NHS
South Worcestershire
Clinical Commissioning Group

Annual Report and Accounts
2016/17

Contents

Performance Report

Dr Carl Ellson
Accountable Officer
NHS South Worcestershire CCG
26 May 2017

Foreword

I'm pleased to present the fourth annual report and accounts for NHS South Worcestershire CCG. This report tells you what we have been up to over the last 12 months and sets out where we want to go for the next year.

Our vision for health is to 'ensure that the population of South Worcestershire enjoy lives which are as healthy as possible'. We have been working hard to realise this vision and to develop services that enable all our residents to have access to the best possible services, in a coordinated way.

It is a challenging time for the health service nationally and we are seeing the impact of that locally. But, we are responding to that challenge. I personally want to thank our staff, Governing Body members and GP member practices for the hard work that they do every day. I am so proud of the commitment and dedication they deliver, working to improve the health of south Worcestershire people and the quality of care available to them.

We are especially grateful to our patients, carers and members of the public who have engaged with us on service redesign and strategy development, provided feedback on services, and represented their communities in groups feeding into service development. Without your feedback we would not have made the progress we have.

Change is never easy but the challenges of the past year have reinforced the conclusion that if we are to meet future demand and provide high-quality services, carrying on as we are is not an option. While we are proud of what we have achieved in south Worcestershire over these last 12 months, we know there is more to do.

We strive for equality, for better health outcomes for all, for pioneering services which make a difference and to a move to a preventative approach where we help people to stay well for longer.

I hope you enjoy reading this Annual Report. If you have any comments on it, or the information contained within it, please let us know by contacting the Communications Team at worcs.comms@nhs.net.

Dr Anthony Kelly
Chairman
NHS South Worcestershire CCG

Performance overview

This has been another challenging year in terms of both finance and performance. I am delighted to report that once again we have maintained our financial balance, providing us with a sound footing for the challenges that lie ahead. However we know that the financial challenges we face are going to be even tougher this year and we will continue to ensure that we are buying the right health services for our local population. Looking ahead this may mean having to make some tough decisions but we are committed to involving patients, clinicians and partners in any potential changes to services.

Our performance against many of performance targets – including our referral to treatment and cancer diagnosis targets – has not been acceptable. We are continuing to challenge performance where it is below our expected standards as healthcare commissioners and I expect to see improvements reflected this coming year.

This year there has been a lot of focus and attention on our proposed model for the Future of Acute Hospital Services in Worcestershire. It was really pleasing to gain full approval on the proposed clinical model and subsequent agreement from NHS England on our business case for public consultation. A full 12 week public consultation finished earlier this year and we are now reflecting on the feedback before deciding how to proceed in 2017/18.

The Herefordshire and Worcestershire Sustainability and Transformation Plan has dominated much of the local strategy and planning and we have welcomed the opportunity to work closer with our partners. We can expect to continue to work ever closer this coming year as this work develops and we begin to deliver better services for our patients.

On the subject of working more closely together, the development of the South Worcestershire Alliance Board has been a highlight for me this past year. We have come a long way in developing a partnership of commissioners and health care providers in South Worcestershire with the aim of delivering more joined-up community care. There is still a huge amount of work to do, but we know where we wish to get to - to create a system without boundaries, where patient interests come first, and where all resources are collectively focused on supporting patients.

In terms of working better together we have also spent a large part of this year working more closely with our CCG colleagues across Worcestershire. We have developed a single Management Team to create the necessary capacity for focusing on some of our key priorities and have revised some of our governance structures with many committees-in-common across Worcestershire now established. This has been a really positive move, allowing us to remove some unnecessary duplication and freeing up time to focus on making the changes that matter most to our local population.

Dr Carl Ellson
Accountable Officer
NHS South Worcestershire CCG

Introduction

The following overview section is designed to provide you with a short summary that provides you with sufficient information to understand the CCG, our purpose, the key risks and challenges to the achievement of our objectives and how we have performed during 2016/17.

About us

NHS South Worcestershire Clinical Commissioning Group (SWCCG) is formed of 32 member GP practices across South Worcestershire and is the organisation responsible for arranging health services on behalf of local patients.

We took over responsibility for commissioning high quality hospital, community and mental health services for South Worcestershire patients from Worcestershire Primary Care NHS Trust on 1 April 2013. We have also since assumed responsibility from NHS England for commissioning local GP services.

Serving a population of more than 300,000 people across South Worcestershire, we are responsible for:

- Planning health services, based on assessing the needs of South Worcestershire patients

- Paying for services that meet the needs of South Worcestershire patients
- Monitoring the quality of the services and care provided to South Worcestershire patients.

There are two other NHS commissioning organisations within Worcestershire. NHS Redditch and Bromsgrove Clinical Commissioning Group (RBCCG) serves the Redditch and Bromsgrove population, and NHS Wyre Forest Clinical Commissioning Group (WFCCG) commissions services for Wyre Forest patients. Although independent organisations with our own statutory duties to fulfil, we are increasingly working more closely together and this year have established a single Executive Leadership Team and hold a number of committees-in-common to help meet some of the common challenges that we face.

Together we commission services from a number of NHS and non-NHS providers. The main local providers of secondary services are:

- Worcestershire Acute Hospitals NHS Trust **–** Worcestershire has three Acute Hospitals which are part of Worcestershire Acute Hospitals NHS Trust (WAHT). The Trust provides a full range of acute and emergency hospital-based services from the Worcestershire Royal Hospital in Worcester and the Alexandra Hospital in Redditch, and also provides some services from the Kidderminster Hospital and Treatment Centre.

- Worcestershire Health and Care NHS Trust **–** Worcestershire Health and Care NHS Trust (WHCT) is the main provider of community and mental health services in Worcestershire. It delivers a wide range of services in a variety of settings including people's own homes, community clinics, outpatient departments, community inpatient beds, schools and GP practices. The Trust also provides in-reach services into acute hospitals, nursing and residential homes and social care settings.

We also commission services from providers outside of Worcestershire including:

- Gloucestershire Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Wye Valley NHS Trust.

The population we serve

We serve patients registered with general practices located across South Worcestershire. As at 31 March 2017 306,342 patients were registered with South Worcestershire GPs.

In line with our statutory duties we have contributed to the development of the Joint Strategic Needs Assessment (JSNA) with our partners from Worcestershire County Council. The JSNA sets out a number of key messages about the nature of the population we serve and which informs our commissioning plans, specifically:

- Health inequalities are not only evident between the South Worcestershire districts, but also within each of those areas, with Worcester having a large socio-economic range
- Recorded prevalence of stroke, hypertension and diabetes in South Worcestershire is significantly higher than national levels (although this could be due to more effective recording of these conditions rather than a reflection of population health)
- Recorded adult obesity prevalence is close to the national average. The proportion of children classed as verweight or obese at age 10/11 is slightly below the national rate of 34%, with Worcester having a higher rate (32%) than Wychavon and Malvern Hills (29% and 30% respectively)
- The teenage conception rate is significantly higher for Worcester (34.8 per 1,000) than in England (27.6 per 1,000).

The JSNA can be found on our website at www.southworcsccg.nhs.uk/about-us/strategy.

Our vision and values

Our vision is to 'ensure that the population of South Worcestershire enjoy lives which are as healthy as possible'. The vision above is supported by seven values, which set out what we care about as an organisation and helps to define how we want to behave. We developed these with the help of clinicians, patients and local people:

- To demand of each other what is right even if our actions impact on our popularity

- Be clinically effective, quality focused and patient-centred
- Be nimble, decisive, proactive and dynamic
- Challenge bureaucratic NHS behaviour
- Not tolerate mediocrity – to have 'why not' rather than 'cannot' embedded in our vernacular
- Be an organisation that values its staff
- Secure value for money in everything we do.

Key challenges

They key challenges we have faced throughout 2016/17 can be categorised into four main areas; system challenges, performance challenges, tackling unwarranted variation and financial challenges:

System challenges

- Worcestershire Acute Hospitals NHS Trust being in special measures and anticipating a financial deficit
- A significant reduction in social care budgets
- Increasing pressure on primary care services
- Dramatic rise in the number of people aged over 75s between now and 2025
- Uncertainty over the future configuration of acute hospital services
- Effective leadership and transformation at all levels to develop and deliver the Sustainability and Transformation Plan (STP) across Herefordshire and Worcestershire.

Performance challenges

- Difficulties in achieving the 4-hour standard for urgent care
- Sustainable delivery of Referral to Treatment (RTT) targets
- Improved delivery of Accident and Emergency (A&E) services and the wider urgent care system
- Improving and sustaining delivery of cancer and stroke targets.

Tackling unwarranted variation

- Responding to the key issues identified in the Commissioning for Value packs and CCG Outcome Indicators which suggest a need for some different commissioning actions
- Recognising and understanding the activity and outcome variations across the county working in partnership with Primary Care and Public Health
- Continuing to close the health inequality gap working closely with partners across the Local Authority and community sectors.

CCG Financial challenges

- Achieving a £22m efficiency savings programme for the three Worcestershire CCGs
- Delivering the challenging Quality, Innovation, Productivity and Prevention (QIPP) while managing demand growth and maintaining good cost control on significant budgets such as prescribing and Continuing Healthcare.

Our approach to addressing these challenges is set out in the following section and more information can be found on our website at www.southworcsccg.nhs.uk/about-us/strategy.

Our strategic approach

Herefordshire and Worcestershire Sustainability and Transformation Plan (STP)

Across Herefordshire and Worcestershire, all health and care organisations are committed to always providing safe and effective services, but together we acknowledge that the way some services are run may need to change. This is because we have a growing population and rising demands on services, and we have to make sure we can do the best we can with the resources available.

This means we must:

- Reduce duplication and make services easier to navigate and access
- Do more to support healthy living or self-care and how some conditions are managed
- Provide more care at home or closer to home, reducing avoidable hospital admissions
- Ensure more specialist services are safely and appropriately staffed with the right level of expertise.

Due to the size of the challenge, health and social care bodies in Herefordshire and Worcestershire are working together to help make sure the NHS is safe and sustainable for the future. This is called the Sustainability and Transformation Plan (STP) but it is really about implementing the NHS' Five Year Forward View.

The initial priorities have been:

- Changing the approach to managing care in the last six months of life, predicated on the National Voices narrative for proactive advanced care planning
- Engaging with the public and politicians about the scope and scale of health and care services
- Supporting the support development of clinical and leadership capability and decision making to effectively deliver our STP plan.

The Herefordshire and Worcestershire STP is currently a draft outline plan and can be found on our website at www.southworcsccg.nhs.uk/about-us/strategy.

Worcestershire Joint Health and Wellbeing Strategy 2016/21

The Worcestershire Health and Wellbeing Board brings together relevant stakeholders from across health, social care, Worcestershire County Council, local district authorities, and the voluntary sector to assess local needs and produce a coordinated strategy for responding to them. Our Chief Clinical Officer and Chair are active members of the Worcestershire Health and Wellbeing Board and lead our organisation's involvement with this work.

The Worcestershire Joint Health and Wellbeing Strategy (2016/21) sets out the Health and Wellbeing Board's vision and priorities for 2016-21. We were actively involved in the development of the Joint Health and Wellbeing Strategy, which sets the context for other health and wellbeing plans and for commissioning of NHS, public health, social care and related children's services.

The strategy is supported by the Joint Strategic Needs Assessment (JSNA) and was developed in line with S116B(1)(b) of the Local Government and Public Involvement in Health Act 2007. The CCG supports the three overarching priorities identified over the next five years:

1. Improving mental health and wellbeing
2. Increasing physical activity
3. Reducing the harm caused by alcohol.

In this strategy we have placed a stronger emphasis on prevention too, working together with partners to meet the rising tide of avoidable ill-health. We will be trying to stop problems before they start, and to resolve them quickly if they do arise.

The strategy provides a basis for us - as commissioners of NHS health and care services - as well as for commissioners of public health, social care and related services, to integrate commissioning plans and pool budgets wherever possible, using the powers under Section 75 of the NHS Act 2006 where appropriate. Our local commissioning plans are therefore produced within the context of this document.

We have continued to consult regularly on a formal and informal basis with the Health and Wellbeing Board, its membership and its Chair. In particular we consult with the Health and Wellbeing Board on our strategies and plans, such as the Future of Acute Hospital Services in Worcestershire (FOAHSW) and our Sustainability and Transformation Plan (STP), and how these are aligned with and contribute to the delivery of the Worcestershire Joint Health and Wellbeing Strategy. There also remains extensive dialogue with colleagues from the Health and Wellbeing Board outside of the formal meetings.

The Worcestershire Joint Health and Wellbeing Strategy can be found on our website at www.southworcsccg.nhs.uk/about-us/strategy.

South Worcestershire Five Year Strategy 2013/18

Our Five Year Strategy (2013/18) is based on an understanding of South Worcestershire's population and health needs and sets out four key strategic aims:

1. Improved quality and patient safety – this will mean fewer serious healthcare incidents and no 'never events', fewer healthcare acquired infections, improved patient experience of care, more people die in their chosen place of care
2. Reduced health inequalities – this will mean improved healthy life expectancy for all and narrower gaps between the best and worst levels of health
3. More independence for the frail elderly and those living with a long term condition – this will mean more people living independently with support to help them safely manage their own health needs, people achieve a full recovery where possible, or where this is not possible they will be helped to reach their new way of life more quickly after illness or injury
4. Better and faster access to urgent care – this will mean fewer avoidable urgent care admissions, rapid access to the most appropriate emergency healthcare option, shorter lengths of stay following an unplanned admission.

Our Five Year Strategy (2013/18) can be found on our website at www.southworcsccg.nhs.uk.

Worcestershire Operational Plan 2016/17

Our Worcestershire-wide Operational Plan (2016/17) has been developed in partnership with the other two Worcestershire CCGs to support the five year strategic priorities and national planning guidance released. Specifically it sets out nine key areas of focus for the three Worcestershire CCGs for 2016/17 as follows:

1. Development of the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP)
2. Supporting high quality, sustainable Primary Care across Worcestershire
3. Improving performance on the emergency access standards for Accident and Emergency (A&E) and ambulance waits
4. Improving performance on the 18-weeks 'Referral to Treatment' standard
5. Achieving the cancer waiting times standard
6. Deliver the required mental health access standards
7. Transforming learning disability services
8. Continuing to improve quality
9. Delivering financial balance

Our Operational Plan (2016/17) can be found on our website at www.southworcsccg.nhs.uk/about-us/strategy.

Better Care Fund

The Better Care Fund (BCF) is a mechanism for us to create a pooled budget with the other two Worcestershire CCGs and Worcestershire County Council using powers contained in Section 75 of the NHS Act 2006.

The budget is then used to support the commissioning of a number of services that contribute to the delivery of integrated care in line with the Worcestershire Joint Health and Wellbeing Strategy and our own plans, as well as supporting the provision of social care.

Although not 'new' money, the BCF sets an ambitious challenge to integrate health and social care. The scale and scope of the Better Care Fund is determined by the Worcestershire Health and Wellbeing Board in line with specific national conditions.

In Worcestershire the focus for intervention from the BCF is to support people who are currently, or who are at risk of becoming, heavily dependent on health and adult social care services to live their normal lives. Within Worcestershire the BCF for 2016/17 is £38.142m, of which we have contributed £17.167m, with the majority of the remainder coming from NHS Wyre Forest and NHS Redditch and Bromsgrove CCGs.

Last year the Worcestershire BCF Plan (2015/16) grouped schemes under three main headings - Admission Prevention, Facilitated Discharge, and Independent Living. The grouping of the schemes for 2016/17 has changed to

reflect our strategic priority to enhance and develop home-based care and support; the groupings are now built around which schemes are included in the integrated recovery projects and urgent care schemes.

The BCF Plan can be found on our website at www.southworcsccg.nhs.uk/about-us/strategy.

Key highlights

Developing new models of care

Responding to the Five Year Forward View has been a key focus for the CCG this year. An Alliance Board has been set up, which includes local health and social care partners, to develop new models of care with an aim to create a system where patient interests come first and resources are collectively focused on improving health outcomes, supporting people to stay well and to live independently for as long as they wish.

Along with our partners we have an ambitious strategy to integrate the delivery of health and social care for the people of Worcestershire. This ambition is supported by our commissioning partners in Worcestershire County Council and our provider partners in General Practice, Worcestershire Acute Hospitals NHS Trust and Worcestershire Heath and Care NHS Trust.

The partners have come together with the CCG to form a South Worcestershire Alliance Board. Our vision for the future of health and care in South Worcestershire is to create a simpler, more joined-up health and care system; one where the people do not see organisational boundaries. Instead, they experience continuity of care; they see familiar faces that are clearly connected to each other regardless of where patients are seen; be that in hospital, in the community or at home.

