NHS
Wiltshire
Clinical Commissioning Group

Annual Report and Accounts 2014/15

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Member Practices' Introduction

Member Practices' Introduction

NHS Wiltshire Clinical Commissioning Group (CCG) is responsible for commissioning healthcare on behalf of the people of Wiltshire. The CCG comprises GP practices across the county and exists to provide local clinical leadership to the big decisions affecting the future of healthcare provision across the county, carefully tailored to meet the differing needs of people locally. We achieve this by putting Wiltshire GPs in the driving seat of all major decisions affecting healthcare provision. Our aim is to make clinically led decisions suited to local needs, and derive plans which address the future requirements of the people of Wiltshire.

The CCG is headed by a Governing Body which is led by local GPs, supported by lay members and an executive team. Because Wiltshire is largely a dispersed, rural community, the collective, specific, local knowledge of our GPs is crucial to our approach. We want to ensure that quality and patient experience remains at the forefront of everything we do. Accordingly, we work closely with our providers (hospitals, community services, social care, mental health, ambulance and transport) – the organisations we commission (or buy) care from – to ensure that system wide we have a patient-centred culture and that we have the right early warning systems in place if anything should go wrong. Indeed, we have developed strong and constructive relationships with our key system partners, which are reaping rewards in terms of county wide transformation and delivery of services. This includes regular Board to Board meetings, as well as very senior regular meetings between the Chief Executives and Finance Directors across the system. 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.

As well as successfully managing the delivery of the performance of health services over the past, very challenging, year, the CCG has also developed a 5 Year Strategic Plan, which complemented the Wiltshire Health and Wellbeing Strategy, and a 2 Year Operational Plan to start to turn that strategy into action. We have already started to deliver; at the same time we worked in close partnership with Wiltshire Council to develop the Wiltshire Better Care Plan. Pleasingly, the subsequent publication of the NHS England Five Year Forward view entirely validated our own strategic aspirations, and we were delighted that Wiltshire's Better Care Plan was one of only five to be fast tracked and achieve early approval nationally. As part of the development of both, we engaged closely with the public, perhaps most notably by hosting a series of public meetings, and attending, alongside colleagues from Wiltshire Council each health and wellbeing themed Area Board meeting in the autumn of 2014. This helped us to respond to valuable feedback, although it is fair to say that the concepts of our plans received very strong levels of public support. We also have drawn heavily on our strong and productive relationships with key system partners from the three major hospitals which support Wiltshire (Salisbury Foundation Trust, the Royal United Hospital in Bath and the Great Western Hospital in Swindon), and they have each been closely involved with the development of our strategy and plans – and of course they are key to our delivery.

Our vision remains that Health and Social Care services in Wiltshire should support and sustain independent healthy living based on three principles:

- People are encouraged and supported to take responsibility for, and to maintain/enhance their well-being.

- 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 close to home:

  - 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.

Absolutely fundamental to the delivery of this vision is the strong system partnership we have with our Acute hospital; colleagues, who absolutely support this direction of travel. We are also committed to the integration of health and social care and yet closer working with Wiltshire Council. Having invested significantly across the system in order to derive and agree our strategy, the CCG's intention is to continue to drive ahead and make commissioning decisions which start to make the necessary changes to deliver the new model of care.

Indeed several of the key elements have already started to be delivered:

- Most importantly we have established 20 Multidisciplinary teams across the county. These fully integrated patient centred local multi-disciplinary teams (comprising community nursing staff, therapists, mental health workers and social workers) based in our communities are a fundamental building block of our strategy. They build on the existing strength of primary care across the county, with the teams designed to wrap around primary care practices, being led and co-ordinated by our GPs. We established 3 pathfinder sites in Calne, Bradford on Avon/Melksham and Salisbury, and each has made excellent progress; we are applying the learning as the remaining 17 rapidly mobilise, assisted by our partners from Great Western Hospital, our current provider of health community services, who are starting to deliver the additional workforce required.

- In that vein we have successfully recruited and established Care Co-ordinators county wide, delivering one of the CCG's very early aspirations. The coordinators, based in GP practices, help 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 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.

All this is already delivering improved out of hospital care. Despite some very significant challenges in the levels of activity we have seen in the health system over the past 12 months, by the latter part of the year we were achieving a reducing trend of activity across the county.

A fundamental building block on our journey is the re-procurement of our Adult Health Community Services provision, a process already underway and with an implementation date of July 2016. This will be a key factor in delivering the transformation we aspire to – with integration of service provision at the heart.

We will continue to build on the excellent foundations of primary care in the county, and strengthen that by encouraging federation across primary care practices. Given the importance of primary care in the delivery of our model, we have exploited the opportunity to become a co-commissioner of primary care services. This will give us more control over the future direction and delivery of primary care, which was previously the domain of our NHS England colleagues. We are also encouraging empowerment of non GP clinicians to free up GP capacity, extended hours and provision of locally tailored support targeted to meet the specific needs of our largely rural, but each individual, communities, and are delivering localised plans to achieve this. We also have an aspiration to enhance primary care provision to include greater access to urgent care services without recourse to A&E. Indeed, we have utilised the funding provided under the Transforming Care of Older People programme to encourage local innovation to improve support to the frail and elderly cohort of our population, and have a scheme live under this programme in every part of the county. The patient is firmly at the centre of our model of care, but we have established significant clinical leadership by local GPs of the multi-disciplinary teams (our horizontal integration lever), assisted by a bespoke development programme, to properly utilise the capability they can deliver, and we aspire to better use new technology to improve the patient experience (as well as reduce unnecessary or unproductive clinician/patient contact time).

We are also establishing a Wiltshire Institute of Health and Social Care to underpin the delivery of our care model, ensuring a workforce which is fit for purpose into the future, and already work well with our Care home providers who we see as fundamental to our success. In this way we aim to deliver more outpatient type services and ambulatory care in the community rather than at an acute hospital, and we are developing proposals to help to manage more activity from an unplanned to a planned setting, including improved access for primary care to diagnostic services. At the same time we are working with our secondary care colleagues to encourage a “hospital without walls” approach, employing more consultant expertise in our community and driving all the potential benefits of vertical integration. We want to grow our capacity in intermediate care, but not just by utilising our community hospital capacity but by working with our providers to radically upgrade the capability of the full range of intermediate care provision and support. We have already enjoyed success with work on our Discharge to Assess scheme, and want to reinforce that in the future by increasing the existing provision of robust rapid response and rehabilitation/ re-ablement.

2014/15 has thrown up many new challenges, one of which has been the significant increase in demand for planned and unplanned care, which has reflected a national phenomenon. This demand has put a huge pressure on the health system across acute, community and primary care as well as significantly challenging the financial position of the CCG. We know that in the NHS, our front line staff have performed exceptionally well, but self-evidently, and as we know from all the analysis which underpinned our Strategic Plan, such trends are not sustainable either in financial or capacity terms. Accordingly, we have worked hard with our system partners to achieve consensus and a commitment to working together to bring the demand for health services within the resources available – and delivery of our strategy is the right tool for the job.

We recognise the importance of safeguarding the sustainability and stability of the entire Wiltshire health economy in order to deliver the quality of healthcare we aspire to in the context of our large, rural and widely dispersed population/geography.

We believe that notwithstanding the many challenges we still face, we have made good progress over the last year. We have commissioned services that are already creating significant improvements to the NHS in Wiltshire, and have the right relationships and strong plans in place, and already being delivered, to take us forward. 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.

Strategic Report

Strategic Report

Introduction

The Governing Body are pleased with the progress made over the last year. The Governing Body has overseen the early delivery of our well received strategy, the development of which was closely guided by Governing Body members. In particular, the Governing Body has been delighted to see the early success being achieved by the delivery of this strategy in the form of integrated teams, care co-ordinators and improved provision of community services. We have been impressed by the strong clinical leadership provided by our productive and constructive System Resilience Group, which includes representation from across the entire county's health and social care system. Indeed via this group we have succeeded in the past year in delivering some unprecedented examples of co-operation and common approaches from our colleagues.

Performance has been regularly and carefully scrutinised utilising the rich depth of information presented in our 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 – this is our performance management framework.

The Governing Body has continued to invest some time and effort in developing and enhancing their own performance. This has included follow up self-analysis and reflection following some specialist consultancy support last year, and an away day session to formulate new ideas about the internal structure of the CCG to even better equip us for the next important stage of our journey. Furthermore, we are investing in a group of emerging GP future leaders, and have implemented an internal development programme to support this element of talent management and succession planning.

The Governing Body recognises the strong development of our crucial partnerships with health system colleagues and Wiltshire Council, which manifested itself in the highly successful Better Care Plan, but more routinely is evidenced by the nature of the Health and Wellbeing Board, and the Joint Commissioning Board which supports it. Indeed we were delighted to note the outcome of a Health and Wellbeing peer review in late 2014, the main conclusion of which was that, as a partnership, we were doing the right things and doing them well.

We remain strongly committed to delivering transformational change and in particular we aspire to much improved vertical and horizontal integration across our system to improve the delivery of seamless care for individuals where services are more effectively joined up. We have already started to make good progress in this regard via a number of developments already in delivery, such as:

- Strong progress made in breaking down pre-existing organisational barriers within the system, characterised by our strong Better Care Plan as well as the well established joint governance underneath the Health and Wellbeing Board of our Joint Commissioning Board, all underpinned by a well found Joint Business Agreement. This has already delivered, amongst other things, pooled budgets for carers and stable emergency admissions. Progress is monitored via a jointly conceived governance group, chaired and led by our Integration Director a post jointly appointed (and funded) with Wiltshire Council.

- We have established 20 integrated Multi-disciplinary teams across the county, and have used 3 lead demonstrator sites to pilot the concept and ways of working. These have made genuinely exciting progress and we have been able to test and adjust to tailor to specific local needs, as well as utilise the learning from each to help speed implementation elsewhere. We have recruited Care Co-ordinators and made significant additional investment in augmenting the current Community Services workforce, as well as the application of modern risk stratification techniques

- With regard to our better Care Plan, as one of only five Fastrack sites in the country, where Wiltshire has led other areas have followed. During 14/15 we have successfully implemented the key priorities resulting in improved outcomes for our population, greater integration at the point of need and active engagement of all our stakeholders. Our ambitious programme led to the launch of a number of integrated schemes including

    - step up intermediate care and crisis management in community settings
    - launch of our access to care service and one number for all health and social care referrals
    - enhanced urgent care at home including rapid access re-ablement and end of life services
    - focused integrated case management at GP level
    - bed based and non bed based discharge to assess -daily system wide operational dashboard
    - system review of intermediate care which involved a range of focused Individual client journey reviews

  This approach has proved successful not only in galvanising our approach across the system but in reducing non elective length of stay, volume of non-elective admissions and readmissions. As a result, we now have a solid evidence base to underpin the Better Care plan and the CCG commissioning priorities for 2015/16.

- We are going to exploit new freedoms such as Co-Commissioning Primary Care, which along with our innovation born out of the Transforming Care for Older People Funding is starting to see new ways of improving locally delivered care and drive ideas for federation within primary care. We have bespoke plans in place covering all our GP practices, locally tailored and clinically conceived to deliver enhanced capacity and capability for the care of our older people in community settings, at our close to their own homes.

- The agreement for future IT support in both our community and out of hours settings to migrate to one platform to facilitate better communication and visibility; we are also committed under the Better Care Plan to pursue a system which enables a single view of the customer system wide. That will enable the sharing of records to improve the consistency and continuity of care to individuals, enabling them to tell their story once and improving the access to and exploitation of information.

- We have achieved good results from implementing a simple point of access, which is able to link health and social care professionals to coordinate and provide rapid access to primary, community, community specialist support, social care etc. especially for complex cases. The Urgent Care at Home Service prevents people from falling between gaps in care and allows people to be held at home while care packages are put in place, preventing over 400 emergency admissions in the last year.

- We have established community step up beds for GPs to access for their patients who are in a crisis and need to be stabilised and managed to return home.

- We have recognised the need for major change across the health and social care system. We want to build a system of integrated care for every person in our county and deliver care and support built around the needs of the individual, their carers and family which gets the most out of every penny we spend. In order to achieve this we have jointly committed to a culture of cooperation and coordination between health, social care, public health, other local services and the third sector, and we have started to make significant strides towards achieving it. Implicit in our aspiration is to end the institutional divide between physical and mental health, primary and secondary care, and health and social care. We want to better exploit the clinical expertise that exists within our acute hospitals, shape it more closely around our population clusters, and thereby better utilise that expertise to support community and primary care. In short we want to provide a seamless service focussed on the individual within their own home, closely tailored to local needs. The manner in which our future community services provider is able to deliver will be key in all of this, and we have specified our requirement for an effective integrator – that being a framework which performs a convening role and works intentionally and systemically to achieve improvements in health and well-being.

  Our transformation progress to date has demonstrated significant enthusiasm by professionals in primary and community care, we believe we are seeing the start of a social movement of change that places the patient at the centre of the delivery of their care and support. We have already invested in the augmentation of our Community Care Teams, and they will provide 33,600 additional contacts per year once the investment is fully realised, a 12% increase. GPs and community clinicians have said to us that as a result of this transformation work they have felt a new energy and enthusiasm which they believe is a major step forward for effective care provision. Placing GPs in the driving seat of clinical leadership has enabled this successful change and we look for your national support, through the vanguard status to build on this.

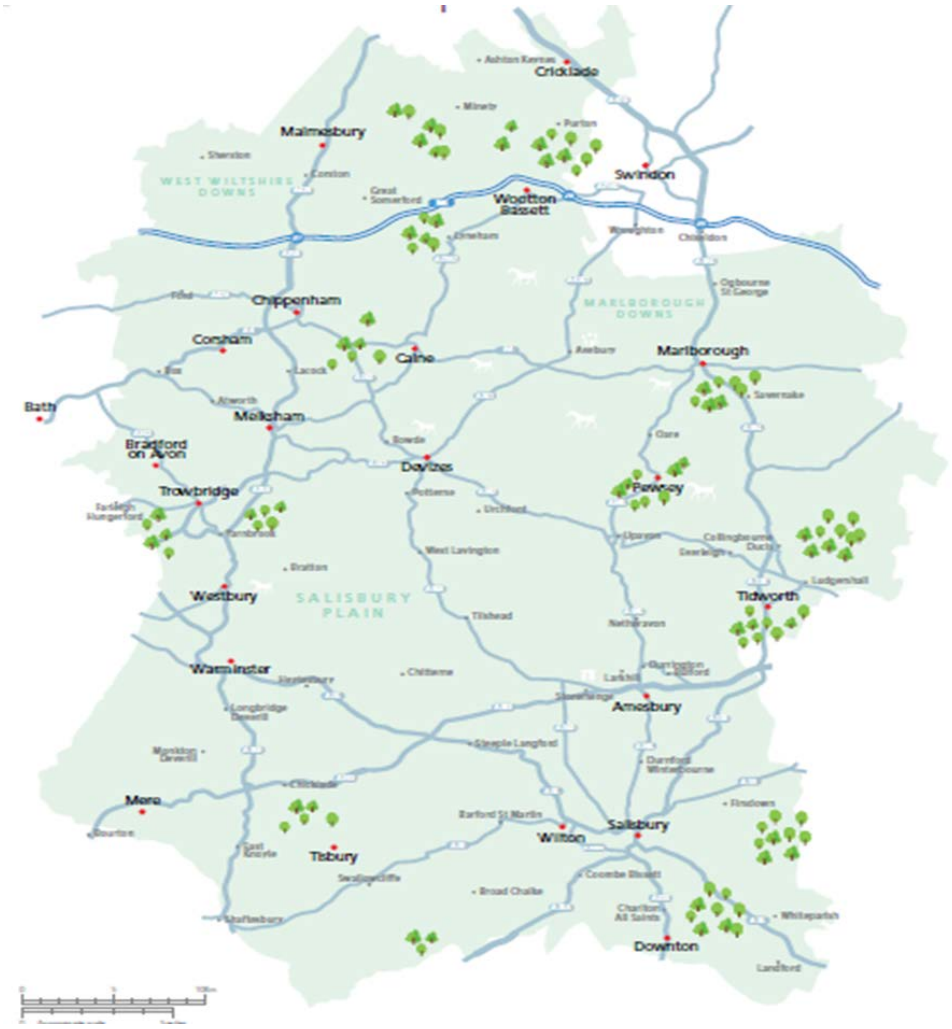
  We intend to continue to make great strides towards the delivery of an integrated out of hospital system, centred around primary and community based care, much of which will be facilitated by our new provision of community services (for which the procurement process is at an early stage, with a projected implementation date of Jul 16). Accordingly, our plans for next year are founded in taking forward change to take us on the next steps towards achievement of our strategic vision.

  During the past year, building on our experience, we have reviewed our commissioning support arrangements. This resulted in the CCG extending our enduring relationship with Central Southern Commissioning Support Unit, albeit under a revised contractual relationship, and with some adjustments to the scope and level of services we procure from them. One of the consequences of this review was to bring entirely back in house staff the provision of quality and finance functions, and we have struck a long term partnership with Attain Commissioning Services to support us with our strategic planning.

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. 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.

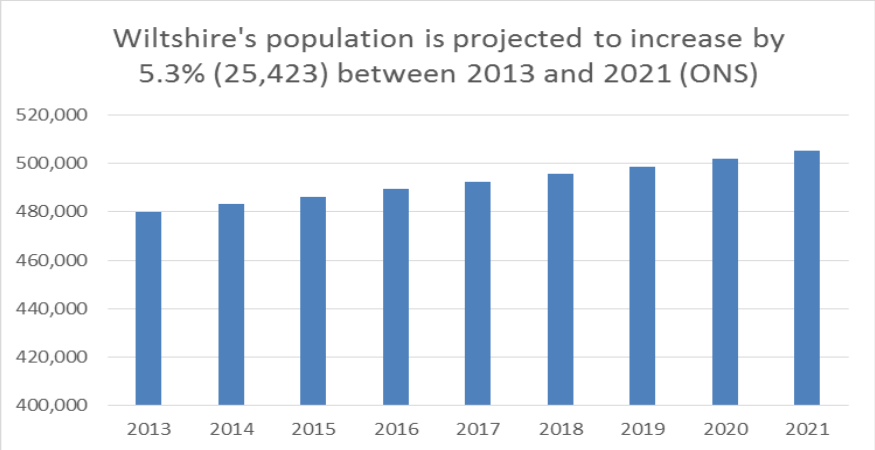
Therefore whilst our population is relatively healthy, we recognise our approach needs to incorporate measures around:

- 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.

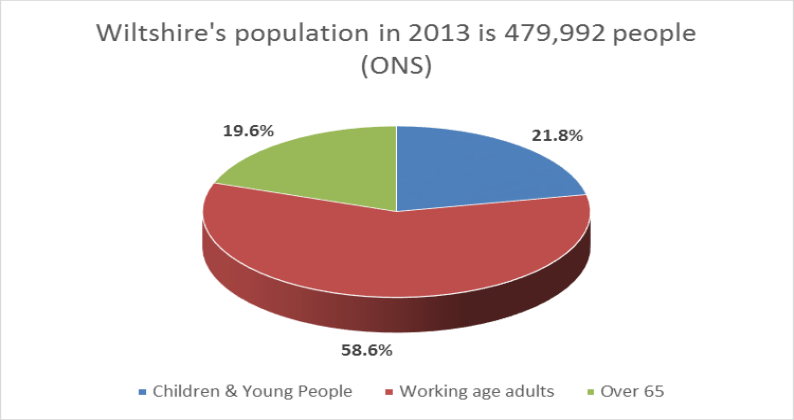
2. **Our population is growing:**

The CCG's population is 480,710 (July 2014), and forecast to grow by an additional 3.3% by 2018, and by 5.3% to 505,416 by 2021. This excludes some additional 10,000 people because of military restructuring and developments in the county.

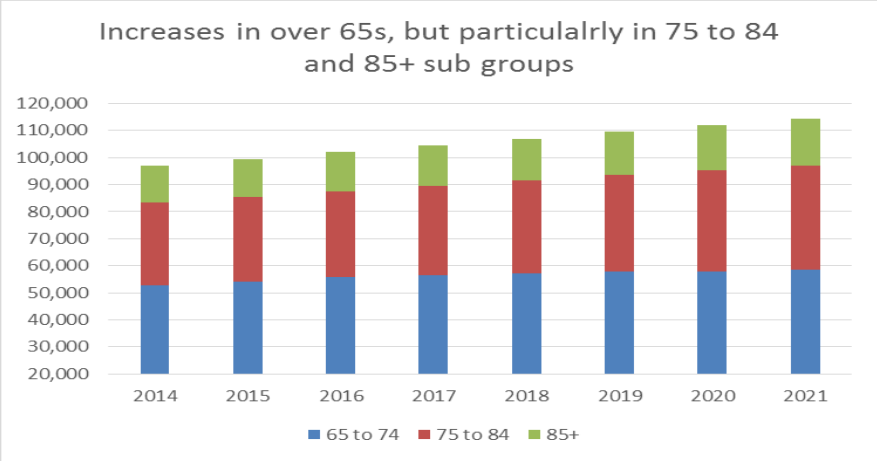


3. Our population is changing:

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.



The CCG has previously used ONS Census population projections when planning future patient activity demand. However, it has become apparent during 2014/15 that the increase in the number of patients registered with Wiltshire GPs has increased by about double the ONS Census rate. Also the growth in GP registered population is greater for the elderly than the younger population. Therefore, the CCG is now planning future levels of demand for NHS services based on GP registered age weighted population growth as it is believed that this is a more accurate method of forecasting future demand. In 2014 Wiltshire saw a 3.23% increase in its population aged over 65 whereas younger people increased by 0.39% and working aged population increased by 0.53%. The elderly consume the largest volume of resources per head, as well as the largest overall proportion of the CCG's resources.

NHS Wiltshire CCG is also involved in modelling the impact on demand for NHS services resulting from the Army 2020 programme which will see additional Army personnel and their dependants locating to Wiltshire over 4 years. Although the numbers are not considered large for Wiltshire as a whole they are a material increase for the Bulford, Larkhill and Tidworth localities.

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).

