Agenda item

Health and Wellbeing Board

20th June 2016

NHS Walsall Clinical Commissioning Group: Annual report and Annual Accounts 2015/2016

1. Purpose

The purpose of this report is to present the statutory NHS Walsall Clinical Commissioning Group (CCG), Annual Report and Annual Accounts 2015/2016 to the Health and Wellbeing Board.

2. Recommendations

2.1 The board note the contents of the report documenting examples of the impact NHS Walsall CCG has had in improving health services in the borough.

2.2 Disseminate the key messages within their own organisations

3. Report detail

3.1 Clinical Commissioning Groups have a statutory duty to produce an annual report and accounts. The annual report and accounts is the key way in which CCGs demonstrate their effective stewardship of public money and discharge their accountability to tax payers.

3.2 The NHS Walsall CCG Annual Report and Accounts 2015/2016 is a single document which presents the story of the CCG's activities during the previous financial year ending 31 March 2016.

3.3 The form and content of the annual report and accounts is directed by NHS England and meets the requirements of the Department of Health.

The CCG's annual report and accounts contains:

- An annual report
- A statement of the accountable officer's responsibilities
- A governance statement
- Four primary financial statements
- Notes to the accounts
- A report and opinion from an independent auditor

3.4 The report sets out the key challenges NHS Walsall CCG's progress against the delivery of national standards outlined in the NHS Constitution

4. Health and Wellbeing Priorities:

The NHS Walsall CCG Annual Report and Accounts 2015/16 documents the activity and progress made against the Joint Strategic Needs Analysis and Health and Wellbeing Strategy.

Salma Ali

Salma Ali Accountable Officer Walsall CCG
☎ 01922 618312

NHS

Walsall Clinical Commissioning Group

Annual Report and Annual Accounts

2015/16

Improving Health and Wellbeing for Walsall

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1. Chair's Introduction

This Annual Report of NHS Walsall Clinical Commissioning Group (CCG) covers the activity of the CCG in the 12 months up to the end of March 2016.

The CCG was established in April 2013, under the Health and Social Care Act 2012 and our role is to plan and buy (commission) the majority of health services for people in the borough. We are a clinically-led and member driven organisation made up of 59 GP member practices in Walsall, which places us in a unique position to understand the needs of our residents.

Reflecting on our third year as a clinically led and locality driven organisation we continue passionately and steadfastly to achieve our vision to *"Improve the health and wellbeing of the people of Walsall".*

Walsall's population is diverse, growing and constantly changing, with significant deprivation in the west of the borough and relative affluence in the east. Alongside this, the health system faces significant health care challenges; these include high levels of morbidity from a range of diseases such as coronary heart disease and diabetes which often sits alongside poorer experiences of health services

We're aware of the need to meet the growing health needs of the local population, while at the same time ensuring we work within the limited budgets and resources available to us. The CCG have made numerous investments during 2015/16 to support improvements in health, wellbeing and quality of life for local people. We have done this despite the challenging financial context for health and social care within which Walsall currently finds itself and have still managed to achieve financial balance. We have a strong commitment to continue local investment during 2016/17.

We recognise our health system is facing significant challenges in a number of key areas including poor performance against some of the NHS Constitutional Standards. In particular, the demand on emergency and urgent care, including A&E, ambulance, and out-of-hours services, continues to present national and local challenges.

Through clinical leadership working with partners and responding to public views, we have redesigned urgent care services and have seen the opening of a new, GP led urgent care centre in February 2016. This fantastic new facility brings a range of benefits to patients including a single point of access to urgent care services, reducing the need for some patients to travel to A&E. This has been a three year vision and it is a real privilege to be part of it becoming a reality. The new centre forms a crucial part of our plans to improve urgent care services for local people and was commissioned following a public consultation in the previous summer, during which we shared our long-term plans for urgent care and asked local people for their views on where the service should be located.

We are pleased to report that the CCG is now full delegated to take on responsibility for primary care services with NHS England. This means that we can begin to really influence improvements in GP and primary care services.

GP Primary care services are good in Walsall but we recognise that there is still work to do. By continuing to work closely with our member practices we will focus on moving towards a more integrated care system which reduces health inequalities and improves health outcomes.

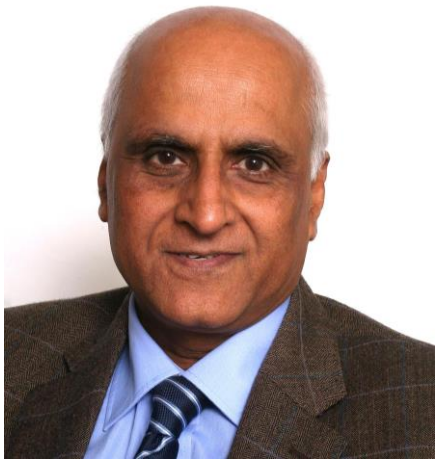
Patients are at the heart of what we do, and throughout the year we have worked hard to engage with the public, patients, service users and their families. Our AGM saw more than double the number of attendees to the previous year as part of our drive to engage with the people of Walsall and shape services to reflect the specific needs of Walsall's population. We are committed to continuing with this work to increase opportunities for patient engagement in our commissioning activity.

Moving forward, we know that the NHS is facing an unprecedented level of future pressure; driven by an ageing population, increase in long term conditions, rising costs and public expectations, and a challenging financial environment. We are however in a good position to continue in the delivery of our Operational Plan and respond to the challenges ahead.

What we have achieved in 2015/16 has only been possible through working closely with our GP member practices, NHS providers, the local authority, voluntary and community organisations, and of course the public and patients. I would therefore like to thank everyone we have worked with this year.

This is my last report as Chair and Clinical Lead for the CCG. It has been a privilege to be part of an organisation, which has made significant improvements in local healthcare.

I have not stood as Chair again as I want to focus on spending time with family and my personal commitments. I therefore feel the time is right to hand this responsibility to someone who will be able to devote the time and energy required to lead the CCG through the coming year.



I am delighted Dr Anand Rischie who is a local GP and our Urgent Care Lead has been elected to the chair role and have no doubt he will work hard to ensure our local NHS offers the kind of care we, as GPs, want for our patients.

Dr Amrik Gill
Chair and Clinical Lead
NHS Walsall Clinical Commissioning Group

2. Performance Report

I am pleased to report that NHS Walsall Clinical Commissioning Group has made good progress in 2015-16 with our Commissioning Strategy and delivering our Operational Plan.

Our Governing Body members have worked hard to develop an outcome based approach to commissioning. This approach takes into account the views of patients and the public, as well as the relevant health issues, so we are clear what outcomes we want services to deliver.

Key challenges:

- It has been a challenging year in many ways, none more so than the pressures at Walsall Manor Hospital which have been well documented over the past few months with the publication of the Care Quality Commission report following an inspection of the hospital. Achievement of the A&E four hour wait standard also continues to be a significant challenge both locally and nationally. At times standards have fallen below that which we would expect and which our patients deserve, and we have been working hard with the Trust and other partners to make significant improvements to the care that patients receive.
- We have also seen continued challenges in meeting the NHS constitutional standards for Referral to Treatment (RTT). This has been a difficult target to try and achieve while also clearing the backlog of patients who have already waited more than 18 weeks. These patients remain a priority for treatment, but we have seen this have a detrimental impact on the overall performance. We're continuing to reduce the number of GP referrals and outsourcing to the independent sector has helped to relieve some of the pressure.

Key successes

- A new Urgent Care Centre has been commissioned as part of our plans to improve urgent care services. The centre opened its doors to patients in January 2015 and is closer integrated with existing services at the Walsall Manor hospital and the GP Out of hour's services.
- We have also put in place measures to improve and stabilise the maternity service and to ensure that every Walsall mother and baby gets effective high quality care. The plans, which include reducing the number of births at the hospital, are part of a longer term model to understand how we manage maternity demands over the coming years.
- A number of improvements to have also been made to local mental health services in partnership with key organisations, people with mental health problems, their carers and the local communities. We have seen progress in the dementia diagnosis and achievement of the national target for recovery for the Improving Access to Psychological Therapies (IAPT).
- We have also made changes as an organisation to further strengthen and increase our clinical input. Three Clinical Executives have been appointed as part of our Governing Body. This will enable us to capitalise on a clinically led approach, with

GPs being best placed to understand the needs of our patients and to guide our commissioning decisions. We will be looking to build on this throughout 2016/17.

- We were successful in our application to take on responsibility for primary care commissioning and will have responsibility for the commissioning of primary care services from the 1st of April 2015. From the 1st of April 2016 these responsibilities will be fully delegated. This is particularly important as most of the contact patients have with the NHS is through their GP.

Over the next year, we will continue to meet our challenges and make the most of our opportunities. As well as managing improvements in the outcomes included in the National Outcomes Framework the CCG will be continuing to ensure that the patient rights in the NHS Constitution are upheld.

Salma Ali,
Accountable Officer,
NHS Walsall CCG

2.1 About NHS Walsall Clinical Commissioning Group (CCG)

NHS Walsall Clinical Commissioning Group (CCG) was formed on 1 April 2013 and is responsible for improving the health of the 274,000 people who live in Walsall by assessing local health needs and commissioning community, hospital and mental health services to meet those needs. Since April 2014 we have also taken on the role of joint commissioning of primary care services with NHS England and as of April 1st, 2016 the CCG will assume full delegation.

The CCG is a clinically-led organisation which means that local GPs and lay representatives use their local knowledge and personal experiences to plan, buy and monitor the quality standards of hospital, community health and mental health services used by Walsall residents.

As a membership organisation the CCG represents local GPs who work at 59 local practices across Walsall.

Our vision

It is within this context, and our understanding of the community we serve, that we present our vision - *to improve the health and well-being of the people of Walsall.*

We will do this by working in partnership with the public, people who use our services, carers, clinicians, our staff and health and social care providers, to design services which:

- Improve health and quality of life outcomes (measured against national and local targets)
- Reduce health inequalities across Walsall
- Target areas where there is greatest need
- Support people to take greater responsibility for living well, staying healthy and living independently.

We will focus on achieving the best health outcomes, regardless of organizational form across the system. This means that we will be advocates 'for the people', working in partnership with our providers, but using market shaping and every contractual lever available to us to achieve sustainable and high quality services.

The key issues and risks that could affect the CCG in delivering its objectives

The assurance framework details the controls and mitigation of our key risks and has been audited by internal audit. An Assurance Framework has been established which is designed and operating to meet the requirements of the 2015/16 AGS and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The organisations major risks for 2015 -16 including challenges in the following areas:

Performance

- 4 hour performance – sustaining 95% standard
- Impact on elective capacity
- Impact on quality & safety
- Elective activity – RTT recovery, impact on quality from delayed treatment and cancer 62 day target

Systems Management

- Joint commissioning the better care programme with local Authority
- Working in partnership with NHS England and the Trust Development Authority to ensure of the local system.

Commissioning Primary Care

- Currently co-commissioning
- Options appraisal to consider next steps
- Not proceeding to full delegation

Procurement

- Premises utilisation linked to void costs chargeable to CCG

Delivering 5 Year Forward View

- Focus on prevention
- New models of care
- QIPP efficiency

Our Role

Walsall Clinical Commissioning Group (CCG) is a clinically led organisation, formed during 2012 as part of the changes brought about in the NHS under the Health and Social Care Act.

The CCG worked with its Governing Body and GP members to achieve formal authorisation with no conditions. The organisation was, therefore, deemed fully fit to take on its new responsibilities from 1 April 2013.

Walsall CCG is responsible for commissioning the majority of healthcare services for the borough. The CCG buys healthcare services from providers across the NHS, commercial and third sectors. The NHS provides the funding for this and NHS England meets with the CCG four times a year to provide assurance to the Department of Health that the CCG is meeting its statutory duties.

As of the 31 March 2016 the CCG employed 80 staff to carry out its work. It also subcontracts some support services to Walsall Healthcare Trust, Midlands and Lancashire Commissioning Support Unit and Walsall Council.

The CCG is committed to improving the healthcare of residents by providing high-quality co-ordinated care that is based around patients' individual needs. The 59 member practices serve communities across the borough, covering a population of 274,000 with a budget of £346 million.

The CCG is based at Jubilee House, Bloxwich Lane, and Walsall. WS2 7JL

Our strategic plan, agreed in the course of 2015/16, describes how we will achieve our vision over the next five years. While everything we are planning will help in delivering our long term goals, we will be concentrating on a small number of priorities that will help to achieve our goals, some of which are nationally mandated and some locally determined.

Figure 1 below shows the agreed priorities:

Figure 1. Walsall CCG Vision and Strategic Objectives and Strategic Priorities

Our Vision	Our Strategic Objectives	Our Priorities
Improve the health and well-being for the people of Walsall.	Improve health outcomes and reduce health inequalities.	Reduce perinatal & infant mortality.
		Increase male life expectancy.
		Reduce the incidence of, and better manage LTCs.
		Improve mental health and well-being and ensure parity of esteem.
	Provide the right care, in the right place, at the right time.	Improve mental health and well-being of children and young people.
		Reduce emergency admissions to hospital.
		Bring Care Closer to Home
		Improve integration of primary, community and social care.
	Commission consistent, high quality, safe services across Walsall.	Enhance the public and patient experience.
		Eliminate recurring significant incidents.
		Improve service quality and performance.
	Secure best value for the Walsall pound and deliver public value.	Deliver cost efficiency programmes (including QIPP)
		Ensure the delivery of provider cost improvement plans.
		Ensure that services are provided by the most capable providers.
		Providers deliver benefits to the Walsall community.

2.2 The CCG's Position at the end of the Financial Year

The planned surplus agreed by the CCG and NHS England for 2015/16 was £5.5m equivalent to 1.5%. The actual surplus for the year was £5.0m. Although nationally the NHS received a comparatively generous settlement relative to other departments, there remains a significant efficiency challenge to cope with demographic changes, the cost of new technology and inflationary pressures within the health service.

This challenge is embodied in the Quality, Innovation, Productivity and Prevention (QIPP) programme. Local schemes have encompassed the principles of:

- Exploring ways in which services can be provided more effectively through the adoption of best practice.
- Building upon relationships with partners to ensure the opportunities for developing the interface between social care and health is maximised.
- Facilitating increased supported care at home through the utilisation of new technologies.
- A recognition that some procedures are of limited clinical value.

During April 2015 the Governing Body approved an annual budget for 2015/16 to invest in priority areas and deliver a planned surplus of £5.5m. This was predicated on the assumption that the combination of local QIPP programmes and the adoption of national efficiency targets would produce savings of £18.0m for re-investment in front line services. Financial performance remained on track during 2015/16 and the CCG exceeded the QIPP target.

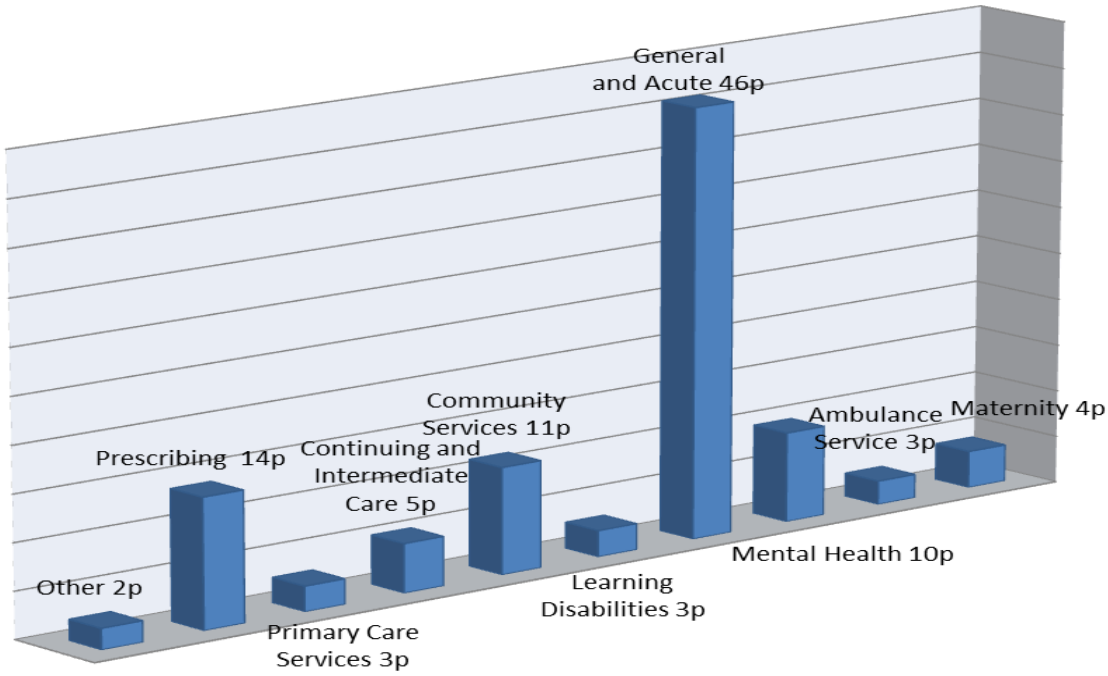
However, in achieving this position there were a number of significant variances from plan which are summarised below:

- Acute contracts were £7m (3.78%) over plan which was attributable to an increase in emergency admissions combined with a non-recurrent funding initiative to improve access to elective care services. The major areas of over performance related to Walsall Healthcare NHS Trust (£1.6m), Royal Wolverhampton NHS Trust (£2.0m) and the independent sector (£2.1m) of the total.
- Learning Difficulties and Mental Health programmes overspent by £585k. This included an increase in specialist rehabilitation placements within mental health totalling £0.6m offset by an underspend in Learning Difficulties services of £74k as a consequence of new placements being lower than anticipated.
- Primary Care Commissioning overspent by £1.8m mainly as a result of an overspend on GP Prescribing of £1.7m.

The recurrent impact of the variances totalling £9.6m was included as first call on the funds available as part of the overall budget approved by the Governing Body in March 2016.

How much a year?

In 2015/16 we spent an average of £1,351 per person on providing healthcare to people who are registered with a Walsall CCG Practice. For each £1 spent, this is where it goes:



Future Plans

The CCG's recurrent allocation for 2016/17 is £419.9m which includes a budget of £37.5m for primary care following the CCG's successful application to become a fully delegated commissioner for these services. Following the adoption of the new allocation formula, Walsall is 8% above the target and as a consequence the pace of change formula has been adopted which resulted in an uplift of 1.99% for 2016/17 compared to the national average of 3.05%. Effectively, Walsall has received £3.9m less than the CCG average.

The CCG faces significant challenges as a consequence of increased emergency admissions and the requirement to improve access to elective services. The 2016/17 budget has focused on the integration of primary, community and mental health services to contribute towards a planned reduction in the level of admissions to secondary care. Investment in community services will increase by £0.6m to secure integration with primary care provision. The investment in mental health services has increased by £0.6m to develop specialist CAMHS provision.

A summary of planned investments is shown in the table below.

Planned Investments 2016/17	**Recurring** £million	**Non Recurring** £million
Inflation and other unavoidable costs including national efficiency requirement	5.3	
Corporate Costs	-0.3	
Recurrent impact of 2015/16 Cost Pressures	9.0	
Projected increased investment attributable to growth in demand		
Acute Services	3.6	
Mental Health	1.3	
Primary Care including Prescribing	1.3	
Non-acute and Other Services	2.1	
Local QIPP Programme	-22.3	
Contingency		2.1
Grand Total	0	2.1

In 2016/17 the CCG faces a significant financial challenge with an unmitigated risk of £6.0m. The CCG will continue to develop new QIPP schemes and review costs in year to mitigate risk. In addition, the CCG will endeavour to ensure that it can attract a large proportion of the £4.1m currently identified as non-recurrent resource.

At the time of writing the CCG's financial plan is still not formally agreed with NHS England.

External Auditors
Ernst & Young LLP is the appointed external auditor for NHS Walsall CCG.

The total fee paid to them is given below, and was paid to cover the cost of the statutory audit and associated services.

	£'000
Statutory Audit	56

Charges for Information
It is government policy that much information about public services should be made available either free or at low cost. In the public interest NHS Walsall CCG follows Treasury guidance in this area as outlined in Appendix 6.3 to the Treasury document "Managing Public Money".

