have established a joint committee with them to commission primary medical services.

We buy most of our acute and community services from the Royal Wolverhampton NHS Trust, but we also have contracts with other acute trusts outside Wolverhampton. We buy most of our mental health services from the Black Country Partnership NHS Foundation Trust. We also sometimes buy services from other healthcare providers outside the city or from non-NHS organisations, depending on the nature of patient's health needs and requirements.

The CCG has opted to join the Black Country footprint with regards to national sustainability and transformation planning. The plan will run over 5 years from October 2016 to March 2021. It realises the need to add value to systems without duplicating effort and responds to public desire for the Black Country Authorities to work together at a Combined Authority level and/or across the Black Country. This is at the same time as contributing to the national challenges of closing the Health and Wellbeing Gap, closing the Care and Quality Gap and closing the Finance and efficiency gap.

Sustainability report

The CCG's sustainability responsibilities are outlined in detail in our Annual Governance Statement. This continues to be an area of development for us as an organisation and we will be making further progress in the coming year. The Governance Statement highlights the work of our accommodation partner and outlines our plans to work with our providers to ensure the services we commission are delivered in a sustainable way. We also continually examine our internal processes to ensure we meet our obligations through initiatives such as the use of technology to further embed paperless working, and the introduction of a Sustainable Development Management Plan in line with national best practice.

Factors likely to affect future development and performance

Risks and uncertainties

There continue to be a number of specific health challenges in Wolverhampton. Health inequalities remain stark, the population has an ageing demographic and is very diverse.

Many of our population live with long term conditions and obesity continues to provide a major health challenge in our city.

Our overriding aim as a CCG is to enable people to live longer and more healthily. Although life expectancy is increasing we need to ensure that people enjoy disability free years of live as well as having increasing longevity. The increasing problem of the frail elderly population means that we have had to look at specific services to support people to remain in their own homes and to receive care closer to home where appropriate. We have also been working with colleagues from public health to try to address prevention and, in particular, the obesity challenge.

We also need to consider the potential future shortage of health professionals available to provide services. Both medical and nursing staff recruitment is proving difficult. Our primary care strategy recognises the issue of many local GPs nearing retirement age, and the difficulties of retention and recruitment. This year we have initiated a primary care workforce survey to look at our current workforce and to help us plan for the future.

We continue to see extreme pressure in Accident and Emergency (A&E) with deterioration in A&E performance over the year. There have been record numbers of people attending A&E. Delayed Transfers of care from hospital to home or community settings have also been a particular challenge and this has meant that bed capacity in our acute hospital has been stretched. Attendances have risen, possibly in response to the demographics of a growing ageing population living with ill health.

The action we are taking to reduce the pressure on A&E, particularly the creation of a specialist urgent care centre, including a primary care-led walk-in centre, is expected to have a positive impact. Other work to deliver more services in the community and to support our local care homes is also proving successful in reducing some of the pressure on our acute hospital.

We know that cuts of funding to social care are of particular concern in Wolverhampton. Plans supported by the ‘Better Care’ programme enable joined working between health and social care and will lead to the long-term transformation of Wolverhampton’s health and social care economy, enhancing people’s independence, health and quality of life through seamless and efficient care. During the year we have been working with social care partners locally to align our strategic objectives and ensure that, together, we transform provision so that it is fit for the future.

Financial review of the year

Wolverhampton CCG is required to meet both national and local financial targets, the national targets being defined in the NHS Act 2006 (as amended). The CCG has achieved all of its

statutory duties and three of its four local targets, (the exception being QIPP which was 87% achieved). The performance against targets is detailed below.

2015/16 Performance	Target	Actual
Statutory duties:		
Expenditure not to exceed income	£5.906m surplus	£6.972m surplus
Capital resource use does not exceed the amount specified in Directions	Nil	Nil
Revenue resource use does not exceed the amount specified in Directions	£341.742m	£334.770m
Revenue administration resource use does not exceed the amount specified in Directions	£6.120m	£5.503m
Non-statutory duties:		
Better Payment Practice Code: NHS	95%	98%
Better Payment Practice Code: Non-NHS	95%	97%
Cash drawdown target	Achieve	Achieved
QIPP (Quality, Innovation, Productivity and Prevention)	£11.8m	£10.31m

The CCG's budget from NHS England to carry out its expected duties this year was £341.742m. This encompasses both the commissioning of healthcare services and management 'running' costs.

The healthcare allocation (programme cost) is determined by NHS England using a complex formula designed to take into account the health needs of our population. It has been spent on healthcare services such as those delivered by The Royal Wolverhampton Trust, The Black Country Partnership Foundation Trust and a wide range of voluntary/third sector organisations.

The running cost allocation pays for the cost of employing staff, running the organisation and all the support systems we need to commission and monitor services. We have developed an organisational structure which best supports the delivery of our strategies. It ensures that decisions are made with effective clinical input through individual Clinicians and membership practices, and that sufficient resource is allocated to monitor the impact of our decisions. The CCG spent £5.5m, approximately £21.84 per head of population on running costs.

During the year the CCG received additional allocations totalling £4.619m. The table below details the move between opening and closing allocations.

	Opening £'m	Closing £'m	Increase £'m
Programme allocation	325.662	329.717	4.055
Running Cost allocation	5.556	6.120	0.564
Total	**331.218**	**335.837**	**4.619**

Within the programme category, large allocations were received to fund our GP IT programme (£0.832m); to support national tariff pricing (£0.958m) and to increase investment in mental health services (£0.743m for IAPT, CAMHs and Eating Disorders).

The running cost budget increased by £0.564m as a result of the award of Quality Premium monies which reward improvements in the quality of the services we have commissioned; better health outcomes and reduced inequalities.

The table below summarises the CCG's performance against its financial allocation as at the end of March 2016 and reflects the financial position reported in the CCG's annual accounts.

	Annual Plan £'m	Actual £'m	Variance under/(over) £'m	Variance %
Healthcare Allocations	329.717	329.717		
Running Cost Allocation	6.120	6.120		
Brought Forward Surplus	5.905	5.905		
Total Allocations	**341.742**	**341.742**		
Expenditure				
Acute Services	175.099	176.659	- 1.560	-0.9%
Mental Health Services	34.060	34.199	- 0.139	-0.4%
Community Services	33.108	33.093	0.015	0.0%
Continuing Care/ Funded Nursing Care	13.198	11.888	1.310	9.9%
Prescribing	45.958	44.565	1.393	3.0%
Other Programme	25.050	28.863	- 3.813	-15.2%
Reserves	3.244	-	3.244	100.0%
Running Costs	6.120	5.503	0.617	10.1%
Total Expenditure	**335.837**	**334.770**	**1.067**	0.3%
Carry Forward Surplus	5.905	5.905	-	
	341.742	340.675	1.067	
Underspend in excess of Plan	-	-	1.067	

In achieving this position there were a number of variances from plan, the most significant of these being:

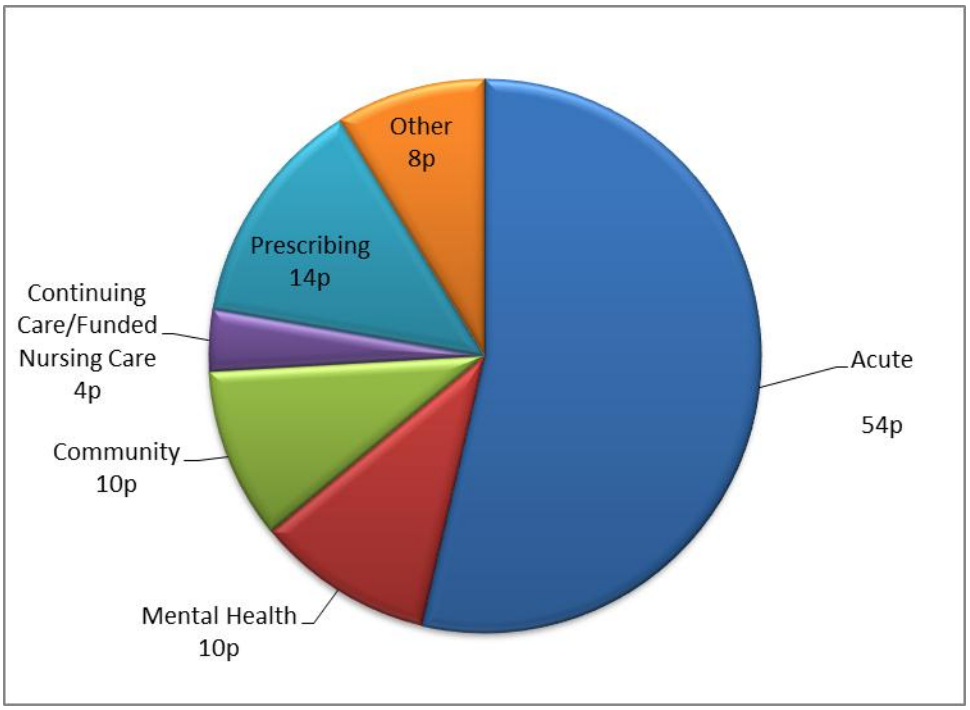
- Acute contracts were £1.56m, (0.9%) over plan which was mainly attributable to increased emergency admissions and to a lesser extent increased outpatient attendances. However, levels of elective activity have been much lower than anticipated primarily due to the increased emergency activity
- Mental Health Service spend exceeded plan by £139k and this reflects the complexity of care required by patients and the need for placements in out of area facilities.
- Prescribing costs are underspent by £1,393k of which £1,072k relates to a technical adjustment from 14/15
- Other Programme costs overspent by £3.813m. The main driver for this overspend is the Better Care Fund, a pooled fund with Wolverhampton City Council. Overspends have been experienced across the portfolio

- Against a QIPP target of £11.8m there was a shortfall of £1.5m (13%) as a result of slippage in schemes associated with contracts and schemes for which plans were not able to be initiated in-year. This position must not be underestimated however as the achievement of £10.31m QIPP is the best performance for the CCG since its establishment in April 2013.

Spend Per Head of Population

In 2015/16 the CCG spend an average of £1,328 per person on providing healthcare services to people registered with a Wolverhampton CCG member practice.

This is how we spent each £1 in 2015/16:



Our Accounts

The CCG's accounts have been prepared under a direction issued by NHS England under the National Health Service Act 2006 (as amended). The CCG's Statement of Financial Position is set out on page **77**.

The financial statements are prepared on a 'going concern' basis as it is expected that the CCG-commissioned services will continue to be provided in Wolverhampton beyond the date for which the statements relate.

The main assets that the CCG holds as at 31st March 2016 are short term receivables (amounts owed to the CCG by third parties) and the main liabilities are short term payables

(amounts owed to other parties by the CCG). The CCG does not hold any significant operational assets such as land, buildings and equipment nor does it have any complex lease arrangements or long term liabilities.

Going concern

The CCG has met all financial targets for the year, including containing our administrative running costs within the allowance of £6.12 million. In preparing our annual financial statements, we are required to undertake an assessment of our financial standing so that we can report on a "going concern" basis. The assessment, which is considered by external auditors, concluded that Wolverhampton CCG remains in a strong financial position, but noted the difficult financial position facing the NHS and local authority in coming years.

How we're doing

Our strategy

Our vision for the future is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.

In order to achieve this, we have four priorities for the coming year:

- continue to commission high-quality, safe healthcare services within our budget
- focus on prevention and early treatment
- ensure our services are cost effective and sustainable
- increase the capacity to deliver services in Primary Care and community settings.

We'll do this with the help of the people of Wolverhampton. It's important to us that people who use our services are fully involved in helping us design them going forward. It's only by understanding what patient's need that we'll get things right for them.

Our five-year strategy for improving healthcare in Wolverhampton focuses on a number of themes:

- we want to reduce hospital admissions and provide more care closer to home through community-based services, improving co-ordination and access
- we will take on more responsibility for GP services and aim to take full control of these in the future
- we will focus more on preventing illnesses, working with public health to look at lifestyle factors that increase the risk, including obesity. We will also work to improve uptake of the NHS Health Check programme
- we want to give patients better access to GPs, but also reduce pressure on practices through support from other healthcare professionals
- we want to improve mental health services, provide better care and more choice to people with long-term mental health problems.
- we will work to improve dementia diagnosis, treatment and care, and implement national standards for mental health service waiting times

- we want better children's services and are working with public health to reduce Wolverhampton's infant mortality rate – currently the highest in England
- we want to improve co-ordination of services and care for children with special educational needs and disabilities. We are working to provide easier and speedier access to children and young people's mental health services
- we want better quality of care. We will continue to monitor the safety of services, will work to reduce healthcare associated infections and improve services based on patient feedback. We also want to increase the uptake of personal health budgets
- we will continue to improve IT in our GP practices to improve access to and sharing of information and will support innovative approaches to improving access through the use of new technology
- we want better seamless health and social care. We will work with the city council to provide joined-up health and social care that delivers high-quality services through best use of our joint investment. We will transform services in a way that is sensitive to local needs and sustainable for the long term.

Primary care co-commissioning

Our ambition is to take on greater responsibility for GP services in Wolverhampton.

Together with NHS England we are developing a co-commissioning model, with a view to taking over full responsibility for commissioning GP services in the future.

Until 1 April 2015, all GP services were commissioned by NHS England. CCGs were invited to take on more responsibility in this area as part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care.

These new arrangements are another step towards plans set out by NHS England to give patients, communities and clinicians more involvement in making decisions about local health services.

Co-commissioning gives CCGs and NHS England an opportunity to more effectively plan and improve the provision of out-of-hospital services. Within this model we will also have the option to pool funding for further investment in seamless, integrated care.

We are already working with NHS England, and have established a joint committee with them to move towards co-commissioning. This new structure will allow the CCG a greater say in areas such as GP contracts, the ability to establish new GP practices and the approval of practice mergers. In order to be ready and able to take on these new co-commissioning responsibilities we have also revised our internal structures.

We believe co-commissioning will lead to a range of benefits for our patients, including:

- improved access to primary care and wider out-of-hospital services, with more
- services available closer to home
- high-quality out-of-hospital care
- improved health outcomes, equity of access, reduced inequalities

- a better patient experience through more joined-up services.

Primary Care Strategy

We have agreed a 5 year Primary Care strategy and implementation plan which will underpin the realisation of our commissioning ambitions listed above. We recognise that to have excellent health services for our residents, we need excellent Primary Care and the CCG are committed to delivering this to the benefit of patients and GPs. In the development of this strategy we held engagement events for both stakeholders and public to allow their input. This included a dedicated members meeting.

Performance analysis

Our Performance

Overall, local healthcare providers have performed well during the year, enabling us to ensure the majority of national and local quality requirements are delivered, and that we're in a relatively good position compared with other parts of the country in meeting our performance targets under the NHS Constitution.

We have worked closely with providers and have been effective in using joint working and, where necessary, contractual levers, to mitigate risks on both sides. Robust governance arrangements mean that contract and performance meetings effectively adhere to our terms of reference, and we also communicate regularly to raise potential problems early on.

In areas where we have faced challenges to meet performance targets we are aware of the underlying reasons and are taking action to address these. For instance, the failure to meet targets for A&E four-hour waiting times was disappointing but not unexpected. We know that current demand for emergency care outstrips capacity both regionally and nationally, and this is why we have developed an urgent care strategy. A new urgent and emergency care centre at New Cross Hospital has been built, with the emergency department (A&E) operational since November 2015, and the urgent care centre (for minor injuries or illnesses), scheduled to open in April 2016.

With all these changes being made, we should see a marked difference in how people across Wolverhampton access emergency care as a whole, leading to reduced pressure on A&E that will cut waiting times and improve both the patient experience and the quality of the service provision.

We've also put a great deal of time, energy and effort, plus some financial investment, into working with The Royal Wolverhampton NHS Trust to bring down waiting times generally and address specific areas of concern.

For instance, to ensure more patients don't have to wait longer than 18 weeks for non-urgent hospital treatment once they've been referred, we've developed plans to review levels of referral into certain services and offer procedures at weekends where necessary. We also regularly

monitor the rare cases where patients may still be waiting for treatment after 52 weeks, and pursue these with providers.

We have supported additional planned care at Cannock Chase Hospital to relieve pressure on existing services and reduce waiting times for treatment, especially in currently underperforming areas like orthopaedics and general surgery.

Performance against the key national NHS Constitution targets for 2015/16

NHS Constitution

Performance against the key national NHS Constitution targets for 2015/16 has been the following:

	TARGET	ACHIEVED	PERFORMANCE RAG BY MONTH											
Referral to Treatment waiting times for non urgent consultant-led treatment			A	M	J	J	A	S	O	N	D	J	F	M
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	92.90%												
Zero tolerance RTT waits over 52 weeks for incomplete pathways	0	6												
Diagnostic test waiting times														
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99.51%												
A&E waits (The Royal Wolverhampton NHS Trust)														
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	91.89%												
No waits from decision to admit to admission over 12 hours	0	1												
Cancer waits - Two-week waits														
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	94.85%												
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where	93%	96.45%												

cancer was not initially suspected)			
Cancer waits - one month (31 days) wait			
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	96.90%	
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	96.13%	
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.73%	
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	99.48%	
Cancer waits - 2 month (62 days) waits			
Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	79.10%	
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	91.67%	
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	No operational standard	90.86%	
Mixed-Sex Accommodation			
Breaches of Mixed-Sex Accommodation	0	0	
Mental Health			
IAPT- 75% of people engaged in the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral	75%	90.40%	
IAPT- 95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral	95%	98.40%	

Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	93.50%	
IAPT- People who have entered treatment as a proportion of people with anxiety or depression (local prevalence)	15%	15.40%	
IAPT - Percentage of people who are moving to recovery of those who have completed treatment in the reporting period	50%	48.90%	
Cancelled Elective Operations (The Royal Wolverhampton NHS Trust)			
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	0	0	
No urgent operation should be cancelled for a second time	0	0	
Category A Ambulance Calls (West Midlands Ambulance Service Foundation Trust)			
Category A calls resulting in an emergency response arriving within 8 minutes – Red 1	75%	83.60%	
Category A calls resulting in an emergency response arriving within 8 minutes – Red 2	75%	77.40%	
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	98.90%	
Health Care Acquired Infections			
Zero tolerance MRSA	0	0	
Minimise rates of Clostridium difficile	71	73	

Ambulance Handovers			
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	0	584	
All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	0	46	

Please Note: All Published March 2016 verified data was not available at time of production. Data correct as at 28th April 2016.