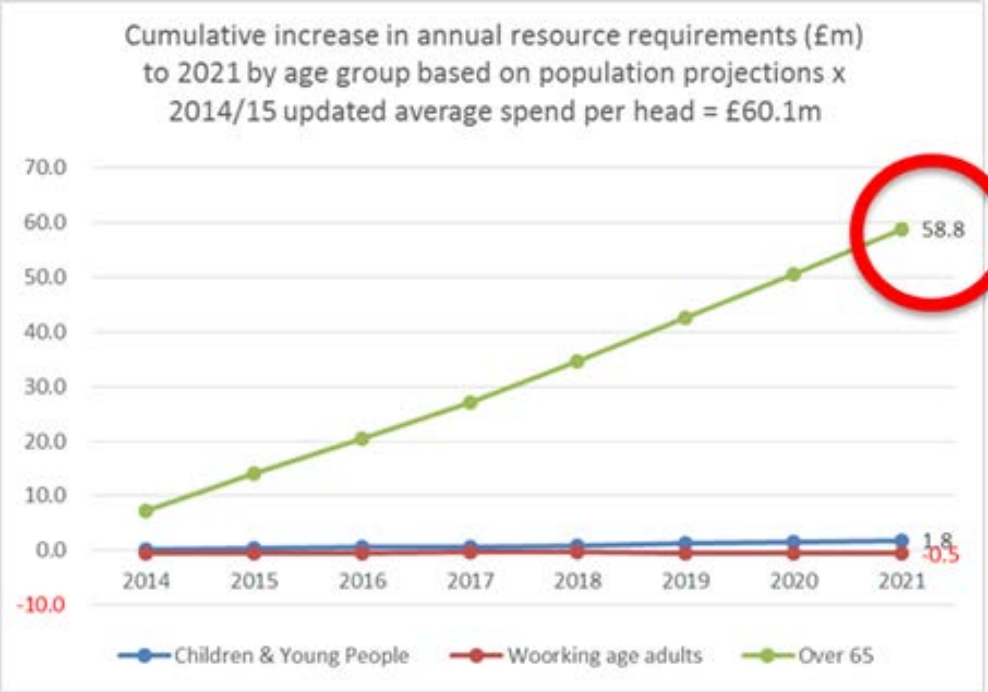
Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS financial resources (48%) are used by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Dementia in particular can affect people of any age, but is most 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 Financial Position

In the last annual report NHS Wiltshire CCG was reporting the strength of its financial position following the achievement of a £5m surplus in 2013/14. It also predicted that in a time of austerity, where nationally the NHS was forecasting a £30billion funding gap by 2020/21, despite NHS budgets being protected by the current government the CCG would start to come under significant financial pressure. For Wiltshire it was predicted that it would have a funding gap of approximately £60million by 2021 if the services it commissioned did not transform in line with the CCG strategy as shown in the graph below:



The financial year 2014/15 has seen the start of the financial pressure that was predicted as the CCG has grappled with the delivery of its strategy. This pressure has come from the expected demographic challenges as the population in Wiltshire is getting older and more frail. Given the CCG spends approximately 48% of its resources on the over 65s who represent 29.9% of the CCG's population the CCG has felt the impact on its financial position which has resulted in a reduced surplus for 2014/15. Given this impact it is essential that the transformational change that was described in the CCG's strategy is delivered at pace in order that the available NHS resources in Wiltshire can cover this pressure.

For 2015/16 the Treasury has recognised the challenge faced by the NHS and has, therefore, increased funding to the NHS by £2billion pounds. For Wiltshire this has resulted in its funding increasing by £13.5million over the original plan.

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

Our Current Performance

NHS Wiltshire CCG and its partners are continuing the transformational journey in a strong 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.
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. Two acute providers score below average, and will be a focus for improvement over the next 12 months.

NHS Outcome Domain	Key Priorities for 2014-16
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 a diagnostic test with a maximum of 6 weeks
- To be admitted, transferred or discharged within 4 hours of their arrival at an A&E department
- 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.

Performance against key national targets

The CCG has 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, the CCG is required to performance manage against a large number of key access and quality standards. The CCG has made significant progress against the achievement of these targets, however, there remain a number of challenges that will be tackled in 2015/16. A summary of the performance achievement is shown in the table below:

Indicator	Achievement (Q1-3)
Referral to treatment for admitted and non-admitted care within 18 weeks	
Number of patients waiting more than 52 weeks	
Patients waiting 6 weeks or more for a diagnostic test	
A&E waits - SFT	
A&E waits - RUH	
A&E waits - GWH	
Cancer patients - 2 week waits	
Cancer waits - 31 days	
Cancer waits - 62 days	
Ambulance calls red 1 response times	
Ambulance calls red 2 response times	
Mixed sex accommodation breaches	
Mental health Care Programme Approach achievement	

Referral-to-Treatment Times (RTT)

It has been a challenging year in relation to delivery of RTT performance for our main providers. Increasing pressure around non-elective care has impacted on elective performance delivery including increased waiting times and cancelled operations. The CCG is seeking further assurance to ensure sustained delivery in particularly relating to waiting times for outpatients, diagnostics and surgical intervention. We are also working with primary and secondary care clinicians to reduce preventable referrals to deliver reduced waiting times for patients. This includes the development of a new MSK model, creation of an integrated community dermatology model and revised pathways for gastroenterology. There have unfortunately been 130 patients who have waited more than 52 weeks. There has been a particular focus on ensuring these patients are booked as quickly as possible.

Diagnostic Waiting Times

The majority of diagnostic performance targets have continued to be met during 2014/15. There is an increasing risk around sustained delivery of six week waits in endoscopy across providers. The CCG is working collaboratively with providers to mitigate this risk. This will be facilitated through the new pan-Wiltshire clinically led gastroenterology working group, which was launched in February 2015.

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).

- As widely reported, the health and social care system encountered an unprecedented level of demand at the end of Quarter 3 2014/15, resulting in a number of system challenges to try and ensure operational resilience. Locally this culmination of demand put pressure on our local hospitals with 4 hour A&E performance at GWH 93.3%, RUH 92.5% and 95.0% up to the end of December 2014. This pressure has continued into quarter 4, with performance YTD to end of February 2015 at GWH 92.2%, RUH 90.7% and SFT 94.9%. Throughout the period the CCG has led escalation calls with the main provider (SFT) and participated in supporting escalation calls with neighbouring CCGs; work is ongoing across the Swindon and Bath systems around the trajectory of performance for Q4.
- During 2014/15 the System Resilience Group, through a variety of funding streams including Operational Resilience and Capacity Planning (ORCP) in two tranches, Marginal Rate, Better Care Fund, Transforming Care for Older Persons and ORCP central allocation, has been responsible for the performance management of a number of investments flowing to health and social care providers to maintain the urgent care system. As of February 2015, there were 28 separately funded initiatives with a total investment of £8.72m of which £4.29m is supported from ORCP funding that was provided in two allocations: £2.76m in tranche one and a further £1.53m in tranche two. With effect from October 2014, for each initiative funded from within the £4.29m, there has been a requirement to identify the main Key Performance Indicators (KPI) baseline and KPI target and report this to NHSE monthly. The funding allocations primary focus has been directed to delivery of the four hour Emergency Department target, and as such the majority of the ORCP investments KPIs have been linked to this objective.

- Great Western Hospitals NHS Foundation Trust has continued to experience difficulties over the past year with the position at the end of March 2015 estimated at 92.2% (as at 15/2/2015). This is below the level seen in 2013/14. There has been a 4.4% increase in patient attendances at the Acute site A&E department.

Cancer Waiting Times

The CCG has continued to achieve the two week wait, 31 and 62 day targets with our providers for the last year. There have been increased pressures particularly related to growth in referrals linked to national awareness campaigns. We will be working during the next year to reduce preventable two week wait referrals by supporting primary and secondary care clinician discussions and service redesign work to ensure patients with suspected cancer continue to have rapid assessment and treatment. We will also be focusing on alternative pathways for follow ups and cancer survivors to support demand and capacity reviews.

Ambulance Calls

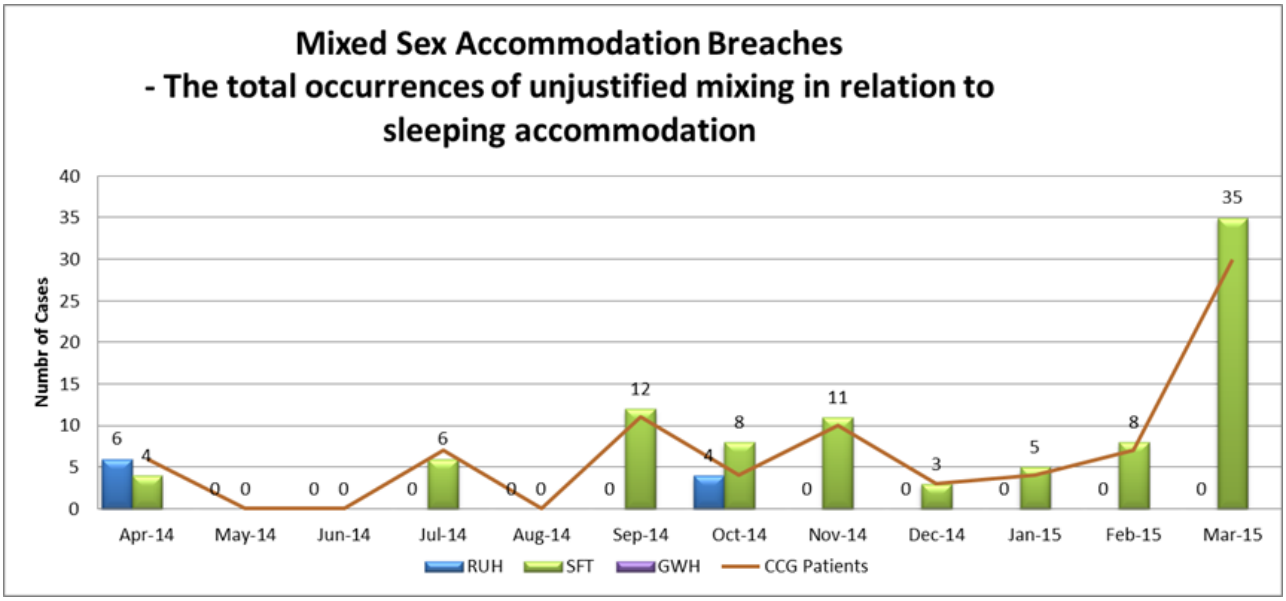
The ambulance calls standards are designed to show the speed of different types of emergency response. Performance around ambulance calls and response times for 2014/15 shows that we have not achieved the required standard of performance we expect for our patients, although there has been a 7.13% improvement for the previous year. We will continue work with our provider around further improvements in Category A Red 1 incidents and achieve a pragmatic way ahead for a large rural county.
Wiltshire is the only CCG in the South West that ended the year 2014/15 under planned activity for the ambulance service. The data also suggests that in addition to being under plan, in Wiltshire the ambulances have to convey a lower percentage to the Accident and Emergency departments than neighbouring areas. There is the lowest percentage of calls conveyed that have originated from an Health Care Professional call, which also indicates that local Health Care Professionals have alternative options.

	All Types See and Convey (A&E Department) Percentage	Excluding HCP Calls See and Convey (A&E Department) Percentage	Originating with HCP See and Convey (A&E Department) Percentage
BaNES	43.93%	40.31%	52.72%
Swindon	42.00%	39.11%	50.56%
Wiltshire	42.65%	40.31%	47.44%

Mixed Sex Accommodation (MSA)

This standard measures whether patients are in mixed sex sleeping accommodation during a hospital stay. The month 11 position in 2013/14 was 25 breaches. For 2014/15 this figure stood at 67 for all Wiltshire acute providers (52 of these were for Wiltshire patients).The year-end total of MSA breaches for all Wiltshire acute providers stands at 102, with 82 of those occurring for Wiltshire patients. Salisbury NHS Foundation Trust has incurred breaches in 9 out of 12 months and has the highest number of breaches (92). Only Great Western Hospitals NHS Trust has achieved their target of zero breaches. The overall MSA position is a significant deterioration on the previous year.

The CCG is determined to address this issue and will continue to work with providers to receive assurance regarding their plans to eliminate MSA breaches during 2015/16.



Cancelled Operations

Increased non-elective pressure in our acute providers has led to both GWH and RUH failing the cancelled operations target for the last financial year. SFT developed actions to protect their elective admissions and delivered the year-end target. NHS Wiltshire CCG will be seeking further assurance during Q1 of the next financial year to reduce the risk of elective operations being cancelled for non-clinical reasons.

Mental Health

During the year we have achieved the following:

Adult Mental Health:

- Commissioned a new service for people with Attention Deficit Hyperactivity Disorder (ADHD) that started operating in Wiltshire in July 2014;
- Successfully agreed, with our partners, a Mental Health Crisis Care Concordat across Wiltshire and Swindon, and agreed a detailed action plan to implement the improvements needed in services that have been identified by the partners;
- Continued to commission a successful Improving Access to Psychological Therapies (IAPT) service through the LIFT psychology service from AWP that offers open access, accessible sessions across Wiltshire for people to book onto on-line and positive outcomes

Learning Disabilities (LD):

- Successfully negotiated the transfer of LD Psychiatrist posts from Southern Health NHS Foundation Trust to AWP;
- Developed the specification for an intensive support service to support people, in their own homes wherever possible, facing challenges or crises. The service will be commissioned from AWP from 1 April 2015;
- Agreed a specification for Community Teams for People with a Learning Disability (CTPLD) that is included in the Community Service Procurement;

- Work continues on the Daisy Project that is being developed to ensure suitable and appropriate local facilities for people that have been affected by the Winterbourne View Enquiry and other people who have complex needs and are currently placed away from Wiltshire.

Progress against agreed targets

In order to deliver our visions and aims, the Governing Body agreed seven key priorities for 2014/15.

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	• We want to provide more integrated, collaborative and seamless health and social care services to support the population of Wiltshire. • We want to provide more of those services in the home or community to support local decision making on health and care issues and to avoid decisions being made in crisis.
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.

Priority	High Level Targets
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

- The Musculoskeletal Programme Board engaged with patients and clinicians to revise the clinical policy and pathway for spinal injections and this was agreed and further reviewed after 6 months;
- The Musculoskeletal Programme Board developed a new MSK model to deliver a fully integrated community based MSK model which promotes self-responsibility through shared decision making and rapid access to the most appropriate intervention or diagnostics. Early adopter sites commencing June 2015;
- Service Level Agreements were put in place to support efficient referral practice and a pilot of a templated system on GP systems was run in the Sarum Group;
- An integrated community and consultant dermatology service model was developed and agreed to be piloted in West Wiltshire during 15/16;
- Additional monies targeting long waits were used to undertake more surgery during the summer and autumn months in collaboration with the three large acute providers;

- Development of clinically led pan-Wiltshire gastroenterology group to reduce waiting times and improve patient experience

3. Unplanned care and care for frail older people

Transforming Care of Older People (TCOP)

In 2014, the CCG invited proposals for local schemes to deliver a series of outcomes based on transforming care for older people. Proposals were assessed against their ability to meet following criteria:

- The CCG strategic vision
- Improved care for vulnerable older people
- Reduced avoidable admissions
- Continuity of care for older people
- Improved overall quality and productivity of services
- Greater integration of health & care services, in particular out of hospital care

16 schemes were supported and are funded on an on-going basis subject to successful delivery of the outcomes (predominantly admissions avoidance) covering every GP Practice across the whole of Wiltshire - while there are a number of different solutions, the key theme is wrapping additional services or releasing primary care capacity to proactively identify, manage and support frail and complex patients using the wider primary care and community teams in line with the CCG Delivery Plan.

The nature of the challenge in terms of reducing non-elective admissions in the over 75s meant that many of the schemes were unproven, so at the outset of the funding allocation it was made clear that on-going funding would be subject to successful delivery of the outcomes. That said the CCG was keen to support locality based schemes that improve care for older people and in particular prevent avoidable admission; and so for that reason the process of project evaluation is to review progress in terms of implementation and outcomes and then work with projects to refine proposals where necessary to ensure the greatest chance of success.

Intended Outcomes
A programme of proactive measures targeted at over 75s at locality level, tailored to local needs will result in:

- A reduction in emergency admissions
- A reduction in A&E attendances
- A reduction in re-admissions
- A reduction in admissions from Care Homes
- Improved access to primary care
- Improved access to integrated care
- Enhanced care closer to the patient's home

The CCG has set up a Review Panel, including representatives from HealthWatch and NHS England to consider the implementation progress, delivery of outcomes, centrally and locally monitored KPIs, subjective feedback and additional information that the projects feel would be beneficial for the review panel to consider.

4. Mental health

The areas we will be focusing on in 2015/2016 are divided into two groups – those intentions which represent our on-going aims in terms of continuous improvement but which are not contractual and those intentions which will result in new or revised contractual commitments.

INTENTIONS WHICH REPRESENT CONTINUOUS IMPROVEMENT

- Improved Care Pathways between Primary Care Liaison Services and Recovery Team
- Explore the implementation of integrated personal health and care budgets in mental health
- Develop a range of appropriate housing options for people with complex needs
- Develop proposals for an integrated health and social care secondary mental health service
- Protocol for the case management of Independent Sector Residential and Hospital placement contracts.
- Consistent and ongoing quality assurance and monitoring of SIRI
- Implementation of the Dementia Strategy Action Plan
- Jointly commissioning more Dementia Nursing Home Beds with Wiltshire Council
- Parity of Secondary Mental Health Services
- Needs Analysis for people with dementia and a learning disability people
- Improve services for people with Personality Disorders by developing evidence based services that are proven to reduce longer term requirements for in-patient admissions
- Improving the transition process from Children and Adolescent Mental Health Service (CAMHs) to adult services
- IAPT Care Pathways

CONTRACTUAL INTENTIONS

- Moving towards Outcome Based Commissioning
- Advanced Dementia Care Modernisation in response to the outcomes from the formal consultation on specialist dementia hospital care.
- System wide Delayed Transfer of Care plan for Mental Health
- Post-Discharge Planning
- Reviewing arrangements for Section 12 Doctors
- Further develop Care Home Liaison service and care pathway
- Community Services – mental health input to Demonstrator Sites and integrated teams
- Medicines Management
- Full year effect of newly commissioned Psychiatry services transferred to AWP from Oxford Health in January 2015
- Commissioning of Intensive Support service for people with a learning disability.

Mental Health Crisis Concordat

The Mental Health Crisis Care Concordat is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis. In February 2014, 22 national bodies involved in health, policing, social care, housing, local government and the third sector came together and signed the Concordat. It focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention; as well as one on aftercare. The Concordat builds on and does not replace existing guidance. The Concordat outlines what people who use mental health crisis services should reasonably expect.

Partners in Wiltshire signed the Wiltshire Declaration on improving outcomes for people experiencing mental health crisis on 25 September 2014. This committed partners to putting in place, reviewing and regularly updating an action plan. A working group comprising leads from the various organisations has been overseeing the development of this.

The group has been chaired by the CCG, with close cooperation from Mental Health Liaison Officer at Wiltshire Police together with representatives from mental health services, child and adolescent mental health services, ambulance services, adults and children's social care, substance misuse services, acute hospitals, and GPs.

5. Long term conditions including dementia

- The diabetes programme board has continued to work with stakeholders with the aim of changing the way diabetes care is provided in Wiltshire, moving services out of hospitals into locally based community settings. Work in 2014/15 has focused on developing prevention and early diagnosis interventions. Working with Public Health Team at Wiltshire Council and Diabetes UK, the programme board has supported initiatives such as case finding through diabetes 'road shows', self-management tools including the diabetes 'Blue Book' and encouraging GPs to find new ways of delivering diabetes annual reviews and helping people achieve their treatment targets. In November 2014, a successful Diabetes Summit brought together multiple stakeholders to share best practice in diabetes care and to agree priorities for the forthcoming year.

- Extensive work has been done to support patients in care homes, helping them to remain in the community and outside hospital care. GPs have introduced a range of initiatives including weekly visits, care planning, regular medication reviews and education of care home staff to help patients manage their conditions more effectively. GPs have used case finding tools to identify and further support patients at risk of admissions have worked with consultants to facilitate early supported discharge when patients have needed to go into hospital .Care home admissions to hospital have reduced as a result of these local interventions.
- Work to identify and support older, frail patients has been a focus of the Transforming Care for Older People (TCOP) programme. GP practices have implemented a number of schemes across Wiltshire to identify older, frail patients and to focus GP and clinical resources on helping them to better manage their complex and multiple conditions taking a holistic approach.

Dementia:

- GP Practices have been assessing, diagnosing and prescribing for people with Dementia. The numbers of people with a diagnosis as a percentage of the expected number of people living with Dementia in Wiltshire has Increased from 44.04% in March 2014 to 56.44% as at March 2015, an increase in 12.4%, against the national (and local) target of 66.67%;
- The Dementia Strategy was approved and an action plan developed by the Dementia Delivery Board that has been set up to implement the strategy. The Dementia Delivery Board includes Alzheimer's Society and Alzheimer's Support, Carer Support organisations and Advocacy organisations.
- Developed options for specialist dementia hospital care from people with advanced dementia and formally consulted on those options. The option recommended was to retain 20 beds at Amblescroft7 South and release resources for more services in the community to support people at home or in specialist Care Home beds when times are difficult.;
- Developed a Care Home Liaison Service to support care homes in developing the skills and capacity to provide improved quality of care for people living with dementia and worked with Care Home Managers, Wiltshire Council and AWP to establish the type of support needed for the future;
- Completed a needs analysis for specialist dementia beds in care homes and developed a specification jointly with Wiltshire Council and AWP for specialist dementia beds in Care Homes to be commissioned .(in the first instance) from the new Order of St John's Home that has just opened in Devizes;
- We invested jointly with Wiltshire Council in a Dementia Advisor Service provided by Alzheimer's Society and Alzheimer's Support. The service provides information and advice to people from the time that they are diagnosed through to end of life;
- Maintained waiting times for Memory Clinics to below 4 weeks, with the majority of people waiting for less than 2 weeks for their initial assessment.

6. End of life care

The End of Life Programme Board has worked collaboratively across the whole health system during the last year to deliver the strategic and operational objectives of improving the experience of patients, relatives and carers. The key achievements to date are:

- Development and implementation of the pan-Wiltshire Treatment Escalation Plan (TEP). This is already reducing preventable admissions to hospital and ensuring the wishes of patients are adhered to. A formal evaluation of the form is being undertaken from April 2015.
- Review of end of life register and electronic communication solutions – linking with TPP project
- Mapping of current service provision and gap analysis
- Education support for nursing and care homes
- Patient, relative and carer quality questionnaire in conjunction with Patients Association
- Review of CHC funding processes and identified actions

The Programme Board will be continuing for the next year and has identified the following work streams:

1. Education
2. Care at Home
3. Advanced Care Planning including patient information
4. Key Workers to reduce professional, geographical and organisational boundaries
5. Medication work stream
6. Dementia End of Life

7. Community services and integrated care

- **The Better Care Fund**

Integration of health and social care is seen is a key national priority through the development of the Better Care Plan programme across the country. Wiltshire has been at the forefront of the Better Care Plan nationally being one of only 5 early implementers and having a plan that has been fully approved. Wiltshire health and social care community have been recognised as a national area of good practice and this has been due not only to the innovative work that has been taken place as part of the Better Care Plan roll out but the strong platform for innovation, integration and service development that was already in place across the system. Some of the projects we have implemented during the year include:

- **Discharge to assess (D2A)**

There has been a commitment across health and social care to progress the discharge to assess scheme across each acute hospitals. In the first instance the aim was to make certain that more patients were discharged once they were medically fit by ensuring that ongoing care and rehabilitation were provided in a non-acute setting (ideally the patients home). This was launched in two ways, a bed based model of care in Salisbury (recognising the significant capacity issues being faced by Mears the care provider in the area) and non-bed based across GWH and RUH.
This approach has been implemented successfully elsewhere in the country and we will continue to extend it across Wiltshire in 2015/16.

