NHS
Wiltshire
Clinical Commissioning Group

Annual Report and Accounts

2013/14

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Section 1:
Annual Report

1.1 Member Practices' Introduction

Wiltshire Clinical Commissioning Group (CCG) comprises 57 GP practices across the county, led by a Governing Body. This is essentially a Council of Members, supported by lay members and an executive team. We are a clinically led organisation with our GPs at the forefront, developing services to meet the needs of local people. Because Wiltshire is largely a dispersed, rural community, the collective, specific, local knowledge of our GPs is crucial to our approach.

We were extremely proud to have been authorised by NHS England in December 2012 and to have been commended in a number of areas of strength and good practice during the assessment process. In particular, our model for integrated care and our emphasis on the importance of placing the patient at the centre of that model drew praise. We were described as having scale and sustainability, a strong unified centre whilst maintaining the distinctive characteristics of our three localities, North and East Wiltshire (NEW), Salisbury and the South (Sarum), and West Wiltshire, Yatton Keynell and Devizes (WWYKD).

Being authorised presented us with a huge opportunity to realise our simple but bold vision to ensure the provision of a health service which is high quality, effective, clinically led and local. We have worked extremely hard and received great support from our staff, the public, partners in provider organisations, co-commissioners, the voluntary sector and GP member practices during this vital first year of operation, for which we are most grateful. In particular we have achieved excellent progress working in partnership with our colleagues in Wiltshire Council towards establishing joint arrangements to deliver far better integrated health and social services in the future. This is a union which is already yielding results as we work together on the Health and Wellbeing Board to deliver the aspirations set out in the Wiltshire Health and Wellbeing Strategy. We share our intent to deliver better integrated services, and have worked closely together on the coherent development of both the Wiltshire Better Care Plan and the new CCG 5 year strategic/2 year operational plan.

During our first year we have achieved some notable successes. Our commitment to reduce the amount of time someone waits to be assessed and then treated for dementia is already yielding some terrific results. People in Wiltshire with dementia are now diagnosed and referred to a memory clinic in less than four weeks. At the start of 2013 the wait was nine months. All Wiltshire GPs are now trained to diagnose dementia in primary care, prescribe for simple cases and they are supported by Memory Service nurses available at every surgery.

In partnership with Great Western Hospitals NHS Foundation Trust (GWH), we have commissioned a care coordinator service focused on helping people live well at home for longer. The coordinators based in GP practices, are also helping to reduce unnecessary admissions into hospital or care home. They act as a point of contact to bring together the medical and social care services that may be available to someone who needs just that little extra support to stay at home. They are increasingly supported by the application of proven risk stratification tools, and we have established an improved, better integrated, co-ordination cell (the Simple Point of Access) to help mobilise the right services, at the right place and right time.

We have also faced some challenges in introducing changes to healthcare that we have commissioned. The implementation of the NHS 111 service was not without problems. Although we know there are still some areas where improvement is needed, there is no doubt that the service has come a long way since early 2013, and the CCG was at the forefront of the region wide effort to work with our provider in order to achieve this. A further challenge has come about by the re-commissioning of non-emergency patient transport services which endeavoured to replace more than 20 separate providers of patient transport with a single organisation to cover Wiltshire, Swindon, Gloucestershire and Bath and North East Somerset, which also presented considerable challenges. Our team worked hard to implement this modernisation effectively and on the whole it is now working very well. Naturally there are still areas we wish to improve, but Arriva conveys hundreds of patients each day very successfully.

On a national level, there is no doubt that 2012/13 was a significant year for the NHS. In March 2013, Robert Francis QC, Chairman of the Inquiry into the failings at Mid Staffordshire Hospital NHS Foundation Trust published his final report. It made difficult and uncomfortable reading for anyone involved in the NHS. Here in Wiltshire we want to ensure that quality remains at the forefront of everything we do. Implicit in this we need to ensure that our providers – the organisations we commission care from - also have a patient-centred culture and that we have the right early warning systems in place if anything should go wrong. We make regular patient safety visits to a range of care providers and at each Governing Body meeting the safety and performance standards of our providers are reviewed and discussed.

Planning ahead, we have devoted considerable energy to developing and commissioning new models of care that should better support our ageing population and deliver their associated health needs, in the context of ensuring a sustainable health system. Our aim remains to put individuals in control whilst ensuring that every opportunity is provided to improve the health and wellbeing of the population – we want to support people in taking more personal responsibility for their health and wellbeing. We aspire to create and commission a model where we avoid unnecessary admissions to hospital, but within which, when care is needed it can be delivered closer to home, creating a system built around individuals and local communities, with a focus on the most vulnerable people, supporting them appropriately to reduce or avert crises. Key to achieving this will be multi-disciplinary teams based in small community based clusters, working across community health, social care, mental health, the voluntary sector and friends and family networks to provide integrated and accessible care. This is at the forefront of our new 5 year strategy, and working with our close partners in Wiltshire Council, we continue to examine ways in which we can pool our resources to achieve this.

We believe that through clinical leadership and by putting the views of patients at the heart of all that we do, we have commissioned services which are creating significant improvements to the NHS in Wiltshire. We look forward with a clear commitment to making further improvements and delivering our vision to improve the health and wellbeing outcomes for our communities.

1.2 Strategic Report

Introduction

Our Progress So Far

As a Governing Body we are pleased with progress during this formative year and consider that significant progress has been made in our own corporate development as an effective strategic leadership board. We have taken a leading role in the development of strategy not least in the form of a new Five Year Strategic Plan and, in close partnership with Wiltshire Council, an ambitious Better Care Plan. We have also overseen the design and introduction of a fully integrated monthly performance report, which brings together in one place, data and metrics to give a coherent indication of the organisation's performance in key areas. This, together with a robust system for the identification and management of risks, and an internal staff appraisal system based on a system of cascaded objectives forms the basis of our output based performance management regime.

The Governing Body has invested time reflecting on their own performance, with the assistance of a specialist external consultant, and will continue to make time to devote to their development. Whilst we remain committed to the locality model in order to deliver real clinically led local solutions, the Governing Body is equally committed to delivering improved outcomes system wide for the whole population. Accordingly, the Governing Body has agreed to implement a county wide and joint programme management approach to achieve the delivery of their ambitious plans.

Looking Ahead

As we look ahead to 2014 and beyond, we will continue to work in partnership to bring care closer to home, to encourage people to take responsibility for their own wellbeing and support them to do so thereby reducing unplanned admissions to hospital.

Our work on the development of our 2014/15 Delivery Plan identified that we faced a major challenge in the future in meeting forecast demand for care within the anticipated level of resources. We recognised that this meant that we would need to derive a new strategic plan focused on a longer timeframe to drive transformation in the delivery of care. In particular, we recognised the vital importance of the integration agenda and that a strong, open and collaborative relationship with Council colleagues would be key.

The nature of the challenge facing Wiltshire is typical of the whole country and in October 2013, NHS England wrote to all CCGs asking commissioners "to develop ambitious plans that look forward to the next 5 years, with the first two years mapped out in the form of detailed operating plans."

We identified that it would be vital for this process to be both clinically led and conducted in an integrated manner with social care partners, as well as being coherent with the Wiltshire Health and Wellbeing Strategy, which was agreed by the Health and Wellbeing Board. This approach has helped us to:

- Develop key design principles for a new model of care.
- Identify the key issues for Children, Adults and Elderly (aligned to the Health & Wellbeing strategy).
- Develop approaches aligned to the design principles for addressing the key issues.

- Test that, taken together, our preferred approaches are likely to meet the needs of our population and result in a coherent new system of social and health care.
- Produce an ambitious and credible 5 year plan, including a detailed first two years operational plan.

Our Five Year Plan sets out the strategic direction for the development of health and care services across Wiltshire over the period 2014-2019 and lays the foundations for transformational change, showing in detail how we will deliver objectives between 2014 and 2016. The Strategy describes transformational change that should provide high quality, effective, clinically led and local services for people in Wiltshire. It has been developed with very close support from Wiltshire Council, guided by the Wiltshire Health and Wellbeing Strategy, and development has been fully coherent with the emergent Better Care Plan. Accordingly, the plan has improved integration of health and social care services as a key deliverable. Throughout 2014/15 there will be a significant programme of patient and public engagement and this follows extensive engagement and involvement of our partners and providers and member GPs in 2013/14.

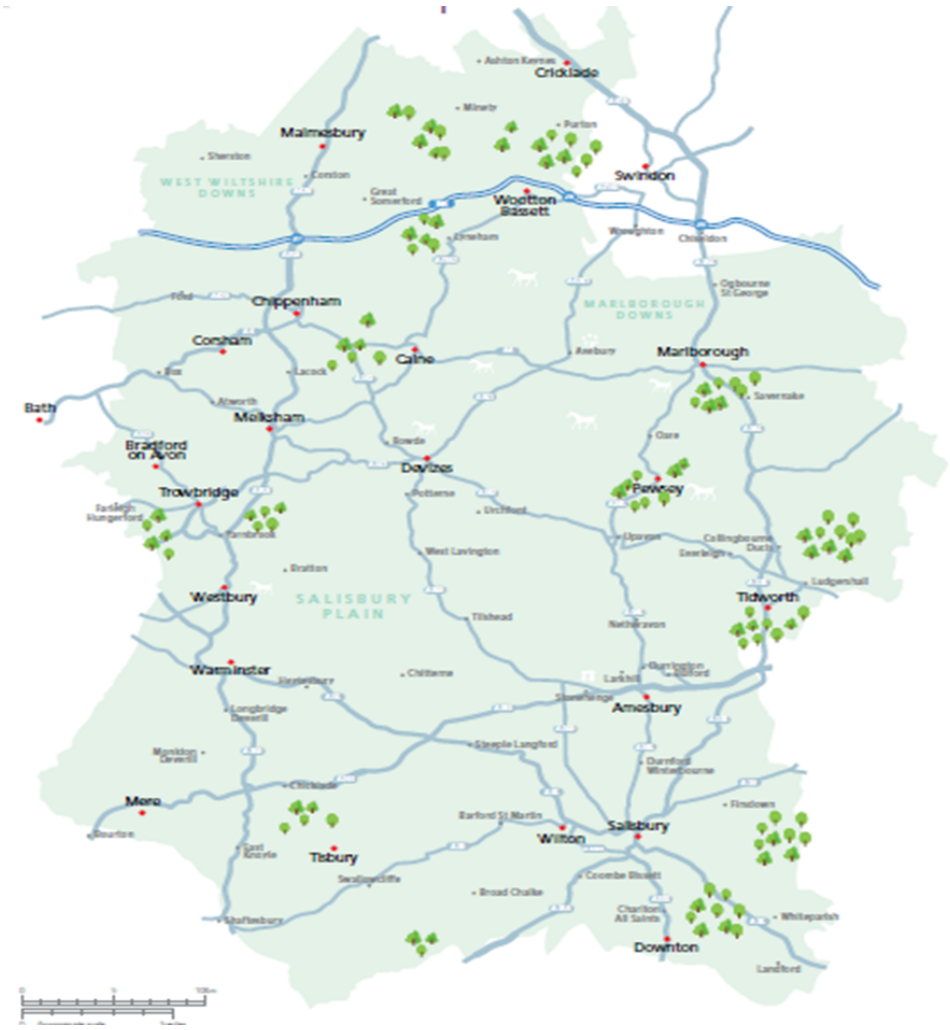
The vision of the plan is that Health and Social Care services in Wiltshire should support and sustain independent healthy living and the design of the future system is based on three key principles:

- People encouraged and supported to take responsibility for, and to maintain and enhance their wellbeing.
- Equitable access to a high quality and affordable system, which delivers the best outcome for the greatest numbers.
- Care should be delivered in the most appropriate setting, wherever possible at, or as close to home as possible.
    - Where acute care is one-off or infrequent, there should be formal and rapid discharge.
    - Where care is on-going (e.g. chronic conditions) the default setting of care should be primary care.

Nature, objectives and strategies of the CCG

Our Population

Wiltshire is a large, predominantly rural and generally prosperous county with a population of nearly 500,000. Almost half of the population resides in towns and villages with less than 5,000 people and a quarter live in villages of less than 1,000 people. Approximately 90% of the county is classified as rural and there are significant areas with a rich and diverse heritage of national and international interest, such as Avebury, Stonehenge and Salisbury Cathedral. With 141 people per sq. km, Wiltshire has a lower population density than the rest of the South West or England overall. The rural nature of the county has implications for the planning and provision of health and social care services, particularly with a shift towards providing more services in the community.



In order to design health services that provide the right care for people both now and in the future, it is important to understand some basic information about the make-up of the population, and how this is going to change in the future. Using this, and other information that we have about the prevalence of disease we can build up a picture of what services we need to develop or change in order to keep our population as healthy as possible.

Analysis reveals four key messages:

1. **Our population is relatively healthy:**

Our analysis of Wiltshire's population shows that overall; people in Wiltshire are healthier than comparative groups in England, with lower than average rates of:

- Mortality from causes considered preventable.
- Smoking related deaths.
- Premature deaths from cancer.

What our analysis also demonstrated is that there is a growing challenge in terms of the ill health effects from lifestyle conditions and a need to improve engagement with healthcare services to address preventable illness. Examples include areas such as:

- Number of overweight and obese children – 20% 4 to 5 year old children classed as overweight or obese, increasing to 29.6% of 10 to 11 year olds
    - Vaccination rates for under-3s which are falling whilst the England average is improving.
    - Over 40% of adults failing to achieve the guidelines for weekly exercise.
    - Falling rates of screening for cancer and low take up of NHS health check.

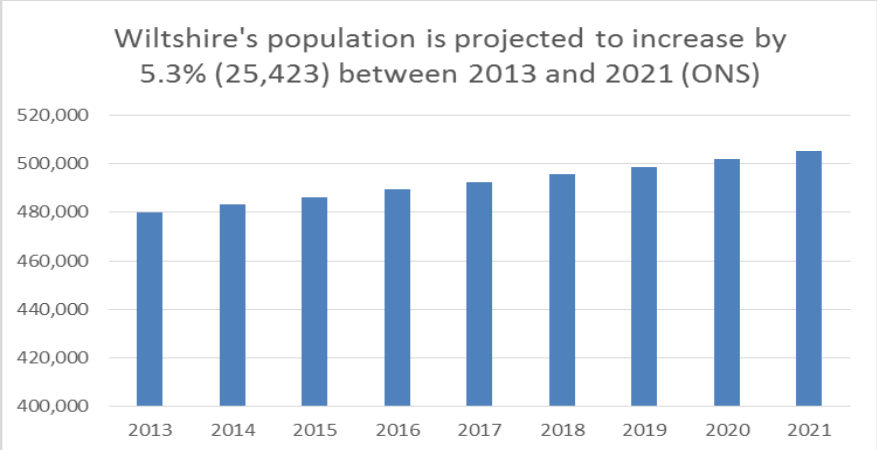
Therefore whilst our population is relatively healthy, we recognise our approach needs to incorporate measures around:

- Prevention.
- Early intervention.
- Developing the individual's personal responsibility for healthy lifestyle choices, health and wellbeing to keep them in health.

These themes feed directly into our developing strategy and approaches for improving health and outcomes within Wiltshire.

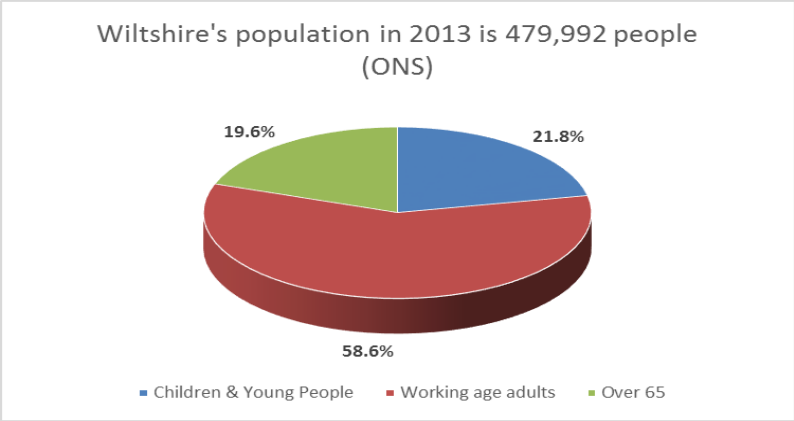
2. **Our population is growing:**

The CCG's current population is 479,992 (2013), and forecast to grow by an additional 3.3% (15,603) by 2018, and by 5.3% (25,423) to 505,416 by 2021. This excludes some additional 10,000 people because of military restructuring and developments in the county.

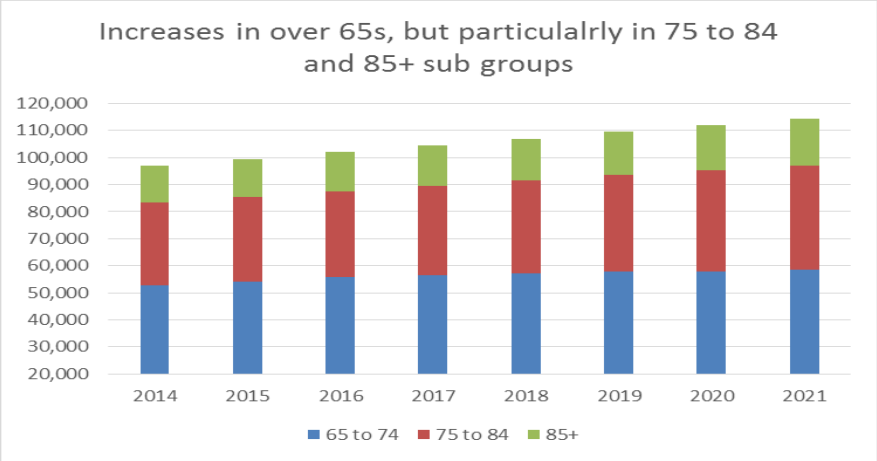


3. Our population is changing:

By 2021 there will be proportionately more children and young people (+5533) and fewer working age adults (-632). People over 65 make up 20% of the county's population and will make up 22.5% of the county's population within the next 7 years, and the number of older people is rising much faster than the overall population of the county (+20,253 by 2021).



Within our over 65s age group, there will be a particular increase in the number of Wiltshire residents aged over 75 (+13,086), and over 85 by 2021.



4. There are specific areas we need to focus upon, including inequalities:

The implications of an ageing population are great in terms of people living longer into older age, with an increased demand for health services, a higher burden of chronic disease and susceptibility to the negative impacts of social isolation. In parallel to this there will be a reduction in working age people, a reduced contribution to the economy and lower incomes, and an increased need for care services (paid and unpaid carers).

Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS financial resources (47.4%) are used by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Dementia in particular can affect people of any age, but is most common in older people. One in 14 people over 65 have a form of dementia and one in six people over 80 have a form of dementia.

The prevalence of dementia in Wiltshire is predicted to rise due to our ageing population. Oxford Brookes University and the Institute of Public Care (2013) estimate that there are approximately 6,538 people with dementia in Wiltshire. It is predicted that this number will increase by 27.8% by 2020 – equating to an additional 1,800 people with dementia and will nearly double by 2030 to 11,878 people. It is also estimated that there will be an increase in those people with severe dementia from approximately 800 in 2012 to 1,600 in 2030.

Additionally, while overall health outcomes in Wiltshire are very good, this masks some specific local issues that we need to address. Some of our towns and their suburbs are among the most deprived in England, with significantly lower life expectancies in the poorest parts of Melksham, Trowbridge, Salisbury, Royal Wootton Bassett and Cricklade. The county also has the second-largest military population in the UK and some unique establishments that affect the way we must plan emergency health services, like Porton Down.

Our future financial position

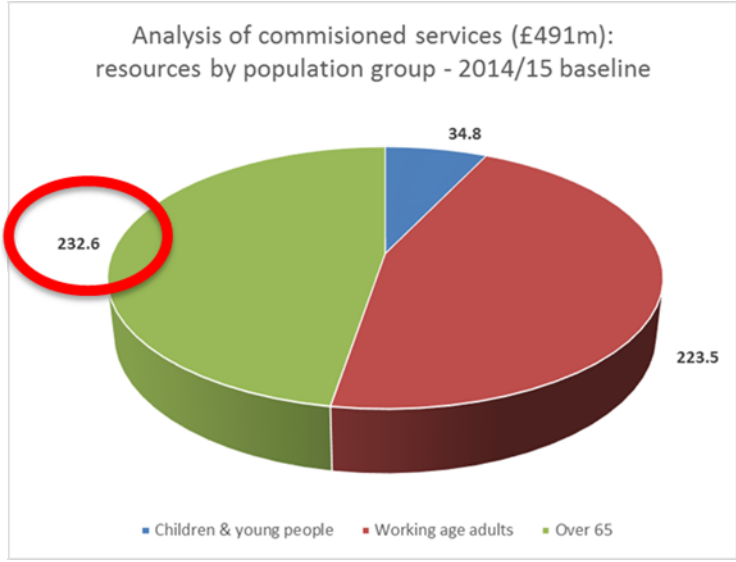
Wiltshire CCG had a strong financial position at the end of 2013/14 with a reported surplus of £5m. Looking forward, the financial future is characterised by austerity, with current national forecasts pointing to a £30billion gap in funding by 2020/21, despite NHS budgets being protected. The biggest factor that creates this pressure is from demographic change, especially increases in the elderly population.

We have undertaken significant work to predict the future costs of Wiltshire's health services and have established a model that determines:

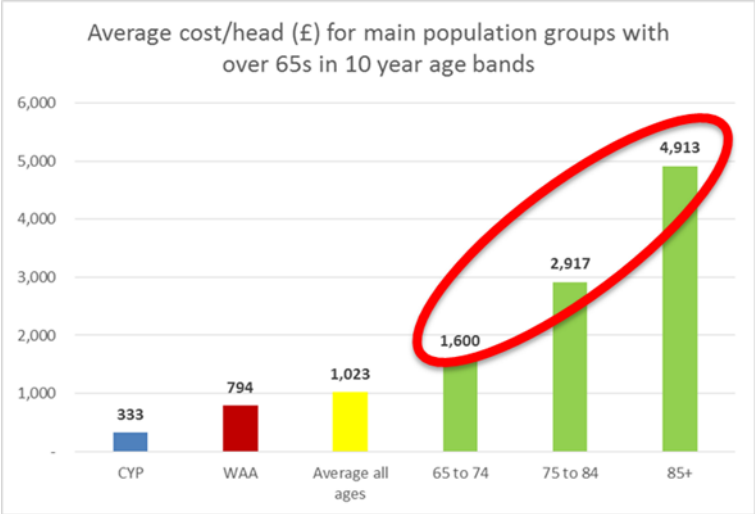
- The relative resource use a by different population groups.
- The impact that this would have on our resources.
- The implications of this change for the services we provide.

This work created a breakdown of resources by population group that showed:

- The smallest overall spend is on Children and Young People (£34.8m).
- The largest overall spend is on over 65s (£232.6m).
- Over 65s consume the largest proportion of our resources (47.4%).



The average spend per head for Wiltshire CCG was £1,023. However, the pattern of spend by population group was significantly different, with a marked distinction between under and over 65s.