Although their end goal is a truly integrated system which moves the boundaries between commissioning and provision, the first step on the journey is to develop an integrated provider model, which will be the focus of this work in 2017/18.

Herefordshire and Worcestershire Sustainability and Transformation Plan

The draft Sustainability and Transformation Plan for Herefordshire and Worcestershire was submitted before the end of November in line with the national timeframes. The plan sets out how we are going to work with our partners and communities to make sure that the NHS is safe and sustainable for the future. Attention subsequently turned to public engagement and involvement in the proposals, with the #yourconversationhw and other online material being used to generate discussion and feedback in addition to roadshows and attendance at various events and groups.

At CCG level efforts have been focused on the development of the Multispecialty Community Provider MCP model and taking forward the work with the alliance boards described above. Governing Bodies across the four CCGs in Herefordshire and Worcestershire also agreed to set up a Joint Commissioning Committee to oversee work relating to the Sustainability and Transformation Plan process in 2017/18.

Supporting General Practice

The General Practice Forward View (GPFV), published in April 2016, sets out significant investment and commitments to strengthen general practice in the short term and support sustainable transformation of Primary Care for the future. The NHS Five Year Forward View states clearly that 'the foundation of NHS care will remain list based primary care'. However, the challenges facing General Practice in Worcestershire means we need to explore and offer opportunities to rethink how the model for General Practice needs to be developed locally in order to be sustainable in the future.

It is becoming increasingly normal for General Practice to work at scale and through a new multispecialty community provider contract we aim to create a new local clinical model and business model for integrated provision of primary and community services. This will be based on GP registered lists and will support integration with a wider range of services including relevant specialists. We endorse the vision for General Practice described in the GPFV being the core role of general practice to provide first contact care to patients with undifferentiated problems, provide continuity of care when needed and act as leaders in larger multidisciplinary teams with greater links to hospital, community and social care specialists.

We remain consistent in our approach that Primary Care will have a strengthened role in delivering sustainability and transformation in Worcestershire and as part of the wider local Sustainability and Transformational Plan's (STP) footprint. Engagement with our member practices has been on-going and will remain at the heart of implementation.

Promoting Clinical Excellence

The CCGs have developed a Promoting Clinical Excellence (PCE) contract for the reinvestment of PMS Premium and some other resources with GP practices. This was piloted with practices in South Worcestershire in 2015/16 and was subsequently rolled out across all practices in Worcestershire in 2016/17.

The key strands of the contract are:

- Workforce development
- Excellent long term conditions care with a particular focus on stroke prevention
- Proactive care of the frail
- Right access – Improving access to other professionals, greater use of technology, care navigation and sign-posting
- Making quality referrals – releasing clinical time to consider patient management options

In 2017/18, the PCE contract will be offered to practices working in groups covering a minimum population footprint of 20,000 patients. The investment will be aimed at supporting release of capacity via practices working across larger economies of scale and to enable skills and expertise to be used more effectively in the coming year.

General Practice working at scale

GP practices are already working collaboratively across some parts of Worcestershire. In Worcestershire we already have three formal Federations established:

- Stay Well Health Care (32 member practices in South Worcestershire)
- North Worcestershire Healthcare (17 member practices in Redditch & Bromsgrove)
- Wyre Forest Federation (11 member practices in Wyre Forest inclusive of a six practice super partnership)

There is also a Bromsgrove Primary Care Network which currently has five member practices.

In February 2017 a conversation started with practices to consider new organisational structures on a wider geographical landscape to increase sustainability and provide economies of scale for General Practice. During 2017/18 a new, strengthened model for General Practice at scale will emerge across Worcestershire.

Financial Recovery Programme

Towards the end of 2016 the three Worcestershire CCG Governing Bodies decided to constitute a Financial Recovery Board. This was in response to the deterioration of the financial position in NHS Redditch and Bromsgrove CCG and with a view to mitigating financial risks in the other two CCGs. The Board has now been established as a formal Committee-in-Common of the three CCGs and will take forward the significant work required to oversee delivery of the combined Worcestershire £45m savings requirement in 2017/18.

Executive Leadership Team

During 2016/17 we have established a single management arrangement across the three Worcestershire CCGs. The aim of this review was to become more efficient by removing duplication of tasks, and to free up management resources to focus on the significant sustainability and transformation work that needed to be undertaken throughout the year. These arrangements will continue into 2017/18 to free up leadership capacity to develop the new models of care and accountable care systems work. There remain no plans to formally merge any of the three Worcestershire CCGs, and Governing Bodies remain in place to ensure that statutory functions are discharged effectively.

The Future of Acute Hospital Services in Worcestershire

A key priority for the three Worcestershire CCGs and Worcestershire Acute Hospitals NHS Trust is to seek a final decision by the CCGs' Governing Bodies on the reconfiguration of acute services. During the year, both the West Midlands Clinical Senate and NHS England Assurance Panel gave assurance that the Future of Acute Hospital

Services in Worcestershire proposed clinical model offered a safe and sustainable service for local patients and this then gave the go-ahead for the public consultation. This consultation process has now come to an end and we are currently reflecting on the responses received as part of this exercise before a final report with recommendations is considered by each CCG's Governing Body in 2017/18.

The work programme has a number of risks associated with it, including the on-going safety services being compromised because of the time taken to complete the review. Further details about these – and other risks to the achievement of our strategic objectives – can be found on page 42.

Performance challenges

It has been another challenging year for our main acute trust provider, Worcestershire Acute Hospitals NHS Trust. There has been significant pressure within the Accident and Emergency (A&E) departments which has resulted in key performance targets not being met. In particular, the Trust has repeatedly failed to meet the national 4-hour target (to see, treat, discharge or admit within 4-hours) at the A&E department at Worcestershire Royal Hospital as well as reporting an increase in 12-hour breaches.

The Trust has also struggled to meet other key targets for certain specialties such as stroke, cancer, and dermatology. A main concern for the CCG has been in relation to the 18-week Referral to Treatment (RTT) target. During the winter months, planned operations were postponed to create extra capacity however this has had a further detrimental effect on achieving the 18-week target. As this is still a challenge for the Trust going into 2017/18, the CCG is working closely to support them to reduce their waiting lists.

Emergency temporary change

Worcestershire Acute Hospitals NHS Trust announced another emergency temporary service change in June when it became apparent that they could not safely staff two paediatric (children) inpatient wards across two sites. The service was subsequently transferred from the Alexandra Hospital in Redditch to the Worcestershire Royal Hospital in Worcester in September 2016.

Improvement required from the Acute Trust

In January the Trust was issued a Section 29A - a statutory warning notice when significant improvement is required in an NHS trust and a simple warning is not enough – following their visit by the Care Quality Commission (CQC) in November and December. The CQC raised many concerns, but the primary reasons for the notice were the systems, processes and the operation of the governance arrangements in place were not effective in terms of identifying and mitigating risks to patients, in relation to which significant improvement is required and providing assurance that actions are taken to improve safety and quality of patient care.

As part of this process the Trust has been required to demonstrate that these identified issues had been acknowledged and initial improvements made by March 2017. The Trust has provided these details to the CQC who is now reviewing their overall improvement plan.

Leadership changes

Some of the challenges that the Trust has faced have not been helped with a number of senior leadership changes and interim appointments in previous years. This year it has been encouraging to see a new Chair appointed who acted quickly to appoint to a new permanent leadership team. A Chief Executive, Chief Nurse, Director of Finance and Medical Director have all now been appointed, and the Trust will start 2017/18 with stable leadership in place for tackling the challenges ahead.

Finance summary

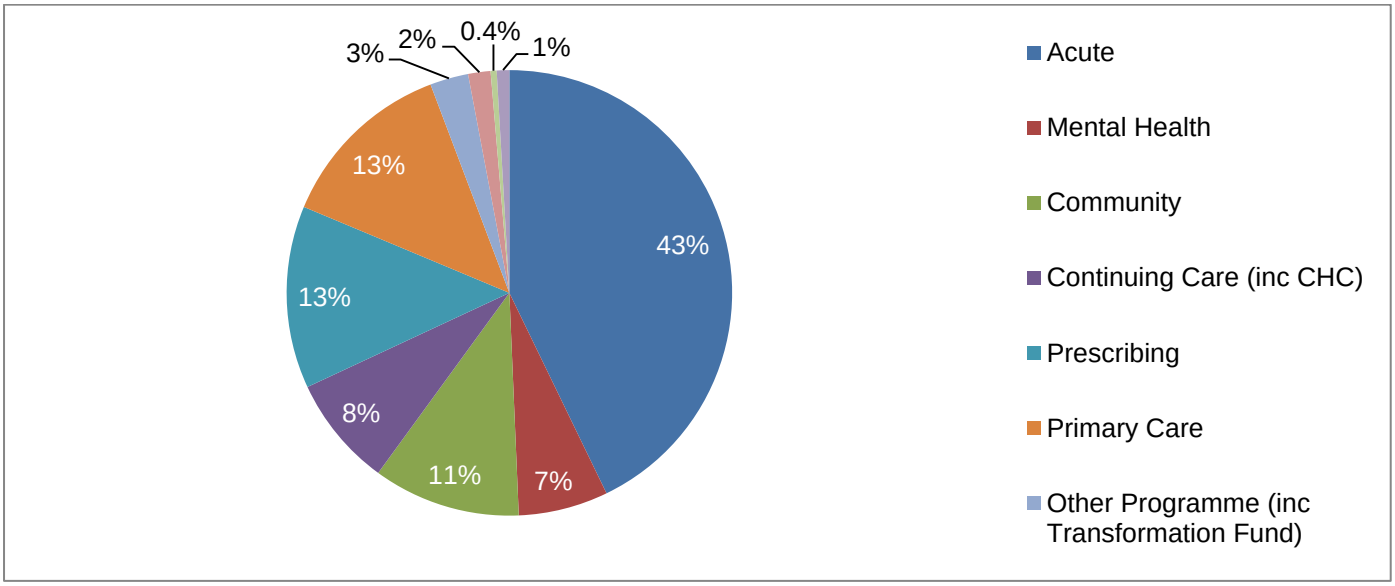
Delivering our Financial Plan

We have delivered our Financial Plan for 2016/17, delivering a total surplus of £7.393m. This included the release of the CCG mandated contribution to the national risk reserve of £3.814m. Adjusting for the impact of the risk reserve the CCG delivered a surplus of £5k compared to the approved financial plan for an in-year breakeven on the resources allocated. This ensured CCG maintained its delivery of its 1% planned cumulative surplus of £3.579m.

This achievement builds on the successful delivery of the Financial Plans in previous financial years. The delivery of our Financial Plan for 2016/17 has been more challenging than previous years, with the on-going requirement to deliver higher levels of cash-releasing efficiency savings against the increasing demand for services, the 40% price impact of the Funded Nursing Care rates and the mandated requirement to freeze 1% of CCG resources to contribute to the national risk reserve for which the CCG would have previously been able to access for Transformational purposes.

During 2016/17 the CCG (in partnership with the other two CCGs in Worcestershire) voluntarily entered a Financial Recovery Process (FRP), this was to support the delivery of the 2016/17 financial plan but also recognising the need to ensure financial stability is maintained heading in to a further challenging financial period within the NHS. Overall 2016/17 saw an increase in expenditure within the Independent Sector where referrals increased throughout the year. Whilst Continuing Healthcare overspent against the plan a huge amount of work was undertaken since the service was brought back in-house from October 2016. This work will ensure we have a head start on the QIPP savings requirement in this area for 2017/18.

The chart below summarises where the CCG money was spent in 2016/17:



Financial Allocation for 2017/18

Our income predominately comes through an approved NHS England allocation which is based on a national funding formula. The allocations for 2017/18 and 2018/19 have been published. These require the CCG to deliver an in-year breakeven. The allocations for 2017/18 included a much reduced inflationary uplift to that seen in previous financial year. The delivery of an in-year breakeven position will ensure we maintain the cumulative 1% surplus.

As part of the financial allocation for 2017/18 this included adjustments for the implementation of the new payment by results system HRG4+. Once the full impact of new prices had been worked through this left the CCG with a cost pressure of £1.4m which partly contributes to the need for a large QIPP savings target in 2017/18.

The allocation will include the return of the 2016/17 surplus that was delivered this year. Current allocations - based on the national funding formula allocated under a place-based process - show that against the CCG programme budget the distance from target has reduced from £11.8m in 2016/17 to £11.3m in 2017/18. Whilst the distance from target is within the NHS England policy of 5%, this leaves the CCG 3.18% away from target which will adds further pressure to the finances during 2017/18.

As part of the place-based allocation our Primary Care allocation remains £8m above fair share funding meaning growth levels in 2017/18 were below inflation. This coupled with the new GMS contractual implications means savings will have to be made within the co-commissioning budget in order to live within the resources allocated.

Other challenges

In addition to the challenging financial allocations we will continue to have financial pressures to manage, mainly around the need to ensure value for money for every pound spent. We will also have on-going recurrent efficiency and productivity savings to make with an ageing population and demand increasing for NHS services.

The CCG will need to ensure focus and attention remains on the underlying surplus position which is a key indicator in terms of the overall financial health of the CCG.

The biggest financial focus of 2017/18 will be the need to recurrently deliver the target savings requirement for 2017/18 of £15.8m (4.0% of overall allocation). This represents a significant financial challenge for 2017/18 and will require some difficult decisions to be made through the FRP process to ensure we live within the financial resources allocated to the CCG.

To further ensure the financial resilience of our organisation is protected we have agreed a full financial risk with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG.

We also hold unallocated contingency reserves to manage any additional costs over agreed financial plans.

System risk reserve

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, we have released our 1% reserve to the bottom line, resulting in an additional surplus for the year of £3.8m. This additional surplus will be carried forward for drawdown in future years.

Long term expenditure trends

As part of the CCG Financial Plan and development of a Medium Term Financial Strategy (MTFS) linked with the overall financial strategy underpinning the Hereford and Worcestershire Sustainability and Transformation Plan (STP) the CCG has modelled in investment in a number of key areas as per the next steps on the NHS Five Year Forward View (FYFV). These areas include increased spend in Primary Care and growth in mental health services through Parity of Esteem.

Going concern

Our annual 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.

The following is clear evidence that the CCG meets the requirements as set out in section 4.13 of the Department of Health Manual of Accounts:

- The CCG was established on 1 April 2013 as a separate statutory body
- The CCG has an agreed Constitution which it is operating to for the governance of its activities
- The CCG has been allocated funds from NHS England for the following financial years 2017/18 and 2018/19
- The CCG has been allocated indicative allocations to 2020/21
- The CCG is allocated a cash drawdown which is based on the cash requirements of the CCG.

After making enquires the directors have a reasonable expectation that the CCG has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt a going concern basis in preparing the accounts.

Areas of focus for 2017/18

In addition to responding to the challenges outlined in the previous sections there are additional areas of focus for us in the coming year:

- Implementing the General Practice Forward View and ensuring that the entire South Worcestershire population has extended access to primary care
- Joint working with the emerging Alliance Board and developing an integrated provider model
- Delivering the 2017/18 Financial Plan (which includes a £15.8m savings requirement) and ensuring that we fulfil our statutory duties by delivering a surplus of £3.573m
- Working with the other two Worcestershire CCGs on the Financial Recovery Plan for Worcestershire
- Continuing to transform local health and care services by embracing new opportunities for us to improve quality, drive integration and focus on a population-based approach to health improvement – key to this will be the Sustainability and Transformation Plan
- Reaching a decision on the future of acute hospital services in Worcestershire and subsequently supporting the implementation of any necessary changes.

Performance analysis

Development and performance during 2016/17

This section describes our performance over the past year. As well as the development of the organisation it sets out how we have performed against some of the requirements set out in the Health and Social Care Act 2012.

We have developed a set of strategic objectives based on the following areas of work:

Transformation

- Transform out of hospital care, developing a new model of care
- Transform the urgent care and patient flow system
- Transform the assessment and review process of those with Continuing Healthcare needs

Improving care and quality

- Improving performance against the NHS constitutional indicators
- Improving the quality of services in providers through implementation of the Quality Strategy

Sustainability

- Sustained financial resilience underpinned by delivery of QIPP
- Sustained clinical services (including the development of STP and delivery of FOAHSW)
- Sustained primary care through sustainable general practice models

Development

- Develop organisational capacity and capability to facilitate effective countywide working
- Develop system-wide infrastructure to ensure successful utilisation of technologies

Performance to date across these objectives has been high with a consistent level of delivery in the majority of areas.

Organisational development

During the year we reviewed the way that we worked with the other two Worcestershire CCGs to remove any unnecessary duplication and free up resources to focus on more transformation and more on the locality work and new models of care.

There were already well established joint teams who worked on commissioning and contracting, medicines management and communications and the review focused on how we could extend these arrangements into other areas.