- **Delayed transfers of care (DTOC)**

Each of our three acute hospitals have experienced higher than planned levels of delayed transfers of care and whilst there has been some in period of reductions , volume of delays have remained at a level that has contributed to operational pressures across the system . Discharge to Assess and more effective linkages with intermediate care and community teams remain the key schemes of focus. The three hospitals, community services and mental health are working together to continue to reduce the lengths of stay for patients in hospital to improve the individual's rehabilitation and quality of life.

- **Enhancing care at the interface**

Having an assessment in A&E by a senior clinician can often prevent an admission, which can avoid the complications that may be associated with a stay in hospital e.g., infections, debilitation. Community services, our out of hours provider and social care continue to support the assessment models that are currently in place at each of the acute hospitals. There are further opportunities to access alternatives urgent care at home, community services and ensure we maximise the ability to discharge patients before they are admitted.

- **Step up beds**

On the 1st September ten step up beds went live in Warminster community hospital and six step up beds went live in Savernake community hospital, the aim being to develop step up intermediate care in community hospitals for direct referral from GPs and other professionals. The intention was to seek to manage patients with high needs in a community setting thus enabling them to avoid an admission to an acute hospital. The wards have medical cover that enables admissions over a seven day period with that cover provided by a mix of community geriatrician, GPs, Advanced Nurse Practitioners, therapists, nurses and pharmacy.

- **End of Life 72hr Pathway**

From Monday the 1st December 2014 MEDVIVO has been working in partnership with the hospices serving Wiltshire in order to provide an enhanced Urgent Care @ Home Service for patients at the end of their life. Initially Dorothy House and Prospect Hospice are providing an additional carer to the pool of staff available for the UC@H service. They are available twenty four hours a day, seven days a week and are providing care for palliative patients (patients within the last year of life).

- **Integrated Teams**

Wiltshire Clinical Commissioning Group has been working with Great Western Hospital and Wiltshire Council on the introduction of 'Integrated Teams' across Wiltshire. These teams are wrapped around and working closely with groups of GP practices to provide more collaborative and flexible care and a more locally focussed community support network.

Work has begun on the introduction of a new community based information system to be used by the Integrated Teams and other community based staff and services. This system is similar to that used by GPs and will therefore allow easier access and sharing of information between clinicians in GP surgeries and those in the community.

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 strengthened our quality and patient safety team to ensure that robust monitoring and processes are in place to provide both the Governing Body and the public with assurances that the care we commission is safe, and of the highest possible quality. We have integrated and embedded quality and patient safety processes into the clinically led commissioning structures, values, practices and business processes.

We have enshrined the three aspects of quality in our approach and quality team structure in line with the international definition of quality, namely:

- Patient safety
- Patient experience
- Clinical effectiveness

Within this definition we have strengthened our approach to the review of quality metrics and ensured that there is joined up working with performance and contracting so that we can be sure the outcome for patients promotes continuous improvement whilst maintaining safety and responding to patients feedback. Seminal reports and recommendations that 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" and the Keogh Review.

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.

Each Governing Body meeting commences with a patient story, ensuring that a patient voice is heard to enable the CCG to understand how the services we commission impact on patients. Patient stories are recognised as an effective and powerful way of hearing the views of patients on both good and bad experiences to better inform the improvement of services.

The Five Year Forward View which was published in October 2014 has laid out the ambitions and challenges in tackling the care and quality gap for the NHS. The theme of reducing variation has been highlighted in terms of improving outcomes for patients and also in terms of quality and safety for patients. Meaningful information and data is essential to ensuring that there is transparency and an ability to hear what patients and their carers are saying to help providers compare their performance against others and make those improvements. The 2015/16 Planning Guidance has also identified preliminary guidance of the key features which CCG s should be considering in their plans. For quality and patient safety these will need to include demonstrating understanding and measurement of harm and how it occurs in healthcare services and how capacity and capability in patient safety can be developed.

As part of 'A Call to Action' published by NHS England in July 2014, commissioning for parity of esteem has been identified as a key focus for commissioners and providers. The CCG has ensured that prior to the required 2016 implementation date assurance has been requested through either the quality schedules or the mental health collaboratives, regarding provider compliance, as detailed in NHS England 'Everyone Counts – Planning for Patients 2014/15 to 2018/19' and the Mental Health Crisis Care Concordat (DH 2014).

Complaints management

In October 2014 the management of Complaints and PALS was repatriated to the CCG from the Central Southern Commissioning Support Unit. The rich source of information that this produces enables the CCG to review the themes and trends of complaints, and use this information to assess any commissioning gaps or improvements which need to be made to the services we commission. 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 along with recent publications, such as 'My Expectations' have been developed by the Ombudsman and Healthwatch. This document is a user-led vision for raising concerns and complaints. The document defines what a good complaints process looks like and will be taken in to consideration when reviewing Complaints and PALS policies locally.

The Complaints and PALS team sit within the Quality and Safety Directorate and provide an effective link to performance and quality leads to help triangulate those themes and trends of concerns and complaints back through the contract management process.

A weekly status report on the complaints that remain open and the action being taken to close is circulated to all senior managers. In addition a regular report regarding number of complaints, themes and trends is submitted to the Quality and Clinical Governance Committee.

NHS Wiltshire CCG for April – March 2014/15 – Formal Complaints

	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	Total
NHS Wiltshire Clinical Commissioning Group	19	23	45	37	124
Member of Parliament	15	19	9	12	55
Total	34	42	54	49	179

Between April 2014 and March 2015 179 formal complaints were received by the CCG. Of these 179 complaints, 77.6% (139) have been closed. For those complaints received via an MP's office, 87.2% (48) have been closed.

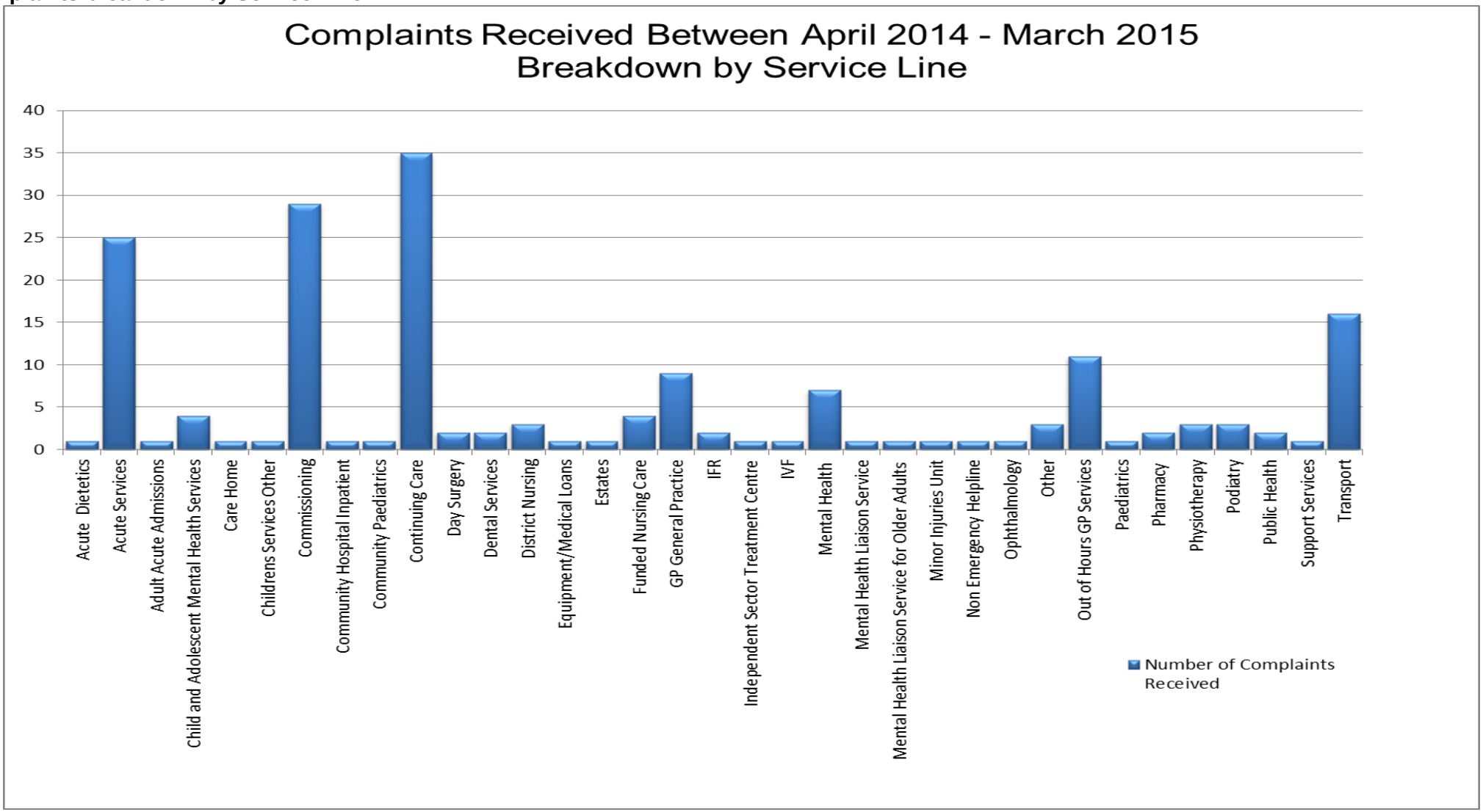
The Complaints and PALS team aim to acknowledge all complaints within 3 working days. Performance in 2014-15 demonstrates that this was achieved in 74% of cases (133), 3% (6) of the cases did not require consent as the complaint response required general information rather than specific information relating to an individual. In 16% (29) of the cases, the 3 working day target was not achieved. In 6% of the cases s (11) the information recorded was incomplete. Over the next 12 months, improving the performance around the 3 day working target is a key performance objective.

There is no set timescale for NHS Complaints (NHS Complaints Regulations 2009), however the Complaints and PALS team use 25 days as a reasonable guide to investigate and provide a response to the complainant; the timescale begins on receipt of consent. Achieving the response time has been challenging as the data shows.

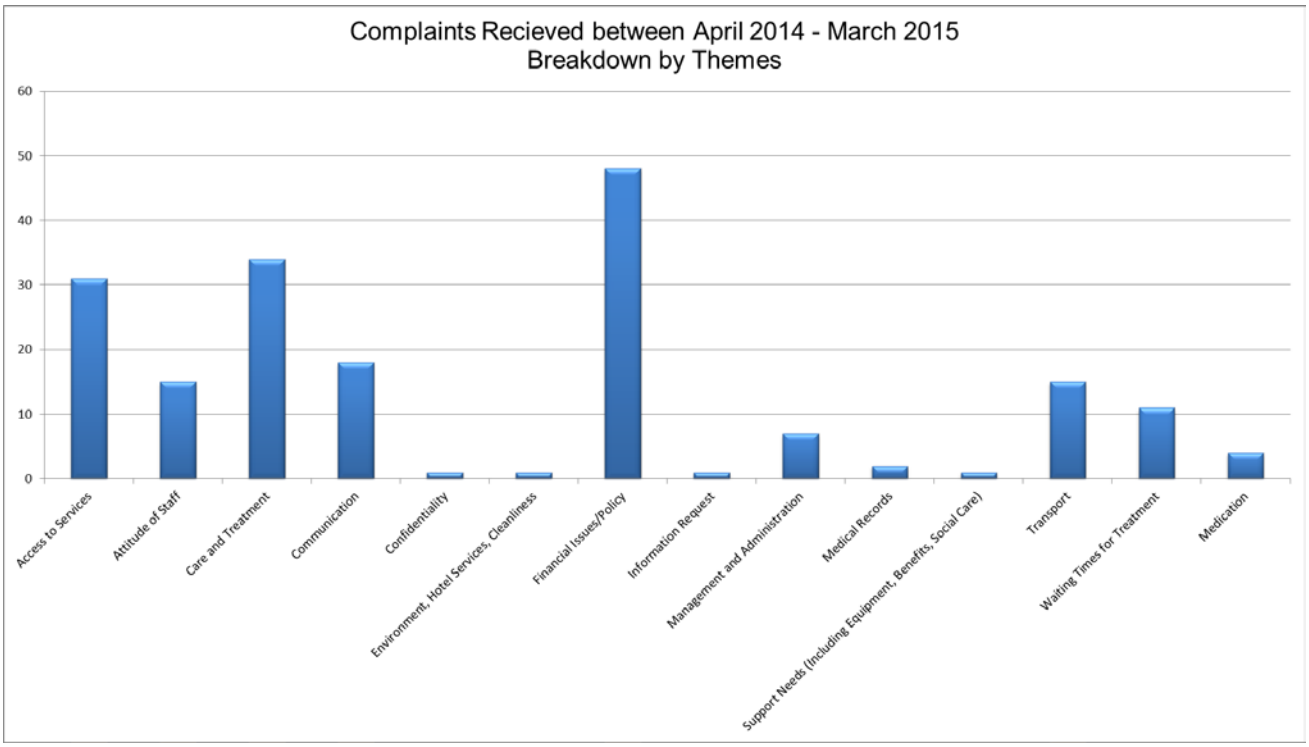
Of the 139 closed complaints, 48% (67) did not follow the full complaints process. 35% (49) of these cases are reported as not requiring consent and therefore would not have 'started the clock'. In 10% (15) of cases, the complainant failed to return the consent form despite a reminder letter and 3 cases were resolved without an investigation.

Of the remaining 52% (72) of cases, 49% (35) were closed within the target of 25 working days. The challenges faced by the department predominately focus around the timeliness and quality of the complaint responses received from the various providers, as a result 51% (37) of cases fell outside of the 25 working day target. This is another key area the department wish to address over the next 12 months.

Complaints breakdown by Service Line



Complaints breakdown by themes

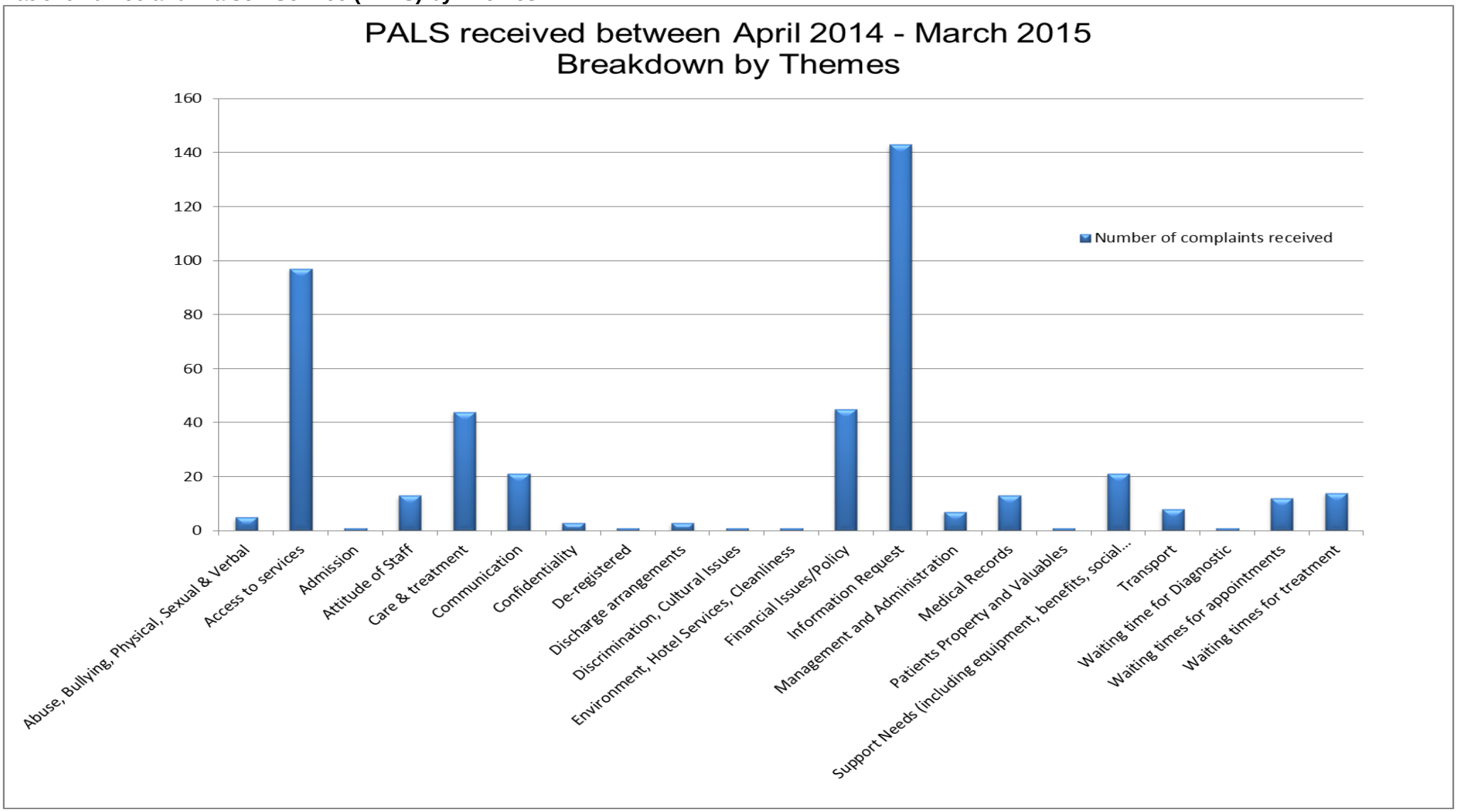


NHS Wiltshire CCG for April – March 2014/15 - PALS

	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	Total
NHS Wiltshire Clinical Commissioning Group	162	155	71	64	452
Member of Parliament	1	0	6	10	17
Total	163	155	77	74	469

Of the 469 PALs enquiries received between April 2014 and March 2015, 93.6% (439) have been closed. Of the remaining 30 open cases, 10 relate to MP office enquiries.

Patient Advice and Liaison Service (PALS) by Themes



The main themes captured through PALs relate to Information requests and access to services

Patient safety

We continue to monitor improvements in patient safety through a variety of sources 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.

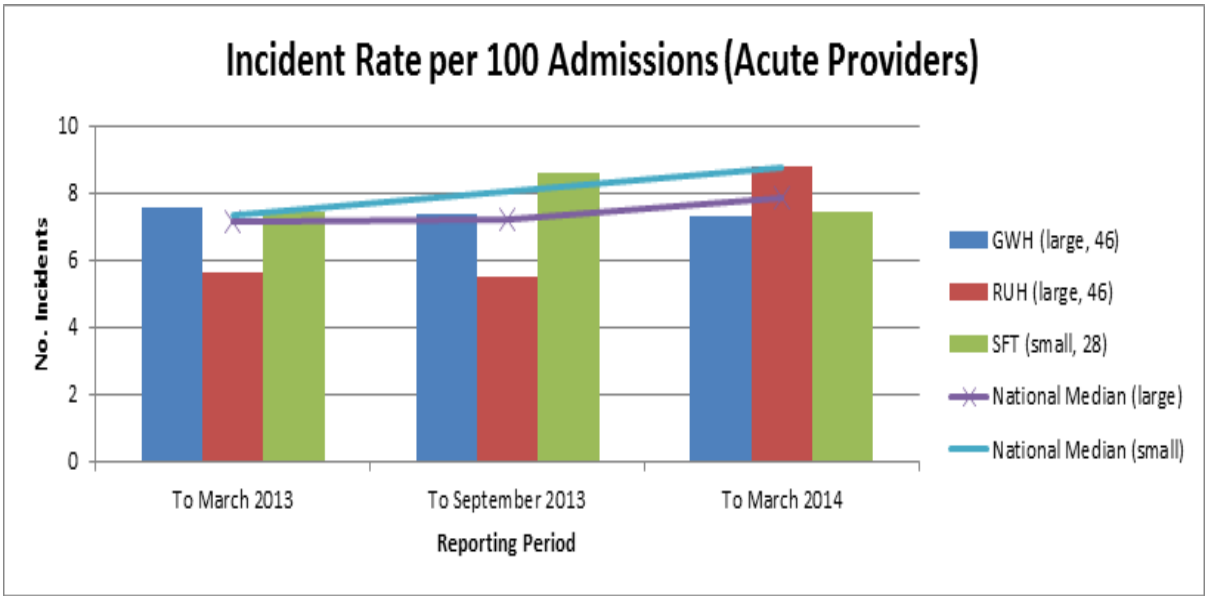
National Reporting and Learning System (NRLS)

Since 2003/2004 all NHS Trusts have shared anonymous patient safety incident reports with the National Patient Safety Agency. From these reports, the Organisation's 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

National reporting and learning system (NRLS)

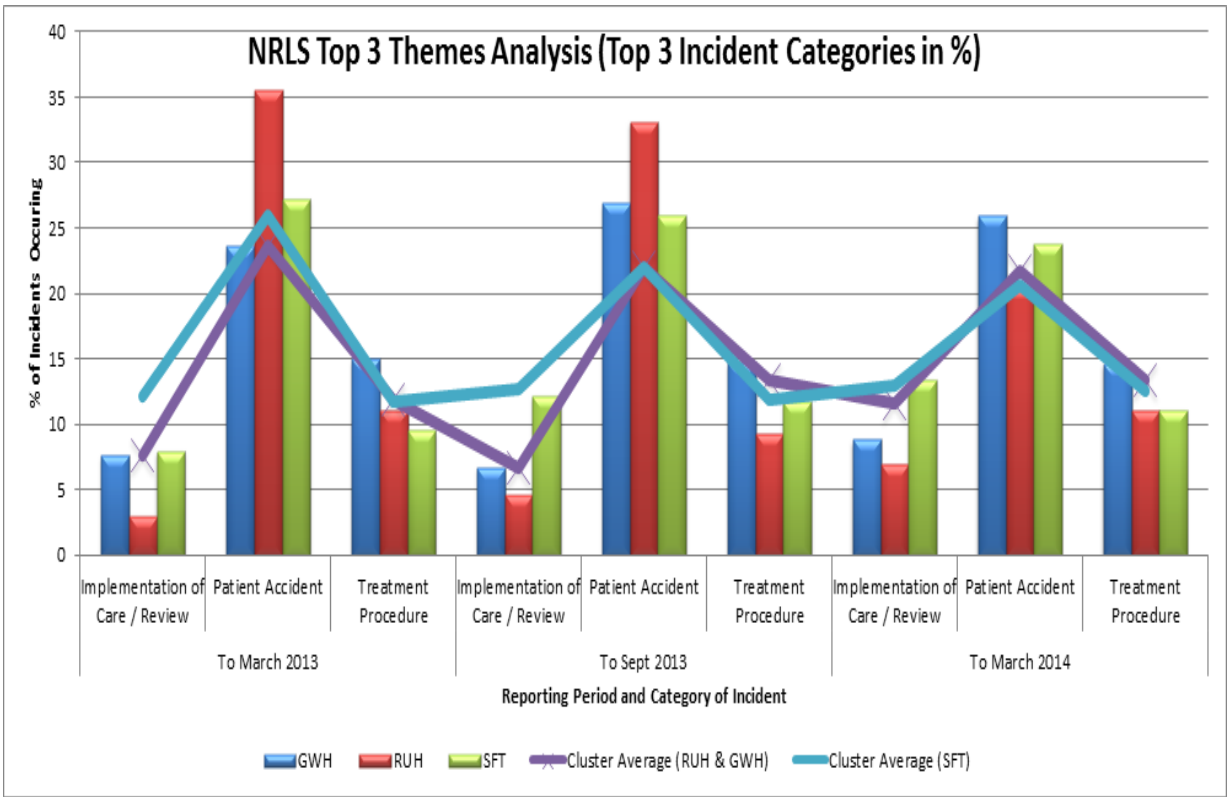
The chart below shows the reported incident rate per 100 admissions for the three acute providers.