Summary of key performance targets

Referral to treatment (RTT) within 18 weeks

Overall performance for patients on incomplete non-emergency pathway waiting times achieved their targets. The CCG continues to work closely with Royal Wolverhampton Trust to reduce delays in specific high flow specialty areas.

There have been six breaches of the 52-week referral to treatment threshold; in all six cases, the patients were being treated by providers outside of Wolverhampton. The CCG is involved in regular discussion with other providers through collaborative commissioner forums and through direct communications to ensure patients are being seen within thresholds and any long waiters have plans for treatment in place.

Diagnostic test waiting times

A number of actions taken in 2015/16 have led to a marked improvement in performance of diagnostic test wait times compared to 2014/15. 99.51% of patients had diagnostic tests within the 6 week threshold against a target of 99.00%.

A&E four-hour waits

This year we struggled to meet targets for combined A&E and walk-in centre four-hour waiting times – 91.89% against a target of 95.00% – for various reasons. There is unprecedented pressure on A&E services generally, and we also had to cope with an increase in patients from South Staffordshire and other CCGs. The CCG has agreed a Remedial Action Plan with The Royal Wolverhampton NHS Trust, including details of actions, including the opening of a new Urgent Care Centre, and a recovery trajectory to support delivery against the 4 hour A&E target.

Cancer waits

The CCG has performed well in its overall performance against the cancer wait targets, with seven of the eight national measured targets being met or exceeded this year.

Underperformance against the percentage of service users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer is being addressed with The Royal Wolverhampton NHS Trust through work detailed in a Remedial Action Plan including details of actions and a recovery trajectory to support delivery against the cancer wait target.

Mixed sex accommodation

Every patient requiring an overnight stay at The Royal Wolverhampton NHS Trust during the year was given a bed in single sex accommodation, as is their right.

Mental health

All Mental Health Referral to Treatment targets were met for the year with only the Improving Access to Psychological Therapies (IAPT) moving to recovery target failing to achieve the minimum requirement of 50% this year, achieving 48.90%. This was as a result of a challenging 6 month period at the start of 2015/16 due to the improvements in identifying patients in need of psychological therapies in 2014/15. We have subsequently conducted a thorough review of the service in conjunction with the Trust and have embedded a new model of care for which we have seen a significant improvement in performance during the second half of the year and the CCG is confident of achieving target in 2016/17. We did not achieve the 95 per cent target for following up adults on the Care Programme Approach within seven days of their discharge from psychiatric inpatient care, achieving 93.50% of cases. The use of hospital daily reports provided to all community teams highlighting patients who are discharged from psychiatric inpatient care has positively impacted on performance and the CCG is confident of achieving target in 2016/17.

Cancelled elective operations

All elective operations cancelled at the last minute for non-clinical reasons were rearranged within 28 days. No urgent operations were cancelled more than once.

Category A ambulance calls

We managed to exceed all three national Category A ambulance call targets this year, and are working closely with West Midlands Ambulance Service to maintain this level of performance.

Healthcare-associated infections

The efforts to minimise the risks of healthcare-associated infections across Wolverhampton continues. There were no cases of MRSA at The Royal Wolverhampton NHS Trust during the year. This is a significantly positive step and shows the strengthened screening processes put in place from previous investigations have directed improvements.
During 2015/16 there were 79 cases (as at 1st March 2016) of Clostridium difficile (C. diff) across services, including 38 at The Royal Wolverhampton NHS Trust – above our planned thresholds of 71 in total and 35 at the trust. We monitor C. diff infections closely through monthly

quality and safety reviews, and have worked hard to tackle what is essentially a clinical issue related to underlying local health problems. For instance, we have commissioned a new antibiotic that can be prescribed to treat C. diff recurrences. We will continue to work to reduce the number of cases of C. diff.

Ambulance handovers

Although ambulance handover times at The Royal Wolverhampton NHS Trust are better than at many other providers, the rise in emergency cases arriving at hospital during the winter meant handovers did not always take place within 15 minutes, and there were hour-long delays in 46 cases.

Trolley waits

There was a single breach in year for a decision to admit exceeding 12 hours. A full investigation was undertaken regarding the breach and actions and lessons learned have been implemented at the Trust.

What we've done

Joint health and wellbeing strategy

The CCG is actively involved in the delivery of Wolverhampton's Joint Health and Wellbeing Strategy, in line with our duties under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007. The strategy is currently being refreshed to address identified local health and social care needs and will present an overarching approach to ensuring good health and a longer life for our population. It will be developed by key leaders from across the local health and social care community, working together through the city's Health and Wellbeing Board.

The Health and Wellbeing Board consists of representatives across health, social care, and the voluntary sector – including Healthwatch, the business community, police and fire services. The CCG is a statutory member of the Board and actively contributes to the development of city-wide policies and initiatives to reduce some of the stark gaps in health experienced across the city. Dr Helen Hibbs, the CCG's Accountable Officer and Steven Marshall, Director of Strategy and Transformation are the CCG's representatives on the Health and Wellbeing Board and they provide feedback on the work of the Board to the Governing Body as well as supporting the Board to understand how the work of the CCG contributes to the delivery of the strategy.

There are three priorities identified by the Health and Wellbeing Board for 2016 onward:

- Childhood obesity
- Child and adolescent mental health and
- Integration with a dual focus on:
  - dementia and
  - care closer to home.

WCCG's vision for health and social care services will be underpinned by this strategy and we will work closely with health and social care partners to effectively commission and deliver services to meet the needs of the local population, both locally within Wolverhampton and more broadly as part of the Black Country Sustainability and Transformation Footprint.

Joint Strategic Needs Assessment (JSNA)

The Joint Health and Wellbeing Strategy will rely heavily on the evidence of need outlined in the Joint Strategic Needs Assessment (JSNA), which is an integral part of improving the health and well-being and reducing health inequalities within a population. Whilst the Health and Wellbeing Board is responsible for the JSNA, the local authority and CCG are jointly required to develop this detailed assessment of current and future health and social care need.

In September 2015 the Health and Wellbeing Board approved a revised JSNA process. This included the formal establishment of a JSNA Steering Group and the compilation of a compendium of health and social care need within Wolverhampton. The CCG is represented on the Steering Group and will participate in, and contribute to, various stakeholder events required in order to identify local need to inform commissioning of services.

Reducing health inequalities

The Director of Public Health Annual Report 2014/15 *Lifestyle Choices: A Time to START and a Time to STOP* outlines a five year lifestyle prevention plan for the population of Wolverhampton. It has been estimated that around 80% of deaths from major diseases, for example, cancer and heart disease, are attributable to lifestyle risk factors such as smoking, excess alcohol consumption, lack of exercise and an unhealthy diet. These lifestyle risk factors are often the result of individual choice, with strong links to social inequalities.

The prevention plan clearly highlights a life course approach to tackling inequalities resulting from poor lifestyle choices, with specific recommendations for primary care over the next five years. Whilst the prevention plan provides a blueprint for tackling health inequalities at all ages, variation exists across the City. With this in mind, Public Health and WCCG have developed locality based health profiles, to support the commissioning of services to meet variation in need in line with our duties under section 14T of the Local Government and Public Involvement in Health Act 2007.. Collaborative work has already commenced between Public Health and GP practices to use the consultation of childhood immunisations to identify numbers of parents who smoke and promote to them smoking cessation and smoke-free homes. Overall, the recommendations in the Public Health Prevention Plan will support the CCG to deliver against the Sustainability and Transformation Plan priority by addressing prevention and reducing inequalities in health and wellbeing.

The WCCG's Primary Care Strategy recognises the need to ensure the most vulnerable groups have access to targeted primary care services. Following the findings of a Public Health comprehensive health needs assessment of migrants in Wolverhampton, we are investing in a GP enhanced service for new arrivals. This work will, in conjunction with the Refugee and Migrant Centre, seek to encourage new arrivals to register with primary care, and access

services targeted to their health needs. Work was completed this year to educate GP Practice staff on both migrant and New Patient Registration in Primary Care.

Better Care Programme

The Better Care Programme (supported by Better Care Fund (BCF)) continues to progress at scale and pace with workstreams in operation that target the areas that we will continue to focus on throughout 16-17:

- Community and primary care
- Dementia
- Mental health
- Intermediate care/reablement.

In addition to these workstreams, the Better Care Programme has committed to develop additional workstreams to focus on:

- Integration (Estates, IT, Joint Commissioning)
- Frail Elderly
- Adult Community Care (the merging of the Community and Primary Care and Intermediate Care/ Reablement)
- Child and Adolescent Mental Health Services

Within each workstream, there have several projects which we will carry forward in to 16-17 and develop further. Schemes such as the Mental Health Psychiatric Liaison Team and Street Triage Service have seen a great impact on the reduction in emergency admissions at the hospital and will continue to develop throughout the next financial year. Also, currently operating as a pilot, the new Rapid Response Service has been greatly received by health and social care professionals and patients and will be mainstreamed and integrated within our existing Community Services contract.

Throughout the second half of 2015-16, the Programme Management Office have undertaken a lessons learned exercise to build on the robustness of the Better Care programme for 16-17 and have worked closely with our key partners to align the programme to each organisations strategic plan allowing the Better Care Programme to be the vehicle of delivery for these where possible.

The Better Care Programme has developed a detailed implementation plan for 16-17 and a robust benefits realisation plan, which will be reviewed by the Health and Wellbeing Board in April 2016. We continue to make good use of our integrated governance and delivery structures, including key partners such as Wolverhampton City Council and The Royal Wolverhampton NHS Trust. We have also strengthened GP representation on our work streams and will continue to build in Voluntary Sector representation.

The CCG, with support from Wolverhampton Voluntary Sector Council (WVSC), was successful in gaining a grant from the Big Lottery Commissioning Better Outcomes Fund to develop a

Business Case that appraises the option of using a Social Impact Bond to finance Voluntary and Community Sector (VCS) preventative well-being interventions for older people. The CCG's overall aim is to make savings by reducing ambulance call outs, emergency hospital admissions, and delayed discharges of older people.

A consultant (Natasha Jolob of Kai-zen) has been commissioned to support the CCG to develop the Business Case and appraise the options. A project plan has been developed and delivery involves needs assessment, evaluation, identifying evidence-based interventions, designing the model, engaging with social investors, and cost benefit analysis. At present the focus is on reducing emergency attendances and admissions, ambulance call outs and delayed discharges of older people with at least 2 long-term conditions, in poverty. We focused on this area because we did some baseline research for a Public Health Transformation project with the Council that identified a link between poverty, long-term conditions, older people and hospital admissions. We need to test this as part of the Business Case, and we can change the potential cohort depending on the research results (in fact we have already identified that isolation and living alone is an issue, and not just poverty).

The Better Care Programme will continue to have a positive effect on reducing admissions in the future. This is based against targeted Hospital Reference Group (HRG) Codes to try and reduce the None Elective Surgeries (NELS) by 3.5% for 16-17. Dementia diagnosis rates in Wolverhampton put us second across the whole of the West Midlands and above national average. Reablement figures currently show that Wolverhampton is rated in the top quartile amongst comparator authorities and the upper mid quartile within the region, demonstrating that older people within the City are being helped to remain independent.

Improving the quality of services

We have a duty to commission safe, high-quality, and value for money health services for the people of Wolverhampton in line with our duties under section 14R of the Local Government and Public Involvement in Health Act 2007.

Our commitment to driving quality, improved patient experience and safety is a 'golden thread' through all our commissioned services: robust quality schedules are built into all contracts, along with a well-applied governance and assurance framework to address concerns.

We are committed to:

- **Improving patient involvement, feedback and dignity**: we work with the local community to hear their experiences of care so that we can learn more about the care they are receiving this helps us to work together to co-produce service changes that lead to improvements in service provision.
- **Learning from the national reports and inquiries**: we continue to recognise learning opportunities identified in reports and inquiries undertaken involving healthcare commissioners and providers elsewhere in the country. This enables us to recognise what the impact may be locally and to make changes to prevent problems arising in Wolverhampton.

- **The Friends and Family Test (FFT)**: this is another opportunity for us to hear patient feedback, we continue to encourage providers to ensure they make best use of the information available from the Friends and Family Test, this spans not only hospital settings but also primary care so that it can be used an indicator of provider service quality and to highlight areas for improvement.
- **Infection prevention**: national and local strategies support the overall aim to deliver harm-free care in a range of care settings. Infection rates are a high priority in the city and the work that continues to be undertaken helps to sustain low infection rates. Where there are increased incidents we work together to understand the reasons for this so that experiences and the effectiveness of healthcare can be as positive as possible.
- **The 'Sign up to Safety' pledge**: our plans are well underway to continue to ensure we continuously learn and improve standards of safe care in the city.
- **Commissioning and delivering services that are compliant with National Institute for Health and Care Excellence (NICE) guidance and quality standards:** improvements in medicine and treatment are made available to patients in line with national guidance. This enables the most up to date and effective care and treatment to be provided to treat the conditions our patients are experiencing.
- **Safeguarding**: We continue to ensure we have the appropriate systems in place for discharging our statutory duties in terms of safeguarding Adults, Children and Looked After Children. In addition, we gain assurances from the organisations from which we commission services they have effective safeguarding arrangements in place and monitor their compliance with their safeguarding duties. There is continued work with others to ensure critical services are in place to respond to children and adults who are at risk or who have been harmed, in order to deliver improved outcomes and life chances for the most vulnerable.
- **Our Care Homes Improvement Plan**: we have made great progress in year two of our plan to improve the standards of safety, patient experience and effectiveness of the care provided in care homes. There is more work to be done to take this work to the next level to ensure that, where NHS funded care is provided, it is equivocal to the standards we expect to be achieved in our care homes framework.

Patient safety

We continue to closely monitor serious incidents that arise involving our patients. This enables us to identify learning opportunities and be assured that care in those settings has been investigated to identify what went wrong and what action is required to prevent further occurrences. We strive to ensure that care provided for our patients is as safe as possible. We have seen a reduction in 'Never Events' and continue to work with our providers to ensure sufficient controls are in place to prevent further incidents of this type occurring again in the future.

Put Safety First – we are committed to working with our providers to reduce avoidable harm. We have seen a reduction in avoidable falls, avoidable pressure ulcers and implementation of Sepsis. Other achievements include preventing admissions to hospital and changing the way patients manage long term conditions through services being available closer to home.

Continually learn – our commitment is to understanding where things have gone wrong, where arrangements are not quite right and where there is room for improvement is continually being considered so that we learn to make care and services safer.

Honesty – being open and honest about patient safety is a value we take seriously and will continue to ensure that patients and their families are kept informed if something goes wrong.

Collaborate – wherever possible we work together across health and social care settings in Wolverhampton and neighbouring towns to enable healthcare to be as equitable and patient centred as possible.

Support – supporting people when things go wrong and providing advice on how to make improvements enables us to work together with patients and other stakeholders and, where we are able to, we celebrate and share success.

Developing mental health services

This year we have continued to work towards giving mental health services the same priority as physical health services across all age groups.

In order to improve clinical outcomes, particularly for people with continuing and longer-term needs, we have continued to develop urgent and planned mental health care pathways as part of our Better Care integration. In the future this work will be aligned with the Wolverhampton Crisis Concordat.

We have also built on the positive impact of existing schemes, such as the Hospital Discharge Service, the Liaison Psychiatry Service, and the Street Triage Service. This is in order to improve urgent mental health care across mental health, police, ambulance and acute hospital services.

Looking forward into 2016/17, the mental health urgent care pathway will look to include a focus on dementia. As well as delivering our Local CAMHS Transformation Plan with improved crisis and home treatment and community services for children and young people. Further to this we have planned to develop and re-specify local community services to improve responsiveness and referral to treatment times. Across the model there will be a focus on intervening early and maintaining a correct level of support to ensure that people stay well and maintain recovery. This will include services for people with a learning disability and / or autism as we will work with local partners to deliver our Transforming Care Plan. The plan will involve working closely with Local Authority colleagues to develop the portfolio and pathway of services that offer supported accommodation and nursing or residential care.

To ensure that, wherever feasible, people from Wolverhampton can access care as close to home as possible, we work with providers and colleagues within the Local Authority to commission community services based care pathways and care packages that provide safe, sound and supportive care for people of all ages. At the same time we will focus on bringing patients closer to home where they are currently being cared for outside of Wolverhampton.

This will improve their experience and outcomes. We also commission services in a way that will improve value for money and financial sustainability.

Urgent and emergency care services

Over the last year the CCG published the joint strategy for urgent and emergency care in Wolverhampton up to 2016/17. These plans were finalised after receiving overwhelming support from the public and patients as well as the support of other health and social care bodies locally, including the independent consumer champion Healthwatch Wolverhampton and the Wolverhampton Health and Wellbeing Board.

In summary, the plans describe how the Health Economy will bring many urgent and emergency care services together into a new purpose-built centre, based at New Cross Hospital which will be open all day, every day.

