NHS
West Hampshire
Clinical Commissioning Group

Annual Report and Accounts 2017/18

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Dr Sarah Schofield
Chairman

I have great pleasure in introducing the fifth Annual Report and Accounts of NHS West Hampshire Clinical Commissioning Group.

As the Clinical Chairman of the CCG I feel very privileged to lead the clinical commissioning agenda for such an interesting and diverse population.

Our area includes an ancient city, modern urban areas and two national parks. Each area brings its own challenges and opportunities and it is our role to ensure that local health services meet the needs of local people.

Since the formation of CCGs in 2013, the health and care landscape has changed with an increased focus on local delivery systems, which join up a range of health and social care in a particular geographical area.

As you will see later in this report, we consulted our member practices about changing our constitution to enable Locality Clinical Directors to join the CCG Board. I am pleased to report that this was supported by our practices, which enables us to remain clinically-led while strengthening our geographical (locality) representation.

A key issue we faced during the year was the closure of a GP practice in Chandler's Ford. This was a challenging time for my primary care and CCG colleagues – but it gave me the chance to speak to many local people.

We met hundreds of patients at various meetings in the local area, and for me personally I valued the feedback I received from patients about local health services.

I am pleased to report that I have been elected for a second term as Chairman of the CCG following the end of my first five-year term of office.

I would like to thank our GP members for their commitment and loyalty to both me and the CCG and I look forward to working with you all in the years ahead as we strive to achieve our shared vision for quality services and better health.

Heather Hauschild

Chief Officer

Our Annual Report provides us with an opportunity to reflect on the challenges and the achievements of the last year.

Our staff have been working hard in partnership with other health and care organisations across Hampshire and the Isle of Wight to continue to reshape the way services are provided so that we can meet the needs of the increasing numbers of older people living with long term conditions in the community and supporting people to stay well and independent for as long as possible.

We were pleased to oversee the opening of the six local hubs offering extended hours in primary care last October which we know have already made a difference to people who need to see their GP urgently and in the evening and at weekends.

We have already made a difference to people who need to see their GP urgently

Within primary care, we are very proud of Hedge End Medical Centre and its role as a national champion of e-Consult. Practice staff are supporting our colleagues at NHS England to share their experience of e-Consult and encourage more GPs across the country to offer the service to their patients.

We have established services for frail older people including health care practitioners from across a number of disciplines to support our doctor-led services and the work our pharmacists have done with local GPs to make sure that medicines are reviewed and this has been very well received.

Our report highlights many areas where services are changing which I hope you will find interesting and informative.

Some of these changes have been shortlisted for prestigious Health Service Journal Awards over the year, which are highlighted within the annual report.

These projects are making a real difference to patients' lives and include the Care Navigators service, for signposting community services, the Medicines Optimisation team for both medication reviews and for making joined-up working a reality, and our Commissioning team for launching a community-based audiology service, which puts into practice our vision for care closer to people's homes.

I would like to take this opportunity to thank our staff who really want to make a difference

We are committed to getting the best value for every pound spent and continuing to manage the £740m of your money effectively. As you know this is challenging when the demand for more health services continues to rise.

We need your help to manage our resource, money and staff well by keeping yourself as well as possible and using services when you need them wisely.

We always want to hear from you about your news on current services and to help shape services for the future.

Please contact us at whccg.communications@nhs.net to join our Health Involvement Network. We will keep you updated on upcoming plans.

Finally I would like to take this opportunity to thank our staff who really want to make a difference to local health and care services.

These include our member practices, who work tirelessly to care for us as the first port of call when we are worried about a health problem, and to our provider organisations (Hospitals Community Services, Voluntary Sector) who work with us to make the changes we need to see a health service we can all be proud of and fit for the future.

1. Performance Overview

1.1. About us

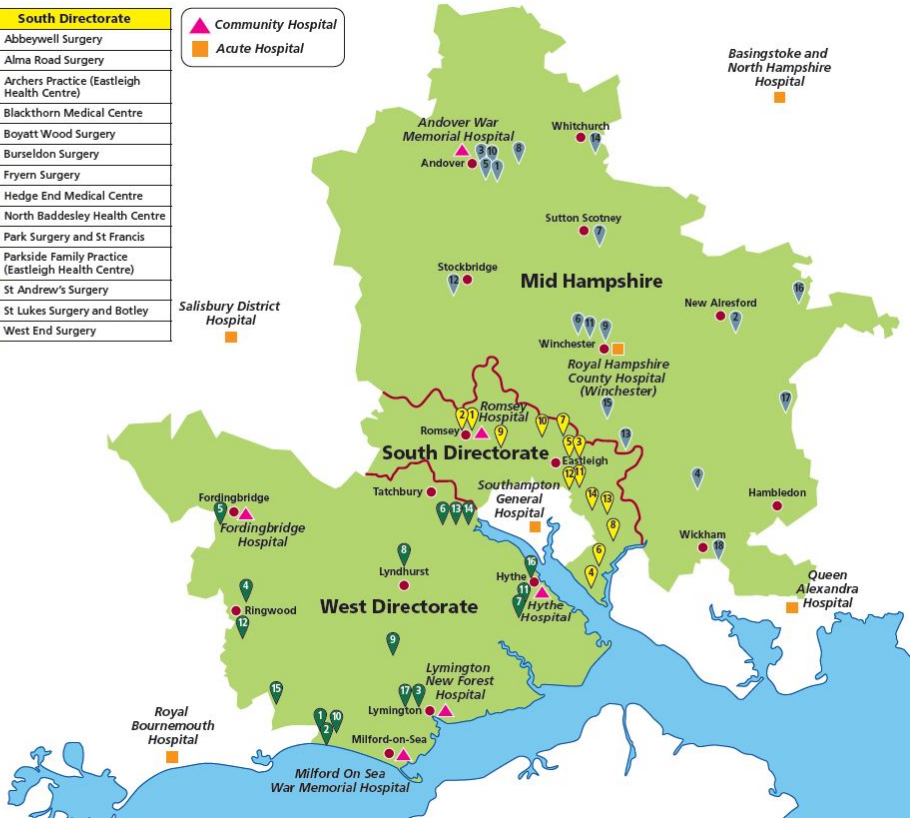
West Hampshire Clinical Commissioning Group is a GP-led organisation responsible for healthcare services for more than 550,000 people across central, west and south west Hampshire. We cover the towns and surrounding areas of Andover, Winchester, Alresford, Romsey, Chandlers Ford, Eastleigh, Bishop's Waltham, Hedge End, Totton, Waterside, Ringwood, Fordingbridge, Lyndhurst and Lymington.

Our area includes two Local Delivery Systems (LDS):

Mid Hampshire Directorate	
1	Adelaide Medical Centre
2	Alresford Group Surgery
3	Andover Health Centre Medical Practice
4	Bishops Waltham Surgery
5	Charlton Hill Surgery
6	Friarsgate Practice
7	Gratton Surgery
8	Shepherd Spring Medical Centre
9	St Clements Partnership
10	St Mary's Surgery
11	St Paul's Practice
12	Stockbridge Surgery
13	Stokewood Surgery
14	Two Rivers Practice
15	Twyford Surgery
16	Watercress Medical Group
17	West Meon Surgery
18	Wickham Group Surgery

South Directorate	
1	Abbeywell Surgery
2	Alma Road Surgery
3	Archers Practice (Eastleigh Health Centre)
4	Blackthorn Medical Centre
5	Boyatt Wood Surgery
7	Burseldon Surgery
8	Fryern Surgery
9	Hedge End Medical Centre
10	North Baddesley Health Centre
11	Park Surgery and St Francis
12	Parkside Family Practice (Eastleigh Health Centre)
13	St Andrew's Surgery
14	St Lukes Surgery and Botley
15	West End Surgery

West Directorate	
1	Arnewood Practice
2	Barton Surgery (Barton Webb-Peploe Partnership)
3	Chawton House Surgery
4	Cornerways Medical Centre
5	Fordingbridge Surgery
6	Forest Gate Surgery
7	Forestside Medical Practice
8	Lyndhurst Surgery
9	New Forest Medical Group
10	New Milton Health Centre
11	Red and Green Practice
12	Ringwood Medical Centre
13	Testvale Surgery
14	Totton Health Centre
15	Twin Oaks Medical Centre
16	Waterfront and Solent Surgery
17	Wistaria and Milford Surgeries



- North and Mid Hampshire – covering the towns and villages around Andover and Winchester (including Alresford and the Meon Valley). It also includes the North Hampshire towns of Basingstoke and Alton, which are part of North Hampshire CCG

- South West Hampshire – covering Eastleigh and the Southern Parishes, Chandler's Ford, Romsey and the New Forest.

Our Locality Clinical Directors each represent their local area within the LDS and since April 2018 they have been members of the CCG Board.

All 49 GP practices are members of the CCG. There are three GP Federations – groups of practices working together:

- Mid Hampshire Healthcare Ltd covering Winchester and Andover,

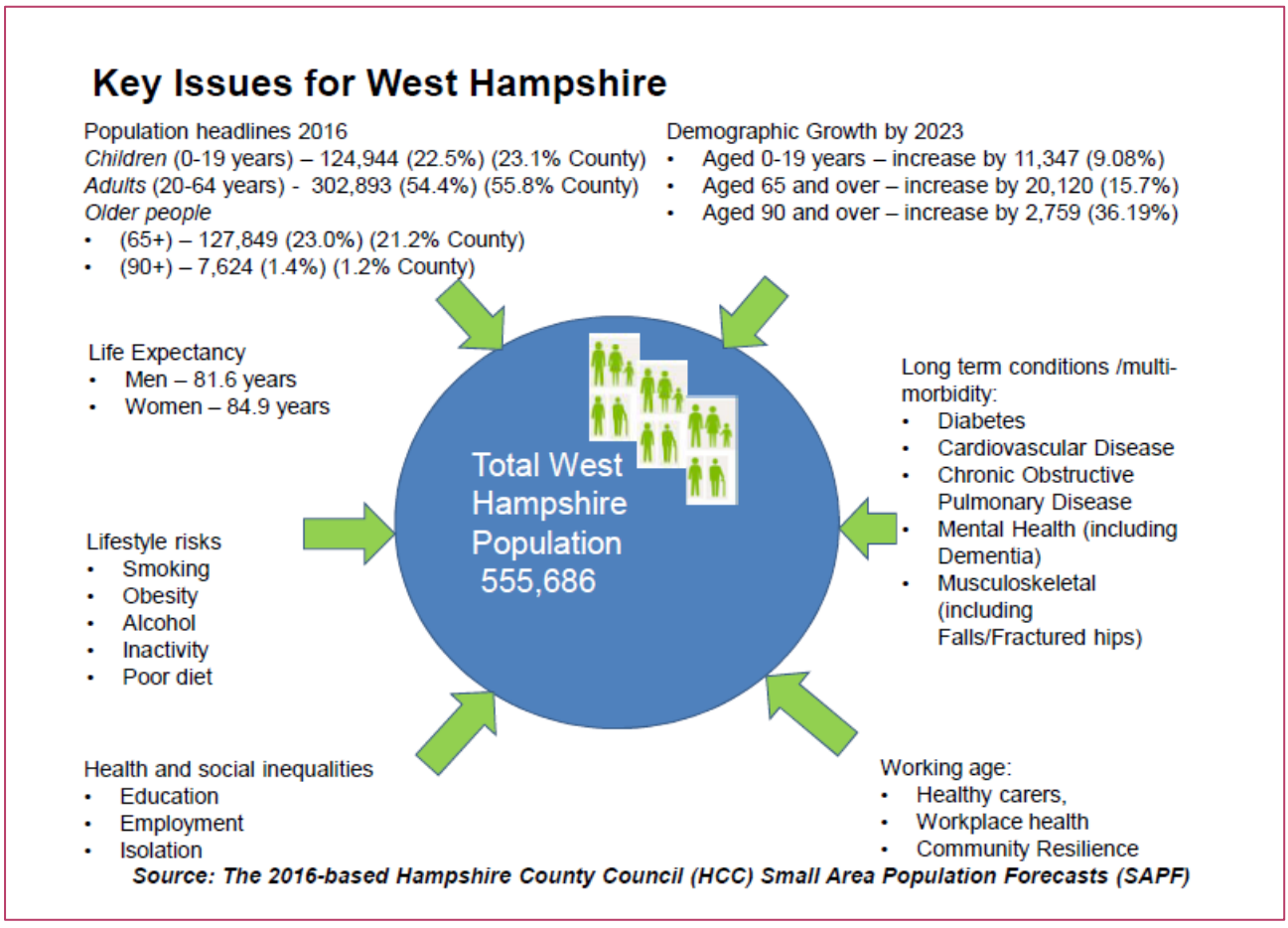
- Tri Locality Care Ltd covering Eastleigh North and Test Valley South
- Eastleigh Southern Parishes Network Ltd covering Eastleigh Southern Parishes.

The GP Federations were created to enhance the delivery of healthcare services by bringing practices together to create community based services that they couldn't deliver alone. This supports and strengthens primary care through by making practices stronger and better able to deal with the increasing challenge across the local area.

1.2. Our population

We have one of the largest CCG populations in England and our aim is to commission high quality services. Our planning and commissioning decisions are informed by the Joint Strategic Needs Assessment (JSNA), published by Public Health Hampshire. The latest report, which shows the CCG is the 12th least deprived in England, is available from the Hampshire County Council website at https://www.hants.gov.uk

The key findings from the JSNA are shown below:



1.3. Health conditions and behaviours

The table below shows the prevalence of conditions and habits in the West Hampshire CCG area and the wider population in England.

Condition	CCG %	England %
Smoking (GP Surveys)	13.8	16.4
Obesity	7.9	9.5
Hypertension (high blood pressure)	14.8	13.8
Coronary heart disease (CHD)	3.3	3.2
Stroke	2.1	1.7
Heart failure	0.8	0.8
Atrial fibrillation	2.2	1.7
Diabetes	5.5	6.5
Chronic kidney disease	3.6	4.1
Cancer	3.1	2.4
Depression	8.4	8.3
Dementia	0.9	0.8
Mental health issues	0.74	0.9
Learning disability	0.4	0.5
Osteoporosis	0.4	0.3
Rheumatoid arthritis	0.8	0.7
Chronic obstructive pulmonary disease (COPD)	1.6	1.9
Asthma	6.2	5.9

1.4. Inequalities

Across the CCG health inequalities (based on life expectancy and quality of life) are evident and the main issues people experience are heart disease, cancer and chronic breathing issues.

Some parts of the CCG area have notable differences:

- Eastleigh and Winchester – Digestive disease including alcohol related disease in women)
- Test Valley and New Forest – Mental and behavioural issues including dementia

People in West Hampshire have a longer life expectancy than the national average. For men it is 81.6 years and for women it is 84.9 years compared with the national averages of 79.3 for men and 83 for women.

However older people are more vulnerable to loneliness and social isolation. In West Hampshire, more than half of those aged 75 and over live alone and around 10% of over 65s say they are lonely most or all of the time.

Our achievements section captures some of the work we have been progressing this year to help tackle these issues.

1.5. How we work

As one of the largest CCGs in the country we have more than 250 members of staff based at two mains sites – Omega House, Eastleigh, and the Borough Council offices, Fareham.

Our staff work in eight directorates:

- Chief Officer
- Clinical Directors
- Quality
- Finance
- Performance
- Strategy and Service Development
- Commissioning – South West Hampshire
- Commissioning – Mid Hampshire

We host and provide Safeguarding and NHS Continuing Healthcare services on behalf of all Hampshire CCGs.

We are the lead Commissioner for Adult Mental Health and Learning Disability services.

Commissioning of Maternity and Children's Health services is led by North East Hampshire and Farnham CCG.

We work closely with GPs, providers and fellow commissioners, such as Hampshire County Council and North Hampshire CCG, within our two Local Delivery Systems.

Local GPs play a central role in planning healthcare services that meet the needs of our local population. They are represented by the CCG's Clinical Chairman, who is elected by member practices.

From April 2018, following a consultation and review of our Constitution with member GP practices, our Locality Clinical Directors joined the CCG Board to strengthen input from the Local Delivery Systems.

We also employ Clinical Directors with expertise in key specialties such as mental health and learning disability, long term conditions, children's care, safeguarding and medicines optimisation.

For more information about the structure and membership of our board see the Corporate Governance Report.

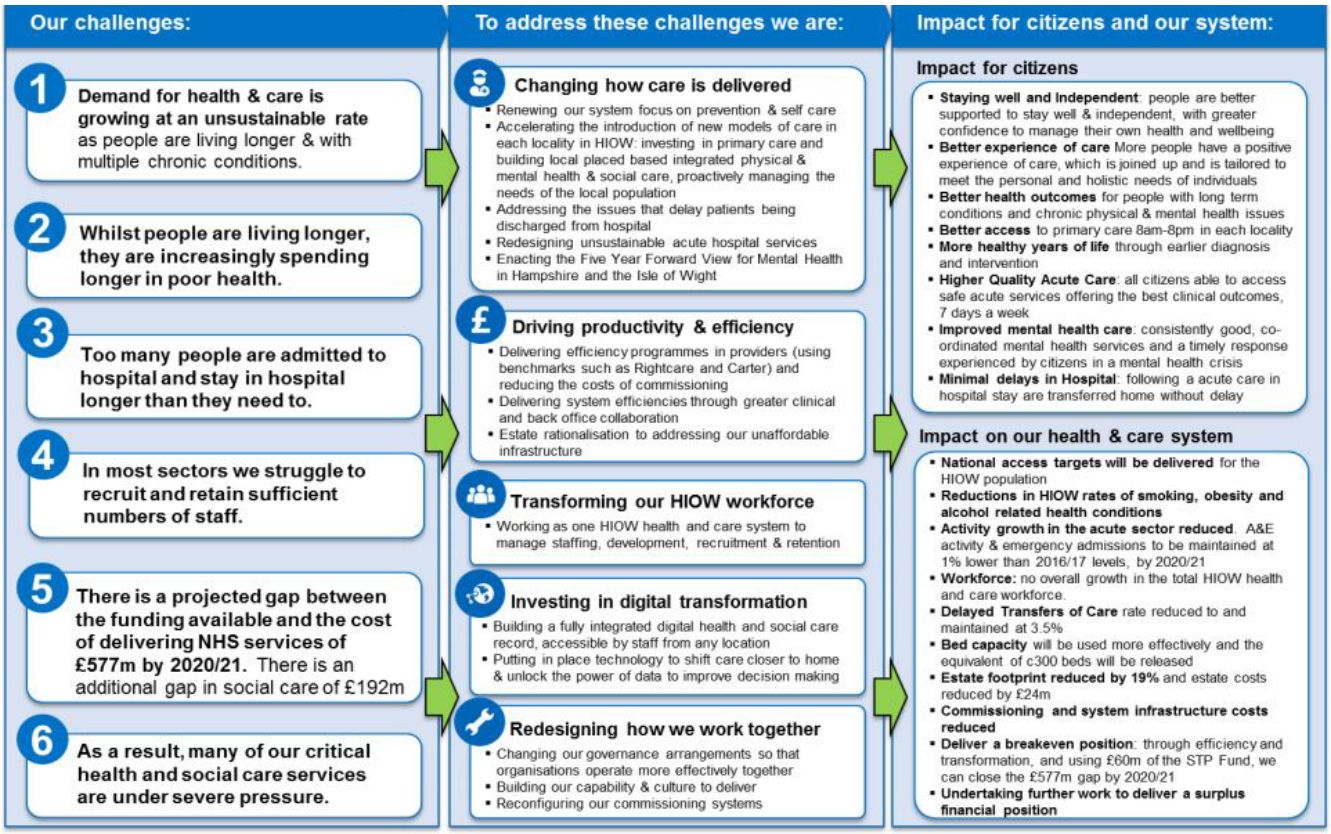
We work with clinicians, patients and carers to ensure health and care services are effective and co-ordinated. In 2018/19 we spent a total of £758m on healthcare services (for children and adults), including:

- Planned surgery (elective hospital care)
- Rehabilitation care
- Urgent and emergency care
- Community health services
- Mental health and learning disability services
- Primary care services (GPs and practice nurses)
- Continuing health care
- Prescribed medicine

1.6. Hampshire and Isle of Wight Sustainability and Transformation Partnership

We have continued to work in partnership with over 20 health and care organisations across Hampshire and the Isle of Wight to draw up sustainable answers to the opportunities and challenges facing the NHS and care system.

The STP's challenges, priorities and the impact we how to achieve are set out in the chart below.



We have a long term plan to ensure we build new ways of designing and providing services that are sustainable in the future – and that means changing how our local NHS works. Given the size and diversity of the STP footprint, many of the aims and ambitions set out in the STP are delivered through Local Delivery Systems.

West Hampshire CCG is part of the South West and the North and Mid Hampshire Local Delivery Systems. The other Hampshire and the Isle of Wight delivery systems are:

- Portsmouth and South East Hampshire
- Isle of Wight
- Southampton
- Frimley Health

2. Our Priorities

Our aim is to ensure patients receive care as close to home as possible which is high quality, effective and offers value for money.

Each year we develop and publicise our plans for the year ahead. Our four key priorities for 2017/18 were:

- Quality and Safety
- Local Delivery Systems (LDS)
- Collaborative Commissioning
- Financial Sustainability

2.1. Quality and safety

Our main priority is to ensure people receive high quality care.

We want people to work in partnership with their health and care professionals to agree their own personal goals for treatment.

We also encourage people to get involved in designing local health services – because to make use of their personal experience.

Medication plays a vital role in treatment and management but we recognise it is important for regular medication to be reviewed to ensure it is still clinically safe and effective.

We support the national vision for more people to take control of their own health and care packages through Personal Budgets – and we are determined to continue to improve the experience of people who are applying for NHS Continuing Healthcare.

We take our Safeguarding role very seriously and work in partnership with many other agencies to protect the most vulnerable children and adults in our area.

2.2. Local Delivery Systems

The North and Mid Hampshire Local Delivery System cover the two localities of Winchester and Andover in West Hampshire together with North Hampshire CCG covering a total population of 424,211. Of this, Mid Hampshire has:

- 18 General Practices with a registered population of 198,211 (36% West Hampshire CCG)
- Main Community and Mental Health Provider: Southern Health NHS Foundation Trust
- Community Hospitals: Andover war memorial Hospital. Patients can also access services at Alton Community Hospital.
- Acute Hospitals: Local people use services at Winchester and Basingstoke.

- Federations: Mid-Hampshire Healthcare

The South West Hampshire Local Delivery System covers the four localities of West New Forest, Totton and Waterside, Eastleigh Southern Parishes and Eastleigh North and Test Valley South with a total registered population of 338,832. Of this South West Hampshire has:

- 31 General Practices with a registered population of 338,832.
- Main Community and Mental Health Provider: Southern Health NHS Foundation Trust
- Community Hospitals: Lymington New Forest Hospital, Fordingbridge Hospital, Milford on Sea War Memorial Hospital, Ashurst Hospital, Hythe War Memorial Hospital
- Acute Hospitals: Local people use services at Southampton, Winchester, Bournemouth, Poole and Salisbury.
- Federations: Eastleigh Southern Parish Network Ltd and Tri-Locality Care Ltd.

The Local Delivery System Transformation Plans set out the priorities which include implementing care to help support those we are more frail, outpatient transformation, ambulatory emergency care and integrated care to help people avoid unnecessary admission to hospital and to get home as soon as they are able following a period of inpatient stay.

2.3. Collaborative Commissioning

We work with other CCGs, Hampshire County Council and the voluntary sector to develop physical, mental health and learning disability services for people of all ages

Our aim is to commission collaboratively to enable people to have faster and more efficient access to support and community-based care to help manage severe mental illness and avoid crisis.

2.4. Families and children

We want parents to have greater choice around birth plans and more control over planning care for children and young people with additional health needs.

We also want families and children to have better access to mental health services.

This includes involving people in their care plans and enabling them to take control with personal budgets.

Our aim is to help people have more information about healthy lifestyle choices and know where services are located. We also want children to experience a better transition to adult services.

2.5. People with mental illness

We give equal value to mental and physical health and are committed to tackling mental illness with the same energy and priority as physical illness or injury. We

believe this can be achieved by improving clinical services such as talking therapies, supporting people through crisis and recovery and helping them to stay well. We are also committed to improving physical health services for people with mental illness and ensuring the workforce in all services has the skills and capabilities for this. We aim to:

- Support people with a serious mental illness with more health checks and follow ups, improve the access to early crisis support and develop better support to reduce suicide rates
- Provide more mental health support for pregnant women and new mums
- Review rehabilitation services ensuring that they are co-designed and build on people's individual needs
- Improve skills within primary care and general practice to work with people with mental health needs.

2.6. People with a learning disability and/or autism

Our aim is to develop more support for both the physical and mental health needs of people with a learning disability.

We want people with a learning disability to receive more support in the community where this best meets their needs including more services in GP surgeries, local hospitals and community-based rehabilitation and relapse prevention services

We are working in partnership to increase the number of personal healthcare assistants and improve housing options to meet people's needs.

We want people to have greater control of their care with personal health budgets.

We value the partnership working that we have in place with our local councils and Hampshire County Council and aim to develop this further during 2017/18 and beyond.

Some of the key areas in which we have been developing joint commissioning include:

- Working with Hampshire County Council through My Life My Way we have introduced personalised care and support planning for people with a learning disability and complex needs and children, young people and adults eligible for continuing care. This has led to individuals, their carers and families taking an active role in their health and wellbeing, with greater choice and control over the care they need. Two hundred and ninety one people across Hampshire now have a personal budget with an element of NHS funding.

- My Life My Way has also supported people to develop their knowledge, skills and confidence to self-manage, through stronger partnerships with the voluntary and community sector (VCSE), community capacity building and peer support.

2.7. Health and wellbeing strategy

We are an active member of the Health and Wellbeing Board which has a responsibility to consider the needs of Hampshire and, with local partners and communities, develop a shared vision for health and wellbeing.

The Board looks at people's health and social care needs and takes account of the bigger picture – for example transport, housing, jobs and leisure – so that services truly help people stay healthy and independent.

Our Clinical Chairman is a member of the Health and Wellbeing Board and our Chief Officer is a member of the Health and Wellbeing Executive, which includes commissioners, providers and officers of the local authority.

We are committed to delivering the joint Health and Wellbeing Strategy. Over the year we have worked together with the Health and Wellbeing Board on the following projects, Better Care Fund, improving patient flow and discharge, improving the mental health crisis systems, establishing One Public Estate in Hampshire, and working together to support vulnerable communities.

We also have strong links with Hampshire County Council's Health and Adult Social Care Select Committee, and we represent health as board members on the Safeguarding Children Board and the Safeguarding Adult Board.

We participate in the Children's Trust, the district Health and Wellbeing Boards and we have established regular meetings with our district and borough council colleagues to develop a more joined up public sector approach to local communities.

2.8. Developing digital technology

We recognise the important role of digital technology in modern health and care services.

We believe digital technology plays an important part in prevention and self-management by enabling people to use NHS Choices and other digital solutions.

Our aim is for healthcare records to be joined up so people can tell their story once and have access to online healthcare professionals, health and care records, appointments and prescriptions.

2.9. Financial sustainability

We continue to strive to use NHS resources efficiently and effectively by supporting GPs, pharmacists and practice nurses to offer more services focussed on prevention and encouraging people to lead a healthy lifestyle.

GPs and local hospitals are working in partnership to improve services in a more preventative and proactive way with telephone follow ups and more outpatient appointments available out of hospital and closer to people's homes.

3. Achievements in 2017/18

Our aim as a Clinical Commissioning Group is to ensure people are able to stay healthy, get the best possible health care and lead long and healthier lives.

Over the last year we have achieved this by commissioning care in the following five key areas:

1. Prevention
2. Proactive support
3. Better access to specialist care
4. Integrated urgent and emergency care
5. Effective 'step up, step down' nursing and residential and discharge support

3.1 Prevention and self-care

A primary aim is to make sure that we are taking effective and concerted action to support people to stay well. Prevention and early intervention programmes, such as those for smoking, weight reduction, lifestyle and long-term condition management, can help people avoid ill health – and increasingly digital technologies can improve this support. We know some patients experience loneliness and isolation that impact on their health and wellbeing. Our communities and volunteers are supporting and improving the lives of local people, and as commissioners we can also contribute to this, for example through social prescribing services.

Our prevention agenda has been wide and varied in 2017/18. Our initiatives are highlighted below:

3.1.1. Promoting physical exercise – Get Hampshire Walking

'Get Hampshire Walking' is a West Hampshire walking campaign based on the work of Dr William Bird[1]. This work ties in with local authority, Sports Council and other agency walking schemes that can then be promoted in a coordinated way by all partners.

We have worked with our partners to promote the benefits of walking by linking with national campaigns as well as developing and encouraging local targeted initiatives.

This has included:

[1] Dr William Bird helped transform the health of millions of people across the UK by developing innovative initiatives. As a family GP, he began to get his patients more active by setting up the first Health Walk scheme in April 1996. This led to him creating the Green Gym one year later as he realised that companionship and contact with nature were major driving forces in keeping people active.

- Production of a short film promoting the benefits of walking
- The creation of posters for Practice waiting rooms, websites and local community venues.
- A leaflet for older people promoted through local flu clinics setting out the benefits of walking
- Specific initiatives, for example, as part of Andover Vision additional walking routes have been developed including a new heritage trail which opened in December. In Lyndhurst a walk to school route has been publicised to encourage physical activity and to take children away from the busy high street
- The New Forest Walking Festival in October 2017, which saw 1,500 people enjoy 75 behind the scenes family strolls, history hikes and wildlife walks and more. All walks were led by an expert from the New Forest National Park Authority.
- Joint work with schools to encourage the uptake of the Golden Mile project which encourages school children to become more active by walking, jogging or running around a measured distance within the safety of the school grounds. By participating in the Golden Mile project pupils get greater access to physical activity, which helps improve classroom behaviour, concentration levels, team work and leadership. We achieved our goal of 25% of primary schools signed up to the schools – a total of 49 schools across West Hampshire.

3.1.2. Weight Management

GPs are referring patients to Weight Watchers if they meet the following criteria to Weight Watchers.

- Aged 16 or over
- A Body Mass Index (BMI) of 30 or more
- For the Asian population and for people with other long term conditions a BMI of 28 or more
- Cardiovascular (heart or stroke) risk or disease type 2 diabetes, metabolic syndrome or weight loss required before surgery
- Overweight/Gestational Diabetes in Pregnancy

Weight Watchers is commissioned by Hampshire public health as part of the whole weight management pathway to support people to lose weight and lead healthier lifestyles. The course is provided free for 12 weeks. Meetings are held in venues across West Hampshire.

3.1.3. Healthier You – National Diabetes Prevention Programme

We were pleased to be chosen as a Wave 2 site for Healthier You, the NHS Diabetes Prevention Programme. We recognise the enormous benefit in helping people who are at risk of developing Type 2 diabetes and are pleased that more than 1,000 people in West Hampshire have been referred to the nine-month programme.