RUH and GWH are ranked in the same cluster of large acute hospitals, whilst SFT is considered a small acute hospital, hence variation in national median and mean comparisons.

Although reporting to NRLS is voluntary, there has been significant variation among the three acute providers for time to reporting. During the March 2014 period, all three acute providers have become more closely aligned to the national reporting median for time to report an incident to NRLS.

The chart below shows the top three themes reported to NRLS by provider March 2013/14.



The highest number of reported incidents across all three acute providers is consistently patient accident.

Analysis by the NPSA of incidents reported above is discussed regularly at the provider Clinical Quality Review meetings to seek assurance of incident reporting and learning.

Management of Serious Incidents

Serious Incidents requiring investigation in healthcare are rare, but when they do occur, we have systematic measures in place to respond to them. Guidance is included in all provider contracts for the reporting of Serious Incidents, with the aim of ensuring that robust investigations are carried out, appropriate action is taken to protect patients, and learning from serious incidents is embedded in the provider organisation to minimise the risk of the incident happening again.

Following the 2013 NHS reforms, the responsibility to close incidents sits with the CCG where the GP of a patient receiving NHS funded care is located. Therefore, NHS Wiltshire CGG has responsibility to review and support closure of incidents and hold to account providers for their responses and implementing organisational learning arising from serious incidents for patients registered with a GP in Wiltshire.

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. NHS England published revised Serious Incident and Never Event Guidance in March 2015. This is currently under review to ensure policy and provider compliance aligns to the updated requirements.

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 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 2014/15, the list of reported incidents by Providers is as detailed below:

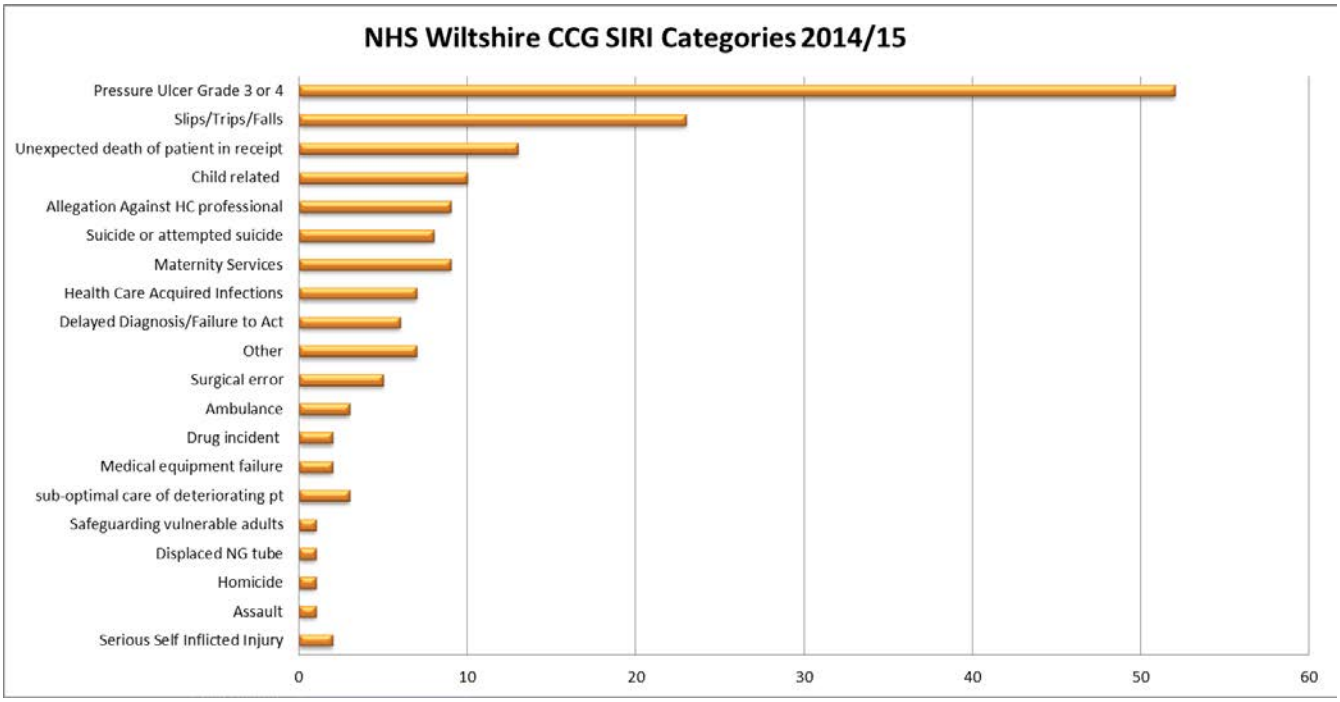
SIRIs reported by Provider, NHS Wiltshire (PCT) and NHS Wiltshire CCG, 2010/11, to 2014/15.

Provider	No of Incidents (involving Wiltshire Patients)				
	2010/11	2011/12	2012/13	2013/14	2014/15
Salisbury Foundation Trust	20	22	12	17	31
Great Western Hospitals NHS Foundation Trust	53*	40	52	Acute: 9 Community: 26 Maternity: 4	Acute: 12 Community: 44
NHS Wiltshire CCG	16	19	13	19	6
Royal United Hospital Bath NHS Trust				8	Acute: 35
Avon and Wiltshire Mental Health Partnership Trust				32	25
Bristol Eye Hospital					1
Cygnet Health Care					1
North Bristol NHS Trust					3
Oxford University Health Trust					1
Papworth Hospital					1
Royal Liverpool and Broadgreen Trust					1
South West Ambulance Service NHS Trust					3
University Hospital Bristol					1
University Hospital Southampton					3
Total	89	81	77	**115	168

These were Wiltshire Community Health

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

Themes and Trends



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 2014/15 there have been four Never Events involving Wiltshire patients: all have been fully investigated. The action plans following the root cause analysis are being monitored by the Clinical Outcomes and Quality Assurance Group.

Provider	Category of Incident	No of Wiltshire Patient(s) involved in a Never Event for 2013/14	No of Wiltshire Patient(s) involved in a Never Event for 2014/15
Great Western Hospitals NHS Foundation Trust	Surgical Error		1
	Retained Swabs	4	
Salisbury NHS Foundation Trust	Surgical Error		2
University Hospital Southampton	Surgical Error		1

NHS Safety Thermometer

The NHS Safety Thermometer is a point prevalence tool to measure the incidence of harm occurring within inpatient healthcare providers. Harm Free care is captured monthly by providers and incudes:

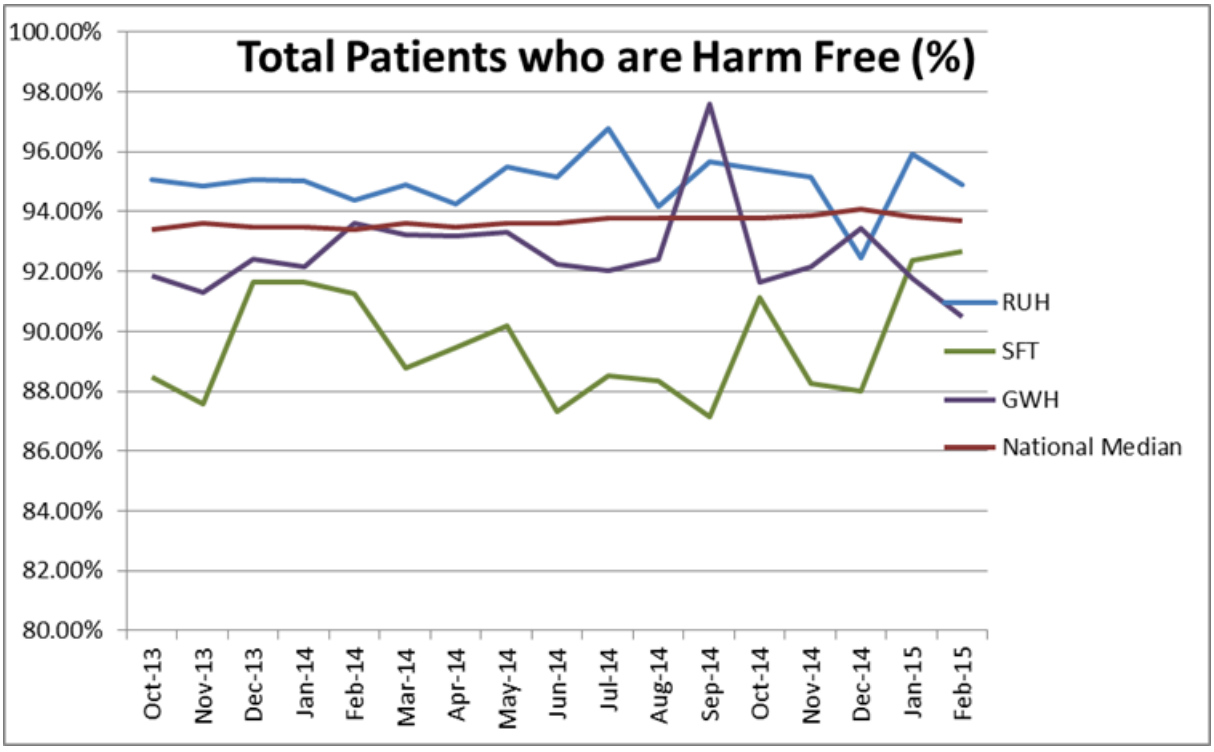
- Falls
- Pressure Ulcers
- Catheter Acquired Urinary Tract Infections (CAUTI)
- Venous Thromboembolism (VTE) (blood clots in limbs or chest)

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.

This data is gathered by the provider on a specific day each month. Data which is produced from this regarding harms should be triangulated against other sources of information and data regarding these key areas by the provider to establish if there are quality concerns requiring specific measures.

Pressure ulcers remain the most frequently reported harm across all three acute trusts. The table below shows the percentage of patients at each acute trust who received harm free care.



Health Care associated infections MRSA and Clostridium difficile 2014/15 targets set by PHE

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 2014/15, Everyone Counts: Planning for Patients 2014/15 to 2018/19 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 must be undertaken to identify why an infection occurred and how future cases can be avoided. The Post Infection Review Guidance has been updated and re-published to help organisations conduct the reviews.

In January 2015 we received NHS England objectives for 2015/16 MRSA and *Clostridium difficile* ambitions as tabulated below. Alongside our local providers, we continue to strive to reduce HCAI.

Provider			Clostridium *difficile*					
	2012/13 Target	2012/13 Actual	2013/14 Target	2013/14 Actual	2014/15 Target	2014/15 Actual	2015/16 Target	2015/16 CDI cases per 100,000 population
SFT	25	25	21	21	18	23	19	13.1
RUH	31	27	29	37	37	29	22	10.9
GWH	21	30	20	23	28	19	20	9.4
Total for Wiltshire	139	160	127	133	140	106	103	21.5

During 2014/15 there have been 3 cases of post 48 hour MRSA bacteraemia and 4 cases of pre 48 hour MRSA bacteraemia. The tables below show the full year performance for MRSA:

MRSA (Providers) - 2014/15	Plan	Actual
RUH, Bath	0	0
GWH, Swindon	0	1 (March 2015)
SFT, Salisbury	0	1 (July 2014)
Other Acute Trust (North Bristol)	0	1(Oct 2014)

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

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. NHS Choices publish against SHMI thresholds for NHS Trusts providing hospital care.

In May 2014 Dr. Foster Intelligence published mortality data for English Acute Trusts (Financial Year 2013/2014) and in February 2015 Dr. Foster published mortality statistics relating to the annual period July 2013 to June 2014. Although quarterly updates are available, full statistics are published six months after the period ended to allow time for capture of data relating to post-discharge deaths and to carry out complex analysis. After reviewing this data in conjunction with the providers' own mortality reports, it was confirmed that SFT, GWH and RUH are evidenced as performing at or above expected rates for both mortality indicators. The quarterly review of Dr Foster morality data carried out by the CCG highlights individual diagnoses groups where improvement is required. Assurance regarding improvement is then sought from the provider and monitored accordingly. The table below shows a tabulated summary of the data.

	RUH				GWH				SFT			
	2011/12	2012/13	2013/14	Current Performance	2011/12	2012/13	2013/14	Current Performance	2011/12	2012/13	2013/14	Current Performance
SHIMI Overall trust Mortality Ratio (June to July)	95.92	101.08	95.06	Better than expected range	102.34	96.42	97.67	Wthin expected range	107.75	105.84	101	Wthin expected range
SMHI by Acute Hospital Site (June to July)	95.87	101.08	95.08	Better than expected range	103.47	99.81	100.12	Wthin expected range	103.51	101.17	97.08	Wthin expected range
HSMR Overall Trust mortality ratio (June to July)	99.38	100.12	94.22	Better than expected range	103.49	99.31	100.12	Wthin expected range	104.97	114.75	100.4	Wthin expected range
HSMR; by Acute Hospital Site Annual (July to June)	99.04	100.12	94.26	Better than expected range	103.5	101.06	99.27	Wthin expected range	103.17	111.36	97.67	Wthin expected range
Deaths in low risk conditions	1.4	1.31	0.67	Wthin expected range	0.7	0.67	0.46	Within Expected Range	0.4	0.74	0.87	Wthin expected range

Source: Dr Foster Mortality Comparator

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 2014/15 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.

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.

A review of the FFT was published in July 2014 and made a number of recommendations. The FFT Review suggested that the presentation of the data should move away from using the Net Promoter Score (NPS) as a headline score and use an alternative measure. In line with this recommendation the NHS England statistical publication moved to using the percentage of respondents that would/wouldn't recommend the service in place of the NPS. Changes took place from October 2014.

The Net Promoter Score (NPS) was calculated using the following formula:

$$NPS = \frac{extremely\ likely - extremely\ unlikely - unlikely - neither}{extremely\ likely + likely + neither + unlikely + extremely\ unlikely} \times 100$$

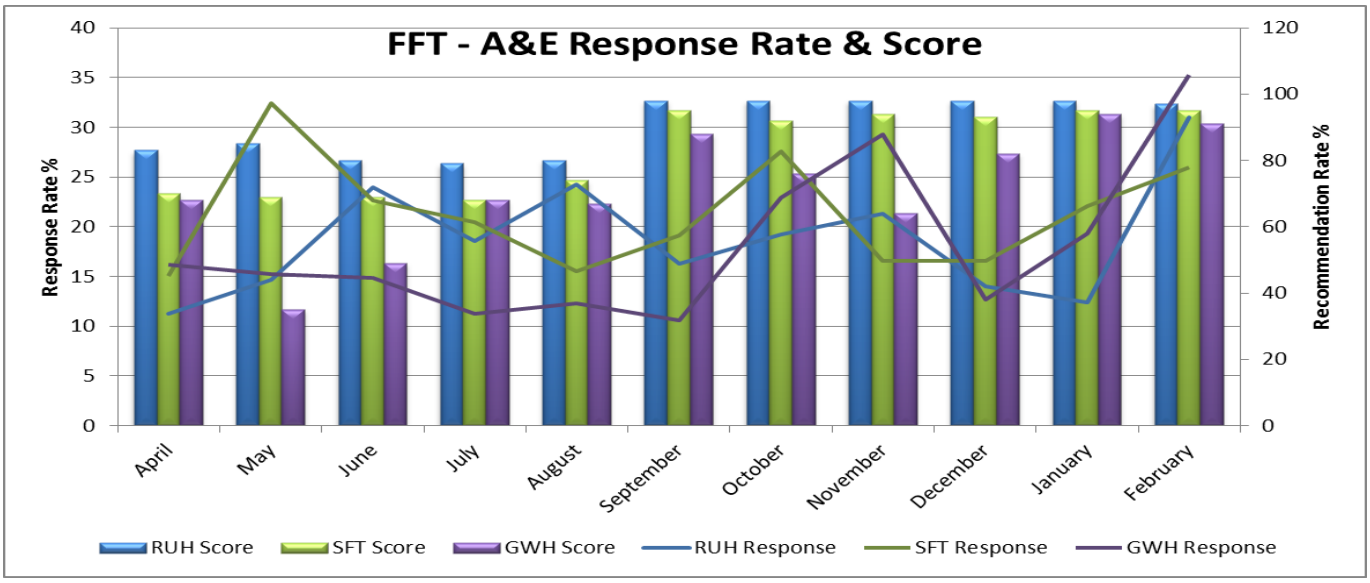
The percentage measures will be calculated as follows:

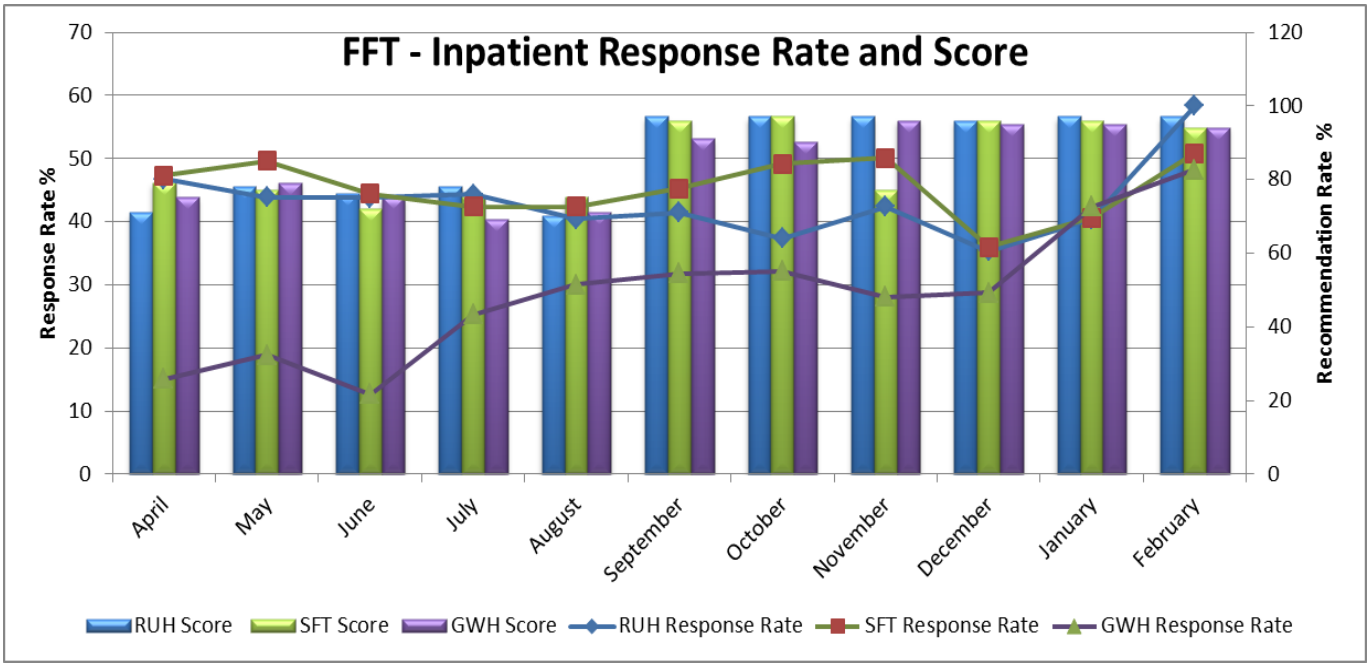
$$Recommend\ (\%) = \frac{extremely\ likely + likely}{extremely\ likely + likely + neither + unlikely + extremely\ unlikely + don't\ know} \times 100$$

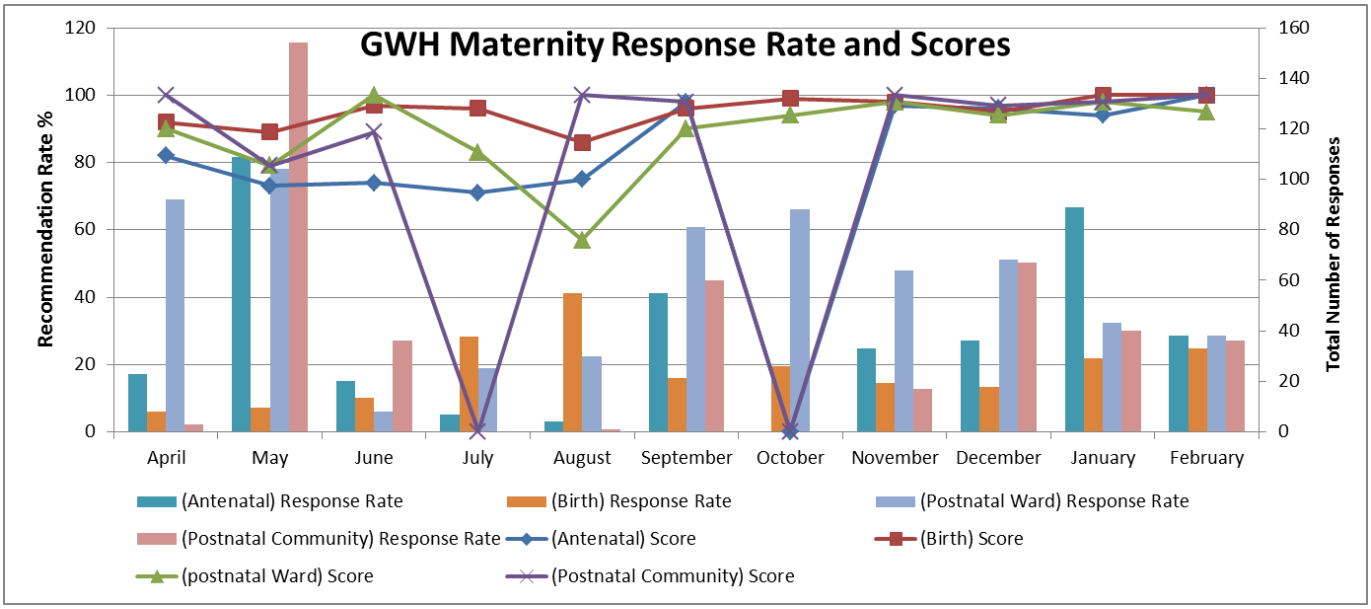
$$Not\ recommend\ (\%) = \frac{extremely\ unlikely + unlikely}{extremely\ likely + likely + neither + unlikely + extremely\ unlikely + don't\ know} \times 100$$

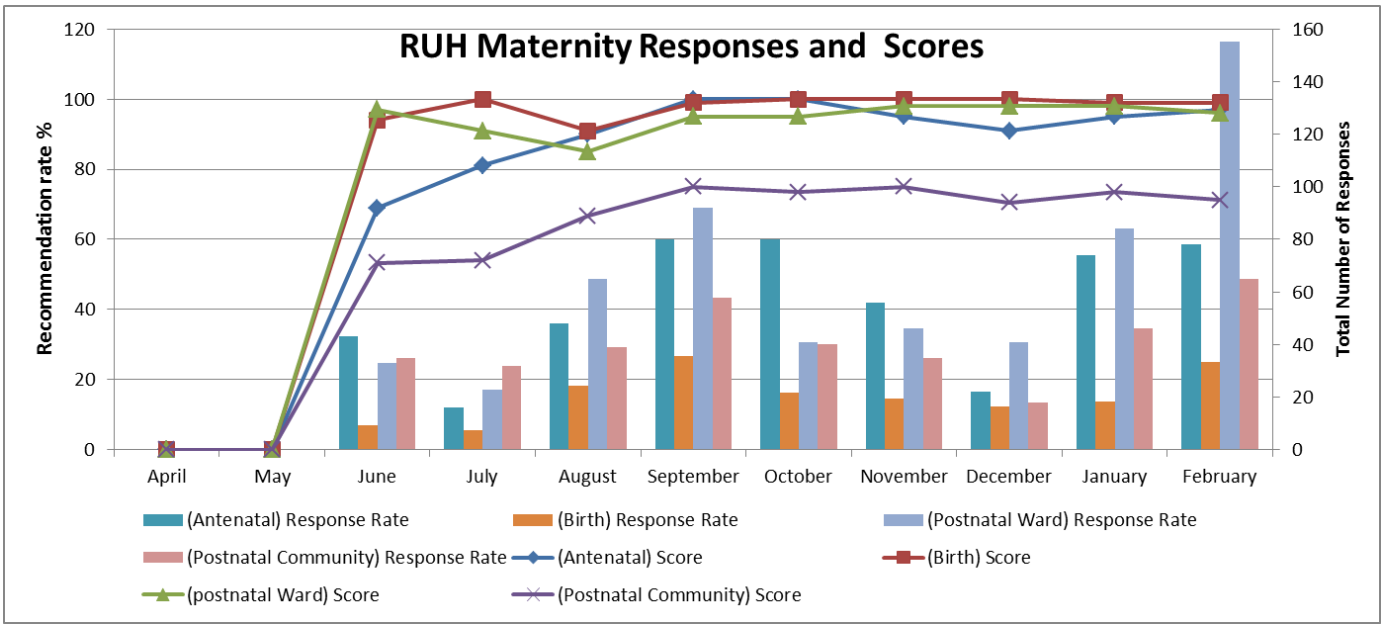
The new guidance also focused on making the FFT inclusive to all patient groups and provided expertise in developing and promoting methods to obtain feedback. The NHS Friends and Family Test has already provided local hospitals with feedback and is playing an active role in transforming the services. The table below shows the FFT response rates and recommended rates for A&E, inpatient and maternity services and illustrates the overall finding that the majority of patients surveyed reported a positive experience with an over 90% recommendation rate. The exception to this is the experience reported from patients visiting GWH A&E; however, improvement measures implemented by the provider appear to be addressing this.