Principal Risks and Uncertainties
In considering the outlook for 2016/17 and beyond, the CCG continues to face significant risks and uncertainties.

- Financial Risks
  The restraint on public sector finance in conjunction with the adoption of the new allocation formula for CCGs will create significant challenges for the CCG and other NHS and partner agencies including Walsall Council.

  The CCG is 8% above its target allocation and as a consequence will receive additional growth funding at a rate less than the NHS average. Plans assume that the CCG will receive an uplift of 1.0% or £4m per annum less than the average as it moves towards its target allocation.

  The CCG faces the challenge of managing increases in demand for services from an increasing, ageing population within a reducing real terms financial allocation. This will require a fundamental change in the way services are delivered requiring a significant shift in activity and resource from the hospital sector to the community. Failure to implement these changes will pose a significant financial risk to the CCG and its partners.

Performance against Key Finance Indicators

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

Walsall CCGs performance against these financial duties during 2015-16 were as follows:

	2015-16 Target	2015-16 Actual	Duty Achieved
STATUTORY DUTIES:			
Expenditure not to exceed income	£380.0m	£375.0m	**YES**
Capital resource use does not exceed the amount specified in Directions	0	0	**N/A**
Revenue resource use does not exceed the amount specified in Directions	£373.7m	£369.5m	**YES**
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	**N/A**
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	**N/A**

Revenue administration resource use does not exceed the amount specified in Directions	£6.4m	£5.5m	**YES**
NON STATUTORY DUTIES:			
Better Payment Practice Code – NHS	95.0%	98.2%	**YES**
Better Payment Practice Code – Non NHS	95.0%	99.2%	**YES**
Efficiency of cash – closing bank balance to be no greater than 1.25% of monthly drawdown	1.25%	Achieved	**YES**
QIPP programme (Quality, Innovation, Productivity and Prevention	£6.2m	£7.2m	**YES**

Better Payments Practice Code

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The CCG successfully achieved compliance with this code and further details are available in Note 7 to the accounts on page 104.

Prompt Payment Code

In addition, the CCG has signed up to the Prompt Payments Code which sets standards for payment processes and best practice. It covers prompt payment as well as wider payment procedures so our suppliers can have confidence that the payments we make will be in line with the code and best practice.

2.3 Performance Analysis

2015/16 saw continued challenges to the delivery of national standards outlined in the NHS Constitution across the whole country, with unprecedented demands on a widening range of NHS services. These standards set out the universal rights and pledges for all NHS patients. Walsall CCG has experienced similar pressures on services over the last year which has resulted in a number of NHS Constitution measures not achieving their annual targets.

Walsall CCG is committed to meeting these requirements for all users of NHS services and will continue to work closely with local providers to ensure these standards are achieved and improvements made where this currently may not be the case.

Our performance in 2015-16 against the requirements of the NHS Constitution is summarised below.

Indicator Short Name	Year End Target	Annual Forecast*
NHS Constitution – Rights and Pledges		
18 weeks Referral to Treatment –Patients on incomplete or non-emergency pathways	≥92%	
Diagnostic tests waiting times	≤1%	
A&E 4-hour waits (Walsall Healthcare NHS Trust only)	≥95%	
Cancer 2-week waits – urgent referral	≥93%	
Cancer 2-week waits – breast symptomatic	≥93%	
Cancer 31-day waits – first treatment	≥96%	
Cancer 31-day waits – surgery	≥94%	
Cancer 31-day waits – drugs	≥98%	
Cancer 31-day waits – radiotherapy	≥94%	
Cancer 62-day waits – first treatment	≥85%	
Cancer 62-day waits – screening service	≥90%	
Cancer 62-day waits – consultant upgrade	≥91%	
Ambulance Category A ‘Red 1’ response within 8 minutes (West Midlands Ambulance Service – WMAS)	≥75%	
Ambulance Category A ‘Red 2’ response within 8 minutes (WMAS)	≥75%	
Ambulance Category A response within 19 minutes (WMAS)	≥95%	
NHS Constitution Support Measures		
Mixed Sex Accommodation Breaches	0	
Cancelled Operations (not offered alternative date within 28 days)	0	
Mental Health CPA 7-day follow up	≥95%	
The number of Referral to Treatment incomplete pathways greater than 52 weeks	0	
Patients who have waited over 12 hours in A&E from decision to admit to admission	0	
Urgent operations cancelled for non-clinical reasons for a second time	0	
Ambulance handover delays of over 30 minutes	0	
Ambulance handover delays of over 60 minutes	0	

*This assessment is made on the latest data available to the CCG

Based on this assessment it is clear that there are a number of challenges facing the CCG under the core NHS Constitution and support measures, with difficulties in delivering the required standards in; A&E waiting times, two cancer waits measures, mixed sex accommodation, RTT 52 week waits and ambulance handover delays. Actions underway to address these issues are summarised below.

A&E Four Hour Wait

Achievement of this standard continues to be a significant challenge both locally and nationally.

There are a number of factors which continue to drive Walsall's 4 hour wait performance;

- General Practice has seen additional pressure on appointments and referrals to care services across primary and secondary care
- Conversion of attendance to admission rate remains high with clinicians reporting high levels of patient acuity
- Sustained increases in emergency admissions to the hospital over 3 years – driven by increased Staffordshire activity as well as Walsall increases. The rate of increase has slowed in the last 12 months
- There remains a set of current hospital processes which are not working well for patients and require significant changes to improve flow
- Similarly current processes within community based beds result in delays, longer length of stay and reduced rates of patient flow
- Arrangements between health and social care do not consistently manage timely discharge and transfer of care

The plan to improve 4 hour wait performance is based upon consistently delivering a co-ordinated set of priorities at pace under the following themes;

- Reducing pressure on admissions
- Improving hospital flow and discharge management processes
- Improving flow to 'Decision to Admit' beds
- Smoothing the transition for patients from Acute to Social Care

To ensure robust monitoring and escalation and to maximise the impact of planned actions, a System Resilience Group has been introduced which is attended by senior representatives from NHS Walsall CCG, Walsall Healthcare Trust and Walsall Council.

Cancer Waits

There are two cancer waits measures that are projected to fail to achieve the standards set in the NHS Constitution.

Cancer 2-week waits – breast symptomatic

- It is forecast that the 93% standard will only be missed during 3 months of the year
- Performance of 63% during June significantly impacted the overall annual performance, resulting in a failure to achieve the standard for the year
- Monthly performance has not been below 93% since July 2015

Cancer 62-day waits – first treatment

Achievement of this standard continues to be a significant challenge both locally and nationally.

The main reasons for breaches under this measure are increased demand, capacity issues and patient choice.

These include:

- Increased referrals on some cancer pathways especially the urology and upper and lower GI pathways which have been difficult to accommodate;
- Diagnostic delays within the Trust including long waits for endoscopy which have had a significant impact on the upper and lower GI pathways;
- Capacity constraints at the tertiary centres to which we refer many of our cancer patients resulting in waits for treatment at those centres. This has been particularly the case for urology patients choosing robot surgery only available at Royal Wolverhampton NHS Trust;
- Difficulties with filling some key roles at the Trust supporting this service including a consultant urologist role (now appointed to), Cancer Manager and administrative support roles for cancer tracking;
- Slippage in delivering actions from previous remedial action plans.

Actions taken by the Trust to improve cancer waits performance include;

- Incorporating an updated series of formal interventions within a revised recovery plan and agreed recovery trajectory to deliver the standard by July 2016.
- Commenced reconstituted clinically led Cancer Steering Group meetings in January 2016 to provide internal leadership and oversight of cancer performance within the Trust
- Cancer trackers reviewing and escalating issues for patients daily across all sites.
- Escalations to key stakeholders at PTL meeting (e.g. endoscopy/imaging)
- Cancer strategy under development
- Multidisciplinary review of PTL meeting held weekly, chaired by the Divisional Director and attended by Interim Chief Operating Officer.

Mixed Sex Accommodation Breaches

Achievement of this standard continues to be a significant challenge at WHNHST with the following issues impacting upon performance;

- All breaches occur within the High Dependency Unit (HDU) at WHNHST
- Patients should be transferred from HDU within 4 hours of a decision to step down
- Rules which apply to HDU state that a patient on critical care should only be counted as a breach if another patient is ready to step down whilst the first patient is still there
- Capacity pressures have prevented timely transfers of patients to appropriate ward areas due to clinical need

- Performance is impacted by estates configuration of HDU at the Trust as bed capacity issues mean there is currently no area for ringed fence step down beds

Actions taken by the Trust to improve performance include;

- The escalation process, including timescales, for HDU step down has been incorporated within the Critical Care operational policy
- Ongoing liaison with the regional network to ascertain how MSA breaches are prevented within other Trusts and potentially implement any new processes that are identified
- Weekly tracker of Critical Care mixed sex accommodation breaches is maintained and reasons established for each breach to identify any themes or trends
- The business care to build the new Integrated Critical Care Unit has been approved which would remove all MSA breaches. This is awaiting confirmation of funding with the new unit completion anticipated during winter 2018

18 Week Referral to Treatment – 52 week waits

Due to data quality concerns over the number of patients on their Patient Tracking List (PTL) WHNHST is not currently submitting monthly data under their 18 weeks Referral to Treatment (RTT) performance. However an agreement has been reached through the Elective Access Performance Group (EAPG) around a set of milestones for returning to reporting.

The Trust Board have approved an external company to complete a data validation exercise of their PTL, with this exercise due to be completed by the End of June 2016. Consequently the Trust is scheduled to return to reporting RTT performance in July with the submission of June 2016 data.

- The number of patients waiting over 52 weeks for treatment has been reducing each month since May 2015
- Since December 2015 there have been no Walsall CCG patients waiting over 52 weeks for treatment

Emergency Department

CQC identified capacity issues as having an impact on patient safety and quality and also identified that the triage process was ineffective.

Assurance/actions taken to address the CQC findings in ED include;

- A task force approach to ED improvement has been put in place by the Trust. Revised recovery plan for ED performance is now in place and will be overseen by Systems Resilience Group. Initial data is showing some signs of improvement.
- Different models of working are being explored, with a focus on advanced nurse practitioners, although it is recognised that this is a longer term model.
- A trial of ‘front door’ clinical screening has been undertaken by the Urgent Care provider, the initial trial (ANP nurse at reception desk) created additional delays in the UCC and some waiting time breaches were experienced. Therefore a further trial commenced 29 April which relocated the streaming nurse from the

triage point in reception to the reception desk from 12pm to 8pm 7 days a week. Early experience of this trial is positive and is being monitored with a view to extending the times to 10am to 10pm. New signage is now in place to direct patients more effectively to the appropriate service.

- An arranged visit to ED, by a clinical team from NHSI, accompanied by a CCG representative, to review progress against CQC recommendations identified positive and engaged ED staff and improvements in paediatric triage, however some areas identified in the CQC report still need addressing, for example interpreting services. The challenges of the estates within ED remain

Patients Waiting over 12 Hours in A&E from Decision to Admit to Admission

- Overall there have been 10 WCCG patients that waited over 12 hours for admission during 2015/16
- All 10 of these patient waits occurred during April 2015. As the result of a thorough review, improved processes have subsequently resulted in no further breaches throughout the rest of the year

Ambulance Handover Delays

- Ambulance handover delay targets are frequently breached, both locally and nationally. This is largely due to increased pressures on Acute services and also Ambulance Trusts
- Throughout the year there have been an increasing number of occurrences where over 90 ambulances per day have arrived at Walsall Healthcare NHS Trust

Actions to improve ambulance handover delays performance include:

- A clear and identified command structure in place across the organisation to enable escalation of issues as they occur
- An Emergency Department (ED) trigger tool is being implemented
- The introduction of an Ambulance Handover Nurse and also an agreement to ensure there is a full complement of staff in ED to cover all roles
- Introduction of a “Push Model” with senior organisational support to accept patients from ED at all times
- Regular Board Rounds to be held in ED
- Regular meetings between West Midlands Ambulance Service and WHNHST are in place and will form the basis of a working group to address issues as they are identified

Maternity Services

The CQC found that Maternity Services provided at Walsall Healthcare NHS Trust had limited capacity and staffing resources which impacted negatively on patient experience and compromised patient safety; this resulted in an n overall inadequate rating for maternity services at the trust

Assurance/actions taken to address the CQC findings in Maternity Services include;

- Additional midwifery capacity is being sought to improve the birth to midwife ratio.
- The Black Country wide sustainable Maternity Services meeting, led by WCCG, has resulted in an agreement to cap birth activity at WHCT to 4000-4200 births per year. The process of moving 500 births per year to the Royal Wolverhampton NHS Trust is monitored on a weekly basis and further movement of 250 births to Sandwell Midwifery Led Unit commenced in May.
- A dashboard to monitor key indicators, to ensure the effectiveness and quality of the revised process, is being monitored through the sustainable maternity board.

Overall Assurance/Action Following CQC Inspection

- WCCG attend Quality Oversight Review meeting for assurance around progress with PCIP
- Quality and Safety workshop conducted and attended by Q and S committee members to review current processes. A set of priorities for assuring improvement were agreed as follows:
    - Seek patient views and experiences and use their stories more effectively
    - Collaboratively identify system levers
    - Ensure sustainability
    - Ensure ownership of the levers and maximise potential of levers

- There remains a continual approach to partnership working to support improvement.
- Clinical visit by NHSI to review progress against CQC actions showed some initial signs of improvement and also identified areas for further development

2.4 Sustainability Report

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

The majority of our environmental and social impact is through the services we commission. We do impact directly, however, through the energy utilised in our buildings; travel undertaken by staff and through procurement decisions taken.

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

Walsall CCG is developing plans to assess risks, enhance its performance and reduce its impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

The CCG will ensure it complies with its obligations under the Climate Change Act 2008, including the adaptation reporting power and the Public Services (Social Value) Act 2012.

The organisation is also setting out its commitments as a socially responsible employer. The CCG leases its office accommodation at Jubilee House from NHS Property Services.

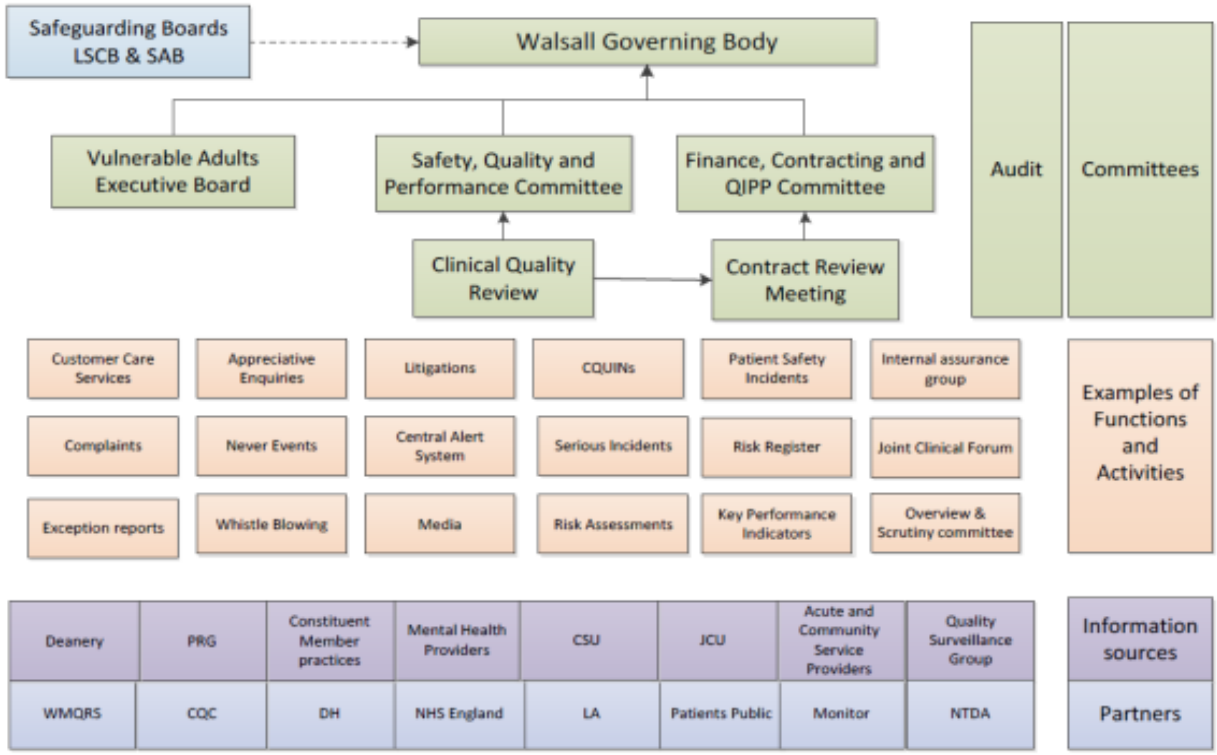
2.5 Quality

The CCG has discharged its duty to improve quality under section 14R of the Health & Social Care Act 2012 through ensuring that a robust quality framework is in place. The quality framework sets out how Walsall CCG manages and sources the quality intelligence required to gain assurance in a systematic, organised manner to comply with its duty for quality improvement. The framework provides a formal structure that describes how the CCG manages quality improvement to:

- Bring greater clarity to quality and planned quality improvements
- Measure quality
- Publish performance about quality
- Recognise and rewarding quality; raising standards
- Safeguard quality
- Support and promoting innovation

In order to provide assurance of our actions and those of our providers to improving quality it is important that we are also clear about respective and joint accountabilities and responsibilities for commissioning arrangements, these include specialised commissioning arrangements, public health commissioning arrangements and future commissioning arrangements for integrated working practices. These responsibilities are reflected within our governance framework which is below.

NHS Walsall CCG Quality Assurance Framework



NHS Walsall Clinical Commissioning Group has also established the Quality & Safety Committee to ensure commissioned services are of good quality, deliver safe effective care and are performing well in line with its corporate objectives.

The Quality & Safety committee focuses its work around the successful delivery of the CCG corporate objectives:

1. Improve health outcomes and reduce health inequalities
2. Provide the right care, in the right place, at the right time
3. Commission consistent, high quality, safe services across Walsall
4. Secure the best value for the Walsall pound and deliver public value

It undertakes to oversee the delegated responsibilities from the Governing Body as set out in the scheme of delegation providing Governing Body. The committee is chaired by the Medical Director (GP) for Walsall CCG and its core membership includes Lay Member representation, Public Health, General Practice and Quality Leads.

2.6 Reducing Inequalities

The CCG has discharged its duty to reduce inequalities under Section 14T of the Health and Social Care Act 2012 through the development and approval of its Operational Plan 2015/6. The Operational Plan takes into full account the requirements of national planning guidance including the 5 Year Forward View and annual planning guidance published by NHS England. The CCG has through the plan developed plans to tackle the three aims of the 5 Year Forward View including addressing the health inequalities, affordability and quality gaps. In addition it has taken steps to address NHS constitutional targets to ensure that patients access services in a timely way that are of high quality and that are safe

The Operational Plan provided the blue print for the transformation work during the 2015/6 year and actions that have been taken during the year in relation to service transformation has helped to bridge and reduce the inequalities gap in Walsall. WMBC public health reports and intelligence will evidence the impact of the CCGs Commissioning Programme in terms of improved health outcomes for the population.

2.7 Health and Well-being

The CCG has contributed to the delivery of the Health and Wellbeing Strategy for the borough in collaboration with its partners and other stakeholders. This is a joint duty under Section 116b (1) (b) of the Local Government and Public Involvement in Health Act 2007. The CCG has worked collaboratively with Public Health Medicine WMBC. In particular the CCG has contributed to the work required to develop the Health Wellbeing Board Strategy and in the refresh of the Joint Strategic Needs Assessment (JSNA) which took place in early 2015. The JSNA is an important document which maps the demographic and epidemiological needs of the population and on which the plans in the Health Wellbeing Board Strategy are based.

In response to the JNSA the Health and Wellbeing Board has developed strategy which has a broad range of objectives and aims which are tackling the broad determinants of health. Therefore the Health Wellbeing Board Strategy is not simply what the CCG does in relation to its commissioning programmes and transformation but it also focuses on the work of the Local Authority, Police, Voluntary Sector and other organisations that can influence the health and wellbeing of the local population.