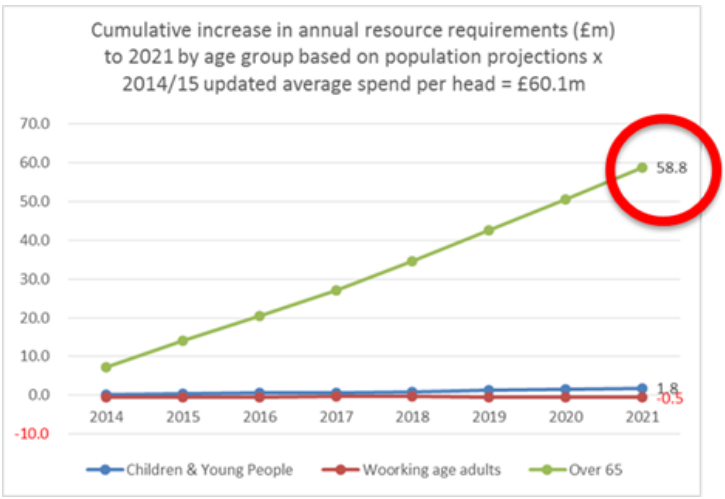


This analysis demonstrated that:

- The over 65s consume the largest volume of resources per head, as well as the largest overall proportion of our resources.
- Once individuals pass 65, average consumption of healthcare resources increases to between three and five times the our average spend per head (from £2,917 to £4,913).

Applying the demographic pressure with the cost by age group the model predicted a significant increase in cost by 2021:

- The estimate of the overall additional cumulative resource requirement resulting from population growth is £60.1m.
- The impact of the changes in the over 65 population is a cumulative additional resource requirement of £58.8m – the vast majority of the projected overall requirement of £60.1m.



As a county we will not be able to absorb this projected increase in cost within our constrained resources, despite the current strength of our financial position, without implementing transformational change. To effectively address the healthcare needs of people in Wiltshire, we

need to commission care that both meets the needs of an increasing number of elderly and frail people but can also be delivered affordably.

Our aim is to change the nature of the healthcare we commission, moving away from care that is largely reactive and focused on acute secondary care as the default care model. Our plans over the next five years will support this transformational change and by frontloading the proposed changes, we anticipate early benefits.

Without this type of fundamental change through a shift in the balance of care, relying less on reactive acute services and more on proactive community care, our financial position will become unsustainable and we will not have the resources available to commission the healthcare needed by people in Wiltshire.

Development and performance of the CCG for the period under review and in the future

Our Current Performance

Wiltshire CCG and its partners begin the transformational journey from a strong starting position in terms of the overall performance of the health and care system. The table below summarises in particular our performance against the NHS Outcomes Framework for England, and in delivering against the pledges and rights our patients should expect as part of the NHS Constitution.

The NHS Outcomes Framework:

The NHS Outcomes Framework describes the health outcomes required from NHS organisations under 5 domains. The CCG Outcome Indicators Set shows that in most cases and against four of the five domains, our relative performance against the England median is either better than average or much better than average.

NHS Outcome Domain	Key Priorities for 2014-16
Domain 1 Preventing people from dying prematurely	Our outcome in this domain, using a range of nationally measured outcomes, is much better than average with fewer potential years of life lost (PYLL) than the England average and a lower mortality rate from preventable causes for under 75s. This reflects the general public health analysis of the local population, which shows a better position against a range of health indicators than the England average for under 75s, which is reflected in the position in this domain.
Domain 2 Enhancing quality of life for people with long term conditions (including dementia)	Our outcome in this second domain is again much better than average, with higher health related quality of life for people with long term conditions than the England average and lower rates of unplanned hospitalisation than the England average for a range of long term conditions. This is reflected in the Outcomes Indicator Set (OIS) data that shows a higher proportion of people feel supported to manage their condition and positively reinforces our ambitions around self-care and self-management.

NHS Outcome Domain	Key Priorities for 2014-16
Domain 3 Helping people to recover from episodes of ill health or following injury	OIS data shows we have a lower level of non-elective admissions and re-admissions than the England average; and better than average reported outcomes reported by patients for four common planned surgical procedures This is a positive position and our strategy will continue to build upon this.
Domain 4 Ensuring that people have a positive experience of care	Our position relative to the England average is much better or better than average for most OIS measures in primary and secondary care, which is positive. One acute provider scores as below average, which is the single instance of below average performance in this domain, and will be a focus for improvement over the next 12 months
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm	An area of focus for us over the next 12-24 months will be to continue to work with our acute and community providers to eradicate any instances of avoidable healthcare-acquired infections (HCAIs)

The NHS Constitution

We recognise our obligations to patients in Wiltshire as set out in the NHS Constitution. Our patients have a right:

- To non-emergency treatment starting within a maximum of 18 weeks from referral.
- To be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.
- To a choice of a number of hospitals for elective care.
- To view their personal health record.
- To be treated with dignity and respect, including single sex accommodation.
- To have complaints dealt with efficiently and investigated properly.

Referral-to-Treatment Times (RTT)

We have performed well in ensuring most of our patients receive treatment within 18 weeks of referral by their GP, with the exception of 25 patients waiting more than 52 weeks. Our future plans will help maintain and improve performance in this area as further developments in triage and referral management reduce the volumes of referrals, making this commitment easier for providers to achieve. Improvements in community based treatments, such as through changes to the Musculoskeletal pathway (MSK), will also have an impact on reducing referrals. The issue of over 52 week waiters is part of current contract discussions and providers will be required to provide explanations and commitments that processes are in place not only to identify long waiters, but to ensure remedial action is taken far earlier than the 52 week target in the standard. Our expectation is that the actions taken will address the issue of over 52 week waiters and ensure that there are no further breaches of this standard.

Diagnostic Waiting Times

This aspect of performance shows whether patients have timely access to treatment, by highlighting delays resulting from not having the required diagnostic tests undertaken promptly. We have consistently met our commitments in this area, and we are working closely with providers

to understand current trends and patterns in diagnostic activity now that tariff arrangements for diagnostics have been implemented. We will review this in detail in the current contracting round to ensure that these changes do not adversely impact upon waiting times. It is therefore expected that we will continue to achieve the current levels of performance and either meet or exceed expectations in this area.

A&E Waiting Times

This standard shows whether patients are promptly treated in an urgent care setting, whether in A&E or a Minor Injuries Unit (MIU). In 2013/14 the CCG was close to achieving the target for all A&E departments, although some adverse performance during the year impacted on overall year to date performance. Individual provider performance is detailed as follows:

- RUH has experienced difficulties in several months, leading to a position at the end of March 2014 of 93.7% and a 2013/14 forecast of amber.
- GWH has experienced difficulties in several months, leading to a position at the end of March 2014 of 94.1% although the 2013/14 overall forecast is green.
- Salisbury NHS Foundation Trust (SFT) has, with the exception of April 2013, consistently met the A&E waiting time target, leading to a position at the end of March 2014 of 96.3% and a 2013/14 forecast of green.

Our main focus over the next 12-24 months will be to work with the RUH and GWH. The RUH has been taking positive measures to address performance with a successful bid for winter pressures funding. The planned improvements in processes are designed to effectively address rather than just acknowledge pressures and form part of a whole system solution.

Cancer Waiting Times

This standard shows the speed with which patients are treated across the cancer pathway and includes both referrals and definitive treatment for patients with cancer or suspected cancer. We have consistently achieved the required level of performance in this basket of targets, whether at two weeks, 31 days or 62 days.

Ambulance Calls

The ambulance calls standards are designed to show the speed of different types of emergency response as well as the time taken to hand over patients from the ambulance service to acute hospitals' A&E. Performance around ambulance calls and response times to date in 2013/14 shows that we have not achieved the required standard of performance we expect for our patients. Our main area of focus to resolve this in the future will be to work with our provider around Category A Red 1 incidents and achieve a pragmatic way ahead appropriate for a large rural county.

Mixed Sex Accommodation

This standard measures whether patients are in mixed sex accommodation during a hospital stay. Performance around this standard in 2012/13 was poor, with only GWH achieving the target. There has been some improvement with a much smaller number of breaches, through 2013, mainly in July and September. Our determination to address this issue and the plans put in place should result in performance being either green for all providers or a mix of green or amber. Month 11 year-to-date reporting shows us at 25 compared to 33 in 2012/13 with January 2014 seeing 12 cases. GWH have reported no cases in either 2012/13 or 2013/14.

Cancelled Operations

This standard measures the number of operations cancelled for non-clinical reasons upon or after admission to hospital. Overall our providers performed very well in this area, with minimal cancellations for our patients. Only RUH had difficulty due to short- term operational problems which were addressed. We will be reviewing this with all providers as part of the contracting round to ensure that patient flows are proactively managed to avoid the need for cancellations.

Mental Health

This standard measures the proportion of people that were promptly followed up after discharge that were treated using a Care Programme Approach. The NHS Constitution requirements for this indicator have been met consistently in 2013/14.

Trends and Factors

The NHS is currently experiencing a range of pressures which challenge the maintenance of high quality and sustainable health and care services to all: an ageing society, increasing expectations, the rise of long-term conditions, increasing costs of providing care, limited productivity gains and constrained public resources.

Older people are forming a larger proportion of the population, with the greatest growth expected in the number of people aged 85 or older. This group is the most intensive user of health and social care. The health needs of older people are particularly apparent in non-elective care within the acute sector where:

- Nearly two-thirds of people admitted to hospital are over 65.
- Unplanned admissions for people over 65 account for nearly 70% of hospital emergency bed days.
- When they are admitted to hospital, older people generally stay longer and are more likely to be re-admitted.

In addition to the ageing population, lifestyle choices amongst the rest of the community are impacting demand. Around 80% of deaths in England are from major diseases, such as cancer, many of which are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet. Forecasts indicate that 46% of men and 40% of women will be obese by 2035. This is projected to result in 550,000 additional cases of diabetes and 400,000 additional cases of stroke and heart disease nationally.

Over 15 million people in England have a Long Term Condition (LTC), around 25% of the population and this cohort currently utilise:

- 50% of all GP appointments.
- 70% of all hospital bed days.
- 70% of the total health and care spend in England.

People with one or more long-term conditions are the most important source of demand for NHS services:

- The 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England.

- Patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year.

The number of patients with long term conditions is projected to grow by 50% in a decade.

This growth in demand is taking place at a time of austerity, which continues to put pressure on NHS funding. Even with NHS budgets protected in real terms, current forecasts point to a £30bn gap in funding by 2020/21.

Costs of healthcare and demand increasing globally as well as in England

Increasing demands for healthcare - combination of "lifestyle" conditions + ageing population

UK economy 3% smaller than pre crash - Austerity continuing to put pressure on NHS funding

£30bn gap by 2020/21, projected to double to £60bn by 2025, even with protected budgets

The above diagram sets out the key drivers that affect the future sustainability of the NHS without transformational change, and reflects wider international trends in the developed world of:

- Healthcare spending taking up increasing proportions of Gross Domestic Product (GDP) across developed countries.
- Changes in demographics, particularly a growing proportion of older people, driving up the demand for, and overall cost of, healthcare.
- Increasing life expectancy which, whilst very welcome, does not reduce the cost of healthcare, but instead postpones the high costs associated with healthcare at the end of a person's life.

To address both the quality and sustainability challenge posed by this combination of trends, the NHS has set out several high level ambitions to ensure quality is improved and services designed around patients and their needs in the future:

Securing **additional years of life** for the people of England with treatable mental and physical health conditions
Improving the health related **quality of life** of the 15 million+ people with one or more long-term conditions, including mental health conditions
Increasing the proportion of **older people living independently at home** following discharge from hospital.
Increasing the number of people with mental and physical health conditions having a **positive experience of hospital care**
Making significant progress towards **eliminating avoidable deaths** in our hospitals caused by problems in care.
Increasing the number of people with mental and physical health conditions having a **positive experience of care outside hospital**, in general practice and in the community
Reducing the amount of **time people spend avoidably in hospital** through better and more integrated care in the community, outside of hospital

The Local Context in Wiltshire

We have a deep understanding of the structure, nature and health position of our local population. This has been developed from a wide range of sources both within and outside the CCG including:

- Public Health analysis looking at the structure and health of the current population, as well as projected changes identified through the Office for National Statistics (ONS) projections.
- Joint work with Public Health through the Health and Wellbeing Board, drawing on a range of indicators such as those in the Public Health Outcomes Framework to understand the state and needs of different population groups.
- Joint work with the Council through the Community Transformation Team to understand the health position and care needs of the elderly population.
- Our own quantitative analysis such as the evaluation of health and outcome indicators, Atlas of Variation, CCG/Local authority "profiles" from NHS England, and our assessment of the impact of population projections, overall and within age bands, which helps us understand health needs and relative performance.

The Imperative for Change

Whilst increased life expectancy is a cause for celebration, the high rate of growth in the number of elderly people and people with dementia in Wiltshire is placing a burden on care budgets, creating financial pressures and capacity issues for health and social care. For NHS services, we have estimated that without transformational change, we would need an additional £60.1m by 2021 – of that 97.85% (£58.8m) would be required for people aged 65 and over. The scale of this

challenge requires fundamental system redesign. There must be a major shift in focus and resources into prevention and care at, or close, to home.

As part of any new model it is essential to increase people's sense of personal responsibility for their wellbeing and to engage with friends and families and local communities to change lifestyles and deal with root causes (such as loneliness) which, if unaddressed, lead to demands on the social and healthcare system. Such fundamental change will not be easy. It requires a different mind-set, deep engagement with the public, communities and partners and a collective resolve to bring the new system to life. However, a failure to achieve such transformational change will result in a reversal of many of the societal gains that the health and social care system has delivered over the years, particularly to the quality of life.

Key Challenges

The main challenges we and our partners face in Wiltshire in bridging this gap and delivering transformational change are:

- Developing a robust and sustainable integrated system - care and support is often fragmented, so people experience gaps in care and patients are treated as a series of problems rather than as a person. Care and support plans do not link together, which is inefficient and frustrating for people on the receiving end of our services. People have to repeat their stories to different agencies and are not always kept informed.
- Too many people make a decision about their long-term care and support whilst they are in hospital often resulting in frail elderly people being rushed into decisions and possibly an unnecessary admission to a residential or nursing home.
- Developing and implementing a robust model of primary and community based care - acute hospitals, specialist hospitals and emergency departments are under pressure, with unacceptably high levels of delayed transfers of care and extended lengths of stay in hospital.
- Increasing personal responsibility for health and well-being - the health and care system gives a higher priority to treatment and repair rather than prevention or early intervention. Often, people are not eligible to receive services until they reach a point of crisis, when a little support earlier may have avoided the crisis from developing.

Progress against agreed targets

In order to deliver our visions and aims, the Governing Body agreed seven key priorities for 2013/14.

Priority	High Level Targets
Staying healthy and preventing ill health	• Improve the overall health of our population through initiatives delivered in partnership with Wiltshire Council, the Health and Wellbeing Board; voluntary and community sector organisations. • Support and sustain people to maintain their own health and wellbeing and be responsible for their own health.
Planned Care	• Ensure that patients receive seamless care, whoever is commissioning or providing it. • Providing more outside hospitals, in the community, with patients able to choose from a range of providers.
Unplanned care and care for frail older people	• Create a model that is simple and straightforward with patients aware of, and able to access, high-quality care and support at the right time and in the right place. • We will develop health, social and community care services that turn unplanned care needs into planned care, wherever possible.
Mental health	• We are keen to support and treat more people at home or in a community setting (such as intensive day support) whenever possible.
Long term conditions including dementia	• Improve the way health organisations work together, so that people with long-term conditions find it easier to move between GPs, community health and mental health care providers. • Work with local GP surgeries to trial new ways of working to improve early diagnosis and quicker access to treatment for people with dementia.
End of Life care	• We want to provide people in Wiltshire with a dignified death, properly supported in a place where they want to die.
Community Services and Integrated Care	• We want to ensure that older people are better supported in the community so that they can stay healthier as they age, and so put less demand on hospital services. • Older people should feel more secure and supported by greater coordination between social care and the health service.

This section of the annual report provides information on how we have made progress in each of these areas, summarising key developments and achievements.

1. **Staying healthy and preventing ill health**

Our colleagues in Public Health at Wiltshire Council report that:

- Life expectancy has increased and for the first time men living in Wiltshire can expect to live to 80 years.
- Teenage pregnancies have reduced to the lowest levels since 1998 when monitoring began.
- Over 8,000 young people aged between 15-24 have been screened for chlamydia.
- Over 9,000 children's weight and height has been measured.
- Over 35,000 health checks have been offered to the eligible population through GPs.
- Over 280 people have been risk assessed for diabetes with 54% being recommended to see their GP.
- Almost 100 clients with mental health problems were referred to the specialist Citizens Advice Bureau (CAB) service and supported with debt advice, claiming benefits and advice on budgeting and money management.
- 50 clients a month with mental health problems engaged with the wellbeing project delivered by Wiltshire Wildlife Trust, undertaking a range of conservation and outdoor activities.
- Wiltshire's Breastfeeding Peer Support programme, Mum2Mum, trained mums who have experienced breastfeeding to provide support to other mums within Children's Centres and on postnatal wards in hospitals across Wiltshire.

2. **Planned care**

- Service Level Agreements were put in place that supported efficient referral practice and identified areas for pathway development.
- A pilot dermatology outreach service was run in the North East of Wiltshire to test the impact on secondary care service use by bring services closer to the community. This is being evaluated to assess roll out potential.
- A revised pathway for chronic neck and back pain was introduced at Salisbury Foundation Trust removing barriers to assess for patients that had existed previously.
- Hip and Knee classes were re-launched in the West of Wiltshire to support patients as an alternative to surgical interventions.

3. **Unplanned care and care for frail older people**

- A Wiltshire Urgent Care Working Group was put in place to both steer the delivery of provider winter plans and monitor their progress.
- Additional primary care capacity was supported, allowing a number of GPs to provide direct or indirect care to complex patients over a weekend period.
- Service Level Agreements were put in place that supported the delivery of additional support to care homes which have shown a reduction in emergency admissions.
- GP practices have undertaken a review or their patients at risk of failure, and working with the care coordinators have been able to ensure that appropriate packages of care are delivered to maintain the patient outside of the secondary care sector.
- Additional clinical resources have supported the introduction of personal health budgets to those individuals funded through Continuing Health Care (CHC).

- We have worked in tandem with Wiltshire Council to increase care home beds over budgeted levels, extend the night sitting service for people discharged from hospital, improve the provision of step up and step down beds to both prevent hospital admissions and improve rapid discharge.
- The CCG has commissioned the provision of a Simple Point of Access which has supported admission avoidance by coordinating the implementing care packages for patients in crisis.
- We have supported a number of investments at our three acute hospitals, all aimed at preventing admission, reducing length of stay and improving timely discharge.

4. Mental health

- Introduced a provider forum to improve cooperation between services and better pathways for patients.
- Significant new investment of funds to provide a range of psychiatric and mental health nurses working in our three acute hospitals. Such services improve quality of care, dignity and quality of life for patients being treated primarily for physical health problems in general hospitals and allow much more rapid mental health assessments.
- Introduced a single point of access to secondary mental health services.
- Introduced NHS mental health places of safety for adults and children in crisis which avoids the use of police custody suites and provides for a mental health assessment in an appropriate NHS setting.
- We have developed a new dementia strategy which, following consultation, will begin implementation in 2014. Early improvements in primary care diagnosis of dementia have already resulted in a reduction in Memory Clinic waiting times from 12 months to 4 weeks for more complex cases.

5. Long term conditions including dementia

- A range of activities has been undertaken to address long term conditions, particularly for the frail elderly in Wiltshire to include improved management of chronic diseases in the community, care homes and liaison between primary and secondary care. Also, enhancing community services and integrated care as described in more detail below.
- A diabetes clinical project group has been established to look at all aspects of the provision of diabetes services across Wiltshire and their integration with the hospital based diabetes services. It has been considering best practice service models across the country with the intention of improving the diagnosis, management and provision of diabetes care in the community and improved access to acute specialist services.
- The dementia strategy has been developed (subject to formal consultation at the time of writing) with input from members of the Wiltshire Dementia Delivery Board, which includes Alzheimer's Society and Alzheimer's Support, Carer Support organisations and Advocacy organisations. Additionally as part of this work we visited and collected views and feedback from people with dementia and carers at various local groups in Wiltshire.
- Dementia - in 2013/14 we invested heavily into Acute Liaison Services, resulting in acute liaison services being in place at the RUH, GWH and Salisbury District Hospital (SWT), seven days a week 9am-5pm. These services are having a positive impact on services in A&E, including the services for individuals who have self-harmed, but also services on the wards for patients with dementia and other mental health conditions.

- All practices have signed up to the new dementia enhanced service which gives practice staff additional training so that they are more aware, and can recognise signs of dementia earlier and can therefore carry out assessments and prescribing in a primary care setting.
- The waiting list for dementia assessments was reduced from 288 in May 2013 to 0 in Aug 2013.
- The targets to provide specialist assessments within 4 weeks of referral and treatment within 13 weeks are now being met.

6. End of life care

The End of Life Strategy has been developed by the CCG and Wiltshire Council, in collaboration with statutory and voluntary partners and local stakeholders. Key priorities are to ensure:

- For individuals access to appropriate high quality care at all times.
- To ensure informed choice for patients and families.
- To provide patient and family centred care.
- To have flexibility of services.
- To provide value for money for services.
- To ensure individuals are empowered to plan for their end of life care.

In 2014/15 we will build on this strategy to:

- Review End of Life Planning including out of hours support to prevent unnecessary admissions.
- Support the people of Wiltshire to be cared for and die in their preferred place of care.
- Reduce crisis admissions to secondary care from care homes.

Children's end of life care needs are excluded from this strategy but will be addressed through or Children's Strategy: transition plans will need to be in place.

7. Community services and integrated care

- Introduction of the Devon Risk Tool to aid the risk analysis and prioritisation of frail elderly patients whose care needs might benefit from Care Coordination.
- The introduction of Care Coordinators across Wiltshire who, based in primary care can work with GPs, community teams, secondary care and the voluntary sector to work with high risk patients to maintain their care in or closer to home.
- Reviewed the existing model of 'Neighbourhood Team' delivery of community services to develop a more integrated model of care based on more flexible 'Community Care Teams' with enhanced skills and training wrapped around "clusters" of GP practices delivering a more locally focused community support network.
- The creation of the 'Appropriate Place of Care' group which has reviewed the number and type of beds that will be required in the community in the future; considering the existing STARR support scheme and the needs of the community in terms of bed based resources to better manage transfers of care.
- The creation and implementation of a 'Rapid Response Service' which provides a single telephone number (Single Point of Access - SPA) and response to help and support health care professionals arrange urgent and immediate care for patients who might otherwise have been admitted to hospital. The service provides a 1 hour urgent response service providing homes based nursing care with the support of social care resources for up to 72

hours, giving immediate home based respite and allowing the patient's needs to be more fully assessed without them having to go into hospital. Still in pilot form, this service is having a significant impact already.