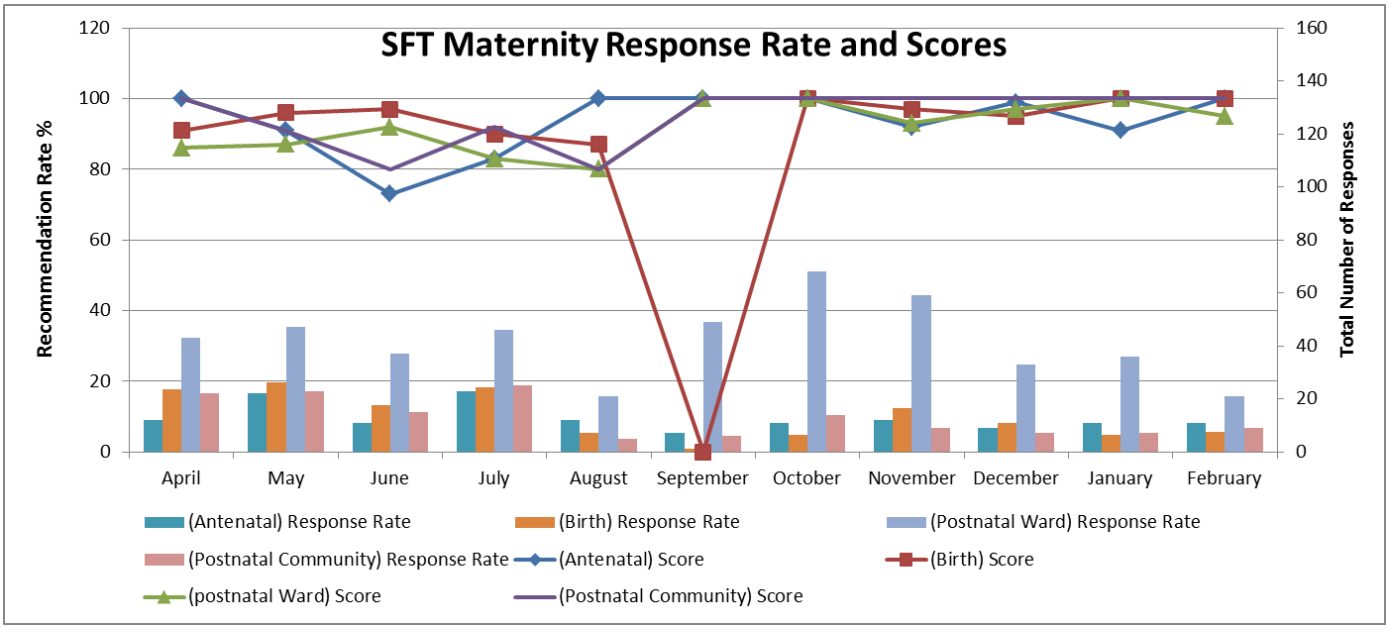
The overall response rate for all services is an area where ongoing improvements are needed.






GWH Maternity Response Rate and Scores
Recommendation Rate %
Total Number of Responses
120
100
80
60
40
20
0
160
140
120
100
80
60
40
20
0
April
May
June
July
August
September
October
November
December
January
February
(Antenatal) Response Rate
(Birth) Response Rate
(Postnatal Ward) Response Rate
(Postnatal Community) Response Rate
(Antenatal) Score
(Birth) Score
(postnatal Ward) Score
(Postnatal Community) Score


RUH Maternity Responses and Scores
Recommendation rate %
Total Number of Responses
120
100
80
60
40
20
0
160
140
120
100
80
60
40
20
0
April
May
June
July
August
September
October
November
December
January
February
(Antenatal) Response Rate
(Birth) Response Rate
(Postnatal Ward) Response Rate
(Postnatal Community) Response Rate
(Antenatal) Score
(Birth) Score
(postnatal Ward) Score
(Postnatal Community) Score


SFT Maternity Response Rate and Scores
Recommendation Rate %
Total Number of Responses
120
100
80
60
40
20
0
160
140
120
100
80
60
40
20
0
April
May
June
July
August
September
October
November
December
January
February
(Antenatal) Response Rate
(Birth) Response Rate
(Postnatal Ward) Response Rate
(Postnatal Community) Response Rate
(Antenatal) Score
(Birth) Score
(postnatal Ward) Score
(Postnatal Community) Score

Next steps for NHS Wiltshire CCG

The FFT was rolled out to GP practices on 1 December 2014 and Community and mental health services on 1 January 2015. NHS Wiltshire CCG continues to monitor the feedback in terms of response rates and recommended rates through the NHS England data source. For further information: http://www.england.nhs.uk/wp-content/uploads/2014/07/fft-imp-guid-14.pdf

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking up to 2.5% of providers' income to the achievement of quality improvement goals. The guidance on the national CQUIN goals for 2014/15 is set out in Everyone Counts: Planning for Patients 2014/12 to 2018/19. There were three nationally mandated CQUIN goals for 2014/15 in addition to up to five local schemes agreed by the CCG with each provider which aligned to local quality concerns or improvement priorities.

The table below highlights the achievement of 2014/15 CQUINs for NHS Wiltshire providers:

Name of organisation	% CQUIN achievement 2014/15
Salisbury NHS Foundation Trust (acute)	98.1
Great Western Hospital NHS Foundation Trust (acute)	76.6
Great Western Hospital NHS Foundation Trust (adult community)	77.7
Royal United Hospital NHS Foundation Trust (acute)	99.1
Royal United Hospital NHS Foundation Trust (Maternity)	100
South Western Ambulance Service NHS Foundation Trust	100
Avon and Wiltshire Mental Health Partnership NHS Trust	100

Ensuring the Providers Deliver Clinically Effective Care

The Care Quality Commission (CQC) publishes Intelligence Monitoring information on acute hospitals on a Quarterly basis. The reports analyse data from a variety of sources including patient surveys, mortality rates, hospital performance information and clinical audit programmes. The most recent information (published in December 2014) is presented in the following table.

Summary Indicators	GWH		RUH		SFT	
	Dec-14	Move From June 14	Dec-14	Move From June 14	Dec-14	Move From June 14
Priority banding for Inspection	**5**	↑ from 3	**6**	Recent Inspection	**6**	↔
Number of 'Risks'	**6**	↑ from 2	**1**	↓ from 2	**1**	↓ from 2
Number of 'Elevated Risks'	**0**	↓ from 4	**1**	↑ from 0	**0**	↓ from 1
Overall Risk Score	**6**	↓ from 10	**3**	↑ from 2	**1**	↓ from 4
Number of Applicable Indicators	**94**	↓ from 96	**89**	↑ from 82	**95**	↓ from 96
Percentage Score	**3.19%**	↓ from 5.21%	**1.69%**	↑ from 1.22%	**0.53%**	↓ from 2.08%
Maximum Possible Risk Score	**188**	192	**178**	164	**190**	192

The CQC use this information to prioritise organisations for inspection. The above table demonstrates that many improvement have been made against previously identified risks for these providers. RUH and SFT are in the lowest priority banding (6) and GWH is in banding 5, having decreased in priority for inspection from a band 3. The CCG has received assurance from all providers regarding the risks identified. Reports have been received from all providers which address the concerns identified above. The mitigating actions are monitored via monthly Clinical Review meetings and through visits to providers. The process is repeated each quarter.

The Clinical Advisory Group (CAG)

The Clinical Advisory Group (CAG) ensures that the CCG has an assurance process in place to support the decision making for health care interventions that may be commissioned for the local population, and to enable their prioritisation in a climate where resources are limited. Meeting bi-monthly, the CAG is a sub-committee of the Quality and Clinical Governance Committee (QCGC) and is responsible for the clinical decision making process within the CCG and provides a forum for the assessment, forward planning and review of NICE technical and clinical guidance. The CAG encourages partnership working with providers of health care to deliver evidence-based, high quality health outcomes for the population of Wiltshire when planning and commissioning future services.

During 14/15 membership of the CAG and its terms of reference have been strengthened. The group is chaired by the CCG medical lead with regular attendance from by medical representative from primary and secondary care. The group has advised on policies for Exceptions and Prior Approvals, and Medicines Management prior to decision making by the QCGC which has led to the publication of improved information to support public and primary care decision making.

Sir Andrew Dillon, Chief Executive of NICE, attended the September CAG meeting and identified Wiltshire CCG as an exemplar in the review and consideration of NICE guidance in commissioning activity and monitoring provider compliance. Through reviews of provider audits and NICE compliance statements, the CAG has identified a need to revise the current monitoring processes for these activities to further strengthen assurance across Wiltshire and to enable triangulation of information to facilitate identification of targeted audits. To gain assurance, these audits of NICE guidance or care pathways will be carried out to address concerns arising at an individual provider level, and across multiple providers where the issue is identified as affecting patients Wiltshire-wide. The CAG will then make recommendations and share learning within the CCG and with the providers as appropriate to ensure that quality improvement plans are put in place and monitored accordingly.

Safeguarding Children and Adults

NHS Wiltshire CCG has 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.

In 2014-15 NHS Wiltshire has further strengthened the contractual standards and reporting mechanisms that monitor the safeguarding arrangements of providers. Evidence of continuous improvement and compliance in safeguarding outcomes for commissioned services are achieved through the use of specific contractual arrangements and metrics with provider organisations. This includes having in place: Key Performance Indicators (KPI's), quality schedules, systems to embed learning from Serious Case Review, incidents and complaints, comprehensive single and multiagency safeguarding policies and procedures 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 strategy and framework
- Recognising and reporting safeguarding issues.
- A clear line of accountability for safeguarding within each organisation.
- 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 adult's lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

NHS Wiltshire CCG 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.

NHS Wiltshire CCG works with the Safeguarding Boards, statutory agencies and its provider organisations to ensure the effectiveness of multi-agency arrangements to safeguard and promote the well-being of children, young people and adults at risk from harm or abuse.

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 budgets (running cost allocations). Approved budgetary resources are devolved to the Directors and Groups 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 risk registers, at a group / directorate and organisational level, to identify operational and financial risks that may affect 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 to ensure that Wiltshire has a high performing and resilient health system. 2014/15 has also seen a strengthening of our relationship with Wiltshire Council for social care and other services that support the local population. This has been reinforced by the first year of the Better Care Programme.

Financial Year 2014/15

Financially 2014/15 has been a challenging year as the impact of Wiltshire's population getting older and frailer comes to fruition. The providers from which we commission services have seen unprecedented demand that was significantly higher than the 2013/14 activity levels and significantly above the planned activity levels that reflect the CCG strategic direction. This pressure was particularly felt in the first quarter of 2014/15 which saw activity peaking at 12% above the same period last year. However, the impact of the CCG's out of hospital strategy has started to take hold and activity levels have progressively reduced with activity levels coming back in line with 2013/14 levels. The CCG also experienced significant financial pressures associated with the cost of the activity it commissions from many of its 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 their health needs more complex.

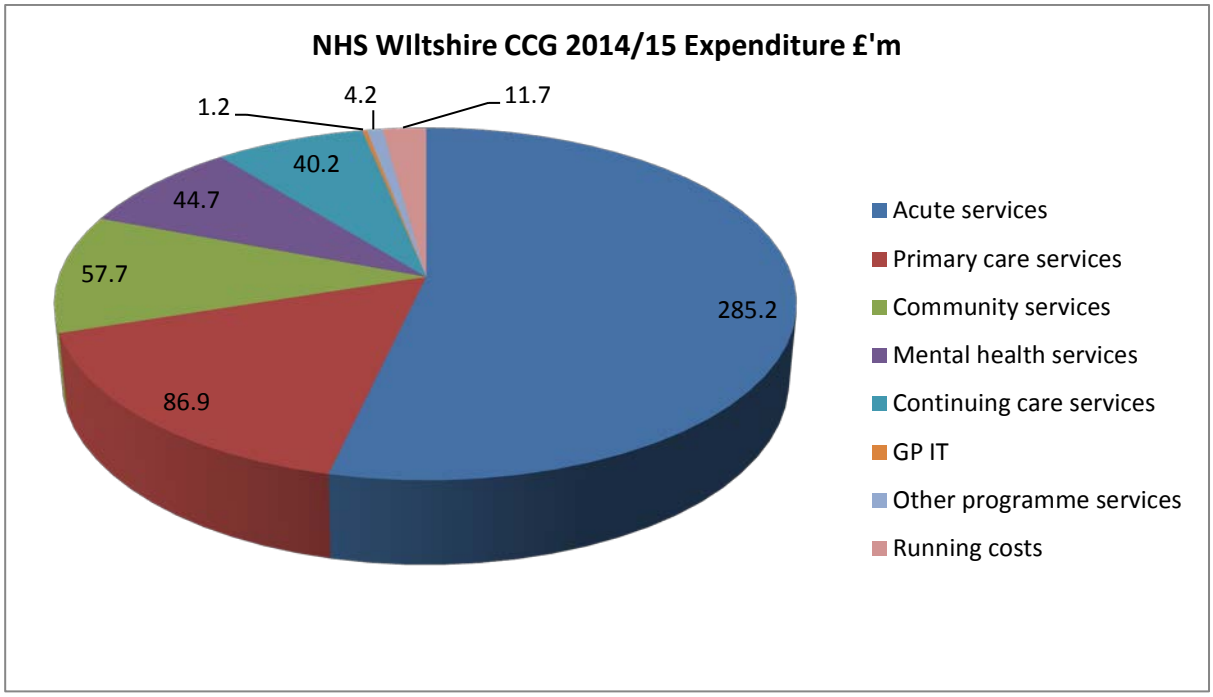
Given the challenges that have been experienced the CCG only achieved a surplus of £3.1m which is £2.2m under the planned target of £5.3m. The CCG achieved all of the other financial targets as listed below:

Target Description	Target	Achievement
Planned Surplus against Resource Limit	£5.25m	£3.09m
Revenue Cash Limit – balance in account	<£0.25m	£0.05m
Capital Resource Limit	£2.7m	£2.7m
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%	98.8% 99.7%
Core Running Cost Allocation Performance of £11.64m	£11.64m	£11.6m

The CCG received funding of £535m of which £12.1m related to the running costs of the CCG (£0.4m of which was non recurrent quality premium funding). Against this total allocation the CCG has spent £531.9m and delivered a surplus of £3.1m - – this is an adverse variance of £2.2m against the plan position of £5.3m due to activity pressures and the non-delivery of QIPP schemes.

The split of this expenditure by programme area is shown in figure below:

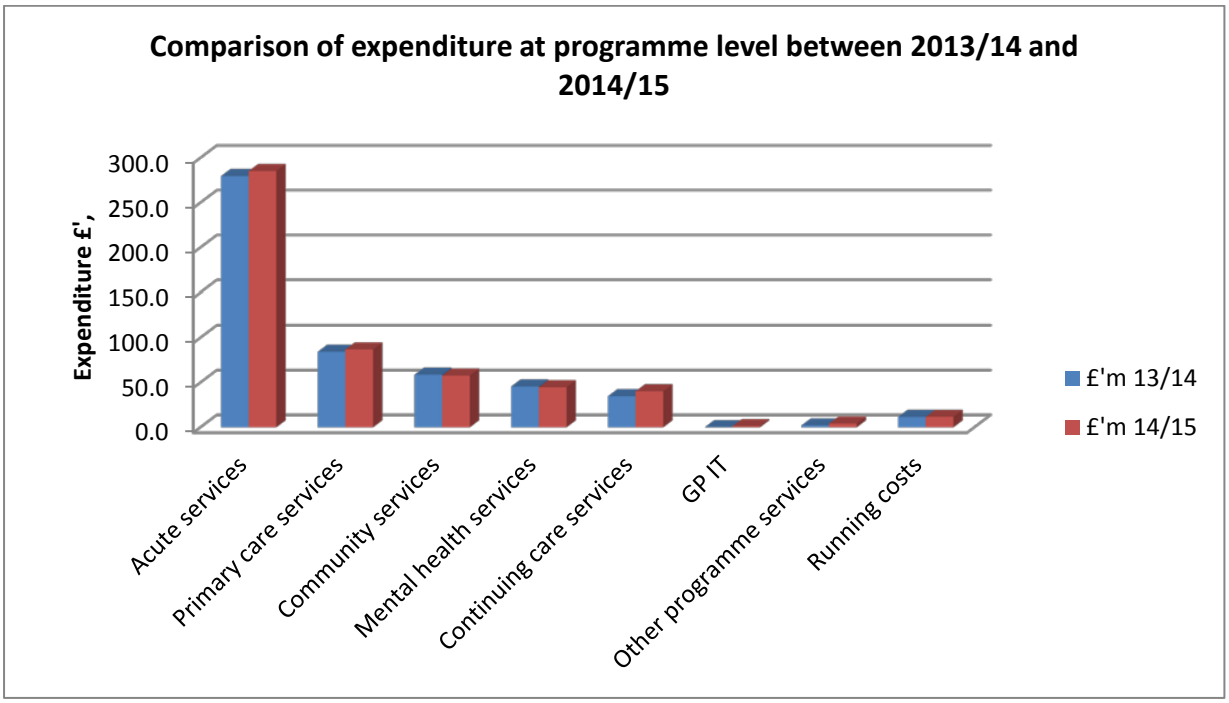
Breakdown of the CCG Expenditure for 2014/15



The CCG achieved its running costs with 29.5% of its allocation paid to the Central Southern Commissioning Support Unit for commissioning and back office functions support and 70.5% relating to direct CCG costs.

The graph below compares the CCG expenditure, at programme level, with the prior financial year. This positon shows that additional monies were spent in most areas with the inclusion of GP IT, which the CCG became responsible for in 2014/15.

Comparison of 2013/14 and 2014/15 expenditure



Financial Year 2015/16

This financial year is set to be as challenging as the one we have just finished. The CCG has set itself a savings target of £9.5m in order to invest in transformed services in line with the CCG 5 year strategic plan. This includes the continuation 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 patients to hospital when they are acutely ill and establish more community capacity across health and social care. Our financial plan for 2015/16 is shown below with comparisons to the actual expenditure for 2014/15. Note that 2014/15 takes account of the impact of tariff deflation, service transfers to other commissioners where appropriate and does include capital grant payments and GP IT.

Programme area	2014/15Actual £'m	2015/16 Plan £'m
Acute services	285.2	278.1
Mental Health services	44.7	45.8
Community services	57.7	57.9
Continuing Care services	30.5	29.0
Better Care Fund	9.7	27.1
Primary Care services	88.1	88.8
Other Programme services	4.2	7.9
Total - Commissioning services	**520.2**	**534.7**
Running Costs	11.7	10.5
Contingency	0.0	2.8

Programme area	2014/15Actual £'m	2015/16 Plan £'m
Total application of funds	**531.9**	**547.9**
Surplus/(Deficit)	**3.1**	**5.5**

The CCG 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.
- **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
- **Mental Health** – CCGs are required to increase its investment in mental health services. The CCG will be investing in mental health to support parity of esteem.
- **Winter Resilience** – the CCG in previous years has received funding to support the resilience of the health system across times of high demand particularly in the winter. This funding is now in the recurrent resources of the CCG. The CCG will look to fund schemes that support the health systems at times of high demand.

The challenges facing the CCG in 2015/16 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

Background

As our world is impacted upon by business and agriculture choices and by peoples' lifestyles, sustainability becomes increasingly important. As part of the 2013 authorisation process, CCGs have self-certified compliance to the statement:
"We declare that at the point of authorisation our CCG will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner". NHS Wiltshire CCG acknowledges the responsibility to our patients, local communities and the environment to take steps to lessen our impact and the impact of the decisions we make and the contracts we put in place for healthcare. We will strive to minimise our carbon footprint and adhere to Sustainable Development principles.