This prevention programme aligns with our 'Time of Your Life' campaign, which featured a 'Healthier You' participant from a Winchester who told us his story. This and other films can be viewed via NHS West Hampshire CCG's YouTube channel.

3.1.4. Influenza and pneumococcal vaccinations

We worked with our GP Practices and local pharmacies and increased the uptake of vaccinations compared with to 2016-17 across all target groups. We achieved the national target of 75% uptake for people aged 65 years and above.

3.1.5. Time of Your Life

We worked with local people in the New Forest to develop 10 key messages for those reaching retirement to think about how they maintain their health and wellbeing as their lifestyle changes when they stop work. We created a 'z-card' with 10-point guide, which is available from all GP Practices and local community venues, as well as on our website. The 'Time of Your Life' campaign was further promoted as part of a New Year Resolutions campaign.

The 10 Key Messages:

1. Think about your current health and wellbeing
2. Understand that ageing is natural
3. Keep moving
4. Stay in touch with friends, family and your local community
5. Be creative
6. Prevention is better than cure
7. Think about your finances
8. Make your home work for you
9. Get everything in order
10. Planning your care

3.1.6. Self-Care

The following initiatives have encouraged people to make the right choices at the right time through easier access to self-help information and guidance regarding the support they need when they are feeling unwell.

e-consult, an on-line consultation system, has been commissioned and is now available across Hampshire. e-Consult enables patients to access symptom checkers, self-help tools, advice, prescriptions and appointments. The system enables patients to make informed decisions regarding the support they need when they are feeling unwell. Across West Hampshire over 20,000 e-consult forms have been completed. Over 60% of people are able to resolve their health concerns without visiting their Practice, saving an estimated 12,300 appointments.

Our Clinical Director – Digital, Dr Karl Graham, is a national expert in online consultation. Hedge End Medical Centre, where he is partner, encourages e-Consult among patients with remarkable success. This is featured as a best practice case study by NHS England via their website at https://www.england.nhs.uk/publication/10-high-impact-actions-new-types-of-consultation-econsult-in-southampton/

Connect to Support Hampshire is being promoted across the county. It is an online directory of local services and community groups developed by Hampshire County Council.

Active signposting more than 50 GP reception staff from 28 Practices trained in. This ensures people receive the right care and support at the right time and can help to reduce GP consultations by 5%

Surgery signposting has been implemented in the Meon Valley. The signposters are based in General Practices and help people find social, emotional and/or practical support such as relationship advice, support for low mood, stress or loneliness and money, debt, housing or benefit advice.

3.2. Proactive support

Proactive joined up care for those with ongoing and complex needs is a key component of our care model. This is delivered through developing teams of multiple professions working collectively to deliver joined up care. These teams bring together primary care, community nursing and therapies, paramedic, mental health, social care and the voluntary sector to work together within local communities.

3.2.1. Frailty

North and Mid Hampshire

We have worked closely with colleagues in North Hampshire CCG to develop a 'Frailty pathway' to support people who at risk of developing frailty. A campaign was launched in January 2018 to raise awareness of the condition and help people avoid it. A Frailty Intervention Team has been established at the Royal Hampshire County Hospital in Winchester and frailty health and wellbeing groups and clinics are being developed.

What is Frailty?

Frailty is a distinctive state of health related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between 25% and 50% of those aged over 85.

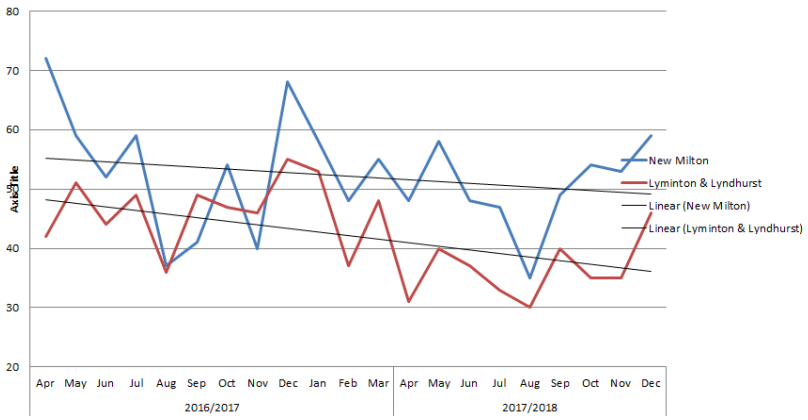
Older people living with frailty are at risk of dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.

Source: British Geriatrics Society

West New Forest, Totton and Waterside

A Frailty Support Team is now in place across West New Forest, Totton and Waterside. The model is building on current commissioned services within Lymington New Forest Hospital, Extended Primary Care Teams and based around natural communities within this defined area.

The service provides both proactive and reactive care. Each General Practice is aligned to a care home to improve care through regular medical reviews and the provision of advice and support in the care of the most vulnerable patients with complex needs. Rapid care is provided by a multi-disciplinary team who can assess and diagnose and provide social care packages for up to six weeks to support people at risk of hospital admission to remain at home. Where the service is fully operational in Lymington and New Milton, we have seen a reduction in acute hospital admissions (see chart below).



Patient story

Maggie Harmer, whose moth
received care from the Frailty
Support Service, said:

"Paramedics and a nurse arr
at my mother's home 15 min
after I called my doctor's sur
The team examined by moth
and arranged for her to be se
at Lymington New Forest
Hospital, which was so much
easier than going to
Southampton General.

"She came home the same d
and was seen every day for
first week by the Frailty Supp
team. The service is a real a
to the area."

3.2.2. Care Navigator Service

Our Care Navigators working across Eastleigh Southern Parishes and the New Forest provide a valuable service supporting people in navigating health, social and voluntary services by providing information and advice and co-ordinating care,
Using a social prescribing model, people are supported to remain safe and independent in their own homes, using existing services and community support.

FOR HEALTHCARE LEADERS HSJ VALUE IN HEALTHCARE AWARDS FINALIST

The service also strengthens links between the different services supporting a patient (or carer) thereby ensuring joined up care. Over 2,501 patients were supported by the team in 2017-18.

The service has also successfully piloted having an in-reach coordinator based at Southampton General Hospital to support and facilitate discharge from hospital.

The service received an Outstanding Team (non-clinical) award by the Thames Valley and Wessex Leadership Academy and were also shortlisted for a HSJ award.

3.2.3. TimeBank

Our social prescribing initiative aims to reduce social isolation.
We worked with Andover Mind and Test Valley Borough Council to support Timebank, which is designed to mobilise communities to give and receive support within their community using a currency of time credits.

TimeBank

Timebank has many benefits including:

- Increasing self-esteem and self confidence
- Creating mutual social and practical support networks
- Tackling loneliness and isolation
- Improving health and wellbeing
- Strengthening communities.

A Timebank is also being established in Totton in collaboration with Hampshire County Council and the local community.

3.2.4. Dementia

We held a Dementia workshop in February to bring together people involved in dementia research, care and support across the New Forest. Over 70 people attended, including GPs, nurses, frailty practitioners, care home workers, Care Navigators, Patient Participation Group members, and representatives from the voluntary sector. Feedback from the event was extremely positive, with the workshop raising awareness of the range of local community support available.

All 17 Practices in the New Forest are Dementia Friendly accredited.

3.2.5. Integrated Pharmacy Service – New Forest

An integrated pharmacy service was implemented in collaboration with Better Local Care and 11 West New Forest GP Practices. The service provides pharmacist-led clinical medication reviews for patients with complex needs, including those with multiple long term conditions, care home residents and patients at high risk of admission to hospital. 6,794 medication reviews have been undertaken. Over 1,717 medications have been de-prescribed (stopped) reducing potential harm. Patient feedback has been good and for every £1 invested, £2 has been saved.

3.2.6. Children's Community Clinics

Paediatric Community Clinics have been introduced in Eastleigh, Chandler's Ford and Romsey.

The clinics are based on the Imperial College NHS Trust model in which a paediatric consultant goes out to practices every five to six weeks, starting with a Multidisciplinary Team meeting.

Connecting Care for Children (CC4C) is a paediatric integrated care model introduced by paediatricians at Imperial College Healthcare NHS Trust working with local GPs, commissioning leads and social care partners. It has improved the way children's care is commissioned, delivered and experienced across northwest London

The clinics provide an opportunity for clinicians to discuss the management of complex cases and for GPs to receive specialist advice and guidance. The clinics facilitate the provision of care closer to home and reduce outpatient attendances through a one-stop approach.

3.2.7. End of Life Care

During the year we developed an enhanced end of life care service for patients living in Totton. This was introduced on 1 April 2018 giving people a choice between Oakhaven Hospice, Lymington or Countess Mountbatten House at West End.

More people are also now able to be supported to die at home with dignity and respect through joint work with Countess of Brecknock House to provide hospice at home care for people living in the Winchester and Andover areas.

3.2.8. Carers

We recognise that statutory care services are supported by unpaid carers – usually a relative or friend – and we are committed to supporting carers. We helped develop a 'resilient carers' programme'.

We also worked with local authority colleagues to ensure home (domiciliary) care provides effective support for families and carers.

We provide a grant with partners for the Princess Royal Trust for Carers in Hampshire, to support carers by giving advice and information on anything from disability aids to benefits claims as well as emotional support.

This year we have been working with Hampshire County Council and Carers to develop a Joint Carers Strategy 2018 to 2023 which sets out a new vision for supporting carers in Hampshire. The draft strategy was written by:

- Carers
- Staff from the voluntary sector
- Health and social care professionals.

The strategy sets out practical steps that social care and health organisations, with carers, will take over the next five years. The aim is to ensure that carers have good levels of health and wellbeing and are supported to maintain their caring relationships.

3.3. Improved access to specialist care

Many patients require specialist input into their care plans, and we are developing services to improve access to this advice. We are also reviewing the process for referring people to specialist care so they get the help first time.

3.3.1. NHS Rightcare

We benchmark ourselves nationally using NHS Rightcare programme resources to compare ourselves with other CCGs against financial and quality criteria.

We have been focusing attention in the following areas of care in which the programme has highlighted opportunities to improve:

- Gastroenterology, providing increased access to newer less, invasive forms of investigation
- Trauma, improving with our county council colleagues, services including in care homes, to prevent falls that often result in fractures
- Orthopaedic/ Musculoskeletal working with providers of health care to ensure people are fully aware of the both the benefits and the risks of hip or knee replacement surgery to ensure they make an informed choice. This has resulted in a 3% increase in patient reported health gain following surgery

- Respiratory, including fast access to more transportable forms of home oxygen, support with use of inhalers, support in a crisis and rehabilitation for people with asthma or Chronic Obstructive Pulmonary Disease. This year we have seen an 8% reduction in emergency admissions for asthma.

Other commissioning achievements include:

- New Deep Vein Thrombosis treatment pathway at both University Hospitals Southampton and Hampshire Hospitals Foundation Trust. This has simplified the pathway so that people go to the right place first time for their care
- We continue to develop our use of the DXS clinical decision support system, to enable GPs to access evidence-based care pathways, referral forms, patient education and support tools during a consultation. During the year we strengthened clinical leadership of DXS, to ensure the system reflected more fully the needs of GPs and their patients. DXS is installed at all practices.

3.3.2. Electronic Referrals

Electronic referrals continue to increase allowing patients to choose the most suitable time and place for their appointments. Over the year, electronic referrals have been introduced in more specialities by providers and now account for 84% of all referrals.

3.3.3. Community cardiology

Demand for heart services has been increasing every year, both nationally and locally, so following feedback from local people, we commissioned a pilot community cardiology service to improve access. The community-based Tier 2 Cardiology pilot is provided by Mid Hampshire Healthcare and has now been extended.

Patients with heart-related conditions from the Winchester and Andover areas are referred by their GP to the Community Cardiology service, which provides the following services: electrocardiograms (ECGs), heart scans (echocardiograms), clinical assessments and management advice. It is available at the following four practices:

- Charlton Hill Surgery, Andover
- Friarsgate Surgery, Winchester
- Wickham Surgery, Wickham
- Watercress Medical Centre, Medstead
- Fryern Surgery
- Park and St Francis Surgery

We have also developed ‘carousel clinics’ to support people with Long Term Conditions. Carousel clinics bring together professionals and specialists from several areas of healthcare so patients can have all the tests and consultations they need in just one visit.

3.3.4. Community audiology

We are very proud that the CCG’s Community Audiology service has been named as a finalist in the 2018 Health Service Journal Value in Healthcare Awards.

We have commissioned a single community-based audiology service for people with hearing impairment as part of a plan to improve local services, meet an increasing demand and avoid duplication.

We recognised that people were experiencing long waits for hospital-based aural care and that demand for the service was increasing by about 15% each year.

The new service was designed in collaboration with local people and patients, who took part in a series of engagement meetings and surveys.

3.3.5. Community respiratory services

We continue to promote the Community Integrated Respiratory Service with GPs through the locality meetings and TARGET events (Time for Audit, Research, Governance, Education and Training). We have also adopted the recommended MyCOPD self-management online programme

Practices are running the nationally-acclaimed GRASP Tool to improve identification of people with Chronic Obstructive Pulmonary Disease (COPD) and asthma.

Three practices in Totton have signed up to a research project to help identify, assess and treat patients with Chronic Obstructive Pulmonary Disease (COPD) or Asthma. This project is run by our local CLAHRCs (collaborative partnership between Southampton University and the surrounding NHS organisations, focused on improving patient outcomes through the conduct and application of applied health research).

3.3.6. Community Diabetes Service

This service has for some years provided access to community specialist consultants and to structured education for newly diagnosed Diabetics. Our service reports that in 2017/18 over 750 people attended group sessions to

- Help understand diabetes
- Keep well by diet, exercise and better for care
- Self-monitoring.

This equates to 65% of new diagnoses in the year.

In 2017/18, our community service ran a new project “WISDOM”, supported by national NHS transformation funds. It provides refresher courses for people who have had Diabetes for a while and supports GPs to improve the management of blood sugar, blood pressure and cholesterol for all people with diabetes.

3.4. Integrated urgent and emergency care

We are working to deliver the seven national priorities for urgent and emergency care.
A key focus is the delivery of integrated urgent care – ensuring that services are joined-up and simple, making it easier for people to access the right care, at the right place, at the right time.

Lymington New Forest Hospital was accredited as an Urgent Treatment Centre in December 2018 as part of the Wave 1 national programme. The service provides a seven-day, GP-led model, providing treatment for minor illness and injury.

There continues to be a high level of focus across Local Delivery Systems to reduce delayed transfers of care to ensure that no patient remains in hospital longer than necessary. Key areas of delay remain home packages of care and nursing and residential home placements which account for the highest proportion of NHS and social care delays.

Our priorities are to:

- Create sustainable acute, primary and community care services and join up care to avoid duplication
- Support patients with increasing frailty, complex needs and long terms conditions
- Adopt a 'life course' approach to support people with mental health issues, to increase the effectiveness of interventions throughout their life.
- Promote and sustain healthy ageing.

3.5. Developing primary and community care

We want to extend health and care services and provide care closer to home, reducing the need to travel.

Practices are working together to provide care across a local geographical area covering a population of 30,000 – 50,000. This is known as a 'local hub' and can be virtual or co-located in a single building.

Area Hubs provide services to a wider population of 100,000+ and include more specialist care, diagnostics and inpatient beds.

3.5.1. Extended Access to Primary Care

People living in West Hampshire now have improved access to both advance and same day appointments from (as a minimum) 6.30pm – 8.00pm weekdays and at weekends. The service is provided from the following locations:

- Lymington New Forest Hospital
- Ringwood Medical Centre (satellite hub - Saturdays only)
- Romsey Hospital
- Andover War Memorial Hospital
- Badgers Farm Surgery, Winchester
- Hedge End Medical Centre.

People can access appointments via their own GP Practice or via NHS 111. The total number of hours available per week is 410; equating to 1,639 appointments. The service is GP-led but provided by a range of professionals.

3.5.2. Eastleigh Health and Wellbeing Centre

We are working closely with local organisations and Eastleigh Borough Council to explore the potential development of a health and wellbeing centre In Eastleigh. The proposed centre could enable a wide range of physical and mental health services to be provided from a single building, facilitating the provision of joined-up, holistic and person centred care in a modern and fit for purpose environment.

In line with our Integrated Care Model, this will facilitate the delivery of primary care at scale, with greater collaborative working to meet the future needs of local people within a community of 30,000+.

Eastleigh has a high number of people of working age and higher levels of deprivation amongst older people and children, resulting in a greater need for health and social care. The population is expected to grow significantly in Eastleigh and neighbouring areas by 20% over the next 20 years, with 16,250 new homes planned by 2036 (provisional planning assumptions).

Under the proposed scheme, three town centre GP practices could relocate into one building together with services such as:

- Children's community services
- Sexual Health services
- Mental Health services
- Community nursing and social care
- Physiotherapy and podiatry
- Community dentistry
- Community outpatient services such as audiology, dermatology and diabetes clinics
- Pharmacy
- Lifestyle services such as stop smoking and weight management
- Citizen's Advice
- Wellbeing café.

Feedback from local people and stakeholders has been supportive, with people highlighting the benefits of more accessible health and wellbeing services in one centrally located building, Further engagement will take place during May and June 2018.

The outline business case for the development of the proposed centre was approved by West Hampshire CCG Board in January 2018. Further work is progressing to develop the Full Business Case.

3.5.3. Andover

Our vision for Andover is for Integrated Extended Primary Care Teams based around GP practices working collaboratively, either collocated or virtually, delivering a wide

range of co-ordinated, joined-up care, supported by appropriate diagnostics and technology. This will include community, mental health and outpatient services, so that patients have their care in one place rather than multiple appointments in different locations and the development of an Urgent Treatment Centre.

We are working with the five GP Practices in Andover to develop new ways of working in order to provide more care locally and improve access to care, enabling primary care clinicians to focus on those patients who need their support most. We are planning to develop an Integrated Health and Wellbeing Hub in Andover which will open up opportunities for GPs to work more closely together and to expand the range of services available.

We know that poor quality buildings impact on our ability to improve care and for GPs to manage the expected growth in their local populations, as well as manage increasing numbers of patients with much more complex needs. Improvements to our GP buildings is essential to enable GPs to work more closely with specialist clinicians and to provide the range of access points from which services can be delivered. The CCG successfully bid for funding to improve some of the poorest estate in Andover. Some improvements to GP Practices' buildings in Andover have been completed and other changes are being planned.

Options to replace Andover Health Centre are being developed and we are expecting to have a preferred option agreed in July 2018.

3.5.4. Brownhill Surgery

Brownhill Surgery was a medium size practice of almost 7,000 registered patients serving the Chandlers Ford area. West Hampshire Clinical Commissioning Group was given 6 months' notice by the GP's of Brownhill Surgery to end their contract to provide general medical services on 30 November 2017. This decision was taken by the GPs (as independent contractors) as a result of a retirement of a GP at the Practice, difficulties in recruiting GPs and increasing workload pressure.

Feedback on whether patients registered with Brownhill Surgery wished to choose their local practice or be allocated was gained through a local survey and four local engagement events. The survey was open from 19 July 2017 to 11 August 2017. 1,648 surveys were completed both on-line and written. Overwhelmingly (88%) of patients wanted choice – the ability to choose their own Practice. The local public engagement events were held in July and August and were attended by 429 people.

82.5% of registered patients were allocated their first choice of practice. The remainder of patients did not express a choice and therefore were registered with their nearest GP Practice.

Brownhill Surgery closed on 30 November 2017. All patients registered with a local GP Practice, ensuring continued local access to primary care services.

3.5.5. Ashurst Hospital

Ashurst Hospital was originally built as a workhouse in 1836. It currently provides accommodation for the New Forest Birth Centre, Child and Adolescent Mental Health Services (CAMHs) and a paediatric audiology service, together with administrative services.

The New Forest Birth Centre is accommodated in a relatively modern unit and its facilities have been updated to ensure it is fit for purpose for the delivery of high quality maternity services.

The Child Development Unit, from which the CAMHs and audiology services operate, is situated in the oldest building on the site which is in a poor condition and not fit for the future provision of modern healthcare services.

Our vision is to develop an integrated centre for children, young people and families with the co-location of services, enabling the provision of holistic, person centred care. This is in line with our Integrated Care Model.

Early engagement with young people and families living in Totton and Waterside and West New Forest demonstrated that there is significant support for the vision and that Ashurst is considered to be local and accessible. 323 surveys were completed, visits undertaken to voluntary organisations and parent support groups and a public event held to hear the views of local people. Work is now progressing to look at options for future provision and next steps. Our aim is to develop an Outline Business Case to be considered by the West Hampshire CCG Board in September 2018.

3.5.6. Hythe Hospital

In August 2017 we submitted our plans for redeveloping Hythe and Dibden War Memorial Hospital. The proposal includes building a smaller community hospital that provides modern and high quality clinical space and is also environmentally sustainable. One of its features will be a living, or sedum, roof.

We recognise the importance of the hospital's 'memorial' status and are working with the local community, particularly the League of Friends and British Legion, to preserve this.

As part of the development, some land will used for residential development - around 21 new homes – which supports the need for local housing without losing green belt or New Forest land.

Consultation with local people

Stakeholder engagement on the proposed development has been ongoing for many years, and in 2017 included:

- Individual stakeholder meetings
- Public and staff drop in sessions
- Press releases in local newspapers (Daily Echo and Hythe Herald) and local radio stations (Wave 105 and Heart Radio)

- Newsletters to stakeholder groups.

Patient and public engagement

We held drop in meetings for staff and for local people in July 2017 at Hythe Hospital.

We displayed the plans on boards at these meetings and local people spoke to the project team to find out more details. Around 150 people attended the meeting.

Comments we received included:

- The importance of the War Memorial to the local area
- The importance of retaining a hospital on the site
- Car parking and vehicle access
- Design of the buildings
- Conditions for staff/patients/residents during the construction period
- Internal layout and facilities within the new hospital
- Questioning the need for residential development and what if the land is needed for future healthcare expansion
- Drainage issues
- Affordable housing is needed.

New Forest District Council's Planning Committee is currently considering the planning application.

3.5.7. Milford-on-Sea War Memorial Hospital

Milford on Sea War Memorial Hospital was built in 1930 by the local community as a War Memorial Hospital. In 2000 there were 19 beds but these were closed in 2007 following the opening of Lymington New Forest Hospital. The hospital now provides accommodation for a number of community clinics, a 6 chair dialysis unit and a pharmacy.

We are working with the community to look at options for future provision to meet the health and well-being needs of local people. Two public meetings were held on 31 October and 8 November and attended by over 300 people, with local people from Milford on Sea and the surrounding area able to talk to representatives from West Hampshire Clinical Commissioning Group about the hospital and their healthcare needs now and in the future.

Feedback from the public meetings is being used to inform the options and next steps.

3.5.8. Transforming care services in north and mid Hampshire

A key priority within the north and mid Hampshire Local Delivery System is to ensure services are clinically effective and financially sustainable and to provide more joined up local care across hospital services, community, primary and social care.

We worked with our partners at North Hampshire CCG and Hampshire Hospitals NHS Foundation Trust to consider all options for hospital and critical care in the area – at Andover, Winchester and Basingstoke.

Our vision was to ensure local people had:

- High quality care in and out of hospital in line with national best practice
- Joined up local care close to home or at home, focused around the patients' whole needs
- Less reliance on acute hospitals
- Benefits of rapidly developing technology.

Our case for change was based on the well-documented shortages of health and care staff, an increasingly challenging financial situation and people living longer with complex needs.

We were also conscious that the quality of local health care services was variable and the current configuration of acute services in north and mid Hampshire is likely to be unsustainable under seven-day working.

We addressed six key questions:

- What is the case for change from a clinical, workforce and financial perspective?
- What evaluation criteria should be used to assess the potential service configuration options?

- What are the range of clinical models that could underpin any future service configuration options?
- What is the shortlist of service configuration options that we should spend time subjecting to more detailed analysis?
- How do those options stack up against our evaluation criteria?
- What preferred option(s) should be taken forward to public consultation?

Following detailed analysis of the all the options, and advice from the Clinical Reference Group, the Programme Board proposed to take two options to a joint meeting of the Boards of North Hampshire CCG and West Hampshire CCG.

- Critical Treatment Hospital at Junction 7, Local General Hospitals at Basingstoke and Winchester
- Critical Treatment Hospital plus at Basingstoke and a Local General Hospital at Winchester.

At a meeting in November 2017, both CCG Boards concluded that a proposed critical treatment centre was not affordable, given the financial challenges facing the local NHS. This meeting attracted considerable media coverage, including live reports on BBC South Today's lunchtime and evening programmes.

The Board agreed to continue to develop and implement plans for joined up local health services both in and out of hospital. This work includes plans to centralise services within the Trust's sites at Andover, Winchester and Basingstoke, and to ensure patients continue to have access to the safest and highest quality care.

The Boards agreed that it was not appropriate to proceed with formal consultation on a future configuration of acute services for the people of north and mid Hampshire.

The two CCGs and Hampshire Hospitals NHS Foundation Trust will continue to work together on this – and with other partners such as local community services and local authorities – to make this vision a reality.

The CCG has supported a review to identify how best to configure services between the sites at Winchester, Basingstoke and Andover. An independent estates survey of these sites was completed at the end of January 2018.

The Trust has also reviewed some of its clinical services to identify whether there are opportunities for further centralisation of some services. This work was completed by the end of March 2018.

Public engagement

The work was underpinned by an engagement programme with local people carried out by an external independent market research company.

The engagement work included:

- On-street interviews (1,083) in Basingstoke, Winchester, Andover, Eastleigh, Alton,
- Bishops Waltham, Romsey, Hook, New Alresford, Stockbridge, Tadley, Odiham,
- Chandler's Ford, North Waltham, Whitchurch and Overton.
- 608 online questionnaires were completed (29% were by NHS employees, 71% not).

- Six focus groups were conducted across the Hampshire and West Berkshire area with a range of demographic profiles that reflected the overall demographics of the area.
- Six local community group sessions were also attended with hard to reach and seldom heard groups as follows: elderly people, carers, BME - Nepalese, homeless and residents of social housing, deaf and hearing impaired.

We also carried out a series of ten in-depth interviews with representatives of a range of harder to reach groups, including the following organisations:

- Southern Health NHS Foundation Trust
- Basingstoke and Deane Borough Council (homeless and socially isolated)
- Age UK Hampshire (elderly)
- The Voice (mental health)
- Carers Together
- Hart Voluntary Action – (mental health amongst young people)
- Dementia Friendly Hampshire (long term health conditions)
- Hampshire Neurological Alliance (long term health conditions)
- Basingstoke and District Disability Forum (all disability types including physical and learning)
- Basingstoke Day Opportunities (physical and learning disability and brain injury)

Two further interviews were conducted with the chief executives of Basingstoke and Deane Borough and Winchester City councils.

4. Services for people with a mental health condition or a learning disability

We are the lead commissioner for adult mental health and learning disability services across Hampshire. We are committed to achieving parity of esteem (valuing mental and physical health equally) so mental health support is embedded cross the system and not seen in isolation.

4.1. Mental Health Services

The Five-year Forward View for Mental Health, the Dementia Implementation Plan the STP Mental Health Alliance's plans and the Wessex Clinical Network's strategic vision provide a blueprint to improve services.

As part of the STP programme, we aim to transform acute and community mental health pathways, rehabilitation and mental health crisis pathways, reduce out of area placements. Within West Hampshire our goal is to improve dementia diagnosis rates and more importantly provide support once a diagnosis is made.

Our achievements over the past year have been as follows:

- Working with Hampshire County Council to expand the work of wellbeing centres to provide more peer support and follow up after a crisis visit to a hospital emergency department. We aim with this work to improve resilience and provide earlier alternatives to seeking help in the community.

- Putting in place, with our acute trusts, staff and systems to improve psychiatric assessment and care for the thousands of people who present in a mental health emergency to general hospitals.

- Working closely with our partners across mental health services, the police, ambulance services and the local authority to ensure that

    - No-one experiencing a mental health crisis is held in a police cell as a place of safety
    - A new provider is in place to support people who are picked up by the police and taken to a place of safety under section 136 of the Mental Health.
    - The needs of specific individuals who frequently use emergency services are considered regularly to support them differently.

Improving access to a range of mental health services including:

- Psychological (talking) therapies
- Early intervention in psychosis teams

- Autism and Attention Deficit Hyperactivity Disorder diagnosis
- Working closely with Southern Health NHS Foundation Trust to improve the quality and governance of its services
- Our dementia diagnosis rate rose to 62% and we are striving to achieve higher than 67%
- Our dementia advice and support service has been expanded to help people who do not yet have full dementia but whose memory is impaired enough for them to need help and monitor their condition
- People living with dementia in New Milton and Barton on Sea have new opportunities to find support and friendship through community cafes which provide support information and friendship for those living in the community. This is supported by the Alzheimer's Society and GPs from New Milton Medical Centre.

4.2. For people with a learning disability

We lead the SHIP (Southampton, Hampshire, Isle of Wight and Portsmouth) Transforming Care Programme. This programme aims to reduce reliance on inpatient care for people with a learning disability and/or autism. Our achievement include:

- Across the partnership 33 people have moved out of hospital into successful community placements
- We have developed a “Better Support” database to help spot when crises are developing and intervene to prevent the need for admission to hospital
- Over 180 supported living placement have been provided to increase the capacity overall of good quality living environments for people when they leave hospital
- We have commissioned a new community service for people with a Learning Disability who have committed low level crimes This means that they do not have to live in hospital for ever because of this
- We have increased the proportion of people with a learning disability receiving an annual physical check and plan with their GP to 58%. We aim for 65% next year. This work builds on the developments achieved by our GP practices that have already been given the status ‘learning disability friendly.
- We aim to improve the ability of mainstream health services to make reasonable adjustments for people with a learning disability. New learning disability liaison workers have therefore been put in place in Hampshire hospitals to achieve this, similar to those already working at UHS and Portsmouth. In February 2018, we hosted a Hampshire-wide conference with hospital providers to improve hospital experience for people with a learning disability.

4.3. Promoting mental health and wellbeing at work

In February 2018, the CCG Chief Officer and Deputy Chair (pictured left) signed the Time to Change pledge to promote mental health and wellbeing at work.

The CCG's support for the campaign, which is led by the charities Rethink and Mind, followed feedback about mental health and resilience at our staff away day in 2017.

5. Children's and maternity services

West Hampshire CCG has ambitions to improve the quality and effectiveness of services for children, young people, families and pregnant women. We work collaboratively with colleagues in health, children's services in Hampshire County Council and Public Health to achieve this.

Our aims include:

- More information about healthy life choices for children, families and pregnant women
- Ensuring that children who are acutely unwell are seen by the most appropriate person, with the right skills, in the right place. Wherever possible this will be close to home. Families are supported to keep children at home where this safe
- Developing emotional resilience in all young people and improving access to mental health services for those who need extra care
- Greater choice around birth plans for pregnant women
- Improved safety for pregnant women and their babies
- Better planning for children and young people who have extra health needs with relevant care plans and personal health budgets to improve choices available to families
- Better transition for children to adult services.