One element of these plans is the building of a new Urgent and Emergency Care Centre at New Cross. This was successfully completed and opened in November 2015. The new centre accommodates a number of services including the new Emergency Department. The second main element of the plans is the development of an Urgent Care Centre. The Walk in Centre at Showell Park and the GP Out of Hours Service to come together to form the Urgent Care Centre based in the new Urgent and Emergency Centre on the first floor above the new Emergency Department. This will mean that any patients who self-present to the Emergency Department will have to the opportunity to speak to a nurse to determine if their care can be managed more appropriately in the Urgent Care Centre.

The CCG met its obligation under the rules that govern procurement, choice and competition by going out to the market to secure the most suitable provider to deliver this service. Vocare were the successful organisation and therefore they began running the new Urgent Care Centre from 1 April 2016. Vocare have a significant level of experience in delivering urgent care centres, out of hours services and NHS 111 across the country.

Clinicians, NHS managers and patient groups will be closely monitoring the new service over the next year to ensure it is of high quality and meets the needs of patients and public.

Prior to the Urgent Care Centre opening we circulated various communications to ensure the patients and public are aware of the changes. This included targeted communication directly to service users of Showell Park Walk in Centre and GP out of hours, leaflet drops in neighbouring areas, posters and temporary signage. It will also include direct communication to GP practices and health & Social Care partners. There will be targeted messages to specific patient groups, travelling communities and the refugee and migrant community who are new to the city.

NHS111 services will be further developed over the next year to ensure they are integrated with the GP Out of Hours Service to provide a seamless service to patients who call NHS111 and need to speak to a clinician.

Musculoskeletal service

During 2014/15 the CCG recognised that it needed to do things differently to meet the current and future demand in musculoskeletal services. Patients with musculoskeletal problems often need assessment and treatment from several different places and our plans are to make the process more effective and much better for the patient by developing a joined-up approach. This needs to be without reducing services to diagnose, treat and care for this sort of injury or condition, or to limit people's options.

Over the last year this idea has grown and we held a public consultation between March and June asking for views on musculoskeletal services. A large majority of people agreed with the CCG's proposal and we are in the process of identifying the new provider. We hope to have the new MSK service in place and operational from early 2017.

MASH

The Multi-Agency Safeguarding Hub (MASH) is the development of a new multi-agency team which will strengthen safeguarding for children, young people and vulnerable adults. Professionals from across the statutory sector – including the council, police and probation services, schools and health providers will work much more closely in the new hub which was launched in January 2016.

The MASH acts as a single central point for Early Help, initially focusing on safeguarding children and young people. The hub setting means that there is now the ability to have more joint assessment and decisions between health and social care on which course of action would be the best to take for the patient.

The MASH is in its early stages but it will later expand to cover vulnerable adults.

Public involvement and consultation

During 2015 we have consulted with the public and other stakeholders to ensure they are advising and influencing the commissioning of healthcare services for the residents of Wolverhampton in line with our duties under section 14Z2 of the Local Government and Public Involvement in Health Act 2007..

MSK - We held a public consultation between March and June asking for views on musculoskeletal services. A large majority of people agreed with the CCG's proposal and we are in the process of identifying the new provider.

Commissioning Intentions – As part of the Patient Engagement Commissioning Cycle, we held two targeted engagement workshops during the year, one being targeted at Mental Health Service users and providers and the second, Care Closer to Home. Both events shaped and informed the commissioning intentions for which services will be commissioned in 2016/17. We have already begun planning for our public events in 2016 to shape the commissioning intentions for 2017/18. Patients are involved and inform in all parts of Engagement Cycle.

'Take Over Day' - On Thursday 19 November we took part in 'Take Over Challenge'. The Take Over Challenge is a national initiative led by the Children's Commissioner for England, which places young people into decision-making roles. This means they are able to be involved with decision making and influence both policy and practice to develop better services. Three young people from the organisation Changing Young Lives took over the roles of Accountable Officer, Chair and Director of Strategy and Transformation. The day enabled the CCG to better understand young people's views and the services we commission for them, so that in the future we can improve services to meet their needs.

Grant Policy – We worked with our colleagues in Heathwatch to develop an engagement strategy to complement our Grant Policy. This policy will allow Third Sector organisations to apply to be directly commissioned by WCCG for their work on social isolation, supporting independent living, people living with long term conditions and those frail and elderly. Phase one has already been completed and funding will commence in 2016/17. Phase two is planned and will begin later on this year.

Feedback mechanisms

We receive concerns, compliments and comments via our many communication channels; these are then fed back to our Quality and Safety and Commissioning teams in the CCG. These channels are our website, local media and social media. It is also via these outlets that we inform the public about the outcomes of our engagement work and how public and patient views have informed our decisions. Our Lay Member for Public and Patient Involvement represents public and patient views at our Governing Body meetings, and ensures that we are fulfilling our obligations in relation to engagement and consultation.

Patients Partners scheme

Over this year our Patient Partner – free membership scheme has been refreshed to ensure that we have a comprehensive list of active members and a record of their areas of interests. We have devised an online form and created a welcome letter to ensure all members are able to sign up at their convenience. We have several of these members who have signed up to become ambassadors of the CCG and we will be developing this aspect of the scheme over the next year.

Public and stakeholder involvement groups

Patient Participation Groups - The number of Patient Participation Groups (PPGs) in our GP practices has continued to grow over the past year with 39 practices now holding PPGs. The CCG has produced a guidance pack which includes templates for the terms of reference and the benefits of having a PPG. The CCG will be encouraging and supporting all the remaining practices to form PPGs. We meet quarterly with the PPG Chairs to inform and update them on WCCG workstreams. We also feedback any of their issues to the Governing Body through our Lay Member.

Joint Engagement Assurance Group –We continued to meet quarterly to share engagement opportunities across the city with our stakeholders and provide assurance to the engagement framework effectiveness.

Citizen's Forum – We continue to meet quarterly with community leaders from faith and disease specific groups to share our current projects. Towards the latter end of the year this group merged with our PPG Chairs meeting and are very active virtually.

Annual General Meeting (AGM)

On Wednesday 29 July we held our second AGM since becoming a CCG. Over 120 people attended, partners from local groups and other organisations as well as clinicians. The event included a presentation about what the CCG has achieved in the last 12 months and the challenges the CCG faces in the future. Questions were posed to our senior management team and an award was presented to our Patient Champion of the Year. The transcript from the full question and answer session is available on our website.

http://wolverhamptonccg.nhs.uk/news/186-agm-2015-success

Marketing campaigns

We have completed a number of campaigns over the past twelve months, including highlighting the current threat of antibiotic resistance as well as encouraging patients to consider alternatives to accident and emergency departments.

The winter campaign this year was centred on the theme of 'Stay well this winter'. This campaign highlighted the importance of preparing for the cold weather and the availability of pharmacies as a point of advice.

Over the past year, we have organised and taken part in a number of events to raise awareness of the CCG and of various specific conditions. For example during May we worked in partnership with Wolverhampton Dementia Action Alliance to launch the Dementia Strategy with a week of events across the City.

Dr Helen Hibbs

Accountable Officer
[x] May 2016

ACCOUNTABILITY REPORT

Members Report

Our member practices

Practice Name	Address
Dr S Agrawal Tudor Medical Practice	1 Tudor Road, Heath Town Wolverhampton, WV10 0LT
Dr S Asghar Caerleon Surgery	Dover Street Bilston Wolverhampton, WV14 6AL
Dr D Bagary MGS Medical Practice	191 First Avenue, Low Hill Wolverhampton, WV10 9SX
Dr R Bilas and A Thomas	75 Griffiths Drive, Ashmore Park, Wednesfield, WV11 2JN
Dr D Bush Penn Surgery	2a Coalway Road, Penn Wolverhampton, WV3 7LR
Dr U Chelliah Showell Park	Fifth Avenue Wolverhampton, WV10 0HP
Dr A Christopher Heath Town Medical Centre	Chervil Rise, Heath Town Wolverhampton
Dr S Cowen and Partners The Surgery	119 Coalway Road, Penn Wolverhampton, WV3 7NA
Dr G Dhillon Ashfield Surgery	39 Ashfield Road, Fordhouses Wolverhampton, WV10 6QX
Dr J Fowler	470 Stafford Road Wolverhampton, WV10 6AR
Dr George and Partner Ashmore Park Health Centre	Griffiths Drive, Ashmore Park Wednesfield, WV11 2LH
Dr Hibbs and Partners Parkfield Medical Practice	255 Parkfield Road, Parkfields Wolverhampton WV14 0EE
Intrahealth (Dr V Rai) Bilston Urban Village Medical Centre	Bankfield Road, Bilston Wolverhampton WV14 0EE
Intrahealth Pennfields Medical Centre	Upper Zoar Street, Pennfields Wolverhampton, WV3 0JH

Dr Jackson and Partners Tettenhall Medical Practice	Lower Street Tettenhall Wolverhampton, WV6 9LL
Dr Jones and Partners Woden Road Surgery	Woden Road, Tettenhall Wood Wolverhampton, WV6 8NF
Dr M Kainth Primrose Lane Health Centre	Primrose Lane, Low Hill Wolverhampton, WV2 3BT
Dr M Kehler Keats Grove Surgery	7 Keats Grove, The Scotlands Wolverhampton, WV10 8RN
Dr A Khan Duncan Street Primary Care Centre	Duncan Street, Blakenhall Wolverhampton, WV2 3AN
Dr R Kharwadkar Fordhouses Medical Centre	68 Marsh Lane, Fordhouses Woverhampton, WV10 8LY
Dr K Krishan Mayfields Medical Centre	272 Willenhall Road Wolverhampton, WV1 2GZ
Dr C Lal Bradley Medical Centre	83-84 Hall Green Street, Bradley Wolverhampton, WV14 8TH
Dr Libberton	60 Cannock Road Wednesfield, WV10 9PG
Dr G Mahay Poplars Medical Practice	Third Avenue, Low Hill Wolverhampton, WV10 6UF
Dr S Mittal Probert Road Surgery	Probert Road, Oxley Wolverhampton, WV10 6UF
Dr J Morgans and Partners	81 Prestwood Road West Wednesfield, WV11 1HT
Dr N Mudigonda Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr P Mundlur and Dr S Reehana All Saints	17 Cartwright Street, All Saints Wolverhampton, WV10 8RN
Dr V Pahwa Bilston Health Centre	130a Park Street South, Goldthorn Hill Wolverhampton, WV2 3JF
Dr J Parkes Alfred Squire Road Health Centre	Alfred Squire Road Wednesfield, WV11 1XU
Parkfields Wolverhampton Medical Services	Herbert Street, Ettingshall

Ltd Ettingshall Medical Centre	Wolverhampton, WV14 0NF
Dr Passi and Handa Leicester Street Medical Centre	Leicester Street, Whitmore Reans, Wolverhampton, WV6 0PS
Dr G Pickavance and Partners The Newbridge Surgery	255 Tettenhall Road Wolverhampton, WV6 0DE
Dr S Ravindran and Majid East Park Medical Centre	Jonesfield Cresent, East Park Wolverhampton WV6 0DE
Dr H Richardson and Partners Thornley Street Surgery	40 Thornley Street, Wolverhampton, WV1 1JP
Dr A Saini and Partner	62-64 Church Street, Bilston Wolverhampton, WV14 0AX
Dr M Sidhu and Partners Lea Road Medical Practice	35 Lea Road, Pennfields Wolverhampton, WV3 0LS
Dr A Sharma Bilston Health Centre	Prouds Lane, Bilston Wolverhampton, WV14 6PW
Dr S Suryani The Surgery	Hill Street, Bradley Wolverhampton WV14 8SB
Dr S Taylor and Cam	80 Tettenhall Road, Tettenhall Wolverhampton, WV1 4TF
Dr P Venkataramanan and Partner Grove Medical Centre	175 Steelhouse Lane Wolverhampton, WV2 2AU
Dr Vij and Partners Whitmore Reans Health Centre	Lowe Street, Whitmore Reans Wolverhampton, WV6 0QL
Dr Wagstaff and Partners Penn Manor Medical Centre	Castlecroft Avenue Wolverhampton WV3 8JN
Dr White and Partners Penn Manor Medical Centre	Manor Road, Penn Wolverhampton, WV6 0DD
Drs Williams, De Rosa and Koodaruth Warstones Health Centre	Pinfold Grove, Warstones Wolverhampton, WV4 4PS

Our Governing Body

The Governing Body is responsible in law for ensuring that the CCG exercises its functions effectively, efficiently and economically in accordance with the principles of good governance. It does this by leading on the setting of the vision and strategy, budgets and commissioning plans for the organisation to ensure services are commissioned effectively in order to achieve our vision of delivering the right care, in the right place at the right time.

During 2015/16 the members of the Governing Body were:

Chair – Dr Dan De Rosa

Accountable Officer – Dr Helen Hibbs

Other elected GP members:

Dr David Bush

Dr Sudhir Handa

Dr Manjit Kainth

Dr Julian Morgans

Dr Rajshree Rajcholan

Dr Anant Sharma

Chief Finance and Operating Officer – Claire Skidmore

Director of Strategy and Transformation – Steven Marshall

Executive Lead for Nursing and Quality – Manjeet Kaur-Garcha

Lay Member for Audit and Governance – Jim Oatridge OBE

Lay Member for Public and Patient Involvement (Deputy Chair) – Patricia Roberts

Practice Manager Representative – Helen Ryan

Secondary Care Consultant – Tony Fox

With the exception of Dr Handa, who resigned in October 2015, all of these members were in post for the full year. Dr Handa had been a member of the CCG's Governing Body since the CCG was authorised in 2013, acting as Finance and Performance lead and chairing the Finance and Performance committee. In addition, Dr Sharma has notified the Chairman that he will be standing down from his role at the end of this year. The Governing Body has passed thanks on to both of them for their contribution to the CCG.

Audit and Governance Committee members

The Governing Body is required to appoint an Audit and Governance Committee, chaired by the Lay Member for Audit and Governance. The committee's other members are independent lay members with significant experience of audit and financial matters:

- Jim Oatridge OBE (Chair)
- Peter Price
- Les Trigg

Full details of the membership of the other Governing Body committees can be found in the Governance Statement. Details of the members and work of the Remuneration Committee can be found in the Remuneration Report.

Governing Body member interests

Details of the interests held by members of the Governing Body are available on our website at http://www.wolverhamptonccg.nhs.uk/about-us/declaration-of-interests.

Statement as to disclosure to auditors

For each Governing Body member at the time the report is approved:

- so far as the Governing Body member is aware, there is no relevant audit information of which the CCG's auditor is unaware
- they have taken all the steps they should have taken to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Member engagement

The relationship between our Governing Body and GP membership is crucial to the CCG's success. We are keen to foster effective engagement and ownership of our plans by our 46 GP member practices and ensure the patient voice is reflected throughout the process.

Our monthly GP locality meetings, attended by GPs and practice managers, have continued, and this engagement with our membership has been essential to the decision making of the CCG. Following last year's changes to our constitution, the Chairs of the localities now sit on the Governing Body, providing a direct link from their locality into the CCG's wider decision making processes. Attendance at these meetings has continued to be strong, leading to constructive discussion to support decision making. We have also continued to circulate regular information and updates to our members by email, e-newsletter and through our intranet.

We have developed a programme of practice support visits where practices are given an opportunity to review their performance, including benchmarking with other practices in the locality. We are also facilitating a peer review process for practices to discuss best practice on referrals into secondary care. Meanwhile, our nationally recognised Quality Matters reporting site is used by member practices to share healthcare experiences with the quality and risk team.

Our Members have approved our primary care strategy during this year and this sets out how we will use our quarterly member meetings to drive the delivery of the strategy. This will include an increasing focus on the role of member practices as commissioners of services, which will also be a key area of focus for locality meetings during the year.

We also hold regular ‘Team W’ – GP and practice staff protected learning time – educational events. These are used to keep practices updated on new developments and to discuss pathway redesign and provide a forum for high quality training events on key issues for practice staff.

Dr Helen Hibbs

Accountable Officer
[x] May 2016

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 Dr Helen Hibbs to be the Accountable Officer of the Clinical Commissioning Group.

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

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

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

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

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

I also confirm that:

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

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

Dr Helen Hibbs

Accountable Officer
[x] May 2016

Governance Statement

Introduction and context

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

As at 1 April 2015, the Clinical Commissioning Group was licensed without conditions. The group has a revenue income of £341M for 2015/16 and a workforce of around 70 staff. Services are delivered through GPs as Commissioners supported by a small corporate team function. The management structure is made up of two interlinked elements, the Governing Body, which is chaired by a GP elected across our 46 practices (see below for the full membership) and the Executive Team made up of the Accountable Officer and three other Directors.

Scope of responsibility

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

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. This Governance Statement is intended to demonstrate the Clinical Commissioning Group's compliance with the principles set out in Code and the Audit and Governance Committee keeps this under regular review.

For the financial year ended 31 March 2016, and up to the date of signing this statement, we complied with the relevant provisions set out in the Code, and applied the principles of the Code. Steps have been taken during the year to address minor issues identified through the Audit Committee's review process, these are detailed throughout the statement but in particular we would like to highlight the following developments:-

- the induction of new members of the Governing Body;
- on-going work to support the organisational development of the Governing Body, including individual member appraisals.