Sustainability Planning

NHS Wiltshire CCG is one of three tenants in Southgate House in Devizes. This property is owned by NHS Property Services who manage waste collection, energy usage and water usage. As NHS Wiltshire CCG was created on 1 April 2013, we have been working with NHS Property Services to establish a baseline for the site and appropriate methods to apportion the usage between the tenants. As Southgate House is an old building, the CCG and NHS Property Services have discussed where some capital investment may be made on sustainability projects to improve the facility. We intend to work on a Sustainability Site Plan during 2015/16 in association with NHS Property Services and the other tenants.

NHS Wiltshire CCG is also considering how our day-to-day operations can have a stronger focus on sustainability. We already have central waste arrangements, rather than waste bins at each desk, with both confidential and non-confidential paper waste being collected by a shredding contractor for recycling (318 trees saved in 2013 and 347 trees saved in 2014). The CCG has worked with NHS Property Services to upgrade the main kitchen used by staff and in support of committee meetings. Equipment has been improved to reduce water usage and A+ rated equipment has been installed. Southgate House benefits from a shower facility and staff are encouraged to cycle to work. The CCG has access to and regularly uses telephone conferencing equipment to reduce the need to travel to meetings. Localised printing has been reduced with centralised energy and ink efficient printers now in place. The CCG will be looking at operational initiatives for sustainability during 2015/16.

The largest impact that the CCG can make is through sustainable commissioning. The CCG is committed to commissioning health care to be provided in a way that supports the UK sustainable development agenda and contributes to environmental improvements, regeneration and reducing health inequalities. As part of the NHS Wiltshire CCG Five Year Strategic Plan (2014 – 2019), we aspire to create a model within which, when care is needed it can be delivered closer to home, creating a system built around individuals and local communities. Key to achieving this will be multi-disciplinary teams based in small community based clusters to provide integrated and accessible care. Current services are being redesigned so that investment can be freed up to develop the necessary infrastructure and services out of hospital to deliver this localised healthcare vision.

Sustainability Policy

NHS Wiltshire CCG is determining its vision for sustainability and its responsibilities for delivery, working with NHS Property Services and our partners in the delivery of healthcare for the growing population of Wiltshire. The Policy will consider commissioning, general operations and travel and actions will be reflected in a Sustainable Development Management Plan (SDMP).

Performance and progress

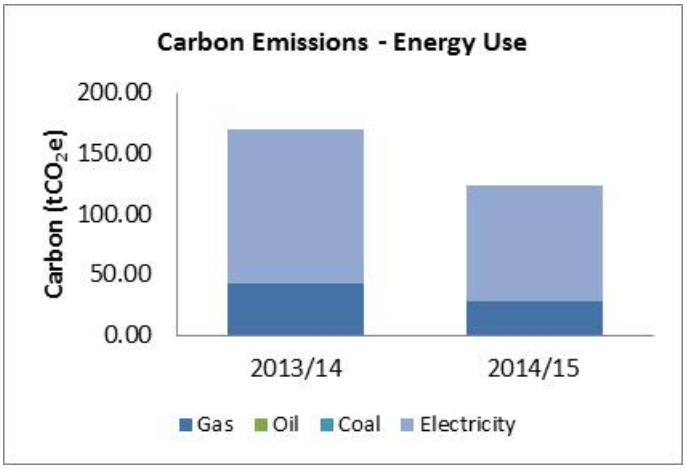
As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions by 10% using 2007 as the baseline year. Here's how we have done:

Energy:

NHS Wiltshire CCG has spent £34,834 on energy in 2014/15 which is a 25.8% increase on 2013/14.

Resource		2013/14	2014/15
Gas	Use (kWh)	202066.1	138401.83
	tCO_2e	42.87	29.04
Oil	Use (kWh)	0	0
	tCO_2e	0	0
Coal	Use (kWh)	0	0
	tCO_2e	0	0
Electricity	Use (kWh)	228150	153840
	tCO_2e	127.74	95.28
Total Energy CO_2e		170.61	124.31
Total Energy Spend		£ 27,683.91	£ 34,833.86

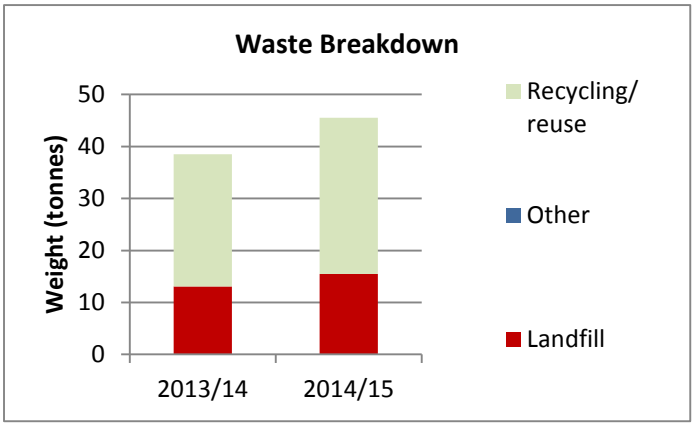
Although the spend on energy has increased, the consumption of both gas and electricity has fallen by approximately 32%.



Waste:

All of the CCG waste is office type waste. In 2014/15 about 66% (65% in 2013/14) of our waste was sent for recycling (materials recovery). Although this shows a percentage improvement we are generating more waste overall and sent more to landfill in 2014/15 than we did in 2013/14. This trend needs to be examined and actions taken to reduce waste.

Waste		2013/14	2014/15
Recycling/ reuse	(tonnes)	25	30
	tCO_2e	0.53424	0.63168
Other	(tonnes)	0	0
	tCO_2e	0	0
Landfill	(tonnes)	13	15.47
	tCO_2e	3.196984259	3.781142698
Total Waste (tonnes)		38.52	45.55
% Recycled or Re-used		0.660436137	0.660373216
Total Waste tCO_2e		3.731224259	4.412822698



Water:

The water usage for NHS Wiltshire CCG has increased by approximately 15% in 2014/15. The CCG needs to investigate the reasons behind this increase to determine if steps may be taken to reduce usage.

Water		2011/12	2013/14
Mains	m^3	1277	1506
	tCO_2e	1	1
Water & Sewage Spend		£ 3,265	£ 3,851

Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

Our main providers Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Avon & Wiltshire Mental Health Partnership NHS Trust all have a score of ‘Good’ for sustainable development while Royal United Hospital NHS Foundation Trust, Bath has a score of ‘Excellent’ based on their 2013/14 returns.

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 over 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 for approval, critically assessing the impact on protected groups and identifying opportunities to promote equality at the start of projects and programmes.

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 & Diversity Strategy 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.

We have an Equality and Diversity Strategy which has identified 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 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 and this is reflected in our CCG Constitution.

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 2015 we had 126 staff (110.5 whole time equivalents). The majority of workforce within the CCG is female (78.6%) and the majority of the workforce has declared an ethnic group of 'White-British' (89.7%). 11.11% of the workforce of the CCG are aged 60 years and over. Although we are monitoring the staff information, the PSED exempts us from publication of detailed information as we have fewer than 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

Breakdown of number of employees of each gender who were on the Governing Body and details of numbers of each gender employed as a Very Senior Manager (VSM)			
	Female Headcount	**Male Headcount**	**Total**
Governing Body	5	7	12
Very Senior Manager(VSM)	0	0	0
All other Employees	96	21	117
Total Employees	101	28	129

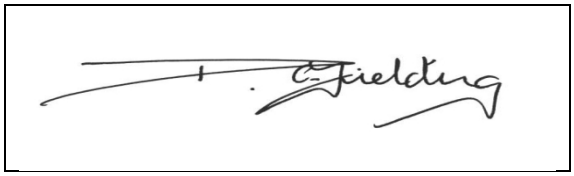
Disabled employees

The CCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics but it has incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance to discipline.

The CCG's 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.

The CCG publishes their employee profile by each of the nine protected characteristics, this helps the organisation to identify and address areas of under-representation in a systematic manner as and when opportunities arise.

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
28 May 2015

Members' Report

Members' Report

Member Practices

North and East Wiltshire (NEW)

Beversbrook Medical Centre - Calne
Box Surgery
Cricklade Surgery, also Ashton Keynes Surgery
Hathaway Medical Centre - Chippenham
Malmesbury Primary Care Centre
New Court Surgery – Wotton Bassett
Northlands Surgery - Calne
Old School House Surgery – Great Bedwyn
Patford House Partnership, also Sutton Benger Surgery - Calne
Pewsey Surgery
Purton Surgery, also Green Gable Surgery, Cricklade
Ramsbury Surgery, also Wanborough Surgery
Rowden Medical Partnership - Chippenham
The Lodge Surgery - Chippenham
The Marlborough Medical Practice
The Porch Surgery - Corsham
The Sprays Surgery - Burbage
The Tolsey Surgery - Sherston
Tinkers Lane Surgery – Wotton Bassett

Sarum

Avon Valley Practice - Upavon
Barcroft Medical Practice - Amesbury
Cross Plains Surgery - Shrewton
Downton Surgery
Endless Street Surgery - Salisbury
Harcourt Medical Centre - Salisbury
Hindon Surgery
Mere Surgery
Orchard Partnership - Wilton
Salisbury Medical Practice
Silton Surgery
Sixpenny Handley - Salisbury & Chalke
Valley Surgery – Broad Chalke
St Ann Street Surgery - Salisbury
The Bourne Valley Practice - Ludgershall
The Castle Practice - Tidworth
Three Swans Surgery - Salisbury
Tisbury Surgery
Whiteparish Surgery
Wilton Health Centre

West Wiltshire, Yatton Keynell and Devizes (WWYKD)

Adcroft Surgery - Trowbridge
Bradford on Avon & Melksham Health Partnership
Bradford Road Medical Centre - Trowbridge
Courtyard Surgery – West Lavington
Giffords Surgery - Melksham
Jubilee Field Surgery – Yatton Keynell
Lovemead Group Practice - Trowbridge
Market Lavington Surgery
Southbroom Surgery - Devizes
Spa Medical Centre - Melksham
St James' Surgery - Devizes
The Avenue Surgery - Warminster
The Lansdowne Surgery - Devizes
Westbury Group Practice
Widbrook Medical Practice - Trowbridge

Governing Body 14/15

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

At 31 March 2015, 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 14 times during the period 1 April 2014 to 31 March 2015.

The details of the Governing Body membership at 31 March 2015 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 Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Richard Sandford-Hill November 2014 onwards	GP Vice Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Chet Sheth September 2014 onwards	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
Dina McAlpine February 2015 onwards	Interim Director of Quality and Patient Safety
Jo Cullen	Group Director – West Wiltshire, Yatton Keynell and Devizes
Mark Harris	Group Director – Sarum
Ted Wilson	Group Director – North and East Wiltshire
Lynn Talbot	Interim Director of Community Transformation
Dr Peter Jenkins	GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
James Roach	Director of Integration
Maggie Rae	Corporate Director, Wiltshire Council
Chris Graves	Chair, Healthwatch, Wiltshire
Diana Hargreaves	Board Administrator, CCG

Non-members who always attend (no voting rights)	
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO
Sarah MacLennan November 2014 onwards	Interim Head of Communications and Engagement

The CCG's 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, the CCG has 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 as a CCG 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	Vice Chair, Lay Member: Patient and Public Involvement
Mary Monnington	Registered Nurse Member
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Dr Anna Collings	GP Vice Chair, NEW
Simon Truelove	Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Lynn Pamment/Natalie Tarr	Internal audit, Price Waterhouse Cooper
Duncan Laird/Jonathan Brown/Tara Westcott	External audit, KPMG UK LLP
Tracey Spragg	Counter Fraud Specialist
Paul Travers November 2014 onwards	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 96. There are more details about all our Governing Body members in the Governing Body and Senior Management Profiles section on page 85.

Pension Liabilities

Note 5.5 of the annual accounts (contained within Appendix 2) provide further information on the relevant pension schemes used by the CCG.

Accessible leadership and responding to staff (Employee consultation)

NHS Wiltshire CCG is a medium sized employer of 129 staff. 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.

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

The CCG recognises 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 the first two years as a CCG, although arrangements for formal staff consultation are likely to be reviewed in light of our Business Plan to consider where our approach may be further strengthened going forward.

The CCG has delegated negotiations over HR policy development to the Central Southern Commissioning Support Unit (CSCSU) Staff Partnership Forum (SPF). The CSCSU SPF considers collated feedback from the CCG as part of this process and ensures staff and trade unions are equally engaged in the development process. Policies are formally reviewed by the Executive Management Team and by staff, who have the opportunity to comment and feedback, before being approved and adopted by the CCG Audit and Assurance Committee.

The CCG has an organisational development plan which sets out how the organisation and individuals within it will progress to full capability. This is a two year programme and substantial progress has been made.

The CCG has adopted a policy of visible and accessible leadership, with senior management engaging with staff.

Managers hold regular one-to-one meetings with their individual staff members and a robust objective-led appraisal system is in place to allow all staff to work towards clearly defined personal objectives, emanating from the Chief Officer down, and to ensure that all staff are contributing to the organisation's objectives and priorities. Staff are supported with learning, training and development opportunities for everyone to help them be the best they can be in order to meet their personal work objectives.

Staff Survey

The CCG recently undertook an annual Staff Engagement Survey and the resulting analysis and Survey Report was carefully considered by the Executive Management Team. The results of the survey will be used to develop an action plan with broad staff involvement in order to tackle any areas of improvement identified through the survey.

Sickness absence data

The organisation has an approved policy and associated procedure to help with the management of sickness absence.

Sickness absence is managed in a supportive and effective manner by CCG managers, with professional advice and support from Human Resources, Occupational Health and Staff Support services. The CCG's approach to managing sickness absence is governed by a clear 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 to the CCG Governing Body on a quarterly basis as part of the workforce reporting mechanism.

NHS Wiltshire CCG Staff sickness absence (April 2014 to March 2015):

Total WTE Days Available	39,635.21
Total WTE Days Sickness	1,302.47
% FTE Days Sickness	3.29%

The data presented in the Annual Accounts (note 5.3) covers the calendar year 2014.

There were no ill-health retirements during this period.

External Audit

The cost of work performed by our external auditors, KPMG, in 2014/15 was £90,000 plus VAT.

Disclosure of "serious untoward incidents"

The CCG has not had any data losses or confidentiality breaches that have been categorised as Serious Untoward Incidents.

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 33.

Communication with our staff

NHS Wiltshire CCG consists of 129 members of staff drawn from a wide variety of professional groups, including clinicians, managers and executive directors.

We communicate with our staff through a number of channels, and employees are encouraged to engage so that the process becomes an open, two-way conversation, so that they can feel supported, informed and valued.

Executive Team Meetings are held once a week and these are attended by our Directors. Relevant news, issues and information is then cascaded to staff within each of the separate directorates / locality groups, through weekly team meetings. These messages are reiterated complimented with additional news (including information about development opportunities, news from the wider health community and social activities) in our fortnightly newsletter “14 Days” which is managed and issued by the Communications Team and to which staff are encouraged to contribute. Quarterly ‘Meet and Greet’ sessions are hosted by the CCG Chair and Chief Executive, at which staff are presented with updates on the CCG’s business and are encouraged to share their views and ask questions. We are also in the process of organising “Directors Corner” open-door events, which will take place once a month as drop-in sessions whereby members of staff can talk to a director face to face, separately or in small groups.

Our intranet is in the process of being upgraded. In its current form it acts as a resource for key information, forms and documents to support staff in their day to day working. At time of writing the intranet is undergoing considerable development, with the aim that it will become the ‘go-to’ place for all pieces of news and information required by CCG staff and our wider GP membership, managed and updated by the Communications team on a daily basis (or as necessary) to create a sense of community which celebrates the CCG’s collaborative culture and underpins our vision and values. “14 Days” will continue to be published to staff, acting as a news round-up which prompts staff to the intranet.

We currently hold an annual staff survey; the results of which are reported to the CCG’s Governing Body before being shared with staff more widely. The results are used to engage our staff in creating key objectives for the organisation, so that we are able to test how staff are feeling, to allow us to see where gaps might be and where improvements can be made.

Managers hold regular one-to-one meetings with staff helping staff to work towards clearly defined personal objectives which are supported with learning, training and development opportunities.

The CCG has delegated negotiations over Human Resource policy development to the South, Central and West Commissioning Support Unit (SCWCSU) Staff Partnership Forum. This Forum considers collated feedback from the CCG as part of the delegated process and ensures that staff members and trade unions are equally engaged in the CCG's development process.

The CCG recognises all of the trade unions outlined in the national Agenda for Change terms and conditions handbook. Since April 2013 a number of policies have been developed to enhance and support staff in the working environment and staff were invited to comment on the following CCG policies:

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

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

All our policies have all 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 SCWCSU Staff Partnership Forum.

Disabled Employees and Equal Opportunities

The CCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics but it has 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 identify 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

We are working on a revision of 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 being assisted in this process by Central Southern Commissioning Support Unit (CSCSU) who provide expertise to take this work forward and facilitate the implementation of the Equality Delivery System Framework. Our aim remains 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 the clinical commissioning group has an Accountable Emergency Officer and complies with NHS England Core Standards for EPRR 2014. The CCG is an active contributor to the EPRR agenda through its involvement in the Wiltshire and Swindon Local Health Resilience Partnership.

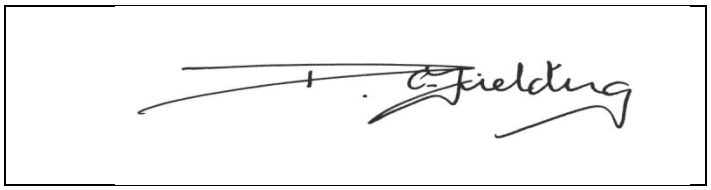
In August 2014, the CCG provided assurance to NHS England about our compliance with the EPRR Framework. As part of this assurance we were required to show how we were going to address any gaps in the provision that we had already identified.

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 clinical commissioning group'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 clinical commissioning group's auditor is aware of that information.



Deborah Fielding
Chief Officer
28 May 2015

Remuneration Report

Remuneration Report

Each CCG has a Remuneration Committee, the role of which is to determine and approve the remuneration package for Very Senior Managers (VSMs). In 2014/15, the CCG Remuneration Committee met on three occasions.

Membership of the Remuneration Committee is made up of the following members:

Name	Role	Member type	Additional information	Number of meetings attended in 2014/15
Peter Lucas	Lay member	Voting	Chair of committee	3
Christine Reid	Lay member	Voting	Vice Chair of committee	3
Mary Monnington	Registered Nurse	Voting		2
Dr Mark Smithies	Secondary Care Doctor	Voting		2
Dr Helen Osborn	GP Chair, West Wiltshire, Yatton Keynell and Devizes	Voting		3
Dr Steve Rowlands	CCG Chair	Non voting		3
Deborah Fielding	Chief Officer	Non voting		0
David Noyes	Director of Planning, Performance and Corporate Services	Non voting		3
Simon Truelove	Chief Financial Officer	Non voting		0
Kate Roberts	HR Business Partner CSCSU	Non voting		3
Diana Hargreaves	CCG Board Administrator	Non voting		3

Remuneration Report – Senior Managers

This table shows the remuneration awarded to the CCG's senior managers. Senior managers are defined as "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

This disclosure is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements.

Salaries and Allowances

The figures reported in this table relate to those individuals who hold or have held office as a senior manager of the CCG (members of the Governing Body) during 2014/15.

Salary – this is the remuneration payable in respect of the period that the senior manager has held office;

Pension Related Benefits –The figures shown under "All Pension Related Benefits" in the table above are a calculation of the change in an individual's accrued pension benefit between the beginning and the end of the financial year.

This is based on the following mandated national formula: [(20 x PE) + LSE] - [(20 x PB) + LSB] less the employee's pension contributions where:

- PE and LSE are the accrued pension and lump sum values at the end of the pension input period, and
- PB and LSB are the accrued pension and lump sum values as at the beginning of the input period, adjusted for inflation.

The impact of this formula is to show the individual's increase in pension during the year, spread over an average period of twenty years (an estimate of how long that pension would be paid for in retirement).

Total – this is the sum of the salary and pension related benefits. However, this is not the actual cash paid by the CCG during the year;

Name & Title	**Salary (bands of £5,000)**	**All Pension Related Benefits (bands of £2,500)**	**Total (bands of £5,000)**
Dr Steve Rowlands, GP Chair	**60-65**		**60-65**
Deborah Fielding, Chief Officer	**115-120**		**115-120**
Simon Truelove, Chief Financial Officer	**100-105**	**0-2.5**	**100-105**
Christine Reid, Lay Member, Patient and Public Involvement	**5-10**		**5-10**
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	**15-20**		**15-20**
Dr Simon Burrell (1), GP Chair, NEW Group	**65-70**		**65-70**
Dr Helen Osborn (2), GP Chair, WWYKD Group	**65-70**		**65-70**
Dr Toby Davies (3), GP Chair, Sarum Group	**45-50**		**45-50**
Dr Anna Collings, GP Vice Chair, NEW Group	**35-40**	**55-57.5**	**90-95**
Dr Debbie Beale (4), GP Vice Chair, WWYKD Group to 6/11/14	**25-30**		**25-30**
Dr Richard Sandford-Hill (5), GP Vice Chair, WWYKD Group from 6/11/14	**20-25**		**20-25**

Name & Title	Salary (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Celia Grummitt (6), GP Vice Chair, Sarum Group to 23/9/14	**30-35**		**30-35**
Dr Chet Sheth (7), Gp Vice Chair, Sarum Group from 23/9/14	**20-25**		**20-25**
Mary Monnington, Registered Nurse Member	**10-15**		**10-15**
Dr Mark Smithies, Secondary Care Doctor	**5-10**		**5-10**
David Noyes, Director of Planning, Performance and Corporate Services	**100-105**	**20-22.5**	**120-125**
Jo Cullen, Group Director – WWYKD Group	**85-90**	**22.5-25**	**110-115**
Mark Harris, Group Director – Sarum Group	**100-105**	**32.5-35**	**135-140**
Ted Wilson, Group Director – NEW Group	**100-105**	**0**	**100-105**
Jacqui Chidgey-Clark, Director of Quality and Patient Safety to 15/3/15	**95-100**	**0**	**95-100**
Dina McAlpine, Interim Director of Quality and Patient Safety from 15/3/15	**0-5**	**25-27.5**	**25-30**
Lynn Talbot (8), Interim Director of Community Transformation	**110-115**		**110-115**
Dr Peter Jenkins, GP Medical Advisor, Safeguarding (children) and Clinical Exceptions	**60-65**		**60-65**
James Roach (9), Director of Integration	**75-80**		**75-80**

No senior manager has received any taxable benefits during 2014/15.

No senior manager has received any form of performance related pay during 2014/15.

1. The costs for Dr Simon Burrell were recharged by The Porch Surgery
2. The costs for Dr Helen Osborn were recharged by Courtyard Surgery
3. The costs for Dr Toby Davies were paid via an agency – Morley Manor Ltd
4. The costs for Dr Debbie Beale were recharged by White Horse Health Centre
5. The costs for Dr Richard Sandford-Hill were recharged by Market Lavington Surgery
6. The costs for Dr Celia Grummitt were paid via an agency - Rainbow 2 Ltd
7. The costs for Dr Chet Sheth were paid via an agency - CS Medical Consultancy
8. The costs for Lynn Talbot were paid via an agency - McLaren Perry Ltd
9. The costs for James Roach were recharged by Wiltshire Council.