As part of this work we explored how a single management team and more collaborative working between the respective quality, finance, strategy, corporate and primary care teams could deliver efficiencies. After a consultation and engagement process with staff a new shared management structure was put in place on 1st May. This involved those members of senior staff affected being ‘assigned’ into new roles for the remainder on 2016/17. No redundancies or changes to pay grades were made as part of this exercise. The focus of this work was on back office efficiency, working at scale and freeing up more management resources in order to focus on the significant work agenda and programme that needs to be delivered across the three Worcestershire CCGs during 2016/17.

In the first instance the senior leadership posts were aligned on a countywide basis, with individual leads where one of the posts was vacant or where there was staff absence/planned retirement (in the case of Strategy, Corporate and Primary Care) and aligned shared responsibility where there remained two senior posts (Quality and Finance).

Work subsequently took place with Governing Body Lay Members to discuss the options for shared governance arrangements between the three CCGs, focused in particular at Governing Body Sub-Committee level, again with a view to seek to remove any unnecessary duplication. This resulted in the establishment of a number of committees-in-

common which have put the CCG in a strong position from which to deliver the long-term strategic priorities, financial recovery plan and operating plan.

Sustainable development

Introduction

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 we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. 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. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

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

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features. Sustainability is considered as part of our procurement processes (in terms of environmental and social impact).

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). We will be putting together an SDMP in the near future for consideration by our Governing Body.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

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 Governing Body-approved plan for future climate change risks affecting our area.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a commissioner, evidence of this commitment will need to be provided in part through contracting mechanisms. More information on these measures is available here: www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Improving quality

Under Section 14R of the Health and Social Care Act 2012 we have a duty to improve the quality of services that we commission.

We consider quality to be central to our function as an effective commissioning body. This focus has played an essential role in helping us to ensure that we commission safe, effective services which provide our patients with the best possible experience of NHS-funded care.

Commissioning in a manner that is supportive of compassionate care that acts to reduce unwarranted variation, maximise self-care opportunities and prevention, whilst maintaining safe and effective integrated services continues to be a key driver for the work that our Quality Team undertakes. Support to the Financial Recovery Programme has ensured that each commissioning decision has been subject to a robust Quality Assurance process, and where required, a full Quality Impact Assessment.

We work in close partnership with the other two Worcestershire CCGs and our providers to ensure that all quality issues across the health economy in Worcestershire have appropriate oversight and scrutiny. Quality updates are shared with senior management and executives at a Quality, Performance and Resource Committee in Common for Worcestershire, and with each of the CCG Governing Bodies held in public. This ensures that we are consistent with our statutory duties and clearly communicate outcomes against our commissioning objectives.

The use of patient stories continue to support us to take the opportunity to consider the impact of commissioning decisions and to evaluate and learn from analysis of the performance of local NHS funded provider organisations.

In terms of our focus on quality there have been a number of key achievements in 2016/17:

- Successfully forming an effective countywide Quality Team that works across Worcestershire to quality assure the services that we commission
- Fully in-housing the Continuing Healthcare (CHC) services to Worcestershire CCGs from a previous arrangement managed by a Commissioning Support Unit, thereby strengthening the consistent application of the national framework for CHC
- Delivering the Worcestershire Tissue Viability Strategy, with the commencement of leg ulcer clinics and streamlined processes for ensuring timely access to wound care dressings for care homes with nursing and district nursing
- Achieving the milestones agreed within the Transforming Care Plan for Worcestershire, approved by NHS England
- Delivering bespoke education sessions to raise awareness of the Mental Capacity Act, Deprivation of Liberty Safeguards and Prevent (counter-terrorism strategy) for primary are colleagues
- Oversight of the completion of all required actions for provider organisations and commissioners, following the Care Quality Commission review of Children Looked After and Safeguarding in September 2015
- Working closely with Worcestershire Acute Hospitals NHS Trust to ensure that patients who have excessive waits in the Emergency Department (12-hour breaches) are reviewed to ensure that any harm experienced as a consequence of this delay is identified and addressed
- Developing two web-based portals - one for Care Homes and one for practice nurses work in primary care - that provide a wealth of quality improvement resources and access to available education and training events
- Commencing the roll-out of a range of resources to improve consistent outcomes for those who have a urinary catheter and reduce unnecessary admissions to the Emergency Department or an acute bed because of urinary tract infections
- Working closely with providers and partner commissioning agencies to strengthen processes for reviewing and learning from mortality for the population of Worcestershire
- Raising awareness to prevent pressure damage to patients skin following the roll out of a programme of education, ‘React to Red’, with a specific focus on the care people receive in residential care homes or in their own homes
- Incentivising quality improvements through the use of Commissioning for Quality and Innovation (CQUIN) schemes to drive further improvements in improving the physical health care of people with serious mental ill-health, evidencing health outcomes for people with a learning disability and providing additional focused support for areas of patient flow.

Principles for Remedy

We aim to conform at all times with the Parliamentary and Health Service Ombudsman's 'Principles for Remedy', which defines good practice in dealing with complaints. Specifically it ensures that we are:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement.

In 2016/17 we received 26 complaints about services that we commission. The complaints are categorised as follows:

Subject	Number of complaints
Commissioning - CHC	12
Provider - Acute	6
Provider - Community	3
Provider - NHS111	2
Provider - Independent Sector	1
Provider - Ambulance	1
Provider - Nursing Home	1
Total	**26**

Patient and public involvement

Under Section 14Z2 of the Health and Social Care Act 2012 we have a duty to involve the public in our commissioning plans and decisions.

Our Communication and Engagement Strategy sets out the strategic direction for communication and engagement activities, aiming to ensure that we involve patients, public, staff, clinicians and stakeholders in our decision making process.

We recognise the fundamental importance and benefit of ensuring that our decisions are shaped through effective communication and engagement with the local population and we use 'The Engagement Cycle' as part of our commissioning and engagement planning. 'The Engagement Cycle' is a strategic tool that helps to identify who needs to do what, in order to engage communities, patients and the public at each stage of commissioning.

Our strategy, culture and systems sit at the centre of 'The Engagement Cycle'. This includes our Engagement Framework, which includes; the Patient and Stakeholder Advisory Group (PSAG) chaired by our Lay Member for Patient and Public Involvement, the Patient Participation Group (PPG) Network comprised of our local GP practice patient groups (some of whom also work in localities to effectively engage with their populations), and the Better Together volunteer membership scheme which has 250 members engaged in a variety of activities, from completing surveys, to attending focus groups and taking part in quality visits. Sustaining this Engagement Framework enables us to ensure involvement at all stages of 'The Engagement Cycle'.

Patient Experience is a vital part of 'The Engagement Cycle' as well as being a fundamental part of delivering and ensuring Quality. Patient stories are gathered and presented at our committees and Governing Body meetings. A Patient Experience Dashboard also enables the monitoring of the Friends and Family Test, which we have supported our providers to implement. We also use volunteers in our quality visits to help us speak with patients and understand their experiences.

Our major achievements this year have included:

- 'Your say on the future of health services' was a countywide prioritisation survey we commissioned Worcestershire County Council research team to run on our behalf between April and June. We received almost 4,500 responses, including 1,800 face-to-face responses which was statistically robust and reflected our patient population. The results of this work have helped to shape our QIPP plans and more recently our Financial Recovery Plan
- As part of our Financial Recovery Plan we are currently seeking public views on whether to reduce access to assisted conception treatment and self-care prescriptions including over the counter medicines, gluten free foods, baby milks and oral nutritional supplements
- The Sustainability and Transformation Plan (STP) has shaped our engagement activity this year and featured in our regular public and patient meetings. Working with partners across the footprint of Herefordshire and Worcestershire we have also undertaken targeted engagement on our STP from November 2016 to February 2017 which has included public drop-ins at community venues across the two counties
- In January we launched the Future of Acute Hospitals consultation which closes at the end of March. It describes the proposed clinical model for the Worcestershire Acute Hospitals NHS Trust and we are currently listening to the public's views on this and the impact it will have on them. We have received over 2,000 surveys and contacts through the drop-ins and targeted presentations
- Throughout Spring the Care Quality Commission (CQC) began a thematic review of Diabetes with Worcestershire as part of their national work. This included the need to engage with hard to reach groups including the learning disabled and rural communities
- Several service transformation workstreams have also worked closely with patients to seek their views. These have included Medicines Waste (in partnership with Prescqipp), Parkinson's, Dermatology, Physiotherapy and Urgent Care (particularly focusing on minor injury units and frailty units). Where a workstream has led to the procurement of a service a patient volunteer has supported this process.

Not all members of the community wish to engage with us through traditional methods and we have been focusing on seldom heard groups and developing our relationships with them in 2016/17. Our major achievements in this area include:

- Working with the Voluntary and Community Sector (VCS) to support engagement with hard to reach groups such as engaging with partially sighted patients through Sight Concern and carers through the Worcestershire Association of Carers
- Supporting the VCS in Worcestershire through a grants application process for those organisations who could support the delivery of our local priorities. Five grants for 2017/18 were agreed with a variety of organisations including the YMCA for young people's counselling and the Alzheimer's Society for self-care training
- Being part of the Worcester Diocesan Health and Wellbeing Group, ensuring that their large network of churches and parishes are aware of issues in the health service
- Engaging groups through the Local Arts Partnership in innovative and creative new ways
- Working with Malvern Hills District Council to deliver an alcohol campaign aimed at Pickersleigh residents
- Engaging with young people through the Worcestershire Youth Engagement Forum, the Youth Board of the Worcestershire Health and Care NHS Trust, Fresher's Fair and Youth Takeover Day
- Becoming members of the Carers Partnership which discusses carer issues across Worcestershire
- Continuing our relationship with Speakeasy (learning disability charity) by attending their meetings and speaking with their clients, especially regarding our prioritisation survey.

Reducing health inequality

Under Section 14T of the Health and Social Care Act 2012 we have a duty to reduce health inequalities for patients across South Worcestershire.

The Herefordshire and Worcestershire Sustainability and Transformation Plan (published in November 2016) states:

> *"There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire. The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcestershire and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access."*

This demonstrates the acknowledgement of this issue and the particular challenge our rural geography poses. The STP continues to explain that we plan to tackle health inequalities particularly in mental health, learning disabilities and by promoting self-care and prevention.

We know that in all three districts across South Worcestershire, deprivation seems to have a greater effect on life expectancy for males than females. Worcester has the greatest range in life expectancy by deprivation for males, this means that interventions in the future here could have the greatest impact on overall population health outcomes.

Potential Years of Life Lost (PYLL) is an outcome in the CCG Outcomes Indicator Set (OIS) measuring the number of years of life lost per 100,000 registered patients from conditions which are usually treatable. Causes considered amenable to health care are those from which premature deaths should not occur in the presence of timely and effective health care. It is pleasing to note that across South Worcestershire there is a significantly low overall PYLL rate compared to England. For individual conditions it is significantly low for respiratory diseases.

Health inequalities are not a problem we can tackle in isolation. Our approach has been to work in partnership with Worcestershire County Council, Public Health, our member GP practices, the Voluntary and Community Sector and patients themselves through co-production.

In August this year we were invited by NHS England to take part in the self-assessment of a new quality standard that brought together the patient and public involvement and reducing health inequality duties. The new standard has been designed to use patient and public insight, experience and involvement to reduce health inequality and to drive improvement. In response we developed a framework to formulate our strategic approach. This included reflecting on how 'The Engagement Cycle' (that forms the base of our engagement approach) could also support us to understand health inequalities, develop solutions and monitor their impact.

The strategic approach can be found on our website at http://www.southworcsccg.nhs.uk/about-us/useful-documents.

Work has also been underway to establish a countywide Worcestershire CCG VCS grant fund. The purpose of the grant is to offer VCS organisations the opportunity to work with the CCG on their priorities. The CCGs received 40 applications and granted 5 across the county. The following organisations and projects were granted funding for 2017/18:

- The Alzheimer's Society – self-care for those with dementia and their carers (Worcestershire)
- Worcestershire YMCA – mental health awareness and counselling (Worcestershire)
- Sight Concern – ActivEYES: physical activity for those with sight loss (Worcestershire)
- Heartstart Malvern – resuscitation training (Malvern Hills)
- Bromsgrove and Redditch Network – micro-volunteering (Bromsgrove and Redditch)

Full details of these grants are available on the CCG website at: http://www.southworcsccg.nhs.uk/get-involved/vcs-grants-application-process-and-criteria. These five projects support a wide range of health inequalities including, those with dementia, BAME communities and carers (Alzheimer's), young people (YMCA), those with sensory impairment (Sight Concern), volunteering aimed at deprived communities (Heartstart) and a variety of hard to reach groups (e.g. single parents, those in work, deprived communities) (BARN).

There are also a number of local specific initiatives we have carried out to help reduce health inequalities across South Worcestershire:

- We are continuing to commission the Homeless Health Hub at Maggs Day centre with a commissioned GP drop-in service from Farrier House Surgery. In May 2016 the Worcestershire Health and Wellbeing Board signed the Charter for Homeless Health and subsequently the Homeless Health Hub Steering Group was formalised and widened to cover all of Worcestershire. The Charter for Homeless Health states that we will: 'Identify Need, Provide Leadership and Commission for Inclusion'
- Time to Talk is a low level listening and signposting service provided by three practices in deprived areas across South Worcestershire and supported by the CCG. This service has acted as a 'pilot' and work is developing on a wider Social Prescribing model to be embedded across Worcestershire after Time to Talk ends in March 2017
- Speakeasy NOW, a local learning disability charity has been commissioned through their 'Healthcheckers' Service to monitor the experience of learning disabled people of health services. Their report on GP practices produced a 'top tips guide for GPs' to help improve access for people with learning disabilities. This was

presented to our Governing Body in January 2016 where we asked them to follow up this work which they have been doing throughout 2016/17.

- Age UK provides a service for Black Minority Ethnic patients at a GP practice in Worcester commissioned by the CCG to provide health and social inclusion sessions. This has included diet and exercise information for Asian women, proactively contacting patients who regulary 'do not attend' (DNA) and promoting preventative screening.
- The CCG has supported GP practices and NHS providers to meet the requirements of the Accessible Information Standard (AIS). This has included promoting translation services to GPs and meeting with providers to review the action plans they had in place to improve access to services.
- Our hard to reach engagement (detailed in the patient and public involvement section above) also includes engagement which aims to reduce health inequalities by increasing our knowledge and understanding of some of these groups.

Equality, inclusion and human rights

This section of the report sets out how we have been demonstrating 'due regard' to the Public Sector Equality Duty (PSED).

In the past year, equality and diversity and human rights have been central to our work in ensuring that there is equality of access and treatment within the services that we commission. Much of this work has been developed through effective partnership work on reducing health inequalities by engaging with the local community, patients and the public.

We are committed to ensuring that equality, inclusion and human rights remains central to business planning, workforce experience, service delivery and community and patient outcomes.

Workforce

We have robust policies and procedures in place which help to ensure that all staff are treated fairly and with dignity and respect and we are committed to promoting equality of opportunity for all current and potential employees. The CCG is aware of the legal equality duties as a public sector employer and service commissioner and have equality and diversity training in place for all staff. Training sessions have taken place in 2016 and further training will be scheduled throughout 2017 so that all staff will have received face-to-face training in addition to online training for Equality, Inclusion and Human Rights.

Legal Compliance

We continue to show due regard to the aims of the Public Sector General Equality Duty through meeting the requirements of the Equality Act 2010 and by adopting appropriate policies and procedures as set out below:

Equality Impact and Risk Assessment (EIRA) process

An EIRA toolkit has been developed to help us to identify potential and actual inequalities, enabling any service changes to be more inclusive of groups who are seldom heard and equipping staff to respond appropriately to any inequalities identified.

We have repeatedly communicated to staff the importance of undertaking EIRAs at the time of developing and reviewing policies and redesigning any services. To equip staff with the necessary skills in undertaking the EIRAs training has been delivered to those specifically responsible for policy development and service redesign.

We have also undertaken equality analysis and human rights screening when carrying out commissioning duties to ensure that the CCG is paying 'due regard' to the three aims of the PSED and the Human Rights Act.

Equality Objectives

The CCG identified a number of Equality Objectives and aligned them to the Equality Delivery System (EDS) Framework in 2013. The Equality objectives were based upon organisational priorities and gaps identified following the dissolution of Worcestershire Primary Care Trust in 2013 and the subsequent authorisation of the Worcestershire

CCGs. During 2016/17 we have made progress against some of the Equality Objectives with more activities planned for 2017/18.

In this coming year the current Equality Objectives and equality strategy will be reviewed and new ones set as informed by information analysis of workforce data, Accessible information Standard (AIS), Workforce Race Equality Standard, Equality Delivery System 2 and local health needs assessment.