The Health and Wellbeing Board have regular meetings to review progress of the strategy and are accessing the impact of our programmes on health outcomes for the Borough.

The Health and Well-being Board have been engaged in developing elements within this report. A copy of the final report will be available at the next meeting in June.

2.8 Patient and Public Involvement

NHS Walsall CCG recognises that engagement and involvement is a key part of how services are planned, commissioned, delivered and reviewed. Throughout 2015/16 we have continued to develop robust methods of listening, engaging and involving patients and the public which have ensured that their insight and experiences have been acted upon at all stages of the commissioning cycle and has influenced our commissioning decisions. We have successfully engaged stakeholders, patients and the public in a range of activities to facilitate community involvement in how we design, deliver and improve local health services.

A new three year Communications and Engagement strategy has been developed for 2016 – 2019 and ratified by the Organisational Development Committee. One of the five objectives is to "Ensure the involvement of public, patients and carers in decisions relating to their care and the commissioning or redesign of local NHS services, in line with the CCG's statutory duty." Effective involvement of communities, patients and the public at each stage of the Engagement Cycle, to help the CCG to understand how to effectively at each stage of the commissioning process, is a key part of the strategy.

Examples in which the CCG has involved public and patients:

Changes to maternity services

Following feedback in a Care Quality Commission (CQC) Hospital Inspection report, maternity services at Walsall Manor hospital were rated as 'inadequate'. There are a number of factors that have had an impact on the quality of maternity services at Walsall Manor Hospital which include an increasing birth rate, closure of some maternity services and birth restrictions at other neighbouring trusts, staffing and estate.

NHS Walsall CCG and Walsall Healthcare Trust have put in place measures to ensure the safety and stability of maternity services at Walsall Manor Hospital. The changes include a reduction on the number of births at the hospital in the short to medium term.

The decision was made jointly by engaging and involving health partners in Walsall, the Maternity Network, local GPs and midwives. The proposal was also shared with Healthwatch Walsall and Walsall Health and Wellbeing Board and the Walsall Health Overview and Scrutiny Committee, Local MPs, councillors, expectant mothers and the wider public.

Patient Participation Groups (PPGs)

Walsall CCG promotes community involvement is through Patient Participation Groups (PPGs). We ensure that the local intelligence gained from these groups' links into the commissioning process. Around forty GP surgery based Patient Participation Groups are so far established in Walsall, many of which we have supported over the last twelve months and continue to do so. We also have a strong and proactive Patient and Participation Liaison (PPLG) that consists of representatives from PPGs across Walsall and provides a forum for networking and sharing best practice. The intention is that all active PPGs are represented on the group but more work needs to be done to ensure it is more representative of Walsall and the four localities.

Working with Healthwatch

We are developing the relationship with Healthwatch Walsall to focus opportunities for joint collaboration where possible and with the potential for the CCG to commission small scale projects. They have also attended the Patient and Participation Liaison Group (PPLG) meeting and will be attending future meetings to support the CCG to engage with patient representatives.

Healthwatch are an active member on the CCGs Primary Care Commissioning Committee. The role of the committee is to make decisions on the review, planning and procurement of primary care services in Walsall, under delegated authority from NHS England.

New Urgent Care Centre

During 2014 the CCG undertook a major consultation exercise on developing the unified Urgent Care System and the immediate relocation of the current walk-in-centre. The most recent phase of this has involved targeted work with specific service-user groups to help advise on the design of the new Urgent Care Centre. Following a full public consultation to shape Urgent Care in Walsall and new urgent Care Centre was commissioned for Walsall. Patients, public and hard- to-reach groups were invited to get involved in the design and interior of building and feedback from these groups has been used to inform the design, layout and interior of the building.

During 2015/ 2016, prior to the building opening, local community members who helped shaped the centre were invited to give their feedback and get a first look at the newly-renovated building located at the Saddler's Centre. There were two tours arranged which were attended by members from Healthwatch Walsall, Carer User Support Partnership Group (CUSP), Walsall Disability Forum and patient representatives. The members took part in a Q&A session and provided initial feedback on the centre. Many members who attended were involved in the initial public consultation which took place before the centre was commissioned and were invited back to see how their input helped to shape the new Urgent Care Centre. Members of the youth of Walsall were all invited to give their views and ideas on the design of the centre

Urgent Care and Flu Public Awareness campaign

An Urgent Care campaign was developed and implemented across Walsall throughout winter to educate and raise awareness about the range of NHS services in Walsall and the importance of the flu vaccination for those people at risk. To reinforce the messages of the campaign, we commissioned 16 days of face-to-face engagement events during November, December and January. Featuring a 'Health Elf' and 'Flu Fairy', they visited a wide range of venues across Walsall, including shopping centres, supermarkets, libraries, offices, colleges, schools, garden centres, leisure centres, community centres and events.

Publicity material used to communicate key messages to the public and patients were developed with feedback from patient representative's to ensure it was public-friendly and easy to understand.

To engage with people and capture feedback at the events, scratch cards we designed to provide a snapshot of people's views on where they should go for different conditions. It also asked whether they had had the flu vaccination and if not, why not. In total, the engagement team spoke to around 2,000 people at 23 venues, with 1,467 filling out scratch cards.

Signed .....

Salma Ali

Accountable Officer

May 2016

3. Accountability Report

3.1 Corporate Governance Report

Details of the Membership Body and Governing Body

Names of the Chair and Accountable Officer from 1 April 2015 – 31 March 2016	
Chair of Walsall CCG	Dr Amrik Gill
Accountable officer	Ms Salma Ali

Names of the Directors	
Chief Finance Officer	Mr Tony Gallagher
Strategic Lead for Service Transformation and Redesign	Mr Phil Griffin
Director of Governance Quality and Safety	Mrs Sally Roberts
Director of Commissioning Transformation and Performance	Mrs Sarah Laing
Director of Primary Care and Integration	Mrs Donna Macarthur

Membership Practices forming the Membership Body of the CCG	
Practice	**Address**
All Saints Surgery	Pinfold Health Centre, Field Road, WS3 3JP
Ambar Medical Centre	Milton House, 151 Wednesbury Road, WS1 4JQ
Beechdale Surgery	Edison Road, WS2 7EZ
Berkley Practice	Bentley Medical Centre, Churchill Road, WS2 0BA
Birchills Health Centre	23-37 Old Birchills, WS2 8QH
Blackwood Health Centre	Blackwood Road, Streetly, B74 3PL
Blakenall Family Practice	Thames Road, WS3 1LZ
Bloxwich Medical Practice	Pinfold Heath Centre, Field Street, WS3 3JP
Brace Street Health Centre - Dr Kumar	Brace Street, Caldmore, WS1 3PS
Brace Street Health Centre - Drs De & Ghosh	Brace Street, Caldmore, WS1 3PS
Brace Street Health Centre – Dr Pal & Dr Mandal	Brace Street, Caldmore, WS1 3PS
Broadway Medical Centre	213 Broadway, WS1 3HD
Chapel Street Surgery – Dr Nambisan	1 Chapel Street, Pelsall, WS3 4LN

Coalpool Surgery	Harden Road, WS3 1ET
Collingwood Family Practice	Collingwood Drive, Great Barr, B43 7NG
Croft Street Surgery	Croft Street, WV13 2DR
Darlaston Health Centre - - Dr I Khan & Dr Merali	Pinfold Street, WS10 8SY
Darlaston Health Centre – Dr N Khan & Dr Qureshi	Pinfold Street, WS10 8SY
Darlaston Health Centre – Dr Saha's Surgery	Pinfold Street, WS10 8SY
Darlaston Health Centre – Dr Vaid	Pinfold Street, WS10 8SY
Darlaston Medical Centre	Birmingham Street, WS10 9JS
Field Road Surgery	Pinfold Health Centre, Field Road, WS3 3JP
Fisher Street Surgery	65 Fisher Street, WV13 2HT
Harden Health Centre – Dr P Kaul & Dr S Kaul	Harden Road, WS3 1ET
Harden Surgery	Harden Road, WS3 1ET
Holland Park Surgery	Chester Road North, WS8 7JG
Khan Medical Practice	Pinfold Health Centre, Field Road, WS3 3JP
Kingfisher Practice	Bentley Medical Centre, Churchill Road, WS2 0BA
Lichfield Road Surgery - Dr RB Latthe	77 Lichfield Road, WS9 9NP
Lichfield Street Surgery – Haire & Partners	19 Lichfield Street, WS1 1UG
Little London Surgery	Little London, WS1 3EP
Lockfield Surgery	Croft Street, WV13 2DR
Lockstown Practice	Gomer Street, WV13 2DR
Lower Farm Health Centre	109 Buxton Road, Bloxwich, WS3 3RT
Mossley & Dudley Fields Medical Practice	Stoney Lane, WS3 2TA
Moxley Medical Centre	10 Queen Street, WS10 8TF
New Invention Health Centre	66 Cannock Road, WV12 5RZ
New Road Medical Centre	Chester Road North, WS8 7JG
Northgate Practice	Anchor Meadow Health Centre, WS9 8AJ
Palfrey Health Centre	151 Wednesbury Road, WS1 4JQ
Parkside Medical Practice	Chester Road North, WS8 7JG
Pelsall Village Centre - Dr Bevan's Surgery	High Street, Pelsall, WS3 4LX
Pelsall Village Centre – Dr Sameja's Surgery	High Street, Pelsall, WS3 4LX
Pleck Health Centre	16 Oxford Street, WS2 9HY
Portland Medical Practice	Anchor Meadow Health Centre, WS9 8AJ
Rough Hay Surgery	44B Rough Hay Road, WS10 8NQ
Rushall Medical Centre	107 Lichfield Road, WS4 1BW
Saddlers Surgery	133 Hatherton Street, WS1 1YB
Sai Medical Centre	1 Forrester Street, WS2 9PL
Sina Health Centre	230 Coppice Farm Way, WV12 5XZ

St Johns Medical Centre	High Street, WS9 9LP
St Lukes Surgery	Pinfold Health Centre, Field Road, WS3 3JP
St Marys Surgery	Pinfold Health Centre, Field Road, WS3 3JP
St Peters Surgery	51 Leckie Road, WS2 8DA
Streets Corner Surgery	79-81 Lichfield Road, WS9 9NP
Stroud Practice	Bentley Medical Centre, Churchill Road, WS2 0BA
Sycamore House Medical Centre – Dr Dugas & Partners	111 Birmingham Road, WS1 2NL
The Keys Family Practice	Willenhall Medical Practice, Field Street, WV13 2NY
The Limes Medical Centre	5 Birmingham Road Walsall, WS1 2LX
The Wharf Family Practice	145a Pleck Road, WS2 9ES
Walsall Walk In Centre	Market Square, WS1 1QZ

Composition of the Governing Body from 1 April 2015 – 31 March 2016		
Dr Amrik Gill	Clinical Chair	April 2015 – March 2016
Ms Salma Ali	Accountable Officer	April 2015 – March 2016
Dr Avtar Suri	Clinical Chair North Locality	April 2015 – March 2016
Dr Nasir Asghar	Deputy Clinical Chair North Locality	April 2015 – March 2016
Dr Rajcholan Mohan	Clinical Chair West Locality	April 2015 – March 2016
Dr Shadia Abdalla	Deputy Clinical Chair West Locality	April 2015 – March 2016
Dr Sandeep Kaul	Chair Trans Locality	April 2015 – March 2016
Dr Francois Bolliger	Deputy Chair South East Locality	April 2015 – March 2016
Dr Anand Rischie	Deputy Chair Trans Locality	April 2015 – March 2016
Mr Tony Gallagher	Chief Finance Officer	April 2015 – March 2016
Mrs Sally Roberts	Lead Nurse Director of Governance Quality Safety	April 2015 – July 2015 August 2015 – March 2016
Mr Phil Griffin	Strategic Lead service Transformation and Redesign	April 2015 – May 2015
Mrs Donna Macarthur	Director of Primary Care and Integration	February 2016 – March 2016
Mrs Sarah Laing	Director of Commissioning Transformation and Performance	February 2016 – March 2016
Mr John Wicks	Interim Director Commissioning Transformation Performance	September 2015 – March 2016
Mr John Duder	Lay member	April 2015 – March 2016
Mr Mike Abel	Lay member	April 2015 – March 2016
Mrs Trudy Cotton	Lay member	April 2015 – December 2015
Mr Robert Freeman	Secondary Care Consultant	April 2015 – March 2016

Mr Keith Skerman	Interim Executive Director of Social Care & Inclusion Walsall Council	April 2015 – March 2016
Dr Barbara Watts	Director of Public Health Walsall Council	April 2015 – March 2016

Membership of the Audit Committee from 1 April 2015 – 31 March 2016	
Mr John Duder	Chair
Mr Mike Abel	Lay member
Mrs Trudy Cotton	Lay member
In attendance	
Ms Salma Ali	Accountable Officer
Mr Tony Gallagher	Chief Finance Officer
Dr Amrik Gill	Clinical Chair
Mrs Sara Saville	Head of Corporate Governance
Steve Clark/Mark Surridge	Ernst & Young LLP (External Audit)
Mr Paul Westwood / Mr Don Ferguson	Local Counter Fraud Specialist
Mrs Tracey Barnard-Ghaut Mr Paul Dudfield	Internal Audit CW Audit Services
Mrs Maggie Lever	Committee Secretary

Membership of the Remuneration Committee from 1 April 2015 – 31 March 2016	
Mrs Trudy Cotton	Lay member for Quality and Patient Engagement
Mr Mike Abel	Lay member for Service Transformation
Mr John Duder	Lay member for Audit and Governance
In attendance	
Accountable Officer	Ms Salma Ali
Chief Finance Officer	Mr Tony Gallagher
Head of Corporate Governance	Mrs Sara Saville

The Governing Body has the following additional committees:

1. Safety Quality and Performance Committee
2. Finance Contracting and QIPP Committee
3. Improving Outcomes Committee
4. Organisational Development Committee
5. Joint Commissioning Committee for Adults

The details of the membership of the remaining Governing Body committees can be found in the Governance Statement.
The full declaration of interest register is available on the Walsall CCG website
http://walsallccg.nhs.uk/about-us/govbody/declaration-of-interests

There have been no personal data related incidents reported to the Information Commissioners Office

Each Director on the Walsall CCG Governing Body confirms that they:

Know of no information which would be relevant to the auditors for the purposes of their audit report and of which the auditors are not aware, and; has taken "all steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

3.2 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 Salma Ali to be the Accountable Officer of the Clinical Commissioning Group.

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

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

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

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

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

Signed .....
Salma Ali
Accountable Officer
May 2016

3.3 Governance Statement

Governance Statement by Salma Ali as the Accountable Officer of Walsall Clinical Commissioning Group

Introduction

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

The Clinical Commissioning Group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

As at 1 April 2014, the Clinical Commissioning Group was licensed as assured with support as follows:

Domain	Assurance level
Are patients receiving clinical commissioned high quality services	Assured with support
Are patients and the public actively engaged and involved	Assured
Are CCG plans delivering better outcomes for patients	Assured with support
Does the CCG have robust governance arrangements	Assured
Are the CCGs working in partnership with others	Assured
Des the CCG have strong and robust leadership	Assured
Overall Assurance	Assured with support

Walsall has a population of approximately 274,000 people. The CCG is committed to working in partnership to achieve health and wellbeing improvements and reduce health inequality for people of Walsall. The mission statement for Walsall CCG is ‘Improving the Health and Wellbeing of the People of Walsall’.

Walsall CCG has the following operating plan objectives:

1. Give every child a heathier start to life
2. Reduce the burden of preventable disease, disability and death
3. Enable an integrated approach to care prevision and commissioning
4. Improve health and wellbeing through healthy lifestyles
5. Enable healthy ageing and independent living
6. Secure be quality and value for every health and social care pound spent in Walsall

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 departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money.*

I also acknowledge my responsibilities as set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Compliance with the Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

Walsall CCG has a constitution compliant with the requirements set out in schedule 1A of the Health and Social Care Act 2012. There is both an Accountable Officer and Chair which prevents one individual having 'unfetted' powers of decision making. The Chair is responsible for the leadership of the Governing Body and has met with each Governing Body member to clarify roles and set objectives for the year. The Governing Body has three lay member roles which cover audit and governance, service transformation and redesign and patient and public involvement.

The Governing Body has a development programme which runs throughout the year to ensure that there is appropriate balance of skills and knowledge within the Governing Body membership to discharge respective duties and responsibilities.

The governance framework for the CCG sets out the arrangements for accountability and enables the Governing Body to assess timely accurate information upon which it can assess the organisation's position in a fair and balanced manner. This includes the risk management and an internal control for corporate objectives that it has received external assurance from the auditors.

There is a Remuneration committee which makes recommendations to the Governing Body on the appropriate remuneration and terms of service for the employees of the CCG.

The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states: The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

Key features of the CCG Constitution

Subject to the limits of its Constitution, Walsall CCG Governing Body is responsible for and is delegated by its Member Practices the power to conduct the overall management and strategic direction of Walsall CCG and the achievement or furtherance of the functions.
Walsall CCG is accountable for exercising the statutory functions of the group. It may grant authority to act on its behalf to:

I. Any of its member practices
II. Its Governing Body
III. Employees
IV. A committee of the Governing Body or a committee

The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the group as expressed through the CCG's Scheme of Reservation and Delegation and for committees their terms of reference

The CCG's Scheme of Reservation and Delegation sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of its Governing Body (and its committees), the groups Committees and Governing Body Committees, individual members and employees.

Walsall CCG remains accountable for all of its functions, including those that it has delegated.

Walsall CCG Governing Body may arrange for any of its functions to be exercised on its behalf by any Member or any employee or any committee or sub-committee as it thinks fit, but the terms of any such delegation must be recorded in the minutes of Walsall CCG Governing Body.

If any function of Walsall CCG Governing Body is being exercised on its behalf by a Member, employee, committee or sub-committee, any reference in this Constitution to the exercise by Walsall CCG Governing Body of that function shall be interpreted as if it was a reference to the exercise by that Member, employee, committee or sub-committee.

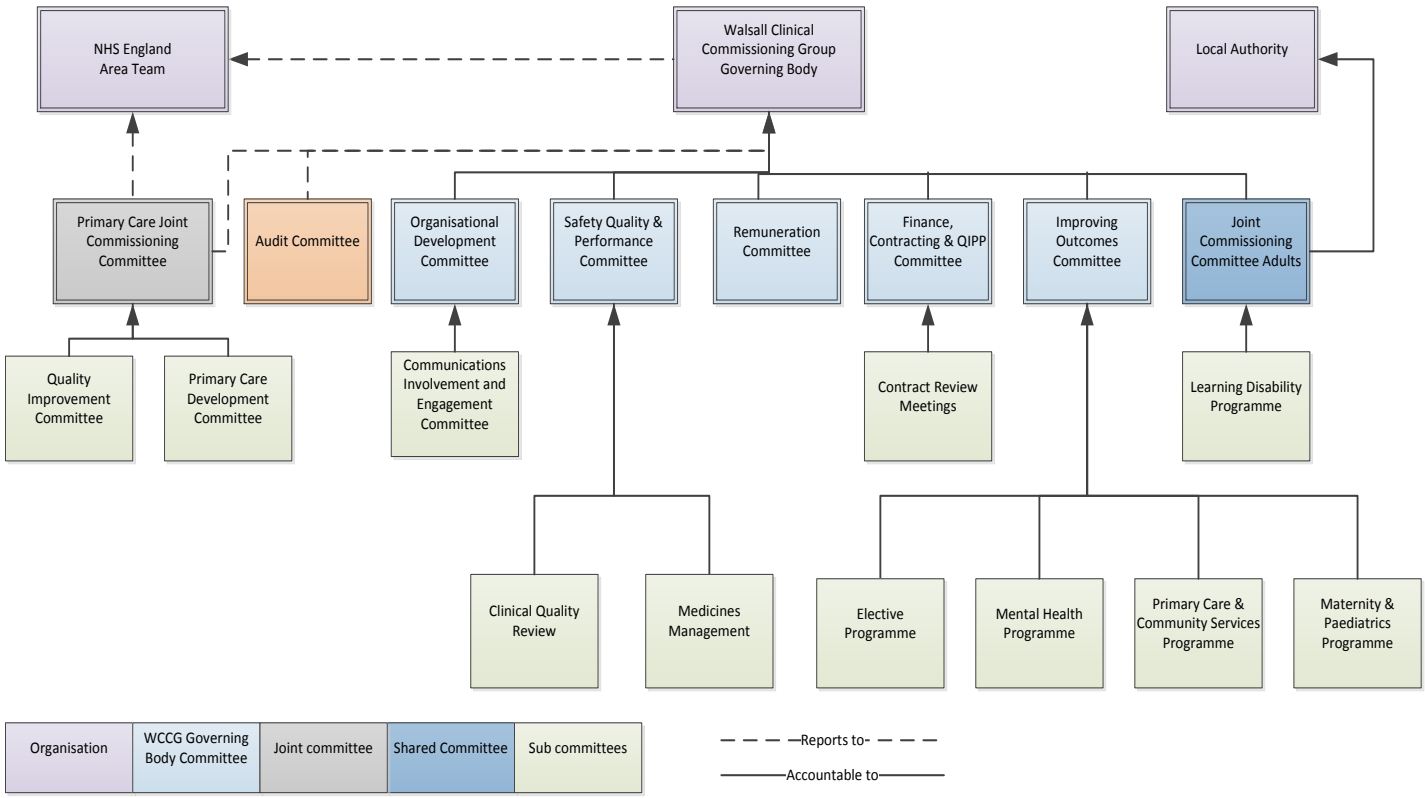
Any Member, employee, committee or sub-committee shall, when discharging any function of Walsall CCG Governing Body, abide by any restrictions or conditions imposed by Walsall CCG Governing Body which may then subsist. In relation to committees or sub-committees exercising functions on behalf of Walsall CCG Governing Body , any such restrictions or conditions may provide for or permit the co-option onto the committee or sub-committee of persons other than Locality Leads and for such persons to have voting rights as members of that committee or sub-committee.