Performance against key national targets

We have the responsibility for commissioning services for Wiltshire that will achieve outcomes that improve the health and wellbeing of the population. To measure the success of Wiltshire's commissioning we are required to perform against a large number of key access and quality standards. We have made significant progress against the achievement of these targets however there remain a number of challenges that will be tackled in 2014/15. A summary of the performance achievement is shown below:

Indicator	Target	Achievement (Q1-3)
Referral to treatment for admitted and non-admitted care within 18 weeks	More than 90% of admitted patients more than 95% of non-admitted patients receive treatment within 18 weeks.	
Referral to treatment for incomplete pathways within 18 weeks	More than 92% of patients should be waiting under 18 weeks at the month end.	
Number of patients waiting more than 52 weeks	No patients are waiting longer than 52 weeks	
Patients waiting 6 weeks or more for a diagnostic test	95% of patients receive there diagnostic test within 6 weeks	
A&E waits - SFT	95% of patients are seen in A&E within 4 hours	
A&E waits - RUH	95% of patients are seen in A&E within 4 hours	
A&E waits - GWH	95% of patients are seen in A&E within 4 hours	
Cancer patients - 2 week waits	93% of patients are seen in within 14 days of referral	
Cancer waits - 31 days	96% of patients have a maximum 31-day wait from diagnosis to first definitive treatment for all cancers	
Cancer waits - 62 days	85% of patients have a maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	
Ambulance calls red 8 minute response times	75% ambulance response to a category 1 call within 8 minutes	
Ambulance calls red 19 minute response times	95% Ambulance response to a category 1 call within 19 minutes	
Mixed sex accommodation breaches	No patient experiences a mixed sex accommodation	
Mental health Care Programme Approach (CPA) achievement	95% of patients CPA are followed up within 7 days of discharge from psychiatric in-patient care.	
Clostridium Difficile (CDiFF)	Incidence of C-Diff healthcare associated infection to be below CCG Target level	
Methicillin-resistant Staphylococcus aureus (MRSA)	No incidence of MRSA healthcare associated infection	

Quality and Patient Safety Report

Introduction

Improvement of quality and patient safety is central to what we do; ensuring that the services we commission provide high quality safe care to patients and their families and carers. During the year we have continued and built upon the quality and patient safety monitoring processes that provide both the Governing Body and the public with assurances that the care we commission is safe, and of the highest possible quality. We want to ensure that quality and patient safety are built into commissioning structures, values, practices and business processes through the annual cycle of clinical quality activity.

We use the three fold approach within the international definition of quality, namely:

- Patient safety
- Patient experience
- Clinical effectiveness

Within this definition we have continued to review quality metrics and strengthen the links with performance and contracting so that we can be sure the impact on and experience of patients is heard and that improvements are made as a result. In the last year a number of seminal reports and recommendations have influenced the quality and safety agenda in England, most notably the Winterbourne View Concordat, the report of Robert Francis QC, the Government's response "Patients first and foremost" and the Berwick Review of patient safety: "A promise to learn – a commitment to act: Improving the safety of Patients in England".

We have embraced the recommendations of the Francis Report from its development of a complaints management process, the identification and monitoring of trends and early warning signs of changes. Although the implementation of the recommendations from these reports is still work in progress, we are committed to commissioning safe, high quality services whether in acute or community settings. We are holding providers to account for the quality and safety of services with structured reports across providers using a range of indicators and metrics from a number of sources, which are regularly reported to our Governing Body.

Since July 2013, we have started the Governing Body meetings with a patient story. This is recognised good practice in sharing a story as it helps us to understand how the services we commission impact on patients. Patient stories are recognised as an effective and powerful way of making sure that the patient's voice is heard and that improvement of services is centred on the need of patients.

Complaints management

Ensuring good handling of complaints and learning from them are ways in which CCGs can improve quality for their patients. In October 2013 the Clwyd & Hart review of the NHS Hospitals complaints system, putting patients back in the picture was a humble reminder of the rich learning we can gain from actively managing complaints and speaking directly with families to listen to their stories.

Working with the Central Southern Commissioning Support Unit (CSCSU) in November 2013, we systematically reviewed our Complaints Management Process. Initially the complaints management process suffered from the establishment of two brand new organisations which produced a situation where there was no clarity on roles and responsibilities within the process.

This led to fragmented processes and significant delays particularly as a result of handovers between the two organisations.

As part of the learning process for the CCG and CSCSU, a business process mapping event took place on 30 October 2013. This was designed to engage with all the key stakeholders in the process and to identify actions for improvement. The whole complaints management process was mapped from start to finish and an action plan was developed to provide significant improvements to the system. Areas covered included communicating information to the public; clarifying roles and responsibilities around investigating officers; recording of risk assessments; escalation processes and holding providers to account; improvements to the administration of the process and recommendations for training improvements.

As a result the complaints management process is much clearer to all stakeholders and business processes have been streamlined and improved. We now receive a weekly status report on the complaints that remain open and the action being taken to close. A new lead for the complaints management process will be starting in May 2014 when another full review of the system will take place.

There is no set timescale for NHS complaints (NHS Complaints Regulations 2009) and timescales are set and agreed in conversation with the complainant. However we and the CSCSU use 25 working days as a reasonable guide to investigate and provide a response to the complainant. Complaints that strand several NHS organisations/providers will usually take longer than 25 working days and this will be explained to the complainant and agreed.

All complaints will be acknowledged within 3 working days; 89.4% of all complaints have met this target. 10.6% of complaints were acknowledged within 4-8 working days. This was due in part the initial handover period from Primary Care Trust (PCT) to the CSCSU. We and the CSU have worked in partnership to ensure a robust system is in place and for the last nine months have been working to 100% of this target.

Our MP letters are treated in the same way as formal complaints and follow the same process with a letter of acknowledgement, investigation and signed final response by the Chair, or the Chief Officer.

NHS Wiltshire CCG for April – March 2013/14

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
NHS Wiltshire Clinical Commissioning Group	16	30	14	30	90
Member of Parliament	21	14	20	15	70
Total	37	44	34	45	160

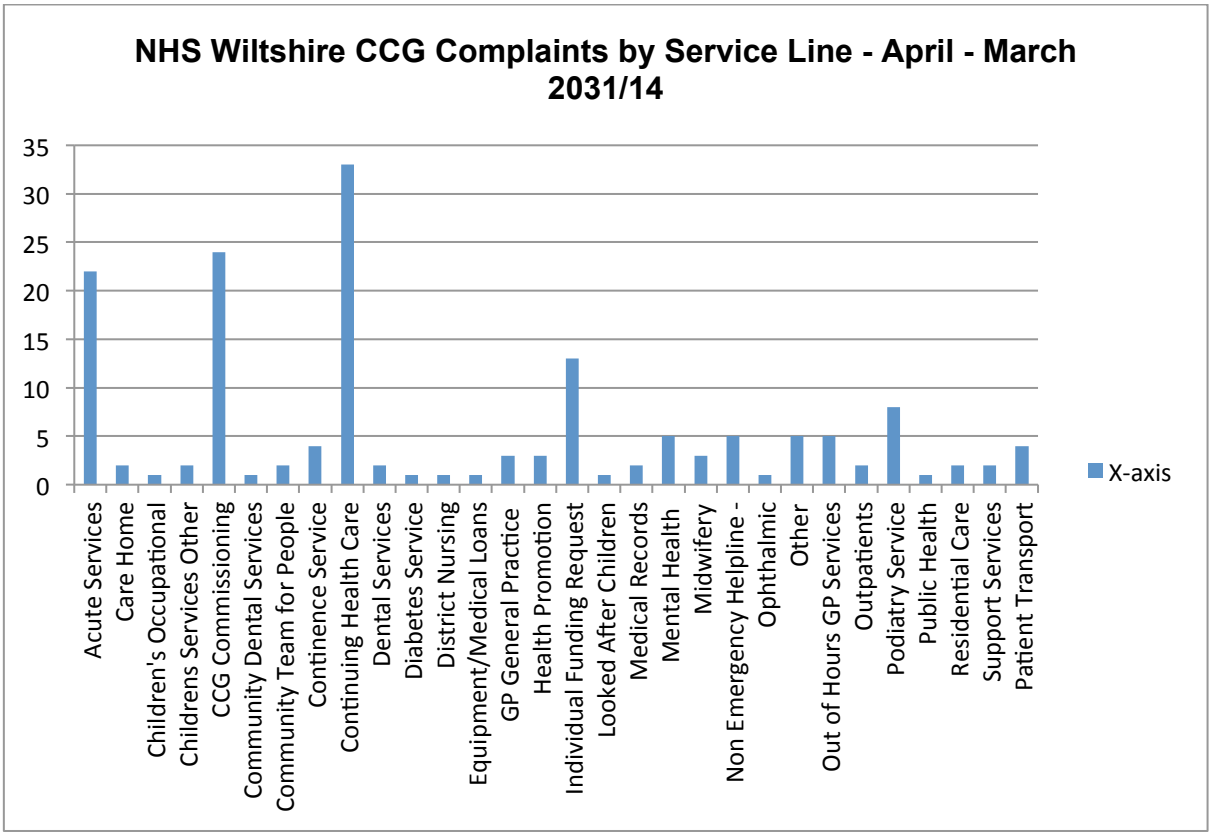
Of the total 90 complaints received in April – March 2013-14, 83 have been closed and 9 remain open. 28 were referred to another organisation for investigation and response direct to the complainant; outcomes were shared with the commissioners.

Of the total 70 MP letters received in April – March 2013/14, 68 have been closed and 2 remain open.

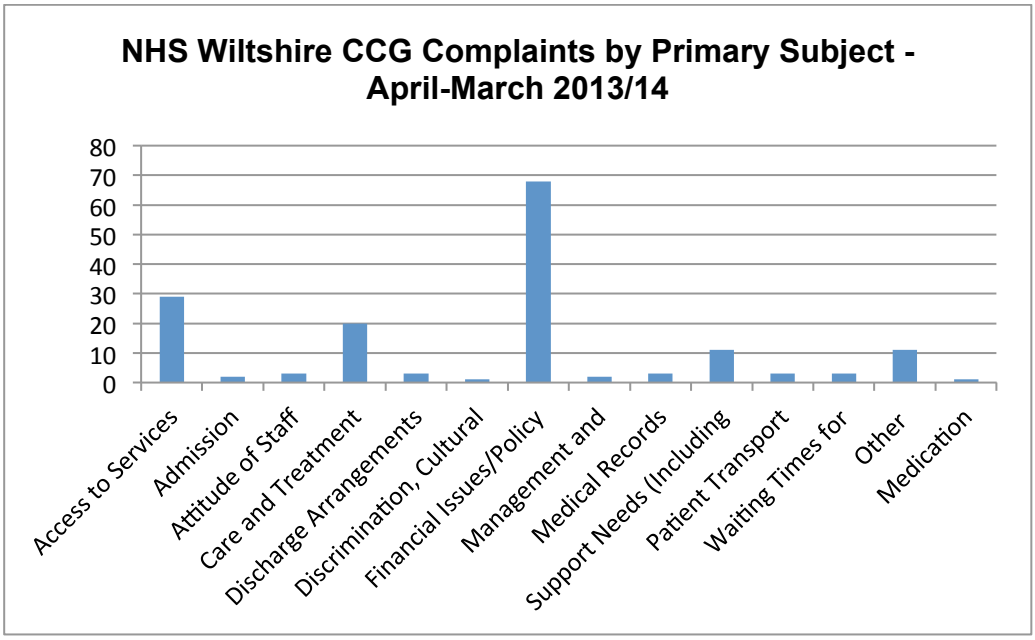
NHS Wiltshire CCG outcomes from complaints and MP received April - March 2013/14

	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Consent Not Granted	0	0	0	2	2
Local Resolution	4	2	0	0	6
Not Upheld	11	13	9	11	44
Partially Upheld	2	0	0	2	4
Upheld	3	4	2	2	11
Apology	1	4	0	2	7
Case not pursued by complainant	1	3	3	1	8
Explanation Given	10	7	13	8	38
Referred to other organisation	4	10	6	8	28
Resolved by Ombudsman	0	1	0	0	1
Serious Incident Requiring Investigation (SIRI)	1	0	1	0	2
Open	0	0	0	9	9
Total	37	44	34	45	160

Complaints breakdown by Service Line



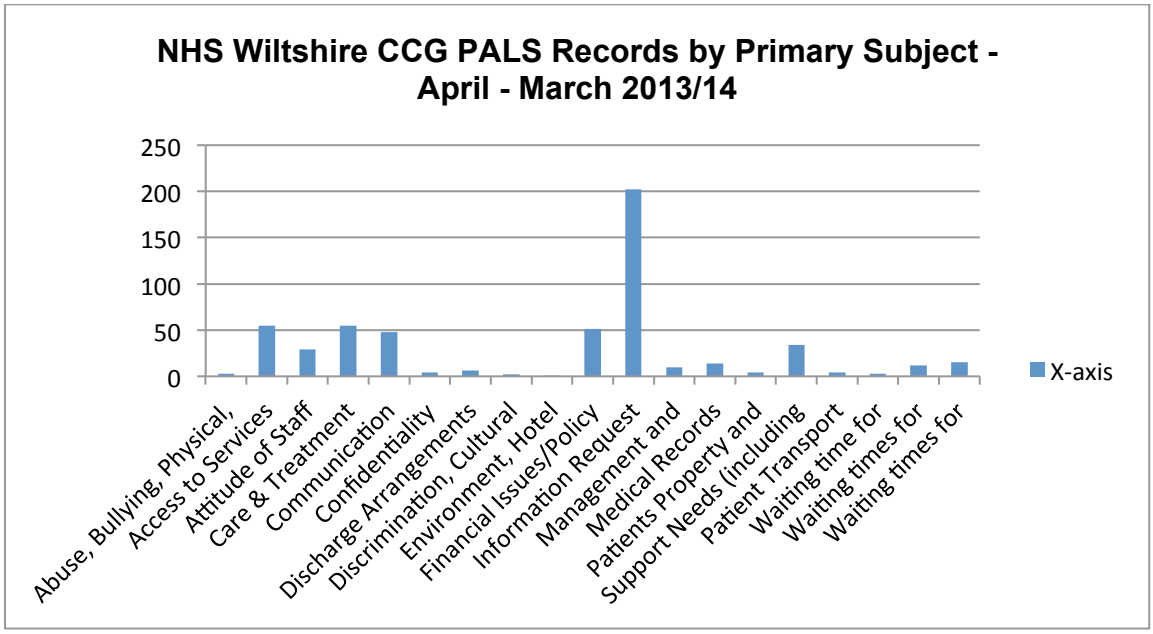
Complaints breakdown by Primary Subject (Top themes)



	13/14 Q1	13/14 Q2	13/14 Q3	13/14 Q4	Total
Wiltshire	168	223	164	210	765
Total	168	223	164	210	765

For the first part of Q1 PALS data was recorded on the former PCT's DORIS Patient Experience system although figures have been added to the above chart to give total figures for 2013/14 I have been unable to include themes within the graph below as data is not compatible.

Patient Advice and Liaison Service (PALS) by Primary Subject (Top Themes)



Patient safety

We have continued to drive improvements in patient safety through projects such as Harm Free Care and the National Patient Safety thermometer with a particular focus on local priorities and clinical risks. We have strengthened the reporting of harm across Wiltshire and encouraged a greater reporting of clinical incidents and investigating incidents. We have also used tools and systems available to us to ensure patient safety is as robustly and proactively monitored as possible, including the National Reporting and Learning System (NRLS) and the National Patient Safety Alerting System (NPSAS). NHS England has published monthly data on their website showing providers compliance with the alerts and we have used this information as part of the Clinical Quality Review Meetings with contracted providers.

National Reporting and Learning System (NRLS)

Since 2003/2004 all NHS Trusts have shared anonymous patient safety incident reports with the National Patient Safety Agency. From these reports, the Organisation Patient Safety Incident Reports data are published by the National Patient Safety Agency (NPSA) on a six monthly basis. These data cover patient safety incidents occurring in a six month period as reported to the NRLS. In publishing the data the NPSA aims to provide tools to support NHS organisations to analyse and learn from safety incidents to prevent patient harm in the future.

The latest six month data release for the period 01 April 2013 until 30 September 2013 was released on 30 April 2014 and details from the Wiltshire main providers are given in the table below. Patient safety alerts, data reports and related information continues to be available from : http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/?char=S

Incident Reporting rate per 100 admissions/bed days:

Provider	1 Apr 11 to 30 Sept 11	1 Oct 11 to 31 Mar 12	1 Apr 12 to 30 Sept 12	1 Oct 12 to 31 Mar 13	1 Apr 13 to 30 Sept 13
RUH	3.9	4.0	3.4	5.6	5.49
SFT	8.2	7.2	7.9	7.4	8.61
GWH	8.2	6.7	6.7	7.6	7.38

Data source: NPSA Incident report

Analysis by the NPSA of incidents reported above is discussed regularly at the provider Clinical Outcomes and Quality Review meetings to seek assurance of incident reporting and learning. Where there is low reporting, investigations are made with the providers.

Management of Serious Incidents

Serious incidents requiring investigation in healthcare are rare, but when they do occur Wiltshire has systematic measures in place to respond to them. These measures are designed to protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again.

Our policy has been written with reference to the national guidance framework issued by NHS England in April 2013 and the revised Never Events Policy Framework.

Providers are required to notify us of a Serious Incident Requiring Investigation (SIRI) within two working days. We oversee and hold providers accountable for their reporting and investigations processes, including adhering to timescales, deadlines and the implementation of actions and learning. We have established monthly Serious Incident Committee meetings to review the root cause analysis reports (RCAs) submitted by the providers. The Committee reviews the reports received from the providers and ensures during the review of the reports that the root cause of the incident has been identified and that lessons have been learned and actions are in place to mitigate the risk of the incident occurring again. We give feedback to the provider requesting further information if necessary and support closure when assurance is received and continue to monitor closed incidents to ensure that the actions are completed.

The types of incidents that have been reported are, falls resulting in a fracture, unexpected death, Intrapartum death, child death, confidential information leak, grade 3 / 4 pressure ulcers, allegations against staff members and adverse media coverage. For 2013/14, the list of reported incidents by Providers is as detailed below:

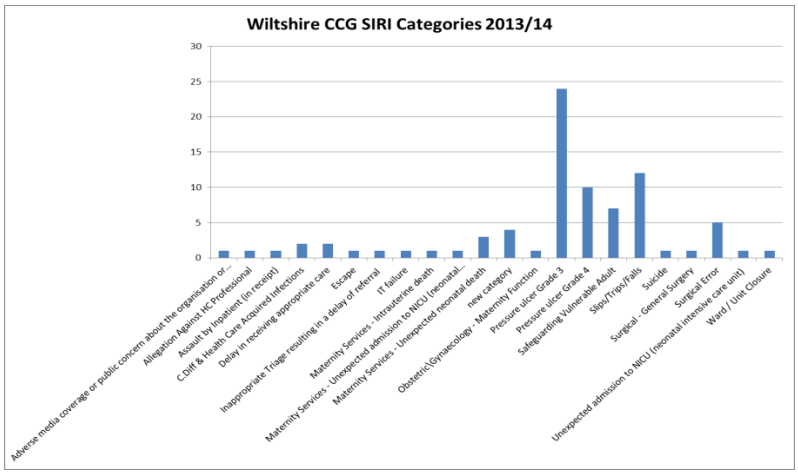
Table 1: Historical SIRIs reported by Provider, NHS Wiltshire (PCT) and NHS Wiltshire CCG

Provider	**No of incidents (involving Wiltshire patients)**				
	2009/10	2010/11	2011/12	2012/13	2013/14
Salisbury Foundation Trust Hospital	5	20	22	12	17
Great Western Hospitals NHS Foundation Trust	25*	53*	40	52	Acute 9 Community 26 Maternity 4
NHS Wiltshire CCG	3	16	19	13	19
Royal United Hospital Bath NHS Trust					8
Avon and Wiltshire Mental Health NHS Partnership Trust					32
Total	33	89	81	77	**115

**These were Wiltshire Community Health*

***It should be noted that 2013/2014 now includes all providers currently commissioned by NHS Wiltshire CCG which mitigates the increase to the year-end total (i.e. AWP).*

Themes and Trends



The above graph provides a breakdown of the SIRIs reported for Wiltshire CCG in 2013/2014. As has been consistent with the periodic reporting, pressure ulcers and slips, trips and falls account for a significant proportion of all SIRIs. The next highest category relates to safeguarding vulnerable adults.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. CCG's are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis.

During 2013-14 there have been four Never Events at GWH: all have been fully investigated. The action plans following the root cause analysis are being monitored by the Clinical Outcomes and Quality Assurance Group.

Harm Free Care

Harm free care is a national programme that helps NHS teams in their aim to eliminate harm in patients from four common conditions:

- Pressure ulcers
- Falls
- Urinary tract infections in patients with a catheter
- Venous thromboembolism (VTE).

These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400million. The programme supports the NHS to eliminate these four harms through one plan within and across organisations. It helps us in Wiltshire to consider complications from the patient's perspective, with the aim of every patient being 'harm free' as they move through the system. This moves away from the more usual approach of addressing these patient safety issues in silos.

The Safety Thermometer provides a 'temperature check' at any particular point in time and can be used alongside other measures of harm to measure progress. The table below shows the total number and % of patients who "received" harm by provider:

2013/14	Q1		Q2		Q3		Q4	
Total number of patients with harm	No	%	No	%	No	%	No	%
RUH			164	9.30%	185	10.30%		
SFT			155	12.10%	102	7.90%		
GWH			167	10.70%	384	10.30%		

Health Care Associated Infections MRSA and Clostridium difficile 2013/14 targets set by HPA

The term Heath Care Associated Infection (HCAI) covers a wide range of infections. The most well-known include those caused by Methicillin-Resistant Staphylococcus Aureus (MRSA) and *Clostridium difficile* (C. difficile). HCAIs pose a serious risk to patients, staff and visitors and can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

NHS England planning guidance for 2013/14, Everyone Counts: Planning for Patients 2013/14, sets a zero tolerance approach to MRSA bloodstream infections. This means that each organisation is expected to achieve zero MRSA bloodstream infections. The NHS planning guidance explains that in the case of an MRSA bloodstream infection, a post infection review will identify why an infection occurred and how future cases can be avoided. The Post Infection Review Guidance has now been published to help organisations conduct such reviews.

In January 2014 we received NHS England objectives for the 2014/15 MRSA and Clostridium *difficile* ambitions as tabulated below. Our local providers are above the national average for low levels of infection and we continue to strive to reduce HCAI.

Provider	Clostridium *difficile*					
	2011/12 Target	2011/12 Actual	2012/13 Target	2012/13 Actual	2013/14 Target	2013/14 Actual
SFT	25	50	25	25	21	21
RUH	59	42	31	27	29	37
GWH	39	26	21	30	20	23
Total for Wiltshire	146	165	139		127	133

During 2013-14 there have been 6 cases of post 48 hour MRSA bacteraemia. The RUH reported a trust apportioned MRSA on 31/03/14. The tables below show the year to date performance for MRSA:

MRSA (Providers) - 2013/14	Plan	Actual
RUH, Bath	0	1
GWH, Swindon	0	6
SFT, Salisbury	0	(2) contaminants

MRSA (Apportioned to CCG)	Plan	Actual total	Of actual total	
			Pre 48 hours	Post 48 hours
NHS Wiltshire CCG	0	0	0	0
Year To Date	0	7	3	4

Mortality indicators

The Hospital Standardised Mortality Ratio (HSMR) is one of the most commonly used measures of overall mortality for trusts. It looks at those conditions which account for the vast majority of deaths in hospital (80%). The Summary Hospital-level Mortality indicator (SHMI) is for non-specialist acute trusts, and covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital. The indicator is also being published on NHS Choices.