Equality Delivery System (EDS2)

We have adopted the Equality Delivery System (EDS2) as our performance toolkit to support us in demonstrating compliance with the three aims of the Public Sector Equality Duty.

The main purpose of the EDS is to help local NHS organisations like ourselves, in discussion with local partners, to review and improve our performance for supporting people with characteristics protected by the Equality Act 2010. The EDS grading process provides our Governing Body with an assurance mechanism for compliance with the Equality Act 2010 and enables local people to co-design our equality objectives to ensure improvements in the experiences of patients, carers, employees and local people.

This year we have focused on EDS2 Goal 4. Plans will be put in place to address the other Goals in 2017/18 as part of the overall action plan. Goal 4 has been completed and the outcome is detailed in the Equality and Inclusion Annual Report which will be published on the CCG's website in 2017. In subsequent years the aim will be to increase the number of projects and themes whilst looking to improve on the previous year's assessment.

Performance monitoring of providers and procurement

We are required by law to make sure that when services are commissioned from providers, there are assurance mechanisms in place to assess compliance with equality legislation. In order to achieve this, we have plans to agree a local set of equality monitoring requirements with provider organisations in 2017/18 contracts.

The CCG has also already strengthened the procurement process by the inclusion of key equality questions at the Pre-Qualification (PQQ) stage. Furthermore, we will plan to ensure that contracts and Service Level Agreements (SLAs) contain information requirements around duties and responsibilities under the Equality Act 2010 and these are quality reviewed.

Meeting Human Rights requirements

Through Equality and Diversity Training and the completion of Equality Impact Risk Assessments (EIRAs) we have ensured that Human Rights screening on all core commissioning activity is undertaken. All Human Rights Screening outcomes are embedded into the equality analysis for consideration when commissioning services.

Workforce Race Equality Standard (WRES)

Our Governing Body ensures, through overview and reporting processes, that we continue to give due regard to using the WRES indicators to help improve workplace experiences - and representation at all levels within the workforce - for Black, Asian and Minority Ethnic (BAME) staff. We will also seek assurance that providers are implementing the NHS Workforce Race Equality Standard.

Accessible Information Standard (AIS)

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. We are committed to the implementation of the AIS and have included information on our website which directs patients and the public on how to access information in an accessible format.

Priorities for 2017/18 and beyond

There is currently a consultation being carried out by NHS England which will introduce a new standard in 2017/18 called the Workforce Disability Equality Standard (WDES). This will apply to all CCGs as well as providers and mirrors the current standard around race equality.

We will be in a position to implement the WDES as guidance starts to filter through by NHS England on timescales for 2017. The following areas also highlight some key areas of focus for 2017/18:

- Development of the Equality Strategy 2017/2020
- Development of Equality Objectives 2017/2020
- Continued work on Workforce Race Standard
- One-to-one training for commissioning staff on the Equality Impact and Risk Assessment (EIRA) process
- Staff training on equality and diversity
- Better and on-going engagement with BAME communities, helping to better understand the health needs and priorities for these communities
- Work on EDS2 Goals 3 and 1
- Quality review of provider annual reports on equality
- Continued work within the procurement process on equality evaluation.

Our performance

We have a duty to improve the quality of services we commission, to promote the NHS Constitution, to provide information on the safety of services provided, and to reduce health inequalities. Our mechanism for doing this has been the establishment of a performance framework that identifies where we do, or do not, meet the standards expected.

There are two main requirements on us as a CCG for which we are accountable:

- Delivery of NHS Constitution requirements
- Delivery of national and local quality requirements.

Performance during 2016/17

NHS Constitutional Targets achievement is a priority to the CCG. During 2016/17 performance has been at the level across a number of areas that the CCG expects or commissions. The main provider where performance has been challenged has been at Worcestershire Acute Hospitals NHS Trust where the CCG commissions the majority acute services for Worcestershire residents. The CCG continues to challenge performance below expected standards through a number of routes but use the NHS Standard Contractual route to formalise remedial action plans (RAPs) with providers.

We describe below our performance for each of the NHS Constitution indicators:

Indicator		Target	Achieved
Cancelled operations	All patients who have operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patients choice	95%	74.30%
A&E waits	Patients should be admitted, transferred or discharged within four hours of their arrival in an A&E Department	95%	81.50%
	Trolley waits in A&E < 12 hours	0	367
Referral to Treatment waiting times for non-urgent consultant led treatment	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	83.98%
	Number of 52 week waiters on an incomplete pathway	0	10
Cancer - 2-Week Waits	Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	75.72%

Indicator		Target	Achieved
	Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	67.69%
Cancer Waits - 31-Days	Maximum one month (31 day) wait from diagnosis to first definite treatment for all cancers	96%	96.86%
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	90.91%
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regime	98%	99.65%
	Maximum 31 day wait for subsequent treatment where that treatment is a course of Radiotherapy	94%	99.24%
Cancer Waits - 62-Days	Maximum two months (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	70.98%
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	88.97%
	Maximum 62 day wait for first definitive treatment following a consultant decision to upgrade the priority of the patient (all cancers)	TBC	87.95%
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than six weeks	99%	95.51%
Category A ambulance calls	Red performance - response within eight minutes	75%	62.46%
	Ambulance handover times - % < 30 minutes (Worcestershire Acute position)	85%	85.29%
Mixed Sex Accommodation Breaches	Minimise breaches	0	30
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within seven days of discharge from psychiatric inpatient care during the period	95%	98.40%
	IAPT - % of patients with depression and/or anxiety disorders who receive psychological therapies	18%	19.37%
	IAPT recovery - % of patients who have completed treatment who are moving to recovery	50%	40.71%
	% of people that wait six weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	75%	65.38%
	% of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	95%	88.46%
	% of people that wait six weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	75%	78.57%
	% of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	95%	95.92%

Indicator		Target	Achieved
	Estimated diagnosis rate for people with dementia for those patients aged 65+	67%	55.93%
Health Care infections	Incidence of healthcare associated infections - MRSA	0	5
	Incidence of healthcare associated infections – C Difficile	63	52

2016/17 Improvement and Assessment Framework

In addition to the NHS Constitution Indicators set out above this year a new Improvement and Assessment Framework for CCGs has been designed to provide greater visibility and accountability around whole system effectiveness and to provide specific indicators to be incorporated in Sustainability and Transformation Plans.

The framework covers four domains:

- Better Health (this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve)
- Better Care (this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas)
- Sustainability (this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends)
- Leadership (this domain assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest).

The latest performance indicators can be found on the My NHS website at https://www.nhs.uk/service-search/Performance/Search.

Accountability Report

Dr Carl Ellson
Accountable Officer
NHS South Worcestershire CCG
26 May 2017

Corporate Governance Report

Members Report

Our GP membership

There are 32 GP member practices which form NHS South Worcestershire CCG. In order to maintain active engagement of all member GP practices across South Worcestershire, and to be able to respond effectively to the healthcare needs of local communities, we have organised our member practices into four distinct locality groups:

Droitwich and Ombersley Locality

- Spa Medical Practice, Droitwich Health Centre, Ombersley Street Droitwich Spa, WR9 8RD
- Corbett Medical Practice, 36 Corbett Avenue, Droitwich Spa, Worcestershire, WR9 7BE
- Salters Medical Practice, Droitwich Medical Centre, Droitwich Spa, Worcestershire, WR9 8RD
- Ombersley Medical Centre, Main Road, Ombersley, Worcester, WR9 0EL

Evesham, Bredon, Broadway and Inkberrow Locality

- De Montfort Medical Centre, Burford Road, Evesham, Worcestershire, WR11 3HD
- Abbey Medical Practice, Abbey Lane, Evesham, WR11 4BS
- Riverside Surgery, Waterside, Evesham, Worcestershire, WR11 1JP
- Merstow Green Medical Practice, Abbey Lane, Evesham, WR11 4BS
- Barn Close Surgery, 38-40 High Street, Broadway, Worcestershire, WR12 7DT
- Bredon Hill Surgery, Main Road, Bredon, Tewkesbury, GL20 7QN
- Grey Gable Surgery, High Street, Inkberrow, Worcestershire, WR7 4BW

Malvern Hills, Pershore and Upton Locality

- Upton Surgery, Tunnel Hill, Upton Upon Severn, Worcester, WR8 0QL
- Tenbury Wells Surgery, 34 Teme St, Tenbury Wells, Worcester, WR15 8AA
- Malvern Health Centre, Prospect View, 300 Pickersleigh Road, Malvern, WR14 2GP
- New Court Surgery, Prospect View, 300 Pickersleigh Road, Malvern, WR14 2G
- Link End Surgery, 39 Pickersleigh Road, Malvern, Worcestershire, WR14 2RP
- St Saviours Surgery, Merick Road, Malvern Link, WR14 1DD
- Whiteacres Medical Centre, Maple Road, Malvern, Worcester, WR14 1GQ
- Abbottswood Medical Centre, Defford Road, Pershore, Worcestershire, WR10 1HZ
- Pershore Medical Practice, Queen Elizabeth Drive, Pershore, Worcestershire, WR10 1PX
- Knightwick Surgery, Bromyard Rd, Knightwick, Worcester, WR6 5PH
- Great Witley Surgery, Worcester Road, Great Witley, Nr Worcester, WR6 6HR

Worcester City Locality

- Elbury Moor Medical Centre, Fairfield Close, Worcester, WR4 9TX
- Haresfield Surgery, Turnpike House Medical Centre, 37 Newtown Road, Worcester, WR5 1HG
- Severn Valley Medical Practice, Henwick Halt Medical Centre, 1 Ingles Drive, Worcester, WR2 5HL
- Barbourne Health Centre, 44 Droitwich Road, Worcester, WR3 7LH
- St John's House Surgery, 299 Bromyard Road, Worcester, WR2 5FB
- Albany House Surgery, Albany Terrace, Worcester, WR1 3DU
- Spring Gardens Health Centre, Spring Gardens, Worcester, WR1 2BS
- St Martin's Gate Surgery, 37 Newtown Rd, Worcester, WR5 1EZ
- Farrier House Surgery, Farrier Street, Worcester, WR1 3BH
- Thorneloe Lodge Surgery, 29 Barbourne Road, Worcester, WR1 1RU

Our Governing Body

Our Governing Body is clinically-led, including seven GPs, a registered nurse and a secondary care clinician, all of whom have day-to-day knowledge of the health problems that residents face.

Its role is to ensure that we have appropriate arrangements in place to exercise our functions effectively, efficiently and economically, and in accordance with the generally accepted principles of good governance, the NHS Constitution and our own local Constitution.

Dr Carl Ellson is our Chief Clinical Officer and Accountable Officer for the organisation and is a member of our Governing Body, as well as chair of the Clinical Executive and the Clinical Development and Innovation Group. Dr Ellson is responsible for the professional and clinical leadership of the other GP Clinical Leads, for liaising with the localities, for championing the NHS Constitution and assumes overall responsibility for the Quality, Innovation, Productivity and Prevention (QIPP) programme and the strategic direction of the organisation.

Our Governing Body meets in formal public sessions six times a year. It is provided with accurate, timely and clear information so it can maintain full and effective control over strategic, financial, operational, compliance and governance issues.

During 2016/17 our Governing Body members were:

- Dr Anthony Kelly | Chairman & Joint Clinical Lead for Droitwich and Ombersley
- Dr Carl Ellson | Chief Clinical Officer & Joint Clinical Lead for Droitwich and Ombersley
- Dr David Farmer | Clinical Lead for Evesham, Bredon and Broadway
- Dr George Henry | Joint Clinical Lead for Malvern, Pershore and Upton
- Dr Jonathan Thorn | Joint Clinical Lead for Malvern, Pershore and Upton
- Dr Nikki Burger | Joint Clinical Lead for Worcester City
- Dr Lindsay Pickerell | Joint Clinical Lead for Worcester City
- Mari Gay | Interim Chief Operating Officer
- Lisa Levy | Interim Executive Nurse
- Lucy Noon | Director of Corporate and Organisational Development
- Mark Dutton | Chief Finance Officer
- David Mehaffey | Director of Strategy
- Lynda Dando | Director of Primary Care
- Alistair Munro | Secondary Care Clinician
- Trish Haines | Lay Member for Integration and Partnerships
- Rob Parker | Lay Member for Audit and Governance
- Sarah Harvey Speck | Lay Member for Public and Patient Involvement

Committees

Our Governing Body is supported by a number of committees and sub-committees who meet on a regular basis throughout the year to review, assess, and regulate the activities and responsibilities of the organisation. The details of these committees, including Audit Committee, and the membership of each one can be found within the Governance Statement.

Each year we aim to assess the effectiveness of our committees by inviting members to rate and comment upon a number of key areas relating to each committee's operation. In order to do this a set of questions are devised, which are shaped by national surveys, to form a local template. This is subsequently distributed in an electronic survey format to each committee member. Intelligence derived from these surveys has previously resulted in amendments to committee terms of reference, the scheme of delegation and our Constitution.

Appraisals

The performance of the Chief Operating Officer and Chief Clinical Officer is appraised by our lay members at Remuneration Committee. The performance of our Chair is appraised by NHS England.

Register of Interests

It is an essential feature of the NHS that CCGs should be able to commission a range of community-based services, including primary care services, to improve quality and outcomes for patients.

Where the provider for these services might be a GP practice, CCGs will need to demonstrate that those services meet clear criteria including that the appropriate procurement approach is used. These services will be commissioned using the NHS standard contract.

CCGs could also make payments to GP practices for promoting improvements in the quality of primary medical care (e.g. reviewing referrals and prescribing); or carrying out designated duties as healthcare professionals in relation to areas such as safeguarding.

Consequently conflicts of interest are likely to arise where GPs who provide healthcare services also input into commissioning decisions about those services in their area. It is how these conflicts are managed that will ensure public funds are spent appropriately and that confidence and trust between the public, patients and GPs is maintained.

Our Governing Body is not aware of any relevant audit information that has been withheld from our external auditors, and members of our Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

We have a Conflicts of Interest Policy in place, publicly available Register of Interests and Register of Procurement Decisions. All of these can be found on our website at http://www.southworcsccg.nhs.uk/about-us/corporate-information/conflicts-of-interest.

Personal data related incidents

A Serious Incident Requiring Investigation (SIRI) is any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and/or the Common Law of Confidentiality.

This includes:

- Unlawful disclosure or misuse of confidential data
- Recording or sharing of inaccurate data
- Information security breaches and inappropriate invasion of people's privacy
- Personal data breaches which could lead to identity fraud or have other significant impact on individuals.

Preventative measures taken during the year included making sure staff completed their annual IG training, awareness raising through quarterly information governance newsletters, and use of confidentiality audit surveys to monitor and maintain staff awareness and understanding around Information Governance.

During 2016/17 one Serious Incident (SI) involving personal data was reported to the Information Commissioner's Office (ICO):

Date of Incident	Nature of Incident	Nature of Data Involved	Number of Data Subjects Potentially Affected	Notification Steps
18th January 2017	Unauthorised Access/Disclosure	A member of staff opened an audio file and heard the content in relation to a HR investigation into another member of staff.	1	Inform member of staff by letter.

Further Action on Information Risk	The CCG completed an IG Incident Reporting Form and have appointed an investigating officer to carry out a Root Cause Analysis (RCA). There is no ICO action required.

There were no other personal data related incidents in 2015/16

Statement of Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

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

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

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

I also confirm that:

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

Dr Carl Ellson
Accountable Officer

Governance Statement

Introduction and context

NHS South Worcestershire CCG is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2016, the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 (as amended).

Scope of responsibility

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

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group as set out in this Governance Statement.

Governance arrangements and effectiveness

The Clinical Commissioning Group is accountable for exercising the statutory functions of the group. However, it may grant authority to act on its behalf to any of its members, its Governing Body, its employees or committees of the group as expressed through the group's scheme of delegation and committees' terms of reference. The members of the group meet monthly as South Worcestershire Localities. The group has delegated all decision making to the Governing Body with these exceptions:

- Approve any material changes to the group's constitution
- Approve the vision, values and overall strategic direction of the group
- Approve the decision to dismiss a member of the group
- Ratify appointments to the group's governing body
- Approve the removal of members of the group's governing body.

The group remains accountable for all of its functions, including those that it has delegated.

Governing Body

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. The role of the Governing Body, the types of decisions taken by the Governing Body or delegated to committees or Executive Officers are detailed in the scheme of delegation and reservation.