Decision making process for the Governing Body
The Governing Body has detailed in the Scheme of Reservation and Delegation, the committees and their delegated responsibilities and accountabilities. Each terms of reference for these committees details the frequency and communication of activity with

the Governing Body. Each Governing Body Committee has a Governing Body member within the committee membership who is the direct link to the Governing Body. Each locality group has a Locality Lead representing their group at the Governing Body. Decisions are taken by Governing Body consensus and if this is not possible a vote is taken.

Figure 1 provides an overview of the CCG's Governance structure (effective from April 2015) and the relationship between the Governing Body and its committees.

Figure 1 CCG Governance Framework



Governing Body and its Committee Membership, Functions and Attendance

The details of attendance of Governing Body members, the membership of the committees to the governing body, each of the committee's main functions and the overall attendance by members between April 2105 and March 2016 are outlined in table 1.

Full Terms of Reference are detailed in annex A of the Constitution

Table 1

Committee	Membership	Key Functions	Average Attendance
Governing Body	Clinical Chair Accountable Officer Chief Finance Officer GP Locality Chair x4 GP Deputy Locality Lead x4 Lay member x3 Director of Governance Quality and Safety Director of Commissioning Transformation and Performance Director of Primary Care (from Feb 16) Director of Public Health Local Authority representative	The Governing Body has been established to drive forward clinical commissioning and to facilitate the delivery of its statutory duties arising from the Health and Social Care Act 2012 and set out in the document 'Functions of Clinical Commissioning Groups' 2012. The Governing Body will set out its arrangements for the effective, efficient and economic discharging of its responsibilities. These arrangements have been agreed with Walsall Clinical Commissioning Group and are compatible with the arrangements set out in its Constitution	81%
Appointments & Remuneration	3x Lay members of the Governing Body	The Committee will consider all aspects of salary (including any performance-related elements/bonuses and any allowances), provisions for other benefits including pensions and cars, as well as arrangements for termination of employment and other contractual terms.	84%
Audit	3x Lay members of the Governing Body	The committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.	69%
Improving Outcomes Committee	Chair – Lay member and Vice Chair Vice Chair - Lay member Governing Body Clinical Lead x3 Director of Governance Quality and Safety Director of Commissioning	The Committee will be responsible for setting the strategy ensuring that the CCGs Strategic Plan is based on the Joint Strategic Needs Assessment and reflects NHS Planning policy and	68%

	Transformation and Performance Consultant in Public Health Medicine CCG Secondary Care Consultant Deputy Chief Finance Officer Head of Contracting and Procurement / Planning Clinical Lead for Paediatrics and Maternity Services Clinical Lead for Learning Disability Services	priorities Guidance issued by NHS England. Review progress and oversee implementation of the work programme. Clinical oversight of governance and assurance to ensure that planning and commissioning activities are informed by Clinical Effectiveness, Clinical Risk issues and considerations.	
Organisational Development	Chair – Governing Body Clinical Chair Governing Body Clinical Lead Accountable Officer Director Commissioning Transformation & Performance Senior Communications and Engagement manager Head of HR & OD	To oversee the development and delivery of the OD plan Consider organisational development implications and advise in the development of plans required to deliver the change in culture, leadership and processes required by the Walsall CCG Provide a forum to debate all issues relating to organisational development and supporting workforce Seek assurance that organisational development arrangements are appropriately designed and operating effectively to ensure the commissioning of high quality ,safe healthcare and services Review OD evaluation and agree measures to address any gaps and ensure delivery and implementation To have an overview of the workforce requirements as the CCG develops To ensure that the influence of external partners is understood and considered in the delivery of the plan	72%
Safety, Quality	Chair - Clinical Lead for	Develop the strategic vision	91%

& Performance	Quality, Safety & Performance Lay member Director of Governance Quality and Safety Head of Performance Director of Commissioning Transformation and Performance GP Primary Care representative GP primary care representative Public Health representative (HCAI Lead	for patient safety and clinical quality, to ensure that there is a robust and timely performance framework in place Agree and ensure that patient safety clinical quality indicators are included and monitored in all provider contracts; Review all information and data in regard to Serious Incidents (SIs), complaints trends, Serious Case Reviews, and clinical benchmarking from all commissioned services, to ensure that corrective and preventative action is taken and lessons learnt are widely disseminated; Commission assessment of services where clinical practice falls below the best practice; Ensure that areas for potential risk are included in the CCGs risk register and Board Assurance framework and ensure action is taken to mitigate or eliminate such risk;	
Finance Contracting & QIPP	Chair Governing Body Clinical Lead Vice Chair Lay member Chief Finance Officer Head of Corporate Governance GP representative x3	Scrutiny and control of in year financial performance. Monitoring and performance of contract management and monitoring and reviewing the delivery of the system plan and QIPP targets	78%
Joint Commissioning Committee	Executive Director ASC&I Group Accountant ASC&I Portfolio Holder Chair Accountable Officer Director of Finance Director Commissioning Transformation and Performance Head of Joint Commissioning	Setting the work programmes of Joint Commissioners ensuring the alignment of national, regional and local health and social care policies and strategies for vulnerable adults Ensuring the delivery of the shared vision and priorities of the Health and Wellbeing	86%

	Director of Public Health	Board through promotion of joint commissioning arrangements Identifying priorities and agreeing structure and resources for the portfolio of programmes within Joint Commissioning.	

Governing Body Effectiveness

The Governing Body have development sessions scheduled throughout the year. The following table indicates the topics that were covered during these sessions.

List of the development session topics: Governing Body Development Sessions 2015-16

- Referral to treatment recovery plan
- Developing strategic transformation plan
- OOH & UC tender evaluation
- Better care fund
- Health and wellbeing board
- Area partnerships
- GP federations
- Primary care commissioning
- Perinatal services
- Governing Body constitutional changes
- Planning requirements
- Voluntary sector
- Governing body elections
- Governing locality roles
- Planning guidance
- Financial allocations
- Clinical leadership
- Review of planning forums
- Action plan for recovery

Membership and Attendance at the Governing Body and its Committees

The table below and the subsequent tables provide information about the Membership Body and Governing Body's committee and sub-committee structure, established by the clinical commissioning group constitution.
Governing Body Meetings = 6 meetings (TOR = minimum of 6)

Governing Body Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Dr Shadia Abdalla	83%	5/6	17%	0	0
Salma Ali	100%	6/6	0	0	0
Mr Mike Abel	83%	5/6	17%	0	0
Dr Nasir Asghar	50%	3/6	50%	0	0
Dr Francois Bolliger	33%	2/6	0	0	67%
Mrs Trudy Cotton	67%	4/6	0%	0	0

Mr John Duder	100%	6/6	0	0	0
Mr Tony Gallagher	100%	6/6	0	0	0
Dr Amrik Gill	83%	5/6	0	17%	0
Dr Barbara Watt	67%	4/6	33%	0	0
Dr Rajcholan Mohan	83%	5/6	17%	0	0
Mr Phil Griffin	83%	5/6	17%	0	0
Dr Sandeep Kaul	83%	5/6	0	0	17%
Mrs Sally Roberts	100%	6/6	0	0	0
Dr Anand Rischie	83%	5/6	17%	0	0
Mr Keith Skerman	67%	4/6	17%	17%	17%
Dr Avtar Suri	83%	5/6	17%	0	0
Mr Robert Freeman	67%	4/6	33%	0	0
Donna Macarthur	100%	1/1	0	0	0
Sarah Laing	100%	1/1	0	0	0

During 2015/16 there were six Governing Body meetings held in public. These calculations do not include the Governing Body meeting in sessions held as development meetings.

I. Mrs Trudy Cotton left WCCG December 2015, and attended all four meetings prior to leaving.
II. Due to previously agreed commitments Dr Francois Bolliger was only able to attend two Governing Body Meetings
III. Donna Macarthur and Sarah Laing came into post in February 2016

Average attendance = 81%

Committees to the Governing Body

The following tables provide individual attendance by core members at committees to the Governing Body.

Audit Committee = 6 meetings held (TOR minimum of 4)

Audit Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Mr John Duder	83%	5/6	17%	0	0
Mr Mike Abel	100%	6/6	0	0	0
Mrs Trudy Cotton	25%	1/4	0	0	75%

NB The core membership requires only two of the three members to be in attendance.

Mrs Trudy Cotton resigned in December 2015

Average attendance = 69%

Organisational Development Committee = 6 meetings (TOR bi-monthly)

Audit Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Dr Amrik Gill	100%	6/6	0	0	0
Phil Griffin	40%	2/5	60%	0	0
Dr Avtar Suri	50%	3/6	50%	0	0
Hardeep Cheema	100%	3/3	0	0	0
Preet Sond	67%	4/6	33%	0	0
Donna Macarthur	100%	1/6	0	0	0
Steve Corton (E&D & Comms)	50%	1/2	50%	0	0

I. Phil Griffin's membership ended January 2016, Phil attended two out of the five meetings
II. Hardeep Cheema's membership started November 2016, Hardeep attended all three meetings
III. Donna Macarthur's membership started March 2016
IV. Steve Cortons membership ended July 2015, Steve attended one of the two meetings.

Average attendance = 72%

Safety Quality Performance Committee = 12 meetings (TOR monthly)

SQP Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Dr R Mohan	83%	9/12	17%	8%	0
Trudy Cotton	89%	8/9	11%	0	0
Dr Julie Harrison	83%	10/12	17%	0	0
Kam Mavi	91%	10/11	9%	8%	0
Phil Griffin	42%	5/12	50%	8%	8%
Sally Roberts	100%	12/12	0	0	0
Dr Uma Viswanathan	100%	12/12	0	0	0
Phil Griffin	100%	12/12	0	17%	0
Yvonne Higgins	100%	6/6	0	0	0
John Wicks	100%	6/6	0	0	0
John Duder	100%	3/3	0	0	0
Donna Macarthur	100%	2/2	0	0	0

I. Mrs Trudy Cotton resigned in December 2015, Trudy attended eight out of nine meeting
II. Yvonne Higgins membership started October 2015, Yvonne attended all six meetings
III. John Wicks membership started October 2015, John attended all six meetings
IV. John Duder's membership started January 2016, John attended all three meetings
V. Donna Macarthur's membership started February 2016, Donna attended both meetings
VI. Kam Mavi's membership ended February 2016, Kam attended ten out of elven meetings.

Average attendance = 91%

Finance Contracting and QIPP Committee = 9 meetings (TOR minimum of 10)

FCQ	Attendance	Number of meetings	Apologies	Part Attendance	DNA
Dr Nasir Asghar	100%	9/9	0	0	0
Mike Abel	100%	9/9	0	0	0
Tony Gallagher	100%	9/9	0	0	0
Sara Saville	89%	8/9	11%	0	0
Dr Shadia Abdalla	0	0	0	0	100%
Phil Griffin	78%	7/9	22%	0	0

NB The core membership requires four comprised of the Chair and three members.

Average attendance = 78%

Joint Commissioning Committee Meeting = 7 meetings (TOR bi-monthly)

JCC Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Salma Ali	71%	5/7	29%	0	0
Tony Gallagher	100%	7/7	0	0	0
Dr Shadia Abdalla	86%	6/7	14%	0	0
Andy Rust	100%	7/7	0	0	0
Keith Skerman	86%	6/7	14%	0	0
Sally Roberts	100%	7/7	0	0	0
Keith Nye	86%	6/7	14%	0	0
Dr Amrik Gill	71%	5/7	29%	0	0
Alan Turrell	71%	5/7	29%	0	0
Lloyd Haynes	71%	5/7	14%	0	14%
Anne Carswell	75%	3/4	25%	0	0
John Wicks	100%	4/4	0	0	0
Donna Macarthur	100%	1/1	0	0	0

I. Anne Carswell's membership started October 2015; Anne attended three out of the four meetings
II. John Wicks's membership started October 2015, John attended all four meetings
III. Donna Macarthur's membership started February 2016.

Average attendance: 86%

Remuneration Committee Meeting Attendance = 7 meetings (TOR minimum of 4)

Audit Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Mr John Duder	100%	7/7	0	0	0
Mr Mike Abel	86%	6/7	14%	0	0
Trudy Cotton	67%	4/6	33%	0	0

I. Mrs Trudy Cotton resigned in December 2015

Average attendance = 84%

Improving Outcomes Committee Meeting = 9 meetings (TOR bi-monthly)

IOC Member	Attendance	Number of Meetings	Apologies	Part Attendance	DNA
Mr Mike Abel	89%	8/9	11%	0	0
Dr Shadia Abdalla	34%	3/9	44	0	22%
Dr Francois Bolliger	11%	1/9	56%	0	33%
Sally Roberts	22%	2/9	78%	0	0
Alan Turrell	33%	3/9	56%	11%	0
Dr Paulette Myers	56%	5/9	44%	0	0
Phil Griffin	100%	9/9	0	0	0
Dr Avtar Suri	56%	5/9	44%	0	0
Dr Sandeep Kaul	89%	8/9	11%	0	0
John Wicks	100%	7/7	0	0	0
Dr Anand Rischie	89%	8/9	11%	0	0
Mr Robert Freeman	78%	7/9	22%	0	0
Michelle Gordon	100%	9/9	0	0	0
Sarah Laing	100%	2/2	0	0	0

I. John Wicks's membership started September 2015, John attended all seven meetings
II. Sarah Laing's membership started February 2016, Sarah attended both meetings.

Average attendance = 68%

Membership and Attendance at the Governing Body and its committees

Table 2 and the subsequent tables provide information about the Membership Body and Governing Body's committee and sub-committee structure, established by the clinical commissioning group constitution (including the names or position within the clinical commissioning group of all members, and where alternates are permitted), attendance records (on a name by name basis identifying where alternates have attended rather than the main member) and work coverage.

Highlights of the Governing Body Committees

Committee	
Safety Quality Performance	Reviewed reporting process to strengthen assurance and accountability to the Governing Body Increased the service lines reporting into the committee Continued with the spotlight item including maternity, dementia and end of life.
Organisational Development	Completion of the management of change process ensuring the CCG has the right capacity and skills to deliver the future challenges and strengthening the clinical leadership and engagement
Improving Outcomes	Approval of personal budget and recommendation to IOC Approval of dementia support workers last year Assessing QIPP achievements of last year from all

	programme boards. QIPP planning for upcoming year
Finance Contracting QIPP	The successful retendering of the urgent care service
Remuneration	Implementation of the VSM bonus scheme and competency framework All five executive directors are on VSM contracts. The salaries for the posts on these contracts are agreed in line with the national groups for determining VSM pay. VSM contracts include an annual performance related pay mechanism. In September 2015 a non-consolidated pay award was agreed for the AO and CFO which related to the year 2014/15.
Audit	The overall significant assurance from the internal audit which included the full assurance for safeguarding Implementation and maintenance of the audit committee risk register
Primary Care Joint Commissioning	Establishment of the committee with meetings held in public.

The Clinical Commissioning Group Risk Management Framework
Key Elements of Risk Management Strategy

Walsall CCG recognises that systematically identifying risks and successfully managing these risks within its governance framework will provide invaluable opportunities to improve commissioning and thereby improve the quality and safety of patient care for the residents of Walsall.

Robust risk management processes must be in place for the Governing Body to be assured that the organisation is delivering on the corporate objectives in a safe and effective manner. The audit committee regularly reviews the risk registers and compliance with the risk management plan. The outcomes of the audit committee are reported to the governing body for assurance and escalation of any gaps in control or unmitigated risks.

The Risk Management Strategy and Plan applies to all employees of Walsall CCG and staff employed on their behalf and to all areas where employees and third party contractors deliver services.

Managing risk is part of every decision made and as such is a responsibility of managers at all levels and ultimately all staff. The Risk Strategy ensures that risk is managed more effectively throughout the organisation; however it does not mean that its implementation will result in the avoidance of all risks (some risks are only evident after the event), only that risk is managed to the best of our ability.

Walsall CCG recognises the need, and its responsibility, to reduce all identifiable negative risk to the lowest practicable level and to embrace and develop any opportunities that are identified.

The key elements for the way in which public stakeholders are involved in managing risks which impact on them, is set out in the engagement and consultation plan to support our five year commissioning strategy. This gives the public a voice where there are changes to services which impact on them. The most extensive example of this for 2014/15 was the urgent care consultation process.

Communication and Learning

Good communication and learning is essential to the risk management process and needs to take place at every stage with the appropriate internal and or external stakeholders.

Communication is an interactive process where the exchange of information and opinions is possible. Transparency in risk communication is vital if the richness of engagement is to be fully achieved. It is important to ensure everyone understands the risk strategy and their role in it. There is a need to ensure that each level of management and the Governing Body actively seeks and receives appropriate and regular assurance about the management of risk within their span of control.

Identification

Walsall CCG adopts a committee led approach to the identification of risk which incorporates the programme management office (PMO) via the Programme Boards and Task and Finish Groups.

The operational lead and chair of the committee/group ensure that any reports presented to the committee or discussions held in committee that identify a risk are recorded on the appropriate committee risk register. This is a continual process and the risk registers will be reviewed by the committee each time that they meet where additional risks are added, previous risks are updated or closed.

Each manager will keep a departmental or functional risk register to record any risks that are not reported to committee.

Evaluation

It is important to have an objective method for assessing risks so that the minor acceptable risks can be separated from the risks that need to be managed.

The scores for likelihood and consequence are put into the risk matrix and that indicates the risk rating. (Table 3)

The risks ratings are used on the risk register and are an indication of how a risk is reduced when controls are put into place.

Control

Table 3

Date of review	Risk Description 3 Cs	Inherent risk LXC	Actions	Residual Risk LXC	Risk Appetite	Risk Owner/ Escalated to
	Describe the **consequence** if the risk were to materialise. Describe the **causal** factors that could make the risk materialise Include the **context** of the risk e.g. define the risk target and the nature of the risk	The risk rating arising from a specific risk before any action has been taken to manage it	Identify the additional control measures to reduce the risk	The anticipated remaining risk once the control measures have been put in place and are effective	The degree of risk that the organisation is willing to take if the risk is realised	If the residual risk is greater than the risk appetite then the risk must be escalated to the next level

Appetite

Any residual risks that are outside of the risk appetite must be escalated to the relevant Strategic Lead for additional management.