In December 2013 the Dr Foster Intelligence 'Inside your Hospital' published triangulation data on HSMR, SHIMI and Deaths after Surgery and in Low Risk Conditions. None of the acute hospitals within the Cluster were listed within the latest Dr Foster Hospital Guide (2013) as either the highest or lowest performing in indicators that particularly focus on mortality rates and those that would indicate that a hospital is working under pressure. The table below shows a tabulated summary of the data; we have been advised by Dr Foster that all of the indicators shown are within the expected ranges:

	RUH		GWH		SFT		
	2013	2014	2013	2014	2013	2014	Range
SHIMI	97.4	99.5	104.2	97.4	104.9	107	67 - 119
HSMR Overall mortality ratio - 1 year	103.5	102.1	106.3	101.1	104.08	111.6	Range not available
HSMR Overall mortality ratio - 3 year	101	101.5	103.89	101.4	99.7	104.3	Range not available
Dr Foster Deaths in low risk conditions	1.4	1.31	0.7	0.67	0.4	0.74	0.3-1.35
Dr Foster Deaths after surgery	109	96.9	112.9	94.5	85.2	54	60 - 150
Source Dr Foster hospital Guide February 2013 and February 2014							

Ensuring that people have a positive experience of care

A critical aspect of high-quality NHS treatment and care is the experience of patients, their relatives and friends. 'Ensuring that people have a positive experience of care' is a key part of the NHS Outcomes Framework.

As a CCG we are keen to learn from patient experiences. During 2013/14 we brought a number of patient stories to the Governing Body Meetings in public. The purpose of this was to show how as a CCG we listened to concerns and then worked with providers to bring about change or improvement.

Inpatient experience

On 8 April 2014 the Care Quality Commission published the 2013 National Inpatient survey results; information drawn from the survey is used by the Care Quality Commission as part of our new Hospital Intelligent Monitoring. The data was collected between September 2013 and January 2014. The results show that nationally there have been improvements for many areas, including questions asking about:

- Information provision
- Communication with staff
- Cleanliness of hospital wards and bathrooms

The inpatient survey helps us understand what patients think about the care they receive in hospital. In order to try to benchmark we have used a specific composite score made up of the responses to 5 key questions, the score is a scale of 0-100, a higher score is better.

The key questions are:

- Were you as involved as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

The table below shows the comparative analysis of the 2013 composite score results by provider: SFT and RUH have shown an improved position from the 2012 results (albeit marginal for the RUH) whilst GWH shows a deterioration from 2012. However, while improvements have been seen in some questions (see Annex 1) when asking about respondents' experiences of leaving hospital, this remains an area where further improvement is needed.

Trust	2009	2010	2011	2012	2013
Salisbury NHS Foundation Trust	65.4	68.8	69.2	71.4	72.2↑
Royal United Hospital Bath Trust	68.4	69.2	65.4	67.5	67.6↑
Great Western Hospital	66.9	66.2	66.8	67.3	66.2

The 'Friends and Family' test

The NHS Friends and Family Test (FFT) is just one of a range of tools available to CCGs to review patient experience within the services we commission. The FFT has been designed to add to, not replace, the current system of high level, comparable national surveys and local information derived from complaints, PALS, patient groups and individual surveys. The CCG local delivery plan builds on the September 2013 action plan we shared with NHS England as part of the roll out programme.

In March 2014 we reported to our Governing Body that the FFT had been implemented across all NHS services and was an integral part of Everyone Counts: planning for patients 2014/15 to 2018/19. Since April 2013, the FFT question has been asked in all NHS Inpatient and A&E departments across Wiltshire and from October 2013, all providers of NHS funded maternity services have also been asking women the same question at different points throughout their care :

> *"How likely are you to recommend our [ward/A&E department/maternity service] to friends and family if they needed similar care or treatment?"*

Answers are on a scale of extremely likely to extremely unlikely and the FFT result, known as net promoter score, is calculated monthly using the equation: proportion of respondents who would be extremely likely to recommend, minus the proportion of respondents who would not recommend

(includes categories 'neither likely nor unlikely, 'unlikely' and 'extremely unlikely'. 'Dont know' answers are omitted from the calculus.

The NHS Friends and Family Test have already provided local hospitals with feedback and is playing an active role in transforming the services. The table below shows the Net Promoter score:

Net Promoter Score 2013									2014		
Site Name	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Across NHS England	64	65	65	64	65	65	65	64	65	64	
Royal United Hospital Bath NHS Trust	71	70	66	68	66	77	78	76	76	75	
Salisbury NHS Foundation Trust	75	70	73	77	72	74	71	72	73	71	
Great Western Hospitals NHS Foundation Trust	71	73	64	72	70	78	75	71	65	69	

Next steps for NHS Wiltshire CCG

It is important that we continue to view FFT data over time. This will enable us to see how local action is impacting on results. At the moment, with only 9 months of data this is hard to interpret, but in the longer term we can link to the Net Promoter scores to gain more consistent assurance. .

NHS England is committed to introducing the FFT to General Practice and community and mental health services by the end of December 2014, and to the rest of NHS funded services by the end of March 2015. For further information: The Friends and Family Feedback tool – http://nww.fft.england.nhs.uk/ (developed by the Quality Observatory and no log in details or passwords required).

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking a percentage of providers' income to the achievement of quality improvement goals. The guidance on the national CQUIN goals for 2012/13 is set out in the NHS Operating Framework for 2013/14 and links 2.5% of the providers' outturn to CQUINS. There are four nationally mandated CQUIN goals for 2013/14 plus recommendations from the NHS South of England Operating Plan.

The table below highlights the achievement of 2013/ 2014 CQUINs for NHS Wiltshire providers.

Name of organisation	% CQUIN achievement 2013 / 14
Salisbury NHS Foundation Trust	99%
Great Western Community (adults)	90%
Great Western Maternity Unit	75%
Great Western Hospital NHS Foundation Trust	85%
Royal United Hospital Bath NHS Trust	85%
South West Ambulance Service NHS Foundation Trust	TBC
Avon and Wiltshire Mental Health Partnership NHS Trust	TBC

Safeguarding Children and Adults

We have a statutory responsibility to have robust governance arrangements in place that ensure that the organisations from which we commission services provide a safe effective system that safeguards children and adults at risk of abuse or neglect.

NHS Wiltshire has further strengthened the contractual standards and reporting mechanisms that monitor the safeguarding arrangements.

In 2013/14 we have undertaken considerable work as the commissioners of local health services to seek assurance that the health providers have effective and appropriate systems in place in their organisations for discharging their responsibilities in respect of safeguarding, including

- Safeguarding training and supervision.
- Recognising and reporting safeguarding issues.
- A clear line of accountability for safeguarding within each organisation.
- Appropriate arrangements to co-operate with local authorities in the operation of Local Safeguarding Children Boards (LSCB), Safeguarding Adult Boards (SAB) and Health and Wellbeing Boards.
- Ensuring effective arrangements for information sharing.
- Securing the expertise of named doctors and nurses for safeguarding children and a paediatrician for unexpected deaths in childhood.
- Having a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

We are represented at a senior level and by designated safeguarding professionals on the Local Safeguarding Children Board (LSCB) and are fully engaged and represented at a senior level on local Safeguarding Adults Board (SAB), working in partnership with local authorities to fulfil their safeguarding responsibilities. The CCG membership extends to the core business conducted through the safeguarding board sub groups.

We have developed principles and ways of working that are equally applicable to the safeguarding of children and young people and of adults in vulnerable situations, recognising that safeguarding

is everybody's business and by detecting and exposing unacceptable care quickly, the CCG has ensured that the system takes real responsibility for fixing problems urgently and effectively.

A review of health safeguarding children arrangements by the Care Quality Commission in October 2013 reported evidence of strong local leadership, with us working as committed partners and improved investment in effective co-ordination and robust quality assurance of safeguarding arrangements.

While the CCG are not directly responsible for commissioning primary medical care they have a duty to support improvements in the quality of primary medical care. The NHS England Area Team commission NHS Wiltshire CCG to provide safeguarding children training to Primary Care clinicians and designated professionals provide advice, support and scrutiny of primary care safeguarding arrangements.

We have worked to ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected. This has included contributing fully to Serious Case Reviews (SCRs) which have been commissioned by LSCBs/SABs and also, where appropriate, conducting individual management reviews.

We have leadership arrangements for adult safeguarding that ensure that we commission safe services for those in vulnerable situations, including effective systems for responding to abuse and neglect of adults and effective interagency working with local authorities, the police and third sector organisations. Our leads for safeguarding adults have a broad knowledge of healthcare for older people, people with dementia, people with learning disabilities and people with mental health conditions. This includes responsibility for supporting the commissioner and providers by ensuring clarity about Mental Capacity Act requirements and ensuring that deprivation of liberty safeguards are in place in commissioned services**.**

Our designated clinical experts (children and adults), are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice. They provide clinical advice, to other health professionals, in complex cases or where there is dispute between practitioners.

We have engaged with the regional and national PREVENT agenda. Work is underway to develop capacity and activity in commissioned providers to increase awareness and improve practice in line with the regional requirements. We can demonstrate that they regularly review their safeguarding arrangements to assure themselves that they are working effectively.

The resources, principal risks and uncertainties and relationships that may affect the CCG's long-term value

We are allocated resources to fund the costs of directly commissioned services that we are responsible for (programme allocations) and to fund the costs of commissioning those services (running costs allocations). Approved budgetary resources are devolved to the groups and directorates in line with our matrix of responsibilities with each party operating in line with our scheme of delegation and the aims and ambitions.

We maintain risks registers, at both a group/directorate and organisational level, to identify operational and financial risks that may affect the our strategies and development. These issues are managed through application and review of mitigating actions and via the application of contingent reserves where applicable.

We work closely with other commissioners and providers of healthcare service to ensure that Wiltshire has a high performing and resilient health system. Moving into 2014/15 we will be strengthening our relationship with social care services through the establishment of the Better Care Fund with Wiltshire Council.

Financial Year 2013/14

Financially 2013/14 has been a challenging year as the new commissioning landscape for the NHS has bedded down. The financial plans that were agreed by the Governing Body in April 2013 changed significantly as the resource distribution between us and NHS England was resolved. These changes throughout the year changed the assumptions with which the financial plan was built on requiring us to identify further savings and to amend the level of in year investments. We also experienced significant financial pressures associated with the cost of the activity, we commission from many of our providers. Although hospital activity has been on plan, the cost of the activity has been higher as patients that are being seen in our hospitals are becoming more frail and complex.

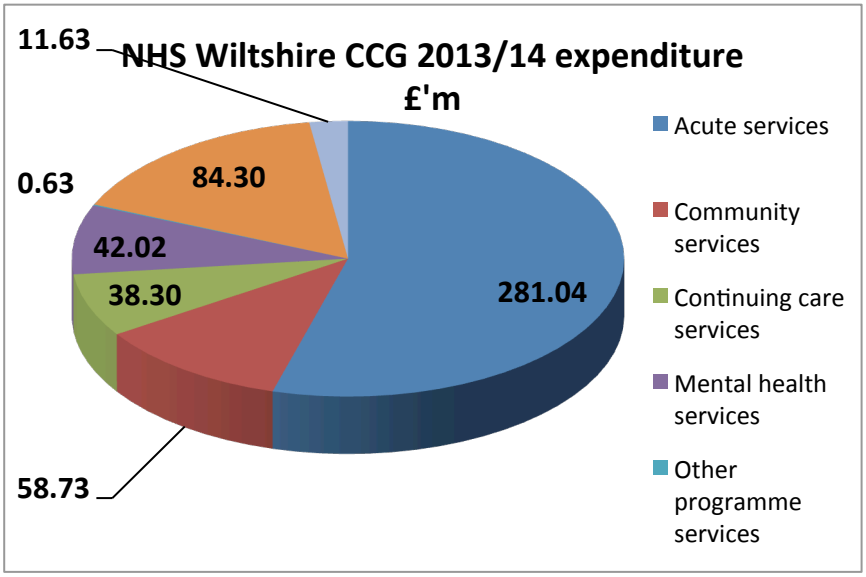
Despite these challenges we have met our statutory duty to contain expenditure within the resource and cash limits set by NHS England and have achieved operational balance and our planned 1% surplus of £5m, which included the achievement of savings of £9.3m. We have also achieved the key financial targets as listed below:

Target	Target	Achievement
Planned Surplus against Resource Limit	£5.04m	£5.04m
Revenue Cash Limit – balance in account	<£0.25m	£0.07m
Capital Resource Limit	£4.0m	£4.0m
Achievement of the Better Payment Policy Code (payment of invoices within 30 days)	Number of Invoices paid within 30 days 95% Value of Invoices paid within 30 days 95%	98.2% 99.5%
Running Cost Allocation Performance of £11.66m	£11.66m	£11.63m

We received funding of £521.7m of which £11.7m related to our running costs of the CCG. Against this total allocation we have spent £516.6m and delivered a surplus, in line with plan of £5.0m - the breakdown of this expenditure by programme area is shown overleaf. There are no

comparisons with previous years as this is the first year that we have been in existence and any comparative figures with the previous commissioning organisation, Wiltshire Primary Care Trust would be inappropriate because of the different services that CCGs are responsible for.

Breakdown of the CCG Expenditure for 2013/14



We achieved our running costs with 29% of our allocation paid to the CSU for commissioning and back office functions support and 71% relating to direct CCG costs.

We have prepared the financial statements on a going concern basis with the full statements and supporting notes contained within part 3. The summary financial statements for 2013/14 can be found below:

Statement of net comprehensive expenditure

	£'000s		
	Total	Programme	Running costs
Gross employee benefits	5,963	0	5,963
Other costs	514,906	508,734	6,172
Other operating revenue	-4,225	-3,718	-507
	516,644	505,016	11,628

Statement of financial position

	£'000s
Non-current assets	0
Current assets	2,371
	2,371
Current liabilities	-25,814
Non-current liabilities	0
	-25,814
TOTAL assets employed	-23,443

Financed by taxpayers equity	-23,443
	-23,443

Statement of change in taxpayer's equity

	£'000s
Balance at 1st April 2013	0
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition	-250
Adjusted balance at 1st April 2013	-250
Net operating costs for the financial year	-516,644
Net Recognised CCG Expenditure for the Financial Year	-516,394
Net funding	492,951
Balance at 31st March 2014	-23,443

Statement of cashflows

	£'000s
Cashflows from operating activities:	
Net operating costs for the financial year	-516,644
Impairments and reversals	250
(Increase)/decrease in trade & other receivables	-2,371
Increase/(decrease) in trade & other payables	25,625
Increase/(decrease) in provisions	168
Net Cash Inflow (Outflow) from Operating Activities	-492,972
Cash Flows from Investing Activities	0
Net Cash Inflow (Outflow) before Financing	-492,972
Cash Flows from Financing Activities:	
Net funding received	492,951
Net Cash Inflow (Outflow) from Financing Activities	492,951
Net Increase (Decrease) in Cash & Cash Equivalents	-21

Financial Year 2014/15

This financial year is set to be as challenging as the one we have just finished. We have set ourselves a savings target of £11.6m in order to invest in transformed services in line with our five year strategic plan. This includes the creation of the Better Care Fund which will operate as a joint funding pool for health and social care with the objective of supporting more people in the community and to reduce the reliance on acute hospitals. The financial plan supports the endeavour of only sending clients to hospital when they are acutely ill and the establishment of more community capacity across health and social care. Our financial plan for 2014/15 is shown in Table xx with comparisons to the actuals expenditure for 2013/14.

(£'000)	2013/14Actual £000s	2014/15 Plan £000s
Acute services	281,035	273,923
Mental Health services	42,020	41,501
Community services	58,732	55,646
Continuing Care services	38,305	30,204
Better Care Fund	0	10,904
Primary Care services	84,299	85,814
Other Programme services	625	7,666
Total - Commissioning services	**505,016**	**505,658**
Running Costs	11,627	11,635
Contingency	0	2,627
Total application of funds	**516,644**	**519,920**
Surplus/(Deficit)	**5,035**	**5,252**

Part of the financial plan for 2014/15 is the creation of the Better Care Programme which will see us working much closer with Wiltshire Council. To facilitate this closer working we are passing funding of £19.2m (£10.9m directly from CCG budgets) over to the Council to be used as a shared fund to meet the objectives of integrating health and social care services. Much of this money is committed against existing expenditure, however £4.4m relates to new investment and will be directed at the overriding vision of the Better Care Plan of treating clients as close to home as possible. The summary of the programme is shown below:

Scheme type	Details of schemes
Scheme 1 – Intermediate care	Development of step up and step down care plus increased reablement capacity – designed to shift the balance of care and reduce demand in the acute sector
Scheme 2 – 7 day working and Rapid response	The first part of this investment will be to support weekend capacity across the whole health system as well as actions through social care to speed up appropriate discharge from acute care. Rapid response includes development of Simple Point of Access and Telecare support to improve access to services whilst retaining the delivery of care within primary care as far as possible. These investments include a strong mental health element to support parity of esteem
Scheme 3 – Protecting social care services	Key focus is working through Help To Live At Home (HTLAH) to ensure robust arrangements are in place to support people being able to successfully live independently
Scheme 4 – Care Bill requirements	Working with Wiltshire Council to support additional demand within the system
Scheme 5 – Supporting communities to be more resilient	Funding for carers and home support with the council and voluntary sector to develop community level support capacity
Scheme 6 – Data sharing and joint assessments	Shared records to improve patient experience, quality and service efficiency
Scheme 7 – Service user feedback and involvement	Support to Healthwatch to develop an effective "patient voice" and develop effective public involvement in services and decision making

We will continue to focus investment in the following areas:

- **Demographic and non-demographic growth** – which is designed to take account of activity and demand pressures resulting from changes in population, principally around the elderly.
- **Call to action** – investment to pump prime services that will be developed through the implementation of our 5 year strategic/2 year operational plan and the Better Care Fund.
- **Primary care older people's support**, following national initiative to improve the quality of GP care through the named clinician initiative, designed to help mitigate increases in non-elective admissions.
- **Local priorities –** we plan to invest in local priority areas that are not included in investments outlined above which helps ensure a local focus for investment priorities particularly within the three groups.

The challenges facing us in 2014/15 will relate in the main to the management of demand and the complexity of clients needing to use NHS services. As the population of Wiltshire become older and more fragile, the pressure on the current health system increases therefore it is imperative that new models of care and client self-responsibility are maximised to the full.

Sustainability Report

We operate from Southgate House in Devizes. This property is owned by NHS Property Services. Information in regard to sustainability will be provided by NHS Property Services but this is not possible for 2013/14. It is intended that information will be available reporting for 2014/15.

Equality Report

Understanding the demographic profile of Wiltshire

The population of Wiltshire based on the NHS Wiltshire Prospectus 2013/14 is approximately 477,000 people. There are 106 self-declared ethnicities in Wiltshire. The Black and Minority Ethnic (BME) population make up 4.7% of this population within which the Moroccan community is considered to be the largest outside London. There are also significant African-Caribbean, Polish, Slovakian, Chinese, Bangladeshi, Filipino, Indian and Pakistani communities in Wiltshire. There is recognised large gypsy and traveller population. For 97.5% of Wiltshire residents the main language is English with Polish as the main language spoken after English.

The majority of Wiltshire's residents reported that they were Christian (63%) or had no religion (26%). The largest other religions are Muslim (0.4%) and Buddhism (0.3%).

Wiltshire has a near equal population split between males and females with children (0-15 years) being approximately 18% of the population and the older population (65 years plus) being approximately 63% of the population.

Using the nationally established statistic that 5-7% of the population is lesbian, gay or bisexual, approximately 23,850 Wiltshire residents are expected to have these sexual orientations.

The Gender Identity Research and Education Society (GIRES)criteria suggests that approximately 3,200 people within Wiltshire would experience some degree of gender variance, the majority of which would continue to live in their birth gender.

Our decision making processes

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

We conduct and publish Equality Impact Assessments (EIAs) on all policies and proposals, critically assessing the impact on protected groups and identifying opportunities to promote equality.

The Governing Body holds meetings in public in various premises around Wiltshire and we ensure that these premises are accessible to the disabled.

Promoting the Public Sector Equality Duty (PSED)

We have an Equality and Diversity Strategy (EDS) in place and carry out Equality Impact Assessments on all policies and decisions presented to the Governing Body. We engage with and consult the public on our plans and major commissioning decisions. We hold healthcare providers to account with regard to the Public Sector Equality Duties. All our staff are required to undertake Equality and Diversity training. Please refer to section 4, the Equality Report, for further information.

Our Equality and Diversity Strategy identifies the following equality objectives for our first four years of operation:

- To improve the quality of information available about prevalence of health conditions in different communities with specific protected characteristics;
- To embed equality and diversity considerations into communications, engagement and consultation;
- To actively identify key services issues for service users to support specific actions to be implemented based on evidence to improve service user outcomes;
- To focus on developing our leadership and capacity to ensure that we continue to comply with the PSED and use the EDS to improve performance and ongoing compliance.

We work closely with Wiltshire Council to determine the demographics of our shared population and the health needs and health inequalities therein. We are also strongly engaged with Healthwatch Wiltshire to support our consultation and engagement with the public, ensuring that a voice is given to the public throughout the decision making processes and that harder to reach populations are approached. We have a Communications and Engagement Strategy in place that clearly recognises the value of interaction with different communities with specific protected characteristics.

We hold healthcare service providers to account to ensure that they comply with the Equality Act 2010 and associated PSED. We hold regular quality review meetings with providers which include the discussion of survey information showing patients' experience of treatment and care outcomes and results of the FFT. These meetings also consider the report from the Patient Advice & Liaison Service (PALS) as the impartial service looking into concerns, problems and complaints in regard to patients' care and treatment. We also require providers to meet the legislative requirements as part of the procurement process for new or revised contracts.

The CCG Workforce

Information is collected on an annual basis regarding our workforce with reference to the protected characteristics. As at 1 January 2014 we had 116 staff (102.05 whole time equivalents). Although we are monitoring the staff information, the PSED exempts us from publication of this information as there are under 150 staff.

We have in place a number of workforce related policies that support and protect staff from discrimination, harassment, bullying and victimisation.

We require all staff to undertake mandatory Equality and Diversity training.

Delivering equality

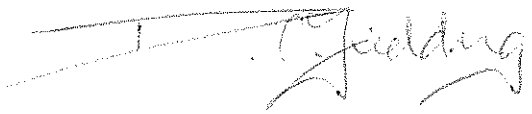
We recognise that inequality exists, that it can be difficult to identify and fully consider the impact that some decisions may have on different communities with specific protected characteristics and that there may be barriers to equality. However, we will strive to critically assess our operations on an ongoing basis to tackle these issues. The CCG intends to self-assess against the NHS Equality Delivery System to inform plans to continue to improve the imbedding of equality and diversity processes into everything we do.

CCG Diversity Breakdown by Gender

	Male Headcount	**Female Headcount**
Governing Body members (voting)	**7** (4 directly employed plus 3 not on the payroll)	**6** (3 directly employed plus 3 not on the payroll)
All CCG employees	**27**	**89**

NB: The employees on VSM (2 posts) are included in the Governing Body membership numbers above.

We certify that we have complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).