Salaries and Allowances 2013/14

The figures reported in this table relate to those individuals who held office as a senior manager of the CCG (members of the Governing Body) during 2013/14.

Name & Title	Salary & Fees (bands of £5,000)	Taxable Benefits (rounded to nearest £00)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Steve Rowlands, GP Chair	**60-65**	**0.7**	**65-67.5**	**125-130**
Deborah Fielding, Chief Officer	**110-115**	**1.8**		**115-120**
Simon Truelove, Chief Financial Officer	**90-95**	**0.5**	**50-52.5**	**145-150**
Christine Reid, Lay Member, Patient and Public Involvement	**10-15**	**0.9**		**10-15**
Peter Lucas, Lay Member, Audit, Governance and Vice Chair	**20-25**	**1.4**		**20-25**
Dr Simon Burrell, GP Chair, NEW Group	**65-70**			**65-70**
Dr Helen Osborn, GP Chair, WWYKD Group	**90-95**			**90-95**
Dr Toby Davies, GP Chair, Sarum Group	**45-50**			**45-50**
Dr Jonathan Rayner, GP Vice Chair, NEW Group	**40-45**			**40-45**
Dr Debbie Beale, GP Vice Chair, WWYKD Group	**45-50**			**45-50**
Dr Celia Grummitt, GP Vice Chair, Sarum Group	**65-70**			**65-70**
Mary Monnington, Registered Nurse Member	**10-15**			**10-15**
Dr Mark Smithies, Secondary Care Doctor	**5-10**			**5-10**
David Noyes, Director of Planning, Performance and Corporate Services	**90-95**	**2.5**	**17.5-20**	**115-120**
Jo Cullen, Group Director – WWYKD Group, from 1/9/2013	**40-45**	**0.3**	**42.5-45**	**85-90**
Mark Harris, Group Director – Sarum Group	**95-100**	**7.6**	**57.5-60**	**165-170**
Ted Wilson, Group Director – NEW Group	**95-100**	**2.3**	**52.5-55**	**155-160**

Name & Title	Salary & Fees (bands of £5,000)	Taxable Benefits (rounded to nearest £00)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Jacqui Chidgey-Clark, Director of Quality and Patient Safety	**95-100**	**2.5**	**212.5-215**	**310-315**
Lynn Talbot, Interim Director of Community Transformation	**95-100**			**95-100**
Dr Peter Jenkins, GP Medical Advisor, Safeguarding (children) and Clinical Exceptions	**65-70**			**65-70**
Mike Relph, Group Director – WWYKD Group, to 30/9/2013	**40-45**	**0.6**	**10-12.5**	**55-60**
Alison Alsbury, Interim Director of Community Transformation, to 31/7/2013	**55-60**			**55-60**

No senior manager has received any form of performance related pay during 2013/14.

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 Ltd.
The costs for Dr Simon Burrell were re-charged by The Porch Surgery
The costs for Dr Jonathan Rayner were re-charged by Ramsbury Surgery
The costs for Dr Toby Davis were partly re-charged by Castle Practice and partly paid via an agency - Morley Manor Ltd
The costs for Dr Celia Grummittt were paid via an agency - Rainbow 2 Ltd
The costs for Dr Debbie Beal were re-charged by White Horse Health Centre
The costs for Dr Helen Osborn were re-charged by Courtyard Surgery

Pension Statement

This table discloses the pension entitlements at the end of the financial year for senior managers, in accordance with the government's Financial Reporting Manual (FReM). The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

Name & 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 2015 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Simon Truelove, Chief Financial Officer	**0-2.5**	**0-2.5**	**20-25**	**65-70**	**329**	**357**	**19**	**0**
Dr Anna Collings, GP Vice Chair, NEW Group	**2.5-5**	**7.5-10**	**5-10**	**20-25**	**80**	**123**	**41**	**0**
David Noyes, Director of Planning, Performance and Corporate Services	**0-2.5**	**0**	**0-5**	**0**	**17**	**37**	**19**	**0**
Jo Cullen, Group Director – WWYKD Group	**0-2.5**	**2.5-5**	**20-25**	**60-65**	**343**	**390**	**37**	**0**
Mark Harris, Group Director – Sarum Group	**0-2.5**	**5-7.5**	**25-30**	**80-85**	**355**	**405**	**40**	**0**
Ted Wilson, Group Director – NEW Group	**0-2.5**	**0-2.5**	**40-45**	**120-125**	**795**	**851**	**34**	**0**
Jacqui Chidgey-Clark, Director of Quality and Patient Safety to 15/3/15	**0-2.5**	**0-2.5**	**25-30**	**85-90**	**524**	**557**	**18**	**0**

Name & 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 2015 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Dina McAlpine, Interim Director of Quality and Patient Safety from 15/3/15	**0-2.5**	**0-2.5**	**10-15**	**30-35**	**151**	**184**	**1**	**0**

- Deborah Fielding and Dr Peter Jenkins are not members of the NHS Pension Scheme, and the CCG does not make any contributions towards a pension. Therefore, there are no disclosures to be made.
- Christine Reid, Peter Lucas, Mary Monnington and Dr Mark Smithies do not receive pensionable remuneration.
- With the exception of Dr Anna Collings, payments to the GP members reported in the salaries and allowances table are made either via their practices or to agencies. As the CCG is not contributing directly to the GP's pension, there are no disclosures to be made.

Pension Statement 2013/14

Name & 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**	**1,561**	**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**	**51**	**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 Davis, GP Chair, Sarum Group	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr Jonathan Raynor, 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**	**17**	**0**

Name & 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
Jo Cullen, Group Director – WWYKD Group (from September 2013)	**0-2.5**	**5-7.5**	**15-20**	**55-60**	**287**	**343**	**50**	**0**
Mark Harris, Group Director – Sarum Group	**2.5-5**	**7.5-10**	**20-25**	**70-75**	**295**	**355**	**53**	**0**
Ted Wilson, Group Director – NEW Group	**2.5-5**	**7.5-10**	**35-40**	**115-120**	**701**	**795**	**77**	**0**
Jacqui Chidgey-Clark, Director of Quality and Patient Safety	**7.5-10**	**27.5-30**	**25-30**	**85-90**	**327**	**524**	**190**	**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**

- Deborah Fielding and Dr Peter Jenkins are not members of the NHS Pension Scheme, and the CCG does not make any contributions towards a pension. Therefore, there are no disclosures to be made.
- No CETV is available for Dr Steve Rowlands or for Mike Relph as they are either over the retirement age and/or currently in receipt of NHS Pension benefits.
- Payments to the GP members reported in the salaries and allowances table are made either via their practices or to agencies. As the CCG is not contributing directly to the GP's pension, there are no disclosures to be made.

This disclosure is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. This disclosure is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements.

The banded remuneration of the highest paid director in NHS Wiltshire CCG in the financial year 2014/15 was £185,000 to £190,000 (2013/14, £165,000 to £170,000) on a whole time equivalent basis. This was 4.95 times the median remuneration of the workforce (2013/14, 4.57 times), which was £37,921 (2013/14, £36,666). The ratio has increased this year due to the appointment, via the local authority, of a specialist director to oversee the integration of care pathways between the CCG and the local authority. The CCG is not fully funding the whole time equivalent remuneration of the role.

If this role is excluded from the calculation, the banded remuneration of the highest paid director reduces to £160,000 to £165,000 on a whole time equivalent basis. The pay ratio also reduces to 4.29 times the median remuneration of the workforce, which stays at £37,921, and is a reduction compared to the 2013/14 ratio of 4.57.

In 2014/15, 0 employees received remuneration in excess of the highest-paid director. Whole time equivalent remuneration ranged from £16,000 to £190,000.

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.

This calculation has been audited by the CCG's external auditor.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The real increase in CETV reflects the increase in CETV which is effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement, and benefits accrued as a result of their purchasing additional years of pension service at their own cost)) and uses common market valuation factors for the start and end of the period.

CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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) Off-payroll engagements as at 31 March 2015, for more than £220 per day and that last longer than 6 months, are as follows:

	Number
Number of existing engagements as of 31 March 2015	12
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	7
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

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) New off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than 6 months, are as follows:

	Number
Number of new engagements between 1 April 2014 and 31 March 2015.	5
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	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	0
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received	0

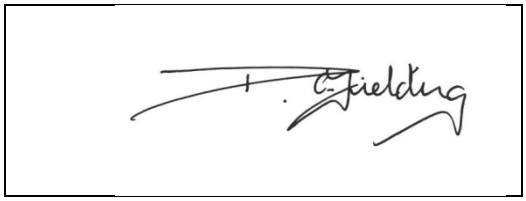
iii) Off payroll engagements of board members and or senior officials with significant financial responsibility between 1 April 2014 and 31st March 2015, are as follows:

	Number
Number of off-payroll engagements of board members and senior officials with significant financial responsibility during the year	4
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.	24

Exit packages disclosure

During 2014/15 there were 3 agreed departures, which have been paid in accordance with standard NHS terms and conditions. These were accounted for and paid during 2014/15. Details are reported in Note 5.4 of the financial statements.

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension scheme. Ill-health retirement costs are met by the NHS Pension scheme and are not included. During 2014/15, the CCG has not agreed any early retirements.



Deborah Fielding
Chief Officer
28 May 2015

Governing Body and Senior Management Profiles

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 NHS Foundation Trust, Bath
- Locum GP

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 / Senior Information Risk 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 Deputy Chief Executive of the Royal United Hospital NHS Foundation Trust, Bath

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:

- Partner in Porch Surgery, Corsham
- Director of Wilcare – no longer an active organisation
- Trustee of Corsham Link

Member of the following committees:

- Governing Body
- Finance Committee

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:

- Owner and GP Partner in Courtyard Surgery Practice, West Lavington
- Employed by Sirona Health & Care to provide contraceptive services

Member of the following committees:

- Governing Body
- Remuneration Committee
- Finance 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 specialists include asthma, cardiology and minor surgery.

Declared Interests:

- Senior Partner in Castle Practice, Lugershall
- Sole Director of Morley Manor which is registered with Company House to provide medical services.
- Castle Practice is a shareholder in WilcoDoc which runs Salisbury Walk In Centre

Member of the following committees:

- Governing Body
- Finance Committee

Dr Anna Collings - GP Vice Chair, NEW

Anna was born and brought up in Wiltshire and is passionate about local services. Anna graduated in London in 1992 and previously worked as a locality chair in Swindon, now practicing in the village where she was brought up.

Declared Interests:

- GP Partner, Pewsey Surgery

Member of the following committees:

- Governing Body
- Audit and Assurance Committee

Dr Richard Sandford-Hill - GP Vice Chair, WWYKD

Richard qualified from St. George's Hospital Medical School in 1988. In 1994, after completing his General Practice training in West Dorset, Richard became a partner in the Market Lavington Surgery, where he has been a senior partner since 2006. Richard's specific clinical interests include minor surgery and palliative care.

Declared Interests:

- GP, Market Lavington Surgery

Member of the following committees:

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

Dr Chet Sheth- GP Vice Chair, Sarum

Chet qualified in 2003 at Imperial College in London. He has worked in several hospitals prior to joining St Ann's Street Surgery in Salisbury in 2009. His clinical interests include all aspects of family medicine, elderly and palliative care.

Declared Interests:

- GP Partner, St. Ann Street Surgery
- Shareholder of WilcoDoc which runs Salisbury Walk in Centre
- Director of Arden's Health Informatics Ltd

Member of the following committees:

- Governing Body
- Finance Committee

Mary Monnington - Registered Nurse Member

Mary qualified as a nurse in 1972 and has worked in a range of nursing posts. In 1978 she migrated 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 - Chair

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 Guys 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
- Financial and close family relationship with ‘Plus Guidance’ internet start-up company

Member of the following committees:

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

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
- Finance Committee

Mark Harris - Group Director – Sarum

Mark has worked for 21 years in 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:

- Great Western Hospitals NHS Foundation Trust Governor on behalf of NHS Wiltshire CCG

Member of the following committees:

- Governing Body
- Finance Committee

David Noyes - **Director of Planning, Performance & Corporate Services**

David retired from the Royal Navy in March 2013, after 28 years' service, to join the Clinical Commissioning Group. 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

James Roach - **Director of Integration**

James has worked in the NHS for the last 12 years. He entered the NHS via the NHS Graduate Management Scheme. James has extensive experience at Director level in both provider and commissioning organisations, more recently as a Chief Operating Officer in a CCG and then Accountable Officer of a large CCG.

Declared Interests:

- Joint appointment with Wiltshire Council

Member of the following committees:

- Governing Body

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:

- GP Partner, Avon Valley Practice which is a shareholder in WilcoDoc which runs Salisbury Walk In Centre
- Director of Bluebird Care (Wiltshire South)
- Director of Dignified Living Ltd
- Family connection to Lansdowne Surgery, Devizes

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee

Dina McAlpine – Interim Director of Quality and Patient Safety / Caldicott Guardian

Dina qualified as an RGN in 1993 having studied at Charing Cross Hospital, London. She initially worked in plastic and reconstructive surgery before specialising in adult intensive care in London. Upon moving to the West Country she continued to work in intensive care nursing.

Dina then left working in the NHS to commence work as a senior manager within the health and social sector. She later joined Wiltshire Primary Care Trust, working as a service improvement commissioner, focussing on older people and long term conditions. She then became associate director responsible for continuing healthcare and later took on responsibility for specialist placements.

Declared Interests:

- None

Member of the following committees:

- Governing Body
- Quality and Clinical Governance Committee

Lynn Talbot

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

Statement of Accountable Officer's Responsibilities

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 Clinical Commissioning Group.

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

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

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

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

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

Deborah Fielding
Accountable Officer
28 May 2015

Governance Statement

Governance Statement

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

Introduction and context

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006. NHS Wiltshire Clinical Commissioning Group was licenced without conditions for 2014/15.

The Governing Body of the CCG is made up of six practicing GP members elected by member practices, four Lay Members, a clinical Chair and two senior executives. Governing Body meetings are held in public every two months, in varying locations around Wiltshire to promote public access, and the public are invited to raise questions or comment on agenda items.

Scope of responsibility

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

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

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 CCG 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 employees and appointees of the CCG 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 the CCG 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 the policy of the CCG 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. The CCG 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 2014/15, the CCG has organised and participated in a number of activities across the County, including Stakeholder Assemblies. These are events at which we bring together around eighty 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 the clinical commissioning group's compliance with the principles set out in Code.

For the financial year ended 31 March 2015, 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'.

The CCG 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 of the CCG has, throughout each year, an on-going role in reviewing the CCG governance arrangements to ensure that the CCG continues to reflect the principles of good governance.

Committee structure

Governing Body:

The Governing Body has been responsible for:

- ensuring delivery of the CCG strategic aims and focus 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, transparent decisions;
- engaging stakeholders and making accountability real.

The Wiltshire GP practices form the Council of Members for the CCG. The Governing Body is made up 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 Stakeholder Engagement and Patient and Public Involvement Engagement and Lay Member for Audit & Assurance – thirteen in total.

The following Governing Body Members are In Attendance:

- Director of Planning, Performance and Corporate Services
- Three Group Directors
- Interim Director of Quality and Patient Safety
- Integration Director
- Interim Director of Transformation
- GP Medical Advisor
- Corporate Director, Wiltshire Council
- Chair, Healthwatch Wiltshire
- Board Administrator

Non-members who always attend:

- Interim Head of Communications and Engagement
- Associate Director, Performance, Corporate Services and Head of PMO

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 Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Debbie Beale April to November 2014	GP Vice Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Richard Sandford-Hill November 2014 to March 2015	GP Vice Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Celia Grummitt April to September 2014	GP Vice Chair, Sarum
Dr Chet Sheth September 2014 to March 2015	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 April 2014 to February 2015	Director of Quality and Patient Safety
Dina McAlpine February 2015 to March 2015	Interim Director of Quality and Patient Safety
Jo Cullen	Group Director – West Wiltshire, Yatton Keynell and Devizes
Mark Harris	Group Director – Sarum
Ted Wilson	Group Director – North and East Wiltshire

Lynn Talbot	Interim Director of Community Transformation
Dr Peter Jenkins	GP Medical Advisor, Safeguarding (Children) and Clinical Exceptions
James Roach	Director of Integration
Maggie Rae	Corporate Director, Wiltshire Council
Chris Graves	Chair, Healthwatch, Wiltshire
Diana Hargreaves	Board Administrator, CCG
Non-members who always attend (no voting rights)	
Rob Hayday	Associate Director, Performance, Corporate Services and Head of PMO
Helen Robinson-Gordon April to September 2014	Head of Communications and Engagement
Sarah MacLennan November 2014 onwards	Interim Head of Communications and Engagement

Remuneration and Terms of Service Committee:
This Committee advises the CCG 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 monitors, evaluates and confirms the satisfactory performance of these posts and ensures 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 where appropriate (no voting rights)	
Dr Steve Rowlands	GP Chair CCG
Deborah Fielding	Chief Officer
David Noyes	Director of Planning, Performance and Corporate Services
Dr Helen Osborn	GP Chair, WWYKD
Simon Truelove	Chief Financial Officer
HR Business Partner	CSCSU

Audit and Assurance Committee:
The role of this committee is 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 includes a clinical GP executive member with executive directors in attendance.

The committee reviews 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
Mary Monnington	Registered Nurse Member
Dr Mark Smithies	Secondary Care Doctor
In attendance (no voting rights)	
Dr Anna Collings	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
Tracey Spragg	Counter Fraud Specialist
Roger Ringham April to September 2014	Security Management Specialist
Paul Travers November 2014 to March 2015	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 considers and advises 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. During 2014/15, the Registered Nurse Lay Member of the CCG has chaired the Committee.

Mary Monnington	Chair, Registered Nurse Member
Dr Mark Smithies	Vice Chair, Secondary Care Doctor
Jacqui Chidgey-Clark April 2014 to February 2015	Director of Quality & Patient Safety
Dina McAlpine February to March 2015	Interim Director of Quality & Patient Safety
Dr Debbie Beale April to November 2014	GP Vice Chair, WWYKD
Dr Richard Sandford-Hill November 2014 to March 2015	GP Vice Chair, WWYKD
Christine Reid	Lay Member: Patient and Public Involvement
Debbie Rigby April to July 2014	Deputy Director of Quality & Patient Safety
Dina McAlpine July 2014 to February 2015	Deputy Director of Quality & Patient Safety
Karen Littlewood	Associate Director for Quality (Safeguarding Adults and Children)
Nadine Fox	Head of Medicines Optimisation
Susannah Long	Governance and Risk Manager
Dr Peter Jenkins	Named GP for Safeguarding Children
Sue Odams April 2014 to January 2015	Public Health Consultant, Wiltshire Council
Jeremy Hooper January 2015 to March 2015	Public Health Consultant, Wiltshire Council

Finance and Information Committee:
The Committee monitors the financial performance of the CCG against the approved detailed financial plans and seeks assurance that robust plans are in place to ensure financial risks are managed.

The Committee has 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. During 2014/15, the Committee was chaired by the CCG Chair.

Dr Steve Rowlands	GP Chair
Peter Lucas	Vice Chair, Lay Member: Audit and Governance
Deborah Fielding	Chief Officer
Simon Truelove	Chief Financial Officer
Steve Perkins	Deputy Chief Financial Officer
David Noyes	Director of Planning, Performance and Corporate Services
Christine Reid	Lay Member: Patient and Public Involvement
Jo Cullen	Group Director – West Wiltshire, Yatton Keynell and Devizes
Mark Harris	Group Director – Sarum
Ted Wilson	Group Director – North and East Wiltshire
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 Anna Collings	GP Vice Chair, North and East Wiltshire
Dr Debbie Beale April to November 2014	GP Vice Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Richard Sandford-Hill November 2014 to March 2015	GP Vice Chair, West Wiltshire, Yatton Keynell and Devizes
Dr Celia Grummitt April to September 2014	GP Vice Chair, Sarum
Dr Chet Sheth September 2014 to March 2015	GP Vice Chair, Sarum

Locality Group Committees:
The CCG has established a committee for each of the three Locality Groups namely North & East Wiltshire, Sarum, and West Wiltshire, Yatton Keynell and Devizes. 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 risks 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 seven Governing Body meetings held during 2014/15 including the Annual General Meeting. Attendance at these meetings was as follows:

Governing Body Voting Members - Attendance 2014/15

Name	Position	May-14	Jul-14	Sep-14	AGM Sep-14	Nov-14	Jan-15	Mar-15
Dr Debbie Beale	GP Vice Chair, WWYKD					n/a	n/a	n/a
Dr Simon Burrell	GP Chair, NEW							
Dr Anna Collings	GP Vice Chair, NEW							
Dr Toby Davies	GP Chair, Sarum							
Deborah Fielding	Chief Officer							
Dr Celia Grummitt	GP Vice Chair, Sarum			n/a	n/a	n/a	n/a	n/a
Dr Andy Hall	GP Sarum	n/a	n/a	n/a	n/a		n/a	n/a
Peter Lucas	Lay Member and Vice Chair							
Mary Monnington	Registered Nurse Member							
Dr Helen Osborn	GP Chair, WWYKD							
Steve Perkins	Deputy Chief Finance Officer	n/a			n/a	n/a	n/a	n/a
Christine Reid	Lay Member							
Dr Steve Rowlands	GP Chair							
Dr Richard Sandford-Hill	GP Vice Chair, WWYKD	n/a	n/a	n/a	n/a			
Dr Chet Sheth	GP Vice Chair, Sarum	n/a	n/a					
Dr Mark Smithies	Secondary Care Doctor							
Dr Elizabeth Stanger	GP Sarum	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 replaced Dr Jonathan Raynor as GP Vice Chair, NEW from May-14 meeting
Dr Elizabeth Stanger, GP Sarum, attended in place of Dr Celia Grummitt for Jul-14 meeting
Steve Perkins, Deputy Chief Finance Officer, attended in place of Simon Truelove, Chief Finance Officer, for Jul-14 and Sep-14 meetings
Dr Chet Sheth replaced Dr Celia Grummitt as GP Vice Chair, Sarum from the Sep-14 meeting
Dr Andy Hall, GP Sarum, attended in place of Dr Chet Sheth for Nov-14 meeting
Dr Richard Sandford-Hill replaced Dr Debbie Beale as GP Vice Chair, WWYKD from the Nov-14 meeting

The CCG continues to work collaboratively with Wiltshire Council to transform the delivery of health and social care for the people of Wiltshire. The CCG has attended joint committees including the Joint Commissioning Board and the Health & Wellbeing Board.