The Clinical Commissioning Group Governance Framework

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

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

The Clinical Commissioning Group Constitution contains the following statement regarding Principles of Good Governance:

"In accordance with section 14L(2)(b) of the 2006 Act, the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) 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;

b) The Good Governance Standard for Public Services;

c) the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the 'Nolan Principles'

d) the seven key principles of the NHS Constitution;

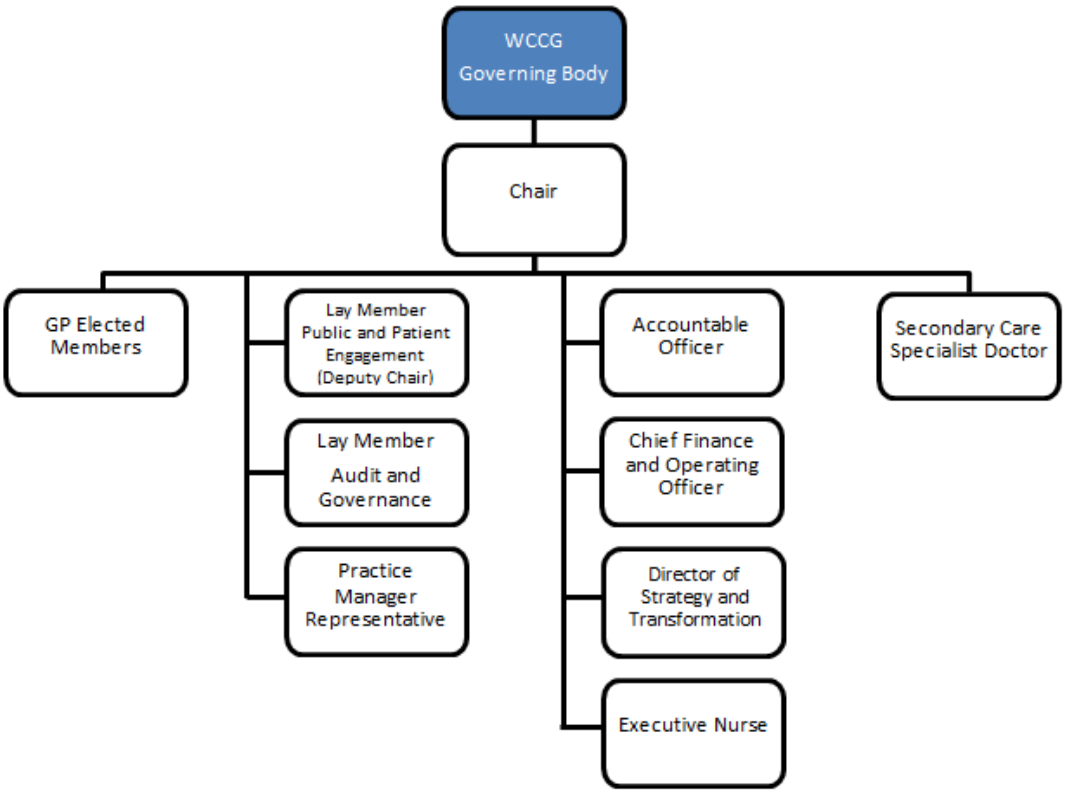
e) the Equality Act 2010."

Independent Committee Members are governed by the NHS Code of Accountability and Executive Directors by the Code of Conduct for NHS Managers. As part of the NHS Code of Accountability, all Governing Body members declare any relevant interests on a public register of Declarations of Interest.

The Clinical Commissioning Group upholds the Seven Principles of Conduct in Public Life known as the Nolan Principles[1] and consequently all Governing Body Members are duty bound to abide by them.

Our membership is currently constituted of 46 practices across Wolverhampton. The Governing Body acting on their behalf includes seven elected GP Members along with the Chair, Executive Members, Lay members, Practice Manager, Secondary Care Specialist and representatives from partner organisations. The structure is shown below:

[1] - *Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, and Leadership.*



Non-voting Observers from the Local Medical Council, City Council, Health and Wellbeing Board and Local Healthwatch also routinely attend Governing Body meetings.

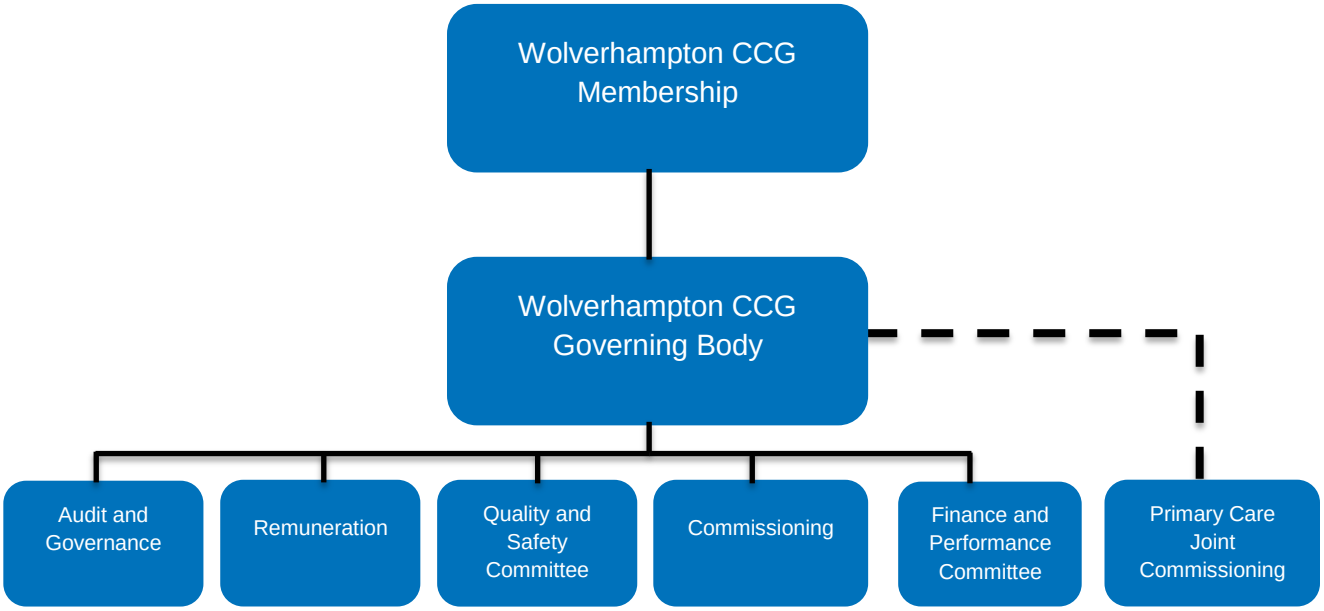
There are five Committees of the Governing Body within the Clinical Commissioning Group, each having delegated responsibilities:

- Audit & Governance
- Commissioning
- Finance & Performance
- Quality & Safety
- Remuneration

There is also a Joint Committee with NHS England for the Co-Commissioning of Primary Care. Each committee has an agreed Terms of Reference and established membership which are set out in the group's constitution http://wolverhamptonccg.nhs.uk/about-us/our-members-constitution.

The structure of the Committees of the Clinical Commissioning Group are detailed below:

WCCG Overall Governance Structure



Each of the Committees (with the exception of the newly established Primary Care Joint Commissioning Committee) has produced an Annual Report which can be made available upon request. These reports contain details of the membership and attendance records for the committee and list the standing items that have been managed by that committee throughout the year as well as highlighting other items of note.

The **Audit and Governance Committee,** as highlighted later in this statement, has a key role in the Group's risk management strategy. During the year it has fulfilled this role by maintaining an overview of the Clinical Commissioning Group's risk register and suggesting ways of improving the robustness of the reporting arrangements. It has also supported the development of the CCG's governance framework, including developing policy around Managing Conflicts Interests, Counter Fraud and Anti-Corruption and Whistleblowing. The Committee has also received reports on compliance with the UK Corporate Governance Code.

The **Quality and Safety Committee**, also plays a key role in risk management (highlighted below) and has received regular reports on the group's Broad Assurance Framework and Risk Register during the year. During the year, the Committee recommended changes to the Board Assurance Framework to reflect changes to the Assurance Framework for CCGs by NHS England. Where necessary, it has escalated issues for consideration by the Governing Board and provided assurance on action taking place. The Committee maintains an overview of a number of significant and potentially high risk issues, including Safeguarding and Information Governance. The Committee has recently begun work on a review of the Group's Risk Management Strategy which will continue in the new financial year.

The **Finance and Performance Committee** has provided the Governing Body with assurance around action taken to address identified issues and underlying risks relating to the group's finance position as well as the assurance provided to NHS England that the Group has met its financial planning requirements. It has also maintained an overview of performance against relevant targets (including NHS constitutional standards) and action taken to address issues. The Committee is responsible for monitoring the Group's performance against its statutory duty to reduce inequalities and has received assurance on work to achieve this. The Committee has recently decided to strengthen its membership with an additional experienced Lay Member to support the Clinical and Lay Governing Body Members on the committee in providing constructive challenge to the Executive Members.

The **Commissioning Committee** has supported the Governing Body in the delivery of its statutory responsibilities as a commissioner of healthcare. This has included providing assurance to the Governing Body on the operation of the group's contracting procedures and undertaking robust, risk based assessments of proposals for service review. This work has ensured that the Group has continued to commission value for money services that are effective deliver positive outcomes for patients.

The **Remuneration Committee,** in addition to its statutory role has delegated responsibility from the Governing Body for the approval of Human Resources Policies. These ensure that the group has an appropriate framework in place to deliver its responsibilities as an employer. The Committee has also considered arrangements for succession planning for Governing Body Members when their term of office ends.

Following receipt of approval with effect from 1 October 2105, the CCG has begun to jointly co-commission Primary Medical Services with NHS England. These arrangements are discharged through the **Primary Care Joint Commissioning Committee.** This Committee is early in its development and has begun by ensuring its Terms of Reference and support arrangements are fit for purpose. The CCG has not delegated any formal powers to the Joint Committee, so the functions it exercises are on behalf of NHS England.

The incorporation of the Joint Commissioning Committee into the governance structure has been the most significant change to the CCG's constitution during the year and was formalised through a variation in November 2015. Other changes made at this time, included amendments to the terms of reference for the Quality and Safety and Commissioning Committees to update the quorum to ensure that the committees always include a clinical perspective and minor changes to our Prime Financial Policies. This work followed on from last year's full scale review of the Constitution and the changes that were made.

During the year, we have also continued our on-going review of the policy documents that support the Governance framework. This includes further reviews of existing policies relating to declaring interests and managing potential conflicts of interest and whistleblowing arrangements. Additional work has also been completed during the year to ensure the CCG has adequate arrangements to counter the risk of fraud and corruption.

Arrangements are in place for the discharge of statutory functions. These have been checked for any irregularities, and they are legally compliant.

The Clinical Commissioning Group Risk Management Framework

The Clinical Commissioning Group has put in place a comprehensive structure of controls to co-ordinate and manage risk within the organisation. This consists of rigid lines of accountability through which issues of risk can be debated and the effectiveness of our risk management arrangements assured.

These controls are underpinned through an integrated governance approach to examine the risks to our strategic and operational objectives, using the same methodology no matter the nature and context of the risk. This approach enables us to manage risk in an identical way across services and provides a uniform method of assurance.

Corporate responsibilities for the Governing Body, myself as Accountable Officer, the other Directors, Heads of Service and all staff are set out as well as the specific roles for the Chief Finance Officer, Executive Lead Nurse and Head of Quality and Risk. The strategy also sets out the relevant aspects of the following committees' terms of reference:-

Quality & Safety Committee responsible for leading the risk management process, taking a strategic view of governance, giving directions to the other Clinical Commissioning Group committees and groups regarding management of risk and receiving assurance from these Groups where NHS Standards are being achieved/not achieved. Its remit includes Business Continuity, Quality and Clinical governance, Risk management (including health & safety), Security management and information governance.

It keeps under active review the content of the corporate risk register, addressing corporate issues, and provides assurances to the Board that directorates and departments within the Clinical Commissioning Group are managing their risks effectively.

The Quality & Safety Committee is accountable to the Clinical Commissioning Group Governing Body through regular integrated assurance reports. The Membership of the Committee includes both patient representatives and representatives from stakeholder organisations (including the local authority). This provides an opportunity for these stakeholders to be actively involved in the management of the risks that affect them.

Audit and Governance Committee fulfils the role of scrutiny and verification of the entire process of governance in accordance with the requirements of standing financial guidance.

The risk management arrangements recognise that it is impossible to eliminate all risks but, as general principle, set out that the Clinical Commissioning Group will seek to eliminate and control all risks which have the potential to:

- harm our staff, service users, visitors and other stakeholders;
- have a high potential for incidents to occur;
- result in loss of public confidence in us and/or our partner agencies;

- have severe financial consequences which would prevent us from carrying out our functions on behalf of our residents.

To achieve this, the arrangements highlight that a robust, continuous risk assessment process is essential, requiring clear arrangements for identifying recording and reviewing risks and set out processes to achieve this based upon clear principles to be adopted by risk handlers. These processes analyse the likelihood, consequence and controllability of the identified risk to rate the risk using a 'Red Amber Green' scale to determine action to be taken. They also highlight that individual managers and heads of service are responsible for profiling risks within their areas of responsibility and set out arrangements for escalating increasing risks or those not progressing satisfactorily.

As a general principle the Clinical Commissioning Group has determined the following levels of risk:

Acceptable Risks

Risks in the low (green) category are considered to be an "Acceptable risk" and their existing controls are regularly monitored. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden.

Unacceptable Risks

Risks in the medium (amber) categories are considered to be "Unacceptable risks" and efforts are made to reduce the risk, weighing up the costs of prevention against the impact of an event.

Significant Unacceptable Risks

Risks in the extreme (red) category will be considered to be "Significant risks" and immediate action must be taken to put in control measures to manage the risk. A number of control measures may be required involving significant resources to reduce the risk. Where the risk involves work in progress urgent action should be taken.

The overall risk management strategy is also supported by specific arrangements to identify and manage risks in key areas. This includes a robust counter fraud strategy and whistleblowing protocols and work continues to ensure risk management is embedded across the organisation. All formal committee papers include sections that require report authors to assess both risk implications and the relevant domains within the assurance framework. This has been strengthened during the year to include stronger references to individual risks and issues and build linkages into the Board Assurance Framework. This approach is being mirrored through other internal processes, particularly through the development of projects for the QIPP programme. The intention of all of this work is to ensure that decision making within the organisation follows a robust process and that all of the relevant considerations are taken into account.

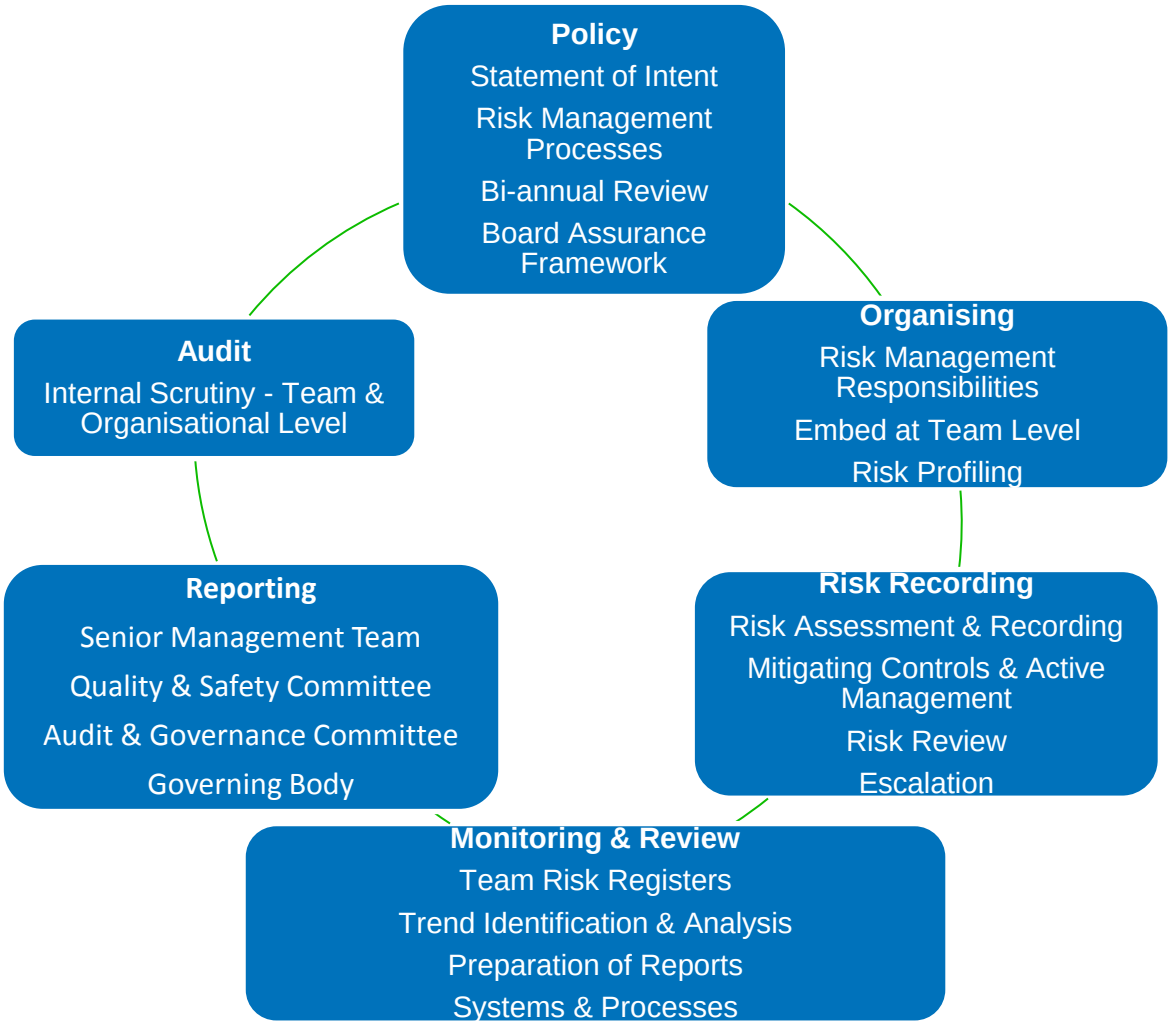
The Clinical Commissioning Group Internal Control Framework

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 Clinical Commissioning Group has a set of processes and procedures in place to ensure it delivers its policies, aims and objectives and this is audited internally. It is designed to identify and prioritise 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 is managed using an electronic database supplied by a nationally recognised risk management specialist, Datix. This 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. As highlighted above, this is based on the principles outlined in the risk management framework which clearly articulates the relevant roles and responsibilities of key individuals and teams as well as the overall corporate responsibilities of all staff. These overall arrangements are summarised in the diagram below:-



Information governance

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. The Group's Information Governance policy and staff handbook have been reviewed during the year to reflect national requirements. We have ensured all staff undertake annual information governance training and have a policy of spot checks to ensure staff are aware of their information governance roles and responsibilities. Every report submitted to formal committees includes details of any information governance implications and specific issues have been considered as part of the key risks identified by the group (see below for further details).