Deborah Fielding
Chief Officer
5 June 2014

1.3 Members' Report

Member Practices

North and East Wiltshire (NEW)

Beversbrook Medical Centre
Box Surgery
Cricklade Surgery
Hathaway Medical Centre
Malmesbury Primary Care Centre
New Court Surgery
Northlands Surgery
Old School House Surgery
Patford House Partnership
Pewsey Surgery
Purton Surgery
Ramsbury & Wanborough Surgery
Rowden Medical Partnership
Smallbrook Surgery
The Lodge Surgery
The Marlborough Medical Practice
The Porch Surgery
The Sprays Surgery
Sutton Benger Surgery
The Tolsey Surgery
Tinkers Lane Surgery

Sarum

Avon Valley Practice
Barcroft Medical Practice
Bemerton Heath Surgery
Cross Plains Surgery
Downton Surgery
Fovant Surgery
Endless Street Surgery
Harcourt Medical Centre
Hindon Surgery
Mere Surgery
Orchard Partnership
Salisbury Medical Practice
Silton Surgery
Sixpenny Handley & Chalk Valley Surgery
St Ann Street Surgery
The Bourne Valley Practice
The Castle Practice
Three Swans Surgery
Tisbury Surgery
Whiteparish Surgery
Wilton Health Centre

West Wiltshire, Yatton Keynell and Devizes (WWYKD)

Adcroft Surgery
Bradford on Avon & Melksham Health Partnership
Bradford Road Medical Centre
Courtyard Surgery
Giffords Surgery
Jubilee Field Surgery
Lovemead Group Practice
Market Lavington Surgery
Southbroom Surgery
Spa Medical Centre
St James' Surgery
The Avenue Surgery
The Lansdowne Surgery
Westbury Group Practice
Widbrook Medical Practice

Governing Body

Our Governing Body has overall responsibility for the formulation and implementation of strategy, policy and performance of the. The Governing Body meets on a monthly basis (every other month in public) and is chaired by Dr Stephen Rowlands.

At 31 March 2014, voting membership of the Governing Body comprised the Chair, the Chief Officer, the Chief Financial Officer, two Lay Members, one of whom leads on Audit and Governance matters and the other on Public and Patient Involvement, who bring an external view to the organisation, along with six GPs (the Chair and Vice Chair of each Locality Group), a registered nurse and a secondary care doctor. The Governing Body met 10 times during the period 1 April 2013 to 31 March 2014.

The details of the Governing Body membership for 2013/14 can be seen below:

Dr Steve Rowlands	GP Chair
Deborah Fielding	Chief Officer
Simon Truelove	Chief Financial Officer
Christine Reid	Lay Member: Patient and Public Involvement
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Dr Simon Burrell	GP Chair, North and East Wiltshire
Dr Helen Osborn	GP Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Toby Davies	GP Chair, Sarum
Dr Jonathan Rayner	GP Vice Chair, North and East Wiltshire
Dr Debbie Beale	GP Vice Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Celia Grummitt	GP Vice Chair, Sarum
Mary Monnington	Registered Nurse Member
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
David Noyes	Director of Planning, Performance and Corporate Services
Jacqui Chidgey-Clark	Director of Quality and Patient Safety
Mike Relph April to September 13	Group Director - West Wiltshire, Yatton Keynell and Devizes
Jo Cullen September 13 onwards	Group Director – West Wiltshire, Yatton Keynell and Devizes
Mark Harris	Group Director – Sarum
Ted Wilson	Group Director – North and East Wiltshire
Alyson Aylesbury April 2013 to July 2013	Interim Director of Community Transformation
Lynn Talbot July 2013 onwards	Interim Director of Community Transformation
Helen Robinson-Gordon	Head of Communications and Engagement
Dr Peter Jenkins	GP Medical Advisor, Safeguarding (children) and Clinical Exceptions
Maggie Rae	Corporate Director, Wiltshire Council
Julia Cramp	Service Director, Commissioning and Performance, Wiltshire Council
Chris Graves	Chair, Healthwatch, Wiltshire
Diana Hargreaves	Board Administrator, CCG

Our committee structure comprises four formal sub-committees of the Governing Body;

- Finance Committee.
- Quality and Clinical Governance Committee.
- Remuneration Committee.
- Audit and Assurance Committee.

In addition, we have established a committee for each of the three Locality Groups: North and East Wiltshire (NEW), Sarum and West Wiltshire, Yatton Keynell and Devizes (WWYKD).

The Audit and Assurance Committee ensures that governance arrangements of the CCG are in place, well designed and appropriately applied. The committee ensures that robust, effective financial management systems are in place and being followed and that we appropriately manage risk. The committee meets bi-monthly and its members are listed below.

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid	Lay Member: Patient and Public Involvement
Dr Mark Smithies	Secondary Care Doctor
Mary Monnington	Registered Nurse Member
In attendance (no voting rights)	
Dr Jonathan Rayner	GP Vice Chair, NEW
Simon Truelove	Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Lynn Pamment/Paul Dalton	Internal audit, Price Waterhouse Cooper
Duncan Laird/Jonathan Brown/Tara Westcott	External audit, KPMG UK LLP
Keren Lovell April 2013 to September 13	Counter Fraud
Tracey Spragg September 13 to March 2014	Counter Fraud
Roger Ringham	Security Management Specialist
Steve Perkins	Deputy Chief Financial Officer
Susannah Long	Governance and Risk Manager
Diana Hargreaves	Board Administrator

You can read more about our Governance procedures and details of membership of the other sub-committees in the Governance Statement on page 49. There are more details about all our Governing Body members in the Governing Body and Senior Management Profiles section on page 63.

Pension Liabilities

Note 4.5 of the annual accounts (contained within Section 3) provides further information on the relevant pension schemes used by the CCG.

Sickness absence data

Sickness absence rates across the CCG remain very low and the full year absence rate is 2.43%.

Sickness absence is managed in a supportive and effective manner our managers, with professional advice and support from Human Resources, Occupational Health and Staff Support services. Our approach to managing sickness absence is governed by a clear Human Relations (HR) policy and this is further reinforced by the provision of HR support and training sessions for all line managers on the effective management of sickness absence.

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported on a quarterly basis as part of the workforce reporting mechanism.

Staff sickness absence and ill health retirements:

Total Days Lost	416
Total Staff Years	92
Average Working Days Lost	5

NB. The above figures were supplied by the Department of Health and are annualised based on the figures for the nine months from April to December 2013.

External Audit

The cost of work performed by our external auditors, KPMG, in 2013/14 was £99,000 plus VAT.

Disclosure of “serious untoward incidents”

We have not had any data losses or confidentiality breaches that have been categorised as SIRIs.

Setting of Charges for Information

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

Principles for Remedy

The Parliamentary and Health Service Ombudsman published a revised Principles for Remedy in May 2010, setting out the following six principles that represent best practice.

1. Getting it right.
2. Being customer focused.
3. Being open and accountable.
4. Acting fairly and proportionately.
5. Putting things right.
6. Seeking continuous improvement.

For further details of how the CCG has adopted these six principles as part of our complaints handling procedure please refer to the section on complaints management on page 26.

Employee Consultation

We are a significant employer and larger than many other CCGs. The workforce is made up of employees from a wide variety of professional groups, in many cases in small numbers and a large proportion of employees sit within the management delivery team.

Communication is carefully managed and staff are encouraged to engage with the various methods of communications covering a wide range of issues and activities.
We use a system of weekly team meetings in each Directorate to cascade information and brief on developments, which is supported by a fortnightly electronic staff brief for those who are unable to attend the briefings in person.

We also hold regular whole CCG staff briefs, ‘Breakfast Briefings’ hosted by our Chair and Chief Officer where staff are invited to share their views and ask questions.

A regularly updated staff website, or intranet provides key information for staff and the annual staff engagement survey results are reported to our Governing Body and used to involve staff in creating key objectives and actions to drive improvement in staff experience. There are plans to significantly update and develop the staff facing website during 2014.

Managers hold regular one-to-one meetings with staff and a robust objective led appraisal system ensures all staff work towards clearly defined personal objectives (derived from the Chief Officer down) which are supported with learning, training and development opportunities.

In building effective and meaningful partnership working with staff and staff side representatives, we have developed partnership arrangements that are sufficiently flexible to accommodate and reflect the workforce in terms of professional group and size.

We recognise all of the trade unions outlined in the national Agenda for Change terms and conditions handbook who have members employed within the organisation.

Local arrangements are determined on an ad hoc basis where formal staff consultation is required, to ensure appropriate and effective consultation arrangements are in place. This approach has worked well in our first year although arrangements may be reviewed in light of our Business Plan to consider where arrangements may be strengthened going forward.

We have delegated negotiations over HR policy development to the CSCSU Staff Partnership Forum. This Forum considers our collated feedback as part of this process and ensures staff and trade unions are equally engaged in the development process.

A number of our current staff were formally employed by NHS Wiltshire Primary Care Trust. Under appropriate employment legislation, they transferred to the CCG on April 1st 2013.
During 2013/14 a number of policies have been developed to enhance and support staff in the working environment. As part of the development staff were invited to comment on the following policies which replaced those transferring from the PCT. The policies are:

1. Maternity Leave (with Maternity User Guide).
2. Paternity Leave.
3. Retirement.
4. Adoption.
5. Parental.
6. Career Break.

More details are contained within our Workforce Report:
http://www.wiltshireccg.nhs.uk/wp-content/uploads/2014/01/GOV140117WorkforceReport-1.pdf

All our policies have been developed in line with Agenda for Change requirements and as a result any variance is generally in terms of presentation, style, tone, and discretionary elements (e.g. delegated authority levels for decision-making) rather than significant changes .The policies have been negotiated and agreed nationally by trade unions and adopted via the CSCSU Staff Partnership Forum.

Disabled Employees and Equal Opportunities

We have developed an integrated approach to delivering workforce equality so we do not have a separate policy for disabled employees or for any other protected characteristics, but we have incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance to discipline. Our aim is to operate in ways which do not discriminate our potential or current employees with any of protected characteristics specified in the Equality Act 2010 and to support our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

We publish our employee profile by each of the nine protected characteristics: this helps us to identify and address areas of under-representation in a systematic manner as and when opportunities arise.

In line with the requirements of the Equality Act 2010 and associated public sector equality duty, we have published our equality objectives and annual equality report on our website, for more details please visit:

1) http://www.wiltshireccg.nhs.uk/publications/equality-and-diversity/information-and-resources

2) http://www.nhsemployers.org/EMPLOYMENTPOLICYANDPRACTICE/EQUALITYANDDIVERSITY/Pages/Home.aspx

Since the publication of the equality report we have further reviewed our equalities performance. As a result we plan to revise our equality and diversity strategy so that action to promote equality is strongly linked to reduction of health inequalities and tangible improvements in patient experiences and outcomes. We are now in the process of identifying capacity and expertise to take this work forward and facilitate the implementation of the Equality Delivery System Framework. Our aim is to integrate equalities (including health inequalities, inclusion and Human Rights) issues in every stage of the commissioning cycle.

We are always keen to hear from members of the public and employees across the nine protected characteristics on how we can improve patient outcomes and experiences of our services and how we can improve the skills and working conditions for our workforce.

Emergency preparedness and response

We certify that we have incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

In November 2013 the CCG provided assurance to NHS England about our compliance with the Emergency Preparedness Framework. As part of this assurance we were required to show how we were going to address any gaps in the provision that we had already identified. Since November 2013. We have put steps in place to close all such gaps and the Audit and Assurance Committee reviewed these to their satisfaction. The Committee also reviewed our Business Continuity Plan. The Business Continuity Plan and our Emergency Preparedness Framework were approved and this is demonstrated in the minutes of the Audit and Assurance Committee, presented to the Governing Body in March 2014.

Statement as to Disclosure to Auditors

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

- So far as the Member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and,
- That the Member has taken all the steps that they ought to have taken as a Member in order to make them self aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Deborah Fielding
Chief Officer
5 June 2014

1.4 Remuneration Report

Each CCG has a Remuneration Committee, the role of which is to determine and approve the remuneration package for senior managers and employees. Membership of the Remuneration Committee is made up of the following members:

Voting member

Peter Lucas - Chair
Christine Reid - Vice Chair
Mary Monnington - Registered Nurse
Mark Smithies - Secondary Care Doctor

Non Voting members (In attendance)

Dr Steve Rowland - GP Chair CCG
Deborah Fielding - Chief Officer
David Noyes - Director of Planning, Procurement and Corporate Services
Dr Helen Osborne - GP Chair WWYKD
Simon Truelove - Chief Financial Officer
Deb Drury - HR Business Partner CSCSU

Remuneration is designed to fairly reward based on each individual's contribution to the organisation's success taking into account the need to recruit, retain and motivate skilled and experienced professionals. This is not withstanding the need to be mindful of paying more than is necessary in order to ensure value for money in the use of public resources and our running cost allowance.

Senior managers' remuneration is set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them. This ensures a fair and transparent process via bodies that are independent of the senior managers whose pay is being set. No individual is involved in deciding his or her own remuneration.

Executive senior managers are on permanent NHS contracts. The length of contract, notice period and compensation for early termination are consistent with employees employed under Agenda for Change contracts and are set out in the Agenda for Change, NHS terms and conditions of service handbook.

Exit packages disclosure

During 2013-14 there were no redundancy and other departure costs that have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included.

Remuneration Report

			2013-14					
Name and Title	**Start Date**	**End Date**	**Salary & Fees (bands of £5,000)**	**Taxable Benefits (rounded to nearest £00)**	**Annual Performance Related Bonuses (bands of £5,000)**	**Long Term Performance Related Bonuses (bands of £5,000)**	**All Pension Related Benefits (bands of £2,500)**	**Total (bands o £5,000)**
Dr Steve Rowlands, GP Chair	**01.04.2013**	**31.03.2014**	**60-65**	**0.7**			**65-67.5**	**125-130**
Deborah Fielding, Chief Officer	**01.04.2013**	**31.03.2014**	**110-115**	**1.8**				**115-120**
Simon Truelove, Chief Financial Officer	**01.04.2013**	**31.03.2014**	**90-95**	**0.5**			**50-52.5**	**145-150**
Christine Reid, Lay Member, Patient and Public Involvement	**01.04.2013**	**31.03.2014**	**10-15**	**0.9**				**10-15**
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	**01.04.2013**	**31.03.2014**	**20-25**	**1.4**				**20-25**
Dr Simon Burrell, GP Chair, NEW Group	**01.04.2013**	**31.03.2014**	**65-70**					**65-70**
Dr Helen Osborn, GP Chair, WWYKD Group	**01.04.2013**	**31.03.2014**	**90-95**					**90-95**
Dr Toby Davies, GP Chair, Sarum Group	**01.04.2013**	**31.03.2014**	**45-50**					**45-50**
Dr Jonathan Rayner, GP Vice Chair, NEW Group	**01.04.2013**	**31.03.2014**	**40-45**					**40-45**
Dr Debbie Beale, GP Vice Chair, WWYKD Group	**01.04.2013**	**31.03.2014**	**45-50**					**45-50**
Dr Celia Grummitt, GP Vice Chair, Sarum Group	**01.04.2013**	**31.03.2014**	**65-70**					**65-70**

Mary Monnington, Registered Nurse Member	**01.04.2013**	**31.03.2014**	**10-15**					**10-15**
Dr Mark Smithies, Secondary Care Doctor	**01.04.2013**	**31.03.2014**	**5-10**					**5-10**
David Noyes, Director of Planning, Performance and Corporate Services	**01.04.2013**	**31.03.2014**	**90-95**	**2.5**			**17.5-20**	**115-120**
Jo Cullen, Group Director – WWYKD Group (from September 2013)	**01.09.2013**	**31.03.2014**	**40-45**	**0.3**			**42.5-45**	**85-90**
Mark Harris, Group Director – Sarum Group	**01.04.2013**	**31.03.2014**	**95-100**	**7.6**			**57.5-60**	**160-165**
Ted Wilson, Group Director – NEW Group	**01.04.2013**	**31.03.2014**	**95-100**	**2.3**			**52.5-55**	**155-160**
Jacqui Chidgey-Clark, Director of Quality and Patient Safety	**01.04.2013**	**31.03.2014**	**95-100**	**2.5**			**212.5-215**	**310-315**
Lynn Talbot, Interim Director of Community Transformation	**01.07.2013**	**31.03.2014**	**95-100**					**95-100**
Dr Peter Jenkins, GP Medical Advisor, Safeguarding (children) and Clinical Exceptions	**01.04.2013**	**31.03.2014**	**65-70**					**65-70**
Mike Relph, Group Director – WWYKD Group (to September 2013)	**01.04.2013**	**30.09.2013**	**40-45**	**0.6**			**10-12.5**	**55-60**
Alison Alsbury, Interim Director of Community Transformation	**01.04.2013**	**31.07.2013**	**55-60**					**55-60**

The costs for Lynn Talbot were paid via an agency - McLaren Perry Ltd.	The costs for Dr Toby Davis were partly re-charged by Castle Practice and partly paid via an agency - Morley Manot Ltd
The costs for Alison Alsbury were paid via an agency - Phoenix Interims Ltd.	The costs for Dr Celia Grummittt were paid via an agency - Rainbow 2 Ltd
The costs for Dr Simon Burrell were re-charged by The Porch Surgery	The costs for Dr Debbie Beale were re-charged by White Horse Health Centre
The costs for Dr Jonathan Rayner were re-charged by Ramsbury Surgery	The costs for Dr Helen Osborn were re-charged by Courtyard Surgery

Pension Statement

Name and Title	Real increase in pension at age 60 (Bands of £2,500)	Real increase in pension lump sum at aged 60 (Bands of £2,500)	Total accrued pension at age 60 at 31 March 2014 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Dr Steve Rowlands, GP Chair	**2.5-5**	**7.5-10**	**70-75**	**210-215**	**1561**	**N/A**	**N/A**	**0**
Deborah Fielding, Chief Officer	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Simon Truelove, Chief Financial Officer	**2.5-5**	**7.5-10**	**20-25**	**60-65**	**272**	**329**	**40**	**0**
Dr Simon Burrell, GP Chair, NEW Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr Helen Osborn, GP Chair, WWYKD Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr Toby Davies, GP Chair, Sarum Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr Jonathan Rayner, GP Vice Chair, NEW Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr Debbie Beale, GP Vice Chair, WWYKD Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr Celia Grummitt, GP Vice Chair, Sarum Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
David Noyes, Director of Planning, Performance and Corporate Services	**0-2.5**	**0**	**0-5**	**0**	**0**	**17**	**5**	**0**
Jo Cullen, Group Director – WWYKD Group	**0-2.5**	**5-7.5**	**15-20**	**55-60**	**287**	**343**	**39**	**0**

(from September 2013**)**								
Mark Harris, Group Director – Sarum Group	**2.5-5**	**7.5-10**	**20-25**	**70-75**	**295**	**355**	**41**	**0**
Ted Wilson, Group Director – NEW Group	**2.5-5**	**7.5-10**	**35-40**	**115-120**	**701**	**795**	**64**	**0**
Jacqui Chidgey-Clark, Director of Quality and Patient Safety	**7.5-10**	**27.5-30**	**25-30**	**85-90**	**327**	**524**	**178**	**0**
Dr Peter Jenkins, GP Medical Advisor, Safeguarding (children) and Clinical Exceptions	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Mike Relph, Group Director – WWYKD Group (to September 2013)	**0-2.5**	**0-2.5**	**5-10**	**15-20**	**118**	**N/A**	**N/A**	**0**

N.B. No CETV figures for 31st March 2014 are available for Dr Steve Rowlands or for Mike Relph as they are either over the retirement age and/or currently receipt of NHS Pension benefits.

Directors' Emoluments Statement

Name and Title	Salary & Fees	Bonuses	Taxable expense allowances	Compensation for loss of office	Benefits in kind	Total of emoluments and compensation
	£000	£000	£000	£000	£000	£000
Deborah Fielding, Chief Officer	115	0	2	0	0	117
Simon Truelove, Chief Financial Officer	93	0	1	0	0	94
David Noyes, Director of Planning, Performance and Corporate Services	95	0	3	0	0	98
Jo Cullen, Group Director, WWYKD Group (from September 2013)	43	0	0	0	0	43
Mark Harris, Group Director, Sarum Group	96	0	2	0	6	104
Ted Wilson, Group Director, NEW Group	99	0	2	0	0	101
Jacqui Chidgey-Clark, Director of Quality and Patient Safety	95	0	3	0	0	98
Mike Relph, Group Director, WWYKD Group (to September 2013)	45	0	1	0	0	46
Alison Alsbury, Interim Director of Community Transformation (to July 2013)	98	0	0	0	0	57
Lynn Talbot, Interim Director of Community Transformation (from August 2013 to Present)	57	0	0	0	0	98

The costs for Lynn Talbot were paid via an agency - McLaren Perry Ltd. The costs for Alison Alsbury were paid via an agency - Phoenix Interims L

Off Payroll Engagements

Under Treasury guidance PES (2013) 09, all Public sector organisations are required to disclose information about high paid off payroll appointments:

i) As at 31 March 2014, for more than £220 per day and that last longer than 6 months.

	Number
Number of existing engagements as of 31 March 2014	4
Of which, the number that have existed:	
for less than one year at the time of reporting	4
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at time of reporting	0
for four years or more at the time of reporting	0

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

ii) Between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than 6 months.

	Number
Number of new engagements between 1 April 2013 and 31 March 2014.	4
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	4
Number for whom assurance has been requested	4
Of which:	
assurance has been received	4
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received	0

iii) For any off payroll engagements of board members and or senior officials with significant financial responsibility between 1 April 2013 and 31st March 2014.

	Number
Number of engagements of board members and senior officials with significant financial responsibility during the year	1
No. of individuals that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both off-payroll and on-payroll engagements.	22

Multiple pay

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

The banded remuneration of the highest paid director in NHS Wiltshire CCG in the financial year 2013-14 was £165,000 to £170,000 on a whole time equivalent basis. This was 4.57 times the median remuneration of the workforce, which was £36,666.

In 2013-14, 0 employees received remuneration in excess of the highest-paid director. Whole time equivalent remuneration ranged from £16,000 to £165,000.

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

Governing Body and Senior Management Profiles

Dr Steve Rowlands, GP Chair
Steve has been a GP in Trowbridge since 1985. He retired as senior partner from Bradford Road Medical Centre in July 2013 but still maintains his role as a GP working as a locum.

Declared Interests:

- Stakeholder governor - Royal United Hospital (Bath)

Member of the following committees:

- Governing Body - Chair
- Finance Committee - Chair
- Remuneration Committee

Deborah Fielding, Chief Officer
Deborah's extensive experience includes Deputy CEO at NHS Havering as well as seven years in a commissioning role as Director of Strategy and Transformation in Essex.

Declared Interests:

- Director of own management company Solutions for Integrated Healthcare (dormant from April 2013)
- Volunteer for the Wilderness Foundation Youth Charity

Member of the following committees:

- Governing Body
- Finance Committee
- Remuneration Committee

Simon Truelove, Chief Financial Officer
Simon has worked as an accountant and Director of Finance for a number of NHS provider and commissioning organisations since 1990 and is a member of the Chartered Institute of the Public Finance and Accountancy.