Children's and maternity services are commissioned across Hampshire by North East Hampshire and Farnham CCG, acting as the lead commissioner.

The shared vision is for improved and integrated models of care for children, young people and families so that all children will live healthier lives and able to reach their full potential

5.1. Maternity and babies

We have been working across Hampshire and the Isle of Wight to ensure maternity services are developed to better meet the needs of women. A key priority is to enable more women to make real choices about where they receive care before and after their baby is born, and where they birth their baby.

This work involves the local hospital services, community midwives, patient representatives and commissioning groups across the whole of Hampshire

and the Isle of Wight working together. By working across traditional boundaries of care we will make it easier for women to receive care that fits their needs more closely. We are one of seven national Maternity Choice and Personalisation Pioneer sites for this work which aims to ensure that all expectant mothers are aware of all the choices available to them for the care they receive, including where, when and how they have their antenatal appointments, as well as where and how they give birth. We have developed a website, app and a booklet to share with women. Further details can be found via the 'My Maternity' website at https://mymaternity.org.uk/.

A key aim is to improve the safety of pregnancy for both mother and baby. We are reducing the number of still births and babies needing enhanced care after birth through a number of initiatives including supporting women to stop smoking in pregnancy, measurements of growth throughout pregnancy and raising awareness of the importance of reporting changes in foetal movements which can give an early indication of developing problems.

As part of our regular engagement, we listen to the views of pregnant women and those who have had their babies.

We work closely with the Hampshire Maternity Services Liaison Committee who represent many local mums and provide information and useful links on their active Facebook page.

We liaise closely with involvement groups, run through local hospitals, to understand areas that are working well and others where improvements are needed. The detailed comments from parents are fed back and inform our commissioning decisions for children and maternity care.

We have listened to parents who have requested more information about both breast feeding and bottle feeding.

We continue to work with colleagues in midwifery, health visiting and the voluntary sector to ensure that women that chose to breast feed are well supported.

We have produced a booklet which health visitors can use with parents who choose to bottle feed. This gives balanced advice on all types of infant feeding and practical advice for both breast feeding and bottle feeding mothers including how to make up bottles safely and how to know when a bottle or breast fed baby has had enough to eat.

We also recognize that there are babies with common feeding problems in infancy. Sometimes they will need advice about medication to manage symptoms or changing the milk that is fed to the baby.

We have worked with colleagues in North Hampshire CCG to develop Infant Feeding Guidelines to support those looking after babies with feeding issues or allergies.

The guidelines have been created in collaboration with Health Visitors, GPs, Paediatricians and dieticians. They aim to help parents get effective advice as quickly as possible so their baby has the correct treatment as early as possible.

5.2. Children's community care

We have gained some national funding to support the development of a pilot project across Hampshire to bring together Paediatricians, GPs and Health Visitors in local practices on a monthly basis to discuss concerns or plans of care for specific children or a discussion on the appropriate management of a child in the community. Many of these children would otherwise have been referred to a hospital for an outpatient appointment. The clinics will also offer the opportunity for families that do need to see a pediatrician to do so at a local practice surgery and for the General Practitioner or Health Visitor to accompany them if that would be helpful. For some families, this will result in a much shorter wait to get specialist advice and will reduce the need to attend a hospital. We have two clinics running in West Hampshire covering seven practices and a third starting imminently. This work is modelled on a successful project which has been running in London. Early feedback from parents and children has been excellent.

We have continued to promote and develop resources for the 'Wessex Healthier Together Resources' website (https://www.what0-18.nhs.uk/) and App in collaboration with partners across Wessex. This includes advice for children, young people, parents and carers, pregnant women and professionals working with children and pregnant women around common conditions. This gives clear advice around self-management of conditions and when you should seek further advice and how quickly. We also, in partnership with Public Health, provided a one page leaflet on recognitions of common conditions and advice as to whether a child needed to stay off school. This was distributed to every child in Hampshire through their local school.

5.3. Child and Adolescent Mental Health Services (CAMHS)

We have worked closely with Sussex Partnership NHS Trust, which provides our CAMHS services at Ashurst Hospital; the Bridge Centre, Eastleigh; Avalon House, Winchester and Advertiser House in Andover.

A Single Point of Access is now available to help young people and their families and carers navigate their way round the service. Referrals can come from families, GPs, schools and other individuals in contact with young people. The Single Point of Access can directly refer to other local services such as counselling services or parenting courses if that is thought to be the most appropriate help for the needs of the young person.

The Eating Disorders Service has put in place a process to see young people quickly after referral, which is in line with national priorities.

We have improved our care for young people with Attention Deficit Hyperactivity Disorder (ADHD) by training community pharmacists to carry out routine physical checkups. This simple change has improved the experience for both young people and their families because they have continuity of care in a familiar place, close to home.

This initiative has received national recognition.

Sussex Partnership Trust has launched a new website for Children and Young people in Hampshire at https://hampshirecamhs.nhs.uk/. This was co-produced with extensive input from children and young people and contains lots of information to support them.

We worked with the Trust to provide workshops for parents/carers and have run education sessions to upskill health and care professionals.

In September 2017 we worked with the Trust on their Starfish and Faces of You campaign, which highlight the issue of suicide among young people and the impact on their families.

Our Chairman, Dr Sarah Schofield, attended the opening of the Faces of You photograph exhibition and said:

“Suicide has a lifelong effect on many, many people but the impact is often unspoken and sometimes hidden. We heard from a police officer who talked about the role the police play in every unexpected death and he helped us to understand that professionals, who have to deal with the impact of an individual’s decision to take their own life, are affected on a daily and an ongoing basis. We heard from the mother of a daughter who killed herself. It was an inspirational and thought provoking exhibition.”

6. Quality Report

We discharged our duty under Section 14R of the National Health Service Act 2006 to improve the quality of services.

6.1. Quality overview

The CCG had an active programme of quality assurance and improvement with providers across primary care, community and care homes and independent, voluntary and acute sectors to ensure commissioned services met the expectations of our population and delivered high standards of care for everyone.

This involved working in partnership to ensure services were accessible, clinically effective and responsive to people's needs with a focus on continual improvement and preventing harm.

We continued to hold organisations to account for the quality of their services, through monitoring and benchmarking performance data, gathering feedback from service users and carrying out regular clinical visits and problem solving exercises (deep dive reviews).

6.1.1. Governance arrangements

We have strong quality assurance monitoring and the Primary Care Quality Monitoring and Care Home Quality Groups collate and analyse quality data and support providers with interventions and specialist reviews.

The Clinical Governance Committee brings together quality intelligence and risks from across the healthcare system and members discuss standards, risks and assurance.

We hold monthly meetings with the Care Quality Commission to improve information sharing and collaboration and we carry out peer review and assurance visits by CCG doctors, nurses and clinical specialists at providers' premises to ensure the quality of services.

Our team takes part in mortality group meetings and Serious Incident panels to help embed quality assurance within providers' assurance mechanisms and we work closely with neighbouring CCGs to ensure we collaborate and share information that benefits patients.

We have expertise within the Quality Team in quality improvement methodology, mental health, primary care nursing, infection prevention, safeguarding, medicines management and leadership to support providers to take prompt action when things go wrong or standards fall below expectations.

6.1.2. Support for CCG projects

During the year the Quality Team supported several specific pieces of work in response to areas for improvement, including the Wheelchair Service Review and an extensive review of local Emergency Departments based on the learning from the CQC inspections at Portsmouth Hospitals NHS Trust. This included a focus on patient privacy and dignity, safeguarding of young children, the prevention of harm during busy periods, medicines management and patient experience.

We supported our GP practices ahead of Care Quality Commission visits and provide ongoing support where needed.

We have embedded the Datix Significant Event recording and learning system for GPs to share learning, prevent patient harm and inform service improvement initiatives. This programme has identified key priorities including electronic referrals, advice to patients waiting for urgent appointments and processes for managing confidential or protected data.

6.1.3. Partnership working

We also worked with providers to resolve backlogs in Serious Incidents and ensure cases are reported and investigated within the mandatory timeframes. By signing off learning and actions we are providing assurance to patients and families that lessons have been learned.

We worked with the provider of the Multi-Agency Safeguarding Hub (health) to review activity, workforce and processes with a view to ensuring that a consistent service that meets the needs of vulnerable children and partner organisations is sustained.

We also reviewed stroke services across west Hampshire from referral to discharge to identify best practice and sharing this across the region to achieve equity of service for patients.

We have also continued to publish to Quest for Improvement (Q4I) bulletin to spread examples of good practice and initiatives across all providers.

6.1.4. Safeguarding

We have sought the views of Looked After Children and Care Leavers to hear their experiences of accessing and receiving health care and support to inform the CCG's future priorities

We recruited a Designated Doctor for Looked After Children to fulfil the CCG's statutory obligations.

The CCG has continued to drive quality improvement throughout the year.

We further developed the specialist GP Hubs to undertake Initial Health Assessments for Looked after Children across Hampshire which ensures that vulnerable children have a thorough assessment to ensure their health needs are clearly identified and addressed by doctors with a special interest.

The hubs have received encouraging reviews from foster carers, children and clinicians, with foster carers reporting very positive experiences around quality *(see quote to the right).*

"The doctor put both boys at ease, very understanding and considerate and took time carrying out the medical. Before going to the doctors both boys were apprehensive of going. On leaving the appointments they had no concerns; in fact the eldest said 'it was not like he thought it would be'.

"Our Practice takes great pride in being able to provide this service, recognising the vulnerability of the children we are seeing and wanting to help. I have enjoyed meeting the children/young adults during the health assessments. I have found the carers to be very supportive, well informed and helpful during the consultations. Overall I find the whole infrastructure provided by the CCG for Child Safeguarding organised and supportive. I have nothing but praise for it."

6.1.5. Working with care homes

Our Nurse Facilitators support 19 care homes during and following safeguarding processes to ensure that they have the necessary leadership and skills to deliver sustained improvements in care.

We supported the development of good governance and quality arrangements in the north and mid Hampshire Local Care System with partners

During the year we rolled out the Adult Physical Observation and Escalation Chart which includes the National Early Warning Score (NEWS) to over 35 care homes to help staff to identify residents at risk of physical deterioration.

This is an excellent way to support early treatment of residents, to prevent more serious illness and avoid or reduce the need for hospital admission. For example, a care home reported that because of the CCG's initiative a resident with a high NEWS score had been identified and the GP had the necessary information to respond promptly.

Care home staff discussed options with the resident's and they jointly decided that it was in the resident's best interests to stay at the home rather than go to hospital.

Another member of staff identified a resident who was flushed and shivery and recalled the soft signs of deterioration on the NEWS chart so called the out of hours immediately who visited within four hours. The resident had a short hospital stay before returning to the home.

We have introduced 'safety huddles' into a number of local care homes to successfully reduce falls by implementing proactive learning strategies. Safety Huddles are used to increase safety awareness among front-line staff and help teams/organisations to develop a safety culture

By joining a local hospital and two care homes to participate in the Mid Hampshire End of Life Care Quality Improvement Fellowship, we have reduced to two hours the time taken to transfer someone who is dying to a care home to receive End of Life Care.

We have continued to improve hydration among care home residents through novel projects such as smoothie making which has a positive impact on reducing falls, pressure ulcers and urinary tract infections. A resident who expended a lot energy walking all day and had poor nutrition and hydration sat for the smoothie session, enjoyed choosing ingredients and drank two high calorie smoothies. Homes are using these approaches to improve hydration

6.1.6. Promoting positive patient experiences

We promoted positive experiences for people with a Learning Disability who receive hospital care. We are working with our providers to develop local qualit y indicators with local NHS Trusts.

We hosted a workshop to improve patient experience, involving people with a learning disability and first-hand experiences of acute care, local experts and charities such as Mencap (see picture right) to promote high quality care

6.1.7. Supporting mental health services

We also supported our mental health services by producing credit card referral resources for GPs to ensure that people with mental health needs are referred to the right services in the most appropriate timeframe. This will help our mental health colleagues spend less time on triage and more time on supporting and treating patients

6.1.8. Supporting primary care

We supported primary care services and care homes through professional forums such as the Infection Control Leads meeting and Practice Nurse Forums which provides networking and educational opportunities to staff. This benefits patients by ensuring they are protected from the risk of healthcare-associated infection and that our workforce has the right skills

6.2. NHS Continuing healthcare

West Hampshire CCG hosts the NHS Continuing Healthcare (CHC) and Funded Nursing Care (FNC) service for the five CCGs in Hampshire. This service coordinates eligibility assesssments for CHC and FNC, commissions packages of care to meet the needs of people who are eligible and monitors the quality of the care provided.

Every month we consider on average:

- 100 CHC applications
- 200 Fast Track applications
- 150 FNC applications
- 20 retrospective reviews

- 15 local appeals.

The CCGs invested in the service to ensure we are able to improve response times for completing NHS Continuing Healthcare assessments.

2017/18 was a year of transformation and we recognise that the service is still under pressure. We delivered three programmes of work.

6.2.1. Increasing staff numbers and improving the quality of our service delivery

- Staffing numbers increased from 40 to 80
- Hub and locality teams established across Hampshire
- Standard operating procedures developed
- The team moved into new office accommodation
- A new telephone system was put in place to handle the volume of calls the service make and receive
- More assessments are taking place in community settings and less in acute hospitals
- More assessments and decisions are taking place within the 28 day target
- More people are being offered and taking up a Personal Health Budget.

6.2.2. Clearing the backlog of cases that had built up during previous years

- 789 cases have been processed to completion
- A further 629 cases will be completed by the end of June 2018
- This work was planned to be an 18 month project, and although it had a delayed start the work will be completed on time

6.2.3. Development of the Funded Nursing Care (FNC) service

- FNC staff have been recruited
- We introduced a new FNC process for all applications from 1 February 2018 that complies with the National Framework

The CHC service has a new leadership team in place. Staffing levels continue to increase. Our plans for 2018/19 are to deliver the national targets of 80% of CHC eligbiltiy decisions being made within 28 days of referral and 85% of assessments taking place in a community setting. We plan to commission Fast Track care much more quickly by having dedicated CHC end of life care available in the community.

We will also be working more closely with Hampshire County Council on commissioning care at home and nursing and residential care for older people and care and support for people with a learning disability.

6.3. Patient experience

We received 1,141 contacts from local people raising complaints and concerns, passing comment or requesting advice and signposting.

The cover a wide range of provider and commissioned services as shown in the table below:

	Complaints	Concerns	Comments advice and signposting	Brownhill Surgery Closure	Compliments	MP / Other enquiry	Total
Quarter 1	50	75	33	N/A	4	21	183
Quarter 2	56	81	58	231	8	20	454
Quarter 3	61	83	49	128	9	2	332
Quarter 4	62	59	43	0	5	3	172
Total	229	298	183	359	26	46	1141

6.3.1. Complaints to the Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman requested complaint files and has ruled on two complaints.

One case related to BMI Healthcare, Sarum Road, Winchester, and was upheld by the Ombudsman. BMI Healthcare was required to reimburse private care costs because it had not explained the patient's option for an individual funding request to the CCG to cover the cost of the procedure.

In the second case, the Ombudsman did not uphold the complaint which related to the CCG's decision not to undertake a full eligibility assessment for NHS Continuing Healthcare following a checklist.

6.3.2. Actions and learning

The CCG continued to demonstrate changes made as a result of the experiences of patients, relatives and carers.

Examples of learning are reported and updated quarterly at the Clinical Governance Committee, and published each quarter on the CCG website.

Ongoing actions are routinely monitored by the team in liaison with the commissioning and quality managers to ensure that improvement actions are robust and routinely implemented across provider and commissioned services.

6.4. Medicines Optimisation

Our medicines team has continued to work with colleagues in primary care to ensure the optimum use of medicines in terms of both prescribing and medicine use. The CCG is committed to involving patients, carers and local people in improving the use of medicines.

In 2017/18 our team of registered pharmacists and pharmacy technicians worked with GPs to improve care in the following areas:

6.4.1. Atrial fibrillation

We continued to work with GPs to identify patients with atrial fibrillation (AF) at high risk of having a stroke and not on optimal anticoagulation treatment. For 2017/18 this included identifying patients prescribed a Direct Oral Anticoagulant (DOAC) checking the indication, adherence to medication, correct dosage for age, weight, kidney function and drug interactions.

As a result, the number of people with AF who were optimally-treated rose, more strokes were prevented and fewer people suffered from side-effects of oral anticoagulant medicines.

6.4.2. Medication review, polypharmacy and de-prescribing

We supported GPs to identify patients who might benefit from a review of their medication regimen because they were being prescribed potentially problematic medicines or just too many medicines (polypharmacy). Patients were called in to discuss their medicines and this initiative included identifying:

- People with a learning disability, assessing their physical and mental health and carrying out appropriate prescribing/ de-prescribing of medications
- Older people living with severe frailty taking more than 10 regular repeat items with a view to de-prescribing and reducing pill burden and risk of falls
- Severely frail older patients on multiple anti-hypertensives with a view to de-prescribing anti-hypertensives (and other medications) if problematic (e.g. causing falls)
- Severely frail older patients on statins with a view to de-prescribing the statin (and other medications) if problematic (e.g. causing muscle pains; high pill burden; poor risk benefit in view of frailty)
- Older patients with diabetes and a low glycated haemoglobin (HBA1c) level currently prescribed a sulfonylurea (SU) for lowering their blood sugar, with a view to de-prescribing and avoiding hypoglycaemic attacks from overtreatment

As a result, fewer patients were exposed to adverse effects of medicines and their treatment was optimised and brought up to date.

6.4.3. Wound formulary

The medicines optimisation team led the implementation of the updated wound formulary to improve patient care and reduce unnecessary spend. We worked with the local tissue viability nurses, practice nurses and care home staff.

This meant that patients received the most effective and cost-effective dressings for their needs and the savings generated could be re-invested in patient care.

6.4.4. Integrated pharmacy

The pharmacy pilot in the New Forest Vanguard and in four other large practices in the CCG enabled pharmacist and technician support to be based in GP surgeries, working directly with primary care clinicians and patients.

This additional resource allowed pharmacist-led medication reviews in high risk patients with frailty, those with multiple long term conditions, care home residents and patients at high risk of admission to hospital including the housebound.

This improved outcomes for the most vulnerable patients and those at risk of harm from medicine combinations. It helped reduce practice workload so GPs and nurses could spend more time with their patients and helped reduce wasted medicines.

6.4.5. Safeguarding Antibiotics

The team carried out root cause analysis for selected patients who had suffered certain bacterial infections such as E.coli and C. difficile.

This allowed healthcare professionals to learn from the circumstances that had led to the infections developing in the first place and to prevent further such occurrences, whilst safeguarding antibiotics.

The team also worked with colleagues in the quality team to discourage use of urine test-strips and antibiotics in elderly patients with bacteria in the urine but no other symptoms of urinary infections. This safeguards the future of antibiotics and helps tackle the growing problem of antibiotic resistance.

6.4.6. Repeat Dispensing

The Medicines Optimisation team helped interested practices identify suitable patients for electronic repeat dispensing. This service enables community pharmacists to dispense regular medicines to certain patients who have been issued batch prescriptions without the involvement of the GP practice at the point of dispensing.

As a result, many patients agreed to try out this new way of obtaining their repeat prescriptions which saves them time. It also helped reduce practice workload so GPs and nurses could spend more time with their patients and helped reduce wasted medicines.

The Medicines Optimisation team actively engaged with patients to discuss how patients can get the best from their medicines.

Presentations were made to a number of practice patient participations groups, patient support groups such as Breathe Easy groups and CCG events such as the AGM and a Health Talk focussed on medicines use.

7. Patient and public involvement

Involvement of local people, patients and carers remains central to our commissioning decisions as a CCG. We continue to value the support, feedback and local knowledge that we receive. As Local Delivery System-working begins to embed further, we recognise that the importance of this insight will continue.

7.1. Involvement Steering Group

The bi-monthly Involvement Steering Group (ISG) provides regular and honest feedback to the CCG on patient involvement in commissioning intentions, proposed new services and service changes.

Members of the ISG include representatives from local Patient Participation Groups, voluntary sector groups, such as Healthwatch Hampshire, Age UK and Carers Together.

The ISG was chaired by Dr Nick Arney, former Clinical Director for Patient and Public Engagement, who stepped down from the role in 2017.

We are pleased to report that Judith Gillow, the CCG's Lay Adviser and a former Director of Nursing, has taken on the role.

We also support other health-specific engagement groups including:

- Neurology Steering Group
- Respiratory Steering Group
- Cancer Steering Group
- West Hampshire Involvement Network (WIN)

Recognising that we need to work harder to understand the needs and views of people who do not attend groups, we have gone to communities in deprived areas in the New Forest and Andover. We had conversations with local people about their particular needs and the barriers they face when using health services. Links with local black and minority ethnic community groups are well established and helps us to review the equality impact of any service changes. For example the impact assessment of the extended access to primary care service (see our website for more details)

7.2. Annual General Meeting

The CCG's AGM was a showcase event to share information about the CCG, its achievements and vision for the future.

The event put into practice our ‘Get Hampshire Walking’ campaign by encouraging people to walk between presentations located around Ashburton Court in Winchester.

Presentations included:

- The Digital Future
- The future of pharmacy
- Future of GP services

In total, all participants clocked up more than 400 steps each.

7.3. Health Talks 2017

In 2017 we hosted a series of Health Talks around our patch focusing on key areas of health need including:

- Getting the most out of your medicines
- Staying fit and well pre-retirement
- Mental health services
- Learning Disability services

The talks provided an opportunity for our clinicians and commissioners to meet local people, share information about local services and gather valuable feedback.

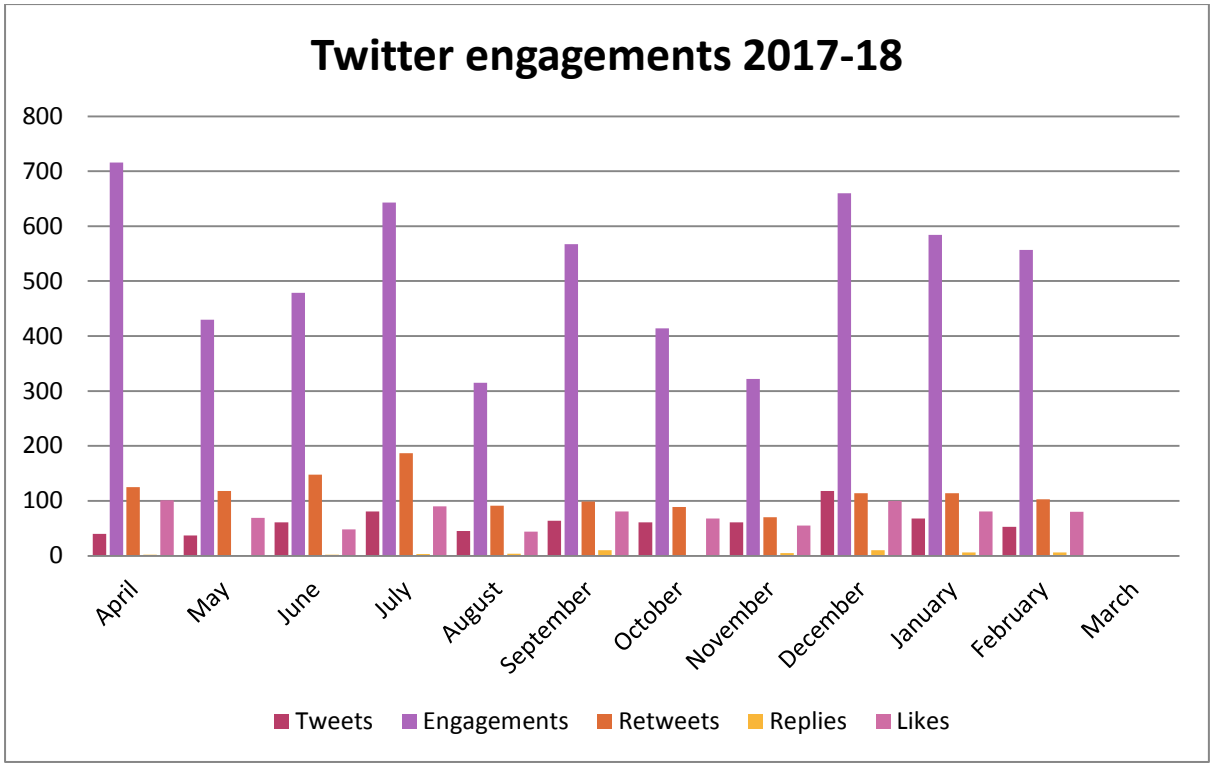
7.4. Social Media

We recognise the important role of social media – particularly Twitter, Facebook and Instagram, as well as YouTube and Soundcloud – in sharing information and providing dialogue.

7.5. Facebook and Twitter

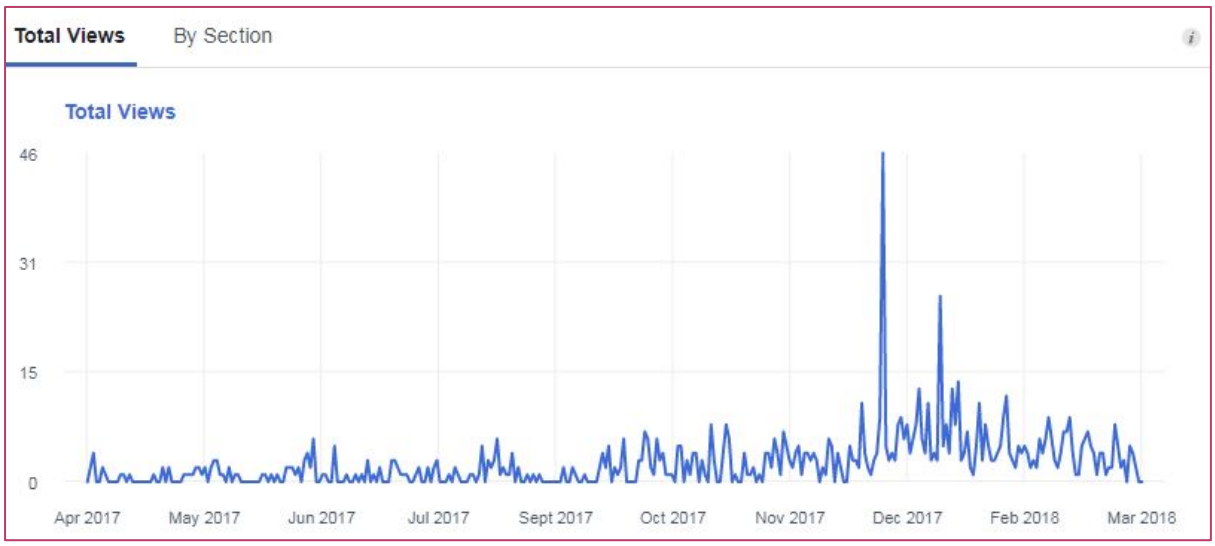
During 2017/18 we increased our engagement on Facebook and Twitter.

We have nearly 6,000 followers on Twitter and tweeted 689 messages (to March 18) during the year. The chart on the next page shows the engagement rate per month. Our monthly tweet rate ranged from 37 (May 2017) to 118 (December 2017), when we used Twitter to post messages about self-care and treatment options when our hospitals were under severe pressure.



Our Facebook page has a steady following each day. We have linked with many local Facebook groups to share messages about specific events, such as The Brownhill Surgery mentioned earlier.

During December 2017 we paid for sponsored posts to target messages about self-care and treatment options while hospitals were under severe pressure, as shown below.



We also harnessed the opportunities provided by community Facebook groups for sharing information and communicating directly with local people. As witnessed during our Brownhill Surgery engagement and young families in Totton for the Ashurst Hospital project. Facebook provided us with the opportunity to allay fears and answer concerns.

7.6. YouTube

We published a series of high quality videos over the year, focusing on key health prevention, health promotion and self-care messages.

These messages were broadcast on YouTube, shared on social media, and embedded on the CCG's website to help signpost people to them.

Visit our YouTube channel at
https://www.youtube.com/user/NHSWestHampshireCCG

7.7. Soundcloud

We recognise the value of local radio within our community and are keen to share our messages on local news bulletins and reports.

As part of our wider communications strategy, we regularly include audio clips of our staff and clinicians, for use by local stations.

You can hear interviews and soundbites at West Hampshire CCG channel on the Soundcloud website
https://soundcloud.com/

7.8. Press and Local TV

The local media continues to retain a loyal following. We share news about local healthcare and public health messages with our local reporters.

ADHD training for pharmacists frees up experts

LOCAL pharmacists have been trained to assess children and young people with attention deficit hyperactivity disorder (ADHD) – freeing up specialist care for those most in need.

The routine six-monthly check-ups of children taking prescribed medication are usually carried out in clinic, but the new initiative has meant specialists from New Forest Children and Adolescent Mental Health Services (CAMHS) can spend 40% more time with patients who need the most support.

"The scheme has been a resounding success with the families involved, and 97% say they want it to continue.

Dr Lesley Ayling, clinical director for children and families at West Hampshire Clinical Commissioning Group (CCG), said: "This common sense approach means young people and their parents don't have to take time out of school or work.

"It also means that CAMHS appointments focus on discussing the family's concerns rather than on measuring the child."

She added: "The scheme has attracted interest from around the country and we're hopeful we can begin to roll it out to other areas."

Dawn, from the Waterside, whose 12-year- old son has ADHD, said: "It's just so much easier —

the pharmacy is just five minutes up the road and I can arrange the assessment at a more convenient time for me.

"And my son actually likes it, because he already knows Helen [the local pharmacist] so he's not so stressed about going. He knows what's coming and he involved in it."

Dr Subha Muthalag consultant child and adolesc psychiatrist at New For CAMHS who led the project, "We are all delighted! Inclu the local pharmacies has wo well for everyone — the fam the NHS and most import the children and young pe

"Finding the extra time those children who need has been important and ha a real difference."

The project was introd September 2016 as a pilot at 15 pharmacies New Forest, and has embedded locally.

"Those living with young person who may benefit from can discuss the mat CAMHS professional appointment.

For further information go to http://www.health.org.uk/programmes/innovating-improvement/projects/developing-community-pharmacies-support-medication

Local NHS shortlisted

TWO healthcare projects that aim to improve people's quality of life have been shortlisted in the health 'Oscars' – the *Health Service Journal* Value in Healthcare Awards.

Both have been devised by NHS West Hampshire Clinical Commissioning Group (CCG).

One involves a new service for people with hearing impairment that brings care closer to home, reduces waiting times and saves the NHS money.

The other involves replacing Amiodarone, a medication for irregular heartbeats, with newe more effective prescriptions, in project spearheaded by pharmacists working in GP surgeries.

The new hearing service was developed after listening to the concerns of patients who want shorter waiting times and serv that are closer to home.

The CCG also found that whil there has been a rising demand Ear, Nose and Throat services, around 80 per cent of patients needed routine appointments t help with hearing aids.