Roles and Responsibilities

The Governing Body voting membership in 2016/17 and attendance rates were as follows:

Name	Role	In office during 2016/17	Attendance
Dr Anthony Kelly	Chair and Clinical Lead	1 April 2016 – 31 March 2017	6/6
Dr Carl Ellson	Chief Clinical Officer	1 April 2016 – 31 March 2017	5/6
Dr David Farmer	GP Member, Clinical Lead for Evesham, Bredon and Broadway	1 April 2016 – 31 March 2017	5/6
Dr George Henry	GP Member, Joint Clinical Lead for Malvern, Pershore and Upton	1 April 2016 – 31 March 2017	6/6
Dr Jonathan Thorn	GP Member, Joint Clinical Lead for Malvern, Pershore and Upton	1 April 2016 – 31 March 2017	5/6
Dr Nikki Burger	Joint Clinical Lead for Worcester City	1 April 2016 – 31 March 2017	5/6
Dr Lindsay Pickerell	Joint Clinical Lead for Worcester City	1 April 2016 - 31 March 2017	6/6
Mari Gay	Interim Chief Executive Officer	1 April 2016 - 31 March 2017	6/6
Mark Dutton	Chief Finance Officer	1 January 2017 – 31 March 2017	6/6
Lisa Levy	Interim Executive Nurse and Director of Quality	1 April 2016 - 31 March 2017	6/6
Alistair Munro	Secondary care Clinician	1 April 2016 - 31 March 2017	6/6
Sarah Harvey-Speck	Lay Member for Patient and Public Engagement	1 April 2016 - 31 March 2017	6/6
Rob Parker	Lay Member for Audit and Governance	1 April 2016 – 31 March 2017	5/6
Trish Haines	Lay Member for Integration and Partnership	1 April 2016 - 31 March 2017	5/6

Re-elections & Appointments to the Governing Body

The CCG Constitution sets out the arrangements for election and re-election of members of the Governing Body. All GP members including the Chairman were re-elected in April 2016 and Dr Lindsay Pickerell was elected into his role for the first time.

Commitment

All Governing Body members allocate time as per a statement of appointment and are in line with national guidance. The frequency of attendance at meetings is monitored throughout the year. The allocation of time is reviewed regularly against the portfolio of responsibilities and adjusted accordingly.

Development

Together with an ongoing programme of individual and organisational development, bi-monthly Governing Body Development sessions take place.

Evaluation & Effectiveness

Individual performance reviews for Governing Body members were completed in 2016/17 and the effectiveness of the Governing Body and committees is reviewed annually. NHS England reviews the performance of the CCG quarterly. The CCG has maintained the nationally required Governing Body composition and membership through 2016/17.

Meetings of the Governing Body

The Governing Body met six times during 2016/17 and held all meetings at alternative locations in South Worcestershire area. The dates of the meetings were published at least three months in advance and papers were made available to members and the public through the Clinical Commissioning Group's website seven days prior to the meeting. Members of the public are invited to put questions to the Governing Body at least 24 hours prior to the meeting and the Governing Body welcome the opportunity to provide a response.

The Governing Body continues to concentrate on strategic issues whilst assuring itself of the performance of the whole organisation. The work of the Governing Body has focused on:

- Review and approval of strategic commissioning plans
- Agreeing plans for financial recovery programme
- Monitoring of quality, performance and finance
- Monitoring of Future of Acute Hospital Services Review
- Monitoring of the activities and decisions taken by the Governing Body's committees.

The Governing Body reviews the effectiveness of the CCG and the Governing Body members and references stakeholder surveys, individual appraisals, NHS England assurance reports and feedback, staff surveys and delivery against commissioning and financial plans.

The organisation development plan is refreshed at intervals informed by staff and stakeholder surveys, individual development plans and the outcome of the self- assessment.

Committees of the Governing Body

To support the Governing Body in carrying out its duties effectively, sub-committees reporting to the Governing Body are formally established. Following the formation of a shared management team across the three CCGs in Worcestershire, during August and September 2016 the CCGs established the following committees as committees in common:

- Audit Committee
- Remuneration Committee
- Quality, Performance and Resource Committee
- Primary Care Commissioning Committee
- Financial Recovery Board (December 2016)

There are further plans to establish Clinical Executive Committee as a committee in common from 1st April 2017.

Committees in common enable the CCGs to work efficiently by holding meetings at the same place at the same time. This governance arrangement facilitates aligned decision making while ensuring that each CCG remains fully accountable for the decisions they make.

The remit and terms of reference of these committees were reviewed during the year to ensure robust governance and assurance. Each sub-committee receives a set of regular reports and provides summary reports to the Governing Body for each Governing Body meeting and these are available with the Governing Body meeting papers.

Audit Committee

This committee provides assurance on integrated governance, risk management, internal control, internal and external audit, counter fraud and security management financial reporting. During 2016/17 the key areas of work of the committees were:

- Integrated governance, risk management and internal control
- Approving internal and external audit plans, reviewing progress against these and receiving assurance on actions taken following audits
- Reviewing counter fraud work programme and reports
- Monitoring the integrity of the financial statements of the Clinical Commissioning Group and any formal announcements relating to the Clinical Commissioning Group's financial performance
- Review of systems for financial reporting to the Clinical Commissioning Group, including those of budgetary control.

The committee operated as a committee in common with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG from 1 October 2016 until 31 March 2017.

The membership of the committee in 2016/17 was as follows:

Name	Role	Membership of the committee during 2016/17
Rob Parker (chair)	Lay Member for Audit and Governance	1 1 April 2016 – 31 March 2017
Trish Haines	Lay Member for Integration and Partnership	1 April 2016 - 31 August 2016
Carol Thompson	Co-opted Lay Member	1 April 2016 - 31 March 2017
David Wigley	Co-opted Lay Member	1 April 2016 - 31 March 2017

Remuneration Committee

This committee makes recommendations to the Governing Body on determinations about pay and remuneration including salary awards and pension as well as other terms and conditions of employment contracts. During 2016/17 the key areas of work of the committee were:

- Recommending to the Clinical Commissioning Group Governing Body the remuneration of GP and lay Governing Body members
- Recommending to the Clinical Commissioning Group Governing Body the remuneration and conditions of service of the Accountable Officer and senior team
- Reviewing the performance of the Accountable Officer and other senior team members and recommending annual salary awards, if appropriate
- Recommending to the Clinical Commissioning Group Governing Body the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees
- Considering the severance payments of the Accountable Officer and other senior staff, and recommend seeking HM Treasury approval as appropriate in accordance with the guidance“ Managing Public Money” (HM Treasury.gov.uk)
- Responsibility for identifying and nominating for the approval of the Clinical Commissioning Group Governing Body/or group candidates to fill non-member practice places on the Clinical Commissioning Group Governing Body.

The committee operated as a committee in common with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG from 1 October 2016 until 31 March 2017.

The membership of the committee in 2016/17 was as follows:

Name	Role	Membership of the committee during 2016/17
Alistair Munro (chair)	Secondary Care Clinician	1 April 2016 – 31 March 2017
Rob Parker	Lay Member for Audit and Governance	1 April 2016 – 31 March 2017
Sarah Harvey-Speck	Lay Member for Public and Patient Involvement	1 April 2016 – 31 March 2017

Quality, Resource and Performance Committee

The function of the committee is to promote a culture of quality and focussed on key areas of work during 2016/17 including:

- Monitoring the quality and safety of all services (primary, secondary and tertiary care, including the independent sector) commissioned by the CCG for its total population
- Seeking assurance relating to financial governance across the CCG to secure value for money and sound financial stewardship
- Receiving reports detailing all commissioner and provider performance targets, set both nationally and locally, and seek appropriate assurances that these are met
- Where possible providing assurance to the CCG Governing Body on these areas of responsibility
- highlighting areas of limited assurance and making recommendations where necessary
- Identifying and mitigating risk associated with quality performance & finance.

The committee was established as a committee in common with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG from 1 October 2016 until 31 March 2017.

The membership of the committee in 2016/17 was as follows:

Name	Role	Membership of the committee during 2016/17
Trish Haines (chair from October 2016)	Lay Member for Integration and Partnership	1 April 2016 - 31 March 2017
Sarah Harvey-Spec	Lay Member for Patient and Public Involvement	1 April 2016 - 31 March 2017
Rob Parker	Lay Member for Audit and Governance	1 April 2016 - 31 March 2017
Alistair Munro	Secondary Care Clinician	1 April 2016 - 31 March 2017
Dr George Henry (chair until October 2016)	GP Quality Lead	1 April 2016 - 31 March 2017
Dr Carl Ellson	Accountable Officer	1 April 2016 - 31 March 2017
Mari Gay	Interim Chief Operating Officer	1 April 2016 - 31 March 2017
Mark Dutton	Chief Finance Officer	1 April 2016 - 31 March 2017
Lisa Levy	Interim Executive Nurse and Director of Quality	1 April 2016 - 31 March 2017
Lucy Noon	Director of Corporate and Organisational Development	1 April 2016 - 31 March 2017
David Mehaffey	Director of Strategy	1 April 2016 - 31 March 2017

Clinical Executive Committee

The function of the committee is to bridge the gap between the role of the Governing Body in setting strategy and delivering health improvements for the people of South Worcestershire, and the operational business of commissioning services and placing contracts on a daily basis. The committee focused on the following key areas of work during 2016/17:

- Ensure that commissioning decisions are consistent with the overall strategies set by the South Worcestershire CCG Governing Body
- Offer advice to the CCG Governing Body on the content and direction of strategies
- Receive and approve outline business cases. To ensure that cases reflect agreed policies and strategies, are consistent with care pathways agreed (or to be agreed) with providers and that procurement proposals are consistent with the Governing Body strategy
- Initiate reviews of services where it appears existing services are not meeting the needs of patients appropriately. This will include when there are concerns about safety, quality, and clinical effectiveness, value for money or patient experience. The CCG Clinical Executive Team will seek advice from relevant stakeholders when initiating reviews, and refers details of any reviews to the CCG Patient and Public Forum for advice on appropriate levels of public and stakeholder consultation
- Agree proposed incentive and CQUIN schemes
- Approve HR strategies and policies.

The membership of the committee in 2016/17 was as follows:

Name	Role	Membership of the committee during 2016/17
Dr Carl Ellson (chair)	Chief Clinical Officer	1 April 2016 - 31 March 2017
Dr Nikki Burger	GP Member	1 April 2016 - 31 March 2017
Mari Gay	Interim Chief Operating Officer	1 April 2016 - 31 March 2017
Mark Dutton	Chief Finance Officer	1 April 2016 - 31 March 2017
Lisa Levy	Interim Executive Nurse and Director of Quality	1 April 2016 - 31 March 2017
David Mehaffey	Director of Strategy	1 April 2016 - 31 March 2017
Lucy Noon	Director of Corporate and Organisational Development	1 April 2016 - 31 March 2017

Lynda Dando	Director of Primary Care	1 April 2016 - 31 March 2017
Nisha Sankey	Associate Director of Transformation	1 April 2016 - 31 March 2017
Jane Freeguard	Head of Medicines Management	1 April 2016 - 31 March 2017

Primary Care Commissioning Committee

NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act. The function of the committee is to evaluate service proposals and makes decisions regarding the commissioning and primary care services, ensuring all decisions are underpinned by robust clinical advice and within agreed governance arrangements. The committee focused on the following key areas of work during 2016/17:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services")
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes).

The committee operated as a committee in common with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG from 1 October 2016 until 31 March 2017.

The voting membership of the committee in 2016/17 was as follows:

Name	Role	Membership of the committee during 2016/17
Trish Haines (chair)	Lay Member for Integration and Partnership	1 April 2016 - 31 March 2017
Sarah Harvey-Speck	Lay Member for Patient and Public Involvement	1 April 2016 - 31 March 2017
Mari Gay	Interim Chief Operating Officer	1 April 2016 - 31 March 2017
Lynda Dando	Director of Primary Care	1 April 2016 - 31 March 2017
Lucy Noon	Director of Corporate and Organisational Development	1 April 2016 - 31 March 2017
Mark Dutton	Chief Finance Officer	1 April 2016 - 31 March 2017

Financial Recovery Board

The Financial Recovery Board (FRB) was established in December 2016. The function of the Committee is to operate as an executive committee in common of the three Governing Bodies of the Worcestershire CCGs to oversee the financial recovery of the NHS Redditch and Bromsgrove CCG and financial risk mitigation for Wyre Forest and South Worcestershire CCGs, specifically to:

- Develop a robust Financial Recovery Plan (FRP) for the Redditch and Bromsgrove CCG Governing Body
- Develop robust Financial Risk Mitigation Plans (FRMP) for the two CCGs not in formal financial recovery, i.e. NHS South Worcestershire CCG and NHS Wyre Forest CCG
- Ensure that the actions contained within the FRP and FRMP are delivered and report to the Governing Bodies on progress
- Provide assurance to the Governing Bodies on the sufficiency of actions to secure delivery of in year financial targets and progress towards medium term financial sustainability
- Make specific recommendations to the Governing Bodies of any additional actions that may be necessary
- Take decisions on actions necessary to support delivery of the financial recovery, within approved delegated limits.

Financial Recovery Board is established as an exceptional committee and will continue to operate whilst there is a requirement for financial recovery on a task and finish basis.

The membership of the committee across all three CCGs in 2016/17 was as follows:

Name	Role	Membership of the committee during 2016/17
Robert Parker (chair)	Lay Member for Audit and Governance (South Worcestershire CCG)	1 December 2016 - 31 March 2017
Bridget Nisbet (vice chair)	Lay Member for Audit and Governance (Redditch and Bromsgrove CCG)	1 December 2016 - 31 March 2017
Fred Mumford	Lay Member for Audit and Governance (Wyre Forest CCG)	1 December 2016 - 31 March 2017
Tim Tebbs	Financial Turnaround Director	1 December 2016 - 31 March 2017
Simon Trickett	Interim Chief Officer (Redditch and Bromsgrove CCG, Wyre Forest CCG)	1 December 2016 - 31 March 2017
Dr Carl Ellson	Chief Clinical Officer (South Worcestershire CCG)	1 December 2016 - 31 March 2017
Mark Dutton	Interim Chief Finance Officer (Redditch and Bromsgrove CCG, Wyre Forest CCG) Chief Finance Officer (South Worcestershire CCG)	1 December 2016 - 31 March 2017
Dr Richard Davies	Chair and Clinical Lead (Redditch and Bromsgrove CCG)	1 December 2016 - 31 March 2017
Dr Anthony Kelly	Chair and Clinical Lead (South Worcestershire CCG)	1 December 2016 - 31 March 2017
Dr Clare Marley	Chair and Clinical Lead (Wyre Forest CCG)	1 December 2016 - 31 March 2017
Lucy Noon	Interim Director of Corporate and Organisational Development (Redditch and Bromsgrove CCG, Wyre Forest CCG) Director of Corporate and Organisational Development (South Worcestershire CCG)	1 December 2016 - 31 March 2017
Lynda Dando	Interim Director of Primary Care (Redditch and Bromsgrove CCG, Wyre Forest CCG) Director of Primary Care (South Worcestershire CCG)	1 December 2016 - 31 March 2017
Mari Gay	Interim Chief Operating Officer	1 December 2016 - 31 March 2017
Jo Galloway	Chief Nursing Officer (Redditch and Bromsgrove CCG, Wyre Forest CCG)	1 December 2016 - 31 March 2017
Lisa Levy	Interim Executive Nurse and Director of Quality (South Worcestershire CCG)	1 December 2016 - 31 March 2017

Legislative Reform Order which amended sections 14Z3 and 14Z9 of the NHS Act 2006 means that CCGs are able to form joint committees in order to undertake collective strategic decisions. The group has formed a joint committee with the following Clinical Commissioning Groups:

- NHS Herefordshire Clinical Commissioning Group
- NHS Redditch and Bromsgrove Clinical Commissioning Group
- NHS Wyre Forest Clinical Commissioning Group

The purpose of the joint committee is to:

- Provide the strategic leadership and operational coordination relating to the STP and development of the operating plan
- Provide strategic leadership but not decision making relating to the transition to future organisational arrangements
- Lead the development of a commissioning strategy for the joint clinical transformation programme

- Lead the joint commissioning of those services which require commissioning over Herefordshire and Worcestershire (the STP) footprint, for example stroke services; and ensure quality and service outcomes are an integral part of the commissioned pathway
- Develop a sustainable commissioning solution across the STP footprint by March 2018
- In line with the agreed Joint Committee work plan, consider future functions such as the joint commissioning of a range of specialist services and make recommendations accordingly to the CCG Governing Bodies
- Provide strategic leadership in relation to the development of new accountable care system arrangements and make recommendations accordingly to the CCG Governing Bodies.

The group has also formed a joint committee with the local authority – Worcestershire Integrated Commissioning Executive Officers Group.