Declared Interests:

- Married to the Finance Director of Gloucestershire Hospitals FT who then was appointed as the Deputy Chief Executive and Finance Director of the RUH, Bath from mid June 2013

Member of the following committees:

- Governing Body
- Finance Committee
- Audit and Assurance Committee
- Remuneration Committee

Christine Reid, Lay Member, Patient and Public Involvement
Christine served as a councillor in Wiltshire until 1998 during which time she held many health related roles. She also served on the national Local Government Association as lead member for rural local authorities and was awarded the OBE for this work. Christine has an ongoing interest in mental health services, carer services, delivering the Equality and Diversity agenda, and working with stakeholders.

Declared Interests:

- Mental Health Act Associate AWP

Member of the following committees:

- Governing Body
- Finance Committee
- Audit and Assurance Committee – Vice Chair
- Remuneration Committee – Vice Chair
- Quality and Clinical Governance Committee

Peter Lucas, Lay Member, Audit, Governance and Vice Chair
Peter's background is in industry, commercial and investment banking and local community activities. His involvement in the NHS began as chair of the Patient Partnership Group of his local GP practice before holding a number of roles with health authorities in the South West.

Declared Interests:

- None

Member of the following committees:

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

Dr Simon Burrell, GP Chair, NEW
Simon qualified in Bristol in 1979 and worked in several hospitals in Bristol and Bath for some years in various specialties, but particularly in obstetrics. He joined the partnership in Corsham in 1985.

Declared Interests:

- Trustee of Corsham Link

Member of the following committees:

- Governing Body
- Remuneration Committee – from April 13 to December 13

Dr Helen Osborn - GP Chair, WWYKD
Helen qualified in 1988 from the University of London. She is a GP and senior partner at Courtyard Surgery in West Lavington near Devizes. Her clinical interests are all aspects of family medicine, family planning, care of the elderly and palliative care.

Declared Interests:

- Employed by Sirona Health & Care to provide contraceptive services

Member of the following committees:

- Governing Body
- Remuneration Committee
- Quality and Clinical Governance Committee

Dr Toby Davies, GP Chair, Sarum
Toby qualified in 1985 at Birmingham University and completed his GP training in Devon after working in Australia. Since 1994 he has been a partner at the Castle Practice in Ludgershall, Wiltshire, and his specialisms include asthma, cardiology and minor surgery.

Declared Interests:

- Dr Davies' practice is a shareholder in WilcoDoc which runs Salisbury Walk In Centre

Member of the following committees:

- Governing Body
- Finance Committee

Dr Jonathan Rayner, GP Vice Chair, NEW
Jonathan qualified in 1983 from the University of London. In 1991, he joined the Ramsbury Practice, near Marlborough, as a GP.

Declared Interests:

- Trustee of John Rayner Charitable Trust which makes donations to a wide variety of registered charities including those involved in healthcare

Member of the following committees:

- Governing Body
- Audit and Assurance Committee

Dr Debbie Beale, GP Vice Chair, WWYKD
Debbie qualified in 1983 from Manchester Medical School and moved to Wiltshire in 1985, qualifying as a GP in 1987. She began working at Eastleigh Surgery in 1988 and became Senior Partner there in 2004

Declared Interests:

- Director and part owner - Leighton Health Company and Bradbury Company

Member of the following committees:

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

Dr Celia Grummitt, GP Vice Chair, Sarum
Celia qualified from the Royal Free Hospital School of Medicine in 1982. After she qualified she served a short service commission in the army, gaining experience across the world. She has worked in general practice throughout her career which has included practicing in secure settings such as prisons and immigration centres.

Declared Interests:

- Director and Owner of Rainbow 2 Ltd
- Voluntary Chief Executive Officer of God Unlimited (Gul) Outdoor Therapy Centre
- Trustee of Fortune Centre of Riding Therapy
- Some family members work part time in Gul

Member of the following committees:

- Governing Body

Mary Monnington, Registered Nurse Member
Mary qualified as a nurse in 1972 and has worked in a range of nursing posts. In 1978 she emigrated to Australia to work at the Alfred Hospital. Upon her return to the UK, she completed postgraduate degrees in economics and nursing and has held a number of senior nursing posts across the South West.

Declared Interests:

- Owner of Mary Monnington Associates – sole trader at present
- Council Member UK Council of Caldicott Guardians
- Registrant / Panel member - Nursing & Midwifery Council
- Nurse Member Dorset CCG

Member of the following committees:

- Governing Body
- Audit and Assurance Committee
- Remuneration Committee
- Quality and Clinical Governance Committee

Dr Mark Smithies, Secondary Care Doctor
Mark qualified in 1981 at the University of London. Prior to becoming Director of Intensive Care at the University Hospital of Wales, in Cardiff, he was a consultant in Intensive Care at Guy's Hospital in London.

Declared Interests:

- Voluntary Board Member and Trustee of Salisbury based charity "Health Care Sudan".
- Editor of a current awareness journal "Intensive Care Monitor" that reviews the world's published literature in the field of critical care.

Member of the following committees:

- Governing Body
- Audit and Assurance Committee
- Remuneration Committee
- Quality and Clinical Governance Committee

Jo Cullen, Group Director, WWYKD
Jo has worked for the NHS for over 30 years, qualifying as a Registered Nurse from Guy's Hospital in London in 1986, and graduating from University of Bath in 1991. She has worked clinically in the RUH; in a GP practice in Bath on a Department of Health funded mental health project, and since 1996 worked for Wiltshire across previous predecessor NHS organisations. Jo was Head of Primary Care since 2009, managing the contracts for GPs, dentists, pharmacists and opticians and led the procurement of the Walk in Centre, Out of Hours and Single Point of Access and NHS 111 for Wiltshire.

Declared Interests:

- None

Member of the following committees:

- Governing Body – September 13 onwards
- Finance Committee – September 13 onwards

Mark Harris, Group Director, Sarum
For the last twenty years, Mark has worked in NHS commissioning organisations throughout the south in Surrey, Hampshire, London and Berkshire. Over that time Mark has led the commissioning of acute, mental health, community and ambulance services in a variety of roles.

Declared Interests:

- None

Member of the following committees:

- Governing Body
- Finance Committee

Ted Wilson, Group Director, NEW
Ted has worked for the NHS for over 30 years in a range of strategic management and planning roles at a senior level. His previous positions include Director of Operations for Shropshire Community Health NHS Trust, Joint Director of Service Delivery at NHS Swindon and Swindon Borough Council as well as a great deal of NHS experience in Wales which culminated in a Chief Executive position of a Local Health Board (LHB) in Merthyr**.**

Declared Interests:

- None

Member of the following committees:

- Governing Body
- Finance Committee

David Noyes, **Director of Planning, Performance and Corporate Services**
David retired from the Royal Navy in March 2013, after 28 years' service, to join the CCG. David joined the Royal Navy in 1985 and spent the majority of his early career at sea, including spells of active duty in the Gulf and during the Bosnia conflict. David was promoted to Commander in 2001, then Captain in 2009, and worked in a variety of strategic planning and support roles in the MOD and Fleet HQ. In early 2011 he was selected to be Deputy Commander of the UK Support Headquarters (Afghanistan) deploying to Helmand for a 6 month tour of duty in late 2011/early 2012.

Declared Interests:

- None

Member of the following committees:

- Governing Body
- Finance Committee
- Audit and Assurance Committee
- Remuneration Committee

Dr Peter Jenkins, **GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions**
Peter qualified from St Mary's Hospital, London, in 1975 and has been a GP in Avon Valley Practice for more than 30 years. Until recently he was a GP Trainer and GP Tutor for Salisbury. Currently he works part-time in the practice and is a GP Appraiser. Peter is the named GP for safeguarding children for the Clinical Commissioning Group.

Declared Interests:

- Dr Jenkins' practice is a shareholder in WilcoDoc which runs Salisbury Walk In Centre

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee

Jacqui Chidgey-Clark, Director of Quality and Patient Safety
Jacqui qualified as an RGN in 1984 having studied at the Bristol Royal Infirmary. She held a number of clinical roles in Bristol and at the RUH before taking up her first General Management role in Wiltshire. She then moved to Somerset Coast Primary Commissioning Group (PCG) to work in an emerging PCG, in a commissioning and professional lead role, which led her to North Devon Primary Care Trust (PCT) where she became the Director of Nursing and Director of Clinical Services. Jacqui has also worked for a national charity and as a Director in Social Care.

Declared Interests:

- Director of the JCC Partnership Ltd
- Partner Dr J Chidgey-Clark is the Director of Patient Services at Dorothy House Hospice, Winsley

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee

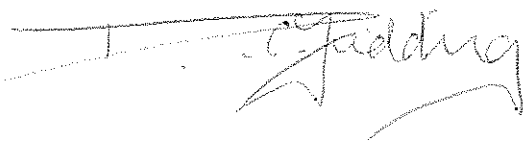
Lynn Talbot, Interim Director of Community Transformation
Lynn has over 25 years' experience in the NHS plus 12 years as an independent consultant. She has held a number of senior positions including Director of Primary Care, Director of Education and Development in an Acute Trust, Director of Modernisation (Eastern Region) and an Associate Dean for General Practice (London).

Declared Interests:

- Director of McLaren Perry Ltd – Management Consultancy

Member of the following committees:

- Governing Body



Deborah Fielding
Chief Officer
5 June 2014

Section 2: Statements by the Accountable Officer

2.1 Statement of Accountable Officer's Responsibilities

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

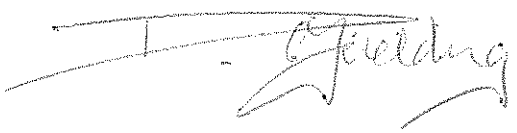
The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the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

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 Manual for Accounts issued by the Department of Health and in particular to:

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

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



Deborah Fielding
Chief Officer
5 June 2014

2.2 Governance statement

Governance Statement by the Chief Officer as the Accountable Officer of NHS Wiltshire Clinical Commissioning Group

Introduction and context

We were licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

We operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior us taking on our full powers.

As at 1 April 2013, we were licensed with two conditions as follows:

- We must have a clear and credible integrated plan that meets authorisation requirements.
- We must have a detailed financial plan that delivers financial balance, sets out how we will manage within our management allowance, and is integrated with the commissioning plan.

Scheduled review by NHS England identified that these conditions had been met and we are now licensed without conditions.

Scope of responsibility

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

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice.

Corporate Governance Code

The Governing Body determines to ensure that the organisation inspires confidence and trust avoiding any potential situations of undue bias or influence in decision-making and protecting the NHS, the CCG and individuals involved from any appearance of impropriety. All our employees and appointees will reflect the seven principles of public life set out by the Nolan Committee:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

The Governing Body engenders a culture of openness and transparency in business transactions ensuring that:

- the interests of patients remain paramount at all times;
- all are impartial and honest in the conduct of their official business;
- public funds entrusted to us are used to the best advantage, always ensuring value for money;
- there is no abuse of official positions for personal gain or benefit;
- no advantage to private or other interests is sought in the course of official duties.

It is our policy to identify, minimise, control and where possible, eliminate any risks that may have an adverse impact on patients, staff and the organisation. The Accountable Officer carries ultimate responsibility for all risks within the control of the organisation. Our risk management strategy and policy describe the responsibilities for risk management from the organisational responsibility of the Governing Body, through all clinicians, managers and staff ensuring commitment to the principles of risk management.

During 2013/14, we organised and participated in a number of activities across the county, including Stakeholder Assemblies. These are events at which we bring together around 80 regular delegates drawn from groups who represent geographical areas, the voluntary sector and charities, service users, patients, carers, elected members and the public.

In addition, a Communication and Engagement Plan has been agreed to ensure that activities support the principles of the NHS Health Act 2012 and ensure that the views of all groups are taken into account when considering the development, commissioning and provision of services.

This Governance Statement is intended to demonstrate our compliance with the principles set out in Code.

For the financial year ended 31 March 2014, and up to the date of signing this statement, we complied with the provisions set out in the Code and applied the principles of the Code.

The Clinical Commissioning Group governance framework

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

Our Constitution states that, at all times it will observe the generally accepted principles of good governance in the way it conducts its business. This includes:

- The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.
- *The Good Governance Standard for Public Services*.
- The standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles'.
- The seven key principles of the *NHS Constitution*.
- The Equality Act 2010.

The Governing Body will, throughout each year, have an on-going role in reviewing governance arrangements to ensure that the we continue to reflect the principles of good governance.

Committee structure

Governing Body

The Governing Body has been responsible for:

- Ensuring delivery of our strategic aims and focussing on the organisation's purpose and on outcomes for patients and the population.
- Creating a culture of openness, transparency and learning; values and behaviours which support continuous improvements in clinical effectiveness, safety and experience of the services they commission.
- Monitoring management of significant risk and seeking assurance that management decisions balance performance within appropriate limits.
- Taking informed and transparent decisions.
- Engaging stakeholders and making accountability real.

We are is made up of the 57 GP practices in Wiltshire who form part of a Council of Members. The Governing Body voting members consist of:

- Six practicing GP Members elected by member practices
- Chair
- Chief Officer
- Chief Financial Officer
- Registered Nurse Member
- Secondary Care Doctor Member
- Lay Member for Patient and Public Involvement
- Lay Member for Audit & Assurance

The following Governing Body Members are In Attendance:

- Director of Planning, Performance and Corporate Services
- Three Group Directors
- Director of Quality and Patient Safety
- Head of Communications and Engagement
- Interim Director of Community Transformation
- GP Medical Advisor
- Head of PMO
- Corporate Director, Wiltshire Council
- Two Service Directors, Wiltshire Council
- Chair, Healthwatch Wiltshire
- Board Administrator

Dr Steve Rowlands	GP Chair
Deborah Fielding	Chief Officer
Simon Truelove	Chief Financial Officer
Christine Reid	Lay Member: Patient and Public Involvement
Peter Lucas	Lay Member: Audit and Governance, Vice Chair
Dr Simon Burrell	GP Chair, NEW
Dr Helen Osborn	GP Chair, WWYKD
Dr Toby Davies	GP Chair, Sarum
Dr Jonathan Rayner	GP Vice Chair, NEW
Dr Debbie Beale	GP Vice Chair, WWYKD
Dr Celia Grummitt	GP Vice Chair, Sarum
Mary Monnington	Registered Nurse Member
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
David Noyes	Director of Planning, Performance and Corporate Services
Mike Relph (April to September 13)	Group Director - WWYKD
Jo Cullen (from September 13)	Group Director – WWYKD
Mark Harris	Group Director – Sarum
Ted Wilson	Group Director – NEW
Jacqui Chidgey-Clark	Director of Quality and Patient Safety

Helen Robinson-Gordon	Head of Communications and Engagement
Lynn Talbot (from July 2013)	Interim Director of Community Transformation
Dr Peter Jenkins	GP Medical Advisor, Safeguarding (children) and Clinical Exceptions
Rob Hayday	Head of Project Management
Maggie Rae	Corporate Director, Wiltshire Council
Julia Cramp	Service Director, Commissioning and Performance, Wiltshire Council
James Cawley	Service Director, Commissioning, Procurement and Strategy, Wiltshire Council
Chris Graves	Chair, Healthwatch, Wiltshire
Diana Hargreaves	Board Administrator, CCG

Remuneration and Terms of Service Committee

This committee has advised the Governing Body about appropriate remuneration, the appointment, termination and terms and conditions of the Accountable Officer, Executive Directors, Clinical Leads and other senior managers with locally determined contracts described by the NHS Very Senior Managers Pay Framework.

The committee has monitored, evaluated and confirmed the satisfactory performance of these posts and ensured contractual arrangements taking account of national guidance where appropriate.

Peter Lucas	**Chair**, Lay Member: Audit and Governance
Christine Reid	**Vice Chair**, Lay Member: Patient and Public Involvement
Mary Monnington	Registered Nurse Member
Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Dr Steve Rowlands	GP Chair CCG
Deborah Fielding	Chief Officer
David Noyes	Director of Planning, Performance and Corporate Services
Dr Simon Burrell (April to December 13)	GP Chair, NEW
Dr Helen Osborn	GP Chair, WWYKD

(from January 2014)	
Simon Truelove	Chief Financial Officer
HR Business Partner	CSCSU
Diana Hargreaves	Board Administrator

Audit and Assurance Committee

The role of this committee has been to consider the adequacy and effective operation of the internal control systems that underpin the delivery of the organisation's objectives. This non-executive committee included a clinical GP executive member with executive directors in attendance.

The committee reviewed the establishment, maintenance and adequacy of the system of integrated governance, internal controls and risk management, across the whole of the organisation's activities (financial, non-financial, clinical, non-clinical, and information). This included advising the Governing Body on internal and external audit services, counter fraud services and local security management services.

The committee monitored compliance with and waiver of the financial policies and scheme of delegation, reviewed every decision to suspend the scheme of delegation, reviewed the schedule of losses and compensations and reviewed the annual financial statements prior to submission to the Governing Body.

Peter Lucas	Chair, Lay Member: Audit and Governance
Christine Reid	Vice Chair, Lay Member: Patient and Public Involvement
Dr Mark Smithies	Secondary Care Doctor
Mary Monnington	Registered Nurse
In attendance (no voting rights)	
Dr Jonathan Rayner	GP Vice Chair, NEW
Simon Truelove	Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Lynn Pamment/Paul Dalton	Internal audit, PwC
Duncan Laird/Jonathan Brown/Tara Westcott	External audit, KPMG
Keren Lovell	Counter Fraud
Tracey Spragg (from September 13)	Counter Fraud

Roger Ringham	Security Management Specialist
Steve Perkins	Deputy Chief Financial Officer
Susannah Long	Governance and Risk Manager
Diana Hargreaves	Board Administrator

Quality and Clinical Governance Committee

This committee considered and advised the Governing Body on service quality issues, performance managing service and clinical issues with particular reference to action plans emerging from Serious Incidents Requiring Investigation (SIRI), Serious Case Reviews (SCR) and Care Quality Commission (CQC) inspections.

The committee provided assurance to the Governing Body regarding organisational learning and the fulfilment of its statutory responsibilities, implementing plans to drive continuous improvement, including the focus on patient feedback and a direct relationship with commissioning decisions. The Registered Nurse Member chaired the committee.

Mary Monnington	Chair, Registered Nurse Member
Christine Reid	Lay Member: Patient and Public Involvement
Dr Debbie Beale	GP Vice Chair, WWYKD
Deborah Rigby	Deputy Director of Quality & Patient Safety
Lynn Franklin	Adult Safeguarding Lead
Karen Littlewood	Associate Director for Quality (Safeguarding Adults and Children)
Dr Mark Smithies	Secondary Care Doctor
Susannah Long	Governance and Risk Manager
Dina Lewis	Associate Director of Quality (Continuing Healthcare and Specialist Placements)
Gail Warnes (April 13 to September 13)	Head of Prior Approvals/Exceptions
Jayne Watt (April 13 to September 13)	Referral Support Manager
Dawn Griffiths	Clinical Support Lead
Dr Peter Jenkins	GP Medical Advisor
Louise French	Quality & Patient Safety Manager
Bianca McClounan	Bank Quality Manager
Jacqui Chidgey-Clark	Director of Quality & Patient Safety
Nadine Fox	Head of Medicines Management
Sue Odams	Public Health Consultant, Wiltshire Council
Beth Graham (April 13 to December 13)	Medicines Management
Joanne Clark (January 14 onwards)	Medicines Management
Sheila Morris (April 13 to November 13)	CSCSU representative
Phillip King (March 14 onwards)	CSCSU representative
Isabelle Tucker	Public Health Nurse, IP&C Lead, Wiltshire Council
Dr Fiona Findlay	Designated Doctor, Safeguarding Children
Dr Paul Borelli	Medical Advisor
James Dunne (January 14 onwards)	Deputy Designated Nurse, Safeguarding Children

Finance Committee

The committee monitored our financial performance against the approved detailed financial plans and sought assurance that robust plans were in place to ensure financial risks are managed.

The committee considered and assessed new investment decisions and made recommendations to the Governing Body and officers of the CCG in line with the Scheme of Delegation. The committee was chaired by the CCG Chair.

Dr Steve Rowlands	Chair, GP Chair
Deborah Fielding	Chief Officer
Simon Truelove	Chief Financial Officer
Steve Perkins	Deputy Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Christine Reid	Lay Member: Patient and Public Involvement
Mike Relph (April to September 13)	Group Director, WWYKD
Jo Cullen (September 13 onwards)	Group Director – WWYKD
Mark Harris	Group Director – Sarum
Ted Wilson	Group Director – NEW
Dr Toby Davies	GP Chair, Sarum
Dr Debbie Beale	GP Vice Chair, WWYKD

Locality Group Committees

We have established a committee for each of the three Locality Groups namely NEW, Sarum and WWKYD. The Locality Group Committees were responsible for the following functions delegated to them:

- Ensuring good governance within the Group.
- Developing and agreeing strategic direction for the Group (and therefore for the CCG), taking account of national directives.
- Commissioning services under the scheme of delegation.
- Engaging with local stakeholders.
- Maintaining risk registers and escalating where appropriate.

Membership

Membership of the Governing Body and committees was arranged to ensure that discussions were comprehensive. Members of the committees were conscious of the responsibility placed on them. Records show that there were ten Governing Body meetings held during 2013/14 including the Annual General Meeting. Attendance at these meetings was as follows:

Governing Body meeting attendance 2013/14

Governing Body Voting Members

Name	Position	Governing Body Meeting Dates									
		Early Apr-13	Apr-13	May-13	Jun-13	Jul-13	Sep-13	AGM Sep-13	Nov-13	Jan-14	Mar-14
Dr Debbie Beale	GP Vice Chair, WWYKD										
Dr Simon Burrell	GP Chair, NEW										
Dr Anna Collings	GP NEW	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a	
Dr Toby Davies	GP Chair, Sarum										
Deborah Fielding	Chief Officer										
Dr Celia Grummitt	GP Vice Chair, Sarum									n/a	
Peter Lucas	Lay Member and Vice Chair										
Mary Monnington	Registered Nurse Member	n/a									
Dr Helen Osborn	GP Chair, WWYKD										
Dr Jonathan Rayner	GP Vice Chair, NEW								n/a		n/a
Christine Reid	Lay Member										
Dr Steve Rowlands	GP Chair										
Dr Mark Smithies	Secondary Care Doctor										
Dr Elizabeth Stanger	GP Sarum	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a
Simon Truelove	Chief Finance Officer										

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

Additional information:
Dr Anna Collings, GP NEW, attended in place of Dr Jonathan Raynor for Nov-13 and Mar-14 meetings
Dr Elizabeth Stanger, GP Sarum, attended in place of Dr Celia Grummitt for Jan-14 meeting
Mary Monnington, Registured Nurse Member, commenced employment after the first meeting

Where a Direct or Clinical Lead cannot attend then a deputy has attended on their behalf.

We are working closely with Wiltshire Council on the development of a five year plan aiming to transform the delivery of health and social care for the people of Wiltshire. We have attended joint committees including the Joint Commissioning Board and the Health and Wellbeing Board.

Governing Body Performance 2013/14

The Governing Body is pleased with progress during this formative year and considers that significant progress has been made in developing as an effective strategic leadership board. The Governing Body have rightly taken a leading role in the development of CCG strategy going forward, not least in the form of a new 5 Year Strategic Plan and, in close partnership with Wiltshire Council, an ambitious Better Care Plan. They have also been assiduous in monitoring performance and identifying areas where greater attention is required, directing action as appropriate.