This prompted the team from Hampshire CCG to bring toge High Street providers and othe community audiology services enable patients get routine hel locally.

Dr Sean Watters, West Hamp CCG clinical director, said: "Th a great example of how the NH can work with patients and the community services."

Our Clinical Director for Families and Children appeared on BBC South Today urging pregnant women to have the flu vaccination.

All CCG Press Releases are on our website.

7.9. Health Matters

We enhanced our Health Matters publication in 2017, to create a people-focused, informative and colourful magazine featuring real stories about health.

The first edition included features on keeping active into older age, plans for New Forest hospitals and new Extended Hours hubs.

To receive Health Matters click here.

7.10. Reducing health inequality

Reducing health inequalities is core to the NHS constitution and values and is a national commissioning priority. We have a number of duties under the Health and Social Care Act (2012) regarding health inequalities in the way we commission and ensure the provision of healthcare. By taking action with local authorities to reduce health inequalities we will realise substantial population health gains, reduced healthcare spend and improved health outcomes.

Social and economic determinants of health such as income, employment, education and environment lead to inequalities in health. We work collaboratively across all sectors, particularly with local authorities, to develop systems to reduce health inequalities. Increased interaction and information sharing between partners will help establish effective initiatives and maximise optimal utilisation of various healthcare.

Our rural geography can often affect accessibility to services. We are aware that we need to create greater access to alternative community, domiciliary or peripatetic services where social networks may be poorly developed. We are exploring the current utilisation of services in these settings to help ascertain if commissioning primary care services, including public health services from these providers can help reduce inequalities in health.

Over the last year we have continued to work hard to identify and address equality issues and health inequalities faced by local communities. We are committed to reducing inequalities as set out in Section 14 of the National Health Service Act 2006 (as amended).

We have achieved improvements through our commissioning work and partnerships with local Health and Wellbeing Boards. To support this work we used the NHS Equality Delivery System (EDS2) and completed equality analysis to assess the impact of commissioning decisions on equality, inclusion and reducing health inequalities.

Our achievements over the past year have been as follows:

- We have worked to address inequalities in access and health outcomes for people with mental health issues or a learning disability and our achievements in these areas are described in section 6.6 of this report.

- We have developed a free 'lunch & learn' weight management service. This involves Nutrition Advisors, who work with Tier 3 patients, visit practices to help them learn about the service and how to support patients with their weight management once they have completed Tier 3. This is especially useful for patients who do not progress to Tier 4 (bariatric surgery).

- Our work to develop locality commissioning plans for each part of west Hampshire has involved data gathering and community involvement work in order to build greater understanding of the needs of our vulnerable populations, in areas of deprivation in Andover, Winchester, Eastleigh and the New Forest.

- We have worked with Healthwatch Hampshire and Eastleigh Borough Council to pilot a 'communication support card' with people from black and minority ethnic (BME) communities in Eastleigh. The idea was raised by people from BME communities and the card is personalised card for people who speak limited English and includes:

    - The person's name
    - NHS number
    - Language for which they require an interpreter.

The card helps GP practice and hospital staff record someone's communication needs and arrange the right interpreter for the appointment. This simple solution will over time remove barriers to accessing health services and improve outcomes.

We have been supporting people with dementia and atrial fibrillation, by providing them with tools to manage their own care more confidently and use services more effectively. The proactive care team supports holistic assessments, direct care, proactive care planning and sign posting to other useful services.

7.11. Valuing our staff

We recognise the value our staff bring to the NHS locally and we are committed to supporting them and their development, and ensuring our internal communication plan creates and maximises opportunities to inform and engage staff.

Our recruitment process is thorough to ensure we attract and appoint the best candidates to deliver our strategy.

We support staff in many ways.

We run fortnightly 'lunch and learn' sessions for staff at both Eastleigh and Fareham providing regular access to relevant and informative training. We also hold an annual Staff Away Day providing a strategic overview of our vision as well as team building and networking opportunities.

Each month we hold a briefing meeting for staff, which features updates on performance, finances, staffing and a spotlight on an area of CCG work.

All staff have access to the Employee Assistance programme, a free and confidential support service, offering unlimited access to advice, information, coaching and counselling where appropriate. It is available 24 hours a day, 365 days a year, and provides health and wellbeing advice and support on the telephone, online or face to face.

Over the past year we have introduced a Flexible Plus policy, which has increased the opportunity for people to work more flexibly – in terms of both location and hours. In March 2018 the mutual benefits of this flexibility came to the fore when adverse weather prevented many colleagues from getting to the office safely.

With staff able to work from home we were able to put our Business Continuity Plan into action to ensure our service was not disrupted while ensuring the safety of staff and avoiding the potential for added pressure on Emergency Departments.

We continue to value the input of our two staff forums – the Omega House forum and the Fareham CHC forum.

These forums provide a platform for raising concerns, gathering feedback on new policies – such as the Flexible Plus policy – and generating ideas to support the CCG. They have also led our charitable work, raising money for local and national charities and good causes.

We also have a staff recognition scheme, which provides a great opportunity for colleagues or line managers to nominate people. Our Intranet has a thank you page to post comments.

7.12. Staff survey

We worked with the Picker Institute Europe to undertake our annual staff survey. The survey is structured around the four pledges in the NHS Constitution, with the additional themes relating to "equality and diversity", "raising concerns" and "patient experience measures".

The NHS Constitution outlines the principles and values of the NHS in England including four pledges that set out what staff should expect from NHS employers.

The following pledges are part of the commitment of the NHS to provide high-quality working environments for staff:

- Pledge 1: To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers, and to communities.

- Pledge 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.

- Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety.

- Pledge 4: To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families

In 2017 our response rate was 75% compared with 70% in 2016 and 62% in 2015. Overall, five results were significantly more positive than in 2016.

The results were published in March 2018 and we are working with our Staff Forum and HR advisers so we continue to develop as a learning organisation.

8. Performance Analysis

8.1. Performance against key standards and targets

The following table summarises the CCG's 2017/18 performance against its key indicators:

NHS CONSTITUTION INDICATORS	17/18 Targets	Reporting Level	Current Period	End of Year position*
Referral to Treatment (RTT) waiting times for non-urgent consultant-led treatment				
RTT: % of incomplete pathways (people who did not complete the course of treatment)	92%	CCG	Mar-18	89.97%
Diagnostic test waiting times				
Diagnostic waiting: % of patients waiting over 6 weeks	99%	CCG	Mar-18	97.73%
A&E waits				
Total time spent in A&E under 4 hours	95%	CCG	Mar-18	89.44%
Cancer 2 week waits				
Cancer patients seen <14 days after urgent GP referral	93%	CCG	Q4 17-18	95.19%
Breast cancer referrals seen <2 weeks	93%	CCG	Q4 17-18	90.72%
Cancer waits – 31 days				
Cancer diagnosis to treatment <31 days	96%	CCG	Q4 17-18	96.85%
Cancer patients receiving subsequent surgery <31 days	94%	CCG	Q4 17-18	91.98%
Cancer patients receiving subsequent Chemo/Drug <31 days	98%	CCG	Q4 17-18	100.00%
Cancer patients receiving subsequent radiotherapy <31 days	96%	CCG	Q4 17-18	99.07%
Cancer waits – 62 days				
Cancer urgent referral to treatment <62 days	85%	CCG	Q4 17-18	85.90%
Cancer patients treated after screening referral <62 days	90%	CCG	Q4 17-18	94.72%
Cancer patients treated after consultant upgrade <62 days	86%	CCG	Q4 17-18	84.03%
Category A Ambulance calls				
Category A (8 minutes) Red 1 - part year only (new metrics from 1/11/17)	75%	South Central Ambulance NHS Foundation Trust	Oct-17	73.88%*
Category A (8 minutes) Red 2 - part year only (new metrics from 1/11/17)	75%		Oct-17	70.63%*
Category A (19 minutes) R1+R2 - part year only (new metrics from 1/11/17)	95%		Oct-17	94.23%*
Mixed sex accommodation				
Mixed sex accommodation breaches	0	CCG	Mar-18	190

Mental Health				
Care Programme Approach (CPA): The proportion of people under adult mental illness appeals on CPA who were followed within 7 days of discharge from psychiatric in-patient care during the period	95%	CCG	Mar-18	97.47%
Healthcare Associated Infections				
HCAI: Clostridium Difficile (C.Diff)	133	CCG	Mar-18	144
HCAI: Incidence of MRSA	0	CCG	Mar-18	3

9. Ipsos Mori 360° Stakeholder Survey

NHS England has commissioned the CCG 360° Stakeholder Survey annually since 2014 to inform both local and national assurance systems. It measures key stakeholders' opinions of the CCG's management, clinical leadership engagement and performance. The fieldwork was conducted in January and February 2018 and we received the report on 29 March 2018.

The CCG 360° stakeholder survey is a key part of ensuring strong relationships with stakeholders are in place. The survey allows stakeholders to provide feedback on working relationships with CCGs. The results from the survey serve two purposes:

1. To provide a wealth of data for CCGs to help with their ongoing organisational development, enabling them to continue to build strong and productive relationships with stakeholders. The findings can provide a valuable tool for all CCGs to be able to evaluate their progress and inform their organisational decisions.

2. To feed into assurance conversations between NHS England and CCGs. The survey forms part of the evidence used to assess whether the stakeholder relationships, forged during the transition through authorisation, continue to be central to the effective commissioning of services by CCGs, and in doing so, improve quality and outcomes for patients.

In the most recent survey, 72% of stakeholders were positive about the effectiveness of their working relationship with the CCG, an increase on the last two years.

Over half of stakeholders (55%) had confidence in the leadership of the CCG to deliver improved outcomes for patients – which is higher than 2017 (45%).

Over 60% are confident that the CCG monitors the quality of the services it commissions in an effective manner – a 5% increase on last year.

Among stakeholders, 90% said that if they had concerns about the quality of local services they would feel able to raise their concerns within the CCG, and 60% said the CCG had effectively communicated its plans and priorities with them.

We are pleased that response rate is similar to 2016 and we continued to receive positive comments and feedback.

We are keen to continue to build our relationships with all our stakeholders, for example:

- Continuing to improve engagement with provider colleagues
- Ensuring GP practices are clear about how they can influence decisions – particularly with the locality clinical directors as members of the CCG Board
- Ensuring GP practices are involved with and understand the aims of the commissioning decisions, the plans for service development and the financial implications of the plans.

10. Sustainable Development and Environmental Matters

Sustainability continues to become increasingly important as the impact on people's lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. We have established mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

In addition a number of initiatives have been successfully implemented in the past year, as part of our commitment to creating a sustainable future including:

- A move towards a 'flexible working' approach which will have a positive impact on commuter miles and office space
- The development of a 'paper light' plan to minimise the impact on valuable resources through printing and paper use
- The introduction of a secure printing system which requires users to release their print jobs from output devices, thereby reducing printed waste from documents left uncollected at the printer
- Introduced a recycling system that has reduced our business waste.
- Reducing our use of single use plastic.

10.1. Our use of resources

The following tables show our resource consumption over the past year.

Financial Data (Spend):	Units	2017/18 Omega House	2017/18 Fareham Health Centre	2017/18 Fareham Borough Council
Total Energy Cost (all energy supplies)	£			
Electricity Cost	£	27,536.05	£19,268.08	
Gas Cost	£	2,978.11	£4610.39	
Water Cost	£	7837.95	£3898.85	
Resource Use:	Units	2017/18	2017/18	
Electricity Consumed Up to 28th feb 2018	kWh	195,500	137547	
Gas Consumed Up to 1st Jan 2018	kWh	106,991	134516	
Water/Sewerage Consumed – up to 22.12.17	m^3	2105	1634	

10.2. Building cost breakdown 2017/18

Building Name	Tenant Occupancy %	Total Tenant Area (m2)	Electricity Cost 17/18	Gas Cost 17/18	Water Cost 17/18
Omega House	47.83	883.95	£27,536.05	£2,978.11	£7837.95
Fareham Health Centre	19.79	462.82	£19,268.08	£4610.39	£3898.85

10.3. Building consumption breakdown 2017/18

Building Name	Tenant Occupancy %	Total Tenant Area (m2)	Electricity Consumption 17/18	Gas Consumption 17/18	Water Consumption 17/18
Omega House	47.83	883.95	195,500kwh	106,991kwh	2105
Fareham Health Centre	19.79	462.82	137547	134516	1634

11. Performance measures

11.1. Financial performance

We have used resources economically and with effectiveness and efficiency in 2017/18 to plan and buy services for our population.

At the start of the year, we submitted our 2017/18 financial plan to NHS England which set out a planned underspend for the year of £8.9m (1.1% of West Hampshire's allocation). This included £7.1m of income in 2017/18 relating to prior years and an in year planned surplus of £1.8m.

This plan was compliant with the requirements of the 2017/18 NHS Planning Guidance, that required clinical commissioning groups to achieve an underspend equivalent to 1% of allocated funding and hold a 1 percent reserve uncommitted from the start of the year as well as a contingency of 0.5 percent. However there were associated net risks of £12m.

The planned underspend of £8.9m depended on the delivery of quality, innovation, prevention and productivity (QIPP) savings of £31.6m for the year.

At 5.2% of our allocation, the total savings requirement was higher than generally accepted levels of annual efficiency and considered to be high risk. The risks to the delivery of our plan were discussed with NHS England during the planning process and our plan was formally accepted by NHS England.

The main financial pressures throughout 2017/18 were activity over-performance within acute contracts, particularly non-elective admissions, continuing healthcare (CHC); and full delivery of the challenging QIPP programme, where we achieved £21.6m (68% delivery). In addition, in medicines management, supply problems on certain generic drugs caused considerable financial pressures nationally because there was no cheaper alternative available to the branded version.

The national position remained such that NHS England continued to be unable to allow CCGs' 1% non-recurrent monies to be spent on new investment. Therefore we were able to release our 1% reserve to the bottom line, mitigating the deterioration from planned position by £7.1m. The CCG was still required to hold a 0.5% contingency unspent as a risk mitigation until month 12.

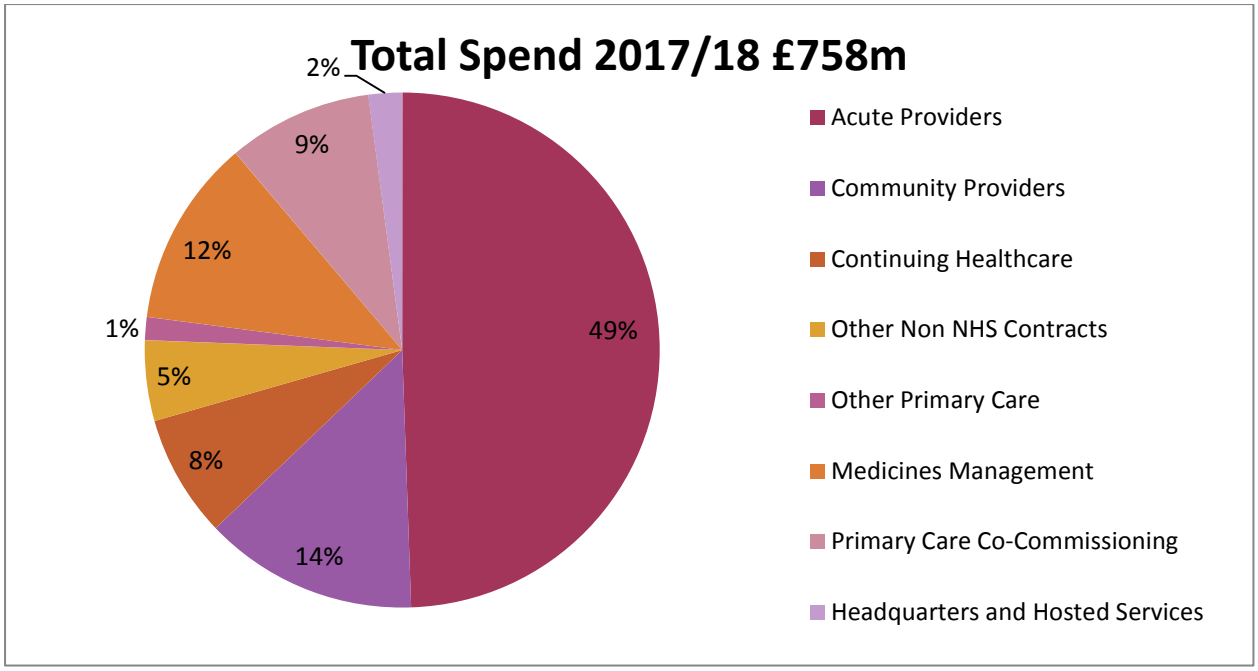
As a result of all of the above pressures, partway through the financial year, we declared a change to our forecast financial position from the £8.9m planned surplus to a forecast position of breakeven after managing significant risk. We ended the financial year with a surplus of £1.5m. This was due to the release of our 0.5% contingency, the release of the national pricing benefit in Category M drugs, some risk materialising at less than the anticipated value and a number of non-recurrent benefits from the Financial Recovery Programme (FRP) at the end of the year including HQ costs.

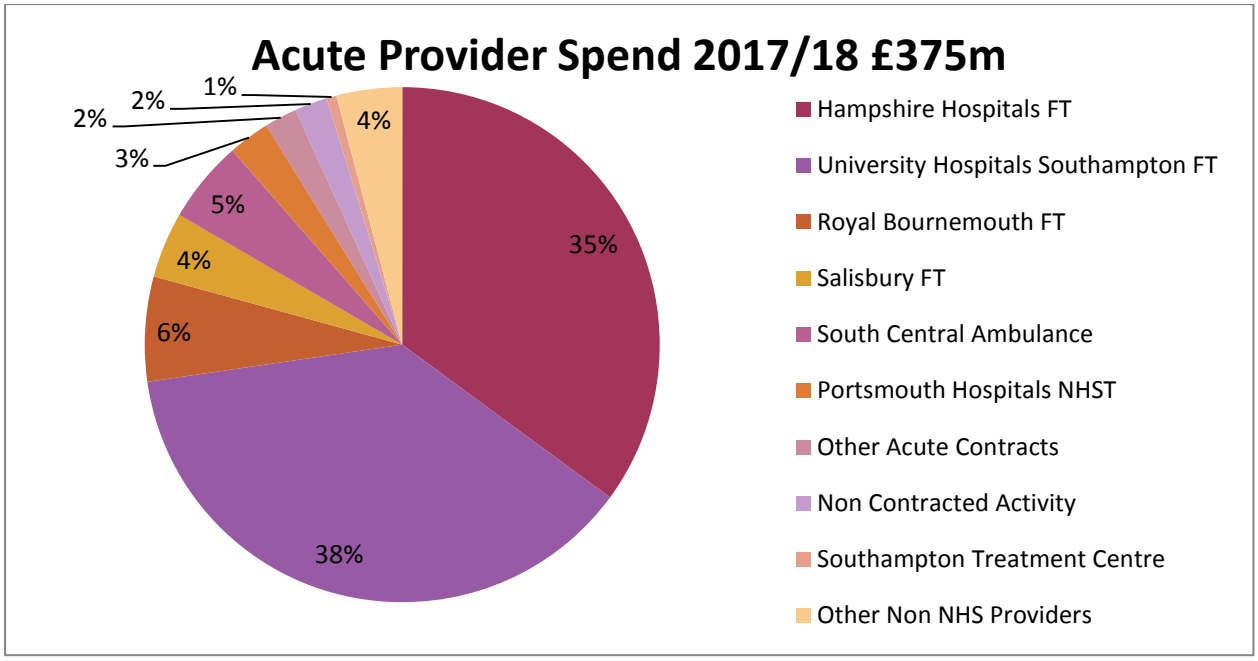
We were successful in achieving all of our other key statutory and administrative financial duties during the financial year ended 31st March 2018. More information on these duties is set out in the annual accounts and summarised in the table in the following section.

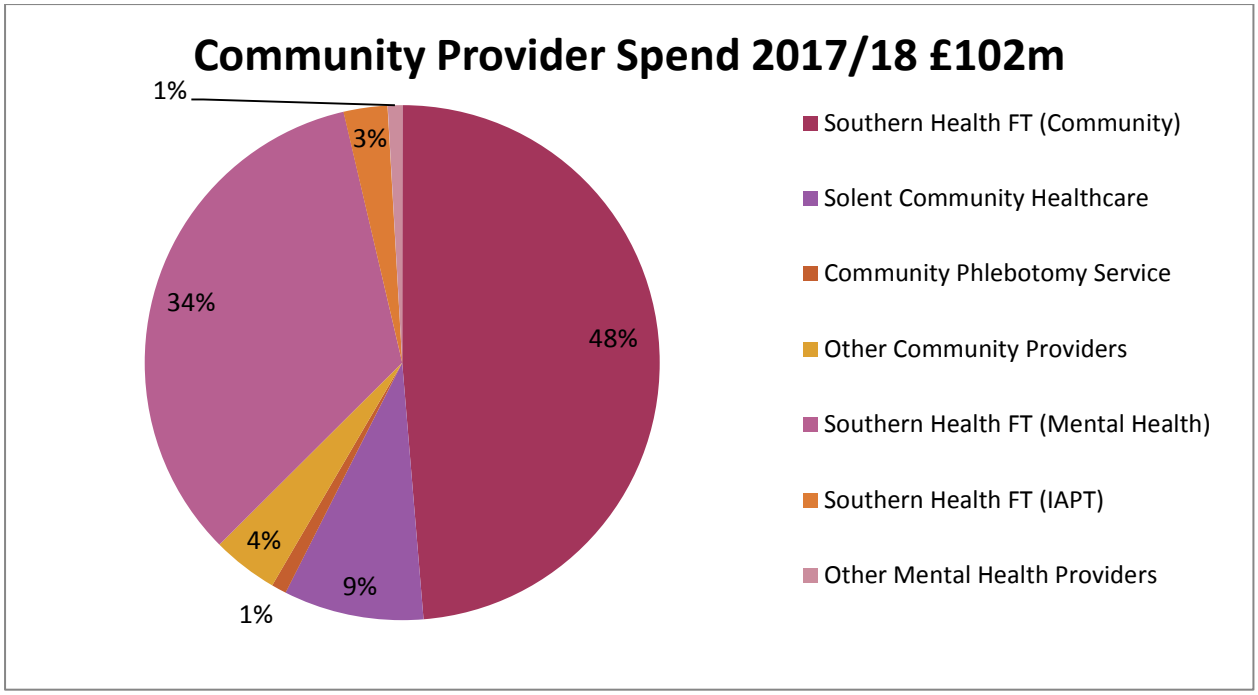
We received total resource allocations of £759.2m, including £71.0m for primary care co-commissioning and £11.9m for running costs. Net expenditure against this allocation totalled £757.7m distributed as summarised in the charts below:

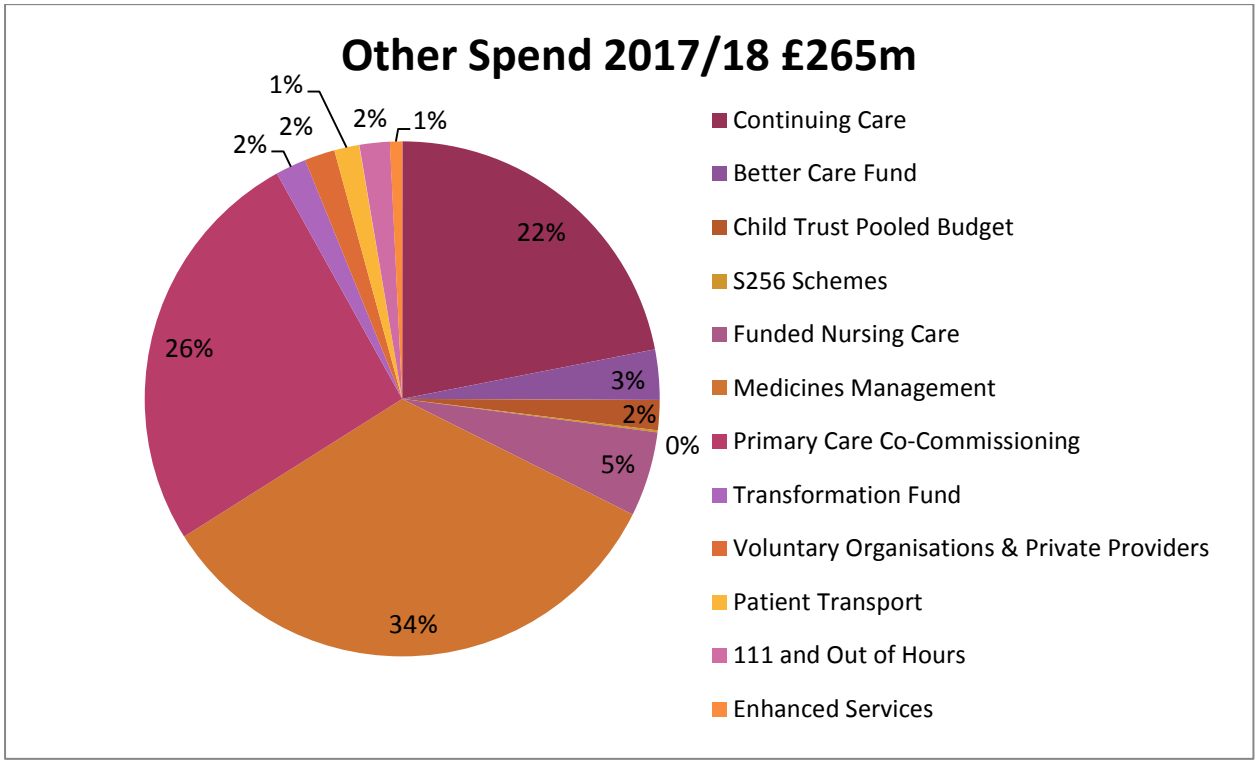
Our FRP continued to focus on curtailing expenditure in 2017/18 and improving the financial position in year. The FRP included some one-off financial benefits. These items will not recur in future but have helped deliver the 2017/18 surplus.

The FRP has been further developed through 2017/18 and will remain in place until the CCG sustains a fully compliant financial position.


Total Spend 2017/18 £758m
2%
9%
12%
1%
5%
8%
14%
49%
Acute Providers
Community Providers
Continuing Healthcare
Other Non NHS Contracts
Other Primary Care
Medicines Management
Primary Care Co-Commissioning
Headquarters and Hosted Services


Acute Provider Spend 2017/18 £375m
1%
2%
2%
3%
4%
5%
4%
6%
35%
38%
Hampshire Hospitals FT
University Hospitals Southampton FT
Royal Bournemouth FT
Salisbury FT
South Central Ambulance
Portsmouth Hospitals NHST
Other Acute Contracts
Non Contracted Activity
Southampton Treatment Centre
Other Non NHS Providers


Community Provider Spend 2017/18 £102m
1%
3%
34%
48%
4%
9%
1%
Southern Health FT (Community)
Solent Community Healthcare
Community Phlebotomy Service
Other Community Providers
Southern Health FT (Mental Health)
Southern Health FT (IAPT)
Other Mental Health Providers


Other Spend 2017/18 £265m
1%
2%
2%
1%
22%
3%
2%
0%
5%
34%
26%
Continuing Care
Better Care Fund
Child Trust Pooled Budget
S256 Schemes
Funded Nursing Care
Medicines Management
Primary Care Co-Commissioning
Transformation Fund
Voluntary Organisations & Private Providers
Patient Transport
111 and Out of Hours
Enhanced Services

11.2. Objectives and performance for the year

Our financial results for 2017/18 are set out in the table below with further information included in the full annual accounts, which are published alongside this annual report.

Headline Results	Target £'000	Actual £'000	Target Achieved
Revenue underspend	£8,905	£1,527	No
Running costs within allocation	£11,921	£10,711	Yes
Cash managed to within 1.25% of Maximum Cash Drawdown limit	£667	£199	Yes
Over 95% of our suppliers paid within 30 days by value	95%	100%	Yes
Over 95% of our suppliers paid within 30 days by volume	95%	99%	Yes

11.3. Prospects for 2018/19 and beyond: Financial Resilience and Going Concern considerations

The CCG approved budgets and a draft plan for 2018/19 on 22nd March 2018 and a final plan for submission to NHSE on 26th April 2018. Given the extent of its off plan closing financial position in 2017/18, the CCG Board formally considered its going concern status and financial resilience going forward when it adopted the final plan. Members concluded that they remain assured about these in the light of the following key points that support the financial outlook for the CCG for 2018/19 and beyond:

- The CCG begins 2018/19 with a small cumulative surplus of £1.5m from 2017/18.
- For 2018/19, a new £400 million Commissioner Sustainability Fund (CSF) has been created, partly mirroring the financial framework for providers, to enable CCGs to return to in-year financial balance, whilst supporting and incentivising CCGs to deliver against their financial control totals. As a result of its off plan closing financial position in 2017/18, the CCG will come under the operation of the CSF in 2018/19. WHCCG has been set a planning control total of a £2.2m deficit for 2018/19 with access to a potential allocation of £2.2m from the CSF that would bring it back to a break even position in 2018/19 if the criteria of the fund are met.
- The 2018/19 Planning Guidance for CCGs *Refreshing NHS Plans for 2018/19* allocated an additional £600m to CCG allocations of which WHCCG received £5.8m. It also lifted the requirement for CCGs to underspend 0.5% of their allocations and to use a further 0.5% of CCGs' allocations solely for non-recurrent purposes releasing £7.1m to support the CCG position going forward.
- The CCG has submitted a plan for 2018/19 that is compliant with all of the CCG business rules with the exception of an underspend equivalent to 1% of its allocation in 2018/19 and with a QIPP challenge of £27.4m (4%) that is considered medium risk. There is net risk of £5.9m associated with delivering the plan.

- The 5 year plan submission shows the CCG consolidating a breakeven position in 2019/20 before returning to delivery of a planned surplus of 1% from 2020/21 onwards.

The CCG accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).

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.

2018/19 Financial Plan	17/18 Outturn	18/19 Plan
	£'000	*£'000*
Commissioning Allocation	669,125	687,772
Primary Care Co-Commissioning	71,046	70,315
Running Costs Allocation	11,921	11,919
B/f surplus	7,145	-
Allocation	**759,237**	**770,006**
NHS Acute Contracts	(349,102)	(349,652)
Other Acute Providers	(24,800)	(22,412)
Mental Health & Community Providers	(107,373)	(106,154)
Non Acute Contracts	(90,991)	(93,576)
Primary Care	(169,772)	(173,789)
Headquarters	(16,513)	(16,805)
Reserves and Contingency	841	(7,619)
Total Expenditure	**(757,710)**	**(770,006)**
I&E	**1,527**	**-**

11.4. External audit's remuneration

The CCG's external auditor is Grant Thornton UK LLP. The audit covers both the CCG's financial statements and arrangements for securing value for money in its use of resources.

The audit fee for the 2017/18 annual accounts is £48,000 plus VAT. No other services were provided by Grant Thornton to the CCG in the financial year.