The purpose of the joint committee is to:

- Progress the integration of NHS, social care, public health and related services for the benefit of Worcestershire residents through
- Commissioning integrated services (in the context of the JSNA, HWB Strategy, the Children and Young Peoples Plan and the Five Year Strategic Plan and other relevant strategic plans across the Council and CCGs)
- Ensuring effectiveness, safety and improved experience of services commissioned under the section 75 agreement and section 256 agreements
- Working within the budgets delegated from partners' governing bodies
- The scheme of delegation of the governing bodies through the powers delegated to lead officers (the Director of Adult Services and Health, the Director of Children's Services and the CCG Accountable Officers).

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the Clinical Commissioning Group and best practice.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Internal Control Framework & Risk management arrangements

The CCG actively encourage a risk aware organisational culture that is open and supportive, while ensuring robust accountability. Organisational culture and the behaviours of leaders play a vital role in the development of good governance, as highlighted by the Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). It is important that we promote and embed a culture of transparency, openness and honesty throughout the CCG to ensure risks are properly identified, evaluated, documented and managed. The CCG is committed to an approach which minimises risks wherever possible, providing a robust framework that is underpinned by the concepts of effective governance and other systems of internal control enabling the identification and management of both acceptable and unacceptable risks.

The three CCGs in Worcestershire (Redditch and Bromsgrove CCG, South Worcestershire CCG and Wyre Forest CCG) operate a shared risk management process. Although a number of risks are specific to individual organisations and are managed as such, there are a significant number of strategic and operational risks linked to countywide objectives. These are managed through the following mechanisms:

- Countywide risk management strategy

- Consistent format of the Governing Body Assurance Framework with countywide objectives and risks
- Shared operational risk register

The risk management strategy forms part of the control framework for NHS South Worcestershire CCG and defines the risk management processes of the whole organisation. It is reviewed annually and sets out the responsibilities and common methodologies for the assessment and the management of risks identified at all levels of the organisation. The strategy sets out South Worcestershire CCG's approach to risk and the accountability arrangements including the responsibilities of the Governing Body and its sub-committees, clinical members, directors, contractors and individual employees. It defines the risk management process including risk identification, analysis and evaluation which will be undertaken to ensure delivery of the strategy and the capacity to handle risk across the organisation and its member practices.

The strategy defines the risk scoring matrix which is used for all risks, both clinical and non-clinical, incidents and complaints within the organisation. The strategy outlines the elements of the Assurance Framework and the process for maintaining and monitoring it. New risks identified for inclusion on the risk register or Board Assurance Framework are assessed for likelihood and severity using a 5 x 5 risk matrix in accordance with the risk management strategy.
The risk management process observes the following principles:

- A culture where risk management is considered an essential and positive element in the provision of healthcare
- Risk reduction and quality improvement should be seen as integral and part of routine activities
- Risk management often works within a statutory framework which cannot be ignored
- A risk management approach should provide a supportive structure for those involved in adverse incidents or errors by enabling a no-blame culture
- Managing risk is both a collective and an individual responsibility
- Every organisation should strive to understand the causes of risk, and the importance of addressing issues
- Where organisations commission services on the CCG's behalf, for example the Worcestershire County Council's Integrated Commissioning Unit, the CCG must be sighted on any risks connected to the commissioning activity and record them as appropriate in line with this strategy.

Risks can be identified by anybody, anywhere and risk identification is an integral part of CCG's everyday activities. Some specific ways of identifying risks include:

- Horizon scanning
- Formal risks assessment exercise (for example health & safety)
- Lessons learnt following an incident or a complaint
- Discussion at a Governing Body / Committee Level
- Completing / reviewing a Project Business Case
- Performance discussions with providers.

Strategic risks are managed through the Governing Body Assurance Framework (GBAF) process. GBAF provides a structured approach to management of principal risks threatening the achievement of organisational objectives. These risks are assigned to Executive Leads and are proactively managed by individual committees. The Audit Committee takes a lead role in reviewing the Assurance Framework and scrutinising controls and assurances which are in place to mitigate strategic risks. The Governing Body has an overarching responsibility for monitoring risks contained within the GBAF.

Operational risks are recorded on the risk register as a countywide or CCG specific risk together with existing controls and assurances and must include a timescale for expected completion of mitigating actions. Each risk is assigned to a senior manager who is responsible for updating the risk register. A responsible director as well as a committee or a sub-committee overseeing the risk is also allocated to the risk. Each committee or sub-committee will periodically review those risks for which they are responsible, ensuring that appropriate controls are in place and mitigating actions have been agreed. Any new risks will be considered as part of this process.

In 2016/17 a training programme was rolled out to CCG staff on how to identify, record, monitor and manage risks. The programme is an ongoing initiative and at the end of 2016/17, approximately 30% of all CCG staff completed their training.

Risk Assessment

The key strategic risks to delivery of the strategic objectives for the Clinical Commissioning Group during 2016/17 were:

- Potential failure of local stakeholders to agree a single implementable new model of care, which strikes the right balance between local focus and scale to create an affordable model
- Potential failure to deliver the urgent care key system priorities, thereby adversely impacting upon the delivery of the agreed improvement trajectories in respect of the 4-hour Emergency Access Standard
- Potential failure to increase the number of individuals with a Personal Health Budget in line with agreed target
- Potential adverse impact upon service delivery due to gaps in staffing and capacity
- Potential failure to deliver agreed improvement trajectories, resulting in non-delivery of constitutional indicators
- Potential inability to deliver the Patient Care Improvement Plan, resulting in improvements not being delivered within urgent care & patient flow, avoidable mortality and organisational development
- QIPP programmes do not deliver, resulting in agreed trajectories not being met and compromising delivery of the underlying surplus
- The governance and decision making process, together with the system wide solution, are not robust enough and don't deliver the scale of change required
- The on-going safety of services is compromised because of the time taken to complete the review
- Primary care workforce capacity issues due to the growing number of GPs retiring early
- Potential failure to deliver countywide organisational structures and operating model, resulting in an inability to fulfil statutory duties and meet organisational objectives
- Inability to successfully deliver upon key themes outlined within Local Digital Roadmap, due to lack of cross organisational agreement/alignment and potential lack of funding.

For each strategic risk, it is ensured that adequate controls, actions and assurances are in place to effectively mitigate the risks identified. Where appropriate, these are agreed with local partners within the health economy and jointly monitored. The progress and impact of actions are reported to the Governing Body through bi-monthly updates which captures detail from reports submitted to QPR, Clinical Executive and Primary Care Commissioning Committees.

The Audit Committee reviews the adequacy of the Board Assurance Framework bi-monthly at each meeting.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCG (published June 2016) requires the CCG to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The audit did not highlight any weaknesses that would materially impact on the achievement of the system's key objectives. The audit did find some low impact control weaknesses which, when addressed, will improve the overall performance of the system. However these weaknesses do not affect key controls and are unlikely to impair the achievement of the system's objectives. As a result, significant assurance was given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

Data Quality

Through regular reviews of Governing Body and committee effectiveness, the quality of the data used is assessed and has been found to be acceptable.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The CCG has achieved a score of 91% on the IG toolkit and is therefore fully compliant with the toolkit requirements.

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. We have ensured all staff undertake annual information governance training and have a suite of policies to support staff in their roles and with their responsibilities.

There are processes in place for incident reporting and investigation of serious incidents.

The Information Risk Policy and the Risk Management Strategy set out how information and data risks are assessed managed and controlled. This consists of proactive risk assessments on key information assets, investigation of information related incidents and review of information related complaints.

Information governance aims to support the delivery of high quality care by promoting the effective and appropriate use of information. The Information Governance Assurance framework is formed by those elements of law and policy from which applicable IG standards are derived, and the activities and roles which individually and collectively ensure that these standards are clearly defined and met.

There has been one level 2 incident involving personal data reported to the Information Commissioner's Office (ICO) in 2016/17. Following a comprehensive investigation, appropriate controls were implemented and lessons learnt.

Third party assurances

The CCG commissions the following services from the Midlands and Lancashire Commissioning Support Unit (CSU):

- Business intelligence
- Procurement
- Information Technology
- Human Resources and Payroll
- Corporate Services (Equality and Inclusion, Information Governance and Freedom of Information).

The CCG has a service level agreement in place with the CSU and manages the performance of the individual services on a monthly basis.

Control Issues

The CCG has identified two significant control issues:

- **Financial position** – although the CCG has managed its finances well in 2016/17, there are increasing financial pressures on the CCG. In November 2016 a neighbouring CCG reported a forecast deficit position and consequently the CCG has worked collaboratively with neighbouring CCGs to implement a financial recovery programme including the appointment of a Financial Recovery Director.

- **Worcestershire Acute Hospitals NHS Trust (WAHT) Contract** – The Trust has under-performed against key targets, such as A&E waiting times. There is also a very significant underlying financial deficit at this Trust which will need to be urgently addressed.

Extensive mitigation plans have been put in place for both risks. Both issues will be the key focus areas for the CCG's strategic objectives for 2017/18.

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

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. It is also informed by comments made by the external auditors in their annual audit letter and other reports.

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

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes committees reviewing their work plans and responsibilities against the annual work plan and allocated areas of responsibility. The Audit Committee receive assurance on committee effectiveness and the Board Assurance Framework.

Counter fraud arrangements

The CCG has Counter Fraud arrangements in place with NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption.

The key features of the arrangements are:

- An Accredited Counter Fraud Specialist is contracted to undertake counter fraud work proportionate to identified risks
- The CCG Audit Committee receives a report against each of the Standards for Commissioners annually. The Chief Finance Officer provides executive support and direction for a proportionate proactive work plan to address identified risks
- The Chief Finance Officer is proactively and demonstrably responsible for tackling fraud, bribery and corruption
- Appropriate action is taken regarding any NHS Protect quality assurance recommendations.

Head of Internal Audit Opinion

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

Roles and responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Governance Statement (GS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

1. How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
2. The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
3. The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the GS requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HOIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

Limitations inherent to the internal auditor's work

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls

and the occurrence of unforeseeable circumstances.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of a risk-based plan generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its GS.

The Opinion

The purpose of my annual HOIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its Governance Statement. My opinion is set out as follows; Overall opinion, Basis for the opinion and supporting commentary.

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.

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk based 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.
3. Any reliance that is being placed upon third party assurances.

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

The design and operation of the Assurance Framework and associated processes

I have reviewed the overall arrangements the Governing Body has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Governing Body has identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed. I have approached this by examining the Assurance Framework documents that you have in place and also by giving consideration to the wider reporting to the Governing Body that informs the Governing Body's assessment of the effectiveness of the organisation's the system of internal control.

It is my view that an Assurance Framework has been established which is designed and operating to meet the requirements of the 2016/17 Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My Opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2016/17 was developed to provide you with independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this our internal audit plan was divided into two broad categories; work on the financial systems that underpin your financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that you had identified in your Assurance Framework. I am satisfied that we have completed sufficient work during the course of the year (see Section 4) to provide my Head of Internal Audit Opinion.

The assurance levels provided for all assurance reviews undertaken are summarised as follows:

Significant Assurance	• Combined Financial Systems • Commissioning and Contracting • Performance Management • Personal Health Budgets • Conflicts of Interest • Financial Delivery • Better Care Fund
Moderate Assurance	• Financial and QIPP Planning • Continuing Healthcare
Limited Assurance	• None

Assurance statements were not provided against the following reviews, due to the scope and nature of work undertaken:

- Assurance Framework – Result: Level A
- IG Toolkit Compliance – Result: minor evidence gaps identified.

I have set out below summary details of the review where we provided moderate assurance level:

- Financial and QIPP Planning – The review noted a gap in QIPP schemes developed against the 2016/17 target. Sample testing noted PIDs were not fully completed / signed off for some of the schemes tested. Reported QIPP data was delayed in being reported due to lack of information from the acute hospital, reported QIPP data was approximately 1 month behind based on this time lapse which could be significant if action needs to be taken urgently to improve QIPP performance.
- Continuing Healthcare – Supporting documentation is being maintained in a number of databases and files. All documentation should be held on Broad Care. Reviews need to be up to date for all CHC patients. Also appeals and retrospective reviews should be actioned timely.

Following up of actions arising from our work

For all reviews we have agreed action plans with management and will continue to monitor the implementation of these plans over the coming months. Outstanding actions are reported at each meeting of the Audit Committee and they take a proactive approach to monitoring them and requesting follow up audit work where there are areas of concern.

All recommendations and agreed actions are uploaded to a central web-based database as and when reports are finalised. Management are then required to update the status against agreed actions. This is a self-assessment and is supplemented by our independent follow-up reviews where this is deemed necessary (for example, following the issue of a limited or moderate assurance report). The status of agreed actions as at 31 March 2017 is as follows:

Summary	1 Critical	2 High	3 Medium	4 Low	Total
Due by 31/03/2017	0	0	1	0	1
In progress but not complete	0	0	1	0	1
Outstanding but not yet started	0	0	0	0	0

Time overdue for actions outstanding or in progress	1 Critical	2 High	3 Medium	4 Low	Total
Less than 3 months	0	0	0	0	0
3-6 months	0	0	0	0	0
Greater than 6	0	0	1	0	1

months					
Total	0	0	1	0	1

There are no level 1 and 2 ranked actions that are yet to be fully implemented.

Reliance on third party assurances

I have sought to place reliance on third party assurances, provided in the form of service auditor reports, as follows:

- NHS Shared Business Services
- AGEM CSU Service Auditor Report

Kristina Woodward
Assistant Director
CW Audit Services
Wayside House
Wilsons Lane
Coventry
CV6 6NY

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

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

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

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

- The Board
- The Audit Committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

No significant internal control issues have been identified.

Dr Carl Ellson
Accountable Officer
NHS South Worcestershire CCG
26 May 2017

Remuneration Report

Remuneration Policy

We have established a Remuneration Committee in line with our constitution, standing orders and scheme of delegation. The purpose of the committee is to make recommendations to our Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group; and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

The following Governing Body members are members of the committee:

- Alistair Munro | Secondary Care Clinician (Chair)
- Rob Parker | Lay Member for Audit and Governance
- Sarah Harvey-Speck | Lay member for Public and Patient Involvement

In line with shared CCG management arrangements that were introduced in 2016/17, a Remuneration Committee in Common was established in October 2016 to include members from all three CCGs' remuneration committees.

In addition to the members listed above the following people are also members of the Remuneration Committee in Common:

- Martin Lee | Secondary Care Specialist Doctor (RBCCG and WFCCG)
- Bridget Nisbet | Lay Member for Audit and Governance (RBCCG)
- Dr Richard Davies | Chair (RBCCG)
- Fred Mumford | Lay Member for Governance (WFCCG)
- Clare Marley | Chair (WFCCG)

The committee is co-chaired by Alistair Munro, Fred Mumford and Bridget Nisbet. Other individuals such as the Accountable Officer, Chief Operating Officer and any HR lead and external advisers are sometimes invited to attend for all - or part of - any meeting as and when appropriate. However, they do not remain in attendance for discussions about their own remuneration and terms of service.

The main responsibilities of the Remuneration Committee are to:

- Recommend to the Governing Body the remuneration of GP and Lay Governing Body members
- Recommend to the Governing Body the remuneration and conditions of service of the Accountable Officer and senior team
- Review the performance of the Accountable Officer and other senior team members and recommending annual salary awards, if appropriate
- Recommend to the Governing Body the financial arrangements for termination of employment, including the terms of any compensation packages and other contractual terms excluding ill health and normal retirement for all employees
- Consider the severance payments of the Accountable Officer and other senior staff, and recommend seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money'
- Identify and nominate the approval of the Governing Body candidates to fill non-member practice places on the Governing Body.