The Governing Body has invested time in reflecting on its own performance with the assistance of a specialist external consultant and will continue to make time to devote to its development. This process of evaluation of effectiveness was conducted by Frontline, a well-respected management consultancy firm with broad experience of the NHS, and CCGs in particular. The process comprised observations of Governing Body meetings and some of our Locality Executive

Meetings, a series of one to one interviews with all Governing Body Members and ultimately a half day workshop with all Governing Body Members present.

The results are already evident in the manner in which the Governing Body does its business and the Governing Body agreed to take on board and implement all the recommendations arising. This commitment is regularly monitored by use of a self-certification check list which the Governing Body makes time to review periodically. Frontline has no other connection with the CCG. Whilst we remain committed to the locality model in order to deliver real clinically-led local solutions, the Governing Body is equally committed to delivering improved outcomes system wide for the whole population. Accordingly, the Governing Body has agreed to implement a county wide and joint programme management approach to achieve the delivery of its ambitious plans.

Highlights of committee reports

Dementia Strategy
The Wiltshire Dementia Strategy 2014 – 2021 is intended to provide the strategic direction for Wiltshire Council and for the CCG to support people with dementia and their carers. It encompasses the care and support pathways available from the point that people notice concerns about their memory through to the end of life as well as addressing the risk factors that can contribute to the development of dementia. The strategy includes a commissioning plan for 2014/15.

In developing the strategy, engagement has taken place with people with dementia, their cares and families in Wiltshire. The strategy was agreed by the Joint Commissioning Board in December 2013 and by the CCG Governing Body in January 2014 moving to formal consultation.

Children's Community Health Services
Children's Community Health Services in Wiltshire have been delivered by five separate organisations where a single provider could lead to more equitable support across the county, easier access to services and the potential for improved joint working with GPs, Wiltshire Council and other partners. The re-commissioning of children's community health services will be undertaken as a joint commissioning project with Wiltshire Council.

Overnight Short Breaks for Disabled Children and Young People
January 2014 Governing Body saw the presentation of a paper looking at proposals for the re-design of overnight short breaks for disabled children. A Steering Group has overseen the review, including key representatives from the CCG, Wiltshire Council and Wiltshire Parent Carer Council. The paper follows a three month consultation which has included current parent carers of disabled children, parent carers of disabled adults, current and former staff and professionals and other interested parties.

Community Transformation
We are working with Wiltshire Council and Great Western Hospital and GP practices on a project to maintain people at home and independent for as long as possible, preventing needless hospital admissions. Clusters of GP practices are forming hubs extending primary care teams and social care support providing integrated accessible care with the Simple Point of Access. The scheme will also support early discharge of patients from acute settings.

Joint Business Agreement (JBA)
We have worked with Wiltshire Council to produce an overarching business agreement which sets out terms and conditions to enable the central coordination of governance and reporting for section 75 and section 256 arrangements made under the National Health Service Act 2006 (as amended). Section 75 arrangements allow us and the Council to enter into partnership agreements for exercising our functions and the health related functions of the Council. Section 256 arrangements allow us to make a payment to the Council in connection with the provision of any local authority function which will affect or is connected with the health of individuals. The Agreement details a transparent way of working with the Council and facilitates future integrated working.

Financial Planning
We have has achieved our financial plan and delivered QIPP of £9.3million for 2013/14.

Five Year Strategic Plan 2014 – 2019
The strategy sets out the strategic direction for the development of health and care services across Wiltshire over the five year period 2014-2019, showing in detail how the CCG will deliver its objectives between 2014 and 2016, and lays the foundations for transformational change. The Strategy describes transformational change that provides high quality, effective, clinically led and local services for people in Wiltshire.

The Clinical Commissioning Group risk management framework

The Governing Body has formally adopted a Risk Management Strategy, originally approved prior to Authorisation but reviewed and revised in September 2013. This sets out our strategic direction for the management of risk including the definition of risk, risk management objectives, roles and responsibilities, the process, risk appetite, training, communication and monitoring.

A key element of the strategy is the Board Assurance Framework (BAF) The BAF outlines systems in place to manage the organisation's strategic objectives and control the risks to these objectives, detailing where assurances on the effectiveness of these controls has been obtained, where there are gaps in control or assurance and any actions required to strengthen assurance or control.

At the year-end the BAF identifies that control could be improved by:

- Agreement of baseline funding for a number of outstanding minor financial issues with NHS England.
- Identifying a specific CCG contract manager for section 75, where services are commissioned on our behalf by a partner organisation.
- Disaggregation of information regarding the prescribing of drugs known as 'specials' to allow us to fully investigate expenditure.

At the year-end the BAF identifies that assurance could be improved by:

- External scrutiny of services commissioned on our behalf by partner organisations.

All risks are recorded on the Risk Register which is the summation of six directorate and locality group risk registers. The risk register is not a static record but a communication device which allows risks to be explored, prioritised for treatment and management actions to be programmed and monitored. Directors provide the ownership and leadership for their teams to share and address risks.

On a two monthly cycle the Risk Register is presented to the Executive Team for discussion. The most prominent risks are determined and presented to the Audit and Assurance Committee for consideration. Of these, ten risks are escalated to the Governing Body in public session to

confirm the extent to which our objectives are threatened and monitor progress holding directors to account as appropriate.

Risk appetite refers to the level of risk that the organisation is willing to tolerate when controlling risks, as the risks arise or when embarking on projects. The Governing Body acknowledges that risk is a component of change and improvement and, therefore, does not consider the absence of risk to be a necessarily positive position. We will, where necessary, tolerate risks where action is not cost effective or reasonably practicable. We will not normally accept risks with a score of between 15 and 25 on the National Patient Safety Agency Risk Matrix, with plans being put in place to ameliorate the risk.

We provide leadership and commitment from the top with the Governing Body supporting a culture of risk awareness and personal, professional and corporate responsibility and accountability. This is supported by a clear framework within which risks are identified, reported, analysed, managed and monitored. Staff representatives assist with risk assessment in their area bringing their specific local knowledge and providing local leadership for risk management. Good practice is shared and independent assurance is sought. Each staff member has objectives set and is provided with appropriate training to ensure they have the correct knowledge and skills to meet their objectives.

The CCG and the members of the Governing Body are committed to ensuring that the organisation values diversity and promotes equality and inclusivity in all aspects of our business considering the full impact of the decisions made. We conduct and publish Equality Impact Assessments (EIAs) on all policies and proposals critically assessing the impact on protected groups and identifying opportunities to promote equality.

We hold healthcare service providers to account at the regular Clinical Quality Review meetings, to ensure that they comply with the Equality Act 2010 and associated Public Sector Equality Duty. We also require providers to meet the legislative requirements as part of the procurement process for new or revised contracts.

We have a robust recruitment process and has in place a number of workforce related policies that support and protect staff from discrimination, harassment, bullying and victimisation. All staff are required to undertake mandatory Equality and Diversity training.

We inform, engage and consult public stakeholders with regards to any changes to health services that may result in a risk impacting upon the public. We use a variety of methods to do this including posters, leaflets and other publicity materials as well as public meetings, workshops and presentations. The public are consulted on proposals from the very earliest stage and their comments are fed back to decision makers so that improvements can be made. Decisions are taken by the Governing Body in public.

The Clinical Commissioning Group internal control framework

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

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

The risk and control framework encompasses the key assurance systems including planning, performance monitoring, audit, management policies, external assessment and risk management. The operation, scrutiny and reporting of these systems facilitates internal control.

We have identified initiatives in our Operating Plan. The initiatives have been developed into projects by the Locality Groups who are responsible for the delivery of target outputs. Internal control is supported by the Programme Management Office (PMO) tracking progress of delivery through meetings with project managers and escalation of any concerns through the project governance structure which includes the Project Governance Group, the Clinical Executive and the Governing Body. All initiatives require agreement on clear planned milestones and outputs that must be delivered and has an embedded project risk register. This project framework enables progress to be monitored and successful delivery evidenced.

On a monthly basis, we produce an Integrated Performance Report monitoring quality, financial performance, access and adherence with the NHS Constitution, and project management. The document is aligned to and utilises the NHS England CCG Assurance Framework and supports the quarterly NHS England Area Team assurance visits. The Integrated Performance Report is presented to the Governing Body and published on our website to inform stakeholders.

The CCG Audit and Assurance Committee oversees the internal control framework on behalf of the Governing Body, satisfying itself that appropriate processes are in place to provide the required assurance.

The committee reviews the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the organisation's activities (financial, non-financial, clinical, non-clinical and information) that supports the achievements of the organisation's objectives.

The committee utilises the work of an effective internal audit control function, which provides appropriate independent assurance, and reviews the work and findings of the External Auditor appointed by the Audit Commission, considering implications and our response. The committee ensures compliance with the Secretary of State's directions on counter fraud by overseeing the effective operation of the Counter Fraud Service, including policies and plans, and considers major findings of reports for management response. The Local Security Management Service is contracted to undertake assessments of healthcare providers' security arrangements which is support by the NHS contract.

The Audit and Assurance Committee seeks reports and assurances from directors and managers as appropriate concentrating on the over-arching systems of integrated governance, risk management and internal control.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Information Governance Toolkit and an annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

We have has self-assessed against the requirements of the Information Governance Toolkit and have received positive assurance from Internal Audit on this programme. We have a trained Senior Information Risk Owner and a trained Caldicott Guardian in place. A suite of Information Governance policies, including Information Security, is in place and all staff have been required to undertake introductory training in Information Governance. An initial assessment of information assets and flows has been undertaken with risks to data security identified and managed. A reporting and investigation framework is in place for incidents and near misses.

Pension obligations

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

Equality, diversity & human rights obligations

Control measures are in place to ensure that we comply with the required public sector equality duty set out in the Equality Act 2010.

Sustainable development obligations

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

We will ensure that we meet our obligations under the Climate Change Act 2008 and the Public Services (Social Value) Act 2012.

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

Risk to the strategic objectives is identified through a number of mechanisms including, but not limited to, the following:

- business decision making and project planning;
- strategy and policy development;
- external/internal audit findings and other scrutiny;
- concerns and complaints;
- risk assessment process;
- Serious Incident Requiring Investigation (SIRI) and adverse event processes.

Identified risks are recorded on our risk register, controls are identified, further mitigating actions are programmed and progress is monitored. Our risk profile is considered by the Governing Body and action against the ten key risks is closely monitored.

A key risk to the organisation continues to be the Delayed Transfer of Care (DTOC) which has the potential to destabilise the health and social care system. DTOC in acute and community providers causes reduced bed capacity leading to heightened escalation in acute hospitals, poor outcomes for patients and disrupted patient journeys. The CCG and partner organisations, as the Urgent Care Board, have worked together to identify likely periods of escalation and put plans in place. Additional bed capacity has been arranged to manage peak demand. Our focus on Community Transformation will aim to give long-term benefits, supporting the health needs of patients within the community. Partners such as Wiltshire Council will be working closely with us to improve the care pathway for patients admitted to hospital.

A continuous risk issue is that of financial balance as we are required to make substantial QIPP efficiency savings. For 2014/15 we are required to make £11.6 million in savings. The Project Management Office (PMO) and project methodology is now well established and progress with QIPP schemes will be closely monitored through developments to the Integrated Performance Report.

Provider contract over-performance has been a risk present on the 2013/14 risk register and is likely to remain on the risk register for 2014/15. Contracts for 2014/15 are being signed with acute

providers and improvements to the contract data monitoring will enable us to closely manage provider activity.

The ambulance service within Wiltshire is routinely failing to meet the target response times. The increase in response times has the potential to adversely affect clinical outcomes for Wiltshire patients. We are working closely with the South West Ambulance Service NHS Trust with a weekly teleconference and an action plan in place.

We have always recognised that, as a new organisation forging new relationships, our own lack of maturity is a risk. 2013/14 has seen embedding of staff and processes, creation and substantiation of partner relationships, and sustained progress against strategic objectives. We have provided training to support our staff and now considers that we are well placed to move forward with its commissioning programmes. However, we are demanding much from its staff and capacity and capability are still identified on the risk register. We have prepared a work plan for 2014/15 and have provided clarity on leadership undertaking a resource assessment. All staff will have objectives set and supporting Performance Development Plans.

We are visited by the NHS England Area Team, on a quarterly basis, to gain assurance of our performance against our licence. The Checkpoint visit is supported by the production of a Balanced Scorecard. This process enables us to demonstrate compliance with our licence.

We have in place sound governance arrangements with established committees reporting to the Governing Body. We operate with a matrix working approach allocating work streams to director portfolios. The Scheme of Reservation and Delegation has been reviewed during the year. A register of Declarations of Interest is maintained to ensure transparency of interests when making decisions. Risks are recorded on the risk register, discussed and mitigating actions planned. Both the Board Assurance Framework and the risk register are reported to the Governing Body at each meeting. Each month, Governing Body members receive the Integrated Performance Report examining quality, financial and access performance and considering progress with projects.

The three quarterly Checkpoint reviews undertaken during 2013/14 we have passed retaining our licence without conditions.

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

Budgets for our first year of operation were set with reference to PCT budgets which had been subject to Value For Money (VFM) audits. To work within the financial resources available to us, the QIPP programme has been targeted where the organisation benchmarks poorly. QIPP initiatives have been identified to challenge historical activity to use resources more efficiently and effectively in line with our vision and values. To support this work we have embedded a framework for project management. There is rigour on business cases and project plans to identify required outcomes and potential risks. Project performance is monitored by the Programme Governance Group and reported to the Governing Body as part of the Integrated Performance Report.

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

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

Capacity to handle risk

As Accountable Officer, I lead on determining the strategic approach to risk with the governance framework arranged and managed by the Director of Planning, Performance and Corporate Services. Leadership for the risk management is provided by the Executive Directors with support from key individuals including the Governance and Risk Manager and Central Southern Commissioning Support Governance Team.

From training at Corporate Induction onwards, all staff are encouraged to report risks and adverse events, and share good practice.

Review of Effectiveness

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

The BAF itself provides me with evidence that the effectiveness of controls, to manage risks to us achieving our principles objectives, have been reviewed.

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

The effectiveness of the system of internal control has been tested and challenged by the following means:

- The Governing Body has participated in 'Board to Board' meetings with partner CCGs and provider organisations. We have contracted with an external organisation to undertake Governing Body assessment and development. The Lay Members have met with Lay Members from the other CCGs within this Area Team geography and have shared issues including internal control arrangements.

- The Audit and Assurance Committee has undertaken a self-assessment to consider its performance against the terms of reference for the committee. The results of this self-assessment confirmed the arrangements for internal control making recommendations for continued improvement. The Audit and Assurance Committee has also received presentations from Locality Group Directors discussing their risk management arrangements and key risks.

- The Quality and Clinical Governance Committee has invited quality leads from provider organisations to present the key issues as they are seen by their organisation as triangulation to the Clinical Quality Review meetings and performance data.

- Internal Audit has undertaken eleven audits across the CCG. Audit reports have been presented to and discussed by the Audit and Assurance Committee with actions to address recommendations noted.

- The Care Quality Commission has undertaken inspections of safeguarding arrangements at acute trusts and with Wiltshire Council. Their findings have informed the oversight of our safeguarding arrangements and have prompted improvements in the control mechanisms.

- The Health and Safety arrangements have been assessed by CSCSU who have been supportive of the progress made.

Significant Control Issues

Internal Audit reports during the year have identified four control issues that we will be addressing as follows:

- Procurement – We agreed to produce and approve a procurement strategy to clarify the processes in place and the procedures to be followed including authorisation limits. A suite of procurement reports would also be produced by the CSCSU to inform managers. This has now been achieved.

- CSCSU – The existing contract with the CSCSU does not explicitly detail service specifications, key performance indicators (KPI) and a full breakdown of cost. Our contract leads, as part of the contract renegotiation, are detailing full service specifications with associated KPI and will be negotiating cost envelopes for each section.

- Business Continuity Planning - NHS Property Services and CSCSU are working on their organisations' business continuity plans. We are largely dependent on these organisations and need to have plans in place that define agreed recovery time objectives. We will be working with these organisations.

- Continuing Healthcare – This audit resulted in five medium risk rated findings relating to case management, the 'stop the clock' mechanism, management reporting information, policy documents, the council resource team, and eligibility decisions. Management action will be taken during 2014/15 to address the recommendations from these findings.

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

Head of Internal Audit Opinion

Our opinion is based solely on work we have completed to assess whether the controls in place support the achievement of management's objectives as set out in our Individual Assignment Reports, but our opinion does not take into account the results of any internal audit or other assurance work conducted in relation to the CSCSU or other service organisations.

We have completed the programme of internal audit work for the year ended 31 March 2014 with the exception of the project key performance indicators workshop. Our work identified low, medium and high rated findings. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and control.

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

- The overall classification of the procurement report, CSCSU – contract monitoring and performance report, Business Continuity Planning report, and QIPP was high risk.
- We identified one high risk finding in our review of the new general ledger system (ISFE), which related to the deliverables to be produced by the CSU for the CCG.
- We identified one high risk finding in our review of information governance, which related to the procedures for the transfer of sensitive information.

During the year the Internal Audit issued no audit reports with a conclusion of limited assurance.

During the year the Internal Audit issued no audit reports with a conclusion of no assurance.

Data Quality

Data is provided to the Governing Body as part of the Integrated Performance Report. The integration of performance data facilitates the overall validation of information provided.

Business Critical Models

We have in place an appropriate and proportionate approach to providing quality assurance of business critical models, in line with the recommendations of the Macpherson Report.

Data Security

We have self-assessed against the Information Governance Toolkit and Internal Audit has reviewed our self-assessment process and elements of our submission to provide assurance to the Governing Body. We have submitted a satisfactory level of compliance with the toolkit. However, further documentation is required with regard to the secure transfer and receipt of personal sensitive information, the identification and recording of key information assets, the approved procedure for handling Subject Access Requests and the responsibilities for the Registration Authority.

During 2013/14, there have been twenty-two recorded breaches of data security; of these, four have been attributed to the acts or omissions of staff. The four incidents were minor breaches and they were dealt with internally with staff involved directed to the appropriate guidance and training materials. No breaches were of a level requiring a report to the Information Commissioners Office.

We have not had any data security incidents deemed to be SIRIs during 2013/14.

Discharge of statutory functions

During establishment, the arrangements we put in place and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. Legal advice also informed the matters reserved for Governing Body decision and the Scheme of Delegation.

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

The scheme of delegation has been reviewed during 2013/14.

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

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

Conclusion

No significant internal control issues have been identified during 2013/14.

Deborah Fielding
Chief Officer
5 June 2014

Appendix:
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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF WILTSHIRE CCG

We have audited the financial statements of Wiltshire CCG for the year ended 31 March 2014 on pages 4 to 38. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of Wiltshire CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members of the CCG, as a body, 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 Members of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 71 of the annual report, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2014 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;

- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of Wiltshire CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Jonathan Brown.

Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

6 June 2014

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4	**5,963**
Other costs	5	**514,906**
Other operating revenue	2	**(4,225)**
Net operating costs before interest		**516,644**
Other operating revenue		**-**
Other (gains)/losses		**-**
Finance costs		**-**
Net operating costs for the financial year		**516,644**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**516,644**
Of which:		
Administration Costs		
Gross employee benefits	4	**5,963**
Other costs	5	**6,172**
Other operating revenue	2	**(507)**
Net administration costs before interest		**11,628**
Programme Expenditure		
Gross employee benefits	4	**-**
Other costs	5	**508,734**
Other operating revenue	2	**(3,718)**
Net programme expenditure before interest		**505,016**

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	**-**
Net gain/(loss) on revaluation of property, plant & equipment	**-**
Net gain/(loss) on revaluation of intangibles	**-**
Net gain/(loss) on revaluation of financial assets	**-**
Movements in other reserves	**-**
Net gain/(loss) on available for sale financial assets	**-**
Net gain/(loss) on assets held for sale	**-**
Net actuarial gain/(loss) on pension schemes	**-**
Share of (profit)/loss of associates and joint ventures	**-**
Reclassification Adjustments	
On disposal of available for sale financial assets	**-**
Total comprehensive net expenditure for the year	**516,644**

The notes on pages 8 to 38 form part of this statement

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment		-
Intangible assets		-
Investment property		-
Trade and other receivables		-
Other financial assets		-
Total non-current assets		-
Current assets:		
Inventories		-
Trade and other receivables	17	2,371
Other financial assets		-
Other current assets		-
Cash and cash equivalents	20	-
Total current assets		2,371
Non-current assets held for sale		-
Total current assets		2,371
Total assets		2,371
Current liabilities		
Trade and other payables	23	(25,625)
Other financial liabilities		-
Other liabilities		-
Borrowings	26	(21)
Provisions	30	(168)
Total current liabilities		(25,814)
Total Assets less Current Liabilities		(23,443)
Non-current liabilities		
Trade and other payables		-
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions		-
Total non-current liabilities		-
Total Assets Employed		(23,443)
Financed by Taxpayers' Equity		
General fund	SOCITE	(23,443)
Revaluation reserve		-
Other reserves		-
Charitable Reserves		-
Total taxpayers' equity:		(23,443)

The notes on pages 8 to 38 form part of this statement

The financial statements on pages 4 to 38 were approved by the Governing Body on 20th May 2014 and signed on its behalf by:

Chief Officer
Deborah Fielding

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	Note	General fund	Revaluation reserve	Other reserves	Total reserves
		£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		**-**	**-**	**-**	**-**
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition		250	-	-	250
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		**250**	**-**	**-**	**250**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year	**SOCNE**	(516,644)	-	-	**(516,644)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets		-	-	-	**-**
Net gain/(loss) on revaluation of financial assets		-	-	-	**-**
Total revaluations against revaluation reserve		**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets		-	-	-	**-**
Net gain (loss) on revaluation of assets held for sale		-	-	-	**-**
Impairments and reversals		-	-	-	**-**
Net actuarial gain (loss) on pensions		-	-	-	**-**
Movements in other reserves		-	-	-	**-**
Transfers between reserves		-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial		-	-	-	**-**
Transfers by absorption to (from) other bodies		-	-	-	**-**
Transfer between reserves in respect of assets transferred under absorption		-	-	-	**-**
Reserves eliminated on dissolution		-	-	-	**-**
Net Recognised CCG Expenditure for the Financial Year		(516,394)	-	-	**(516,394)**
Net funding	**SCF**	492,951	-	-	**492,951**
Balance at 31 March 2014		**(23,443)**	**-**	**-**	**(23,443)**

The notes on pages 8 to 38 form part of this statement

Statement of Cash Flows for the year ended 31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(516,644)**
Depreciation and amortisation		**-**
Impairments and reversals	**22**	**250**
Other gains (losses) on foreign exchange		**-**
Donated assets received credited to revenue but non-cash		**-**
Government granted assets received credited to revenue but non-cash		**-**
Interest paid		**-**
Release of PFI deferred credit		**-**
(Increase)/decrease in inventories		**-**
(Increase)/decrease in trade & other receivables		**(2,371)**
(Increase)/decrease in other current assets		**-**
Increase/(decrease) in trade & other payables		**25,625**
Increase/(decrease) in other current liabilities		**-**
Provisions utilised		**-**
Increase/(decrease) in provisions	**30**	**168**
Net Cash Inflow (Outflow) from Operating Activities		**(492,972)**
Cash Flows from Investing Activities		
Interest received		**-**
(Payments) for property, plant and equipment		**-**
(Payments) for intangible assets		**-**
(Payments) for investments with the Department of Health		**-**
(Payments) for other financial assets		**-**
(Payments) for financial assets (LIFT)		**-**
Proceeds from disposal of assets held for sale: property, plant and equipment		**-**
Proceeds from disposal of assets held for sale: intangible assets		**-**
Proceeds from disposal of investments with the Department of Health		**-**
Proceeds from disposal of other financial assets		**-**
Proceeds from disposal of financial assets (LIFT)		**-**
Loans made in respect of LIFT		**-**
Loans repaid in respect of LIFT		**-**
Rental revenue		**-**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(492,972)**
Cash Flows from Financing Activities		
Net funding received		**492,951**
Other loans received		**-**
Other loans repaid		**-**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**-**
Capital grants and other capital receipts		**-**
Capital receipts surrendered		**-**
Net Cash Inflow (Outflow) from Financing Activities		**492,951**
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**(21)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(21)**

The notes on pages 8 to 38 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 *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2013-14* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.
For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

Notes to the financial statements

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in Note 11 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in Note 30 to these financial statements.