There are processes in place for incident reporting and investigation of serious incidents. We have taken steps during the year to develop information risk assessment and management procedures and a programme is in place to fully embed an information risk culture throughout the organisation. The Quality and Safety Committee are regularly updated on the operation of the Group's Information Governance framework, including details of information security incidents, learning from 'near misses' and compliance with the Freedom of Information Act.

Data security risks are managed using a variety of security tools and policies such as EAL4 firewalls, malicious code control, end point control, encryption management applied to all files transferred from CCG equipment and web filtering control. These systems are used to help control and where possible log device and user activity. Security tools are regularly updated to ensure that they keep abreast of the latest vulnerability exploits and PCs are regularly patched to ensure they are up-to-date with Microsoft Windows patches and other third party software such as Adobe, Java etc.

Audit records of access to PCs by individual accountable user accounts are logged. In addition access to files, folders and applications is restricted to authorised users and logging is in place to log the transfer of files through the Windows File System to removable media ICT System Administrators responsible for managing these servers and databases are also subject to a 'Code of Conduct' which dictates the expected professional, ethical and moral responsibilities of a user with elevated privileges.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. We have submitted a satisfactory level of compliance with this year's information governance toolkit assessment of 91% achieving Level 3 on the majority of requirements, an improvement from last years' submission.

Pension obligations

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

Equality, Diversity and Human Rights obligations

Control measures are in place to ensure that the Clinical Commissioning Group complies with the required public sector equality duty set out in the Equality Act 2010. We are continuing to ensure that robust and proportionate equality impact assessments form a key part of our decision making processes and training has been provided to staff and Governing Body members on the processes we have in place to achieve this.

Sustainable Development Obligations

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

In order to fulfil our responsibilities for the role we play, NHS Wolverhampton CCG has the developed the following sustainability mission statement located in our sustainable development management plan (SDMP): "To ensure that the healthcare system in Wolverhampton remains sustainable for the future."

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. We work closely with our accommodation partner Wolverhampton University to ensure our largest environmental impact (accommodation) is minimised. The University has a robust sustainability strategy and is committed to a 40% reduction in Carbon emissions by 2020 and is engaging on a range of initiatives to achieve this including voltage optimisation, piloting the use of a combined heat and power plant and LED light replacement. We encourage all our staff to work in partnership with the University and we are committed to working with them in the future to reduce our carbon footprint even further.

In order to embed sustainability within our business we consider both the social and environmental impact of our commissioning decisions, as well as assessing the sustainability of suppliers through the procurement process. One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan

(SDMP). We have established an SDMP during the year which has been approved by the Governing Body. The SDMP has set key milestones for embedding sustainability throughout the organisation across three key themes:-

- Developing an organisational infrastructure for sustainability
- Commissioning for Sustainability
- Being a Sustainable Organisation

Work since the plan was embedded has included the appointment of a Governing Body lead for sustainability (The Chief Finance and Operating Officer) and work to establish baselines for future activity. Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need for the development of a board approved plan for future climate change risks affecting our area.

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms. We have not currently established any strategic partnerships but will be actively considering this as part of the development of sustainability policies.

Risk assessment in relation to governance, risk management and internal control

This is directly linked to the Clinical Commissioning Group Risk Management Strategy (outlined above) and is underpinned by challenge from responsible committees and Internal Audit. The Governing Body maintains the overall oversight of the group's performance, tasking the Finance and Performance committee to undertake specific detailed support in this area.

Red risks that are currently open at the end of the year that have implications for governance are as follows:-

- **Better Care Fund – Financial risks**
  The CCG's integrated arrangements with the local authority through the Better Care Fund aim to deliver a reduction in emergency acute admissions. The agreement governing these arrangements recognises that there is a risk that, these reductions not occurring will result in a cost pressure for both partners. Whilst the arrangements in place are robust (underpinned by a Section 75 agreement) and effective in providing mitigating controls, the level of cost pressure involved means that the risk level is high.
- **NHS Constitutional Performance measures**
  Of the Key Performance Indicators the CCG has performance management responsibilities for, a number, including waiting time at Accident and Emergency and 62 day referral to treatment times for Cancer Referrals, have not reached required targets during the year. The CCG has been working closely with provider trusts to ensure action is taken to address this, including using contractual measures such as, Contract

Performance Notices, Remedial Action Plans (RAP's) and Contractual Sanctions as appropriate. The CCG has provided assurance to the Area Team using RAP actions and recovery trajectories to address the performance issues and recover performance against targets.

- **Primary Care Co-Commissioning**
  As highlighted above, the CCG has begun work to take on responsibilities for commissioning Primary Medical Services with NHS England. As this is a significant new area of work, there will be an impact on teams across the CCG and the staffing structure has been reviewed and new roles are being created to support delivery of our strategy for Primary Care.

There are also a number of other risks relating to existing contracts and services, including with vulnerable groups of patients such as children and young people with mental health needs or learning difficulties. These risks are being actively mitigated through discussion with providers and commissioning partners to ensure that agreed actions are taken and improvements delivered. A further risk based on the fact that a proportion of the required savings from the QIPP programme were not allocated to specific projects has been mitigated during the year. Robust and timely action during the year has ensured that a significant proportion of this requirement has been delivered and, while it is forecasted that there still will be a gap at the end of the year, this has been managed within the overall financial position.

During the year, to mitigate the impact of a number of key risks and to respond to the on-going challenges to deliver the Five Year Forward we have reviewed the Clinical Commissioning Group's leadership structure. This included bringing in interim support for Operations and development of a Primary Care Strategy and, more recently, the appointment of an Associate Director of Operations to increase capacity within the Leadership team. This will enable us to continue to develop our operating model and governance arrangements to ensure that we maintain focus on delivery of our ambitious plans and strategies. Member practices have agreed our Primary Care Strategy during the year, which will provide a focus for much this work and will involve responding to the challenges, including those around governance, of moving towards new models of care.

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

The organisations economy, efficiency and effectiveness of the use of resources is the responsibility of the Governing Body. The Governing Body undertakes fulfilling this responsibility via its committees whose job it is to deliver and be open to inspection. The Audit and Governance Committee is accountable to the group's Governing Body and its remit is to provide the Governing Body with an independent and objective view of the group's systems, information and compliance with laws, regulations and directions governing the group. It delivers this remit in the context of the group's priorities and the risks associated with achieving them.

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

The Group has robust measures in place to ensure that, where responsibilities are delegated to other organisations (such as the Commissioning Support Unit), assurance is provided to ensure that resources are used economically, efficiently and effectively. This includes ensuring that clear contracts are in place for the delivery of services that are then managed through the Group's contracting processes. Additionally, the Group's arrangements with Commissioning Support Unit ensure that both internal and external audit have adequate access to records to provide assurance on the effectiveness of these arrangements.

The Group's Pooled Fund arrangement with the City of Wolverhampton Council under the Better Care Fund is managed through a Section 75 agreement that details the responsibilities of the local authority as the host for the Pooled Fund and the associated Governance Arrangements. This arrangement has been reviewed by internal audit during the year and they have concluded that substantial assurance can be given that the controls are operating effectively.

No feedback has been received through these mechanisms or external reports into organisations with which the Group has delegated arrangements that provides evidence of internal control failures or poor risk management.

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 Clinical Commissioning Group.

Capacity to handle risk

The Clinical Commissioning Group has a fully staffed in house quality team which is responsible for risk management including incidents and risk recording. These are captured in a central management system (Datix) which is used as the basis for reporting.

Risk is seen as the responsibility of every member and employee of the Clinical Commissioning Group. Risk is owned at all levels and there is a robust challenge system in place at Senior Management Team level as well as Directors and Committees.

The Risk Management Strategy aims to provide the Clinical Commissioning Group with a framework for the development of a robust risk management framework and related processes throughout the organisation.

The Quality and Risk Team provide one to one and group demonstrations on how to use the Clinical Commissioning Groups Datix system. These sessions include advice and guidance on how to document a risk and manage it thereafter. Emphasis is placed upon the importance of linking all risks to the Clinical Commissioning Group's Board Assurance Framework, the appropriate domain(s) are linked to each risk to enable the responsible committees and lead

directors to regularly review the influencing factors from new risks and their impact on the control measures for the respective assurance framework domain(s).

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 annual audit letter and other reports, including reports on the internal controls in organisations which support us, including NHS Shared Business Services and the Commissioning Support Unit.

The *Board Assurance Framework,* which is based on the national assurance framework for CCG's used by NHS England itself provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed.

I have reviewed the work of both the Audit and Governance and Quality and Safety Committees in discharging their responsibilities set out in the risk management strategy. This ensures that there is robust and regular monitoring of the adequacy of the effectiveness of the system of Internal Control throughout the year, which is reported to the Governing Body on a regular basis. This review highlights the Clinical Commissioning Group's commitment to securing continuous improvement of the system and the approach to identifying and addressing any weaknesses that have been identified and as such I confirm that the systems are currently effective. 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 Governance Committee and Quality and Safety committee.

NHS England and the CCG are engaged in a process of continuous assessment against the defined Assurance Framework. This includes monthly discussions on performance issues, an on-going work plan to provide assurance around Financial Management and scrutinised self-assessment of the CCG's governance and leadership arrangements. As part of this process Executive Directors also attend risk based checkpoint reviews with NHSE where the NHSE Area Team scrutinise the effectiveness of on-going performance. The considerable improvements made by the CCG to improve performance and address financial challenges recognised in the last year mean that it is currently assured as good. This means that, on the risk based system used by the Area Team the CCG will move to twice yearly assessments.

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 significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls

put the achievement of particular objectives at risk. During the year the Internal Audit team issued the following audit report with a conclusion of 'requires improvement':

- **Penetration Testing –** Issues were identified in relation to a number of issues relating to the security of the CCG website, including vulnerability to 'phishing attacks'. Staff and Governing Body members have been reminded of their responsibilities through Information Governance training and the CCG are working with our website provider to address other areas of weakness. The report concluded that, whilst there were vulnerabilities, the website was unlikely to be successfully attacked without a threat actor guessing passwords or obtaining user names and passwords.

During the year the Internal Audit team did not issue any audit reports with a conclusion of limited or no assurance.

Data quality and quality of services

The Clinical Commissioning Group employs Lancashire and Midlands CSU to provide data and analysis. The CSU has provided the following statement:

"The CSU is committed to maintaining high standards in its management of data, working in accordance with best practice to provide appropriate assurance regarding data quality. The CSU recognises its statutory responsibilities in relation to the quality and management of data under the Data Protection Act 1998, the Freedom of Information Act 2000, and associated Legislation.

The underlining principles to our data quality are as follows;

- Accuracy – Data should be sufficiently detailed for the purposes for which It is collected.
- Validity – Data will be collected and used in compliance with internal and external requirements, to ensure consistency and it reflects the intended requirements.
- Reliability – Data is collected and processed consistently and in accordance with our defined processes to ensure that any changes in data are genuinely reflective of the activities represented;
- Timeliness – Data is collected as promptly as possible after the associated activity and be available for use within a reasonable timeframe;
- Relevance – Data collected should be relevant for the purposes for which they are obtained;
- Completeness – Data should be complete and as comprehensive as necessary to provide an accurate representation of the activity concerned and meet the information needs of the customer.

In addition depending on data sources required additional validation rules are applied within processing to improve the accuracy of the data for use in reporting, for example stage 1 and 2 validations within acute data.

All outputs are quality assured through our integrated Quality Assurance Process."

Business critical models

The Macpherson Report, issued in March 2013, emphasised the importance of strong leadership which values and expects effective challenge, a clear governance framework and time for quality assurance of business critical models. The review recommendations highlighted best practice which should apply across organisations, in particular, the responsibility of the Governing Body in ensuring that an appropriate framework and processes are in place.

Whilst the review did not specifically cover the NHS, its principles and recommendations can be translated to a number of the CCG's business critical functions such as procurement of services and major transformation programmes and associated QIPP schemes. Within the CCG the principles of the Macpherson Report recommendations have been adopted. An appropriate framework and environment is in place to provide quality assurance of business critical models including transparency of reporting, a robust Freedom of Information process and a robust programme management structure to support the delivery of QIPP objectives.

Data security

Throughout the year the Quality and Safety Committee have met regularly and have overseen Information Governance and monitored the IG Toolkit improvement plan. A Senior Information Risk Officer and Caldicott Guardian are named offices within the Constitution and these individuals ensure robust mechanisms are in place for all information governance concerns throughout the Clinical Commissioning Group. As highlighted above, we have submitted a satisfactory level of compliance with the information governance toolkit assessment of 91% achieving Level 3 on the majority of requirements, an improvement from last years' submission.

There have been no Serious Untoward Incidents relating to data security breaches by the Clinical Commissioning Group, including any that were reported to the Information Commissioner. Data security breaches by other organisations that the Clinical Commissioning Group has become aware of have been reported to the relevant organisations to manage within their own relevant reporting structures.

Discharge of statutory functions

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

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

functions. Work continues to ensure that these responsibilities are clearly articulated within the Clinical Commissioning Group's structures to provide the necessary capability and capacity to discharge our statutory duties effectively.

Conclusion

As Accountable Officer I can confirm that no significant internal control issues have been identified for the CCG in 2015/16. This Governance Statement is a true reflection of the CCG's position at its date of publication.

Dr Helen Hibbs

Accountable Officer

[x] May 2016

Remuneration Report

Remuneration committee report

The Chair of the Remuneration Committee is Mr Jim Oatridge. The other members of the Remuneration Committee in 2015/16 were as follows:

- Dr David Bush
- Mr Tony Fox
- Dr Julian Morgans.

There have been no changes to membership in-year. The number of meetings and individuals' attendance at each are as follows:

	26.5.15.	21.7.15	26.1.16
Members			
Jim Oatridge, Independent Committee Member (Chair)	✓	✓	✓
Dr David Bush, Governing Body Member, CCG	✓	✓	✓
Mr Tony Fox, Governing Body Member, CCG	✓	✓	✓
Dr Julian Morgans Governing Body Member, CCG	✗	✓	✗

A number of individuals provided advice or services to the committee that materially assisted the committee in its consideration of matters. Three of these were from the CCG – Dr Dan De Rosa (Chair), Dr Helen Hibbs (Chief Officer) and Mrs Claire Skidmore (Chief Finance and Operating Officer).

The CCG also engaged the HR services of MLCSU. The CCG's designated HR representative has acted in the capacity of adviser to the committee.

Policy on remuneration of senior managers

Senior managers for the organisation have one of three types of contract depending on their role:

Office Holder – Governing Body members are engaged by the CCG on office holder contracts as advised by the legal advisors Bevan Britain and Capsticks. Their pay was determined by the national guidance published in September 2012 for lay members and GPs on the Governing Body. The Governing Body members are engaged on varying lengths of term to enable stability within the organisation and, at the end of each term, consideration will be given at the Remuneration Committee as to whether pay for each session or role requires review.

Very Senior Manager (VSM) – The Accountable Officer, Chief Finance and Operating Officer, and Director of Strategy and Transformation are engaged by the CCG on VSM contracts.

Salaries were established in line with the national groups for determining VSM pay in September 2012.

Agenda for Change – The CCG's Executive Lead for Nursing and Quality is engaged by the CCG on Agenda for Change terms and conditions. Pay is in line with national pay scales and pay awards.

A mechanism for reviewing Officer and VSM pay was agreed by the Remuneration Committee in June 2014. The policies adopted provide a framework for considering any uplift to remuneration for VSM and officer members of the Governing Body. They provide an opportunity for consideration of an annual uplift and, in addition, the VSM framework details a structure for the setting and awarding of a performance-related payment.

Senior managers' performance-related pay

The Remuneration Committee agreed in 2015/16 that a reserve for an overall maximum of 10 per cent of VSM base pay would be set aside for performance-related payment. Within the 10 per cent, 2.5 per cent is allocated to each of the four categories identified below:

- leadership
- finance
- quality
- stakeholder engagement.

All performance-related payments are non-consolidated.

The appraisal process for VSMs includes objective setting aligned to the four categories noted above, as well as regular review of progress. Following year end, the Chair and Accountable Officer (the line managers for the VSM posts) are required to present their case for award of payment to the Remuneration Committee. The committee holds delegated responsibility to agree any award to be made.

VSM appraisal relating to 2015/16 performance is scheduled to take place early in the new financial year with a plan for the Remuneration Committee to make a final decision regarding award by the summer.