Senior manager remuneration (including salary and pension entitlements)

Salaries and allowances (2016/17) – subject to audit

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	Total salary of shared staff (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000
Dr Carl Ellson Chief Clinical Officer	140-145	-	-	-	-	140-145	-
Mark Dutton Chief Finance Officer	90-95	-	-	-	32.5-35	125-130	105-110
Mari Gay Interim Chief Operating Officer	110-115	-	-	-	82.5-85	195-200	-
Lisa Levy Interim Executive Nurse	85-90	-	-	-	42.5-45	130-135	-
David Mehaffey Director of Strategy	75-80	-	-	-	22.5-25	95-100	90-95
Lucy Noon Director of Corporate and Organisational Development	45-50	-	-	-	65-67.5	110-115	85-90
Lynda Dando Director of Primary Care	35-40	-	-	-	62.5-65	100-105	75-80
Dr Anthony Kelly Chair	70-75	-	-	-	-	70-75	-
Dr Nikki Burger Clinical Lead	80-85	-	-	-	30-32.5	110-115	-
Dr Lindsay Pickerell Clinical Lead	15-20	-	-	-	0-2.5	15-20	-
Dr David Farmer Clinical Lead	60-65	-	-	-	7.5-10	70-75	-
Dr George Henry Clinical Lead	60-65	-	-	-	32.5-35	95-100	-
Alistair Munro Secondary Care Clinician	5-10	-	-	-	-	5-10	-
Jonathan Thorn Clinical Lead	30-35	-	-	-	7.5-10	40-45	-

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)	Total salary of shared staff (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000
Rob Parker Lay Member	20-25	-	-	-	-	20-25	-
Sarah Harvey-Speck Lay Member	20-25	-	-	-	-	20-25	-
Trish Haines Lay Member	15-20	-	-	-	-	15-20	-

Salaries and allowances (2015/16) – subject to audit

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Simon Trickett Chief Operating Officer	95-100	4	-	-	5-7.5	105-110
Dr Carl Ellson Chief Clinical Officer	140-145	4	-	-	-	140-145
Mark Dutton Chief Finance Officer	95-100	1	-	-	52.5-55	150-155
Mari Gay Director of Quality and Patient Safety	40-45	3	-	-	47.5-50	85-90
Mari Gay Interim Chief Operating Officer	5-10	-	-	-	7.5-10	15-20
Lisa Levy Interim Executive Nurse	45-50	1	-	-	25-27.5	70-75
David Mehaffey Director of Strategy	85-90	3	-	-	15-17.5	100-105
Lucy Noon Director of Corporate and Organisational Development	75-80	-	-	-	5-7.5	80-85
Rosemary Williams Director of	25-30	2	-	-	-	25-30

Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Practice Engagement						
Dr Anthony Kelly Chair	70-75	-	-	-	-	70-75
Dr Felix Blaine Clinical Lead	30-35	-	-	-	12.5-15	45-50
Dr Nikki Burger Clinical Lead	80-85	-	-	-	57.5-60	135-140
Dr David Farmer Clinical Lead	60-65	1	-	-	5-7.5	70-75
Dr George Henry Clinical Lead	45-50	-	-	-	12.5-15	60-65
Alistair Munro Secondary Care Clinician	5-10	-	-	-	-	5-10
Dr Jonathan Thorn Clinical Lead	30-35	-	-	-	7.5-10	40-45
Rob Parker Lay Member	15-20	2	-	-	-	20-25
Sarah Harvey-Speck Lay Member	15-20	3	-	-	-	15-20
Trish Haines Lay Member	15-20	-	-	-	-	15-20

Pension benefits (2016/17) – subject to audit

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2017
	£000	£000	£000	£000	£000	£000	£000
Mark Dutton Chief Finance Officer	0-2.5	0-2.5	25-30	60-65	278	27	305
Mari Gay Interim Chief Operating Officer	2.5-5	12.5-15	45-50	135-140	715	98	812
Lisa Levy	2.5-5	12.5-15	30-35	90-95	445	84	530

Interim Executive Nurse							
David Mehaffey* Director of Strategy	0-2.5	*	10-15	*	112	20	132
Lucy Noon Director of Corporate and Organisational Development	2.5-5	10-12.5	25-30	85-90	448	75	523
Lynda Dando Director of Primary Care	2.5-5	7.5-10	20-25	65-70	421	74	501
Dr Lindsay Pickerell Clinical Lead	0-2.5	0-2.5	5-10	25-30	181	5	185
Dr Jonathan Thorn Clinical Lead	0-2.5	0-2.5	10-15	25-30	119	16	135
Dr George Henry Clinical Lead	0-2.5	2.5-5	5-10	20-25	128	37	165
Dr David Farmer Clinical Lead	0-2.5	0-2.5	0-5	5-10	30	19	49
Dr Nikki Burger Clinical Lead	0-2.5	0-2.5	10-15	20-25	115	29	143

* *No lump sum applicable as Section 2008 Member*

Pension benefits (2015/16) – subject to audit

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2017
	£000	£000	£000	£000	£000	£000	£000
Simon Trickett Chief Operating Officer	0-2.5	*	30-35	*	301	13	319
Mark Dutton Chief Finance Officer	2.5-5	2.5-5	20-25	60-65	245	31	278
Mari Gay Interim Chief Operating Officer	5-7.5	15-17.5	40-45	125-30	605	103	715
Lisa Levy Interim Executive Nurse	0-2.5	5-7.5	25-30	80-85	389	30	445

David Mehaffey Director of Strategy	0-2.5	*	10-15	*	96	15	112
Lucy Noon Director of Corporate and Organisational Development	0-2.5	0-2.5	25-30	75-80	427	16	448
Rosemary Williams Director of Practice Engagement	0-2.5	0-2.5	25-30	85-90	653	**	**
Dr Felix Blaine Clinical Lead	0-2.5	0-2.5	10-15	30-35	148	11	164
Dr Jonathan Thorn Clinical Lead	0-2.5	0-2.5	10-15	25-30	113	5	119
Dr George Henry Clinical Lead	0-2.5	0-2.5	5-10	20-25	115	12	128
Dr David Farmer Clinical Lead	0-2.5	2.5-5	0-5	0-5	12	17	30
Dr Nikki Burger Clinical Lead	2.5-5	5-7.5	5-10	20-25	76	38	115

* *No lump sum applicable as Section 2008 Member*
** *CETV Not applicable as over Normal Retirement Age*

Cash equivalent transfer values – subject to audit

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Losses and special payments

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

	Total Number of Cases	**Total Value of Cases**	Total Number of Cases	Total Value of Cases
	2016/17	**2016/17**	2015/16	2015/16
	Number	**£'000**	Number	£'000
Fruitless payments	0	0	1	239
Total	**0**	**0**	**1**	**239**

Fair Pay Disclosure – subject to audit

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

The disclosures made in 2015/16 have been restated to rectify ESR inaccuracies that have since been identified. The disclosures for 2015/16 quoted in the following paragraphs are, therefore, the corrected figures.

The banded remuneration of the highest paid Director in NHS South Worcestershire CCG in the financial year 2016/17 was £140k to £145k (this is the same as in 2015/16 but was erroneously quoted as £200k to £205k in the original 2015/16 disclosures). This is 4.22 times (2015/16, 4.37 times) the median remuneration of the workforce, which was £33,560 (2015/16: £32,086).

There has been a reduction in the ratio between the remuneration of the highest paid Director/Member and the median level of remuneration. This is due to the CCG bringing a number of new staff onto its payroll in 2016/17, including the Continuing Healthcare Team, Financial Services Team and a number of new posts. In total, 45 staff have transferred onto the CCG's payroll, with a total whole time equivalent of 38.51. Overall these new members of staff have pushed the median remuneration of the total workforce up, and the ratio referred to above has gone down.

In 2016/17, no employees (2015/16: none) received remuneration in excess of the highest-paid member. Remuneration, excluding the highest paid director/member ranged from £9k to £113k (2015/2016: £9k to £112k).

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

Staff Report

Staff composition

The total breakdown of people employed by NHS South Worcestershire CCG (based on 28/02/2017) is as follows:

Staff Grouping	Female		Male		Total
	Headcount	%	Headcount	%	
Governing Body	6	37.5%	10	62.5%	**16**
Other Senior Management (Band 8C+)	11	73.3%	4	26.7%	**15**
All Other Employees	78	85.7%	13	14.3%	**91**
Total	**95**	**77.87%**	**27**	**22.13%**	**122**

The workforce analysis by Band (based on 28/02/2017) is as follows:

Pay Band	Headcount	Pay Band	Headcount
Band 3	9	Band 8B	7
Band 4	11	Band 8C	2
Band 5	10	Band 8D	5
Band 6	24	VSM	23
Band 7	12	Medical Payscale	7
Band 8A	18	**Total**	**122**

Staff numbers and costs (2016/17) – subject to audit

Employee Benefits	ADMIN			PROGRAMME			TOTAL		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	2,619	325	2,944	464	274	738	3,083	599	3,682
Social security costs	290	0	290	44	0	44	334	0	334
Employer contributions to the NHS Pension Scheme	339	0	339	57	0	57	396	0	396
Gross employee benefits expenditure	**3,248**	**325**	**3,573**	**565**	**274**	**839**	3,813	599	4,412
Total - Net admin employee benefits expenditure including capitalised costs	**3,248**	**325**	**3,573**	**565**	**274**	**839**	3,813	599	4,412
Net employee benefits excluding capitalised costs	**3,248**	**325**	**3,573**	**565**	**274**	**839**	3,813	599	4,412

Staff numbers and costs (2015/16) – subject to audit

Employee Benefits	ADMIN			PROGRAMME			TOTAL		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	2,476	287	2,763	163	12	175	2,639	299	2,938
Social security costs	233	0	233	16	0	16	249	0	249
Employer contributions	319	0	319	23	0	23	342	0	342

to the NHS Pension Scheme									
Gross employee benefits expenditure	**3,028**	**287**	**3,315**	**202**	**12**	**214**	**3,230**	**299**	**3,529**
Total - Net admin employee benefits expenditure including capitalised costs	**3,028**	**287**	**3,315**	**202**	**12**	**214**	**3,230**	**299**	**3,529**
Net employee benefits excluding capitalised costs	**3,028**	**287**	**3,315**	**202**	**12**	**214**	**3,230**	**299**	**3,529**

Sickness absence data

Average FTE 2016	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
74	286	3.9	27,069	464

Our approach to the effective management of sickness absence includes:

- Developing the role of line and senior managers in their engagement with managing absence and the health and welfare of their staff
- Monitoring, measuring and understanding absence
- Managing sickness absence when it happens
- Tackling the underlying causes of absence
- Assessing any underlying causes of absence, especially where they might be improved through better organisation and job design
- Helping people to remain in work when they have health problems and facilitating their return to work following illness or injury (this can include making reasonable adjustments in line with our duty as an employer e.g. changes to duties, shifts or hours, changes to the place of work, allowing staged/phased return to work)
- Creating a working environment where people can be provided with the support and encouragement to take responsibility for improving their own health
- Supporting early intervention where applicable, such as occupational health services, counselling and confidential employee assistance support
- Applying HR / Health and Safety-related policies such as Health and Safety, Lone-working, Respect in the Workplace, Working Time and Stress Awareness policies.

Staff policies

We consult and engage with our staff on key HR policy development. Each policy is developed in draft and then shared with staff for consideration at Staff Council. Policies are then ratified and signed off by our Clinical Executive Team before being circulated to staff and the senior management. We have a system of regularly refreshing our HR policies and ensure that we have appropriate policies in place to ensure equal opportunities for all. This includes the same development opportunities and training being offered to all staff without discrimination and recognises that adaptations we may need to make for some individuals to ensure access to training and development is the same across the organisation.

We have approved a range of policies to enable people with disabilities to work for us. People with disabilities who meet the minimum criteria for a job vacancy are guaranteed an interview. The adjustments that people with disabilities might require in order to take up a job or continue working in a job are proactively considered. All employees undertake mandatory equality and diversity training which includes awareness of a range of issues impacting on people with disabilities.

We offer equal opportunities for all members of our team and are committed to building a workforce whose diversity reflects the community we serve. We recognise the specific needs of individuals whether it is access to the CCG offices where we are based, time and space to pray privately or recognising individual needs when they attend for interview or on appointment.

Everyone who works for us is treated fairly and equally. Our contracts of employment reflect our values and job descriptions fit both the needs of the CCG and those who work for us regardless of age, disability, race, nationality, ethnic origin, gender, religion, beliefs, sexual orientation, domestic and social circumstance, employment status, HIV status, gender reassignment, political affiliation or trade union membership.

Expenditure on consultancy

During 2016/17 we spent £148k on consultancy fees.

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	37
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	34
for 4 or more years at the time of reporting	0

Payments to GP practices for the services of employees and GPs are deemed to be 'off-payroll' engagements, and are therefore subject to these disclosure requirements.

All existing off-payroll engagements, as outlined above, have been subject to a risk based assessment and assurance has been received that tax obligations have been met.

Table 2: New off-payroll engagements

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	3
Number of new engagements which include contractual clauses giving NHS South Worcestershire CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	3
Of which:	
assurance has been received	3
assurance has not been received	0
engagements terminated as a result of assurance not being received.	0

All existing off-payroll engagements, as outlined above, have been subject to a risk based assessment and assurance has been received that tax obligations have been met.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	17

Exit packages – subject to audit

There were no exit packages agreed in 2016/17.

There were no other departures to report during 2016/17.

Parliamentary Accountability and Audit Report

NHS South Worcestershire CCG is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included within the Accountability Report.

An audit certificate and report is also included in this Annual Report at page 44.

Annual Accounts

Dr Carl Ellson
Accountable Officer
NHS South Worcestershire CCG
26 May 2017

Contents

The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(764)	(765)
Other operating income	2	(2,073)	(415)
Total operating income		**(2,837)**	**(1,180)**
Staff costs	4	4,412	3,529
Purchase of goods and services	5	384,007	378,099
Depreciation and impairment charges	5	70	28
Other Operating Expenditure	5	585	784
Total operating expenditure		**389,074**	**382,440**
Net Operating Expenditure		**386,237**	**381,260**
Finance income			
Net expenditure for the year		**386,237**	**381,260**
Total Net Expenditure for the year		**386,237**	**381,260**
Other Comprehensive Expenditure			
Comprehensive Expenditure for the year ended 31 March 2017		**386,237**	**381,260**

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	8	226	265
Total non-current assets		226	265
Current assets:			
Inventories	9	98	109
Trade and other receivables	10	13,303	8,199
Cash and cash equivalents	11	189	127
Total current assets		**13,590**	8,435
Total current assets		**13,590**	8,435
Total assets		**13,816**	8,700
Current liabilities			
Trade and other payables	12	(26,796)	(25,080)
Total current liabilities		**(26,796)**	(25,080)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,980)**	(16,380)
Non-current liabilities			
Assets less Liabilities		**(12,980)**	(16,380)
Financed by Taxpayers' Equity			
General fund		(12,980)	(16,380)
Total taxpayers' equity:		**(12,980)**	(16,380)

The notes on pages 66 to 82 form part of this statement.

The financial statements on pages 62 to 65 were approved by the Audit Committee on 26/5/17 and signed on its behalf by:

Dr Carl Ellson
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17		
Balance at 01 April 2016	(16,380)	**(16,380)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(16,380)**	**(16,380)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17		
Net operating expenditure for the financial year	(386,237)	(386,237)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(402,617)**	**(402,617)**
Net funding	389,637	389,637
Balance at 31 March 2017	**(12,980)**	**(12,980)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16		
Balance at 01 April 2015	**(12,664)**	**(12,664)**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2016	**(12,664)**	**(12,664)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16		
Net operating costs for the financial year	(381,260)	(381,260)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(393,924)**	**(393,924)**
Net funding	377,544	377,544
Balance at 31 March 2016	**(16,380)**	**(16,380)**

The notes on pages 66 to 82 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2017

	Note	**2016-17 £'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(386,237)	(381,260)
Depreciation and amortisation	5	70	27
(Increase)/decrease in inventories	9	11	(8)
(Increase)/decrease in trade & other receivables	10	(5,104)	329
Increase/(decrease) in trade & other payables	12	1,716	3,571
Net Cash Inflow (Outflow) from Operating Activities		**(389,544)**	(377,341)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	8	(31)	(209)
Net Cash Inflow (Outflow) from Investing Activities		**(31)**	(209)
Net Cash Inflow (Outflow) before Financing		**(389,575)**	(377,550)
Cash Flows from Financing Activities			
Parliamentary Funding Received		389,637	377,544
Net Cash Inflow (Outflow) from Financing Activities		**389,637**	377,544
Net Increase (Decrease) in Cash & Cash Equivalents	11	**62**	(6)
Cash & Cash Equivalents at the Beginning of the Financial Year		**127**	133
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**189**	127

The notes on pages 66 to 82 form part of this statement.

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. However, a trading entity needs to consider whether it is appropriate to continue to prepare its financial statements of a going concern basis where it is being, or is likely to be wound up.

The following is clear evidence that the CCG meets the requirements highlighted above and as set out in section 4.13 of the Department of Health Manual of Accounts

- NHS South Worcestershire CCG was established on 1 April 2013 as a separate statutory body
- the CCG has an agreed Constitution which it is operating to for the governance of its activities
- the CCG has been allocated funds from NHS England for the following financial years - 2017/18 and 2018/19 and
- the CCG has been allocated indicative allocations to 2019/20
- the CCG is allocated a cash drawdown which is based on the cash requirements of the CCGs

Based upon the above, it is therefore concluded that under the Government Financial Reporting Manual (FreM) that NHS South Worcestershire CCG is a going concern for financial reporting purposes

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 Section 75 Agreements

The clinical commissioning group is party to a Section 75 Agreement under the National Health Service Act 2006 and as party to a "jointly controlled operation", recognises:

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

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

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

1.4 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.