1.5 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 Pooled Budgets

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

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

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

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

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

1.7 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.

1.7.1 Critical Judgements in Applying Accounting Policies

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

· There has been no critical judgements made by the clinical commissioning group's management.

1.7.2 Key Sources of Estimation Uncertainty

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

· the Provision for Continuing Health Care was based on assumptions detailed in Note 30

Notes to the financial statements

1.8 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.

1.9 Employee Benefits

1.9.1 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.

1.9.2 Retirement Benefit Costs

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

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

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

1.10 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.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,

- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.11.2 Valuation

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

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

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

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,

- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

Notes to the financial statements

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

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

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.17.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

Notes to the financial statements

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Notes to the financial statements

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.
On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.
The balance is subsequently released to operating income over the life of the concession on a straight-line basis.
On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.
The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 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.

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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.

Notes to the financial statements

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

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Carbon Reduction Commitment Scheme

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

1.25 Contingencies

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

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

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

1.26 Financial Assets

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

Financial assets are classified into the following categories:

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

Notes to the financial statements

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

1.26.1 Financial Assets at Fair Value Through Profit and Loss

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

1.26.2 Held to Maturity Assets

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

1.26.3 Available For Sale Financial Assets

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

1.26.4 Loans & Receivables

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

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

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

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

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

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

1.27 Financial Liabilities

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

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

1.27.1 Financial Guarantee Contract Liabilities

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

Notes to the financial statements

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

1.27.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.27.3 Other Financial Liabilities

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

1.28 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.

1.29 Foreign Currencies

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

1.30 Third Party Assets

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

1.31 Losses & Special Payments

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

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

1.32 Subsidiaries

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Notes to the financial statements

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.33 Associates

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 Joint Operations

Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.36 Research & Development

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

2 Other Operating Revenue

	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	£000	£000
Recoveries in respect of employee benefits	**-**	-	-
Patient transport services	**-**	-	-
Prescription fees and charges	**-**	-	-
Dental fees and charges	**-**	-	-
Education, training and research	**-**	-	-
Page	**-**	-	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-	-
Receipt of donations for capital acquisitions: NHS Charity	**-**	-	-
Receipt of Government grants for capital acquisitions	**-**	-	-
Non-patient care services to other bodies	**3,727**	61	3,666
Income generation	**-**	-	-
Rental revenue from finance leases	**-**	-	-
Rental revenue from operating leases	**-**	-	-
Other revenue	**498**	446	52
Total other operating revenue	**4,225**	**507**	**3,718**

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

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

3 Revenue

	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	£000	£000
From rendering of services	**4,225**	**507**	**3,718**
From sale of goods	**-**	**-**	**-**
Total	**4,225**	**507**	**3,718**

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Total Other	Admin Total	Admin Permanent Employees	Admin Other	Programme Total	Programme Permanent Employees	Programme Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**5,123**	3,843	1,280	**5,123**	3,843	1,280	**-**	-	-
Social security costs	**348**	348	-	**348**	348	-	**-**	-	-
Employer Contributions to NHS Pension scheme	**492**	492	-	**492**	492	-	**-**	-	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**-**	-	-	**-**	-	-	**-**	-	-
Gross employee benefits expenditure	**5,963**	**4,683**	**1,280**	**5,963**	**4,683**	**1,280**	**-**	**-**	**-**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**5,963**	**4,683**	**1,280**	**5,963**	**4,683**	**1,280**	**-**	**-**	**-**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**5,963**	**4,683**	**1,280**	**5,963**	**4,683**	**1,280**	**-**	**-**	**-**

4.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	-	-	-
Social security costs	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**-**	**-**	**-**

4.2 Average number of people employed

	2013-14		
	Total Number	Permanently employed Number	Other Number
Total	**110**	94	16
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	416
Total Staff Years	92
Average working Days Lost	5

The above figures were supplied by the Department of Health and are based on the figures for the 9 months from April to December 2013.

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**

Ill health retirement costs are met by the NHS Pension Scheme

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

The CCG has no exit packages agreed in 2013/14.

4.5 Pension costs

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

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

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

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 Pension costs (continued)

4.5.1 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• 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 the statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	4,489	4,489	-
Executive governing body members	1,474	1,474	-
Total gross employee benefits	**5,963**	**5,963**	**-**
Other costs			
Services from other CCGs and NHS England	**4,881**	3,639	1,242
Services from foundation trusts	**236,581**	-	236,581
Services from other NHS trusts	**115,363**	-	115,363
Services from other NHS bodies	**-**	-	-
Purchase of healthcare from non-NHS bodies	**77,996**	-	77,996
Chair and lay membership body and governing body members	**126**	126	-
Supplies and services – clinical	**796**	-	796
Supplies and services – general	**173**	173	-
Consultancy services	**1,143**	1,143	-
Establishment	**526**	335	191
Transport	**6**	6	-
Premises	**394**	69	325
Impairments and reversals of receivables	**-**	-	-
Inventories written down	**-**	-	-
Depreciation	**-**	-	-
Amortisation	**-**	-	-
Impairments and reversals of property, plant and equipment	**250**	250	-
Impairments and reversals of intangible assets	**-**	-	-
Impairments and reversals of financial assets	**-**	-	-
· Assets carried at amortised cost	**-**	-	-
· Assets carried at cost	**-**	-	-
· Available for sale financial assets	**-**	-	-
Impairments and reversals of non-current assets held for sale	**-**	-	-
Impairments and reversals of investment properties	**-**	-	-
Audit fees	**110**	110	-
Other auditor's remuneration			
· Internal audit services	**45**	45	-
· Other services	**-**	-	-
General dental services and personal dental services	**-**	-	-
Prescribing costs	**68,822**	-	68,822
Pharmaceutical services	**-**	-	-
General ophthalmic services	**-**	-	-
GPMS/APMS and PCTMS	**3,250**	-	3,250
Other professional fees excl. audit	**229**	229	-
Grants to other public bodies	**4,000**	-	4,000
Clinical negligence	**1**	1	-
Research and development (excluding staff costs)	**-**	-	-
Education and training	**46**	46	-
Change in discount rate	**-**	-	-
Other expenditure	**168**	-	168
Total other costs	**514,906**	6,172	508,734
Total operating expenses	**520,869**	**12,135**	**508,734**

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

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	7,665	61,063
Total Non-NHS Trade Invoices paid within target	7,518	59,603
Percentage of Non-NHS Trade invoices paid within target	98.08%	97.61%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,550	339,327
Total NHS Trade Invoices Paid within target	2,521	338,895
Percentage of NHS Trade Invoices paid within target	98.86%	99.87%

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

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

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	-

7 Income Generation Activities

The CCG does not undertake any income generation activities to report in 2013/14

8. Investment revenue

The CCG has no investment revenue to report in 2013/14

9. Other gains and losses

The CCG has no gains or losses to report in 2013/14

10. Finance costs

The CCG has no finance costs to report in 2013/14

11. Net gain/(loss) on transfer by absorption

The CCG has no gain/loss on transfer by absorption to report in 2013/14.

12. Operating Leases

12.1 As lessee

The CCG occupies and pays rent on Southgate House, Devizes, a property owned by NHS Property Services Limited. There is no contract currently in place even though the nature of the transaction conveys the right for the CCG to use the property. Under paragraph 9 of IFRIC 4 these arrangements are a lease and as such accounted for in accordance with IAS 17. Payments in respect of this arrangement for 2013-14 are disclosed below. The CCG receives income from other organisations which occupy part of the property, although no contracts are in place relating to this arrangement. The lease income for 2013-14 is separately disclosed in these accounts. In the absence of formal contracts it is not possible to quantify the future minimum lease payments or lease income receivable.

12.1.1 Payments recognised as an Expense

	2013-14			
	Land	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Payments recognised as an expense				
Minimum lease payments	**-**	**365**	**8**	**373**
Contingent rents	**-**	**-**	**-**	**-**
Sub-lease payments	**-**	**-**	**-**	**-**
Total	**-**	**365**	**8**	**373**

12.1.2 Future minimum lease payments

	2013-14			
	Land	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Payable:				
No later than one year	**-**	**-**	**6**	**6**
Between one and five years	**-**	**-**	**5**	**5**
After five years	**-**	**-**	**-**	**-**
Total	**-**	**-**	**11**	**11**

12.2 As lessor

The CCG has no operating leases as a lessor.

13 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**-**	**-**	**-**	**-**	**7**	**-**	**243**	**-**	**250**
Adjusted Cost or valuation at 1 April 2013	**-**	**-**	**-**	**-**	**7**	**-**	**243**	**-**	**250**
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	**-**
Additions purchased	-	-	-	-	-	-	-	-	**-**
Additions donated	-	-	-	-	-	-	-	-	**-**
Additions government granted	-	-	-	-	-	-	-	-	**-**
Additions leased	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	**-**
Disposals other than by sale	-	-	-	-	-	-	-	-	**-**
Upward revaluation gains	-	-	-	-	-	-	-	-	**-**
Impairments charged	-	-	-	-	(7)	-	(243)	-	**(250)**
Reversal of impairments	-	-	-	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	**-**
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	**-**
At 31 March 2014	**-**	**-**	**-**	**-**	**0**	**-**	**-**	**-**	**-**
Depreciation 1 April 2013	-	-	-	-	-	-	-	-	**-**
Adjusted depreciation 1 April 2013	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	**-**
Disposals other than by sale	-	-	-	-	-	-	-	-	**-**
Upward revaluation gains	-	-	-	-	-	-	-	-	**-**
Impairments charged	-	-	-	-	-	-	-	-	**-**
Reversal of impairments	-	-	-	-	-	-	-	-	**-**
Charged during the year	-	-	-	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	**-**
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	**-**
At 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net Book Value at 31 March 2014	**-**	**-**	**-**	**-**	**0**	**-**	**-**	**-**	**0**
Purchased	-	-	-	-	0	-	(0)	-	**(0)**
Donated	-	-	-	-	-	-	-	-	**-**
Government Granted	-	-	-	-	-	-	-	-	**-**
Total at 31 March 2014	**-**	**-**	**-**	**-**	**0**	**-**	**(0)**	**-**	**(0)**
Asset financing:									
Owned	-	-	-	-	0	-	(0)	-	**(0)**
Held on finance lease	-	-	-	-	-	-	-	-	**-**
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	**-**
PFI residual: interests	-	-	-	-	-	-	-	-	**-**
Total PFI & LIFT assets	-	-	-	-	-	-	-	-	**-**
Total at 31 March 2014	**-**	**-**	**-**	**-**	**0**	**-**	**(0)**	**-**	**(0)**

Revaluation Reserve Balance for Property, Plant & Equipment

The CCG has no revaluation reserve.

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction
The CCG has no assets under construction in 2013/14

13.2 Donated assets
The CCG has no donated assets to report in 2013/14

13.3 Government granted assets
The CCG has no government granted assets to report in 2012/13

13.4 Property revaluation
The CCG has no property revaluations to report in 2012/13

13.5 Compensation from third parties
The CCG has no compensation from third parties to report in 2013/14

13.6 Write downs to recoverable amount
The CCG has no write downs to recoverable amounts to report in 2013/14

13.7 Temporarily idle assets
The CCG has no temporarily idle assets to report at 31 March 2014

13.8 Cost or valuation of fully depreciated assets
The CCG has no fully depreciated assets to report at 31 March 2014

13.9 Economic lives
The CCG has no economic lives to report in 2013/14

14 Intangible non-current assets
The CCG has no intangible non-current assets to report in 2013/14

15 Investment property
The CCG has no investment property at 31 March 2014

16 Inventories
The CCG has no inventories at 31 March 2014

17 Trade and other receivables

	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	**1,195**	**-**
NHS receivables: Capital	**-**	**-**
NHS prepayments and accrued income	**3**	**-**
Non-NHS receivables: Revenue	**1,028**	**-**
Non-NHS receivables: Capital	**-**	**-**
Non-NHS prepayments and accrued income	**8**	**-**
Provision for the impairment of receivables	**-**	**-**
VAT	**137**	**-**
Private finance initiative and other public private partnership arrangement prepayments and accrued income	**-**	**-**
Interest receivables	**-**	**-**
Finance lease receivables	**-**	**-**
Operating lease receivables	**-**	**-**
Other receivables	**-**	**-**
Total	**2,371**	**-**
Total current and non current	**2,371**	
Included above:		
Prepaid pensions contributions	**-**	

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

17.1 Receivables past their due date but not impaired

	2013-14 £000
By up to three months	**44**
By three to six months	**-**
By more than six months	**-**
Total	**44**

£16k of the amount above has subsequently been recovered post the statement of financial position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables

The CCG has not provided for impairment of receivables.

18 Other financial assets

The CCG has no other financial assets to report at 31 March 2014

19 Other current assets

The CCG has no other current assets to report at 31 March 2014

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	**-**
Net change in year	**(21)**
Balance at 31 March 2014	**(21)**
Made up of:	
Cash with the Government Banking Service	**(21)**
Cash with Commercial banks	**-**
Cash in hand	**-**
Current investments	**-**
Cash and cash equivalents as in statement of financial position	**(21)**
Bank overdraft: Government Banking Service	**(21)**
Bank overdraft: Commercial banks	**-**
Total bank overdrafts	**(21)**
Balance at 31 March 2014	**-**

The CCG does not hold any patients monies

21 Non-current assets held for sale

The CCG has no non-current assets held for sale to report at 31 March 2014

22 Analysis of impairments and reversals

22.1 Analysis of impairments and reversals: property, plant and equipment

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Total charged to departmental expenditure limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	(250)
Change in market price	-
Total charged to annually managed expenditure	(250)
Total impairments and reversals charged to the statement of comprehensive net expenditure	(250)
Impairments and Reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total impairments and reversals of property, plant and equipment charged to the revaluation	-
Total impairments and reversals of property, plant and equipment	(250)

22 Analysis of impairments and reversals cont'd

22.2 Analysis of impairments and reversals: Intangible assets

The CCG has no intangible non-current assets to report in 2013/14

22.3 Analysis of impairments and reversals: investment property

The CCG has no investment property to report in 2013/14

22.4 Analysis of impairments and reversals: inventories

The CCG has no inventories to report in 2013/14

22.5 Analysis of impairments and reversals: financial assets

The CCG has no impairments and reversals of financial assets to report in 2013/14

22.6 Analysis of impairments and reversals: non-current assets held for sale

The CCG has no non-current assets to report in 2013/14

22.7 Analysis of impairments and reversals: totals

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Departmental expenditure limit	(250)
Annually managed expenditure	-
Total impairments and reversals charged to the SoCNE	(250)
Impairments and reversals charged to the revaluation reserve	-
Total impairments	(250)
Of the above:	
Impairment on revaluation to “modern equivalent asset” basis	-
Impairments and reversals of donated and government granted assets charged to the statement of comprehensive net expenditure included above:	
Property, plant & equipment charged to departmental expenditure limit	-
Intangible assets charged to departmental expenditure limit	-
Total charged to departmental expenditure limit	-
Property, plant & equipment charged to annually managed expenditure	-
Intangible assets charged to annually managed expenditure	-
Total charged to annually managed expenditure	-
Total impairments and reversals of donated and government granted assets charged to the statement of comprehensive net expenditure	-

The CCG inherited fixed assets from Wiltshire Primary Care Trust at the 1 April 2013 as a consequence of the government reorganisation of the National Health Service resulting in the closure of PCTs. The assets had been classified as Information Technology and Plant And Machinery. The CCG was unable to substantiate the existence of individual assets and their value, and therefore impaired these assets at their inherited value at 1 April 2013.

23 Trade and other payables

	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	6,258	-
NHS payables: capital	-	-
NHS accruals and deferred income	73	-
Non-NHS payables: revenue	2,426	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	16,546	-
Social security costs	52	-
VAT	-	-
Tax	59	-
Payments received on account	-	-
Other payables	211	-
Total	25,625	-
Total payables (current and non-current)	25,625	

There are no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years.
Other payables include £73k outstanding pension contributions at 31 March 2014.

24 Other financial liabilities

The CCG has no other financial liabilities to report at 31 March 2014

25 Other liabilities

The CCG has no other liabilities to report at 31 March 2014

26 Borrowings

	Current 2013-14 £000	Non-current 2013-14 £000
Bank overdrafts:		
· Government banking service	21	-
· Commercial banks	-	-
Total overdrafts	21	-

The CCG cash position is reported in the financial statements as an overdraft due to payments scheduled to clear after the year end. As at 31 March 2014, the CCG had a net positive cash balance deposited in its Government Banking Service bank accounts of £67k.

27 Private finance initiative, LIFT and other service concession arrangements

The CCG has no private finance initiative, LIFT or other service concession arrangements to report at 31 March 2014.

28 Finance lease obligations

The CCG has no finance lease obligations to report at 31 March 2014

29 Finance lease receivables

The CCG has no finance lease receivables to report at 31 March 2014

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	-	-
Redundancy	-	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	-	-
Continuing care	168	-
Other	-	-
Total	168	-

Total current and non-current	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	-	-	-	-	-	168	-	168
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	168	-	168
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	168	-	168
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	168	-	168

Continuing Care - This provision relates to existing retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the CHC panel. The liability has been estimated based on claims received, periods covered and estimated weekly costs.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £3,148k.

From 2014/15, all CCGs will contribute to a risk-sharing pool to be used by NHS England for legacy provision payments.

31 Contingencies
The CCG has no contingencies to report at 31 March 2014

32 Commitments

32.1 Capital commitments
The CCG has no capital commitments to report at 31 March 2014

32.2 Other financial commitments
The CCG has no other financial commitments to report at 31 March 2014

33 Financial instruments

33.1 Financial risk management
Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

Treasury management operations are carried out by the Central Southern Commissioning Support Unit under contract with the CCG, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG's internal auditors.

33.1.1 Currency risk

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

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

33.1.3 Credit risk
Because the majority of the CCG's revenue comes parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk
The CCG is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, from NHS England, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	1,195	-	1,195
· Non-NHS	-	1,028	-	1,028
Cash at bank and in hand	-	-	-	-
Other financial assets	-	-	-	-
Total at 31 March 2014	-	2,223	-	2,223

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	6,330	6,330
· Non-NHS	-	18,972	18,972
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	21	21
Other financial liabilities	-	-	-
Total at 31 March 2014	-	25,323	25,323

33.4 Maturity of Financial liabilities

All financial liabilities mature within one year.

	Payable to DH	Payable to Other Bodies	Total
	£000	£000	£000
In more than one year but not more than two years		25,302	25,302
In more than two years but not more than five years			
In more than five years			
Total at 31 March 2014	-	25,302	25,302

34 Operating segments

The CCG considers it has only one segment - the commissioning of healthcare services.

	2013-14 £000
Gross expenditure	520,869
Income	(4,225)
Net expenditure	516,644
Total assets	2,350
Total liabilities	(25,793)
Net assets	(23,443)

35 Pooled budgets

The CCG has no pooled budgets to report in 2013/14

36 NHS Lift investments

The CCG has no Lift investments to report at 31 March 2014

37 Intra-government and other balances

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	-	-	231	-
· Local Authorities	524	-	1,595	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	505	-	255	-
· NHS Trusts and Foundation Trusts	693	-	6,076	-
Total of balances with NHS bodies:	1,198	-	6,331	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	649	-	17,468	-
Total balances at 31 March 2014	2,371	-	25,625	-

38 Related party transactions

During the year none of the board members of the governing body or members of the key management staff, or parties relating to any of them, have undertaken any material transactions with the CCG other than those disclosed below.

			Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Avon Valley Practice	Dr Peter Jenkins	GP Medical Advisor	379	0	5	0
Bourne Valley Practice	Dr Celia Grummitt	GP Vice Chair-Sarum	16	0	0	0
Bradford Road Medical Centre	Dr Steve Rowlands*	GP Chair	53	0	0	0
Castle Practice	Dr Toby Davies	GP Chair-Sarum	196	0	1	0
Courtyard Surgery	Dr Helen Osborn	GP Chair-WWYKD	145	0	1	0
Cross Plain Surgery	Dr Celia Grummitt	GP Vice Chair-Sarum	228	0	4	0
Porch Surgery	Dr Simon Burrell	GP Chair-NEW	268	0	1	0
Ramsbury Surgery	Dr Jonathon Raynor	GP Vice Chair-NEW	879	0	0	1
Westbury Group Practice	Dr Debbie Beale	GP Vice Chair-WWYKD	624	0	3	0
NHS Dorset CCG	Mary Monnington	Registered Nurse	169	550	0	0
Rainbow 2 Ltd	Dr Celia Grummitt	GP Vice Chair-Sarum	55	0	0	0
Salisbury Walk-in Centre (WilcoDoc)	Dr Toby Davis, Dr Peter Jenkins	GP Chair - Sarum GP Medical Advisor	942	0	0	0

GP practices within the area have joined other professionals in the CCG in order to plan, design and pay for services. Under these arrangements some services are designed to be delivered in a primary care setting. This involves paying GP practices for the delivery of these services. A GP is also paid by the CCG for taking a lead role on clinical services. All such arrangements are in the ordinary course of business and follow the CCG's strict governance and accountability arrangements. Material transactions are disclosed appropriately in the accounts.

* Dr Steve Rowlands retired as a partner in the practice in July 2013

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

Avon and Wiltshire Mental Health Partnership NHS Trust
Great Western Hospitals NHS Foundation Trust
Royal United Hospital Bath NHS Trust
Salisbury NHS Foundation Trust
South West Ambulance Service NHS Foundations Trust
NHS England

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

39 Events after the end of the reporting period

There are no events after the end of the reporting period which will have a material effect on the financial statements of the CCG.

40 Losses and special payments

The CCG has no losses or special payments to report in 2013/14

41 Third party assets

The CCG has no third party assets to report at 31 March 2014

42 Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended).
This CCG's performance against those duties was as follows:

	2013-14		
	Maximum £000	**Performance £000**	**Duty Achieved**
Expenditure not to exceed income	525,904	520,869	**Yes**
Capital resource use does not exceed the amount specified in Directions	-	-	-
Revenue resource use does not exceed the amount specified in Directions	521,679	516,644	**Yes**
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	4,000	4,000	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	11,660	11,627	**Yes**

43 Impact of IFRS

IFRS has no material impact on the financial statements of the CCG.

44 Analysis of charitable reserves

The CCG has no analysis of charitable reserves to report at 31 March 2014