11.5. Pension liabilities

The CCG's accounting policy for Pension Liabilities is included at note 1.9.2 (Retirement Benefit Costs) with the CCG's statement on Accounting Policies. Detailed information on Senior Managers pension benefits is included within the Remuneration Report.

11.6. Cost allocation & setting of charges for information

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

11.7. Better Payments Practice Code

The Better Practice Payment Code requires the CCG to aim to pay all valid invoices by the due date or with 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within the agreed contract terms. Details of compliance with the code are given in note 6.1 to the accounts.

11.8. Prompt Payments Code

The CCG has signed up to the Prompt Payments Code. Code signatories undertake to pay suppliers on time, give clear guidance to suppliers and encourage good practice by requesting that lead suppliers encourage adoption of the code throughout their own supply chains.

11.9. Off-payroll engagements

We have had two off-payroll engagements during the financial year. Details of these payroll engagements are provided in the Remuneration Report.

Signed 

Heather Hauschild

Accountable Officer

23 May 2018

12. Corporate Governance Report

12.1. Members' / Directors' report

12.1.1. Our member practices

In 2017/18 there were 50 GP Member Practices covered within West Hampshire CCG. This reduced to 49 during the year following the closure of The Brownhill Surgery on 30 November 2017. The practices are organised into six localities led by GPs working in the local area.

Locality	GP practices
Andover ***Clinical lead:*** **Dr Andrew Isbister**	Andover Health Centre Charlton Hill Surgery Shepherds Spring Medical Centre St Mary's Surgery The Adelaide Medical Centre Two Rivers Medical Partnership (*also known as Whitchurch Surgery and Derrydown Clinic)*
Eastleigh North and Test Valley South ***Clinical lead:*** **Dr Dina Foy (for April 2017)** **Dr Roland Fowler (from May 2017)**	Abbeywell Surgery Alma Road Surgery Archers Surgery Boyatt Wood Surgery Brownhill Surgery *(closed on 30 November 2017)* North Baddesley Health Centre Park and St Francis Surgery Parkside Family Practice St. Andrew's Surgery The Fryern Surgery
Eastleigh Southern Parishes ***Clinical lead:*** **Dr Karl Graham**	Blackthorn Medical Centre Bursledon Surgery Hedge End Medical Centre St Luke's and Botley Surgery West End Surgery

West New Forest ***Clinical lead:*** **Prof Johnny Lyon-Maris**	Barton Surgery Chawton House Surgery Cornerways Medical Centre Lyndhurst Surgery New Forest Central Medical Group New Milton Health Centre Ringwood Medical Centre The Arnewood Practice The Fordingbridge Surgery Twin Oaks Medical Centre Wistaria and Milford Surgery
Winchester ***Clinical lead:*** **Dr Andrew Isbister**	Alresford Group Surgery Bishops Waltham Surgery Friarsgate Practice Gratton Surgery St Clements Partnership St Paul's Practice Stockbridge Surgery Stokewood Surgery Twyford Surgery Watercress Medical Group West Meon Surgery Wickham Group Surgery
Totton and Waterside ***Clinical lead:*** **Dr Charlie Besley**	Totton Health Centre Forest Gate Surgery Testvale Surgery Red and Green Practice Forestside Medical Practice Waterfront and Solent Surgery

12.1.2. Our Board (governing body) and audit committee

Our Chairman throughout the year and up to the signing of the Annual Report and Accounts has been Dr Sarah Schofield, and our Accountable Officer has been Heather Hauschild.

12.1.3. Board members

The Board comprised the following members during the year:

- Dr Nick Arney, Clinical Executive Director (to August 2017)
- Dr Tim Cotton, Clinical Executive Director and Vice Clinical Chairman (to September 2017)
- Mike Fulford, Chief Finance Officer and Deputy Chief Officer
- Simon Garlick, Lay Member, Governance
- Judith Gillow, Lay Member, Quality (all year) and Interim Board Nurse (from March-August 2017)
- Ian Green, Lay Member, Patient and Public Involvement (to May 2017)
- Heather Hauschild, Chief Officer
- Dr Simon Hunter, Clinical Executive Director
- Dr Andrew Isbister, Locality Clinical Director/Board GP (from September 2017)
- Professor Johnny Lyon-Maris, Locality Clinical Director/Board GP (from October 2017)
- Ellen McNicholas, Director of Quality and Nursing (from August 2017)
- Dr Sarah Schofield, Clinical Chairman
- Dr Tim Thurston, Clinical Executive Director
- Caroline Ward, Lay Member, New Technologies (from June 2017)
- Dr Sallie Bacon, Director of Public Health, Hampshire County Council*
- Jenny Erwin, Director of Commissioning, Mid Hampshire*
- Beverley Goddard, Director of Performance and Delivery*
- Rachael King, Director of Commissioning, South West*
- Heather Mitchell, Director of Strategy and Service Development*
- Barbara Moorhouse, Lay Member, Strategy and Finance* (to May 2017)
- Helen Pardoe, Secondary Care Consultant*
- Alison Rogers, Lay Member, Strategy and Finance* (from September 2017).

* Non-voting member

12.1.4. Audit committee members

- The CCG's audit committee has comprised the following members during the year:

- Simon Garlick, Lay Member, Governance and Chair
- Judith Gillow, Lay Member, Quality
- Ian Green, Lay Member, Patient and Public Involvement (to May 2017)
- Alison Rogers, Lay Member, Strategy and Finance (from September 2017)
- Caroline Ward, Lay Member, New Technologies (from June 2017)

The CCG's Chief Officer, Chief Finance Officer and other managers are in attendance at or invited to meetings of the committee along with representatives of the internal and external audit service providers, and the local counter fraud specialist

12.1.5. Further details and references

The appendix to the Annual Governance Statement provides details of the membership, attendance records and declarations of interests for members of the Board and all of its sub-committees.

The register of Board members' interests is also published as part of the agenda and papers for Board meetings held in public and is available on the CCG's website.

In line with the statutory guidance on managing conflicts of interests (revised in June 2017), the CCG also publishes online the register of interests for all employed staff.

12.1.6. Personal data related incidents

Two incidents were graded as Serious Incidents Requiring Investigation (SIRIs) throughout 2017/18 and were therefore reported to the Information Commissioner's Office (ICO). The ICO has responded to both of the SIRIs and confirmed that no further action would be taken.

The ICO also ruled on one complaint about a response to a Freedom of Information (FOI) Request. This did not involve personal data. The requestor considered that neither the initial response to their FOI request nor the subsequent internal review were satisfactory, and therefore asked the ICO to rule whether the CCG should disclose further information. The ICO upheld part of the CCG's response and review, but required further information to be released within a timescale, and the CCG complied.

The ICO notified West Hampshire CCG in March 2018 of a further complaint regarding an FOI response. The ICO carried out an initial assessment of this case and the complaint will be formally passed to West Hampshire CCG for a response in due course.

The CCG reviewed its processes for responding to FOI requests as a result of these complaints and established an in-house team to manage FOI requests from April 2018.

12.1.7. Statement as to disclosure to auditors

At the Board meeting held on 22 March 2018, each individual who is a member of the Board (governing body) has confirmed:

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

12.1.8. Modern Slavery Act

West Hampshire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2017 is published on our website.

13. Statement of Accountable Officer's Responsibilities

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

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG 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 CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

To the best of my knowledge and belief, with the exception of the duty to breakeven against the in-year revenue resource limit, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), 'managing public money' document, and in my CCG Accountable Officer appointment letter.

I confirm that:

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

14. Annual Governance Statement 2017/18

1. Introduction and context

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

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

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

West Hampshire CCG comprises 49 GP practices (following the closure of one practice during the year and works through a membership model with an allocated budget of over £740 million. We work in partnership with members, patients, carers, the public, local authorities, the voluntary and community sectors and neighbouring commissioners to plan, buy, manage and ensure the quality of local healthcare services for a population of over 550,000 people. The CCG, by virtue of its geographical breadth, has the opportunity to work with a diverse range of acute, community and mental health service providers with their own unique configurations and challenges.

2. Scope of responsibility

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

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

3. Governance arrangements and effectiveness

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

3.1 CCG governance framework

Constitution

- The governance framework of West Hampshire CCG is set out in the constitution, which was approved by members and made effective by NHS England in January 2013, as part of the authorisation process. The constitution sets out:

- The arrangements made by the CCG for the discharge of its functions and the Board's (governing body) functions.
- The procedures to be followed by the CCG and the Board in making decisions.
- Arrangements for the discharge of duties in respect of registers of interests and management of conflicts of interests.
- Arrangements made by the CCG and the Board for ensuring that there is transparency about decision-making and the manner in which decisions are made.

This includes supporting documents such as the standing orders, the scheme of reservation and delegation and prime financial policies. The constitution and supporting documents are published on the CCG's website.

The constitution was last amended following an application to and approval by NHS England in January 2015. These amendments included a change to the number of member practices (following practice mergers), amendments to enable the CCG to take on joint or delegated commissioning arrangements for primary care from April 2015, and eligibility for clinical Board membership and succession planning.

A review of the constitution was completed 2017/18 and an application for amendment was submitted to NHS England in January 2018. The changes aim to ensure that the CCG is fit for purpose for the strategic priorities and challenges of the next few years, with particular to the sustainability and transformation plan and the establishment of local delivery/care systems with partners.

The proposed amendments also reflected:

- A change in the number of member practices in the CCG
- Changes in clinical membership of the Board to strengthen the locality focus of the CCG's work, and the appointment of a directly elected Clinical Chairman
- The publication in 2016 and 2017 of revised statutory guidance for the management of conflicts of interest in CCGs (and the CCG's revised policies)

The CCG's governance structure in 2017/18 comprised the following bodies, committees and sub-committees:

- Members
- Board (governing body)
- Audit Committee
- Remuneration Committee
- Clinical Cabinet
- Clinical Governance Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee

Members

The members are a body comprising representatives from each of the CCG's member practices, established under the constitution. Each practice within the CCG have a representative on the members group, which meets at least annually to review progress and influence future plans, particularly with regard to developing new models of care in line with the NHS Five Year Forward View. The Annual General Meeting was hosted in September 2017 and there have been meetings of the localities throughout the year.

Board

The Board's functions and composition are specified within the constitution and supporting documents. The Board has a minimum of 14 members of which ten are voting members – the five GP members, two lay members (one leading on audit / governance matters and one leading on patient and public participation / quality matters), the Chief Officer, the Chief Finance Officer and the Director of Quality and Nursing (Board nurse). Other members include a secondary care consultant, a public health representative, an officer of the Hampshire County Council, two additional lay members (one leading on strategy and finance, and one leading on new technologies), and directors of commissioning. Information about the membership of the Board and its committees, including attendance records and declaration of interests, is included in Appendix A to this statement.

The Board meets formally in public on a bi-monthly basis, which includes regular reports covering commissioning developments and strategy, and updates on performance, incorporating finance, quality and other key indicators. Papers and minutes of meetings are published routinely on the CCG's website. In alternate months, meetings are held for informal briefings in private as well as Board development.

Subject to the formal approval by NHS England of the proposed amendments, the composition of the Board will change in 2018/19 to reflect that

- The role of Board GP will be undertaken by the Locality Clinical Director, as elected by each CCG Locality.
- The role of CCG Clinical Chairman will be elected by the CCG membership, and is independent from the role of Locality Clinical Director.

Audit Committee

The Audit Committee has been established to provide an independent and objective review of the CCG's financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. The Committee's primary purpose is to support the CCG Board to discharge its functions relating to CCG financial duties and its main function of overseeing efficiency, effectiveness, economy and governance.

In line with Board-approved terms of reference, the Committee works to deliver and support an integrated governance, assurance and scrutiny process covering all the objectives of the CCG and any risks to them being achieved, including corporate and clinical governance, financial control and internal control. In particular, the Committee with internal control procedures:

- supports the CCG Board in its governance and oversight role
- provides assurance and scrutiny on objectives and risks
- reviews the effectiveness of systems and controls
- reviews the Board Assurance Framework (BAF) and corporate risk management arrangements
- oversees the external audit, internal audit and local counter fraud services, and other external assurance functions
- reviews the CCG's annual accounts prior to approval by the CCG Board
- reviews the register of gifts and hospitality
- reviews the register of interests.

A comprehensive work programme has been prepared and implemented reflecting both mandatory requirements and key risk areas. Meetings have been

held five times during the year and are quorate when there are two lay members in attendance.

Approved minutes of the Audit Committee meetings are submitted to the Board and are published on the CCG's website. Information about the membership of the Audit Committee, including attendance records and declaration of interests, is included in Appendix A to this statement.

Remuneration Committee

It is required by statute for a CCG's governing body to have a Remuneration Committee. As set out in the remuneration report, the Committee on behalf of the Board:

- reviews and approves pay arrangements for employees of the CCG
- reviews and approves remuneration for Board members
- considers national guidance and requirements in relation to pay and remuneration.

The Committee has also been established to:

- scrutinise any termination payments, taking account of advice and guidance as appropriate and seek advice from NHS England on any significant proposed termination payments
- review alternative pension scheme arrangements the group might establish.

Only members of the Board are members of the Remuneration Committee and member practice representatives should not be in the majority. The Committee comprises the four lay members and two elected member practice representatives from the Board. The Chief Officer and Chief Finance Officer may attend Committee meetings, but will not be present for matters involving their personal remuneration, as is the case for all other Committee members.

The remuneration report is submitted as part of the annual report. Information about the membership of the Remuneration Committee, including attendance records and declaration of interests, is included in Appendix A to this statement.

Clinical Cabinet

The Clinical Cabinet comprises clinical directors each with a specific clinical portfolio (including medicines management, children and families, primary and community care, planned care and long term conditions, and IT) and clinical leads drawn from each of the group's six localities. The Chair and Deputy Chair of the Clinical Cabinet shall be clinicians employed by the CCG, appointed and approved by the Board.

Membership of the Clinical Cabinet also includes elected Board GPs and executive directors to bring together all clinical leads and senior management to undertake the following core responsibilities:

- approve strategy and clinical policies as delegated by the Board
- develop a common approach to commissioning strategies
- provide an opportunity for collective working and sharing of intelligence and learning
- maintain an overview of all commissioning, including activities undertaken by localities
- facilitate engagement with the wider clinical body
- provide timely clinical commissioning consideration of key work programmes
- maximise clinical engagement in commissioning and quality, innovation, prevention and productivity (QIPP) and reform plans
- provide a forum for decisions relating to clinical networks.

As part of the implementation of the NHS Five Year Forward View, the Clinical Cabinet provides the clinical insight and energy to drive change in our local health systems, to develop new care models. CCG members are at the heart of transforming local health and care services to keep people well, and bring home care, mental health and community nursing, GP services and hospitals together. The primary vehicle for reporting to the Board is through the Commissioning Reports (locality and collaborative).

Approved minutes of the Clinical Cabinet meetings are submitted to the Board at each meeting and are published on the CCG's website. Information about the membership of the Clinical Cabinet, including attendance records and declaration of interests, is included in Appendix A to this statement.

Clinical Governance Committee

The CCG Clinical Governance Committee seeks assurance that the population of west Hampshire receives safe and high quality care and that services deliver health benefits and positive clinical outcomes and patient experience. The core responsibilities of the Clinical Governance Committee are to:

- provide an assurance to the CCG Board on all matters concerning duties, obligations and responsibilities relating to patient safety, patient experience and clinical effectiveness
- provide assurance to the CCG Board that the process and compliance issues concerning Serious Incidents (SIs) and Never Events are robust
- receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans

- ensure that all sub-optimal professional and organisational clinical performance within commissioned services is effectively identified and performance managed via contract mechanisms and that the wider implications and trends are addressed
- ensure there are effective early warning systems which draw on a range of quality indicators and other sources of information to identify gaps in assurance about providers
- respond to specific clinical governance and healthcare assurance issues identified by the clinical executive, Clinical Cabinet, the Finance and Assurance Committee, Primary Care Commissioning Committee, other CCGs or external regulatory bodies
- to ensure that decisions made by the Individual Funding Request (IFR) Panel for both adults and children on behalf of the CCG are appropriate and that, where an individual appals the decision of the IFR Panel, that an IFR appeals panel is established
- approve and review the CCG's arrangements for handling complaints
- approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes
- support the CCG and NHS England in discharging its responsibilities in relation to securing continuous improvement in quality of general medical services
- seek assurance on the performance of NHS organisations in terms of the Care Quality Commission, NHS Improvement and any other relevant regulatory bodies.

On behalf of Hampshire CCGs, the Committee provides assurance to each of the five Hampshire CCGs' Quality / Governance Committees on all matters concerning duties, obligations and responsibilities relating to safeguarding children and looked after children. It also provides assurance to North Hampshire and North East Hampshire CCGs' Quality/ Governance Committees on all matters concerning duties, obligations and responsibilities relating to safeguarding adults. The Committee also:

- receives assurance that safeguarding adults and children processes for NHS commissioned services are robust and work in collaboration with other statutory partners. This will include the progress of providers against the respective quality assurance frameworks
- ensures there are annual work plans for safeguarding adults, safeguarding children and children in care
- reviews CCG policies for safeguarding children and adults and make recommendations to the Hampshire CCGs on their approval
- receives assurance on the quality of health checks, including subsequent health outcomes for looked after children.

The Committee has an action tracker which is reviewed at each meeting and provides a thorough review mechanism. In addition, the Committee has developed an annual work plan / annual reporting plan for the Committee. This is a 'live' document which provides assurance that relevant items will be covered at appropriate stages throughout the year.

The primary vehicle for the Committee to report to the Board is via the quality section of the Integrated Performance Report, which is submitted to the Board at each meeting held in public. These provide assurance on the quality of services and identify areas for development and action where there are exceptions.

Recent issues escalated to the Board for review include: never events at Royal Bournemouth and Christchurch NHS Foundation Trust; the quality impact from long Emergency Department waits at Hampshire Hospitals NHS Foundation Trust; chronic staff shortages and instability in Mental Health, Learning Disability, Older People's Mental Health services and Integrated Community Services at Southern Health NHS Foundation Trust (which has the potential to compromise directly patient care provision and impact delivery of new models of care); stroke care at University Hospital Southampton NHS Foundation Trust; the resource/capacity and activity of the Safeguarding and Looked After Children's Team; concerns with the ongoing management of the emergency pathway within the South East Hampshire / Portsmouth system and the impact on wider system partners and their delivery of quality and key performance targets; and increases in waiting list, and the corresponding decrease in performance for children waiting to receive a wheelchair.

Approved minutes of the Clinical Governance Committee meetings are submitted to the Board at each meeting and are published on the CCG's website. Information about the membership of the Clinical Governance Committee, including attendance records and declaration of interests, is included in Appendix A to this statement.

Finance and Performance Committee

The role of the Finance and Performance Committee is to provide robust scrutiny of the CCG's financial position and to provide the Board with assurance that the risks to the CCG's finances (in-year recovery and medium term financial planning) and operational performance are being appropriately managed, including the reporting of key issues and concerns to the Board for information or further consideration.

In 2017/18 the priority of the Committee was to strengthen and support the finance and performance functions of the CCG given the significant local and

national pressures and challenges, to ensure longer term sustainability of services and finance. To facilitate this, the Committee strives to:

- Seek a specific managerial response in terms of delivery of Directors' own areas of responsibility
- Identify best practice and innovations and to seek ways to access expertise and bring this into the work of the CCG
- Ensure a cost effective, best practice, evidence-based approach is applied rigorously to the CCG's business, particularly in relation to areas of procurement
- Recognise and identify constraints and opportunities for driving improvements
- Interface and engage with clinical business management.

Approved minutes of the Finance and Performance Committee meetings are submitted to the Board at each meeting and are published on the CCG's website. Information about the membership of the Finance and Performance Committee, including attendance records and declaration of interests, is included in Appendix A to this statement.

Primary Care Commissioning Committee

West Hampshire CCG took on delegated arrangements from 1 April 2015 and a formal Delegation Agreement is in place with NHS England. The CCG has established a Primary Care Commissioning Committee, which carries out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act, including:

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

During 2017/18 the Committee has undertaken a range of activities:

- Regular review of the 2017/18 financial position and the submission of the 2018/19 primary care financial plan

- A review of the Quality Progression Scheme 2017/18, including the development, approval and implementation of Locality Plans – and the development of plans for the 2018/19 Scheme
- A regular review of quality performance metrics and to receive assurance that appropriate support is in place for all practice
- Management of the closure of the Brownhill Surgery in Chandlers Ford (after their decision to end their contract to provide general medical services on 30 November 2017 due to the retirement of a GP at the Practice, difficulties in recruiting GPs and increasing workload pressure) and ensuring the continuity of GP access for its patients. There were 7,000 patients registered with the Surgery and by the time of closure all patients have been transferred to other practices - either to their first choice surgery or the one closest to their homes.

The Primary Care Commissioning Committee holds its meeting in public on at least four times per year and agenda papers are available on the CCG's website. Approved minutes of the Primary Care Commissioning Committee meetings are also submitted to the CCG Board at each meeting and are published on the CCG's website. Information about the membership of the Primary Care Commissioning Committee, including attendance records and register of interests, is included in Appendix A to this statement.

Joint arrangements

The CCG has entered into separate joint arrangements with neighbouring CCGs – Southampton City CCG and NHS North Hampshire CCG – to co-ordinate arrangements in relation to system resilience / planning and quality review / monitoring with common providers of acute and community services regarding delivery.

There are also collaborative arrangements with the five CCGs within the Hampshire local authority area and the eight CCGs including Portsmouth, Southampton City and the Isle of Wight, with the latter forming the footprint for the development of the sustainability and transformation plan with local providers, which was submitted in October 2016.

The Sustainability and Transformation Partnership's (STP) seven core programmes focus on transforming the way health and care is delivered (prevention at scale, new models of integrated care, effective patient flow and discharge, Solent acute alliance, North and Mid Hampshire configuration, mental health alliance, and children and maternity) and four enabling programmes to create the infrastructure, environment and capabilities to deliver successfully (digital infrastructure, estate infrastructure rationalisation, workforce, and new commissioning models). This portfolio of programmes is the shared system

delivery plan for the STP. The CCG is a core member of the STP Executive Delivery Group, and leads on a number of key work streams.

The group has formal arrangements with the local Health and Wellbeing Board. Representation on this Board is by the chair of the CCG, who ensures shared duties are discharged by the CCG.

The CCG has strong links with Hampshire County Council's Health and Adult Social Care Select Committee, the Safeguarding Children Board, the Safeguarding Adult Board, the district Health and Wellbeing Boards, and public health.

A key area is the implementation of the iBCF (Improved Better Care Fund), whereby the five Hampshire CCGs have agreed to a partnership approach with Hampshire County Council to support and accelerate the local transformation and integration of health and social care services. The Hampshire plan aims to join up care and support services, reduce duplication and provide local people with the right care, in the right place, at the right time.

The CCG has strong links with the Wessex Local Medical Committee in relation to the sustainability of primary care, the development of integrated care with other providers, and the provision of advice and support with regard to membership issues.

The CCG has no other joint operations with any other agencies or bodies.

Board performance and effectiveness

All Board members have clear objectives and a schedule of regular one-to-one meetings is held to oversee progress, culminating in a year-end appraisal of performance, undertaken by the chair and / or Chief Officer, as appropriate.

During the year there have been a number of changes in the membership of the Board with the appointment of a new Director of Quality and Nursing (from August 2017) and two new lay members with the portfolios of new technologies (from June 2017) and strategy and finance (from September 2017) respectively. Together with the clinical leadership changes in-year and in train for the start of the 2018/19 (as set out in the revised Constitution), the composition of the Board differs substantially from a year ago.

A programme of personal and corporate Board development has commenced as part of the wider organisational development plan. This includes a facilitated review of corporate Board performance and effectiveness focusing on:

- increasing understanding of different skills and personality types of Board members and how they work together
- planning for increasing the effectiveness of Board interactions – both in formal meetings and in briefing
- a shared understanding of the role of the Board and its corporate strategic responsibilities including the role of its constituent members (including Board GPs/Locality Clinical Directors, lay members and executive directors)
- a shared understanding of the challenges and risks facing the Board, including the Board's appetite for risk
- helping the Board to implement any changes to improve Board effectiveness.

Assurance is also derived from the performance improvement and scrutiny role undertaken by a range of different groups and individuals including:

- the active and comprehensive counter fraud service employed by the CCG, and detailed reviews from internal auditors and external auditors, which regularly report to the Audit Committee

- NHS England's Improvement and Assessment Framework (IAF), which is the formal assurance process for CCGs. The IAF was introduced in 2016/17 and is structured around four domains (better health; better care; sustainability; and leadership), and six clinical priorities (mental health; dementia; learning disabilities; cancer; diabetes; and maternity). The CCG has not yet received its annual IAF rating for 2017/18. Final ratings will be published in June 2018

- The latest published full year IAF ratings relate to 2016/17. The CCG was pleased to note that 2016/17 ratings were higher than the previous year with a number of areas of improvement. The final overall rating received for 2016/17 was "requires improvement" - in which WHCCG was rated Outstanding for Cancer and Mental Health care, Good for Learning Disability and Maternity Care. Dementia was rated as requiring improvement, and Diabetes care as inadequate – and full action plans are in place for both these areas, which are already delivering some improvements. Quality of leadership and finance were both rated Amber

- However, as part of the Annual assessment there are 51 detailed clinical indicators which are updated quarterly. The latest indicators relate to the March / Quarter 4 position with the exception of Ambulance Standards where the national recording of pre-existing constitution standards ended in October. Within this section the CCG performs well against a large number of indicators, but has particular challenges relating to Accident and Emergency care, Diabetes and Dementia.

- Regular assurance reviews led by NHS England (Wessex), which focus on the IAF and include regular review of any IAF indicators where further action is required. They are also reviewed as part of the internal CCG assurance process

- Participation in regular joint strategic meetings with the Chief Officer and directors of Hampshire County Council to foster enhanced partnership working across a range of programme areas.

- Partnership working with health services and provider trusts serving west Hampshire, which has developed rapidly during the year, through the development of the sustainability and transformation plan and partnership, and the local delivery/care systems that will deliver the work of the STP. This includes assurance meetings for local delivery systems led by the STP in addition to the assurance process led by NHS England. The local delivery system assurance meetings focus on delivery of system targets and collaborative working for the benefit of the local population.

3.2 UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. However, this Governance Statement is intended to demonstrate the CCG's compliance with the principles set out in the code by drawing on best practice available, including aspects of the code we consider to be most relevant to the CCG, including:

- Leadership – an effective Board which is collectively responsible for the long term sustainability of the CCG.
- Effectiveness – the Board and its committees have an appropriate balance of skills, experience, independence and knowledge to enable them to discharge their respective duties and responsibilities effectively.
- Accountability – the Board is responsible for determining the nature and extent of the principal risks it is willing to take in achieving its strategic objectives. The Board maintains sound risk management and internal control systems.
- Remuneration – remuneration is designed to promote the long-term success of the CCG.
- Relations with stakeholders – engagement and joint working are undertaken with a wide range of stakeholders based on the mutual understanding of objectives.

This Governance Statement is intended to demonstrate compliance with the Best Practice elements set out in Code. For the financial year ended 31 March 2018, and up to the date of signing this statement, we have not complied with the provisions set out in the Code, or applied the principles of the Code.

3.3 Discharge of statutory functions

During establishment, the arrangements put in place by the CCG and explained within the corporate governance framework were developed with extensive expert external legal input to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for members and the Board's (governing body) decision and the scheme of delegation. These arrangements continue to be reviewed through the Board and its Committees, and are updated following legislation changes.

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

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

4. Risk management arrangements and effectiveness

4.1 Overview

The CCG has robust and transparent processes in place for the governance and management of risk. This is the Board Assurance Framework. This outlines to the Board at its public meetings what the key risks to our strategic objectives are, and provides assurance the risks are being managed in line with the Board's risk appetite.

Key risks over the last year include ensuring our financial situation remains sustainable; ongoing financial pressures for our key partners; closing key workforce gaps; ensuring our providers are delivering on the constitutional standards; tackling system pressures across the health economy and ensuring quality is maintained across all our services to ensure the best possible outcome for patients.

The CCG has carried out a range of successful actions and initiatives to address these risks. We have implemented a comprehensive financial recovery plan, engaged with partners to help mitigate the wider financial pressures, developed innovative and collaborative ways to close very challenging clinical workforce gaps, developed the role of A&E Delivery Boards to address system pressures, and continuously review and improve our quality processes. However, we are mindful of ongoing risks for current and future challenges that we are actively tackling regarding further financial pressures, estates and workforce planning, sustainable transformation and progressing new models of care. These are highlighted in our operating plans and will be actively managed through our risk management process.

4.2 Risk Management Policy

West Hampshire CCG recognises that commissioning healthcare services and the activities associated with this process, such as redesigning care pathways, monitoring performance and quality, and managing finances, all involve a degree of risk.

The Board is committed to improving and implementing a risk management policy and strategy that identifies, analyses, evaluates and controls the risks that threaten the delivery of the CCG's strategic objectives. The Board Assurance Framework is used to provide assurance to the Board regarding the identification, evaluation, mitigation and monitoring of aggregated risks to the successful delivery of the strategic objectives, and is considered alongside other key management tools, such as performance and quality dashboards, and financial reports, to give the Board a comprehensive picture of the organisational risk profile.

In early 2018, the CCG reviewed and refined its risk policy, strategy and Board Assurance Framework to provide more emphasis on strategic assurance.

The purpose of the policy is to provide guidance to the Board and all staff on the management of strategic and operational risks and issues within the organisation. In summary, the policy:

- sets out respective responsibilities for strategic and operational risk management for the Board and staff throughout the organisation
- describes the process to be used in identifying, analysing, evaluating and controlling risks to the delivery of the strategic objectives

The objectives of the CCG's risk management strategy are to:

- minimise the chances of risks developing into issues by effective risk

identification, prioritisation, treatment and management
- maintain a risk management process, which provides assurance to the Board that risks to the delivery of the strategic objectives are being managed effectively
- maintain a cohesive approach to corporate governance and effectively manage risk management resources
- ensure that risk management is an integral part of West Hampshire CCG's culture

4.3 Capacity to handle risk

The overall responsibility for the management of risk rests with the Chief Officer, supported collectively and individually by the Board members / Directors. The Audit Committee monitors and reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the CCG and the Corporate Risk Group is responsible for reviewing the operation of the risk management process on a monthly basis. Other standing committees of the Board, such as the Clinical Governance Committee support the CCG in its risk management, escalating information to the Audit Committee, and where necessary directly to the Board to provide assurance with regards to patient safety, patient experience and clinical effectiveness. These responsibilities are clearly set out in the Committees' terms of reference.

Guidance on all matters relating to risk management is available to all staff from the risk management lead, located within the Performance and Delivery directorate.

All directors are fully engaged with the system to maintain and update the Board Assurance Framework and Corporate Risk Register. Risks are systematically identified, evaluated and controlled by each directorate within the CCG. Significant risks and changes are identified – with the risk management lead facilitating and reviewing this process. During 2017/18, West Hampshire CCG has provided access to a range of induction and ongoing training activities in relation to risk management activities. Particular emphasis has been placed on refining the CCG's risk management policy and ensuring the completion of information governance training by all staff, including information risk management for those staff who have specific responsibilities as data custodians and information asset owners.