Policy on duration of contracts, notice periods and termination payments

The policy for senior manager contracts varies according to the role:

VSM contracts – senior managers on VSM contracts are engaged on a permanent contract with a notice period of six months. Any termination payments will be made in line with Agenda for Change terms and conditions for severance payments.

Agenda for Change – senior managers on Agenda for Change contracts are engaged on a permanent contract with a notice period of three months. Any termination payments will be made in line with Agenda for Change terms and conditions for severance payments.

Elected GP office holders – these office holder contracts are for a tenure period of between one and three years. All elected GP office holders stood down from their roles on 31 March 2015

after an election to recruit to a restructured Governing Body. New roles were successfully appointed to in readiness for 1 April 2016.

Practice manager representative office holder – this role has a maximum length of tenure of three years.

Lay member and secondary care doctor office holders – these roles have a maximum length of tenure of five years.

The notice of all office holder contracts could be with immediate effect based on a number of criteria within the contract, for example, the CCG no longer requiring a role under statute.

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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008. 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 membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table).

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement that 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.

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

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

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 figures have been prepared in accordance with the Hutton Review of Fair Pay implementation guidance. The median remuneration is the total remuneration of the staff members lying in the middle of the linear distribution of the total staff, excluding the highest paid director. This is based on the annualised, full-time equivalent remuneration as at the reporting period date i.e. March 31st 2016. A median will not be significantly affected by large or small salaries that may skew an average (mean) hence it is more transparent in highlighting whether a director is being paid significantly more than the middle staff in the organisation

The banded remuneration of the highest paid member of the Governing Body in the Clinical Commissioning Group in the financial year 2015-16 was £130-£135k, (2014-15 £135k-£140k). This was 3.7 times (2014-15 4.2 times) the median remuneration of the workforce, which was £35,225, (2014-15 £33,227).

In 2015-16, one (2014-15, nil) employee received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £8k-£171k, (2014-15 £8k-£117k). This individual was engaged on a short-term basis to increase the capacity of the executive team and support a review of the senior structure of the organisation in readiness for increased primary care responsibilities.

Median pay for the workforce (excluding the highest paid member), has increased by £2k compared to 2014-15. This has the effect of reducing the differential between the highest paid member and the rest of the workforce when compared to 2014-15.

In 2015/16 all staff on Agenda for Change spine points 1-42 received a 1% consolidated pay increase. Staff on spine points 43-54 did not receive a pay increase. A 1% consolidated pay increase was also applied to all non-Agenda for Change posts (for example VSM and Governing Body posts). Staff on spine points 2-33 were also eligible to earn an incremental uplift in line with Agenda for Change terms and conditions.

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

Consultancy expenditure

The CCG spent £135k in 2015/16 on consultancy which is included within the gross operating costs note to the accounts (Note 5). The breakdown of this was:

- £105k paid to Venn Group Ltd in relation to interim support for the development of the Primary Care Strategy;
- £30k paid to GE Healthcare Finnamore in relation to support for the New Models of Care delivery project.

Pension benefits

The table below illustrates the pension benefits accrued by the CCG's senior managers. Note that certain members do not receive pensionable remuneration, therefore they will not have an entry in this table.

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£00
H Hibbs - Accountable Officer	0-2.5	2.5-5	20-25	65-70	427	24	457	0
C Skidmore - Chief Finance & Operating Officer	0-2.5	0-2.5	25-30	70-75	296	15	315	0
M Garcha - Executive Lead for Nursing & Quality	0-2.5	0-2.5	30-35	90-95	568	21	595	0
S Marshall - Director of Strategy & Transformation #	2.5-5	0	5-10	0	82	43	126	0

These figures have been provided by the Greenbury team at the NHS Business Services Authority (NHSBSA).
Figures are not given for GP Board Members since any pension contributions are processed by NHS England through the GP SOLO process.
As lay members do not receive pensionable remuneration there are no entries in respect of pensions for these members.
No lump sum is shown since only a member in the 2008 Section NHS pension scheme

Salaries and allowances

The following tables present the salaries and allowances paid to the CCG's senior managers

2015/16						
Name & Title	**Salary (bands of £5000)**	**Expense Payments (taxable) (rounded to the nearest £100)**	**Performance Pay & Bonuses (bands of £5000)**	**Long-term Performance Pay & Bonuses (bands of £5000)**	**All Pension Related Benefits (bands of £2500)**	**Total (bands of £5000)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
H Hibbs - Accountable Officer	75-80	0	5-10 **	0	7.5-10	90-95
C Skidmore - Chief Finance and Operating Officer	105-110	0	10-15 **	0	22.5-25	140-145
M Garcha - Executive Lead for Nursing & Quality	85-90	0	0	0	5-7.5	95-100
S Marshall - Director of Strategy & Transformation	90-95	0	10-15 **	0	50-52.5	150-155
Dr D De-Rosa - Chair	60-65	0	0	0	0	60-65
Dr S Handa - GP Board Member *	5-10	0	0	0	0	5-10
Dr J Morgans - GP Board Member	15-20	0	0	0	0	15-20
Dr D Bush - GP Board Member	15-20	0	0	0	0	15-20
Dr A Sharma - GP Board Member	15-20	0	0	0	0	15-20
Dr M Kainth - GP Board Member	15-20	0	0	0	0	15-20
Dr R Rajcholan - GP Board Member	20-25	0	0	0	0	20-25
J Oatridge - Lay Member	10-15	0	0	0	0	10-15
P Roberts - Lay Member	5-10	0	0	0	0	5-10
H Ryan - Board practice manager representative	5-10	0	0	0	0	5-10
T Fox - Secondary care specialist doctor	5-10	0	0	0	0	5-10

* Left post 31/10/15.

All other members have been in post for the duration of 2015/16

** Estimate - in accordance with the CCG's policy for review of VSM pay the Remuneration Committee will consider and award the bonus relating to 2015-16 early in 2016-17.

GP Board Members are paid through the CCG's payroll provider with the relevant tax and NI deducted at source. Pension contributions are processed through NHS England via the GP SOLO process and therefore pension related benefits are not reported in the table above.

As lay members do not receive pensionable remuneration there are no entries in respect of pension related benefits for these members.

2014/15						
Name & Title	**Salary (bands of £5000)**	**Expense Payments (taxable) (rounded to the nearest £100)**	**Performance Pay & Bonuses (bands of £5000)**	**Long-term Performance Pay & Bonuses (bands of £5000)**	**All Pension Related Benefits (bands of £2500)**	**Total (bands of £5000)**
	£000	**£00**	**£000**	**£000**	**£000**	**£000**
H Hibbs - Accountable Officer	75-80	0	5-10 **	0	5-7.5	90-95
C Skidmore - Chief Finance and Operating Officer	105-110	0	10-15 **	0	15-17.5	135-140
M Garcha - Executive Lead for Nursing & Quality	85-90	0	0	0	47.5-50	135-140
R Young - Director of Strategy & Solutions *	50-55	0	0	0	150-152.5	205-210
S Marshall - Director of Strategy and Transformation #	5-10	0	0	0	32.5-35	40-45
Dr D De-Rosa - Chair	60-65	0	0	0	0	60-65
Dr K Ahmed - GP Board Member	15-20	0	0	0	0	15-20
Dr R Booshan - GP Board Member	15-20	0	0	0	0	15-20
Dr D Bush - GP Board Member	15-20	0	0	0	0	15-20
Dr S Handa - GP Board Member	10-15	0	0	0	0	10-15
Dr J Morgans - GP Board Member	15-20	0	0	0	0	15-20
Dr J Parkes - GP Board Member	15-20	0	0	0	0	15-20
Dr R Rajcholan - GP Board Member	10-15	0	0	0	0	10-15
Dr T Ravindran - GP Board Member	10-15	0	0	0	0	10-15
Dr S Sinha - GP Board Member	15-20	0	0	0	0	15-20
J Oatridge - Lay Member	10-15	0	0	0	0	10-15
P Roberts - Lay Member	5-10	0	0	0	0	5-10
H Ryan -Practice Manager Representative	5-10	0	0	0	0	5-10
A Fox - Secondary Care Specialist Doctor	5-10	0	0	0	0	5-10

* left the CCG 31/07/14, salary includes £32k in respect of severance payments (see note 4.4 of the annual accounts)

joined the CCG 02/03/15.

All other members have been in post for the duration of 2014/15

** Estimate - in accordance with the CCG's policy for review of VSM pay the Remuneration Committee will consider and award the bonus relating to 2014-15 early in 2015-16.

Details of the clinical commissioning group’s overall expenditure on salaries and wages can be found within Note 4 of the annual accounts

Dr Helen Hibbs

Accountable Officer
[x] May 2016

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Staff Report

Staff consultation

We are committed to encouraging an open and healthy dialogue with our staff and have established the following ways through which we do this:

- Staff Forum – monthly meetings attended by CCG management, staff
- Representatives from across each function, HR and union representatives
- Joint Negotiating Consultative Committee (JNCC)
- Staff Briefing sessions held monthly
- Monthly staff e-bulletin
- Regular e-mails

Digital signage network – information displayed on strategically placed screens.

The JNCC encourages effective communication with our staff through formal, quarterly meetings attended by CCG Executive management, HR and union representatives.

Members discuss topics of interest, including national and local strategies, national HR policy, employment legislation and local initiatives. The group also assesses the impact of these policies on the CCG and develops implementation plans where appropriate.

In the past year, the JNCC has completed work to agree our staff policies and the CCG's terms and conditions of employment. Policy awareness sessions, including on the sickness absence policy, have been well received. The JNCC has also worked with the communications team to look at ways to improve staff communication.

We have enhanced the internal communications screens which now include live RSS feeds from the CCG website, news agencies, weather and traffic reports. Content is updated daily with staff encouraged to contribute news from within their own areas.

A successful Away Day was held in June 2015 which included updates from the Executive Team and a team building exercise including all staff members. The day was well received and an event is planned for the same time in 2016.

The CCG has consistently low levels of staff turnover (0.87% average up to December) and sickness (Average 1.74% up to December) thanks to a proactive approach to managing and motivating staff.

We also encourage our providers to actively obtain and respond to feedback from their employees using the National Staff Survey or other local methods.

Equality

The CCG monitors its workforce and where employees identify as having a disability or long term condition as set out in the Equality Act 2010, access audits are completed and reasonable

adjustments are made to support the employees. The CCG also ensures fair and equitable access in its recruitment processes. This means that where an applicant indicates they have a disability or long-term condition, as set out in the Equality Act 2010, reasonable adjustments are put in place to support the applicant.

WCCG produce an annual Equality and Inclusion Report, which sets out how the CCG has demonstrated 'due regard' to the Public Sector Equality Duty's three aims for 2015/16 and provides evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually.

Provider contract monitoring

WCCG is in the process of reviewing provider contracts which is opportune and allows the timely review of monitoring arrangements, Key Performance Indicators (KPIs) and information required. Internally, WCCG has ensured that robust policies, practices and procedures are in place to provide assurances of compliance with the equality legislation, in respect of its providers. We are committed to maintaining a diverse workforce, which is reflective of the population served and have the Equality Strategy in place with identified key equality objectives aligned to the Equality Delivery System 2 (EDS2). The EDS2 is a system developed for NHS to help treat everyone equitably.

Equality Objectives

WCCG approved a five-year Equality and Diversity Strategy in 2013 in compliance with the Public Sector Equality Duty and specific duties set out in s149 Equality Act 2010. As part of the Equality and Diversity Strategy there are nine equality objectives that remain relevant and it is the activity towards maintaining of the objectives that change. These can be accessed by visiting http://wolverhamptonccg.nhs.uk/images/docs/Wolverhampton-CCG-Equality-Strategy-11_10_20131.pdf

Equality Impact and Risk Assessment (EI&RI)

This year, all of the CCG's policies, including corporate and service-specific policies, have been assessed. The EI&RAs also takes Human Rights and Privacy Impact Assessment into consideration as part of the process.

Staff analysis by gender

Staff Grouping	Female	Male	Total
Governing Body	6	8	14
Other Senior Management (Band 8C+)	5	4	9
All Other employees	53	21	74
Grand Total	**64**	**33**	**97**

**Note: Headcount as at 31 March 2016*

Pension liabilities

Details of how pension liabilities are treated in the accounts of the CCG can be found under note 4.5 (page 89) of the annual accounts.

Pension calculations relating to senior managers can be found within the Accountability Report.

Sickness absence data

Figures Converted by DH to Best Estimates of Required Data Items		**Statistics produced by Health and Social Care Information Centre from electronic staff record data warehouse**		
Average full-time equivalent (FTE) 2015 calendar year	Adjusted FTE days lost to Cabinet Office definitions 2015 calendar year	FTE – days available	FTE – days lost to sickness absence	Average sick days per FTE
71	310	25,871	503	4.4

As per note 4.3 of the CCG's annual accounts, the average number of staff sick days lost per full-time equivalent (FTE) in 2015 was 4.4 (7.8 in 2014).

The CCG takes the welfare of its staff seriously and is pleased that sickness rates have fallen from the 2014-15 figure. This is due to the hard work of the management team with the support of the Midlands and Lancashire Commissioning Support Unit HR team working to proactively manage sickness absence.

Health and safety

Our Health and Safety Management Plan continues to be actively applied to safeguard our staff and visitors. Whilst we are considered to be a low risk organisation, we have a variety of arrangements in place that enable us to maintain low incident rates. When problems are identified, we work with teams to address and resolve those issues.

Our Senior Management Team and Quality and Safety Committee receive regular assurance to confirm how health, safety and wellbeing is being pro-actively managed in the CCG. Some of our achievements this year include:-

- Fire Marshall training was provided to support the on-going application of our Fire Response Procedure, along with regular fire drills that have been arranged by our landlord.

- Workplace inspections have been undertaken at quarterly intervals to ensure safety standards are being maintained and where issues have been identified they have been acted upon.
- Our Health and Safety dashboard continues to provide positive assurance about our compliance with statutory duty and management of risks to our staff and the public.
- Review of the CCG's Health and Safety Risk Assessment.
- Investment in replacement office seating that is ergonomically designed, as well as ensuring our work environment affords sufficient space for our teams to work comfortably has also been actively managed.
- Where necessary, referrals for sight check and corrective appliances have taken place in line with the relevant regulations.

A Stress and Wellbeing Policy has been developed, in line with NICE Guidance, which actively promotes the wellbeing of our staff. The policy is further complemented by specific employee and line manager guides, with a key aim of each, being to enable a supportive and productive workplace for all. To do this we have:

- Developed a Stress Management Plan along with department-level risk assessments and a series of responsive actions for our managers to ensure the principles of staff wellbeing are actively applied. In Spring 2016, rolled out Stress and Wellbeing Training as part of the launch of the aforementioned Stress and Wellbeing Policy
- Regularly provided access to fresh fruit, various physical and social activities and a range of benefits to staff
- Offered a range of work experience and placements to encourage young people to consider pursuing a career in healthcare. Placements have been complemented by joint risk assessments for those young people undertaken with the placing school/organisation
- Supported our pregnant workers throughout their pregnancy and return to work, to ensure they have a suitable and sufficient assessment of risk to safeguard themselves and their unborn child from harm whilst at work
- Engaged competent/named personnel for areas including first aid, display screen equipment, electrical safety and testing, and water management.

The Health and Safety Management Plan is available for staff to access on the CCG's intranet, and is supported by an end-of-year report to the CCG's Quality and Safety Committee.

Fraud

CCG staff have access to risk specialists employed in functions such as health and safety, infection control, information governance and internal audit/counter fraud. Staff also have access to the Local Counter Fraud Specialist's intranet page, which contains policies and guidance relating to reporting concerns about fraudulent behaviour.

The CCG has a whistleblowing policy that also encourages staff to report fraudulent activity to the Local Counter Fraud Specialist.

The Audit and Governance Committee approves the CCG's counter fraud work plan on an annual basis and monitors progress on the implementation of counter fraud activities at each of its meetings.

Exit packages and severance pay

The CCG made no payments in lieu of notice in 2015/16 (1 in 2014/15).

Exit packages totalled £0 (£31,752 in 2014/15).

Off-payroll engagements

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

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

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

New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	0
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations	
Number for whom assurance has been requested	
Of which:	
• Assurance has been received	
• Assurance has not been received	
• Engagements terminated as a result of assurance not being received	

Governing Body Members

	Number

Number of off-payroll engagements of Governing Body members, and/or, senior officials with significant financial responsibility, during the year	0
Number of individuals that have been deemed " Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year. This includes both off-payroll and on-payroll engagements	15

Customer care

Our complaints procedures reflect the Parliamentary Health Service Ombudsman's six principles for remedy:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement

The views and opinions of the people we commission services for are vital in helping us deliver the best healthcare to our communities. We are committed to providing accessible, equitable and effective services and welcome views about services we provide and are responsible for commissioning. We actively encourage feedback through public participation groups, and routinely monitor patient experience feedback with service providers.

We place a high priority on the handling of complaints and we recognise that suggestions, constructive criticisms and complaints can be valuable aids to improving services and informing service redesign.

We share an information protocol with Healthwatch Wolverhampton in order to triangulate patient issues. This then feeds into the CCG via Quality Matters.

The CCG's quality and risk team handles all customer care enquiries that are directed to the organisation. The team deals with all complaints relating to CCG commissioning responsibility (for example, hospitals and community services, continuing healthcare, individual funding requests, out-of-hours and walk-in centre services), and points other enquiries to NHS England or the relevant provider where appropriate.

We are confident we have a clear complaints policy that signposts the public to the correct point of contact, and we will continue to receive complaints information from not only our providers, but also NHS England about primary care services in Wolverhampton.

The policy also has implications for providers of services to the CCG – they have a duty to have a complaints policy structured in line with national policy.