Table 4

	Low	Moderate	High	Extreme
Risk Appetite	1-3	4-6	8 -12	15 – 25
	Not willing to accept any risk under any circumstances	Willing to accept some risk under some circumstances	Willing to accept risks that may result in identified impact	Accepts risks that are likely to results in identified impact

Embedding Risk Management into Core Activity of the CCG

The committee based approach to risk management ensures that risk management is continual and the registers are live documents. The assurance reports from the Governing Body Committees include an update on the risk management activity of the committee which strengthens the reporting processes.

Where the CCG has established joint committees the risk management arrangements are detailed in the terms of reference.

The partnership governance arrangements are used to ensure that partner organisations are aware of joint risks and agreed actions are documented in the minutes.

Management of identified risks that affect stakeholders must be communicated with them to give assurance that the organisation will deliver in the way which they expect.

There is a need to ensure that transferable lessons are learned and communicated to those who can benefit from them.

The Clinical Commissioning Group Internal Control Framework

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

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

The CCG's Assurance Framework details the CCG's strategic objectives, the principal risks have been mapped to the strategic corporate objectives. The key controls to mitigate risks have been identified, evaluated and recorded against each risk identified. Any gaps in control/assurance are recorded on the Assurance Framework as an action.

The Assurance Framework report the principal risk with cause and effect, the strategic lead (risk owner), risk rating, key controls, assurances on controls, positive assurances, and gaps in control/assurance, residual risk, action plan and timescales.

The Assurance Framework report provides the sources of assurance to mitigate risks. The sources of assurance have been identified by the Strategic Lead (Risk Owner), Audit Committee, and Safety, Quality and Performance Committee.

The assurances are categorised into Assurance on Controls (Management, Independent) and Outcomes from Assurances. Where there are gaps in control/ assurances these are also recorded, and an entry made in the "Actions required". Assurances given in the Assurance Framework are supported by appropriate evidence reflecting governance arrangements and management.

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 places 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 have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff is aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of incidents and serious incidents. We have developed information risk assessment and management

procedures and a programme is established to fully embed an information risk culture throughout the organisation against identified risks. There have been no serious information governance incidents reported by the CCG.

We have received full assurance following a review on our procedures by Internal Audit and have achieved an overall score of 100% for the Information Governance Toolkit.

Risk Assessment in Relation to Governance, Risk Management & Internal Control

The risk identified in Table 5 provides a brief description of the Clinical Commissioning Group's major risks to its corporate objectives

Table 5

Corporate objective	Ref	Risk identified	Inherent Risk Rating	Residual Risk Rating	Direction of travel
Involve patients and public in decision making	CO 01a	Failure to engage and involve patients and the public appropriately and effectively in commissioning decisions may lead to challenge or commissioning services that do not meet local needs.	4 x 4 = 16	3 x 4 = 12	⇔
Ensure strong leadership and good governance	CO 02a	Failure to comply with constitutional duties may risk the organisations ability to operate effectively as a statutory body and may result in remedial action from NHS England	3 x 5 = 15	3 x 5 = 15	⇧
	CO 02b	Weak governance between and within partner organisations has the potential for duplication, omission, conflict and blurred ownership of risk and accountability that would impact on the effectiveness of all organisations to be effective.	4 x 4 = 16	3 x 4 = 12	⇔
	CO 02c	Weak leadership in the CCG has the potential to impact on motivation, decision making, delegation of actions and clarity of roles and responsibilities which may result in the failure of the CCG to achieve its objectives	3 x 5 = 15	4 x 4 =16	⇧
Promote good health and sound treatment of ill health	CO 03a	Failure to deliver the system objectives as outlined in the strategic plan will result in the risk that the CCG do not achieve its vision to improve the Health and Wellbeing of the people of Walsall.	4 x 5 = 20	3 x 4 = 12	⇧
Commission high quality care	CO 04a	Failure to develop, implement and monitor an effective quality improvement and assurance framework across all commissioned services.	3 x 5 = 15	3 x 4 = 12	⇔

Ensure value for money	CO 05a	Failure to achieve financial balance and meet its statutory requirement to break even will impact on the organisations viability	3 x 5 = 15	2 x 5 = 10	⇔
	CO 05b	Failure to ensure the delivery of the savings described in each programme may impact on service redesign	3 x 4 = 12	2 x 4 = 8	⇔
Work in Partnership	CO 06a	Failure to work with partners to enable an integrated approach to care provision and commissioning	4 x 4 = 16	2 x 3 = 6	⇔

The organisations major risks for 2015 -16 included:

- Performance
- 4 hour performance – sustaining 95% standard
- Impact on elective capacity
- Impact on quality & safety
- Elective activity – RTT recovery, impact on quality from delayed treatment and cancer 62 day target
- Systems Management
- Implementation of BCF priority work schemes
- System wide co-ordination of performance at WHCT (TDA and NHSE)
- Commissioning Primary Care
- Currently co-commissioning
- Options appraisal to consider next steps
- Not proceeding to full delegation
- Procurement
- Premises utilisation linked to void costs chargeable to CCG
- Delivering 5 Year Forward View
- Focus on prevention
- New models of care
- QIPP efficiency

The management of each of these risks has been through the relevant committees and operational groups where the risk registers detail the controls, ownership and residual risks. Any risks which are not managed are escalated through to the corporate risk register.

Each of the Governing Body committees is chaired by a governing body clinical lead and supported by the relevant Strategic Lead. This enables the Governing Body to manage the access to timely and accurate information, emerging risks and participate in challenge and scrutiny of its delegated functions.

The Governing Body receive regular assurance reports from each of its committees to update on their risk management for their delegated duties.

The CCG has completed a management of change process which reviewed its governance structures, reporting lines and accountabilities.

The Governing Body receives regular Finance, Performance and Safety & Quality reports which details the risks to achieving national and local measures and if there is an impact on safety, quality or finance.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

The Governing Body receive regular assurance reports from the Finance Contracts and QIPP committee on the use of resources, the internal audit plan was divided into two broad categories; work on the financial systems that underpin the financial processing and reporting and then broader risk focused work driven essentially by principal risk areas identified in the Assurance Framework.

During the year internal audit have undertaken reviews of the input and output controls within the CCG's core financial systems and given full assurance with regard to the management of risk in these areas. They have also provided significant assurance in relation to in-year financial management arrangements.

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

The CCG has agreed through the scheme of delegation the governance arrangements for its delegated functions to the governing body committees. The Chair of each governing body committee submits an assurance report to the governing body each time it meets. The Chair of each committee also maintains a register of risks that may adversely impact on its delegated functions. This is reviewed at each committee meeting and reported quarterly to the audit committee. The risk management plan has been reviewed by internal audit and significant assurance has been given.

Review of Effectiveness

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group

Capacity to Handle Risk

The risk management process is dependent on a robust governance and management structure to ensure that the appropriate information is communicated throughout the organisation and received at the right level enabling action to be taken when required.

The Governing Body is responsible for ensuring the organisation consistently follows the principles of good governance applicable to NHS organisations. This includes the development of systems and processes for internal control, financial control, organisational control, corporate governance and risk management.

The Governing Body has the overall responsibility for reviewing and testing the effectiveness of internal controls for Walsall CCG. The key document for this is the Assurance Framework

All staff must participate in the implementation of the risk strategy. Walsall CCG staff have a duty to:

1. Report incidents/accidents and near misses using the appropriate channels including the 'Whistle blowing policy'. This includes any information security breaches or loss of personally identifiable information.
2. Be aware that they have a duty under legislation to take reasonable care for their own safety and the safety of all others who may be affected by the organisation's business.
3. Comply with the Risk Management Strategy and Plan and all Walsall CCG policies, regulations and instructions.

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

The *Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and the Safety, Quality and Performance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The framework to support the system of internal control is detailed in figure 2. The framework outlines the roles that the audit committee, management, audit and policy has in implementing an effective system of internal control to ensure that risk to the delivery of the corporate objectives is managed and appropriate levels of assurance is obtained. The CCG has maintained the Assurance framework during 2015/16 which contains all of the required components, corporate objectives, key risks, key controls, assurance, gaps in controls and assurance and actions required. The Governing Body view the assurance framework as the key overarching document that considers all risks which may affect the achievement of corporate objectives being managed. The Governing Body members attended a development session where the corporate risk register and assurance framework were revised to include risk appetite and assurance levels and form the basis of the assurance framework. The audit committee has monitored the assurance framework and corporate risk register throughout the year and the Audit chair reports process reports to the Governing Body to highlight any key risk areas as necessary.

The key controls to mitigate risks have been identified, evaluated and recorded against each risk identified. Any gaps in control/assurance are recorded on the assurance framework as an action with a risk owner, rating and timescales.

Table 6: Formal Structure of the Assurance Framework

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 Control concluded that:

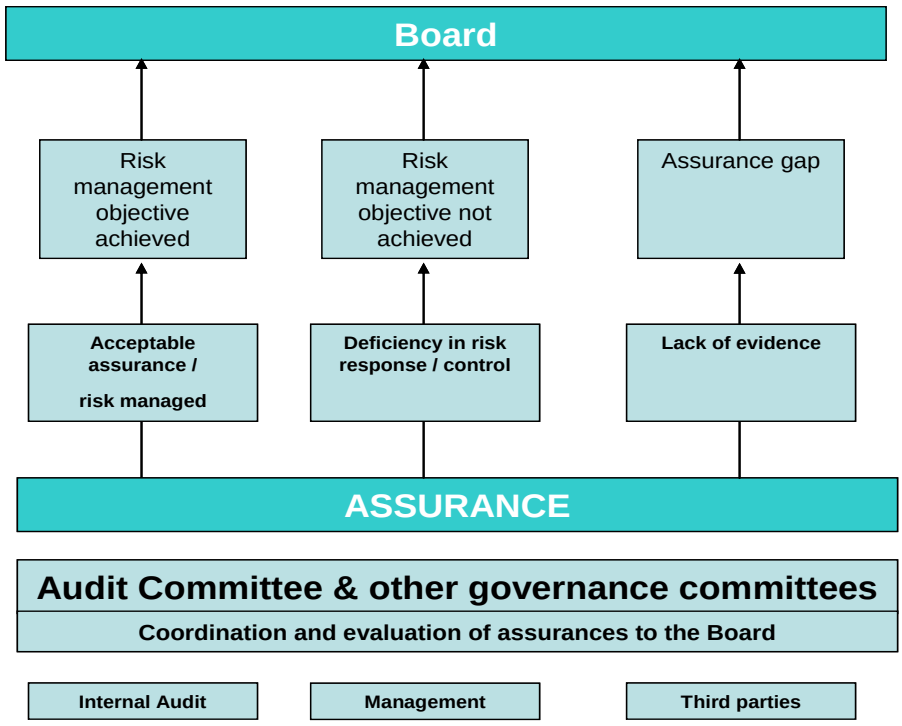
This annual report provides my opinion as the Head of Internal Audit to NHS Walsall Clinical Commissioning Group. It also summarises the activities of Internal Audit for the period 1st April 2015 to 31st March 2016.

The requirement for me to give an annual opinion is specified in the guidance issued by the Department of Health. This requires me to give one opinion based on my views of:

- your overall arrangements for gaining assurance i.e. the Assurance Framework;
- the work carried out by Internal Audit during the year on the effectiveness of the management of those principal risks identified within your Assurance Framework;
- any reliance that is being placed upon third party assurances.

This opinion forms part of the overall arrangements put in place by the Governing Body to produce their Annual Governance Statement (AGS).

The Governing Body should consider my opinion, together with management assurances, its own knowledge of the organisation and assurances received throughout the year from other review bodies when producing its Annual Governance Statement.



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

- 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;
- 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;
- 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 AGS 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.
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 AGS.

Head of Internal Audit 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 Boards 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 Annual Governance Statement.

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion;
3. Commentary

Overall opinion

Significant

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

Basis for the opinion

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 an internal audit risk-based plan that has 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 overleaf provides the context for my opinion and together with the opinion should be read in its entirety.

Commentary

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 issues are being controlled. 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 would inform on the effectiveness of 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 2015/16 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

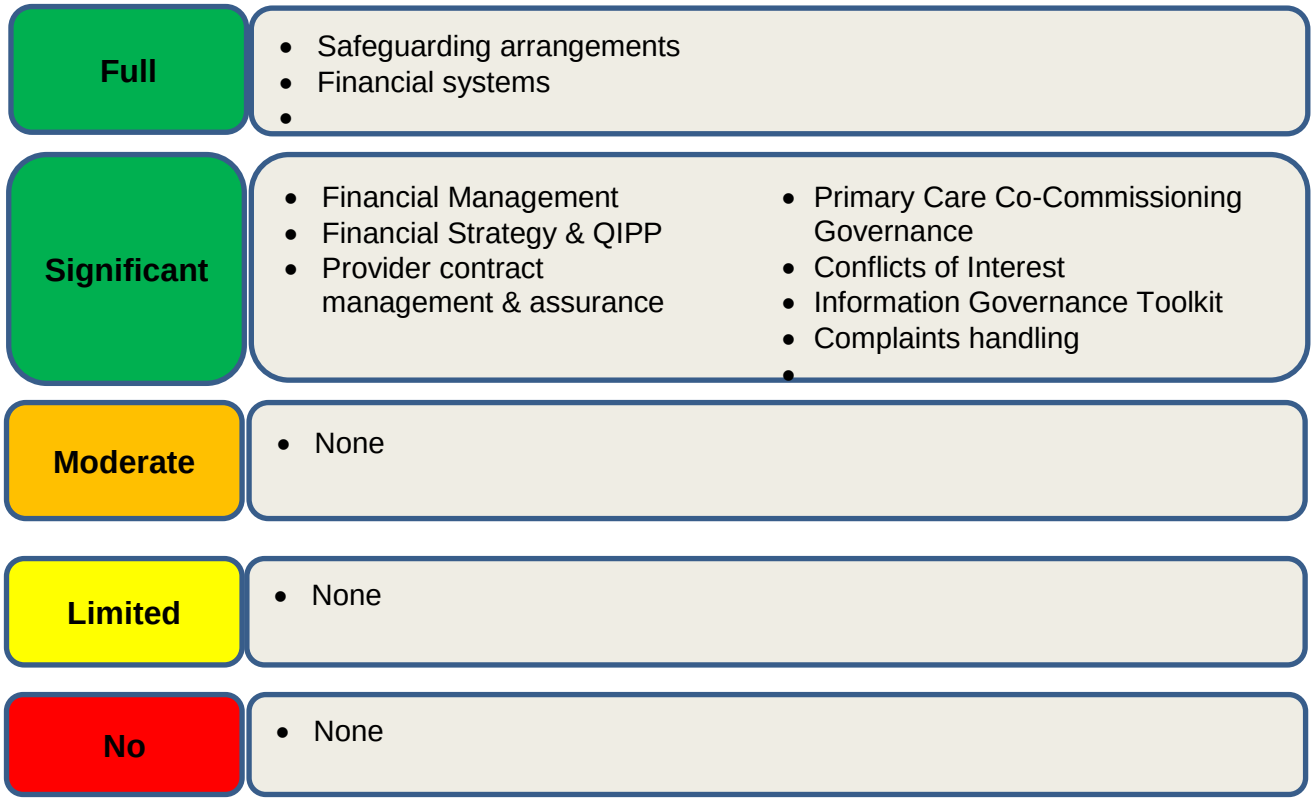
The system of internal control based on internal audit work undertaken

My opinion also takes into account the range of individual opinions arising from risk-based audit assignments that have been reported throughout the year. An internal audit plan for 2015/16 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.

A summary of work undertaken is included below and summarised in the following table:

- During the year we have undertaken reviews of your core financial systems (financial ledger and transaction systems as operated by the CCG).
- We have reviewed your financial management and QIPP processes including budget setting, investigation and reporting.
- We have undertaken a number of pieces of work on areas of principal risk identified from your Assurance Framework and reviews requested during the year.

The assurance levels provided for all reviews undertaken is summarised below:



We have made recommendations in some areas and agreed action plans with management and will continue to monitor the implementation of these plans over the coming months. All outstanding actions are reported at each meeting of the Audit Committee. They take a proactive approach to monitoring these and request follow up audits where there is cause for concern.

Following up of actions arising from our work

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, and when requested by the Audit Committee).

We are pleased to report that the CCG has responded positively to the recommendations we have made, and as such, has made significant progress implementing agreed actions. High level recommendations due for implementation by 31st March 2016 have been implemented.

Reliance on third party assurances

In arriving at my overall opinion I seek to place reliance on third party assurances, provided in the form of service auditor reports, from:

- NHS Shared Business Services (SBS)
- McKesson Payroll
- Midlands and Lancashire CSU

In recent years the CCG has taken some services in-house and has received less services from the CSU during 2015-16.

To date, I have received and taken into account the Type 2 Service Auditor Report from Midlands and Lancashire CSU relating to the period 1st April 2015 to 30th September 2015.

I understand that a Type 2 Service Auditor Report will be issued relating to the period 1st October 2015 to 28th February 2016. It is also my understanding, that the NHS SBS and McKesson service auditor reports are not yet available to the CCG. Consequently, I therefore reserve the right to revise this opinion in the event that either of these reports identifies any significant control failings that would impact on the CCG, and thereby affect my overall HoIA opinion.

Overall view

It is my view, taking account of the respective levels of assurance provided for each audit review, an assessment of the relevant weighting of each individual assignment and the extent to which agreed actions have been implemented, that you have a generally sound system of internal control.

During the year, internal audit issued the following audit reports which identified governance, risk management and or control issues which were significant to the organisation.

Internal audit gave full assurance for the safeguarding arrangements and financial systems. Significant assurance was allocated for provider contract assurance and management, complaints handling arrangements, conflicts of interest arrangement, primary care co-commissioning arrangements and financial management. There were no audits where moderate or limited assurance was given.

Data Quality

The Membership Body and the Governing Body are provided with data from a number of sources, this data is organised into three levels i.e. the first level is management data provided via monthly assurance reports from committees to the Governing Body, internal reviews, results analysed by committee. The second level is Governing Body Assurance i.e. National and Local KPIs and the third level is reports received from and assured by external sources i.e. Internal and External Audit, Independent review, NHS England.

Business Critical Models

There is an appropriate framework and environment in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report.
All business critical models have been identified and information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

Two key business critical models are the finance model and finance activity plans which have been submitted to the Department of Health as part of the overall planning submission. These have been subject to external scrutiny as part of our assurance framework.

Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment. The overall score of 100% for Confidentiality and data protection assurance and for Information security assurance

Discharge of Statutory Functions

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

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

Responsibility for each duty and power has been clearly allocated to a lead Director. (Table 6) Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

Table 6

Duty/Act	Lead	Committee	Strategy/Document
Develop JSNA	Clinical Chair	GB monitoring progress and assurance	JSNA , H&WBS
Develop JHWS	Clinical Chair	GB monitoring progress and assurance	JSNA , H&WBS
Promote NHS Constitution	Clinical Chair	GB monitoring progress and assurance	Walsall CCG Constitution, Communication and Engagement Strategy, CCG Strategy, Operational Plan
Exercise its functions effectively, efficiently and economically	CFO	Audit Committee oversight FQC monitoring progress and assurance	Financial plan, SFI, SO, SoRD
Improve the quality of services	Lead Nurse	SQP	Quality Improvement Strategy Quality Account
Quality of primary care medical services	Clinical Lead for primary care development	SQP – monitor the quality of PC. IOC oversight of PCD Strategy	Primary Care Development Strategy
Reducing inequalities	Accountable officer	SQP	ED strategy HWB Strategy JSNA Commissioning strategy
Promote involvement of each patient carers and representatives	Clinical Lead for Patient involvement	SQP	Engagement and Involvement Strategy Quality Improvement Strategy
Patient Choice	GB clinical lead	SQP	Communication and Engagement Strategy Quality Improvement Strategy
Obtain appropriate advice	Accountable Officer	GB	Within constitution
Promote innovation	Strategic Lead for Service Transformation and Redesign	IOC	OD plan
Promote research	Director of Governance Quality and Safety	SQP	Quality Improvement Strategy OD Plan
Promote education and training of the NHS workforce	Director of Governance Quality and Safety	OD	OD plan
Promote integration	Accountable Officer (SA)	GB	Within annual report
Make arrangements to secure public involvement	Director of Governance Quality and Safety	SQP CIE	Engagement Strategy ED strategy
Safeguarding	Director of Governance Quality and Safety Designated Nurse	SQP	Quality Improvement Strategy
Equality Act 2010	Clinical Chair (AG)	SQP	ED strategy
Human Rights Act 1997	Director of Governance Quality and Safety	SQP	ED Strategy
Employments Rights Act 1996	Director of Governance Quality and Safety	OD	HR Policy

Freedom of Information Act 2000	Director of Governance Quality and Safety	SQP	IG policy
Data Protection Act 1998	Director of Governance Quality and Safety	SQP	IG policy

Conclusion

There is an effective system of internal control to manage principal risks identified by the CCG. No significant internal control issues have been identified.