Specific responsibilities and accountability

In overview, directorate management teams identify risks which are recorded on the CCG's risk management system. These risks are regularly updated by the risk handlers as appropriate. Risks that score 12 or above are updated at least every two months, for review and assurance by the Corporate Risk Group.

These risks inform the Board Assurance Framework report which is reviewed by the Corporate Risk Group and presented to the Board at each public meeting.

The West Hampshire CCG Board is responsible for:

- setting the strategic direction of the organisation, interventions, outcomes and measures
- protecting the reputation of the CCG
- ensuring that assurances demonstrate that risk has been identified, assessed and all reasonable steps taken to manage it appropriately
- providing leadership on the management of risks and
- determining the risk appetite.

The Audit Committee is responsible for:

- scrutinising the application of the Board's risk management policy and strategy
- providing robust challenge to provide assurance to the Board on the application of the risk management policy
- scrutinising the application of the Board's risk appetite
- ensuring the approach to risk management is consistently applied.

The Finance and Performance Committee is responsible for highlighting to the Audit Committee or Board any risks for review, escalation or inclusion on the Corporate Risk Register, as a result of its review of the CCG's finance and performance, and plans to meet statutory responsibilities and constitutional standards.

The Clinical Governance Committee is responsible for approving and monitoring arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes. It also highlights to the Audit Committee any risks for review, escalation or inclusion on the Corporate Risk Register, as a result of its work programme.

The Corporate Risk Group**,** which consists of the executive team who review and update the Corporate Risk Register, and the Board Assurance Framework Report before its consideration by the Board. The group fulfils this role in part by:

- applying the Board's risk appetite to the management of risks
- assessing the current and target risk levels for particular risks
- deciding upon the addition or removal of risks on the Corporate Risk Register
- assigning risk managers and risk handlers as appropriate
- identifying any gaps in the Corporate Risk Register
- recommending actions to close identified gaps and

- developing a common approach to the risk process.
- assessing the aggregated risk to strategic objectives.

Directorate management teams keep risks under regular review. Directors act as risk managers for their respective areas of the business. In respect to risk management, directorate management teams are responsible for:

- ensuring that within their directorate all risk managers and handlers are coordinating, managing, monitoring and reviewing their risks
- ensuring engagement with the risk process
- notifying their director of any risks affecting the delivery of strategic objectives for
- inclusion on the CCG's risk system.
- ensuring staff comply with the risk management policy and strategy
- leading the management of risks by devising short, medium and long term strategies to tackle identified risks, including the production of any action plans
- ensuring all staff fulfil their responsibility for risk management by identifying, reporting, monitoring and reviewing risks
- ensuring that all activities undertaken within their directorate are consistent with safe operation and
- ensuring that appropriate directorate risk registers are produced and actively managed within their directorate.

Internal and external auditors are responsible for agreeing (with the Audit Committee) a programme of audits which assess the exposures and adequacy of mitigation of the principal risks affecting the organisation. The priorities contained in the audit programme should reflect the risk evaluation set out in the Board Assurance Framework. The reports and advice produced by audit should inform the management of risk by directorates although responsibility remains with the relevant lead directors.

The Chief Officer has responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's strategic objectives. In respect to risk management, the Chief Officer:

- ensures that management processes fulfil the responsibilities for risk management as set out in the risk management policy
- ensures that full support and commitment is provided and maintained in every activity relating to risk management plans for adequate staffing, finances and other resources, to ensure the management of those risks which may have an adverse impact on the staff, finances or stakeholders

- ensures an appropriate Board Assurance Framework is prepared and regularly updated and receives appropriate consideration and
- ensures that an Annual Governance Statement, adequately reflecting the risk management status, is prepared and signed off each year.

The risk management lead (currently the emergency management and risk manager) is responsible for:

- producing the Corporate Risk Register
- facilitating the CCG's risk management policy and strategy
- producing the Board Assurance Framework
- scheduling risks on executive team agendas as appropriate and
- reviewing the format and content of risk documents as required.

All members of staff are responsible for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager for escalation as appropriate. In addition, they will ensure that they familiarise themselves and comply with the risk management policy and attend mandatory and other relevant training courses.

4.4 Risk assessment

The CCG has refined its Board Assurance Framework throughout the 2017/18 financial year, so that it represents reasonable assurance for risks affecting the strategic objectives.

The CCG has a uniform process for classifying risk, which exists across all produced risk registers. This is clearly set out within the CCG's corporate risk management strategy. The framework states that for each risk, there is a score which is a measurement of the likelihood of the risk materialising and its potential impact. The risk rating is derived from the risk matrix.

The Board Assurance Framework and Corporate Risk Register enable the executive directors and Board to be reasonably assured and informed about the aggregated risks to the achievement of the CCG's strategic objectives and the controls in place which are intended to manage these risks. The documents comprise:

- The CCG's strategic objectives.
- The principal risks associated with achieving these objectives.
- The key controls / systems in place to minimise the risks.
- The positive assurances available to the Board in the form of internal and external scrutiny, assessments and reports.

- Details of any gaps in controls and / or assurance and describes the specific actions designed to address these gaps.

As per the WHCCG Corporate Risk Management Policy, the Board receives the Board Assurance Framework at each public meeting. The Corporate Risk Register which informs the Board Assurance Framework is reviewed by the Corporate Risk Group every month. The Board Assurance Framework is a *high level, aggregated risk* description of the risks that relate to the achievement of the CCG's strategic objectives. It is to provide assurance to the Board in relation to the management of key risk areas that threaten the ability of the organisation to achieve these objectives.

These strategic risk areas are:

- Finance (financial sustainability, FRP, STP control total)
- Performance (constitutional standards, significant areas of non-delivery)
- Quality (patient experience)
- Developing New Models of Care (STP, local delivery systems)
- Workforce (provider and CCG).

The controls, mitigations and assurances are outlined in the BAF within the Board Papers published on our website.

Board development has taken place early to help embed the new arrangements, including a review of how the Board Assurance Framework is presented to the Board. The West Hampshire CCG Board has a high risk appetite when seeking reward or when designing new corporate processes that drive innovation and positive outcomes for patients. The Board will not tolerate very high risks that could affect the welfare of the public and patients or the CCG's ability to meet financial probity requirements.

The CCG's values include fostering an open and transparent approach to risk management wherever possible. Our work as clinical commissioners can only be successful if we develop effective working relationships with all our stakeholders, including neighbouring CCGs, Hampshire County Council, the Hampshire Health and Wellbeing Board, NHS England, providers, our patients and the public. We will therefore ensure that all risk management developments and ideas are shared with our stakeholders to create the most effective environment for understanding and mitigating the risks that we face. The development of the sustainability and transformation plan has helped to strengthen the risk management approach.

Mindful of the CCG's obligations in respect of public involvement and consultation and its duties to promote integration, the CCG expressly acknowledges the potential importance of information received from patients, members of the public for whom services are being or may be provided, and partner health and social care organisations in the effective identification of risk.

The CCG also has an accredited local counter fraud specialist (LCFS) operating in accordance with the NHS Counter Fraud Standards who regularly reports to the Chief Finance Officer and the Audit Committee against an annual plan. These reports may highlight recommendations for action where appropriate, as risks or weaknesses in control are identified. This covers details of live and closed investigations, as well as the dissemination of issues highlighted from other NHS organisations nationwide.

Knowledge of any actual, suspected or alleged fraud is reported directly to the Audit Committee. Systems and processes are in place to ensure that recommendations are implemented and evidenced to be effective. A detailed annual report is submitted to the Audit Committee each year.

Equality impact assessments are required for all new policies and strategies before they can be agreed. An equality section is built into all papers that go to the Board so that these risks can be identified and mitigated.

In summary, the CCG has developed an integrated approach to risk management, incorporating governance, risk management, and internal control. With the exception of the details set out in section 6, there were no risks or issues during 2017/18 relating specifically to governance, risk management, and internal control highlighted, and none have been identified post 31 March 2018. There were no risks to compliance with the CCG licence identified during the year.

5. Other sources of assurance

5.1 Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG 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.

Each year, we review our strategic objectives and the risks to delivering these objectives are detailed in our Board Assurance Framework (BAF), which follows Government guidance. The BAF also provides evidence to support our Annual Governance Statement. This framework provides us with a simple yet comprehensive method to manage effectively the principal risks in delivering our objectives. It is a high level document, which sets out the risk for each objective, the controls in place and assurances available on their operation.

As set out in section 4 above, this framework is reviewed continually and adjusted to reflect any new circumstances, risks and initiatives. The objectives are then reviewed to reflect lessons learned from the past, current risks and future potential threats. The BAF assures the Board and external stakeholders that risks are being managed effectively.

5.2 Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016 and revised in June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG has carried out its annual internal audit of conflicts of interest. The scope of this audit covered:

- A follow-up review of the specific findings and recommendations made in 2016/17.
- Implementation of new guidance since the previous review.
- Review of the specific processes around conflicts of interest in relation to medicines management.

The audit concluded that substantial assurance can be provided by the CCG's arrangements. It highlighted that the CCG has updated its processes to align with the NHS England statutory guidance. A small number of routine recommendations have been made to support the CCG in its continued development of these processes.

The report was received by the Audit Committee at its meeting held on 5 February 2018.

5.3 Data quality

The CCG works hard to ensure it meets its responsibility to collate and use appropriately good quality data. We have a data quality policy that provides guidance for our staff and our contractors and sets out our principles and the

standards we expect. Our IT provider supports and assures the CCG on the implementation of software countermeasures and management procedures to protect our vital information / assets against the effects of malicious software and other risks.

We have identified our data owners and data processors and, through our information asset owners and data custodians, ensure that there are appropriate processes, use and quality checking of the data we use, receive and share. We set clear roles and responsibilities for staff in relation to data quality and ensure that all staff recognise those responsibilities as an integral part of their job and profession. We provide training and support for teams and ensure working procedures are fully documented and regularly updated, including all job descriptions that support the responsibilities within the policy.

We undertake data validation to ensure that information is of good quality. These processes deal with data that is being added continuously and also can be used on historical data to improve its quality. We undertake regular validation processes on data being recorded to assess its completeness, accuracy, relevance, accessibility and timeliness. These processes include department spot-checks, data correlation and validation, and internal record audits.

We maintain and regularly review our data / data quality framework to ensure that it continues to underpin data quality principles. Staff are required to abide by the principles contained in all related policies and procedures. This is tested through our ongoing information governance processes.

5.4 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 CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

Information governance plays a key role in supporting all areas of our work. The CCG recognises the importance of reliable information, in terms of the efficient management of the services it commissions and the resources it manages.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework, and 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 developed a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are policies and processes in place for incident reporting and the investigation of serious incidents. We have developed information risk assessment and management procedures and a programme has been established to fully embed an information risk culture throughout the organisation against identified risks.

Staff are encouraged to report information governance risks and incidents and there is a strong culture of reporting. This reflects the regular raising awareness of reporting incidents including face to face training, which has encouraged staff to report information governance incidents. Standard operating procedures have been reviewed and strengthened, particularly in areas where there have been increased numbers of temporary staff. All reported information governance / data security incidents are logged on the CCG's incident reporting systems.

Data custodians in all teams have undertaken and returned an information governance spot check and record keeping audit, all of which have been signed off by the respective information asset owner. Audits indicate that there is very good staff awareness of their information governance responsibilities, local information governance procedures and knowledge of key information governance staff within the CCG. This is further evidenced by over 95% of all staff completing their mandatory training.

Reviews by the internal auditors have concluded that the CCG has provided substantial assurance to support its assessment of its levels of attainment against the Information Governance Toolkit Version 14.1 requirements. The CCG has achieved two level 2 and five level 3 requirements.

5.5 Business critical models

The CCG has considered the HM Treasury report *Review of quality assurance of Government analytical models: final report* and its implications for quality assurance of business critical models. We do not employ business critical models as implied by the report. Our work as clinical commissioners relies on information gathered from other organisations which provide the services that we commission. When we model and analyse this data, we use multiple tools and sources to verify and check the output, and therefore quality assurance is built into all the analytical work that we undertake.

5.6 Third party assurances

The CCG relies on third party providers for support services, as follows:

- South, Central and West Commissioning Support Unit (SCWCSU) which provides a range of commissioning support services including contract management, payroll, financial ledger, accounts payable, accounts receivable, financial reporting, treasury and cash management, and business intelligence.
- NHS Shared Business Services (SBS) which provides general ledger and financial accounting services for the NHS England group. This includes cash management, debt management, procure to pay, eProcurement, payroll and VAT services.

We receive regular audit reports covering business process areas for which it relies on third party providers.

Effective control procedures are in place; SCWCSU has developed an action plan to improve its internal assurance processes. There are no areas of exception in third party assurances related to West Hampshire CCG services.

6. Control issues

As described in earlier sections, the CCG has developed an integrated approach to risk management, incorporating governance, risk management, and internal control. With the exception of the details set out below, there were no risks or issues during 2017/18 relating specifically to governance, risk management, and internal control highlighted via the Month 9 Governance Statement, and none have been identified post 31 March 2018. There were no risks identified during the year to compliance with the CCG licence.

Financial recovery programme

The CCG submitted a financial plan for 2017/18 to NHS England which set out a planned underspend for the year of £8.9m surplus of income above expenditure. This included £7.1m of income in 2017/18 relating to prior years. This plan was formally accepted by NHS England, and reflected the business rules requirements of:

- An ‘in-year’ 0.3% surplus (agreed with NHS England as part of a trajectory to a full 1% surplus requirement under business rules).
- A 0.5% contingency.
- Budgets for running cost set within the running cost allocation and workforce plans.
- A minimum of 2% ‘parity of esteem’ investment in mental health services.

- The provision of a 0.5% risk (headroom reserve)

The forecast underspend of £3.0 million depended on the delivery of savings with consideration for quality, innovation, prevention and productivity (QIPP) which totalled £31.6 million for the year. At 4.2% of the CCG's allocation the total savings requirement was higher than generally accepted levels of annual efficiency. The risks to the delivery of the Clinical Commissioning Group's plan were discussed with NHS England during the planning process.

Many of the risks to the CCG's financial plan that were identified at planning stage have had an impact on the financial position for the year. For example potential risks from unidentified savings, over-performance on acute contracts, and increased medicines management and continuing healthcare expenditure have become real pressures which were forecast to prevent the CCG from achieving its financial plan.

In February 2018 the CCG updated its forecast to declare a breakeven position for the year end. This was reported formally to NHS England, following review by the Finance and Performance Committee and Board. In the Finance Report in March 2018, the month 11 position maintained the breakeven forecast, utilising the centrally held risk reserve and category M drugs adjustments.

The financial recovery programme (FRP) is an embedded part of the CCG structure, with the aim of maintaining financial stability on a recurrent basis, and of identifying and delivering further savings as a sound basis for financial plans for 2018/19, 2019/20 and beyond.

Constitutional Standards for Emergency Department (95% within 4 hours)

There is a constitutional standard for 95% of patients to be seen within four hours in emergency departments. The CCG did not achieve this standard throughout 2017/18, nor did the CCG's two main acute service providers – Hampshire Hospitals NHS Foundation Trust (HHFT) and University Hospital Southampton NHS Foundation Trust (UHSFT). Action plans are in place to address issues such as delayed transfers of care, available community capacity, patient flows, and staffing/access to timely clinical decisions. Contractual recovery action plans continue to be reviewed with both Trusts.

The Board has received briefing presentations at its meetings throughout the year and has been assured by the actions being taken under the auspices of the South West and North and Mid Hampshire A&E Delivery Boards, and that the success criteria, system dashboard and key performance indicators for monitoring at system level are in place. Provider specific Sustainability and

Transformation Fund (STF) recovery trajectories are also in place with NHS Improvement, the regulator for provider organisations.

In summary, for both these issues (financial sustainability and emergency department performance):

- The Board and its Committees received regular briefings and assurance updates, and internal and external auditors are aware of the mitigating actions taken
- Delivery of the standards expected of the Accountable Officer have not been at risk and regular assurance discussions have been held with NHS England, including other commissioners and providers in the respective care system
- It has not made it harder to resist fraud or other misuse of resources
- It is not expected to have a material impact on the accounts
- National security of data integrity has not been put at risk.

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

As Accountable Officer, I have overseen the key processes to ensure that resources are used economically, efficiently and effectively, with the aim of delivering our strategic objectives as a CCG within our funding allocation. Our processes to ensure value for money in everything that we do mean that economy, efficiency and effectiveness are interwoven with our governance framework and internal controls.

The key processes include:

- Monthly reviews of activity and finance culminating in reports to the Board, which have been reviewed by the Finance and Performance Committee
- The establishment of a financial recovery programme (with weekly meetings led by the Director of Performance and Delivery) to ensure financial delivery in 2017/18 and financial stability into 2018/19 and future years, in response to emerging financial pressures and known changes in funding
- Detailed reports from internal auditors, external auditors and the local counter fraud service to the Audit Committee, which are reported to the Board via minutes and exception reporting
- Robust approval processes for business cases for new investment or dis-investment
- A project management approach to delivering and monitoring our quality, innovation, prevention and productivity (QIPP) programme, supported by a programme management office

- Review of benchmarking data to ensure all opportunities for efficiency are considered when compared to similar CCGs (such as RightCare, and other national benchmarking tools e.g. Atlas of Variation)
- Regular monitoring through the NHS England assurance process, which includes financial measures as part of quarterly assessments, and other financial measures required by NHS England
- Regular assurance meetings for local delivery systems led by the STP (in addition to the assurance process led by NHS England). The local delivery system assurance meetings focus on delivery of system targets and collaborative working for the benefit of the local population
- The CCG has a strong budgetary control system which ensures that central management costs, also known as running costs, are within the financial envelope set by NHS England for the CCG. All recruitment requests are formally approved and recorded at executive team meetings to ensure oversight of staffing costs which make up the majority of the CCG's management costs
- The CCG has strong efficiency controls built into its day-to-day governance processes with clear delegated limits for expenditure set out in its standing financial instructions. The CCG's clear focus on financial recovery strengthens its efficiency controls as all staff are asked to consider financial efficiency in all decision making. The project management office approach to savings and financial efficiency means that there is an ongoing process for reviewing expenditure and opportunities for greater financial efficiency which are then monitored as QIPP (Quality Innovation Prevention and Productivity) savings.

Delegation of functions

West Hampshire CCG works in partnership with other CCGs to commission health and social care collaboratively; to commission services at the appropriate tier to achieve the best possible outcomes for patients. This includes:

- *Mental Health and Learning Disabilities* – West Hampshire CCG (WHCCG) lead on collaborative commissioning for mental health and learning disabilities on behalf of the five Hampshire CCGs, and also leads on the Transforming Care Partnership (Learning Disabilities) for the whole of Hampshire and the Isle of Wight
- *Children and maternity* – West Hampshire is part of the commissioning collaborative for Children's services which is led by North East Hampshire and Farnham CCG
- *Continuing Healthcare* – West Hampshire CCG leads the continuing healthcare commissioning collaborative for the five Hampshire CCGs
- *Medicines Management* – The CCG's Head of Medicines Optimisation is leading work within the Hampshire and Isle of Wight sustainability and

transformation plan to develop and share best practice in medicines management across our region.

Through the range of assurance mechanisms outlined in this Annual Governance Statement, including the work of the Board, the Finance and Performance Committee, the Clinical Governance Committee, the Clinical Cabinet and the Audit Committee/internal audit as well as the joint governance arrangements in place, a thorough assessment of feedback from delegation chains has been undertaken to ensure that resources are used economically, efficiently and effectively.

Counter fraud arrangements

The CCG's arrangements in relation to the risks of fraud are primarily through the active and comprehensive counter fraud service employed by the CCG. There is a statutory requirement for each health body to have clear counter fraud arrangements and access to appropriate accredited counter fraud support. The Hampshire and Isle of Wight Counter Fraud and Security Management Service provide the CCG with:

- A nominated professional accredited Local Counter Fraud Specialist (LCFS), with additional support from the team as required
- Access to the team as a nationally recognised centre of expertise that understands the requirements of CCGs and providers having delivered the counter fraud service in Hampshire since 2003
- A complete counter fraud service locally implementing the NHS Counter Fraud Authority anti-fraud strategy in the four key areas of**;** 'strategic governance', 'inform and involve', 'prevent and deter' and 'hold to account'.

West Hampshire CCG's counter fraud work plan for 2017/18 was developed by the Hampshire and Isle of Wight Counter Fraud and Security Management Service in conjunction with the Chief Finance Officer (who is the executive Board member responsible for tackling fraud bribery and corruption), and approved by the Audit Committee prior to the start of the financial year. This plan identifies work to be undertaken to address identified risks as well as clear outcomes in each of the four strategic areas.

The LCFS reports to each meeting of the Audit Committee, highlighting recommendations for action where appropriate, as risks or weaknesses in control are identified. This covers details of live and closed investigations as well as the dissemination of issues highlighted from other NHS organisations nationwide. Knowledge of any actual, suspected or alleged frauds is reported directly to the Committee. Systems and processes are in place to ensure that recommendations are implemented and evidenced to be effective. A detailed

annual report is prepared for the Audit Committee each year, including a report against each of the Standards for Commissioners.

8. Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the head of internal audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The head of internal audit (TIAA) concluded that:

Reasonable 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.

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

Area of Audit	Level of Assurance Given
Payroll and Human Resources Systems (Off-Payroll Staff – Governance Arrangements)	Substantial Assurance
Assurance Framework and Risk Management	Reasonable Assurance
Service Transformation / QIPP Delivery	
Governance Arrangements – Phase 1	Substantial Assurance
QIPP Delivery – Phase 2	Reasonable Assurance
Primary Care Commissioning	Reasonable Assurance
Financial Accounting Systems	Substantial Assurance
Payroll and HR systems	Substantial Assurance
Corporate Governance Arrangements	Substantial Assurance
Conflicts of Interest	Substantial Assurance

Continuing Healthcare	
Continuing Healthcare – Phase 1 Review	Not assigned (follow-up review)
Continuing Healthcare – Phase 2 Review	Limited Assurance in respect of backlog status
Information Governance Toolkit v14.1	
Phase 1 – Status Update	Not assigned (operational review)
Phase 2 – Review	Substantial Assurance

During the year the internal auditors have identified no emerging risks which could impact on the governance, risk and internal control framework of the CCG.

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

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

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal strategic 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 Board, the Audit Committee, Finance and Assurance Committee and Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:

- Monthly activity and finance reports to the Board, which have been reviewed by the Finance and Assurance Committee
- Weekly reviews of the financial recovery programme, which reports on progress to ensure financial delivery in 2017/18 and financial stability into 2018/19 and future years, in response to emerging financial pressures and known changes in funding

- Bi-monthly reviews of quality and safety reports and scorecards, which have been reviewed in further detail by the Clinical Governance Committee
- Detailed reports from internal auditors, external auditors and the local counter fraud service to the Audit Committee, which are reported to the Board via minutes and exception reporting
- Bi-monthly updates to the Board on the key strategic and operational issues being managed by the CCG commissioning directorates, including its clinical directors, jointly with Clinical Cabinet
- Updates on progress against the Board Assurance Framework and associated action plans following respective reviews by the Risk Review Group, Audit Committee and Board
- The formal CCG Improvement and Assessment Framework, which is operated quarterly through NHS England (Wessex). This is structured around four domains (better health; better care; sustainability; and leadership), and six clinical priorities (mental health; dementia; learning disabilities; cancer; diabetes; and maternity)
- Assurance meetings for local delivery systems led by the Sustainability and Transformation Partnership (in addition to the assurance process led by NHS England). The local delivery system assurance meetings focus on delivery of system targets and collaborative working for the benefit of the local population
- Regular one-to-one meetings with all Board members, including a year-end appraisal of performance. Moreover, I exercise internal management controls through regular executive team and senior management team meetings and attendance at various committees
- Regular internal directorate assurance meetings which review progress on the implementation of the CCG's strategic objectives.

10. Conclusion

There have been no significant internal control issues identified and I believe this Annual Governance Statement is a balanced reflection of the risks and controls operating within the CCG during 2017/18.

15. APPENDIX A: Membership of the CCG's Board and committees (by body / committee)

Board members 2017/18

Dr Nick Arney, Clinical Executive Director (to August 2017)

Dr Tim Cotton, Clinical Executive Director and Vice Clinical Chairman (to September 2017)

Mike Fulford, Chief Finance Officer and Deputy Chief Officer

Simon Garlick, Lay Member, Governance

Judith Gillow, Lay Member, Quality (all year) and Interim Board Nurse (from March-August 2017)

Ian Green, Lay Member, Patient and Public Involvement (to May 2017)

Heather Hauschild, Chief Officer

Dr Simon Hunter, Clinical Executive Director

Dr Andrew Isbister, Locality Clinical Director/Board GP (from September 2017)

Professor Johnny Lyon-Maris, Locality Clinical Director/Board GP (from October 2017)

Ellen McNicholas, Director of Quality and Nursing (from August 2017)

Dr Tim Thurston, Clinical Executive Director

Caroline Ward, Lay Member, New Technologies (from June 2017)

Dr Sallie Bacon, Director of Public Health, Hampshire County Council*

Jenny Erwin, Director of Commissioning, Mid Hampshire*

Beverley Goddard, Director of Performance and Delivery*

Rachael King, Director of Commissioning, South West*

Heather Mitchell, Director of Strategy and Service Development*

Barbara Moorhouse, Lay Member, Strategy and Finance* (to May 2017)

Helen Pardoe, Secondary Care Consultant*

Alison Rogers, Lay Member, Strategy and Finance* (from September 2017)

Dr Sarah Schofield, Clinical Chairman

* Non-voting member, in attendance

Audit Committee members 2017/18

Simon Garlick, Lay Member, Governance and Chair

Judith Gillow, Lay Member, Quality and Interim Board Nurse (from March-August 2017)

Ian Green, Lay Member, Patient and Public Involvement (to May 2017)

Alison Rogers, Lay Member, Strategy and Finance (from September 2017)

Caroline Ward, Lay Member, New Technologies (from June 2017)

The CCG Chief Officer, Chief Finance Officer and other managers are invited and/or in attendance at meetings of the Committee as well as representatives of the internal and external audit service providers, and the local counter fraud specialist.

Remuneration Committee members 2017/18

Simon Garlick, Lay Member, Governance – Committee Chair

Judith Gillow, Lay Member, Quality

Ian Green, Lay Member, Patient and Public Involvement (to May 2017)

Barbara Moorhouse, Lay Member, Strategy and Finance (to May 2017)

Alison Rogers, Lay Member, Strategy and Finance (from September 2017)

Dr Sarah Schofield, Clinical Chairman

Dr Tim Thurston, Clinical Executive Director

Caroline Ward, Lay Member, New Technologies

The CCG Chief Officer, Chief Finance Officer and other executive directors may be invited to attend meetings of the Committee but must withdraw for any issue that relates to them personally. No Committee member is present for discussions about their own remuneration or terms of service.