Personal data-related incidents

There have been no Serious Untoward Incidents relating to data security breaches by the CCG, including any that were reported to the Information Commissioner.

Data security breaches by other organisations that the CCG has become aware of have been reported to the relevant organisations to manage within their own reporting structures.

Emergency preparedness

Emergency planning and resilience and response (EPRR), is a statutory function under the Civil Contingencies Act (CCA) 2004. All NHS organisations and healthcare providers are required to have plans and processes in place for responding effectively to a major incident.

Wolverhampton CCG is a Category Two responder as defined by the CCA 2004. This means that the CCG is part of the response to any emergency affecting the population, in partnership with its commissioned services, NHS England, the local authority, Public Health England, the emergency services and other health bodies.

In Wolverhampton we work to continually plan for all eventualities on a West Midlands wide footprint. Last year this included working with providers and NHS England to ensure reassurance in the future for the public following the terror events in Europe during 2015/16.

We have also continued to develop our emergency preparedness and maintain a close working relationship with partners, including our Category 1 responders in Wolverhampton, to ensure a capability to respond to any incident or emergency. In November we held media training for all our Executive Directors followed by a training exercise to help them be prepared in the event of any future incidents. One example of a crisis which we had to prepare for last year was the Ebola outbreak should anything have occurred widely in the UK.

In July 2015 a New Counter Terrorism Security Act was passed. The Prevent Strategy is part national guidance for the prevention of violent extremism. The CCG has worked with West Midlands Police and other partners over the last year to ensure that we protect the most vulnerable people in Wolverhampton and thus try to prevent situations arising in the future.

The CCG completes an annual self-assessment against EPRR core standards, participates in local and regional training, and continues to develop and improve its business continuity arrangements exploring mutual aid arrangements with other CCGs locally.

Further assurance and more detailed information regarding the requirements specified for NHS providers can be found within the standard NHS contract, section SC30 Emergency Preparedness and Resilience Including Major Incidents.

A senior managers/executives rota system is in place across the Black Country to deal with issues that arise out of hours. To support senior managers/executives on call, technology is being developed to streamline the recording of information that will provide a robust evidence trail and ensure a structured approach to the transition between in-hours and out-of-hours.

Payments and Charges

Better Payments Practice (prompt payment) Code

The CCG is an approved signatory to the prompt payment code. The code sets standards for payment practice and best practice. Signatories agree to pay suppliers on time, give clear guidance to suppliers, and encourage the adoption of the code through supply chains. This means suppliers can have confidence in the CCG paying bills in line with the code.

Details of the CCG's compliance with the code are given in Note 6 of the accounts.

Cost Allocation & Setting of Charges for Information

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

External Auditor's Remuneration

The CCG's external auditor is Ernst & Young LLP. Work performed for the CCG in 2015/16 related solely to the statutory audit and amounted to £52,500, (£63,000 inc VAT).

This is shown within Audit Fees in Note 5 of the annual accounts.

Head of Internal Audit Opinion on the effectiveness of the system of internal control at Wolverhampton CCG for the year ended 31 March 2016

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:

My overall opinion is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

Basis for formulation of the opinion:

The basis for forming my opinion includes:

- *An assessment of the design and operation of the underpinning Assurance Framework (AF) and supporting processes - 'substantial' assurance.*

- *An assessment of the range of individual opinions, arising from risk-based and management requested audit assignments contained within Internal Audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.*
- *An assessment of the process by which the organisation has arrived at its overall rating under the DH Information Governance Toolkit - 'substantial' assurance.*

During the year, Internal Audit did not report any material concerns regarding governance, risk management and/or control issues which were significant to the organisation. During the year the Internal Audit issued the following audit reports with a conclusion of moderate assurance:

- Penetration testing (Information Management & Technology)
- Children's joint funding and pooled arrangements with LA

Mr C Larby, April 2016
Head of Internal Audit
Head of Internal Audit 2015/16,Wolverhampton CCG

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The Primary Statements:

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

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	3,905	4,091
Operating expenses	5	333,359	325,813
Other operating revenue	2	(2,495)	(2,917)
Net operating expenditure before interest		**334,770**	**326,987**
Investment revenue		0	0
Other (gains)/losses		0	0
Finance costs	7	0	2
Net operating expenditure for the financial year		**334,770**	**326,989**
Net (gain)/loss on transfers by absorption		0	0
Total Net Expenditure for the year		**334,770**	**326,989**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,656	2,752
Operating expenses	5	2,917	3,380
Other operating revenue	2	(70)	(8)
Net administration costs before interest		**5,503**	**6,124**
Programme Income and Expenditure			
Employee benefits	4.1.1	1,249	1,339
Operating expenses	5	330,443	322,433
Other operating revenue	2	(2,425)	(2,909)
Net programme expenditure before interest		**329,267**	**320,863**

Statement of Financial Position as at 31-March-2016

	Note	31-Mar-16 £000	31-Mar-15 £000
Non-current assets:			
Property, plant and equipment	9	0	0
Intangible assets		0	0
Investment property		0	0
Trade and other receivables		0	0
Other financial assets		0	0
Total non-current assets		0	0
Current assets:			
Inventories		0	0
Trade and other receivables	10	2,435	4,229
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	11	42	46
Total current assets		**2,477**	4,275
Non-current assets held for sale		0	0
Total current assets		**2,477**	4,275
Total assets		**2,477**	4,275
Current liabilities			
Trade and other payables	12	(28,173)	(20,935)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	13	(273)	(1,059)
Total current liabilities		**(28,446)**	(21,994)
Non-current assets plus/less net current assets/liabilities		**(25,969)**	(17,719)
Non-current liabilities			
Trade and other payables	12	0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	13	0	0
Total non-current liabilities		**0**	0
Assets less liabilities		**(25,969)**	(17,719)
Financed by taxpayers' equity			
General fund		(25,969)	(17,719)
Revaluation reserve		0	0
Other reserves		0	0
Charitable reserves		0	0
Total taxpayers' equity:		**(25,969)**	(17,719)

The notes on pages 86 to 105 form part of this statement

The financial statements on pages 75 to105 were approved by the Governing Body on [date] and signed on its behalf by:

Helen Hibbs
Accountable Officer

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(17,719)	0	0	**(17,719)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(17,719)**	**0**	**0**	**(17,719)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(334,770)			(334,770)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to/(from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(334,770)**	**0**	**0**	**(334,770)**
Net funding	326,520	0	0	326,520
Balance at 31 March 2016	**(25,969)**	**0**	**0**	**(25,969)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(15,741)	0	0	(15,741)
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 1 April 2014	(15,741)	0	0	(15,741)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating costs for the financial year	(326,989)			(326,989)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	0	0	0	0
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial/gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to/(from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(326,989)	0	0	(326,989)
Net funding	325,011	0	0	325,011
Balance at 31 March 2015	(17,719)	0	0	(17,719)

The General Fund reflects the CCG's cumulative net operating costs transferred each year together with the cumulative parliamentary funding. This balance cannot be released back to the SOCNE.

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

	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	(334,770)	(326,987)
Depreciation and amortisation	0	176
Impairments and reversals	0	0
Movement due to transfer by modified absorption	0	0
Other gains/(losses) on foreign exchange	0	0
Donated assets received credited to revenue but non-cash	0	0
Government granted assets received credited to revenue but non-cash	0	0
Interest paid	0	0
Release of PFI deferred credit	0	0
Other gains & losses	0	0
Finance costs	0	(2)
Unwinding of discounts	0	0
(Increase)/decrease in inventories	0	0
(Increase)/decrease in trade & other receivables	1,794	(943)
(Increase)/decrease in other current assets	0	0
Increase/(decrease) in trade & other payables	7,238	1,881
Increase/(decrease) in other current liabilities	0	0
Provisions utilised	(439)	(82)
Increase/(decrease) in provisions	(346)	950
Net Cash Outflow from Operating Activities	**(326,524)**	(325,007)
Cash Flows from Investing Activities		
Interest received	0	0
(Payments) for property, plant and equipment	0	0
(Payments) for intangible assets	0	0
(Payments) for investments with the Department of Health	0	0
(Payments) for other financial assets	0	0
(Payments) for financial assets (LIFT)	0	0
Proceeds from disposal of assets held for sale: property, plant and equipment	0	0
Proceeds from disposal of assets held for sale: intangible assets	0	0
Proceeds from disposal of investments with the Department of Health	0	0
Proceeds from disposal of other financial assets	0	0
Proceeds from disposal of financial assets (LIFT)	0	0
Loans made in respect of LIFT	0	0
Loans repaid in respect of LIFT	0	0
Rental revenue	0	0
Net Cash Inflow/(Outflow) from Investing Activities	**0**	0
Net Cash Outflow before Financing	**(326,524)**	(325,007)
Cash Flows from Financing Activities		
Grant in Aid funding received	326,520	325,011
Other loans received	0	0
Other loans repaid	0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	0	0
Capital grants and other capital receipts	0	0
Capital receipts surrendered	0	0
Net Cash Inflow from Financing Activities	**326,520**	325,011
Net Increase/(Decrease) in Cash & Cash Equivalents	**(4)**	5
Cash & Cash Equivalents at the Beginning of the Financial Year	**46**	42
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**42**	47

Notes to the Financial Statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Pooled Budgets

The clinical commissioning group entered into a pooled budget arrangement with Wolverhampton City Council on 1st April 2015 under a section 75 (NHS Act 2006) partnership agreement. This was for the purpose of commissioning health and social care services under the Better Care Fund (BCF). The Host Partner is Wolverhampton City Council.

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.

Notes to the Financial Statements (continued)

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.6.1 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:

- Leases

The clinical commissioning group applies the tests contained in IAS17 to all of its present and proposed leases in order to ascertain if they should be classed as operating or finance leases. Often the information available can be inconclusive and therefore judgement is made regarding the transfer of the risks and rewards of ownership of the associated assets in order that a decision can be made.

1.6.2 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:

- Provisions

When estimating provisions the clinical commissioning group uses estimates based on expert advice from solicitors, other external agents and the experience of its managers.

1.7 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.

1.8 Employee Benefits

1.8.1 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.

1.8.2 Retirement Benefit Costs

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

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

1.9 Other Expenses

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

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

Notes to the Financial Statements (continued)

1.10 Property, Plant & Equipment

1.10.1 Recognition

Property, plant and equipment is capitalised if:

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

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

1.10.2 Valuation

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

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

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

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

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

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

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

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

1.10.3 Subsequent Expenditure

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

1.11 Depreciation, Amortisation & Impairments

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

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

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

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

Notes to the Financial Statements (continued)

1.12 Leases

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

1.12.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.13 Cash & Cash Equivalents

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

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

1.14 Provisions

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

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

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

1.15 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.

1.16 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.

1.17 Continuing Healthcare Risk Pooling

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

1.18 Carbon Reduction Commitment Scheme

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

1.19 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.

Notes to the Financial Statements (continued)

1.20 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.20.1 Financial Assets at Fair Value Through Profit and Loss

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

In 2015/16 the clinical commissioning group did not hold any financial assets at fair value through profit and loss.

1.20.2 Held to Maturity Assets

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

In 2015/16 the clinical commissioning group did not hold any held to maturity assets.

1.20.3 Available For Sale Financial Assets

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

In 2015/16 the clinical commissioning group did not hold any available for sale financial assets.

1.20.4 Loans & Receivables

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

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

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

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

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

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

Prepayments in respect of the maternity pathway are accrued at the Statement of Financial Position date with movements being recorded within gross operating costs in the year they occur.

Notes to the Financial Statements (continued)

1.21 Financial Liabilities

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

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

1.21.1 Financial Guarantee Contract Liabilities

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

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

Financial liabilities in respect of partially completed contracts for patient services are accrued at the statement of financial position date with movements being recorded within gross operating costs in the year they occur.

1.21.2 Financial Liabilities at Fair Value Through Profit and Loss

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

In 2015/16 the clinical commissioning group did not hold any financial liabilities at fair value through profit and loss.

1.21.3 Other Financial Liabilities

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

1.22 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.

1.23 Foreign Currencies

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

1.24 Third Party Assets

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

1.25 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).

1.26 Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows. The pooled budget held with Wolverhampton City Council in relation to the Better Care Fund has been accounted for as a joint operation.

1.27 Research & Development

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

1.28 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

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

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

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

2. Other Operating Revenue

	2015-16 Total	2015-16 Admin	2015-16 Programme	2014-15 Total
	£000	£000	£000	£000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	20	0	20	35
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	21	0	21	11
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	0	0	0	0
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	2,453	70	2,383	2,871
Total other operating revenue	**2,495**	**70**	**2,425**	**2,917**

Programme revenue is revenue received for activities for which the sole or primary purpose is to improve the quality of health services.

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

3. Revenue

The clinical commissioning group receives no revenue from the sale of goods.

4. Employee Benefits and Staff Numbers

4.1.1 Employee benefits 2015/16

	Total	**Total Permanent Employees**	**Total Other**	**Admin**	**Admin Permanent Employees**	**Admin Other**	**Programme**	**Programme Permanent Employees**	**Programme Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	3,304	2,796	508	2,247	1,804	443	1,057	992	65
Social security costs	248	248	0	168	168	0	80	80	0
Employer Contributions to NHS pension scheme	353	353	0	241	241	0	112	112	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**3,905**	**3,397**	**508**	**2,656**	**2,213**	**443**	**1,249**	**1,184**	**65**
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,905**	**3,397**	**508**	**2,656**	**2,213**	**443**	**1,249**	**1,184**	**65**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,905**	**3,397**	**508**	**2,656**	**2,213**	**443**	**1,249**	**1,184**	**65**

4.1.2 Employee benefits 2014/15

	Total	Total Permanent Employees	Total Other	Admin	Admin Permanent Employees	Admin Other	Programme	Programme Permanent Employees	Programme Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	3,338	2,781	557	2,312	1,793	519	1,026	988	38
Social security costs	410	410	0	180	180	0	230	230	0
Employer Contributions to NHS Pension scheme	311	311	0	228	228	0	83	83	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	32	32	0	32	32	0	0	0	0
Gross employee benefits expenditure	4,091	3,534	557	2,752	2,233	519	1,339	1,301	38
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	4,091	3,534	557	2,752	2,233	519	1,339	1,301	38
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	4,091	3,534	557	2,752	2,233	519	1,339	1,301	38

4.2 Average number of people employed

	2015-16			2014-15		
	Total Number	**Permanently employed Number**	**Other Number**	Total Number	Permanently employed Number	Other Number
Total	**73**	**69**	**4**	75	70	5

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	**2014-15 Number**
Total Days Lost	310	465
Total Staff Years	71	59
Average working Days Lost	**4**	8

(2015/16 numbers will be made available by NHSE early in May)

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	0	0
	£000	£000
Total additional pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2015-16					
	Compulsory redundancies		**Other agreed departures**		**Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2014-15					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	31,752	1	31,752
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	0	0	1	31,752	1	31,752

The CCG has made no special payments in respect of employee departures (nil in 2014/15)

4.4.1 Analysis of other agreed departures

	2015-16		2014-15	
	Other agreed departures		Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	1	31,752
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	1	31,752

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

Redundancy and other departure costs have been paid in accordance with Agenda for Change terms and conditions.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

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

4.5 Pension costs

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

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

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

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

4.5.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £353,082 were payable to the NHS Pension Scheme (2014-15: £338,877) at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.1.

5. Operating Expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	3,429	2,180	1,249	3,716
Executive governing body members	476	476	0	375
Total gross employee benefits	**3,905**	**2,656**	**1,249**	**4,091**
Other costs				
Services from other CCGs and NHS England	2,446	1,431	1,016	2,174
Services from foundation trusts	48,528	83	48,445	48,252
Services from other NHS trusts	189,804	0	189,804	192,596
Services from other NHS bodies	3	0	3	0
Purchase of healthcare from non-NHS bodies	27,572	0	27,572	28,846
Chair and Non Executive Members	248	248	0	295
Supplies and services – clinical	965	0	965	493
Supplies and services – general	12,112	216	11,895	1,415
Consultancy services	135	135	0	90
Establishment	1,632	371	1,261	1,776
Transport	4	4	0	4
Premises	666	204	462	379
Impairments and reversals of receivables	146	0	146	0
Inventories written down	0	0	0	0
Depreciation	0	0	0	176
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	63	63	0	84
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	1	1	0	1
General dental services and personal dental services	0	0	0	0
Prescribing costs	45,165	0	45,165	44,529
Pharmaceutical services	0	0	0	0
General ophthalmic services	209	0	209	83
GPMS/APMS and PCTMS	2,978	0	2,978	3,067
Other professional fees excl. audit	92	80	12	59
Grants to other public bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	46	26	20	26
Education and training	65	31	34	50
Change in discount rate	0	0	0	0
Provisions *	(346)	22	(369)	950
Funding to group bodies		0	0	0
CHC Risk Pool contributions	825	0	825	467
Other expenditure	0	0	0	0
Total other costs	**333,359**	**2,917**	**330,443**	**325,813**
Total operating expenses	**337,264**	**5,573**	**331,692**	**329,905**

Programme expenditure is expenditure incurred on direct payments for the provision of healthcare or healthcare services.

Programme expenditure includes £56m in relation to services commissioned under Better Care Fund pooled budget arrangements. The majority of this expenditure is reflected within healthcare purchased from NHS and non-NHS bodies with £9.4m shown against supplies and services general. Note 17 provides further detail regarding this pooled budget.

Admin expenditure is all other expenditure and will include items such as staff costs, hosting arrangements and accommodation costs.