1.4.1 *Critical Judgements in Applying Accounting Policies*

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

(1) As disclosed in note 35 to the financial statements, the clinical commissioning group is party to a Section 75 agreement including the Better Care Fund. The clinical commissioning group's management have made a critical judgement in relation to Section S75 accounting policies. The substance of each programme has been assessed as to whether it meets the principles within IFRS 11: 'Joint Arrangements'. Specific programmes have been assessed as either: (1) Joint Commissioning arrangements under which each Pool Partner accounts for their share of expenditure and balances with the end provider; (2) Lead Commissioning arrangements under which the lead commissioner accounts for expenditure with the end provider and other partners report transactions and balances with the lead commissioner; or (3) Sole Control arrangements under which the provisions of IFRS 11 do not apply. Of the above, the Integrated Community Equipment Service is a pooled budget arrangement, with each partner reflecting its share of the income, expenditure, assets and liabilities within their financial statements.

1.4.2 **Key Sources of Estimation Uncertainty**

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

- Partially completed spells (based on workings by NHS provider Trusts). The estimates by providers have been updated based on work in progress in the hospitals as at 31 March 2017. These will be settled as part of the April and May actual activity paid once discharged from hospital. (£1,195k for 2016-17, £1,098k for 2015-16)
- Prescribing position for March 2017 (based on February PPD year-end forecast). This will be resolved during May when the final year-end position is reported. (£7.6m for 2016-17, £7.7m for 2015-16)
- Continuing Healthcare accruals (based on CHC database). These will be resolved as invoices for agreed CHC packages are paid by the CCG. (£0.9m for 2016-17, £1.7 for 2015-16)

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**

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

1.7 **Other Expenses**

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

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

1.8 **Property, Plant & Equipment**

1.8.1 **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 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.

1.8.2 **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.

1.8.3 **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.

1.9 **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.

1.9.1 **The Clinical Commissioning Group as Lessee**

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.

1.10 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.11 **Cash & Cash Equivalents**

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

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

1.12 **Provisions**

The Clinical Commissioning Group has no provisions as at 31 March 2017.

NHS England has a provision in its accounts relating to historical claims that were outstanding in respect of CCG patients as at the demise of the former Worcestershire Primary Care Trust.

- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **Continuing healthcare risk pooling**

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

1.16 **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.

1.16.1 **Loans & Receivables**

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

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

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

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

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

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

1.17 **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.

1.18 **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.

1.19 **Losses & Special Payments**

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

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

1.20 **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 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Non-patient care services to other bodies	764	75	689	765
Other revenue	2,073	0	2,073	415
Total other operating revenue	**2,837**	**75**	**2,762**	**1,180**

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 direclty into the bank account of the CCG

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	2,837	75	2,762	1,180
Total	**2,837**	**75**	**2,762**	**1,180**

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2016-17 Total

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,682	3,083	599
Social security costs	334	334	0
Employer Contributions to NHS Pension scheme	396	396	0
Gross employee benefits expenditure	**4,412**	**3,813**	**599**
Total - Net admin employee benefits including capitalised costs	**4,412**	**3,813**	**599**
Net employee benefits excluding capitalised costs	**4,412**	**3,813**	**599**

4.1.1 Employee benefits 2015-16 Total

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	2,938	2,639	299
Social security costs	249	249	0
Employer Contributions to NHS Pension scheme	342	342	0
Gross employee benefits expenditure	**3,529**	**3,230**	**299**
Total - Net admin employee benefits including capitalised costs	**3,529**	**3,230**	**299**
Net employee benefits excluding capitalised costs	**3,529**	**3,230**	**299**

There is an increase in employee benefits due to the 'in-housing' of continuing healthcare and financial accounting staff from NHS Arden and GEM CSU

4.2 Average number of people employed

	2016-17			2015-16
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**88**	**77**	**11**	**72**

Of the above:

There is an increase in the average number of people employed due to the 'in-housing' of continuing healthcare and financial accounting staff from NHS Arden and GEM CSU

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	286	166
Total Staff Years	74	61
Average working Days Lost	3.9	2.7

4.4 Pension costs

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

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

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

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

4.4.1 Full actuarial (funding) valuation

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

For 2016-17, employers' contributions of £396k were payable to the NHS Pensions Scheme (2015-16: £384k) 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 2012.

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	3,759	2,920	839	2,866
Executive governing body members	653	653	0	663
Total gross employee benefits	**4,412**	**3,573**	**839**	**3,529**
Other costs				
Services from other CCGs and NHS England	2,104	847	1,257	3,207
Services from foundation trusts	32,486	50	32,436	30,621
Services from other NHS trusts	203,402	43	203,359	197,176
Services from other WGA bodies	0	0	0	1
Purchase of healthcare from non-NHS bodies	50,614	0	50,614	48,898
Chair and Non Executive Members	476	476	0	443
Supplies and services – clinical	141	0	141	39
Supplies and services – general	164	155	9	398
Consultancy services	149	101	48	108
Establishment	347	218	129	631
Premises	188	79	109	310
Inventories written down and consumed	109	0	109	101
Depreciation	70	70	0	28
Audit fees	63	63	0	63
Other non statutory audit expenditure				
Prescribing costs	47,690	0	47,690	48,071
General ophthalmic services	252	0	252	277
GPMS/APMS and PCTMS	45,973	0	45,973	47,257
Other professional fees excl. audit	40	38	2	44
Clinical negligence	0	0	0	2
Education and training	47	47	0	30
CHC Risk Pool contributions	347	0	347	867
Other expenditure	0	0	0	239
Total other costs	**384,662**	**2,187**	**382,475**	**378,811**
Total operating expenses	**389,074**	**5,760**	**383,314**	**382,340**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

Under national directions the CCG contributed to a risk pool to cover the costs arising from retrospective claims for continuing healthcare. The value of the CCG's contribution for 16/17 was £347k (15/16 £867k)

6 Better Payment Practice Code

Measure of compliance	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	16,301	136,538	13,136	111,766
Total Non-NHS Trade Invoices paid within target	15,369	132,905	12,655	109,828
Percentage of Non-NHS Trade invoices paid within target	**94.28%**	**97.34%**	**96.34%**	**98.27%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,949	237,487	2,909	205,616
Total NHS Trade Invoices Paid within target	2,849	236,718	2,738	204,496
Percentage of NHS Trade Invoices paid within target	**96.61%**	**99.68%**	**94.12%**	**99.46%**

The CCG aims to pay 95% of invoices (by value and number) within 30 days

7. Operating Leases

As lessee

7.1 Payments recognised as an Expense	2016-17 Buildings £'000	Other £'000	Total £'000	2015-16 Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	43	21	**64**	186	20	**206**
Total	**43**	**21**	**64**	**186**	**20**	**206**

The lease payments disclosed above relate to The Coach House and The Triangle (with effect from 1 Oct 2016).
Other' leases relate to photocopiers.

7.2 Future minimum lease payments	2016-17 Buildings £'000	Other £'000	Total £'000	2015-16 Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	102	20	**122**	88	20	**108**
Between one and five years	153	7	**160**	233	27	**260**
After five years	0	0	**0**	-	-	**0**
Total	**255**	**27**	**282**	**321**	**47**	**368**

The future minimum lease payments disclosed above relate mainly to The Coach House, the lease for which has recently been renegotiated and runs until 27 Feb 2020.

The Triangle lease is currently under negotiation and, therefore, future commitments amount to only 3 months rent for this property.

8 Property, plant and equipment

2016-17	Information technology £'000	Total £'000
Cost or valuation at 01 April 2016	348	348
Additions purchased	31	31
Cost/Valuation at 31 March 2017	**379**	**379**
Depreciation 01 April 2016	83	83
Charged during the year	70	70
Depreciation at 31 March 2017	**153**	**153**
Net Book Value at 31 March 2017	**226**	**226**
Purchased	226	226
Total at 31 March 2017	**226**	**226**
Asset financing:		
Owned	226	226
Total at 31 March 2017	**226**	**226**

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	5

9 Inventories

	Consumables £'000	Total £'000
Balance at 01 April 2016	109	109
Additions	98	98
Inventories recognised as an expense in the period	(109)	(109)
Balance at 31 March 2017	**98**	**98**

10 Trade and other receivables	Current 2016-17 £'000	Current 2015-16 £'000
NHS receivables: Revenue	6,550	5,517
NHS prepayments	2,125	0
Non-NHS and Other WGA receivables: Revenue	4,474	2,559
Non-NHS and Other WGA prepayments	48	51
VAT	106	72
Total Trade & other receivables	**13,303**	**8,199**
Total current and non current	**13,303**	**8,199**

NHS prepayments is a prepayment to Worcestershire Acute Hospitals NHS Trust in respect of maternity pathways, included for the first time in 2016/17

10.1 Receivables past their due date but not impaired	2016-17 £'000	2015-16 £'000
By up to three months	667	156
By three to six months	20	110
By more than six months	104	404
Total	**791**	**670**

£114k of the amount above has subsequently been recovered post the statement of financial position date.

11 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	127	133
Net change in year	62	(6)
Balance at 31 March 2017	**189**	**127**
Made up of:		
Cash with the Government Banking Service	189	127
Cash and cash equivalents as in statement of financial position	**189**	**127**
Balance at 31 March 2017	**189**	**127**

12 Trade and other payables	Current 2016-17 £'000	Current 2015-16 £'000
NHS payables: revenue	4,801	5,163
NHS accruals	1,195	1,093
Non-NHS and Other WGA payables: Revenue	7,558	6,414
Non-NHS and Other WGA accruals	12,243	11,893
Social security costs	66	41
Tax	63	50
Other payables and accruals	870	426
Total Trade & Other Payables	**26,796**	**25,080**
Total current and non-current	**26,796**	**25,080**

Other payables include £457k outstanding pension contributions at 31 March 2017 (£59k at 31 March 2016)

13 Financial instruments

13.1 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 NHS 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 NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

13.1.1 Currency risk

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

13.1.2 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.

13.1.3 Credit risk

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

13.1.3 Liquidity risk

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

13 Financial instruments cont'd

13.2 Financial assets

	Loans and Receivables 2016-17 £'000	**Total 2016-17 £'000**
Receivables:		
· NHS	6,550	6,550
· Non-NHS	4,474	4,474
Cash at bank and in hand	189	189
Total at 31 March 2017	**11,213**	**11,213**

	Loans and Receivables 2015-16 £'000	Total 2015-16 £'000
Receivables:		
· NHS	5,517	5,517
· Non-NHS	2,559	2,559
Cash at bank and in hand	127	127
Total at 31 March 2017	**8,203**	**8,203**

13.3 Financial liabilities

	Other 2016-17 £'000	**Total 2016-17 £'000**
Payables:		
· NHS	5,996	5,996
· Non-NHS	20,671	20,671
Total at 31 March 2017	**26,667**	**26,667**

	Other 2015-16 £'000	Total 2015-16 £'000
Payables:		
· NHS	6,256	6,256
· Non-NHS	18,733	18,733
Total at 31 March 2017	**24,989**	**24,989**

14 Operating segments

The CCG consider that the only operating segment is the Commissioning of healthcare services

15 Section 75 Agreements

The CCG is party to a number of joint commissioning arrangements with NHS Redditch and Bromsgrove CCG, NHS Wyre Forest CCG and Worcestershire County Council as part of a Section 75 Agreement. Each partner reflects its share of the income, expenditure, assets and liabilities of the pool within their financial statements.
The Agreement enables alignment or pooling of funds that are used to commission a range of acute, community, mental health and Children's services and also incorporates the Better Care Fund.
The flow of funds included within the Agreement varies dependent upon the nature of the services, although the Council acts as 'banker' in the majority of cases with CCGs making monthly contributions to the council which are then passed onto providers in accordance with contractual arrangements.
Investment and disinvestment decisions are made jointly by the Partners to the Agreement through the Integrated Commissioning Executive Oversight Group (ICEOG), on which each partner is represented.

NHS South Worcestershire CCG invests the amounts below within the section 75 Agreement:

Expenditure Description	**2016-17 £'000**	2015-16 £'000
Better Care Fund	17,079	16,866
Wheelchair Service	750	865
Integrated Community Equipment Service	571	552
Learning Disabilities	2,023	2,138
Mental Health	27,684	27,218
Funded Nursing Care	5,295	3,977
Children's Services (including CAMHS)	7,324	6,708
Other Community Services	889	480
Total Agreement	**61,615**	**58,804**

Note 16 Related party transactions

The Department of Health is regarded as a related party. During the year NHS South Worcestershire CCG has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

Related Party	Purpose of Transaction
Gloucestershire Hospitals NHS Foundation Trust	Purchase of Healthcare
NHS Midlands & Lancashire CSU	Purchase of Support Services
NHS Sandwell & West Birmingham CCG	Purchase of Healthcare
Royal Orthopaedic NHS Foundation Trust	Purchase of Healthcare
University Hospitals Birmingham NHS Foundation Trust	Purchase of Healthcare
West Midlands Ambulance Service NHS Foundation Trust	Purchase of Healthcare
Worcestershire Acute NHS Trust	Purchase of Healthcare
Worcestershire Health & Care NHS Trust	Purchase of Healthcare
Wye Valley NHS Trust	Purchase of Healthcare

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

Related Party	Purpose of Transaction
Worcestershire County Council	Purchase of Community Care
HM Revenue & Customs	Payment of Income Tax etc.
NHS Pensions Scheme	Payment of Superannuation

During the year the following Board Members or members of the key management staff or parties related to them have undertaken the following material transactions with NHS South Worcestershire CCG
GPs that are members of the governing body are no longer considered to have significant influence within the GP Practice unless they are sole members of that Practice

Related Party	Purpose of Transaction
SW Healthcare (Various GPs shareholders)	Healthcare Contract
Droitwich HC Ltd (Dr Anthony Kelly - Shareholder)	Rent
Prospect Medical (Dr G Henry - Director and Shareholder)	Hire of Room

NHS South Worcestershire CCG has a shared management team with NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG. This results in transactions between the 3 CCGs covering staff recharges. There are also lead commissioning arrangements in place, consistent with prior years

Prior Year Comparator
NHS South Worcestershire Clinical Commissioning Group - Annual Accounts 2015-16

The Department of Health is regarded as a related party. During the year NHS South Worcestershire CCG has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

Related Party	Purpose of Transaction
Worcestershire Acute Hospitals NHS Trust	Purchase of Healthcare
Worcestershire Health and Care NHS Trust	Purchase of Healthcare
West Midlands Ambulance Service NHS Foundation Trust	Purchase of Healthcare
Gloucestershire NHS Foundation Trust	Purchase of Healthcare
University Hospitals Birmingham NHS Foundation Trust	Purchase of Healthcare
NHS Arden & GEM CSU	Purchase of Support Services
Royal Orthopaedic NHS Foundation Trust	Purchase of Healthcare
Wye Valley NHS Trust	Purchase of Healthcare
NHS Sandwell & West Birmingham CCG	Purchase of Healthcare
Birmingham Children's NHS Foundation Trust	Purchase of Healthcare
NHS England	Purchase of Healthcare
Sandwell & West Birmingham Hospitals NHS Trust	Purchase of Healthcare
University Hospital Coventry & Warwick NHS Trust	Purchase of Healthcare

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

Related Party	Purpose of Transaction
Worcestershire County Council	Purchase of Community Care
HM Revenue & Customs	Payment of Income Tax etc.
NHS Pensions Scheme	Payment of Superannuation

During the year the following Board Members or members of the key management staff or parties related to them have undertaken the following material transactions with NHS South Worcestershire CCG
GPs that are members of the governing body are no longer considered to have significant influence within the GP Practice unless they are sole members of that Practice

SW Healthcare (Various GPs shareholders)	Healthcare Contract
University of Worcester (Sarah Harvey-Speck - Governor)	Workshop

17 Events after the end of the reporting period

There were no relevant events after the end of the reporting period

18 Financial performance targets

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

	2016-17 Target	2016-17 Performance	Duty Achieved? Yes/No	Explanation	2015-16 Target	2015-16 Performance
Expenditure not to exceed income	396,497	389,104	Yes	The CCG underspent it's 2016/17 revenue resource limit by £7.393m	386,220	382,649
Capital resource use does not exceed the amount specified in Directions	31	31	Yes	The CCG spent it's capital resource limit	209	209
Revenue resource use does not exceed the amount specified in Directions	393,629	386,236	Yes	The CCG underspent it's 2016/17 revenue resource limit by £7.393m	384,831	381,260
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	N/A	N/A	N/A	N/A	N/A	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	N/A	N/A	N/A	N/A	N/A	N/A
Revenue administration resource use does not exceed the amount specified in Directions	6,390	5,685	Yes	The CCG underspent it's 2016/17 administration revenue resource allocation by £705k	7,280	6,079

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means. In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore to comply with this requirement, NHS South Worcestershire CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £3.813m. This additional surplus will be carried forward for drawdown in future years.