Signed .....

Salma Ali

Accountable Officer

May 2016

3.4 Remuneration Report

Salaries and Allowances 2015-16

The following information is subject to audit and will be referred to in the audit opinion.

Name and Title		Salary (bands of £5,000) £000	Expense Payments (taxable) to nearest £100 £00	Performance Pay and Bonuses (bands of £5,000) £000	Long-Term Performance Pay and Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Ms S Ali – Accountable Officer		120 – 125	1	0 - 5	0	2.5 – 5	125 – 130
Mr T Gallagher – Chief Finance Officer		95 - 100	0	0 - 5	0	5 – 7.5	105 – 110
Ms D Macarthur – Director of Primary Care and Integration (from Feb '16))		10 – 15	0	0	0	10 – 12.5	25 - 30
Ms S Laing – Director of Commissioning and Performance (from Feb '16)		10 – 15	0	*0*	*0*	*2.5 – 5*	15 - 20
Mr J Wicks – Interim Director of Commissioning (from Sep '15 to Mar '16)	**Note 2**	120 - 125	0	0	0	0	120 – 125
Mrs S Roberts – Director of Safety and Quality		85 - 90	0	0	0	155 – 157.5	245 – 250
Mr P Griffin – Programme Director – Planned Care and Market Development		80 - 85	0	0	0	10 – 12.5	90 - 95
Mr A Turrell – Programme Director for Contracting, Procurement and QIPP (to Mar '16)		85 - 90	0	0	0	25 – 27.5	110 - 115
Dr Barbara Watt – Director of Public Health, Walsall Council		**Note 1**					
Mr K Skerman – Interim Executive Director of Social Care and Inclusion, Walsall Council		**Note 1**					
Mr R Freeman – Secondary Care Specialist, Robert Jones & Agnes Hunt NHS Foundation Trust		10 - 15	0	0	0	0	10 - 15
Dr A Gill – Clinical Chair of Walsall CCG Governing Body	**Note 3**	70 - 75	0	0	0	0	70 – 75
Dr S Abdalla – Deputy Chair – West Locality	**Note 3**	50 - 55	0	0	0	0	50 – 55
Dr N Asghar – Deputy Chair – North Locality	**Note 3**	65 - 70	0	0	0	0	65 - 70
Dr F Bolliger – Clinical Chair – South East Locality	**Note 3**	25 - 30	0	0	0	0	25 – 30
Dr R Mohan – Clinical Chair – West Locality	**Note 3**	65 - 70	0	0	0	0	65 – 70
Dr A Rischie – Deputy Chair – Trans Locality	**Note 3**	90 - 95	0	0	0	0	90 – 95
Dr A Suri – Clinical Chair – North Locality	**Note 3**	65 - 70	0	0	0	0	65 – 70
Dr S Kaul – Deputy Chair – Trans Locality	**Note 3**	50 - 55	0	0	0	0	50 – 55
Mr M Abel – Lay Member – Transformation and Redesign		10 - 15	0	0	0	0	10 – 15
Mrs T Cotton – Lay Member – Patient and Public Involvement (to Dec '15)		5 - 10	0	0	0	0	5 – 10
Mr J Duder – Lay Member – Governance and Audit		10 - 15	0	0	0	0	10 - 15

Salaries and Allowances 2015-16

Name and Title		Salary (bands of £5,000) £000	Expense Payments (taxable) to nearest £100 £00	Performance Pay and Bonuses (bands of £5,000) £000	Long-Term Performance Pay and Bonuses (bands of £5,000) £000	Note 6 All Pension Related Benefits (bands of £2,500) £000	Restated Total (bands of £5,000) £000
Ms S Ali – Accountable Officer		120 - 125	5	0	0	0	120 – 125
Mr T Gallagher – Chief Finance Officer		95 - 100	0	0	0	0	95 - 100
Dr I Gillis – Director of Public Health, Walsall Council (to Aug '14)		**Note 1**					
Dr Barbara Watt – Interim Director of Public Health, Walsall Council (from Aug '14)		**Note 1**					
Dr Paulette Myers, Interim Director of Public Health, Walsall Council (from Aug '14)		**Note 1**					
Ms Y Sheward – Strategic Lead – Integrated Governance and Organisational Development (to Feb '15)		85 - 90	0	0	0	25 – 27.5	110 – 115
Mr K Skerman – Interim Executive Director of Social Care and Inclusion, Walsall Council (from Feb '14)		**Note 1**					
Mr P Griffin – Strategic Lead for Transformation and Redesign		80 - 85	0	0	0	0	80 – 85
Mrs S Roberts – Lead Nurse (Quality and Partnerships		65 – 70	0	0	0	25 – 27.5	95 – 100
Mr R Freeman – Secondary Care Specialist		10 – 15	0	0	0	20 - 22.5 *	30 – 35
Dr A Gill – Clinical Chair of Walsall CCG Governing Body	**Note 3**	70 – 75	0	0	0	0	70 – 75
Dr S Abdalla – Deputy Chair – West Locality	**Note 3**	50 – 55	0	0	0	0	50 - 55
Dr N Asghar – Deputy Chair – North Locality	**Note 3**	65 – 70	0	0	0	0	65 - 70
Dr A Benjamin – Deputy Chair – South East Locality (to Mar '15)	**Note 3**	25 – 30	0	0	0	0	25 - 30
Dr F Bolliger – Clinical Chair – South East Locality	**Note 3**	25 – 30	0	0	0	0	25 – 30
Dr R Mohan – Clinical Chair – West Locality	**Note 3**	65 – 70	0	0	0	0	65 - 70
Dr D Nair – Clinical Chair – Trans Locality (to Mar '15)	**Note 3**	65 – 70	0	0	0	0	65 - 70
Dr A Rischie – Deputy Chair – Trans Locality	**Note 3**	50 – 55	0	0	0	0	50 - 55
Dr A Suri – Clinical Chair – North Locality	**Note 3**	65 – 70	0	0	0	0	65 - 70
Mr M Abel – Lay Member – Transformation and Redesign		10 – 15	0	0	0	0	10 - 15
Mrs T Cotton – Lay Member – Patient and Public Involvement		10 – 15	0	0	0	0	10 - 15
Mr J Duder – Lay Member – Governance and Audit		10 – 15	0	0	0	0	10 - 15

Pension Benefits

As GPs and Lay Members do not receive pensionable remuneration, there will be no entries in respect of them in the table below.

Name and Title	Note 5 Real Increase in Pension at pension age (bands of £2,500) £000	Note 5 Real Increase in Pension Lump Sum at pension age (bands of £2,500) £000	Total Accrued Pension at pension age at 31 March 2016 (bands of £5,000) £000	Lump Sum at pension age related to Accrued Pension at 31 March 2016 (bands of £5,000) £000	Note 6 Cash Equivalent Transfer Value at 1 April 2015 £000	Notes 5&7 Real Increase in Cash Equivalent Transfer Value £000	Note 7 Cash Equivalent Transfer Value at 31 March 2016 £000	Employer's Contribution to Stakeholder Pension £000
Ms S Ali – Accountable Officer	0 – 2.5	2.5 – 5	45 – 50	135 – 140	870	29	909	N/A
Mr T Gallagher – Chief Finance Officer	0 – 2.5	2.5 – 5	30 – 35	95 – 100	616	23	646	N/A
Ms D Macarthur – Director of Primary Care and Integration	0 – 2.5	0 – 2.5	30 - 35	95 - 100	486	13	571	N/A
Ms S Laing – Director of Commissioning and Performance	0 – 2.5	0 – 2.5	15 – 20	55 – 60	310	4	348	N/A
Mrs S Roberts – Director of Safety and Quality	5 – 7.5	20 – 22.5	30 – 35	90 – 95	394	125	524	N/A
Mr P Griffin – Strategic Lead for Transformation and Redesign	0 – 2.5	2.5 – 5	35 – 40	110 – 115	816	30	855	N/A
Mr A Turrell – Programme Director for Contracting, Procurement and QIPP (to Mar '16)	0 – 2.5	5 – 7.5	35 – 40	115 – 120	841	**Note 4**	0	N/A
Mr R Freeman – Secondary Care Specialist	0	0	20 – 25	70 – 75	412	0	415	N/A

Notes:

Note 1 Salaries paid in full by Walsall Metropolitan Borough Council therefore no cost to the CCG

Note 2 Employed as an off-payroll worker and therefore the amount disclosed as salary includes more than just remuneration. This arrangement is shown in the 'Off Payroll Engagements' note on page 71 – 72.

Note 3 GP Board Members employed under a contract for service are classed as 'off payroll workers'. However HMRC have deemed these long term contract holders as 'office holders' of the CCG which requires the CCG to deduct income tax and national insurance at source. Since the CCG have assurance around the tax and NI obligations of these 'off payroll workers', there is no requirement to disclose these arrangements under the 'Off Payroll Engagements' note on page 71 - 72
The salary shown for GP Board Members may include additional sessions paid for Clinical Lead work they undertake for the CCG

Note 4 CETV calculations are not provided by the Pensions Agency for members who are either over 60 or in receipt of benefits

Note 5 A pensions multiplier of 1.2% has been applied in calculating the real increase in pension, lump sum and CETV

Note 6 Following guidance issued from the Department of Health, these figures have been restated to take into account employee's pension contributions paid into the NHS Pension Scheme during the year.

***** Figure not restated and therefore does not exclude employee's pension contributions.

Note 7 On 16th March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

CASH EQUIVALENT TRANSFER VALUES (CETV)

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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.

Pay Multiples

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

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

The banded remuneration of the highest paid Director/Member in NHS Walsall CCG in the financial year 2015-16 was £120k - £125k (2014-15, £120k - £125k). This was 2.6 times (2014-15 2.6 times) the median remuneration of the workforce, which was £47,559 (2014-15 £47,559).

In 2015-16, nil employees (2014-15, nil) received remuneration in excess of the highest paid Director/Member. Remuneration ranged from £6k to £121k (2014-15 £7k to £120k).

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

The median pay for the workforce (excluding the highest paid Director/Member) remains the same as it was in 2014/15. Although the CCG went through a Management of Change process during the year resulting in changes to the organisational structure, the changes were predominantly at Director rather than at middle management level. This has had no effect on the differential between the highest paid Director/Member and the rest of the workforce.

3.5 Staff Report

Average Number of People Employed

Staff Group	Permanently Employer Number *	Other Number	Total Number
Medical and Dental	0.20	1.40	**1.60**
Administration and Estates	57.70	3.31	**61.01**
Nursing, Midwifery and Health Visiting Staff	3.17	0	**3.17**
Scientific, Therapeutic and Technical Staff	3.03	0	**3.03**
Total	**64.10**	**4.71**	**68.81**

* *Excludes Non Executives, Lay Members and GP Governing Body Members*

Staff Composition by Gender

Staff Grouping	Female	Male	Unknown*	Totals
Governing Body	4	10	3	**17**
Other Senior Management (Band 8C+)	4	4	0	**8**
All other employees	50	13	0	**63**
	58	**27**	**3**	**88**

% by Gender Female	Male	Unknown*
23.5%	58.8%	17.6%
50.0%	50.0%	0.0%
79.4%	20.6%	0.0%
65.9%	**30.7%**	**3.4%**

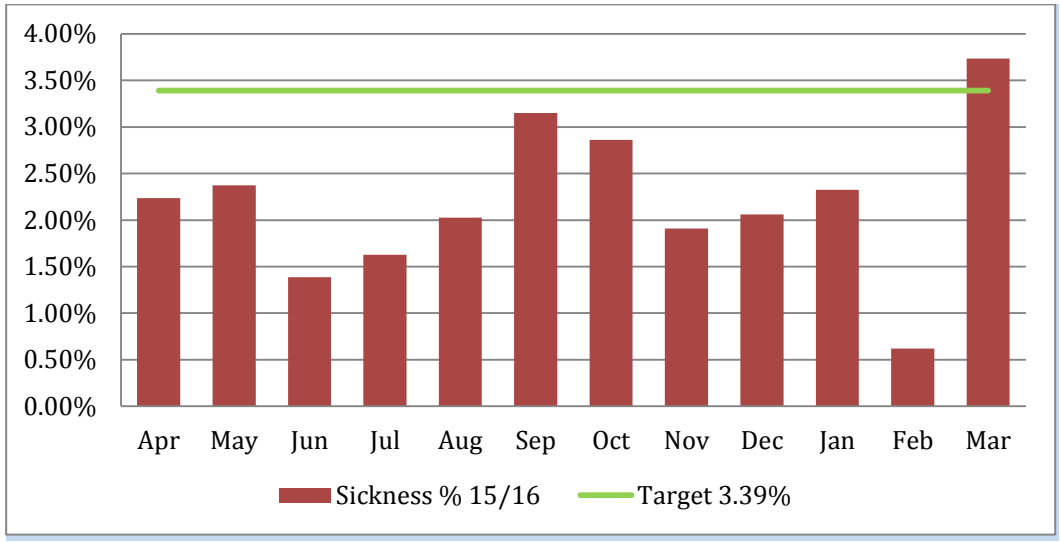
**Unknown Gender pertains to Governing Body Members without an entry in the CCG Electronic Staff Record (ESR) system*

Although Walsall employs less than 150 staff and is therefore exempt under the Equality Act 2010 from publishing employee information, it has made the decision to be as open as possible without any member of staff being identifiable. It has therefore published information on gender, ethnicity and disability, which can be found on the CCG's website in the Equality Summary

Walsall CCG has implemented an Equality and Diversity Policy in 2015 and also has a Recruitment and Selection policy to ensure compliance with the Equality Act and offers an interview to disabled candidates who meet the minimum person specification for a job. Walsall CCG also offers support to disabled staff to keep them in employment by making reasonable adjustments to workstations, patterns of working or other adaptions as necessary.

All employees of the CCG have an annual performance development review in line with the CCG policy in which training is agreed and career development is discussed.

Sickness absence data



Pension liabilities

Details of how pension liabilities are treated in the CCG accounts can be found under Note 5.5 of the annual accounts – see page 101

Pension disclosures for the CCGs senior managers are shown in the Pension Benefits table within the Remuneration Report – see page 52

Consultancy expenditure

The CCG have spent a total of £190,563 during the financial year on external consultancy fees.

The main areas of spend are detailed below:

Interim support to complete the CCGs' Management of Change process at a cost of

£37,380. The project had previously been overseen at Director level, but due to staff re organisation it became necessary to bring in external support to bring the project to a successful conclusion.

With the local Walsall health and social care system facing significant pressure to improve its Urgent Care and RTT performance, the CCG employed interim support to supplement its internal resource and help co-ordinate and lead this implementation of change. The total cost of this in the year was £38,743.

Spend of £29,580 for the provision of assessment and support around Continuing Healthcare and Personal Health Budgets and £21,077 relating to a recharge from Walsall Metropolitan Borough Council for the provision of services of a Health Emergency Planner.

Professional support for Primary Care Estates to include the production of the CCG Estates Strategy at a cost of £13,200.

Off Payroll Engagements

Treasury require public sector bodies to disclose arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and NI arrangements, not being classed as employees). The requirement was introduced in 2013-14 and remains in place for 2015-16.

Table 1: For all off payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

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

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

Table 2: For all new off payroll engagements between 1 April 2015 and 31 March 2016, 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 2015 and 31 March 2016	2
Number of new engagements which include contractual clauses giving NHS Walsall CCG the right to request assurance in relation to income tax and national insurance obligations	
Number for whom assurance has been requested	2
Of which	
assurance has been received	2
assurance has not been received	
engagements terminated as a result of assurance not being received	

Table 3: For any off payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016:

	Number
Number of off payroll engagements of board members and/or senior officers with significant financial responsibility, during the year *	1
Total number of individuals on payroll and off payroll that have been deemed "board members, and/or, senior officers with significant financial responsibility" during the financial year. This figure should include both on payroll and off payroll engagements	20

* The CCG contracted an interim Director of Commissioning during the financial year. This arrangement lasted six months in duration until the post was recruited to substantially in March 2016.

Exit Packages during this year

This information is subject to audit and will be referred to in the audit opinion.

The Remuneration Committee agreed two compulsory redundancies in the year at a total cost of £50,893.

These arose from changes to the establishment in the Commissioning function as part of the CCGs Management of Change process.

Signed .....

Salma Ali
Accountable Officer
May 2016

i. 4. Financial Statements

Foreword to the Accounts

NHS Walsall CCG

These accounts for the year ended 31 March 2016 have been prepared by NHS Walsall Clinical Commissioning Group in accordance with sections 17(4)(a) and (b) of Schedule 1A of the National Health Service Act 2006 (as amended) in the form which the NHS Commissioning Board, with the approval of the Secretary of State for Health has directed.

Financial Statements

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

	2014-15 £000	2014-15 £000	Note
Total Income and Expenditure			
Employee benefits	**4,373**	3,856	*5.1.1*
Operating expenses	**371.899**	359,876	*6*
Other operating revenue	**(1,264)**	(822)	*3*
Net operating expenditure before interest	**375,008**	362,850	
Investment revenue	**-**	-	*9*
Other (gains)/losses	**-**	-	*10*
Finance costs	**-**	-	*11*
Net operating expenditure for the financial year	**375,008**	362,850	
Net (gain)/loss on transfers by absorption	**-**	-	*12*
Total Net Expenditure for the year	**375,008**	362,850	
Of which:			
Administration Income and Expenditure			
Employee benefits	**3,471**	3,434	*5.1.1*
Operating expenses	**2,044**	3,204	*6*
Other operating revenue	**(8)**	(64)	*3*
Net administration costs before interest	**5,507**	6,574	
Programme Income and Expenditure			
Employee benefits	**902**	422	*5.1.1*
Operating expenses	**369,855**	356,672	*6*
Other operating revenue	**(1,256)**	(818)	*3*
Net programme expenditure before interest	**369,501**	356,276	

Other Comprehensive Net Expenditure	2014-15 £000	2014-15 £000	
Impairments and reversals	**-**	**-**	*23*
Net gain/(loss) on revaluation of property, plant & equipment	**-**	**-**	
Net gain/(loss) on revaluation of intangibles	**-**	**-**	
Net gain/(loss) on revaluation of financial assets	**-**	**-**	
Movements in other reserves	**-**	**-**	
Net gain/(loss) on available for sale financial assets	**-**	**-**	

	Net gain/(loss) on assets held for sale	-	-	
	Net actuarial gain/(loss) on pension schemes	-	-	
	Share of (profit)/loss of associates and joint ventures	-	-	
	Reclassification Adjustments	-		
	On disposal of available for sale financial assets	-	-	
	Total comprehensive net expenditure for the year	**375,008**	362,850	

The notes on page 84 to 122 form part of this statement

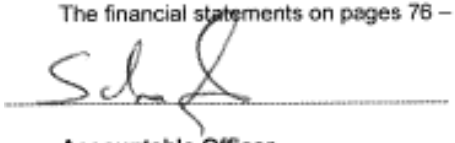
Statement of Financial Position as at 31 March 2016

	31 March 2015 £000	31 March 2015 £000	*Note*
Non-current assets:			
Property, plant and equipment	**-**	-	*14*
Intangible assets	**-**	-	*15*
Investment property	**-**	-	*16*
Trade and other receivables	**-**	-	*18*
Other financial assets	**-**	-	*19*
Total non-current assets	**-**	-	
Current assets:			
Inventories	**-**	-	*17*
Trade and other receivables	**5,168**	2,823	*18*
Other financial assets	**-**	-	*19*
Other current assets	**-**	-	*20*
Cash and cash equivalents	**48**	53	*21*
Total current assets	**5,216**	2,876	
Non-current assets held for sale	**-**	-	*22*
Total current assets	**5,216**	2,876	
Total assets	**5,216**	2,876	
Current liabilities			
Trade and other payables	**(23,237)**	(22,408)	*24*
Other financial liabilities	**-**	-	*25*
Other liabilities	**-**	-	*26*
Borrowings	**-**	-	*27*
Provisions	**-**	-	*31*
Total current liabilities	**(23,237)**	(22,408)	
Non-Current Assets plus/less Net Current Assets/Liabilities	**(18,021)**	(19,532)	
Non-current liabilities			
Trade and other payables	**-**	-	*24*
Other financial liabilities	**-**	-	*25*
Other liabilities	**-**	-	*26*
Borrowings	**-**	-	*27*
Provisions	**-**	-	*31*
Total non-current liabilities	**-**	-	

Assets less Liabilities	**(18,021)**	(19,532)
Financed by Taxpayers' Equity		
General fund	**(18,021)**	(19,532)
Revaluation reserve	-	-
Other reserves	-	-
Charitable Reserves	-	-
Total taxpayers' equity:	**(18,021)**	(19,532)

The notes on pages 84 to 122 form part of this statement.