Clinical Cabinet members 2017/18

Dr Nick Arney, Clinical Executive Director, Patient and Public Engagement (to August 2017)

Dr Lesley Ayling, Clinical Director, Children and Families

Dr Rachel Barrass-Stones, Clinical Director, Primary Care and Community Services (to June 2017)

Dr Charlie Besley, Locality Clinical Director, Totton and Waterside

Simon Bryant, Consultant in Public Health * (from June 2017)

Dr Tim Cotton, Clinical Executive Director and Vice Clinical Chair (to September 2017)

Jenny Erwin, Director of Commissioning, Mid Hampshire

Dr Roland Fowler, Locality Clinical Director, Eastleigh North and Test Valley South (from May 2017)

Dr Dina Foy, Locality Clinical Director, Eastleigh North and Test Valley South (to April 2017)

Mike Fulford, Chief Finance Officer and Deputy Chief Officer

Beverley Goddard, Director of Performance and Delivery

Dr Karl Graham, Clinical Director, IT and Locality Clinical Director, Eastleigh Southern Parishes

Dr Emma Harris, Clinical Director, Medicines Management

Heather Hauschild, Chief Officer

Dr Simon Hunter, Clinical Executive Director

Dr Andrew Isbister, Locality Clinical Director, Mid Hampshire

Rachael King, Director of Commissioning, South West

Marie-Claire Lobo, Consultant in Public Health * (to May 2017)

Prof Johnny Lyon-Maris, Locality Clinical Director, West New Forest

Ellen McNicholas, Director of Quality and Nursing (from August 2017)

Beverley Meeson, Deputy Director, Service Development *

Heather Mitchell, Director of Strategy and Service Development

Matthew Richardson, Deputy Director of Quality * (to May 2017) – cover for director

Dr Sarah Schofield, Clinical Chairman

Dr Tim Thurston, Clinical Executive Director

Dr Sean Watters, Clinical Director, Planned Care and Long Term Conditions

Dr Katrina Webster, Clinical Director, Mental Health

Professor Clare Wedderburn, Clinical Director, Primary Care and Community Services (from October 2017 to January 2018)

* Non-voting member, in attendance

Clinical Governance Committee members 2017/18

Lesley Ayling, Clinical Director, Children and Families

Helen Cruickshank, Public Health Consultant, Hampshire County Council

Jenny Erwin, Director of Commissioning, Mid Hampshire

Simon Garlick, Lay Member, Governance

Judith Gillow, Lay Member, Quality *(Chair)* (all year) and Interim Board Nurse (from March-August 2017)

Beverley Goddard, Director of Performance and Delivery

Heather Hauschild, Chief Officer

Dr Simon Hunter, Clinical Executive Director

Rachael King, Director of Commissioning, South West

Ellen McNicholas, Director of Quality and Nursing (from August 2017)

Heather Mitchell, Director of Strategy and Service Development

Matthew Richardson, Deputy Director of Quality

Dr Sarah Schofield, Clinical Chairman

Caroline Ward, Lay Member, New Technologies

Dr Sean Watters, Clinical Director, Planned Care and Long Term Conditions

John Carr, Patient Representative*

Don Hedges, Patient Representative *

* Non-voting member, in attendance

Finance and Performance Committee members 2017/18

Dr Nick Arney, Clinical Executive Director (to August 2017)

Dr Tim Cotton, Clinical Executive Director and Vice Clinical Chairman (to September 2017)

Mike Fulford, Chief Finance Officer and Deputy Chief Officer

Simon Garlick, Lay Member, Governance

Judith Gillow, Lay Member, Quality (all year) and Interim Board Nurse (from March-August 2017)

Ian Green, Lay Member, Patient and Public Involvement (to May 2017)

Heather Hauschild, Chief Officer

Dr Andrew Isbister, Locality Clinical Director/Board GP (from September 2017)

Dr Simon Hunter, Clinical Executive Director

Professor Johnny Lyon-Maris, Locality Clinical Director/Board GP (from October 2017)

Ellen McNicholas, Director of Quality and Nursing (from August 2017)

Dr Tim Thurston, Clinical Executive Director

Caroline Ward, Lay Member, New Technologies (from June 2017)

Jenny Erwin, Director of Commissioning, Mid Hampshire

Beverley Goddard, Director of Performance and Delivery

Rachael King, Director of Commissioning, South West

Heather Mitchell, Director of Strategy and Service Development

Barbara Moorhouse, Lay Member, Strategy and Finance (to May 2017)

Helen Pardoe, Secondary Care Consultant

Matthew Richardson, Deputy Director of Quality (deputising Director of Quality)

Alison Rogers, Lay Member, Strategy and Finance* *(Chair)* (from September 2017)

Dr Sarah Schofield, Clinical Chairman

Primary Care Commissioning Committee members 2017/18

Dr Sallie Bacon, Director of Public Health, Hampshire County Council*

Rachel Barrass-Stones, Clinical Director, Primary Care and Community Services* (to June 2017)

Tim Cotton, Clinical Executive Director, Primary Care and Vice Clinical Chair (to September 2017)

Jenny Erwin, Director of Commissioning, Mid Hampshire

Mike Fulford, Chief Finance Officer and Deputy Chief Officer

Simon Garlick, Lay Member, Governance

Judith Gillow, Lay Member, Quality and Interim Board Nurse (from March-August 2017)

Ian Green, Lay Member, Patient and Public Involvement *(Chair)* (to May 2017)

Heather Hauschild, Chief Officer

Rachael King, Director of Commissioning, West (all year) and South (from March 2017)

Ellen McNicholas, Director of Quality and Nursing (from August 2017)

Heather Mitchell, Director of Strategy and Service Development (from May 2016)

Barbara Moorhouse, Lay Member, Strategy and Finance (to May 2017)

Alison Rogers, Lay Member, Strategy and Finance (from September 2017)

Helen Pardoe, Secondary Care Consultant

Caroline Ward, Lay Member, New Technologies *(Chair)* (from June 2017)

Professor Clare Wedderburn, Clinical Director, Primary Care and Community Services (from October 2017 to January 2018)

* Non-voting member, in attendance

A-Z membership of the West Hampshire Clinical Commissioning Group Board and Committees 2017/18, incorporating attendance records and declared conflicts of interests (* denotes non-voting member, in attendance)

Name	Title	Board / Committee membership:	Attendance record (actual/possible)	Declared interests throughout the year
Dr Nick **Arney**	Clinical Executive Director (to August 2017)	Board Clinical Cabinet Finance and Performance Committee	2/2 2/3 3/4	Nick is a GP Partner at Forest Gate Surgery. Nick's practice is a shareholder of New Forest Healthcare Limited and a fast follower in the Vanguard Programme. The Forest Gate Surgery was a member of New Forest Healthcare Limited (company ceased trading) Nick's wife is the West Hampshire CCG Representative on the Individual Funding Request Panel. 4 hours p/wk contract. Last updated: July 2017
Dr Lesley **Ayling**	Clinical Director, Children and Families	Clinical Cabinet Clinical Governance Committee	8/10 1/1	Lesley is a salaried GP at Ringwood Medical Centre Lesley is a GP appraiser in the Wessex Area. Lesley's son works for HMG Treasury (Tax administration) Last updated: March 2018
Dr Sallie **Bacon**	Director, Public Health, Hampshire County Council	Board * Primary Care Commissioning Committee *	3/6 0/5	Sallie is employed by Hampshire County Council in the role of Director, Public Health. Sallie is a member of the Governing Body of NHS North Hampshire Clinical Commissioning Group Last updated: March 2018
Dr Rachel **Barrass-Stones**	Clinical Director, Primary Care and Community Services (to June 2017)	Clinical Cabinet Primary Care Commissioning Committee *	0/2 1/1	Rachel is a GP partner and business lead at Ringwood Medical Centre. Rachel's practice has contracts with a number of local providers for the provision of outreach clinics. Rachel's practice is a part of Better Local Care MCP. Rachel's practice was a member of New Forest Healthcare Limited (company ceased trading) Rachel's practice has a primary care research contract with University Hospital Southampton NHS Foundation Trust. Rachel's' brother is employed by Biomet which manufactures joint replacements. Last updated: May 2017

Dr Charles **Besley**	Locality Clinical Director, Totton and Waterside	Clinical Cabinet	9/10	Charles is a partner in the Red and Green Practice, Waterside Health Centre, Hythe. The practice was a shareholder in New Forest Healthcare Ltd (ceased trading). Charles is a speciality Doctor at Oakhaven Hospice, Lower Pennington Lane, Lymington (part time contract) Charlie is UK Board Chair of 'Bethany Kids', a charity supporting paediatric surgery in East Africa. Last updated: March 2017
Simon **Bryant**	Associate Director, Public Health, Hampshire County Council	Clinical Cabinet	8/9	Simon is an employee of Hampshire County Council. Simon gives ad-hoc lectures for the University of Southampton and University of Portsmouth. Last updated: March 2018
John **Carr**	Patient representative	Clinical Governance Committee *	6/6	John is: • Chair: Hythe Hospital League of Friends • Member : Hythe and Blackfield patient participation group • Member: Hythe Hospital stakeholder group • Member: Hythe Hospital project board Last updated: March 2018
Dr Tim **Cotton**	Vice Clinical Chair Clinical Executive Director (to September 2017)	Board Clinical Cabinet Finance and Performance Committee Primary Care Commissioning Committee	3/3 4/4 5/5 3/3	Tim is a sessional GP working in the West Hampshire CCG health economy. Tim's wife is a physiotherapist employed by Hampshire Hospitals NHS Foundation Trust as a community rehabilitation therapist. Last updated: September 2017
Helen **Cruickshank**	Public Health Consultant, Hampshire County Council	Clinical Governance Committee	5/6	Helen has no interests to declare. Last updated: March 2018
Jenny **Erwin**	Director of Commissioning, Mid Hampshire	Board Clinical Governance Committee Clinical Cabinet Finance and Performance Committee Primary Care Commissioning Committee	5/6 2/6 9/10 9/10 4/5	Jenny has no interests to declare. Last updated: March 2018

Dr Dina **Foy**	Locality Clinical Director, Eastleigh North and Test Valley South (to April 2017)	Clinical Cabinet	1/1	Dina is a GP partner at St Andrew's Surgery, Eastleigh. Dina's practice is shareholder of the Tri-Locality Care Limited, a primary care provider company. Dina's practice is a member of Eastleigh North Test Valley South Better Local Care MCP Last updated: April 2017
Dr Roland **Fowler**	Locality Clinical Director, Eastleigh North and Test Valley South (from May 2017)	Clinical Cabinet	7/9	Roland is a Partner at North Baddesley Surgery. Roland is Medical Director of Tri-Locality Care, GP Federation for Eastleigh North and Test Valley South. Roland is Better Local Care Clinical Lead. Last updated: March 2018
Mike **Fulford**	Chief Finance Officer and Deputy Chief Officer	Board Clinical Cabinet Finance and Performance Committee Primary Care Commissioning Committee	6/6 6/10 10/10 4/5	Mike has no interests to declare. Last updated: March 2018
Simon **Garlick**	Lay Member, Governance	Board Audit Committee (Chair) Clinical Governance Committee Finance and Performance Committee Remuneration Committee (Chair) Primary Care Commissioning Committee	6/6 5/5 5/6 10/10 1/1 4/5	Simon undertakes voluntary work at Salisbury Hospice, and assists with washing up and serving meals to patients. Simon was previously a Director for Grant Thornton LLP UK (until 1 April 2015) Last updated: March 2018
Judith **Gillow**	Lay Member, Quality Interim Board Nurse (from March to September 2017)	Board Audit Committee Clinical Governance Committee Finance and Performance Committee Remuneration Committee Primary Care Commissioning Committee	5/6 4/5 6/6 10/10 1/1 5/5	Judith is Trustee on the Board of the Enham Trust Judith is Senior Nurse Advisor, Health Education Wessex Judith is Specialist Advisor, Care Quality Commission – Judith is Non-Executive Director for Dorset County Hospital. Judith was Interim Board Nurse at West Hampshire CCG (from March to September 2017) Last updated: March 2018

Beverley **Goddard**	Director of Performance and Delivery	Board * Clinical Cabinet Clinical Governance Committee Finance and Performance Committee	4/6 10/10 5/6 8/10	Beverley is a director of Beverley Goddard Consulting Ltd, a company which has provided financial management consultancy to NHS bodies from 2005 to 2007. The company has not undertaken any trading activity since 2007. Beverley's sister is a biomedical scientist working in the pathology department at Salisbury NHS Foundation Trust. Last updated: March 2018
Dr Karl **Graham**	Clinical Director, IT	Clinical Cabinet	10/10	Karl is a GP at Hedge End Medical Centre. Karl is a practice shareholder of Eastleigh Southern Parishes Network Limited. Hedge End Medical Centre is a member of the Eastleigh Southern Parishes MCP Vanguard. Last updated: March 2018
Ian **Green**	Lay Member, Patient and Public Involvement (to May 2017)	Board Audit Committee Finance and Performance Committee Remuneration Committee Primary Care Commissioning Committee (Chair)	1/1 0/1 0/2 0/0 1/1	Ian is: • Chief Executive of the Terrence Higgins Trust • Chair, Advance Housing Association • Non-executive director, Wandle Housing Association • Member of disciplinary committee, Royal College of Veterinary Surgeons • Member of Public Health England's HIV, Sexual Health & Reproductive Board • Member of Public Health England's Community Advisory Board on Pre-Exposure Prophylaxis Ian held senior roles (including Chief Executive Officer) and has a long involvement with the YMCA, part of which contracts with the NHS Last updated: May 2017
Emma **Harris**	Clinical Director, Medicines Management	Clinical Cabinet	9/10	Emma is a GP partner at West Meon Surgery, West Meon Surgery is a shareholder member of Mid Hampshire Healthcare Limited. West Meon Surgery is a member practice of Rural East Better Local Care Group. Emma's husband is a consultant urologist at University Hospital Southampton NHS Foundation Trust, and with private sector provider South Coast Urology. Emma's cousin works for Astellas and covers Hampshire. Last updated: March 2018

Heather **Hauschild**	Chief Officer	Board Clinical Cabinet Clinical Governance Committee Finance and Performance Committee Primary Care Commissioning Committee	6/6 7/10 5/6 7/10 5/5	Heather's husband works for Ascribe, a company that designs software for use in hospitals. Heather is a member of LIFE, a Roman Catholic charity providing pro-life advocacy and education work with nationwide services with positive alternatives to abortion Heather's son was Service Improvement Manager at University Hospital Southampton NHS Foundation Trust (until August 2017) Last updated: March 2018
Don **Hedges**	Patient representative	Clinical Governance Committee *	3/6	Don is ambassador for Wessex Cancer Trust. Don has been employed in a casual work role by University Hospital Southampton NHS Foundation Trust as a consultant to provide a patient perspective in relation to a research project involving drugs/surgery. Last updated: March 2018
Dr Simon **Hunter**	Clinical Executive Director	Board Clinical Cabinet Clinical Governance Committee Finance and Performance Committee	5/6 8/10 3/3 9/10	Simon is a GP Partner at Testvale Surgery. Simon was the CCG's Governor for University Hospital Southampton NHS Foundation Trust (to July 2017). Testvale Surgery receives income from Southern Health to provide medical cover for some residents at Tatchbury. Simon's wife is a partner at Forest Gate Surgery. Last updated: March 2018
Dr Andrew **Isbister**	Locality Clinical Director, Mid Hampshire Board GP (from September 2017)	Board Clinical Cabinet Finance and Performance Committee	4/4 7/10 6/6	Andrew was a partner at Watercress Medical, Medstead Andrew's wife, Amanda Masters, was also a partner at Watercress Medical Watercress Medical is a member practice of Mid Hampshire Healthcare Limited Andrew was Chairman of Winchester City Council Health and Wellbeing Board Andrew was Vice Chairman of Mid Hampshire Alliance Steering Group. Andrew is a sessional GP in the Mid Hampshire Locality. Last updated: March 2018

Rachael **King**	Director of Commissioning, South West	Board * Clinical Cabinet Clinical Governance Committee Finance and Performance Committee Primary Care Commissioning Committee	4/6 9/10 2/6 8/10 5/5	Rachael has no interests to declare. Last updated: March 2018
Marie-Claire **Lobo**	Public Health Consultant, Hampshire County Council	Clinical Cabinet *	1/2	Marie-Claire has no interests to declare. Last updated: March 2017
Prof Johnny **Lyon-Maris**	Locality Clinical Director, West New Forest Board GP (from September 2017)	Board Clinical Cabinet Finance and Performance Committee	2/3 8/10 3/5	Johnny was a Partner, Lyndhurst Surgery Johnny is a GP retention doctor at Lyndhurst Johnny is an Associate GP, Dean Health Education Wessex. Johnny receives funding from the General Medical Council, Health Education Wessex. Johnny has been appointed as International Development Advisor in Family Medicine for Kosovo. This is a Royal College of General Practitioners appointment. Johnny is the Consultant civilian advisor in General Practice to the Royal Navy. Johnny is a Care Quality Commission Inspector. Last updated: March 2018
Ellen **McNicholas**	Director of Quality and Nursing (from August 2017)	Board Clinical Cabinet Clinical Governance Committee Finance and Performance Committee Primary Care Commissioning Committee	4/4 4/6 4/4 7/7 1/2	Ellen is a Governor at University Hospital Southampton Foundation Trust (from September 2017) Last updated: March 2018
Beverley **Meeson**	Deputy Director, Service Development	Clinical Cabinet	8/10	Beverley has no interests to declare. Last updated: March 2018

Heather **Mitchell**	Director of Strategy and Service Development	Board * Clinical Cabinet Clinical Governance Committee Finance and Performance Committee Primary Care Commissioning Committee	5/6 8/10 6/6 10/10 4/5	Heather has no interests to declare. Last updated: March 2018
Barbara **Moorhouse**	Lay Member, Strategy and Finance (to May 2017)	Board * Finance and Performance Committee Primary Care Commissioning Committee Remuneration Committee	0/1 0/2 0/1 0/0	Barbara is a Non-Executive Director of Agility Trains Barbara is a trustee, Guy's and St Thomas' Charity Barbara is an Independent Director, Lending Standards Board Barbara is a Non-Executive Director of Idox plc, a supplier of document management solutions. Non-Executive Director of Microgen plc, a software provider primarily to the telecoms and financial services industries Last updated: March 2017
Helen **Pardoe**	Secondary Care Consultant	Board Finance and Performance Committee Primary Care Commissioning Committee	6/6 8/10 2/5	Helen was Consultant, colorectal surgery at Homerton University NHS Foundation Trust *(to May 2017)* Helen is Associate Medical Director, Princess Alexandra Hospital NHS Trust (Harlow) *(from June 2017)* Helen is Physician Advocate, Cerner UK (health information technology company) *(ceased May 2017)* Helen's sister was Chair of Sussex Partnership NHS Foundation Trust *(ceased September 2017)* Last updated: March 2018
Matthew **Richardson**	Deputy Director of Quality	Clinical Governance Committee Finance and Performance Committee (deputising for Director) Primary Care Commissioning Committee	6/6 6/6 4/5	Matthew is Director of Malmesbury Infection Solutions Ltd, which provides infection control consultancy to public, private and charitable organisations. The company does not contract with NHS West Hampshire CCG or providers or with any GPs in the West Hampshire area. Matthew has an honorary contract with Southern Health NHS Foundation Trust – to allow him to work as a registered nurse on behalf of WHCCG. Matthew is a specialist advisor for the Care Quality Commission. Last updated: March 2018

Alison **Rogers**	Lay Member, Strategy and Finance (from September 2017)	Audit Committee	2/4	Alison has no interests to declare.
		Board *	4/4	Last updated: March 2018
		Finance and Performance Committee	6/6	
		Primary Care Commissioning Committee	2/2	
		Remuneration Committee	1/1	
Dr Sarah **Schofield**	Clinical Chairman	Board (Chairman)	5/6	Sarah is an Associate GP at St Francis / Park Surgery in Chandlers Ford
		Clinical Cabinet	7/10	Sarah is a member of Editorial Board, the Commissioning Review
		Clinical Governance Committee	5/6	Sarah is a member of the HSJ Events Advisory Board.
		Finance and Performance Committee	9/10	Sarah is a member of Standards Certification & Awards Committee for Faculty Medical Leadership and Management.
		Remuneration Committee	1/1	Last updated: March 2018
Dr Tim **Thurston**	Clinical Executive Director, Innovation and Membership	Board	6/6	Tim is a GP Partner at New Milton Health Centre.
		Clinical Cabinet	8/10	Tim's GP practice subleases space to community providers.
		Finance and Performance Committee	9/10	Last updated: March 2018
		Remuneration Committee	1/1	
Caroline **Ward**	Lay Member, New Technologies (from June 2017)	Audit Committee	4/4	Caroline has no interests to declare.
		Board *	4/5	Last updated: March 2018
		Clinical Governance Committee	3/3	
		Finance and Performance Committee	7/8	
		Primary Care Commissioning Committee	4/4	
		Remuneration Committee	1/1	
Dr Sean **Watters**	Clinical Director, Planned Care and Long Term Conditions	Clinical Cabinet	9/10	Sean was formerly a Partner of Watercress Medical.
		Clinical Governance Committee	3/3	Last updated: March 2018
Dr Katrina **Webster**	Clinical Director, Mental Health and Learning Disabilities	Clinical Cabinet	10/10	Katrina is a salaried GP at St Mary's Surgery in Andover. Katrina's husband is a Principal Academic at Bournemouth University, Head of Education for healthcare programmes (physiotherapy, occupational therapy, paramedic science, operating department practice, sports therapy). These are all now non-NHS commissioned programmes.

				Katrina's husband was previously the programme lead for the physiotherapy undergraduate course at Bournemouth University (until August 2017). Last updated: March 2018	
Professor Clare **Wedderburn**	Clinical Director, Primary Care and Community Services (from October 2017 to January 2018)	Clinical Cabinet Primary Care Commissioning Committee	1/3 1/1	Clare has no interests to declare.	Last updated: October 2017

16. Remuneration and Staff Report

16.1. Definition of Senior Managers

The definition of 'senior managers' within the Department for Health Group Manual for Accounts is:

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

I confirm that for this Remuneration Report 'senior managers' constitute both voting and non-voting members of the CCG Board (governing body)

16.2. Remuneration Committee

It is required by statute for a CCG's Governing Body to have a Remuneration Committee to determine and approve remuneration packages for the chief officer, chief finance officer, executive (including clinical) directors and Board members, and policies relating to remuneration and terms and conditions of employment for all CCG staff.

The Committee membership in 2017/18 comprised:

- Simon Garlick, Lay Member, Governance – Committee Chair
- Ian Green, Lay Member, Patient and Public Involvement (to May 2017)
- Judith Gillow, Lay Member, Quality
- Barbara Moorhouse, Lay Member, Strategy and Finance (to May 2017)
- Caroline Ward, Lay Member, New Technologies (from June 2017)
- Alison Rogers, Lay Member, Strategy and Finance (from September 2017)
- Dr Sarah Schofield, Clinical Chairman
- Dr Tim Thurston, Clinical Executive Director

The Chief Officer, Chief Finance Officer and other managers may be invited to attend meetings of the Committee but must withdraw for any issue that relates to them personally. No Committee member is present for discussions about their own specific remuneration or terms of service. The Committee met once during the financial year to approve new Executive Director Recruitment and Remuneration as part of organisation restructuring, agree on Agenda for Change (AfC) pay awards for all staff and the equivalent increase to be applied to Very Senior Manager (VSM) and non-VSM/non-AfC staff, receive briefing and guidance around changes introduced by Her Majesty's Revenue and Customs (including a review of all non-clinical 'off payroll' engagements – IR 35), and review the committee's terms of reference.

16.3. Statement of Policy

The Committee has absolute discretion over the terms, conditions and remuneration of the Accountable Officer and directors. This discretion is exercised through the following guiding principles:

- That all decisions are made within the legally constituted powers of the CCG.
- Ensuring that all executive directors', Board members and staff remuneration represents value for money.
- The need to attract, retain and motivate, high quality executive directors.

The Committee makes satisfactory arrangements to ensure it receives adequate independent advice on remuneration arrangements elsewhere in the NHS and other similar organisations, as well as trends and developments in the area of employment benefits, and terms and conditions of employment for directors.

Directors' remuneration reviews take account of the size, scope, complexity and impact of the individual job, considering any appropriate market rates and/or special circumstances, as well as national guidance and with regard to other pay settlements in the NHS and the public sector.

For 2017/18:

- All employees of the CCG were employed on terms and conditions of employment in line with the Agenda for Change framework.
- Remuneration was reviewed annually for all staff and any uplifts were in accordance with the Agenda for Change framework.
- The remuneration levels for GP Executive/Board Members, Clinical Directors and Clinical Leads, remains in line with those agreed by the CCG in the previous year.
- Remuneration for the Chief Officer and Chief Finance Officer was agreed and remains in line with guidance published by NHS England.
- In recognition that there is not a Very Senior Manager (VSM) scale within national CCG remuneration guidance, there remains a spot salary commensurate with the top of Band 9 Agenda for Change for Executive Directors.
- The remuneration for lay members (who were recruited by the former NHS Appointments Commission) remained in line with remuneration for lay members agreed for the establishment and authorisation of the CCG.

The CCG requires 12 weeks' notice of termination in respect of its senior managers. Termination payments may be applicable depending on circumstances. Senior managers have indefinite contracts, i.e. there are no fixed-term or rolling contracts.

Given the election process and fixed terms of office (as set out in the CCG Constitution), the GP Executive/Board Members are not entitled to Redundancy Payments. The CCG would, however, make provision for a severance payment, equivalent to a three month notice period.

16.4. Trade Union Facility Time

Table 1

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
NIL	NIL

Table 2

Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	*Number of employees*
0%	NIL
1-50%	NIL
51%-99%	NIL
100%	NIL

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	NIL
Provide the total pay bill	NIL
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	NIL

Table 4

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

16.5. Salaries and Allowances

THIS TABLE IS SUBJECT TO AUDIT	***2017-18***						***2016-17***					
Name & Title	***(a)***	***(b)***	***(c)***	***(d)***	***(e)***	***(f)***	***(a)***	***(b)***	***(c)***	***(d)***	***(e)***	***(f)***
	Salary	*Expense payments (taxable)*	*Performance pay and bonuses*	*Long term performance pay and bonuses*	*All pension related benefits*	*Total (a to e)*	*Salary*	*Expense payments (taxable)*	*Performance pay and bonuses*	*Long term performance pay and bonuses*	*All pension related benefits*	*Total (a to e)*
	(bands of £5,000)	*(Rounded to the nearest £100)*	*(bands of £5,000)*	*(bands of £5,000)*	*(bands of £2,500)*	*(bands of £5,000)*	*(bands of £5,000)*	*(Rounded to the nearest £100)*	*(bands of £5,000)*	*(bands of £5,000)*	*(bands of £2,500)*	*(bands of £5,000)*
	£000	*£00*	*£000*	*£000*	*£000*	*£000*	*£000*	*£00*	*£000*	*£000*	*£000*	*£000*
Dr Nick Arney, Clinical Executive Director (to 31 August 2017)	10-15	0	0	0	5-7.5	20-25	35-40	0	0	0	5-7.5	40-45
Inger Bird, Director of Commissioning, Mid Hampshire (to May 2016 – on secondment)	0	0	0	0	0	0	95-100	0	0	0	15-17.5	110-115
Dr Tim Cotton, Clinical Executive Director (from April 2015 to 30 September 2017)	45-50	0	0	0	27.5-30	75-80	90-95	0	0	0	12.5-15	100-105
Michaela Dyer, Director of Commissioning, Acute Services (Maternity Leave from December 2015 to October 2016, no longer director on return from Maternity Leave)	0	0	0	0	0	0	30-35	0	0	0	72.5-75	125-130

Jenny Erwin, Director of Commissioning, Mid Hampshire (from August 2016)	90-95	0	0	0	57.5-60	145-150	55-60	0	0	0	0	55-60
Mike Fulford, Chief Finance Officer and Deputy Chief Officer	120-125	0	0	0	27.5-30	150-155	120-125	0	0	0	27.5-30	145-150
Simon Garlick, Lay Member, Governance	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Judith Gillow, Lay Member, Quality / Interim Board Nurse	15-20	0	0	0	0	15-20	5-10	0	0	0	0	5-10
Beverley Goddard, Director of Performance and Delivery (from June 2016)	80-85	0	0	0	10-12.5	90-95	75-80	0	0	0	0	75-80
Ian Green, Lay Member, Patient and Public Involvement (to 31 May 2017)	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Heather Hauschild, Chief Officer	130-135	0	0	0	7.5-10	140-145	130-135	0	0	0	17.5-20	150-155
Dr Simon Hunter, Clinical Executive Director (to 31 March 2018)	50-55	0	0	0	0	50-55	50-55	0	0	0	0	50-55
Dr Andrew Isbister, Clinical Executive Director, covering Board GP role (from 1 September 2017 to 31 March 2018)	30-35	0	0	0	0-2.5	35-40	0	0	0	0	0	0
Natasha Kerrigan, Interim Director of Commissioning, South, (from December 2015 to February 2017)	0	0	0	0	0	0	95-100	0	0	0	75-77.5	175-180

Rachael King, Director of Commissioning, South and West	100-105	0	0	0	27.5-30	125-130	95-100	0	0	0	97-100	195-200
Prof Johnny Lyon-Maris, Clinical Executive Director, covering Board GP role (from 1 September 2017 to 31 March 2018)	30-35	0	0	0	0	30-35	0	0	0	0	0	0
Ellen McNicholas, Director of Quality and Board Nurse (from 8 September 2017)	60-65	0	0	0	7.5-10	70-75	0	0	0	0	0	0
Heather Mitchell, Director of Strategy and Service Development (from May 2016)	100-105	0	0	0	20-22.5	120-125	90-95	0	0	0	50-52.5	140-145
Barbara Moorhouse, Lay Member, Strategy and Finance (to 31 May 2017)	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Andrea O'Connell, Director of Quality and Safety (Board Nurse) (to 31 March 2017)	0	0	0	0	0	0	95-100	0	0	0	22.5-25	120-125
Dr Helen Pardoe, Secondary Care Consultant	5-10	0	0	0	0	5-10	5-10	0	0	0	0-2.5	5-10
Alison Rogers, Lay Member, Strategy and Finance (from 1 June 2017)	0-5	0	0	0	0	0-5	0	0	0	0	0	0
Dr Sarah Schofield, Chair	110-115	0	0	0	0	110-115	115-120	0	0	0	0	115-120

Dr Tim Thurston, Clinical Executive Director (to 31 March 2018)	40-45	0	0	0	0	40-45	40-45	0	0	0	0	40-45
Caroline Ward, Lay Member, New Technologies (from 1 June 2017)	0-10	0	0	0	0	0-10	0	0	0	0	0	0

Dr Sallie Bacon, Director of Public Health, does not receive any salary or allowances from the CCG. Dr Andrew Isbister received £46,000 and Professor Johnny Lyon-Maris received £28,000 in relation to duties that relate to a non-managerial role.

The calculation for all pension related benefits for 2016-17 has been recalculated to reflect the real increase in pension benefits accruing to senior managers from membership of the NHS Pension Scheme. Accrued benefits balances represent the annual increase in pension entitlement. Where Jenny Erwin and Beverley Goddard became senior managers in 2016-17 pension information as at 1 April 2016 is not available and the real increase in pension benefits cannot be calculated, therefore all pension related benefits for 2016-17 have not been included.

The CCG has not made any Annual Performance Related Bonuses or any Long Term Performance Related Bonuses to Senior Managers during the past financial year.

The CCG has not made any payments to any individual who was a senior manager during the past financial year for loss of office or as part of an exit package. In addition, the CCG has not made any payments to any individual who is a past senior manager during the past financial year.

16.6. All Pension Related Benefits

The figures shown under “All Pension Related Benefits” in the table above are a calculation of an individual’s accrued pension benefit at the beginning and the end of the financial year. This is based on the following mandated national formula:

[(20 x PE) + LSE] - [(20 x PB) + LSB]

where:

- PE and LSE are the accrued pension and lump sum values at the end of the pension input period, and
- PB and LSB are the accrued pension and lump sum values as at the beginning of the input period.
- The impact of this formula is to show the individual’s increase in pension over the average period of twenty years.

16.7. Pension Benefits

THIS TABLE IS SUBJECT TO AUDIT	*(a)*	*(b)*	*(c)*	*(d)*	*(e)*	*(f)*	*(g)*	*(h)*
Name & Title	*Real increase in pension at pension age*	*Real increase in pension lump sum at pension age*	*Total accrued pension at pension age at 31 March 2018*	*Lump sum at pension age related to accrued pension at 31 March 2018*	*Cash Equivalent Transfer Value at 1 April 2017*	*Real increase in Cash Equivalent Transfer Value*	*Cash Equivalent Transfer Value at 31 March 2018*	*Employer's contribution to stakeholder pension*
	(bands of £2,500)	*(bands of £2,500)*	*(bands of £5,000)*	*(bands of £5,000)*				
	£000	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*	*£000*
Dr Nick Arney	0-2.5	0-2.5	0-5	5-10	41	9	50	0
Dr Tim Cotton	0-2.5	2.5-5	10-15	35-40	200	37	237	0
Jenny Erwin	2.5-5	2.5-5	15-20	40-45	199	43	242	0
Mike Fulford	2.5-5	0-2.5	30-35	75-80	478	53	531	0
Beverley Goddard	0-2.5	2.5-5	25-30	80-85	528	34	562	0
Heather Hauschild	0-2.5	2.5-5	50-55	150-155	979	77	1,056	0
Rachael King	0-2.5	0-2.5	30-35	85-90	511	36	547	0
Heather Mitchell	0-2.5	0-2.5	15-20	0-5	131	19	150	0
Dr Helen Pardoe	0-2.5	2.5-5	35-40	110-115	729	42	771	0
Dr Sarah Schofield	0-2.5	0-2.5	15-20	50-55	348	15	363	0

As Non-Executive / lay members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members / lay members. In addition, Dr Simon Hunter, Dr Tim Thurston and Professor Johnny Lyon-Maris have opted out of the NHS Pension Scheme.

Pension information for Dr Andrew Isbister is not applicable at 31 March 2018 as the member is in receipt of an NHS Pension.

West Hampshire CCG failed to request pension information for Ellen McNicholas, Director of Quality and Board Nurse, ahead of the nationally mandated deadline. As a result this information has not been made available to West Hampshire CCG from NHS Pensions, and hence is not included in this report.

Cash Equivalent Transfer Values

i. 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

ii. 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.

16.8. 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. This is subject to audit.

The banded remuneration of the highest paid director/member in the clinical commissioning group in the financial year 2017-18 was £132,500 (2016-17, £137,500). This was 3.4 times (2016-17, 3.4 times) the median remuneration of the workforce, which was £39,070 (2016-17, £40,613).