The liability in respect of partially completed patient spells is included within the statement of financial position with annual movements being charged to gross operating costs. The movement in 2015/16 was a reduction of £83k which is reflected within services from foundation trust & other NHS trusts in the gross operating costs shown above.

In addition a prepayment is included within the statement of financial position in relation to maternity services, with the corresponding credit movement included within services from other NHS trusts in the gross operating costs shown above. This is to recognise that an upfront block payment is made for maternity pathways which include all episodes of care from first ante-natal appointment to delivery. The movement in 2015/16 was an increase in the prepayment of £99k.

Services from foundation trusts includes £83k in relation to internal audit services provided by West Midlands Ambulance Service NHS Foundation Trust.

* Movements in provisions charged to operating expenses.

~ The CCG contributed £825k to the national CHC Risk Pool in 2015/16 (£467k in 2014/15). This pool was created in 2014/15 by NHS England for continuing healthcare claims for periods prior to 31 March 2013. The pool is used to settle these claims.

6. Payment Practice

6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	7,566	87,382	7,442	35,728
Total Non-NHS Trade Invoices paid within target	7,346	85,167	7,271	34,758
Percentage of Non-NHS Trade invoices paid within target	**97.09%**	**97.47%**	97.70%	97.29%
NHS Payables				
Total NHS Trade Invoices paid in the year	3,078	248,232	3,184	247,553
Total NHS Trade Invoices paid within target	3,019	247,310	3,128	246,999
Percentage of NHS Trade Invoices paid within target	**98.08%**	**99.63%**	98.24%	99.78%

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2015-16 £000**	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	2
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**2**

7. Finance Costs

	2015-16 £000	2014-15 £000
Interest		
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts:		
· Main finance cost	0	0
· Contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
· Main finance cost	0	0
· Contingent finance cost	0	0
Interest on late payment of commercial debt	0	2
Other interest expense	0	0
Total interest	**0**	**2**
Other finance costs	0	0
Provisions: unwinding of discount	0	0
Total finance costs	**0**	**2**

8. Operating Leases

8.1 As lessee

8.1.1 Payments recognised as an expense

	2015-16				2014-15			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£000	**£000**	**£000**	**£000**	£000	£000	£000	£000
Minimum lease payments	0	597	5	**602**	0	333	22	355
Contingent rents	0	0	0	**0**	0	0	0	0
Sub-lease payments	0	0	0	**0**	0	0	0	0
Total	**0**	**597**	**5**	**602**	0	333	22	355

The clinical commissioning group held an operating lease with University of Wolverhampton Science Park Ltd for the rental of office accommodation at a cost of £141k in 2015/16, (£138k in 2014/15).

Minimum lease payments in respect of buildings also include void and subsidy charges of £268k from NHS Property Services and £189k from Community Health Partnerships.

Other leases of £5k relate to leases held with Canon UK for the rental of photocopiers.

8.1.2 Future minimum lease payments

	2015-16				2014-15			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£000	**£000**	**£000**	**£000**	£000	£000	£000	£000
Payable:								
No later than one year	0	38	0	**38**	0	35	2	37
Between one and five years	0	0	16	**16**	0	-	-	0
After five years	0	0	0	**0**	0	-	-	0
Total	**0**	**38**	**16**	**54**	0	35	2	37

Minimum lease payments for buildings relate to the operating lease with University of Wolverhampton Science Park Ltd.

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 these arrangements.

8.2 As lessor

The clinical commissioning group does not have any leasing arrangements as a lessor.

9. Property, Plant and Equipment

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01-April-2015	0	0	0	0	0	0	209	0	209
Addition of assets under construction and payments on account	0	0	0	0	0	0	0	0	0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**209**	**0**	**209**
Depreciation 01-April-2015	0	0	0	0	0	0	209	0	209
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**209**	**0**	**209**
Net Book Value at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Purchased	0	0	0	0	0	0	0	0	0
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Asset financing:									
Owned	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP LIFT contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000	Buildings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Balance at 01-April-2015	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

9. Property, Plant and Equipment (continued)

9.1 Economic lives

	Minimum Life (Years)	Maximum Life (Years)
Buildings excluding dwellings	3	99
Dwellings	27	27
Plant & machinery	3	15
Transport equipment	7	10
Information technology	5	10
Furniture & fittings	5	15

The clinical commissioning group does not currently hold any non-current assets. The asset lives given above reflect the group's policy in respect of the depreciation of such assets should the group purchase these in the future.

10. Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: revenue	1,143	0	1,429	0
NHS receivables: capital	0	0	0	0
NHS prepayments	805	0	706	0
NHS accrued income	199	0	522	0
Non-NHS receivables: revenue	372	0	1,572	0
Non-NHS receivables: capital	0	0	0	0
Non-NHS prepayments	7	0	8	0
Non-NHS accrued income	0	0	2	0
Provision for the impairment of receivables	(146)	0	(35)	0
VAT	56	0	25	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total trade & other receivables	**2,435**	**0**	**4,229**	0
Total current and non current	**2,435**		**4,229**	
Included above:				
Prepaid pensions contributions	0		0	

NHS prepayments and accrued income include £805k in relation to the maternity pathway prepayment. £799k of this relates to activity with the Royal Wolverhampton NHS Trust.

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

The majority of other receivables that are neither past due nor impaired relate to other NHS bodies or local government. No credit scoring of these bodies is considered necessary.

10.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	597	387
By three to six months	0	0
By more than six months	0	254
Total	**597**	**641**

£100k of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2016.

10.2 Provision for impairment of receivables	**2015-16 £000**	2014-15 £000
Balance at 01-April-2015	(35)	(35)
Amounts written off during the year	0	0
Amounts recovered during the year	35	0
(Increase)/decrease in receivables impaired	(146)	0
Transfer (to)/from other public sector body	0	0
Balance at 31-March-2016	**(146)**	**(35)**

The increase in receivables impaired relates to four invoices against Wolverhampton City Council (WCC) for the reclaim of CHC costs

	2015-16 %	2014-15 %
Receivables are provided against at the following rates:		
NHS debt	0%	0%
Local authority debt greater than 90 days old	100%	13%
Local authority debt less than 90 days old	12%	0%
All other non-NHS debt greater than 90 days old	100%	100%

Local authority debt less than 90 days old has been provided for at 12% since the CCG has undertaken a detailed review of the outstanding debt and has assessed that £29k (12%) of the total debt of £216k is at risk.

11. Cash and Cash Equivalents

	2015-16	2014-15
	£000	£000
Balance at 01-April-2015	46	42
Net change in year	(4)	4
Balance at 31-March-2016	**42**	**46**
Made up of:		
Cash with the Government Banking Service	42	46
Cash with commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**42**	**46**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**42**	**46**

12. Trade and Other Payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	2,105	0	2,063	0
NHS payables: capital	0	0	0	0
NHS accruals	5,845	0	3,185	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	3,746	0	491	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	16,288	0	15,031	0
Non-NHS deferred income	46	0	60	0
Social security costs	42	0	0	0
VAT	0	0	0	0
Tax	42	0	0	0
Payments received on account	0	0	0	0
Other payables	59	0	105	0
Total trade & other payables	**28,173**	**0**	**20,935**	**0**
Total current and non-current	**28,173**		**20,935**	

NHS payables include £1,288k in respect of partially completed patient spells. £1,108k of this relates to activity with the Royal Wolverhampton NHS Trust.

Other payables include £60k outstanding pension contributions at 31 March 2016, (£0k as at 31 March 2015).

13. Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	56	0	171	0
Other	217	0	888	0
Total	**273**	**0**	**1,059**	**0**
Total current and non-current	**273**		**1,059**	

	Continuing Care £000s	**Other £000s**	**Total £000s**
Balance at 01-April-2015	**171**	**888**	**1,059**
Arising during the year	0	33	33
Utilised during the year	(31)	(408)	(439)
Reversed unused	(84)	(296)	(380)
Unwinding of discount	0	0	0
Change in discount rate	0	0	0
Transfer (to)/from other public sector body	0	0	0
Balance at 31-March-2016	**56**	**217**	**273**
Expected timing of cash flows:			
Within one year	56	217	273
Between one and five years	0	0	0
After five years	0	0	0
Balance at 31-March-2016	**56**	**217**	**273**

The Continuing Care provision includes claims for individuals who have their care package assessed late and are entitled to a reimbursement of their nursing home fees. This late assessment is due to a delay in nursing homes advising the clinical commissioning group of the individual's placement. This is not expected to be resolved in the near future and a provision is therefore required for future cases. Costs have been estimated based on the value of cases settled in 2015/16 and it is expected that the provision will be utilised within one year. The Continuing Care provision also includes an estimate of claims for cross border placements where the corresponding clinical commissioning group is still to complete the assessment of the individual's case. The provision has been based on similar cases settled in 2015/16 and it is expected that this will also be utilised within one year.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the clinical commissioning group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this clinical commissioning group at 31 March 2016 is £634k.

Other provisions include £109k in respect of an anticipated pension shortfall under New Deal arrangements with the clinical commissioning group's non-emergency patient transport provider. The clinical commissioning group is liable for these costs under the terms of the contract with the provider. This provision was created at the end of 2014/15 and the final calculation of these costs is still awaited but it is expected that this will be settled within the next 6 months.

Also included within other provisions is £27k in respect of an estimated charge from NHS Property Services for loss of rental revenue in respect of buildings previously occupied by a continuing care provider. The clinical commissioning group has terminated the contract with this provider and is liable for these costs under the terms of the agreement with NHS Property Services. It is expected that information will be available from NHS Property Services within the next few months regarding any invoices to be raised in respect of this and so this provision will be settled within one year.

£11k is included within other provisions for anticipated claims from GPs in respect of local enhanced services. GPs are currently assessing whether they have any outstanding claims and the provision has been based on an assessment of the average level of claims by weighted practice list size. It is expected that this provision will be fully utilised within the next 6 months.

Other provisions also include £34k in respect of dilapidations and £37k in respect of legal and professional fees.

The clinical commissioning group currently has no legal claims lodged with the NHS Litigation Authority, (nil in 2014/15).

£67k is included in the provisions of the NHS Litigation Authority as at 31 March 2016 in respect of clinical negligence liabilities of the clinical commissioning group, (nil in 2014/15).

14. Contingencies

The clinical commissioning group has no quantifiable contingent assets or liabilities as at 31st March 2016.

However, final figures are still awaited from Wolverhampton City Council in respect of council run schemes within the Better Care Fund pooled budget held with the clinical commissioning group. These figures will not be available until after the submission of local authority accounts (July 2016), and there is a risk that there will be an increase in the figures currently being reported since there have been increases over the last 2-3 months. This cannot be accurately quantified due to the later year-end closedown date for local authority accounts.

The year-end report from the NHS Litigation Authority confirms that the clinical commissioning group has no member liability as at 31st March 2016.

15. Financial Instruments

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the Clinical Commissioning Group's revenue comes from parliamentary funding, it 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.

15.1.4 Liquidity risk

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

15. Financial Instruments (continued)

15.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,342	0	1,342
· Non-NHS	0	372	0	372
Cash at bank and in hand	0	42	0	42
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**1,755**	**0**	**1,755**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,429	0	1,429
· Non-NHS	0	1,572	0	1,572
Cash at bank and in hand	0	46	0	46
Other financial assets	0	0	0	0
Total at 31-March-2015	**0**	**3,047**	**0**	**3,047**

15.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,950	7,950
· Non-NHS	0	20,094	20,094
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**28,043**	**28,043**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	5,248	5,248
· Non-NHS	0	15,687	15,687
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2015	**0**	**20,935**	**20,935**

Fair value is the same as carrying amount for all financial assets and liabilities.

16. Operating Segments

The term 'Chief Operating Decision Maker', per IFRS8, identifies a function, not necessarily a manager with a specific title. That function is to allocate resources to and assess the performance of the operating segments of an entity. The CCG's chief operating decision maker is its group of executive and non-executive officers (the Governing Body). The CCG considers it has only one operating segment: commissioning of healthcare services. Finance and performance information is reported to the Governing Body as one segment and these financial statements have been prepared in accordance with this reporting.

17. Pooled Budgets

Wolverhampton CCG entered into a pooled budget arrangement with Wolverhampton City Council on 1st April 2015. This is a section 75 (NHS Act 2006) partnership agreement relating to the commissioning of health and social care services under the Better Care Fund (BCF). The BCF has been established by the Government and it is a requirement of the Fund that that the CCG and the Council establish a pooled fund for this purpose. The Host Partner is Wolverhampton City Council.

The partners' contributions to the Fund are outlined below. The share of any over/(under) spend is allocated according to the Section 75 agreement.

	2015-16 £000
Pool Expenditure:	
Community & Primary Care	22,952
Dementia	4,835
Mental Health	10,265
Intermediate Care/Reablement	37,320
Total Pool Expenditure	**75,372**
Gross Funding:	
Wolverhampton CCG	46,644
Wolverhampton City Council	24,219
Total Gross Funding	**70,863**
Net Over/(Under) Spend	**4,509**
Share of Over/(Under Spend):	
Wolverhampton CCG	3,074
Wolverhampton City Council	1,435
	4,509

18. Related Party Transactions

During the year the following Governing Body members or members of the key management staff have declared interests with other organisations that have undertaken material transactions with the clincal commissioning group:

	2015/16				2014/15			
	Payments to Related Party £000	**Receipts from Related Party £000**	**Amounts owed to Related Party £000**	**Amounts due from Related Party £000**	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Mrs Claire Skidmore, Chief Finance & Operating Officer, Public Sector Director of Community Health Partnerships	118	0	0	0	0	0	0	0
Ms Helen Ryan, Practice Manager Representative, Practice Manager at Penn Manor Medical Centre	138	0	0	0	171	0	0	0
Mr Anthony Fox, Secondary Care Consultant Representative, Consultant Surgeon - Shrewsbury & Telford NHS Trust	369	0	0	0	484	0	0	(42)
Mrs Pat Roberts, Lay Member, Member of Wolverhampton Council for Voluntary Services	159	0	0	0	58	0	0	0
Dr J Morgans, GP Board Member, Shareholder, Wolverhampton Doctors on Call Ltd	8	0	0	0	5	0	0	0

The following General Practitioners were members of the clinical commissioning group Governing Body during 2015/16. Payments were made to the practices of these GPs for Enhanced Services delivered to the population of Wolverhampton. Other payments were also made in respect of items such as the Prescribing Incentive Scheme and collaborative fees. Payments listed are in relation to the whole GP practice and therefore do not reflect the remuneration of the individual.

GP Governing Body Member	**Practice**	**2015-16 £000**	2014-15 £000
Dr H Hibbs; Chief Accountable Officer	Parkfields Medical Practice	100	141
Dr H Hibbs; Chief Accountable Officer	Ettingshall Medical Centre	20	27
Dr D De Rosa; Chair	Dr D De Rosa and Williams	58	57
Dr S Handa; GP Member	Dr Passi and Partners	62	74
Dr J Morgans; GP Member	Dr Morgans and Partners	141	190
Dr D Bush, GP Member	Dr Bush & Partners	51	41
Dr R Rajcholan, GP Member	Dr George & Rajcholan	29	57
Dr A Sharma, GP Member	Dr Sharma's Practice	30	16
Dr M Kainth, GP Member	Dr M S Kainth	31	39

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

	2015-16 £000	2014-15 £000
The Royal Wolverhampton NHS Trust	188,215	190,330
NHS Business Services Authority	45,195	42,558
Black Country Partnership NHS Foundation Trust	29,108	29,589
West Midlands Ambulance Service NHS Trust	9,248	8,990
The Dudley Group of Hospitals NHS Foundation Trust	4,379	5,126
NHS England (including Central Midlands CSU)	1,397	1,597

In addition, the clinical commissioning group has had a number of transactions with other government departments and other central and local government bodies. Most of these transactions have been with Wolverhampton City Council, (£60,636k in 2015/16, £7,172k in 2014/15). This increase in payments compared to 2014/15 is due to payments made into the Better Care Fund pooled budget held with the council. Payments have been made back to the clinical commissioning group from the council of £45,082k for health related schemes.

19. Events After The End of The Reporting Period

The clinical commissioning group does not have any events after the end of the reporting period to disclose.

20. Losses and Special Payments

20.1 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 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	0	0	0	0
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	**0**	**0**	**0**	**0**

20.2 Special payments

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Compensation payments	0	0	0	0
Extra contractual payments	0	0	0	0
Ex gratia payments	1	9	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**1**	**9**	**0**	**0**

21. Financial Performance Targets

The Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

Performance against those duties was as follows:

	2015-16 Target	**2015-16 Performance**	2014-15 Target	2014-15 Performance
Expenditure not to exceed income	5,905	6,972	9,000	9,206
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	341,742	334,770	336,195	326,989
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	6,120	5,503	6,673	6,124

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

21.1 Revenue Resource Limit

	2015-16 £000	2014-15 £000
Total net operating cost for the financial year	334,770	326,989
Revenue Resource Limit	341,742	336,195
Underspend Against Revenue Resource Limit (RRL)	6,972	9,206

Included in these figures are the clinical commissioning group's running costs. The clinical commissioning group's performance was as follows:

21.1.1 Running Cost

	2015-16 £000	2014-15 £000
Total Running Cost for the financial year	5,503	6,124
Running Cost Allocation (included in the Revenue Resource Limit shown in note 22.1 above)	6,120	6,673
Underspend Against Running Cost Allocation	617	549

The running cost allocation includes £564k in respect of the quality premium awarded. The expenditure in relation to this is contained within programme costs.

21.2 Capital Resource Limit

The clinical commissioning group is required to keep within its Capital Resource Limit.
The clinical commissioning group did not receive a Capital Resource Limit in 2015/16 and did not incur any capital expenditure, (nil in 2014/15).