The financial statements on pages 76 – 83 were approved by the Governing Body on 25th May 2016 and signed on its behalf by:



Accountable Officer
Salma Ali
May 2016

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Change in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(19,532)	-	-	**(19,532)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(19,532)**	**-**	**-**	**(19,532)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(375,008)	-	-	(375,008)
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets	-	-	-	**-**
Net gain/(loss) on revaluation of financial assets	-	-	-	**-**
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	**-**
Net gain (loss) on revaluation of assets held for sale	-	-	-	**-**
Impairments and reversals	-	-	-	**-**
Net actuarial gain (loss) on pensions	-	-	-	**-**
Movements in other reserves	-	-	-	**-**
Transfers between reserves	-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	**-**
Transfers by absorption to (from) other bodies	-	-	-	**-**
Reserves eliminated on dissolution	-	-	-	**-**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(394,540)**	-	-	**(394,540)**
Net funding	376,519	-	-	376,519
Balance at 31 March 2016	**(18,021)**	**-**	**-**	**(18,021)**

The notes on pages 84 to 122 form part of this statement.

Clinical Commissioning Groups *(CCGs) typically run with a high level of trade and other payables – this is mainly as a result of the delays in being charged for items such as prescribing costs (typically 8 weeks in arrears) and over performance on healthcare contracts.*

The CCG receives a maximum cash drawdown limit each year (adjusted for forecasts of end of year payables and receivables balances) which is used to cover their net outgoings. The deficit above of £18.02m reflects the difference between the CCGs cash funding in the year and their net expenditure and is covered by the net current liabilities as shown in the Statement of Financial Position

Statement of Changes in Taxpayers Equity for the year ended 31 March 2015 (Cont)

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Change in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(20,173)	-	-	**(20,173)**
Transfer between reserves in respect of assets transferred from closed N bodies	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(20,173)**	**-**	**-**	**(20,173)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(362,850)	-	-	(362,850)
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets	-	-	-	**-**
Net gain/(loss) on revaluation of financial assets	-	-	-	**-**
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	**-**
Net gain (loss) on revaluation of assets held for sale	-	-	-	**-**
Impairments and reversals	-	-	-	**-**
Net actuarial gain (loss) on pensions	-	-	-	**-**
Movements in other reserves	-	-	-	**-**
Transfers between reserves	-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	**-**
Transfers by absorption to (from) other bodies	-	-	-	**-**
Reserves eliminated on dissolution	-	-	-	**-**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(362,850)**	-	-	**(362,850)**
Net funding	363,491	-	-	363,491
Balance at 31 March 2015	**(19,532)**	**-**	**-**	**(19,532)**

Statement of Cash Flows for the year ended 31 March 2016

	2014-15 £000	2014-15 £000	Note
Cash Flows from Operating Activities			
Net operating expenditure for the financial year	(375,008)	(362,850)	
Depreciation and amortisation	-	-	6
Impairments and reversals	-	-	6
Movement due to transfer by Modified Absorption	-	-	
Other gains (losses) on foreign exchange	-	-	
Donated assets received credited to revenue but non-cash	-	-	
Government granted assets received credited to revenue but non-cash	-	-	
Interest paid	-	-	
Release of PFI deferred credit	-	-	
Other Gains & Losses	-	-	
Finance Costs	-	-	
Unwinding of Discounts	-	-	
(Increase)/decrease in inventories	-	-	
(Increase)/decrease in trade & other receivables	(2,345)	868	18
(Increase)/decrease in other current assets	-	-	
Increase/(decrease) in trade & other payables	829	(1,521)	24
Increase/(decrease) in other current liabilities	-	-	
Provisions utilised	-	-	31
Increase/(decrease) in provisions	-	-	31
Net Cash Inflow (Outflow) from Operating Activities	**(376,524)**	(363,503)	
Cash Flows from Investing Activities			
Interest received	-	-	
(Payments) for property, plant and equipment	-	-	
(Payments) for intangible assets	-	-	
(Payments) for investments with the Department of Health	-	-	
(Payments) for other financial assets	-	-	
(Payments) for financial assets (LIFT)	-	-	
Proceeds from disposal of assets held for sale: property, plant and equipment	-	-	
Proceeds from disposal of assets held for sale: intangible assets	-	-	
Proceeds from disposal of investments with the Department of Health	-	-	
Proceeds from disposal of other financial assets	-	-	
Proceeds from disposal of financial assets (LIFT)	-	-	

	Loans made in respect of LIFT	**-**	**-**	
	Loans repaid in respect of LIFT	**-**	**-**	
	Rental revenue	**-**	**-**	
	Net Cash Inflow (Outflow) from Investing Activities	**-**	**-**	
	Net Cash Inflow (Outflow) before Financing	**(376,524)**	(363,503)	
	Cash Flows from Financing Activities			
	Parliamentary funding received	376,519	363,491	
	Other loans received	**-**	-	
	Other loans repaid	**-**	-	
	Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	**-**	-	
	Capital grants and other capital receipts	**-**	-	
	Capital receipts surrendered	**-**	-	
	Net Cash Inflow (Outflow) from Financing Activities	**376,519**	363,491	
	Net Increase (Decrease) in Cash & Cash Equivalents	**(5)**	(12)	21
	Cash & Cash Equivalents at the Beginning of the Financial Year	**53**	65	
	Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	**-**	-	
	Cash & Cash Equivalents (inc bank overdrafts) at the End of the Financial Year	**48**	53	

Notes to the Financial Statements

1 Accounting Policies

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

1.1 Going Concern

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

1.4 Movement of Assets within the Department of Health Group (Cont'd)

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

1.5 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the Clinical Commissioning Group is in a "jointly controlled operation", the Clinical Commissioning Group recognises:

- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,
- The Clinical Commissioning Group's share of the income from the pooled budget activities.

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.

Walsall CCG has pooled budget arrangements in place with Walsall MBC for Learning Disabilities and the Integrated Community Equipment Store. The council are the host for this fund and the CCG accounts for its share of the income and expenditure of the fund.

The clinical commissioning group also entered into a new Section 75 pooled budget arrangement with Walsall MBC on 1st April 2015. This arrangement relates to the commissioning of health and social care services under the Better Care Fund (BCF). This fund was established by the Government with the requirement that the CCG and the council establish a pooled fund for this purpose.

The fund is hosted by Walsall MBC and the partners each commission services for each individual scheme on behalf of each other.

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.6.1 Critical Judgements in Applying Accounting Policies

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

The Clinical Commissioning Group is not aware of any judgements, other than estimation uncertainty, that require disclosure.

1.6.2 Key Sources *of Estimation Uncertainty*

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

Healthcare accruals – A significant degree of estimation is required for healthcare accruals in the latter part of the year where the activity data has not been received before closure of the accounting period.

Provision balances - It is recognised that a degree of estimation is inevitable when making provisions, particularly claims for retrospective entitlement to NHS continuing healthcare; NHS England is accounting for those continuing healthcare provisions held by Walsall Clinical Commissioning Group at 31st March 2016 on the CCG's behalf in accordance with the accounts direction.

1.7 Revenue

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

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

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

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

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

1.8.2 Retirement Benefit Costs

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

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

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

1.9 Other Expenses

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

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

1.10 Leases

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

1.10.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.11 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

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

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

A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

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 has 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 Contingencies

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

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

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

1.17 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.17.1 Financial Assets at Fair Value through Profit and Loss

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

1.17.2 Held to Maturity Assets

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

1.17.3 Available For Sale Financial Assets

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

1.17.4 Loans & Receivables

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

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

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

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

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

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

1.18 Financial Liabilities

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

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

1.18.1 Financial Guarantee Contract Liabilities

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

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

1.18.2 Financial Liabilities at Fair Value through Profit and Loss

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

1.18.3 Other Financial Liabilities

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

1.19 Value Added Tax

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

1.20 Foreign Currencies

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

1.21 Third Party Assets

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

1.22 Losses & Special Payments

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

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

1.23 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 2014-15, all of which are subject to consultation:

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

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

2 Financial Performance Targets

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

Duty	2015-16 Maximum	2015-16 Performance	Duty Achieved	2014-15 Maximum	2014-15 Performance	Duty Achieved
Expenditure not to exceed income	380,063	375,008	**YES**	368,356	362,850	YES
Capital resource use does not exceed the amount specified in Directions	-	-	**N/A**	-	-	N/A
Revenue resource use does not exceed the amount specified in Directions	373,664	369,501	**YES**	361,339	356,276	YES
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**N/A**	-	-	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**N/A**	-	-	N/A
Revenue administration resource use does not exceed the amount specified in Directions	6,399	5,507	**YES**	7,017	6,574	YES

3 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	**-**	-	-	-
Patient transport services	**-**	-	-	-
Prescription fees and charges	**-**	-	-	-
Dental fees and charges	**-**	-	-	-
Education, training and research	**73**	7	66	58
Charitable and other contributions to revenue expenditure: NHS	**-**	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	**231**	-	231	226
Receipt of donations for capital acquisitions: NHS Charity	**-**	-	-	-
Receipt of Government grants for capital acquisitions	**-**	-	-	-
Non-patient care services to other bodies	**937**	-	937	528
Income generation	**-**	-	-	-
Rental revenue from finance leases	**-**	-	-	-
Rental revenue from operating leases	**-**	-	-	-
Other revenue	**23**	1	22	70
Total other operating revenue	**1,264**	**8**	**1,256**	**882**

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

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

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

4 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2014-15 Total £000
From rendering of services	**1,264**	**8**	**1,256**	882
From sale of goods	**-**	**-**	**-**	-
Total	**1,264**	**8**	**1,256**	882

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no revenue from the sale of goods.

5 Employee Benefits and Staff Numbers

5.1.1 Employee Benefits

	2015-16 Total £000	Total Permanent Employees £000	Other £000	Total £000	Admin Permanent Employees £000	Other £000	Total £000	Programme Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	**3,617**	3,335	282	**2,839**	2,613	226	**778**	722	56
Social security costs	**290**	285	5	**237**	237	-	**53**	48	5
Employer Contributions to NHS Pension scheme	**415**	409	6	**344**	344	-	**71**	65	6
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**51**	**51**	-	**51**	51	-	**-**	-	-
Gross employee benefits expenditure	**4,373**	**4,080**	**293**	**3,471**	**3,245**	**226**	**902**	**835**	**67**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**

Total - Net admin employee benefits including capitalised costs	**4,373**	**4,080**	**293**	**3,471**	**3,245**	**226**	**902**	**835**	**67**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**4,373**	**4,080**	**293**	**3,471**	**3,245**	**226**	**902**	**835**	**67**

5.1.1 Employee Benefits (Cont)

	2014-15 Total £000	Total Permanent Employees £000	Other £000	Total £000	Admin Permanent Employees £000	Other £000	Total £000	Programme Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	**3,227**	3,144	83	**2,841**	2,801	40	**386**	343	43
Social security costs	**261**	261	-	**246**	246	-	**15**	15	-
Employer Contributions to NHS Pension scheme	**368**	368	-	**347**	347	-	**21**	21	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**-**	-	-	**-**	-	-	**-**	-	-
Gross employee benefits expenditure	**3,856**	**3,773**	**83**	**3,434**	**3,394**	**40**	**422**	**379**	**43**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**3,856**	**3,773**	**83**	**3434**	**3,394**	**40**	**422**	**379**	**43**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**3,856**	**3,773**	**83**	**3434**	**3,394**	**40**	**422**	**379**	**43**

5.1.2 Recoveries in respect of Employee Benefits

	2015-16 Total £000	Permanent Employees £000	Other £000	2014-15 Total £000
Employee Benefits – Revenue				
Salaries and wages	-	-	-	-
Social security costs	-	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-	-
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Total recoveries in respect of employee benefits	-	-	-	-

5.2 Average Number of People Employed

	2015-16 Total Number	2015-16 Permanently employed number	2015-16 Other Number	2014-15 Total Number
Medical and Dental	1.60	0.20	1.40	1.23
Administration and Estates	61.01	57.70	3.31	63.05
Nursing, Midwifery and Health Visiting Staff	3.17	3.17	-	3.00
Scientific, Therapeutic and Technical Staff	3.03	3.03	-	3.62
Total	**68.81**	**64.10**	**4.71**	70.90

Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

5.3 Staff Sickness Absence and Ill Health Retirements

	2015-16 Number	2014-15 Number	No.
Average FTE for the period	73	72	*1*
FTE days lost to sickness absence in the period	333	439	
Average annual sick days per FTE	**4.56**	6.10	*2*

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

ESR does not hold details of the normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365 day year

1. Average FTE in post for the period January-December 2015.
2. The average annual sick days per FTE has been estimated by dividing the estimated number of FTE days sick by the average FTE.

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

Ill health retirement costs are met by the NHS Pension Scheme.

5.4 Exit Packages agreed in the Financial Year

	2015-16		2015-16		2015-16	
	Compulsory Redundancies		Other Agreed Departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-		-
£10,001 to £25,000	1	23,119	-	-	1	23,119
£25,001 to £50,000	1	27,774	-	-	1	27,774
£50,0001 to £100,000	-	-	-	-		-
£100,001 to £150,000	-	-	-	-		-
£150,001 to £200,000	-	-	-	-		-
Over £200,001	-	-	-	-		-
Total	**2**	**50,893**	-	-	**2**	**50,893**

	2014-15		2014-15		2014-15	
	Compulsory Redundancies		Other Agreed Departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,0001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	-	-	-	-		-

These tables report the number and value of exit packages agreed in the financial year. The expenses associated with these departures have been recognised in full in the period ended 31st March 2016.

Redundancy costs have been paid in accordance with the provisions of the NHS Scheme (Pension Scheme and Compensation for Premature Retirement) Amendment Regulations 2006 and Section 16 of Agenda for Change.

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

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

5.5 Pension costs

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

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

Therefore the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

5.5.1 Full Actuarial (Funding) Valuation

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

For 2015-16, employers' contributions of £398,419 were payable to the NHS Pensions Scheme (2014-15: £358,600) 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 9th June 2014.

6 Operating Expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	3,736	2,834	902	3,269
Executive governing body members	637	637	-	587
Total gross employee benefits	**4,373**	**3,471**	**902**	**3,856**
Other costs				
Services from other CCGs and NHS England	**1,857**	820	1,037	2,260
Services from foundation trusts	**30,199**	72	30,127	28,429
Services from other NHS trusts	**219,012**	-	219,012	220,398
Services from other NHS bodies	**2**	-	2	1
Purchase of healthcare from non-NHS bodies	**60,234**	-	60,234	49,852
Chair and Non-Executive Members	**392**	392	-	628
Supplies and services – clinical	**75**	1	74	99
Supplies and services – general	**48**	11	37	263
Consultancy services	**191**	139	52	520
Establishment	**1,421**	310	1,111	1,704
Transport	**83**	-	83	144
Premises	**2,284**	168	2,116	2,192
Impairments and reversals of receivables	**-**	-	-	-
Inventories written down	**-**	-	-	**-**
Depreciation	**-**	-	-	**-**
Amortisation	**-**	-	-	**-**
Impairments and reversals of property, plant and equipment	**-**	-	-	**-**
Impairments and reversals of intangible assets	**-**	-	-	**-**
Impairments and reversals of financial assets	**-**	-	-	**-**
· Assets carried at amortised cost	**-**	-	-	**-**
· Assets carried at cost	**-**	-	-	**-**
· Available for sale financial assets	**-**	-	-	**-**
Impairments and reversals of non-current assets held for sale	**-**	-	-	**-**
Impairments and reversals of investment properties	**-**	-	-	**-**
Audit fees	**68**	68	-	91
Other non-statutory audit expenditure				

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
· Internal audit services	**-**	-	-	-
· Other services	**-**	-	-	-
General dental services and personal dental services	**-**	-	-	-
Prescribing costs	**50.210**	-	50,210	48,097
Pharmaceutical services	**-**	-	-	-
General ophthalmic services	**73**	-	73	39
GPMS/APMS and PCTMS	**4,908**	-	4,908	4,543
Other professional fees excl. audit	**26**	17	9	34
Grants to other public bodies	**-**	-	-	-
Clinical negligence	**-**	-	-	-
Research and development (excluding staff costs)	**-**	-	-	-
Education and training	**77**	46	31	69
Change in discount rate	**-**	-	-	-
Other expenditure	**-**	-	-	-
Provisions	**-**	-	-	-
CHC Risk Pool contributions	**739**	**-**	739	513
Other expenditure	**-**	-	-	-
Total other costs	**371,899**	**2,044**	**369,855**	**359,876**
Total operating expenses	**376,272**	**5,515**	**370,757**	**363,732**

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

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

The liability in respect of partially completed spells is included within the Statement of Financial position with the movement each year being shown within operating costs above. The movement in 2015-16 is £63k and this is included within Services from Foundation Trusts and other NHS Trusts.

The prepayment in respect of maternity services is included within the Statement of Financial position with the movement each year shown within operating costs above. The movement of £83k in 2015-16 is included within Services from other NHS Trusts.

Penalty charges in 2015-16 to Walsall Healthcare NHS Trust totalled £2.7m (2014-15 £1.0m) and has been netted off against expenditure with the Trust.

The CHC risk pool contribution of £739k reflects payments made to NHS England to settle legacy Continuing Healthcare provision claims pre 31st March 2013.

7 Better Payment Practice Code

	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Measure of compliance				
Total Non-NHS Trade invoices paid in the Year	12,998	79,882	12,040	59,651
Total Non-NHS Trade Invoices paid within target	12,892	78,953	11,950	58,653
Percentage of Non-NHS Trade invoices paid within target	**99.18%**	**98.84%**	99.25%	98.33%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,546	251,903	2,351	253,725
Total NHS Trade Invoices Paid within target	2,501	251,820	2,324	253,490
Percentage of NHS Trade Invoices paid within target	**98.23%**	**99.97%**	98.85%	99.91%

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

The Clinical Commissioning Group applied to become a signatory to the Prompt Payment Code during the financial year and this application was approved in July 2015.

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

The Clinical Commissioning Group made no payments in respect of late payments in 2015-16.

8 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities.

9 Investment Revenue

The Clinical Commissioning Group had no investment revenue during 2015-16.

10 Other Gains and Losses

The Clinical Commissioning Group did not have any gains or losses during 2015-16.

11 Finance Costs

The Clinical Commissioning Group did not incur any finance costs during 2015-16.

12 Net Gain/(Loss) on Transfer by Absorption

The Clinical Commissioning Group did not transfer any functions during 2015-16.

13 Operating Leases

13.1 As Lessee

13.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2015-16 Total £000	Land £000	Buildings £000	Other £000	2014-15 Total £000
Payments recognised as an Expense								
Minimum lease payments	**-**	**2,213**	**-**	**2.213**		2,096		2,096
Contingent rents	**-**	**-**	**-**	**-**				
Sub-lease payments	**-**	**-**	**-**	**-**				
Total	**-**	**2,213**	**-**	**2,213**		2,096		2,096

The Clinical Commissioning Group occupies property owned and managed by Community Health Partnerships Ltd and NHS Property Services Ltd. For 2014-15, the property costs have been invoiced on an actual cost basis plus 20% management overhead. This is reflected in Note 13.1.1.