In 2017-18, nil (2016-17, nil) employees received remuneration in excess of the highest paid member of the Membership Body/Governing Body. Remuneration ranged from £17,000 to £133,000 (2016-17, £14,000 - £133,000).

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

It should be noted that the clinical commissioning group has not made any performance related bonuses nor paid any other benefits-in-kind during the past financial year.

The slight reduction in median pay from the prior year is a result of a significant increase in substantive staff numbers at band 5 and 6 within the Continuing Healthcare team and a reduction in the use of agency staff.

5. Fees and Charges

The CCG charges a fee to individuals who exercise their right to obtain a copy of the information that the CCG holds about them. This is known as a subject access request and is subject to audit.

A £10 charge is made for all types of records whether held in manual or electronic format. The CCG will also charge 50 pence per page for photocopying up to a maximum of £40.

During the financial year the CCG received fees from 29 subject requests to a value of £1,168.

The CCG receives no other fees and charges.

16.9. Staff Report

A detailed analysis of staff costs and average number of people employed can be found within Note 4 to the Accounts. Expenditure on consultancy services can be found within Note 5 to the Accounts.

16.10. Staff Numbers

THIS TABLE IS SUBJECT TO AUDIT

Occupation	Average number of employees during the year (Whole Time Equivalent)	Number of employees in post as at 31 March 2017 (Whole Time Equivalent)
Ambulance staff	0	0
Administration and estates staff	169.81	182.85
Health care assistants and other support staff	1.48	1.48
Medical and dental staff	7.22	6.17
Nursing, midwifery and health visiting staff	32.76	41.22
Nursing, midwifery and health visiting learners	0	0
Scientific, therapeutic and technical staff	17.62	18.56
Healthcare science	0	0
Total staff numbers	**228.89**	**250.28**

The CCG hosts a number of headquarters functions on behalf of the five CCGs in Hampshire. The average number of whole time equivalent staff employed in relation to West Hampshire CCG's own population is 182.59.

16.11. Staff Composition

Gender	Employee Analysis	Total
Female	Board members	11
	GPs (excluding Board members)	10
	Managers (Band 8c and above)	16
	Employees (up to and including Band 8b)	199
Male	Board members	6
	GPs (excluding Board members)	7
	Managers (Band 8c and above)	7
	Employees (up to and including Band 8b)	34
Total		**290**

The staff composition numbers is the total for the CCG and has not been netted down for any hosted services.

16.12. Staff Costs

This Table is subject to audit

Employee Benefits	Total £'000	Permanent Employees £'000	Other £'000
Salaries and wages	8,364	7,522	842
Social security costs	833	832	1
Employer contributions to NHS Pension scheme	1,025	1,023	2
Apprenticeship Levy	22	22	0
Gross employee benefits expenditure	**10,244**	**9,399**	**845**
Less recoveries in respect of employee benefits	0	0	0
Total – Net admin employee benefits including capitalised costs	**10,244**	**9,399**	**845**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**10,244**	**9,399**	**845**

16.13. Sickness absence data

The staff sickness rate for the past 12 months averaged 2.65%.

16.14. *Supporting Staff with Disabilities*

The Recruitment and Exit Policy defines the CCGs approach to recruitment, including encouraging and handling applications from prospective employees with a disability. The CCG is a *Two Ticks* employer which means where an applicant meets the minimum requirements for a role they are automatically invited for interview. We ask prospective employees if they have an impairment so that we can make adjustments to ensure the interview venue and process are accessible to all.

If an existing member of staff becomes impaired we have a number of policies to guide how managers should respond. All policies are subject to equality impact

assessment to ensure that the needs of staff with different protected characteristics (including those with disabilities) are not disadvantaged and equal opportunities are promoted. The policies include:

- Conduct, Performance, Grievance and Absence Management Policy
- Learning and development policy
- Leave and Flexible Working Policy
- Stress management policy

The manager will support the individual and seek expert support from Human Resources, Occupational Health or the Equality and Diversity Lead if necessary. In line with policy, managers work in partnership with individual staff members to put reasonable adjustments in place so that the employee can remain in employment and access training.

In line with the CCG Equality, diversity and human rights policy anonymous staff equalities monitoring is used to identify trends and potential unfairness in recruitment, access to training and career progression. This looks at all protected characteristics and includes disability. If unfairness is found the CCG uses positive action to address this.

Further detail regarding our policies can be accessed from the NHS West Hampshire CCG website.

16.15. Expenditure on Consultancy

The CCG spent £183,938 on external consultancy in 2017/18.

16.16. Off-payroll Engagements

Off-payroll engagements, as of 31 March 2017, for more than £245 per day that last longer than six months, are as follows:

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

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which…	
Number assessed as within IR35	0
Number assessed as outside of IR35	0
Number engaged directly (via PSC contracted to department) and are on the department payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	2
Number of engagements that saw a change to IR35 status following the consistency review	0

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	25

16.17. Exit Packages

As a CCG, we are required to make disclosures regarding exit packages which have taken place during the financial year. The table below provides anonymised data for those packages.

Exit package cost band (including any special payment element)	Number of agreed departures	Cost of agreed departures £
Less than £10,000	0	0
£10,000 - £25,000	0	0
£25,001 - £50,000	1	£45,562
£50,001 - £100,000	0	0
£100,001 - £150,000	0	0
£150,001 - £200,000	0	0
>£200,000	0	0
Total	**1**	**£45,562**

16.18. Non-compulsory departure payments

	Number of agreements	Total value of agreements £
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	1	£45,562
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**1**	**£45,562**

16.19. Losses

The total number of NHS clinical commissioning group losses, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000	Total number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	0	0	9	75
Fruitless payments	39	1	36	1
Store losses	0	0	0	0
Book keeping losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**39**	**1**	**45**	**76**

Parliamentary Accountability and Audit Report

West Hampshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

Signed 

Heather Hauschild

Accountable Officer

23 May 2018

NHS WEST HAMPSHIRE CLINICAL COMMISSIONING GROUP

ANNUAL ACCOUNTS 2017-18

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The Primary Statements:

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

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(1,230)	(73)
Other operating income	2	(121)	(74)
Total operating income	2	**(1,351)**	**(147)**
Staff costs	4	10,244	9,607
Purchase of goods and services	5	748,111	713,348
Provision expense	5	696	1,850
Other Operating Expenditure	5	9	403
Total operating expenditure		**759,060**	**725,208**
Net operating expenditure		**757,709**	**725,061**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**757,709**	**725,061**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total net expenditure for the year		**757,709**	**725,061**
Other comprehensive expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to net operating costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive expenditure for the year ended 31 March 2018		**757,709**	**725,061**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		0	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	6,026	3,279
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	213	122
Total current assets		**6,239**	**3,401**
Non-current assets held for sale	21	0	0
Total current assets		**6,239**	**3,401**
Total assets		**6,239**	**3,401**
Current liabilities			
Trade and other payables	23	(53,864)	(52,113)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(2,124)	(2,469)
Total current liabilities		**(55,988)**	**(54,582)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(49,749)**	**(51,181)**
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		0	0
Assets less Liabilities		**(49,749)**	**(51,181)**
Financed by Taxpayers' Equity			
General fund		(49,749)	(51,181)
Total taxpayers' equity:		**(49,749)**	**(51,181)**

The notes on pages 5 to 25 form part of this statement
The financial statements on pages 1 to 25 were approved by West Hampshire CCG's Audit Committee, as delegated by the Governing body on 23 May 2018 and signed on its behalf by:

Signed .....

Heather Hauschild
Chief Accountable Officer
23 May 2018

Statement of Changes In Taxpayers Equity for the year 31 March 2018

Changes in taxpayers' equity for 2017-18	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2017	**(51,181)**	**0**	**0**	**(51,181)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 01 April 2017	**(51,181)**	**0**	**0**	**(51,181)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(757,709)	0	0	(757,709)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(757,709)**	**0**	**0**	**(757,709)**
Net funding	759,141	0	0	759,141
Balance at 31 March 2018	**(49,749)**	**0**	**0**	**(49,749)**

Changes in taxpayers' equity for 2016-17	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2016	**(45,197)**	**0**	**0**	**(45,197)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 01 April 2016	**(45,197)**	**0**	**0**	**(45,197)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(725,061)	0	0	(725,061)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	0
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(725,061)**	**0**	**0**	**(725,061)**
Net funding	719,077	0	0	719,077
Balance at 31 March 2017	**(51,181)**	**0**	**0**	**(51,181)**

The notes on pages 5 to 25 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

		2017-18	2016-17
Cash Flows from Operating Activities	Note	**£'000**	£'000
Net operating expenditure for the financial year		(757,709)	(725,061)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(2,747)	1,035
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	1,751	3,573
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(1,041)	(418)
Increase/(decrease) in provisions	30	696	1,850
Net Cash Inflow (Outflow) from Operating Activities		**(759,050)**	**(719,021)**
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		0	0
Net Cash Inflow (Outflow) before Financing		**(759,050)**	**(719,021)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		759,141	719,077
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**759,141**	**719,077**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**91**	**56**
Cash & Cash Equivalents at the Beginning of the Financial Year		122	66
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	20	**213**	**122**

The notes on pages 5 to 25 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis noting that the clinical commissioning group's External Auditors have issued a report to the secretary of state for Health under Section 30 of the Local Audit and Accountability Act 2014.

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 and Social Care 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.

Notes to the financial statements

Other transfers of assets and liabilities within the Department of Health and Social Care 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.

The clinical commissioning group is in a "jointly controlled operation" for the Hampshire Equipment Store, and as such 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.

Other expenditure within the pooled budget has been assessed as having control either by Hampshire County Council or individual Clinical Commissioning Groups party to the agreement.

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 clinical commissioning group has made critical judgements in respect of prescribing expenditure as a result of estimation (see below), and the nature of the pooled budget arrangements. Except for these items there are no critical judgements that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.6.2 **Key Sources of Estimation Uncertainty**

The clinical commissioning group has accrued £13.3 million of prescribing expenditure into the 2017/18 accounts. This is based on the Prescriptions Pricing Division (PPD) forecast updated for month 11 actual expenditure, and therefore there is only one month of estimation uncertainty contained within that accrual. The accrual is based on the professional expert opinion of the Prescription Services NHS Business Services Authority estimating the forecast prescribing outturn for the year.

Notes to the financial statements

1.7 **Revenue**

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

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

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

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

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

1.8.2 **Retirement Benefit Costs**

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

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

1.9 **Other Expenses**

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

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

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.

Notes to the financial statements

1.10.1 **The Clinical Commissioning Group as Lessee**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

Whilst our arrangements with NHS Property Services Limited fall within the definition of an operating lease, rental charges for future years have not yet been agreed. Therefore, future estimated minimum lease payments with NHS Property Services have been estimated based upon the costs incurred in 2017/18 and information on the current and future status of properties.

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

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

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.

Notes to the financial statements

1.13 **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 Resolution 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.

1.14 **Continuing healthcare risk pooling**

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

1.15 **Financial Assets**

Financial assets are recognised by the clinical commissioning group as 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.

1.16 **Value Added Tax**

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

1.17 **Losses & Special Payments**

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

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

Notes to the financial statements

1.18 **Hosted Services Arrangements**

The clinical commissioning group hosts services on behalf of the five clinical commissioning groups (CCGs) in Hampshire: West Hampshire CCG (as host), Fareham and Gosport CCG, South Eastern Hampshire CCG, North East Hampshire and Farnham CCG and North Hampshire CCG.

Under these arrangements the following services are hosted: Continuing Healthcare and Non Continuing Healthcare High Cost Placements; Funded Nursing; Medicines Management (including Prescribing); and Safeguarding Children.

The costs and associated income incurred on behalf of the 5 CCGs in Hampshire are shown net so that only the costs attributable to West Hampshire CCG are shown in these accounts.

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

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

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

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2 Other Operating Revenue

	2017-18 Total £'000	2016-17 Total £'000
Non-patient care services to other bodies	1,230	73
Other revenue	121	74
Total other operating revenue	**1,351**	**147**

3 Revenue

	2017-18 Total £'000	2016-17 Total £'000
From rendering of services	1,351	147
Total	**1,351**	**147**

Revenue is exclusively from the supply of services. The clinical commissioning group receives no revenue from sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2017-18 Total £'000	2017-18 Permanent Employees £'000	2017-18 Other £'000
Salaries and wages	8,364	7,522	842
Social security costs	833	832	1
Employer Contributions to NHS Pension scheme	1,025	1,023	2
Apprenticeship Levy	22	22	0
Gross employee benefits expenditure	**10,244**	**9,399**	**845**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**10,244**	**9,399**	**845**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**10,244**	**9,399**	**845**

4.1.1 Employee benefits

	2016-17 Total £'000	2016-17 Permanent Employees £'000	2016-17 Other £'000
Salaries and wages	7,932	6,400	1,532
Social security costs	772	772	0
Employer Contributions to NHS Pension scheme	903	903	0
Gross employee benefits expenditure	**9,607**	**8,075**	**1,532**
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	**9,607**	**8,075**	**1,532**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**9,607**	**8,075**	**1,532**

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	201	183	19	159
Of the above:				
Number of whole time equivalent people	0	0	0	0

The CCG hosts a number of headquarters functions on behalf of the five CCGs in Hampshire. Therefore, the above staffing number has been netted down under net accounting rules. The gross whole time equivalent employed is 199.

4.3 Exit packages agreed in the financial year

	2017-18		2017-18	
	Other agreed departures		Total	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	1	45,562	1	45,562
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**1**	**45,562**	**1**	**45,562**

	2016-17		2016-17	
	Other agreed departures		Total	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2017-18		2016-17	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	1	45,562	0	0
Total	**1**	**45,562**	**0**	**0**

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

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

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

4.5 Pension costs

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

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

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

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers' contributions of £1,025,657 were payable to the NHS Pensions Scheme (2016-17: £902,562) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.

5. Operating expenses	**2017-18 Total £'000**	2016-17 Total £'000
Gross employee benefits		
Employee benefits excluding governing body members	8,872	8,235
Executive governing body members	1,372	1,372
Total gross employee benefits	**10,244**	**9,607**
Other costs		
Services from other CCGs and NHS England	4,168	4,064
Services from foundation trusts	445,658	425,951
Services from other NHS trusts	21,645	20,381
Services from other WGA bodies	48	55
Purchase of healthcare from non-NHS bodies	111,241	103,117
Chair and Non Executive Members	192	173
Supplies and services – general	229	256
Consultancy services	184	126
Establishment	991	564
Transport	2	0
Premises	1,086	1,014
Impairments and reversals of receivables	0	76
Audit fees	58	88
Other non statutory audit expenditure		
· Internal audit services	42	31
Prescribing costs	88,692	85,376
Pharmaceutical services	927	692
GPMS/APMS and PCTMS	72,833	69,755
Other professional fees excl. audit	115	242
Legal fees	70	0
Grants to Other bodies	147	130
Education and training	122	83
Provisions	696	1,850
CHC Risk Pool contributions	0	1,552
Other expenditure	(330)	25
Total other costs	**748,816**	**715,601**
Total operating expenses	**759,060**	**725,208**

The CCG's external auditor is Grant Thornton UK LLP. The audit covers both the CCG's financial statements and arrangements for securing value for money in its use of resources. The audit fee for the 2017/18 annual accounts is £48,000 excluding irrecoverable VAT.

The auditor's liability for external audit work carried out for the financial year 2017/18 is limited to £500,000.

6. Better Payment Practice Code and Late Payment of Commercial Debts

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	50,672	299,858	42,763	276,138
Total Non-NHS Trade Invoices paid within target	49,980	298,908	42,177	275,773
Percentage of Non-NHS Trade invoices paid within target	**98.63%**	**99.68%**	**98.63%**	**99.87%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,516	472,592	3,855	447,129
Total NHS Trade Invoices Paid within target	3,484	472,220	3,750	445,895
Percentage of NHS Trade Invoices paid within target	**99.09%**	**99.92%**	**97.28%**	**99.72%**

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

The clinical commissioning group had no late payment of commercial debts in the year ended 31 March 2018.

7. Income Generation Activities

The clinical commissioning group does not undertake and income generation activities.

8. Investment revenue

The clinical commissioning group had no investment revenue in the year ended 31 March 2018.

9. Other gains and losses

The clinical commissioning group had no other gains or losses in the year ended 31 March 2018.

10. Finance costs

The clinical commissioning group had no finance costs in the year ended 31 March 2018.

11. Net gain/(loss) on transfer by absorption

The clinical commissioning group had no net gains/losses from transfer by absorption in the year ended 31 March 2018.

12. Operating leases

12.1 As lessee

12.1.1 Payments recognised as an expense

	2017-18			2016-17		
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	1,414	13	**1,427**	1,254	9	1,263
Total	**1,414**	**13**	**1,427**	**1,254**	**9**	**1,263**

12.1.2 Future minimum lease payments

	2017-18			2016-17		
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:						
No later than one year	1,403	13	**1,416**	1,271	9	1,280
Between one and five years	5,600	30	**5,630**	5,084	3	5,087
After five years	0	0	**0**	3,132	0	3,132
Total	**7,003**	**43**	**7,046**	**9,487**	**12**	**9,499**

12.2 As lessor

The clinical commissioning group had no operating leases as a lessor in the year ended 31 March 2018.

13 Property, plant and equipment

The clinical commissioning group had no property, plant and equipment in the year ended 31 March 2018.

14 Intangible non-current assets

The clinical commissioning group had no intangible assets in the year ended 31 March 2018.

15 Investment property

The clinical commissioning group had no investment property in the year ended 31 March 2018.

16 Inventories

The clinical commissioning group had no inventories as at 31 March 2018.

17 Trade and other receivables

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	1,428	0	678	0
NHS prepayments	653	0	673	0
NHS accrued income	2,253	0	1,436	0
Non-NHS and Other WGA receivables: Revenue	362	0	555	0
Non-NHS and Other WGA prepayments	1,228	0	149	0
Non-NHS and Other WGA accrued income	25	0	74	0
Provision for the impairment of receivables	(28)	0	(364)	0
VAT	94	0	76	0
Other receivables and accruals	11	0	2	0
Total Trade & other receivables	**6,026**	**0**	**3,279**	**0**
Total current and non current	**6,026**		**3,279**	
Included above:				
Prepaid pensions contributions	0		0	

The majority of trade is with NHS England which is funded by the Government to provide dunding to clinical commissioning group to commission serivces, no credit scoring is therefore considered necessary.

The remining NHS receivables are due to recharges of healthcare costs and have all been agreed in advance with those organisations. Non-NHS receiveables have been impared in full for debts in excess of 30 davs bevond the due date.

17.1 Receivables past their due date but not impaired

	2017-18 £'000	**2017-18 £'000**	2016-17 £'000
	DH Group Bodies	**Non DH Group Bodies**	All receivables prior years
By up to three months	0	235	183
By three to six months	0	0	0
By more than six months	0	0	0
Total	**0**	**235**	**183**

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

17.2 Provision for impairment of receivables

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	(364)	(289)
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	0
(Increase) decrease in receivables impaired	0	336	(75)
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**0**	**(28)**	**(364)**

Following a review of the aged debt profile outstanding non-NHS debts over 30 days were impaired in full. The majority of CCG income is from NHS organisations and therefore no security or collateral is held.

	2017-18 £'000	2016-17 £'000
Receivables are provided against at the following rates:		
NHS debt	0%	0%
Non-NHS debt over 30 days at 100%	100%	100%

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2018.

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2018.

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	122	66
Net change in year	91	56
Balance at 31 March 2018	**213**	**122**
Made up of:		
Cash with the Government Banking Service	199	109
Cash in hand	14	13
Cash and cash equivalents as in statement of financial position	**213**	**122**
Balance at 31 March 2018	**213**	**122**

The clinical commissioning group held no patients' money as at 31 March 2018.

21 Non-current assets held for sale

The clinical commissioning group had no non-current assets for held for sale at 31 March 2018.

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals in the year ended 31 March 2018.

23 Trade and other payables

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS payables: revenue	8,857	0	8,536	0
NHS accruals	6,414	0	5,974	0
Non-NHS and Other WGA payables: Revenu	9,082	0	16,993	0
Non-NHS and Other WGA accruals	22,191	0	13,443	0
Social security costs	162	0	124	0
Tax	132	0	108	0
Other payables and accruals	7,026	0	6,935	0
Total Trade & Other Payables	**53,864**	**0**	**52,113**	**0**
Total current and non-current	**53,864**		**52,113**	

Other payables include £753,697 outstanding pension contributions at 31 March 2018

24 Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2018.

25 Other liabilities

The clinical commissioning group had no other liabilities as at 31 March 2018.

26 Borrowings

The clinical commissioning group had no borrowings as at 31 March 2018.

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT and other service concession arrangements as at 31 March 2018.

28 Finance lease obligations

The clinicial commissioning group had no finance lease obligations as at 31 March 2018.

29 Finance lease receivables

The clinicial commissioning group had no finance lease receivables as at 31 March 2018.

30 Provisions	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Continuing care	2,124	0	2,469	0
Total	**2,124**	**0**	**2,469**	**0**
Total current and non-current	**2,124**		**2,469**	

	Continuing Care £'000	**Total £'000**
Balance at 01 April 2017	**2,469**	**2,469**
Arising during the year	1,940	1,940
Utilised during the year	(1,041)	(1,041)
Reversed unused	(1,244)	(1,244)
Balance at 31 March 2018	**2,124**	**2,124**
Expected timing of cash flows:		
Within one year	2,124	2,124
Between one and five years	0	0
After five years	0	0
Balance at 31 March 2018	**2,124**	**2,124**

The continuing healthcare retrospective provision is based upon 66 claims, using a 8.3% conversion rate with an average of 93 weeks per claim. The 8.3% conversion rate is based upon the average number of weeks from all retrospective claims paid to the end of 2017/18. The value of the provision relating to retrospective claims is £744,000. In addition, a provision has been made relating to a backlog in the assessment of claims for ongoing continuing healthcare funding. A total of 26 cases will be reviewed, with an expected conversion rate of 30% with an average of 65 weeks per case. The total value of the provision relating to the backlog in assessments is £1,380,000.

As at 31 March 2018 the clinical commissioning group has no outstanding legal or pension liabilities. No provision is included for NHS Litigation Authority in respect of clinical negligence liabilities.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting 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 as at 31 March 2018 is £204,000.

31 Contingencies

The clinical commissioning group had no contingent liabilities or assets as at 31 March 2018.

32 Commitments

The clinical commissioning group had no commitments as at 31 March 2018.

33 Financial instruments

The carrying amount of the following financial assets and liabilities is considered a reasonable approximation of fair value:

- trade and other receivables
- cash and cash equivalents
- trade and other payables

33.1 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	**Loans and Receivables 2017-18 £'000**	**Total 2017-18 £'000**
Receivables:			
· NHS	0	3,681	3,681
· Non-NHS	0	387	387
Cash at bank and in hand	0	213	213
Other financial assets	0	11	11
Total at 31 March 2018	**0**	**4,292**	**4,292**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Total 2016-17 £'000
Receivables:			
· NHS	0	2,115	2,115
· Non-NHS	0	629	629
Cash at bank and in hand	0	122	122
Other financial assets	0	1	1
Total at 31 March 2017	**0**	**2,867**	**2,867**

33.2 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	**Other 2017-18 £'000**	**Total 2017-18 £'000**
Payables:			
· NHS	0	15,272	15,272
· Non-NHS	0	38,299	38,300
Total at 31 March 2018	**0**	**53,571**	**53,571**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Payables:			
· NHS	0	14,510	14,510
· Non-NHS	0	37,370	37,370
Total at 31 March 2017	**0**	**51,880**	**51,880**

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	759,060	(1,351)	**757,709**	6,239	(55,988)	**(49,749)**
Total	**759,060**	**(1,351)**	**757,709**	**6,239**	**(55,988)**	**(49,749)**

34.1 Reconciliation between Operating Segments and Statement of Comprehensive Net Expenditure

	2017-18 £'000
Total net expenditure reported for operating segments	757,709
Total net expenditure per the Statement of Comprehensive Net Expenditure	**757,709**

34.2 Reconciliation between Operating Segments and Statement of Financial Position

	2017-18 £'000
Total assets reported for operating segments	6,239
Total assets per Statement of Financial Position	**6,239**

	2017-18 £'000
Total liabilities reported for operating segments	(55,988)
Total liabilities per Statement of Financial Position	**(55,988)**

35 Pooled budgets

The £5.3bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. In order to deliver these objectives in 2017/18, the clinical commissioning group entered into a pooled budget arrangement under Section 75 of the 2006 Health and Social Care Act with Hampshire County Council, Fareham and Gosport CCG, South Eastern Hampshire CCG, North East Hampshire and Farnham CCG and North Hampshire

Under the arrangement, the pooled fund was established to fund schemes which promote better integration between health and social care services with the aim of improving outcomes for and experience of the people in Hampshire who need care. Included in this is the intention to reduce non-elective admissions to hospital and permanent residential care resulting in savings to the CCGs and to the Council. The total pooled budget value was £105m and West Hampshire CCG's contribution to this was £31.6m. The total spend by West Hampshire CCG under pooled budget arrangements in 2017/18 was £31.6m, comprising £30.5m of expenditure under the better care fund related to services other than the Hampshire Equipment store, and £1.1m related to the Hampshire Equipment store.

35. Pooled budgets cont.

Under the arrangement, the Hampshire Equipment Store is treated as a joint operation whereby each member of the group recognises its share of the assets, liabilities, revenues and expenses of the joint arrangement. Other expenditure has been assessed as having control either by Hampshire County Council or individual Clinical Commissioning Groups party to the agreement.

The memorandum account for the pooled budget is:

	Better Care Fund (Excluding Equipment Store) 2017-18 £'000	**Equipment Store 2017-18** £'000	**Total 2017-18** £'000
Allocation	30,514	1,112	31,626
Expenditure	(30,514)	(1,112)	(31,626)
	0	0	0
Cash/(overdrawn)	0	12	12
Fixed Assets	0	0	0
Debtors	0	4	4
Less Creditors	0	(16)	(16)
	0	0	0

36 NHS Lift investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2018.

37 Related party transactions

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 Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

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 Hampshire County Council.

Details of related party transactions with individuals are as follows:

	2017-18			
	Payments to Related Party £'000	**Receipts from Related Party £'000**	**Amounts owed to Related Party £'000**	**Amounts due from Related Party £'000**
Forest Gate Surgery (re Dr Nick Arney to August 2017 and Dr Simon Hunter, whose wife is a Partner)	1,643	0	65	0
Lyndhurst Surgery (Dr Johnny Lyon-Maris)	767	0	36	0
Mid Hampshire Healthcare Limited (Dr Tim Cotton and Dr Andrew Isbister's practices are shareholders)	535	0	118	0
New Forest Healthcare Limited (Dr Tim Thurston, Dr Simon Hunter, Dr Johnny Lyon-Maris, Dr Nick Arney's practices are shareholders)	0	0	0	0
New Milton Health Centre (Dr Tim Thurston)	1,482	0	74	0
Park Surgery and St Francis Surgery (Dr Sarah Schofield)	1,864	0	68	0
St Pauls Surgery (Dr Tim Cotton)	1,895	0	66	0
Testvale Surgery (Dr Simon Hunter)	1,717	0	71	0
University Hospitals Southampton NHS Foundation Trust (Ellen McNicholas - Govenor from October 2017)	141,555	0	5,979	648
Watercress Medical Group (Dr Andrew Isbister)	1,325	0	55	5

	2016-17			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Forest Gate Surgery (re Dr Nick Arney to August 2017 and Dr Simon Hunter, whose wife is a Partner)	1,601	0	6	0
Lyndhurst Surgery (Dr Johnny Lyon-Maris)	781	0	52	0
Mid Hampshire Healthcare Limited (Dr Tim Cotton and Dr Andrew Isbister's practices are shareholders)	918	0	217	0
New Forest Healthcare Limited (Dr Tim Thurston, Dr Simon Hunter, Dr Johnny Lyon-Maris, Dr Nick Arney's practices are shareholders)	1,280	0	0	0
New Milton Health Centre (Dr Tim Thurston)	1,397	0	8	0
Park Surgery and St Francis Surgery (Dr Sarah Schofield)	1,671	0	2	0
St Pauls Surgery (Dr Tim Cotton)	1,697	0	2	0
Testvale Surgery (Dr Simon Hunter)	1,631	0	8	0
Watercress Medical Group (Dr Andrew Isbister)	1,302	0	26	0

In the prior financial year the CCG included all member practices in it's related party transactions note. In the current financial year the CCG is reporting a tighter definition of related parties and as such member practices are not deemed to be a related party in themselves. As such the prior year comparatives have been restated.

38 Events after the end of the reporting period
There were no events after the reporting period.

39 Special payments, gifts, and fees and charges
There are no special payments, gifts, and fees and charges incurred by the clinical commissioning group in the year ended 31 March 2018.

40 Third party assets
There are no third party assets held by the clinical commissioning group as at 31 March 2018.

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

	2017-18 Target	**2017-18 Performance**	2016-17 Target	2016-17 Performance
Expenditure not to exceed income	753,443	759,060	732,353	725,208
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	752,092	757,709	732,206	725,061
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	11,921	10,711	11,926	10,903

During the year the clinical commissioning group had an in-year revenue resource limit of £752,092,000. The clinical commissioning group also received £7,145,000 in surplus funding carried forward from previous years to give a total allocation of £759,237,000. Against this allocation the clinical commissioning group had a net actual spend of £757,710,000 giving a net in-year deficit of £5,618,000. The CCG has a cumulative surplus at the 31 March 2018 of £1,527,000. The clinical commissioning group's External Auditors issued a notification under section 30 of the Local Audit and Accountability Act 2014 for breach of financial duty to breakeven relating to the in-year deficit.

The clinical commissioning group's admin allocation includes an additional £14,000 received in 2017/18 as a non-recurrent allocation to mitigate the impact of NHS Property Services move to market rents.

42 Impact of IFRS
There is no material impact of changes to International Financial Reporting Standards on the clinical commissioning groups reported figures in the year ended 31 March 2018.

43 Analysis of charitable reserves
The clinical commissioning group had no charitable reserves as at 31 March 2018.

Independent auditor's report to the members of the Governing Body of NHS West Hampshire Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS West Hampshire Clinical Commissioning Group, (the 'CCG') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and

have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 4 to 136, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the CCG's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG ended the year with a cumulative surplus of £1.5 million, however it reported in its financial statements for the year ended 31 March 2018 that expenditure exceeded income and the CCG also reported a £5.6 million overspend against its total in-year revenue resource limit, thereby breaching its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its expenditure does not exceed income and that the revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 17 May 2018 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the CCG's breach of its revenue resource limit for the year ending 31 March 2018.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities set out on page 74 to 75, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Report on other legal and regulatory requirements – Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter**.**

Responsibilities of the Accountable Officer

As explained in the Annual Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS West Hampshire Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Peter Barber

Peter Barber
Director
for and on behalf of Grant Thornton UK LLP

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23rd May 2018