While our arrangements with Community Health Partnerships Ltd and NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

13.1.2 Future Minimum Lease Payments

	Land £000	Buildings £000	Other £000	2015-16 Total £000	Land £000	Buildings £000	Other £000	2014-15 Total £000
Payable:								
No later than one year	-	-	-	-	-	-	-	-
Between one and five years	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-

13.2 As Lessor

The Clinical Commissioning Group is not a lessor and therefore does not receive any rental revenue..

14 Property, Plant and Equipment

The Clinical Commissioning Group does not hold any property, plant and equipment on its balance sheet.

15 Intangible Non-Current Assets

The Clinical Commissioning Group does not hold any intangible non-current assets on its balance sheet.

16 Investment Property

The Clinical Commissioning Group does not hold any investment property on its balance sheet.

17 Inventories

The Clinical Commissioning Group does not hold any inventories on its balance sheet.

18 Trade and Other Receivables

	Current 2015-16 £000	Non-current 2015-16 £000	Restated Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	**2,564**	**-**	710	**-**
NHS receivables: Capital	**-**	**-**	-	**-**
NHS prepayments	**1,643**	**-**	1,560	**-**
NHS accrued income			16	
Non-NHS receivables: Revenue	**546**	**-**	351	**-**
Non-NHS receivables: Capital	**-**	**-**	-	**-**
Non-NHS prepayments	**82**	**-**	87	**-**
NHS accrued income	**315**		80	
Provision for the impairment of receivables	**-**	**-**	-	**-**
VAT	**16**	**-**	19	**-**
Private finance initiative and other public private partnership arrangement prepayments and accrued income	**-**	**-**	-	**-**
Interest receivables	**-**	**-**	-	**-**
Finance lease receivables	**-**	**-**	-	**-**
Operating lease receivables	**-**	**-**	-	**-**
Other receivables	**2**	**-**	-	**-**
Total Trade and other receivables	**5,168**	**-**	**2,823**	**-**
Total current and non-current	**5,168**	**-**	**2,823**	**-**
Included above:				
Prepaid pensions contributions	**-**	**-**	**-**	**-**

The majority of trade is within the NHS England group. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

Other NHS receivables include prepayments made for tariff payments such as maternity services. As this reflects an advance payment for services that will be delivered, there is no risk to the Clinical Commissioning Group.

18.1 Receivables Past their Due Date but not Impaired

	2015-16 £000	2014-15 £000
By up to three months	**1,040**	144
By three to six months	**61**	**1**
By more than six months	**5**	**4**
Total	**1,106**	149

£264k of the amount above has subsequently been recovered post the Statement of Financial Position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2016.

18.2 Provision for Impairment of Receivables

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	**-**	**-**
Amounts written off during the year	**-**	**-**
Amounts recovered during the year	**-**	**-**
(Increase) decrease in receivables impaired	**-**	**-**
Transfer (to) from other public sector body	**-**	**-**
Balance at 31 March 2016	**-**	**-**

19 Other Financial Assets

The Clinical Commissioning Group had no other financial assets as at 31 March 2016.

20 Other Current Assets

The Clinical Commissioning Group had no other current assets as at 31 March 2016.

21 Cash and Cash Equivalents

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	53	65
Net change in year	(5)	(12)
Balance at 31 March 2016	**48**	**53**
Made up of:		
Cash with the Government Banking Service	48	53
Cash with Commercial banks	**-**	**-**
Cash in hand	**-**	-
Current investments	**-**	**-**
Cash and cash equivalents as in statement of financial position	**48**	**53**
Bank overdraft: Government Banking Service	**-**	**-**
Bank overdraft: Commercial banks	**-**	**-**
Total bank overdrafts	**-**	**-**
Balance at 31 March 2016	**48**	**53**
Patients' money held by the Clinical Commissioning Group, not included above	0	0

22 Non-Current Assets Held for Sale

The Clinical Commissioning Group had no non-current assets held for sale as at 31 March 2016.

23 Analysis of Impairments and Reversals

The Clinical Commissioning Group did not recognise any impairments or reversals of impairments in expenditure during 2015-16.

24 Trade and Other Payables

	Current 2015-16 £000	Non-current 2014-15 £000	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	-	-	-	-
NHS payables: revenue	4,649	-	2,774	-
NHS payables: capital	-	-	-	-
NHS accruals	3,330	-	2,152	-
NHS deferred income	20			
Non-NHS payables: revenue	4,916	-	4,366	-
Non-NHS payables: capital	-	-	-	-
Non-NHS accruals	9,726	-	12,466	-
Non NHS deferred income				
Social security costs	47	-	47	-
VAT	-	-	-	-
Tax	53	-	53	-
Payments received on account	-	-	-	-
Other payables	496	-	550	-
Total Trade and Other Payables	**23,237**	-	**22,408**	-
Total current and non-current	**23,237**		**22,408**	

Other payables include £66k outstanding pension contributions at 31 March 2016.

25 Other Financial Liabilities

The Clinical Commissioning Group had no other financial liabilities as at 31 March 2016.

26 Other Liabilities

The Clinical Commissioning Group had no other liabilities as at 31 March 2016.

27 Borrowings

The Clinical Commissioning Group had no borrowings as at 31 March 2016.

28 Private Finance Initiative, LIFT and other Service Concession Arrangements

28.1 Off-Statement of Financial Position Private Finance Initiative and Other Service Concession Arrangements

The Clinical Commissioning Group does not hold any private finance initiative, LIFT or other service concession arrangements that require disclosure as at 31 March 2016.

29 Finance Lease Obligations

The Clinical Commissioning Group does not hold any finance leases and therefore has no finance lease obligations as at 31 March 2016.

30 Finance Lease Receivables

The Clinical Commissioning Group does not hold any finance leases and therefore has no finance lease receivables due as at 31 March 2016.

31 Provisions

The Clinical Commissioning Group held no provisions as at 31 March 2016.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2016 is £341,000

32 Contingencies

The Clinical Commissioning Group had no contingencies requiring disclosure as at 31st March 2016.

33 Commitments

33.1 Capital Commitments

The Clinical Commissioning Group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2016.

33.2 Other financial commitments

The Clinical Commissioning Group had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2016.

34 Financial Instruments

34.1 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.

Since NHS Walsall 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's Standing Financial Instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group's internal auditors.

34.1.1 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 Clinical Commissioning Group therefore has low exposure to currency rate fluctuations.

34.1.2 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.

34.1.3 Credit Risk

Since the majority of the NHS Clinical Commissioning Group's revenue comes from parliamentary funding, the 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.

34.1.3 Liquidity Risk

NHS Clinical Commissioning Groups are 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 risk

34.2 Financial Assets

	At 'fair value through Profit and loss' 2015-16 £000	Loans and Receivables 2015-16 £000	Available for Sale 2015-16 £000	Total 2015-16 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	2,564	-	2,564
· Non-NHS	-	861	-	861
Cash at bank and in hand	-	48	-	48
Other financial assets	-	3	-	3
Total at 31 March 2016	**-**	**3,476**	**-**	**3,476**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	710	-	710
· Non-NHS	-	351	-	351
Cash at bank and in hand	-	53	-	53
Other financial assets	-	-	-	-
Total at 31 March 2015	-	1,114	-	1,114

34.3 Financial Liabilities

	At 'fair value through profit and loss' 2015-16 £000	Other 2015-16 £000	Total 2015-16 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	7,978	7,978
· Non-NHS	-	15,138	15,138
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2016	-	**23,116**	**23,116**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	2,774	2,774
· Non-NHS	-	4,366	4,366
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	550	550
Total at 31 March 2015	-	7,690	7,690

35 Operating Segments

The Clinical Commissioning Group considers that it has only one segment: commissioning of healthcare services.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioner	376,272	(1,264)	375,008	5,216	(23,237)	(18,021)
Total	**376,272**	**(1,264)**	**375,008**	**5,216**	**(23,237)**	**(18,021)**

36 Pooled Budgets

NHS Walsall Clinical Commissioning Group has entered into a pooled budget arrangement with Walsall MBC. This is a Section 75 (NHS Act 2006) partnership agreement relating to the commissioning of health and social care services under the Better Care Fund.

The fund is hosted by Walsall MBC. The partners' contribution to the fund is outlined below. The share of any over/(under) spend is allocated according to the Section 75 agreement.

Workstream	2015-16 Budget £000	2015-16 Spend £000	2015-16 WMBC Spend £000
A – Community Integration	2,170	2,114	0
B – Transitional Care Pathways – non bed based	6,684	1,964	4,709
C – Transitional Care Pathways – bed based	7,110	3,542	3,635
D – Assistive Technology	1,982	423	1,559
E – Dementia	220	0	220
F – Mental Health	519	519	0
G – Support to Carers	450	0	450
H – Long Term Social Care Community & Residential Placements	1,193	0	1,193
I – Independent Sector Impact on Hospital Flows	170	39	131
J – Contingency	1050	1050	0
Sub Total Revenue Funding	21,548	9,651	11,897
Capital Funding	2,429		
Total Better Care Fund 2015-16	**23,977**	**9,651**	**11,897**
Funding			
Walsall Clinical Commissioning Group	21,548		
Walsall MBC	2,429		
Total	**23,977**		

The Clinical Commissioning Group also has a separate pooled budget with Walsall MBC. Under this arrangement, funds are pooled under Section 75 of the NHS Act 2006 for Learning Disabilities and Community Equipment activities.

The ICES pooled budget for Community Equipment activities has now been incorporated into the Better Care Fund – work stream D – but is shown separately in the note below. Walsall MBC is the host for this pooled fund.

The memorandum account for the pooled budget is shown on pages 121 and 122.

The CCG's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2015-16 £000	2014-15 £000
ICES		
Income	608	601
Expenditure	(608)	(601)
LD		
Income	8,918	8,864
Expenditure	(8,918)	(8,864)

37 NHS LIFT Investments

The Clinical Commissioning Group does not hold any investments in NHS LIFT schemes.

38 Intra-Government and Other Balances

	Current Receivables 2015-16 £000	Non-current Receivables 2015-16 £000	Current Payables 2015-16 £000	Non-current Payables 2015-16 £000
Balances with:				
· Other Central Government bodies	84	-	494	-
· Local Authorities	341	-	2,829	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	-	-	-	-
· NHS bodies within the NHS England Group	991		111	
· NHS Trusts and Foundation Trusts	3,216	-	7,887	-
Total of balances with NHS bodies:	**4,207**	-	**7,998**	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	536	-	11,916	-
Total balances at 31 March 2016	**5,168**	-	**23,237**	-

38 Intra-Government and Other Balances

Restated	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	20	-	809	-
· Local Authorities	351	-	3.754	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	-	-	-	-
· NHS bodies within the NHS England Group	510		281	
· NHS Trusts and Foundation Trusts	1,775	-	4,644	-
Total of balances with NHS bodies:	**2,285**	-	**4,925**	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	167	-	12,920	-
Total balances at 31 March 2015	**2,823**	-	**22,408**	-

39 Related Party Transactions

During the year, certain members of the Governing Body or key members of staff declared interests with other organisations that have undertaken material transactions with the Clinical Commissioning Group.

Transactions with GPs are mostly for enhanced services which are processed through NHS England. The payments are made to the practices as a whole and do not specifically relate to individuals within a practice.

Details of those transactions are as follows:

	Payments to Related Party		Receipts from Related Party		Amounts owed to Related Party		Amounts due from Related Party		Business Entity of Related Party
Related party transactions	'15-16 £000	'14-15 £000	'15-16 £000	'14-15 £000	'15-16 £000	'14-15 £000	'15-16 £000	'14-15 £000	
Mr Robert Freeman – Secondary Care Specialist & Member of Governing Body	151	157 *	-	-	-	-	-	-	Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT
Mr J Wicks – Interim Director of Commissioning & Member of Governing Body	107	-	-	-	13		-	-	John G Wicks Healthcare Management Ltd
Dr S Kaul – Deputy Chair – Trans Locality/Member of Governing Body	425	-	-	-	37	-	-	-	Acepay Ltd
Dr A Rischie – Deputy Chair – Trans Locality/Member of Governing Body	-	-	-	-	37	-	-	-	Walsall Alliance Federation
Dr A Gill - Clinical Chair of Governing Body	62	40	-	-	17	13	-	-	Berkley Surgery
Dr S Abdalla - Deputy Chair - West Locality/Member of Governing Body	211	126	-	-	52	49	-	-	Lockfield Surgery
Dr N Asghar - Deputy Chair - North Locality/Member of Governing Body	78	44	-	-	17	22	-	-	All Saints Surgery
Dr A Benjamin - Deputy Chair - South East Locality/Member of Governing Body	-	117	-	-		33	-	-	Little London Surgery
Dr F Bolliger - Clinical Chair - South East Locality/Member of Governing Body	210	103	-	-	48	39	-	-	Northgate Surgery
Dr R Mohan - Clinical Chair - West Locality/Member of Governing Body	67	55	-	-	22	19	-	-	Sina Health Centre
Dr D Nair - Clinical Chair - Trans Locality/Member of Governing Body	-	8	-	-		5	-	-	Manor Medical Practice
Dr A Rischie - Deputy Chair - Trans Locality/Member of Governing Body	119	86	-	-	27	31	-	-	Pleck Health Centre
Dr A Suri - Clinical Chair - North Locality/Member of Governing Body	37	28	-	-	16	11	-	-	Birchills Surgery
Dr S Kaul – Deputy Chair – Trans Locality/Member of Governing Body	28	-	-	-	7	-	-	-	Kaul & Partners
Dr S Kaul – Deputy Chair – Trans Locaility/Member of Governing Body	17	-	-	-	4	-	-	-	New Road Medical Centre

* Amounts restated for 2014-15

39 Related Party Transactions (Cont'd)

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England
- NHS Midlands & Lancashire CSU
- NHS Sandwell and West Birmingham CCG
- Dudley and Walsall Mental Health Partnership NHS Trust
- The Royal Wolverhampton NHS Trust
- Sandwell & West Birmingham Hospitals NHS Trust
- Shrewsbury & Telford Hospital NHS Trust
- University Hospitals Coventry & Warwickshire NHS Trust
- University Hospitals of North Midlands NHS Trust
- Walsall Healthcare NHS Trust
- Birmingham & Solihull Mental Health NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust
- Birmingham Women's NHS Foundation Trust
- Black Country Partnership NHS Foundation Trust
- Burton Hospitals NHS Foundation Trust
- Heart of England NHS Foundation Trust
- Mid Staffordshire NHS Foundation Trust
- South Staffordshire & Shropshire Healthcare NHS Foundation Trust
- The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust
- The Dudley Group of Hospitals NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- West Midlands Ambulance Service NHS Foundation Trust
- NHS Property Services
- Community Health Partnerships

In addition, the Clinical Commissioning Group 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:

- HM Revenue & Customs - VAT
- HM Revenue & Customs - Other taxes and duties
- National Insurance Fund (Employer's contributions)
- NHS Pension Scheme (Employer's contributions)
- Walsall Metropolitan Borough Council
- Sandwell Metropolitan Borough Council

40 Events after the End of the Reporting Period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2016. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Walsall Clinical Commissioning Group has been approved under delegated commissioning arrangements which mean that the Clinical Commissioning Group will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2016.

41 Losses and Special Payments

The Clinical Commissioning Group had no losses and special payments cases during 2015-16.

42 Third Party Assets

The Clinical Commissioning Group held no third party assets as at 31st March 2016.

43 Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2015-16 financial year.

44 Analysis of Charitable Reserves

The Clinical Commissioning Group does not hold any charitable funds.

LEARNING DISABILITIES POOLED FUND MEMORANDUM ACCOUNT
For the period 1st April 2015 to 31st March 2016

Gross Funding	Ref	Total £000
Walsall Clinical Commissioning Group	2i	**8,918**
Walsall Metropolitan Borough Council	2i	**22,683**
Total Funding		31,601

Expenditure	Ref	Total £000
Integrated Team	2a	**1,092**
Community Support	2b	**16,285**
Day Care	2c	**2,377**
Residential & Nursing	2d	**7,809**
Supported Employment	2e	**691**
Management & Admin	2f	**1,086**
NHS Provider Contract	2g	**3,001**
Total Expenditure		32,340
Net overspend		740

Due to ongoing discussions with CCG on Pooled Budget disaggregation it has been agreed by JCC that CCG will not contribute to 2015/16 over spend

Walsall Clinical Commissioning Group	0.00%	-
Walsall Metropolitan Borough Council	100.00%	*740*

Note

Total estimated net liabilities relating to Pooled Budgets Creditors and Debtors of £1,297,968 shared in proportion to each partners contribution (as per the 2010/11 Pooled Budget contribution levels)

Walsall Clinical Commissioning Group	*27.90%*	*362,133*
Walsall Metropolitan Borough Council	*72.10%*	*935,835*
		1,297,968

CERTIFICATE OF CHIEF FINANCIAL OFFICER/DIRECTOR OF FINANCE/THEIR REPRESENTATIVE

I certify that the above pooled fund memorandum account accurately discloses the income received and expenditure incurred in accordance with the partnership agreement, as amended by any subsequent agreed variations, entered into under section 31 of the Health Act 1999.

Signed

Lloyd Haynes
Senior Finance Manager

ICES POOLED FUND MEMORANDUM ACCOUNT
For the period 1st April 2015 to 31st March 2016

Gross Funding	Ref	Total £	
Walsall Clinical Commissioning Group	3c	608,000	42.35
Walsall Metropolitan Borough Council	3c	827,538	57.65
Total Funding		1,435,538	100.00

Expenditure		Total £
Staffing Costs	3a	325,685
Non pay	3a	55,395
Transport	3a	42,789
Equipment (Net of VAT Reimbursement and Other Income)	3a	970,364
Total Expenditure		1,394,233
Net under spend		- 41,305

The benefit of the Pooled Budget under spend position will be asplit as per each partner's contribution:

Walsall Clinical Commissioning Group	*42.35%*	*-£17,494*
Walsall Metropolitan Borough Council	*57.65%*	*-£23,811*

Note
Initial calculation showed £16,905 owing to the CCG and, in agreement with the CCG, this has been carried forward into 2016/17 to fund future costs. The council element has been used in 2015/16 ot offset other over spends relating to Better Care Fund

Note
Total estimated net liabilities relating to Pooled Budgets Creditors and Debtors of £36,620 shared in proportion to each partners contribution

Walsall Clinical Commissioning Group	*42.35%*	*13,816*
Walsall Metropolitan Borough Council	*57.65%*	*18,804*
		32,620

CERTIFICATE OF CHIEF FINANCIAL OFFICER/DIRECTOR OF FINANCE/THEIR REPRESENTATIVE

I certify that the above pooled fund memorandum account accurately discloses the income received and expenditure incurred in accordance with the partnership agreement, as amended by any subsequent agreed variations, entered into under section 31 of the Health Act 1999.

Signed

Lloyd Haynes
Senior Finance Manager

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	14	0	0
Intangible assets	15	0	0
Investment property	16	0	0
Trade and other receivables	18	0	0
Other financial assets	19	0	0
Total non-current assets		0	0
Current assets:			
Inventories	17	0	0
Trade and other receivables	18	5,168	2,823
Other financial assets	19	0	0
Other current assets	20	0	0
Cash and cash equivalents	21	48	53
Total current assets		**5,216**	2,876
Non-current assets held for sale	22	0	0
Total current assets		**5,216**	2,876
Total assets		**5,216**	2,876
Current liabilities			
Trade and other payables	24	(23,237)	(22,408)
Other financial liabilities	25	0	0
Other liabilities	26	0	0
Borrowings	27	0	0
Provisions	31	0	0
Total current liabilities		**(23,237)**	(22,408)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(18,021)**	(19,532)
Non-current liabilities			
Trade and other payables	24	0	0
Other financial liabilities	25	0	0
Other liabilities	26	0	0
Borrowings	27	0	0
Provisions	31	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(18,021)**	(19,532)
Financed by Taxpayers' Equity			
General fund		(18,021)	(19,532)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(18,021)**	(19,532)

The notes on pages 84 to 122 form part of this statement.

The financial statements on pages 76 to 83 were approved by the Governing Body on 25th May 2016 and signed on its behalf by

Accountable Officer
Salma Ali