Governing Body Performance 2014/15

The Governing Body has continued to devote time to reflect on their own performance and to invest time in their development. The Governing Body have revisited the findings of the specialist external consultant (from 2013/14) looking at their effectiveness. The Governing Body is working on increased utilisation of the robust infrastructure of the CCG by channelling communications through the Groups to the member practices and the communities they represent. The Governing Body is ensuring that the experience and input of staff in both management and clinical roles is available in meetings where challenging discussions are conducted and vital decisions made. The decision making process has been reviewed to give further rigor to the thought process and action planning to implement the 5 year plan. Crucially, the Governing Body is facilitating both clinical and management leaders conveying the same messages and speaking with a corporate voice.

During 2014/15 the Governing Body worked with Wiltshire Council to develop Systems Thinking as an approach to focusing on the intended outcomes, measuring performance in the right way and fostering the right culture and leadership.

The CCG continues to undertake monthly performance monitoring with a disciplined approach to project performance monitoring from July 2014. Transparency of performance is evidenced by the Integrated Performance Report being published on the CCG website each month.

Highlights of committee reports

5 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. During the first quarter of 2014/15 the CCG undertook wide ranging public engagement events to further develop awareness and understanding of the Plan with specific focus on the proposals for the future models of care. There was recognition that the NHS is facing increased pressure on resources and that the situation needs to be addressed, particularly in the light of an aging population with a broad range of medical conditions. There is strong support for the principles of both encouraging people to take more responsibility for their own health and wellbeing and also providing more care nearer to home but recognition that there needs to be better signposting to what support is available and how to access it appropriate to the diverse population.

100 day Challenge:
Integration of health and social care is seen is a key national priority through the development of the Better Care Plan programme across the country. Wiltshire has been at the forefront of the Better Care Plan nationally being one of only 5 early implementers and receiving national fast track status in July 2014. The ‘100 day challenge’ ran from the 1 September to 9 December 2014 to:

- Launch a system wide approach to reduce attendances, admissions and conveyances for frail patients in Wiltshire and reduce the amount of time they spend in hospital
- Launch a range of innovative integrated schemes testing the concept of ***delivering right care in in the right place at the right time*** in advance of the national policy start date of April 2015.

The ‘100 day challenge’ has identified that the CCG needs to:

- ensure that the right data is being collected to enable us to manage the system effectively;
- undertake consistent and rigorous implementation of systems and processes that have been proven to work;
- encourage strategic alignment around the Better Care Plan with all partner organisations;
- encourage collaboration and strong relationships across all partner organisations to ensure that service users see no distinctions between services as they move through the system;
- foster a clear vision in commissioning for outcomes allowing obstacles that impact on the effective operation of the system to be tackled jointly.
- build a system wide model of care with schemes that avoid duplication and are of a sufficient size to make a difference.

The Better Care Plan, 100 day challenge and the system review has changed the way the system operates and has provided a strong platform for future integration of services. All partners have demonstrated a commitment to manage risks, review internal processes and systems, develop alternatives, change patient expectations, change pathways, challenge behaviours and consider how we operate together.

Primary Care Co-Commissioning:
Primary Care is currently directly commissioned by NHS England. NHS England invited CCGs to express interests in taking on an increased role in the commissioning of primary care services. The intention being to empower and enable CCGs to improve primary care services locally for the benefit of patients and local communities. In January 2015, the CCG submitted an expression of interest to undertake Joint Commissioning; this has subsequently been approved by NHS England.

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 and easier access to services. The re-commissioning of children’s community health services is being undertaken as a joint commissioning project with Wiltshire Council with a planned start date of January 2016. There are 16 different service elements for which detailed specifications are being developed to sit within an over-arching service specification for Children’s Community Health Services. The range and complexity of these services means that there is a need to engage with a large number and range of stakeholders including the people who currently use or may need to use services in future.

Transforming Primary Care for Older People:
Early in 2014/15, the Department of Health announced additional funding of £5 per head to support the transformation of care for older people. The CCG was keen to support practices to make best use of the funding to transform the care of patients over 75 and reduce avoidable admissions, while ensuring alignment to the Five Year Plan. The CCG has received and considered a number of business cases for primary care schemes and advised on refinements to these. Where schemes have subsequently been recommended for approval, the CCG has worked with applicants to complete a due diligence assessment. Project implementation plans are underway.

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. The Strategy was agreed by the Joint Commissioning Board in December 2013 and by the CCG Governing Body in January 2014. From February 2014 to May 2014 a formal public consultation was held. The consultation indicated support for the strategy but crucially identified areas where the strategy could be strengthened including around the support available to those who fund their own care, dementia friendly primary care, discharge planning from hospital, and the role and importance of safeguarding. The revised strategy received approval from the Health & Wellbeing Board.

The Clinical Commissioning Group risk management framework

The Governing Body has formally adopted a Risk Management Strategy, originally approved prior to Authorisation but reviewed annually and most recently revised in September 2014. This sets out the CCG 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:

- implementing further mechanisms to address contract over-performance;
- agreement of baseline funding for a number of outstanding minor financial issues with NHS England; and
- quality and outcome reports for services commissioned on behalf of the CCG by partner organisations.

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

- external scrutiny of services commissioned on behalf of the CCG by partner organisations; and
- verification of resource expenditure on s75 requirements.

All risks are recorded on the CCG 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 that 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 CCG 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 the CCG 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. The CCG will, where necessary, tolerate risks where action is not cost effective or reasonably practicable. The CCG will not normally accept risks with a score of between 15 and 25 using a 5 by 5 Risk Matrix, with plans being put in place to ameliorate the risk.

The CCG provides 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 of Employee Safety assist with risk assessment in their area contributing their specific local knowledge and providing local leadership for risk management. Good practice is shared and independent assurance is provided by external experts in Security, Counter Fraud, and Health & Safety. All staff are encouraged to report incidents using the existing paper based system and by contacting the Governance & Risk Manager.

Each staff member has objectives set and is provided with appropriate training (both mandatory and specialist) to ensure they have the correct knowledge and skills to meet their objectives, and identify and prevent risk.

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. The CCG conducts and publishes Equality Impact Assessments (EIAs) on all policies and proposals critically assessing the impact on protected groups and identifying opportunities to promote equality.

The CCG holds 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. The CCG also requires providers to meet the legislative requirements as part of the procurement process for new or revised contracts.

The CCG has 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.

The CCG informs, engages and consults public stakeholders with regards to changes to health services that may impact upon the public. The CCG uses 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 in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

The 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.

The CCG has identified initiatives in the CCG Operating Plan. The initiatives have been developed into projects by the CCG 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 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. An Equality Impact Assessment (EIA) is completed for each project and the impact on privacy of individuals is also considered. This project framework enables progress to be monitored and successful delivery evidenced.

On a monthly basis, the CCG produces an Integrated Performance Report monitoring quality, financial performance and access, 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 the CCG 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 the CCG response. Please see the section on Significant Control Issues on page 112. 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. The Local Security Management Service is contracted to undertake assessments of healthcare Providers' security arrangements which is support by the NHS contract. The Committee receives reports from both Counter Fraud and the Local Security Management Service.

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. The Committee also seeks assurance from External Audit to benchmark the CCG.

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.

The CCG places high importance on protecting patient, staff and corporate information and has established an information governance management framework. Please see the section on Data Security on page 117.

The CCG has self-assessed against the requirements of the Information Governance Toolkit and has received positive assurance from Internal Audit on this programme. The CCG has a trained Senior Information Risk Owner and a trained Caldicott Guardian in place with deputies in support of these roles. A suite of Information Governance policies, including Information Security, is in place and all staff have been required to undertake training in Information Governance and records management. The CCG Staff Handbook contains a comprehensive information governance section. An 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 supported by Information Governance expertise provided by Central Southern Commissioning Support Unit.

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 all the Clinical Commissioning Group complies with the required public sector equality duty set out in the Equality Act 2010.

Sustainable development obligations

The CCG is 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.

Working with NHS Property Services, we will ensure that the CCG meets its obligations under the Climate Change Act 2008 and the Public Services (Social Value) Act 2012 and demonstrate our commitment as a socially responsible employer.

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

Risk to the CCG 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 the CCG risk register, controls are identified, further mitigating actions are programmed and progress is monitored. The risk profile of the CCG is considered by the Governing Body and action against the ten key risks is closely monitored.

During 2014/15 the NHS has seen activity continuously over agreed activity plans. Over-performance on contracts adversely effects the financial position of the CCG resulting in greater QIPP requirements. The CCG has implemented actions associated with the Better Care Fund, QIPP projects and ongoing projects which have the potential to reduce activity levels and promote treatment of patients in the right place at the right time. However, continued activity pressures have resulted in the CCG reducing its achievement against the planned surplus position which will have an impact into 2015/16 when the CCG must restore the required 1% surplus figure. Delivery of the QIPP programmes for 2015/16 is vital with Directors planning delivery of projects to ensure that staff are clear regarding the delivery expectations and the skills required to do so.

Working with partner organisations, the CCG is developing the provision of health services within our health economy. However, plans are hampered by a lack of staff across the health and social care system due to difficulties in recruitment, national staff shortages and a competitive local market. The CCG is working with partner organisations to analyse the shortfall of staffing and identify potential solutions to meet demand for services and provide safe high quality care both now and in the future. This includes making the best use of the workforce already in the system, by reducing inefficiencies or duplication of roles or tasks, and the development of existing staff. The Wiltshire Health Institute of Health & Social Care has been established and a Health & Social Care workforce strategy is under development.

A key risk to the organisation continues to be the Delayed Transfer of Care (DTOC) which has the potential to destabilise the health & 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, have worked together to identify likely periods of escalation and put plans in place. Additional bed capacity has been arranged to manage peak demand. Wiltshire Council and Avon and Wiltshire Mental Health Partnership NHS Trust are working closely with the CCG to improve the care pathway for patients admitted to hospital.

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. The CCG is working closely with the South Western Ambulance Service NHS Foundation Trust with agreed action plans having a positive effect.

The CCG has in place sound governance arrangements with established committees reporting to the Governing Body. The CCG operates 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 CCG risk register, discussed and mitigating actions planned. Both the Board Assurance Framework and the CCG 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, and project performance.

The CCG is visited by the NHS England Area Team, on a quarterly basis, to gain assurance of the CCG performance against its licence. The CCG retains its licence without conditions.

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

NHS Wiltshire CCG is required to work within the financial resources available and return a surplus. QIPP initiatives have been identified to improve health care provision while using resources more efficiently in line with the vision and values of the CCG. This work is supported by an embedded framework for project management supported by the Project Management Office (PMO) which has been reviewed and acclaimed as exemplary by Internal Audit. Project workbooks identify required outcomes and potential risks before the expenditure of resources.

As part of the Internal Audit programme, the CCG asked Internal Audit to undertake an assessment of the Continuing Healthcare arrangements in operation. It was found that care home placements were not consistently secured at the best value for money and that placements were not always reviewed after the stipulated review period. The CCG has worked with Wiltshire Council to identify and monitor KPIs to improve placement review compliance and ensure best value for placements.

External Audit, as part of the Annual Accounts process for 2013/14, have satisfied themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

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

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 risk management is provided by the Executive Directors with support from key individuals including the Governance and Risk Manager and Central Southern Commissioning Support Unit

From training at Corporate Induction onwards, all staff are encouraged to report risks and adverse events, and share good practice. The Representatives of Employee Safety meet on a regular basis to share issues and good practice. Commissioning Managers and members of the Quality team work with contracted provider organisations to discuss the appropriate management of contractual and patient safety risks. The Senior Information Risk Officer is focused on reducing the likelihood and impact of information governance related risks. The Audit and Assurance Committee review the risk register and discuss risk issues at each meeting, where appropriate calling on directors, senior managers and GP representatives to attend the meeting to discuss specific risk issues.

Review of Effectiveness

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

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls, to manage risks to the CCG achieving its principles objectives, have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit 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 Accountable Officer and Chief Finance Officer have met with the Chief Executives and Directors of Finance from the local acute trusts. The Lay Members are meeting with Lay Members from the other CCGs within this Area Team geography, three times a year, and have shared issues including internal control arrangements. The CCG Accountable Officer and Chair have a programme of meeting with member GP practices.

- The Audit and Assurance Committee has undertaken a self-assessment to consider their 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 CCG 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 audits across the CCG. Audit reports have been presented to and discussed by the Audit and Assurance Committee with actions to address recommendations noted and progress against actions monitored.

- The Health and Safety arrangements have been assessed by Central Southern Commissioning Support Unit who has been supportive of the progress made.

Significant Control Issues

Internal Audit reports during the year have not identified any significant control issues. However, three control issues rated as high risk were identified and the CCG will be addressing these as follows:

- Integrated Care / Collaborative Working – The CCG agreed to ensure that financial information for integrated care (Better Care Fund, Mental Health & Learning Disabilities) is reported and reviewed to facilitate challenge in the appropriate forum.

- QIPP – Programme Directors will ensure that all workbooks are fully populated as soon as possible to encourage project delivery and provide management with information for monitoring.

- Performance Management – The CCG will define and publish its objectives for the year and linkages to longer term strategies. All staff will have personal objectives, relevant to their roles, that link to the CCG objectives. All staff are accountable for their objectives which are reported through a robust performance framework.

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

Head of Internal Audit Opinion

We are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

Opinion
Our opinion is as follows:

Adequate and effective	Improvement Required	Major Improvement Required	Unsatisfactory
There are weaknesses in the framework of governance, risk management and control which potentially put the achievement of organisational objectives at risk and there is non-compliance with controls that may put the achievement of organisational objectives at risk. Improvements are required in those areas to enhance the adequacy and effectiveness of governance, risk management and control.			

Basis of opinion

Our opinion is based on:

- All audits undertaken during the year
- Any follow up action taken in respect of audits from previous periods
- The effects of any significant changes in the organisation's objectives or systems
- Any limitations which may have been placed on the scope or resources of internal audit
- What proportion of the organisation's audit needs have been covered to date

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

Commentary

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

- We have completed the programme of internal audit work for the year ended 31 March 2015. Our work identified 15 Low, 18 medium and 3 high risk rated findings.
- The overall classification of the Performance Management review was high risk. Findings related to the lack of a defined Performance Management Framework, inadequate completion of objectives and appraisals, and the need to improve the structure and content of the Integrated Performance Report.
- We identified one high risk finding in our review of QIPP, which related to Programme Management Office (PMO) workshops not being used appropriately by project teams reporting to project Directors.
- We identified one high risk finding in our review of Integrated Care which related to a lack of evidence in reporting of financial information outside of the Better Care framework such as mental health and learning disability.

- There are 10 recommendations from the prior year relating to Continuing Healthcare and Business Continuity Planning that are still outstanding. Within these are 3 high and 4 medium risk rated findings.
- The number of high risk findings is lower compared to last year (3 in 2014/15 compared to 11 in 2013/14).

There were no other findings rates as high risk.

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

The CCG has 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

The CCG has 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. The CCG has determined compliance at level 2 of the toolkit.

During 2014/15, there have been sixteen recorded breaches of data security; of these two have been attributed to the acts or omissions of NHS Wiltshire CCG staff. The two incidents attributed to the CCG were an e-mail sent to an insecure email account and a staff personal file left in a CCG area. Both breaches were dealt with internally with staff involved directed to the appropriate guidance and training materials. As a result of the staff file breach, there has been a change of process around access to staff files which will create an audit trail. No breaches were of a level requiring a report to the Information Commissioners Office.

NHS Wiltshire CCG has not had any data security incidents deemed to be Serious Untoward Incidents during 2014/15.

Discharge of statutory functions

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

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

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

The scheme of delegation has been reviewed during 2014/15. The CCG Constitution has been reviewed during 2014/15 and has been approved by NHS England.

The CCG has mechanisms in place with Internal Audit, External Audit and NHS England to scrutinise the execution of statutory functions and confirm that the CCG is legally compliant.

Conclusion

No significant internal control issues have been identified during 2014/15.

Deborah Fielding
Accountable Officer
28 May 2015

Appendices

Appendix 1: Independent Auditor's Report to the Members of Wiltshire CCG

Appendix 2: Annual Accounts 2014/15

Appendix 1

Independent Auditor’s Report to the Members of Wiltshire CCG

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 2015 on pages 2 to 22 of Appendix 2. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups 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 pages 94 and 95 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 2015 and of its net operating expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups 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 polices directed by the NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and

- the information given in the Strategic Report and Members' 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

Respective responsibilities of the CCG and auditor

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

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 to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCGs arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience; and

- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, Wiltshire CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

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 for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

28 May 2015

APPENDIX 2

NHS WILTSHIRE CCG

FINANCIAL STATEMENTS

YEAR ENDED 31 MARCH 2015

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	5.1	5,810	5,963
Operating Expenses	6	529,130	514,906
Other operating revenue	3	(3,054)	(4,225)
Net operating expenditure before interest		**531,886**	**516,644**
Investment Revenue		0	0
Other (gains)/losses		0	0
Finance costs		0	0
Net operating expenditure for the financial year		**531,886**	**516,644**
Net (gain)/loss on transfers by absorption		0	0
Total Net Expenditure for the year		**531,886**	**516,644**
Of which:			
Administration Income and Expenditure			
Employee benefits	5.1	5,786	5,963
Operating Expenses	6	6,072	6,172
Other operating revenue	3	(188)	(507)
Net administration costs before interest		**11,670**	**11,628**
Programme Income and Expenditure			
Employee benefits	5.1	24	0
Operating Expenses	6	523,058	508,734
Other operating revenue	3	(2,866)	(3,718)
Net programme expenditure before interest		**520,216**	**505,016**

Other Comprehensive Net Expenditure	2014-15 £000	2013-14 £000
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Movements in other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net gain/(loss) on assets held for sale	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Share of (profit)/loss of associates and joint ventures	0	0
Reclassification Adjustments	0	0
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**531,886**	**516,644**

The notes on pages 9 to 22 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	9	0	0
Intangible assets	9	0	0
Investment property		0	0
Trade and other receivables	11	0	0
Other financial assets		0	0
Total non-current assets		**0**	0
Current assets:			
Inventories	10	0	0
Trade and other receivables	11	4,548	2,371
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	12	46	0
Total current assets		**4,594**	2,371
Non-current assets held for sale		0	0
Total current assets		**4,594**	2,371
Total assets		**4,594**	2,371
Current liabilities			
Trade and other payables	13	(30,946)	(25,625)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings	14	0	(21)
Provisions	15	(71)	(168)
Total current liabilities		**(31,017)**	(25,814)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(26,423)**	(23,443)
Non-current liabilities			
Trade and other payables	13	0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings	14	0	0
Provisions	15	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(26,423)**	(23,443)
Financed by Taxpayers' Equity			
General fund		(26,423)	(23,443)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(26,423)**	(23,443)

The notes on pages 15 to 20 form part of this statement

The financial statements on pages 2 to 22 were approved by the Audit and Assurance Committee, under delegated authority from the Governing Body on 19 May 2015 and signed on its behalf by:

Accountable Officer
DEBORAH FIELDING

Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(23,443)	0	0	**(23,443)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Wiltshire CCG balance at 1 April 2014	**(23,443)**	**0**	**0**	**(23,443)**
Changes in NHS Wiltshire CCG taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(531,886)			(531,886)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Wiltshire CCG Expenditure for the Financial Year	**(531,886)**	**0**	**0**	**(531,886)**
Net funding	528,906	0	0	528,906
Balance at 31 March 2015	**(26,423)**	**0**	**0**	**(26,423)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**250**	**0**	**0**	**250**
Adjusted NHS Wiltshire CCG balance at 1 April 2013	**250**	**0**	**0**	**250**
Changes in NHS Wiltshire CCG taxpayers' equity for 2013-14				
Net operating costs for the financial year	(516,644)			(516,644)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Wiltshire CCG Expenditure for the Financial Year	**(516,394)**	**0**	**0**	**(516,394)**
Net funding	492,951	0	0	492,951
Balance at 31 March 2014	**(23,443)**	**0**	**0**	**(23,443)**

Statement of Cash Flows for the year ended 31 March 2015

	Note	**2014-15 £000**	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(531,886)	(516,644)
Depreciation and amortisation	6	0	0
Impairments and reversals	6	0	250
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	11	(2,177)	(2,371)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	5,321	25,625
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	15	(5)	0
Increase/(decrease) in provisions	15	(92)	168
Net Cash Inflow (Outflow) from Operating Activities		**(528,839)**	(492,972)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(528,839)**	(492,972)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		528,906	492,951
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**528,906**	492,951
Net Increase (Decrease) in Cash & Cash Equivalents	12	**67**	(21)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(21)**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**46**	(21)

The notes on pages 14 to 16 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 2014-15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

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

1.3 **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.

1.3.1 ***Critical Judgements in Applying Accounting Policies***

No critical judgements with a significant effect on the amounts recognised in the financial statements were required.

1.3.2 ***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 continuing healthcare provision has been calculated based on outstanding claims, periods of care and weekly fees, and is an estimate. By its nature, the provision could be higher or lower, depending on the specific cases that pass the eligibility criteria for continuing healthcare funding, but is calculated at a point on time, using the information available.
- the CCG makes an estimate of non-contract activity (healthcare performed in NHS and private providers with which the CCG does not have a contract) which has not been billed by the year end. This estimate is based on information received from providers during period when the accounts are prepared, along with past experience. The estimate could therefore be higher or lower than calculated once actual invoices are received from providers. The non contract activity accrual is included within the payables balance in the SOFP.

1.4 **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.

1.5 **Employee Benefits**

1.5.1 **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.

1.5.2 **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.

1.6 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements

1.7 **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.

1.8 **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.

1.8.1 **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.

1.9 **Services Received**

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

1.10 **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.

1.11 **Provisions**

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

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

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

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

1.12 **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.

1.13 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS 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.

1.14 **Continuing healthcare risk pooling**

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

1.15 **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.

1.16 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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.
The only class of financial assets held by the CCG is "Loans and Receivables"

1.16.1 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 **Financial Liabilities**

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

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

The only class of financial liabilities held by the CCG is "Other Financial Liabilities"

1.17.1 **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.

1.18 **Value Added Tax**

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

1.19 **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.

1.20 **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.

1.21 **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).

1.22 **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.

1.23 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

2 Financial performance targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).
The performance of NHS Wiltshire Clinical Commissioning Group in 2014-15 against those duties was as follows:

	2014-15 Target £000	2014-15 Performance £000	2014-15 Variance £000	Target achieved?
Expenditure not to exceed income	538,029	534,940	-3,089	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	534,975	531,886	-3,089	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	2,700	2,700	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	12,072	11,670	-402	Yes

NHS England set a Revenue Resource Limit of £534,975,000 for 2014/15, and the CCG achieved an underspend of £3,089,000 against this target.
The CCG also underspent by £402,000 on administration costs, against the target spend of no more than £12,072,000 in 2014/15.

Performance in 2013-14 was as follows:

	2013-14 Target £000	2013-14 Performance £000	2013-14 Variance £000	Target achieved?
Expenditure not to exceed income	525,904	520,869	-5,035	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	521,679	516,644	-5,035	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	4,000	4,000	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	11,660	11,627	-33	Yes

The CCG was set a Revenue Resource Limit of £521,679,000 for 2013-14, and achieved an underspend of £5,035,000 against this target.
The target for administration costs was set at £11,660,000 for 2013-14, and an underspend of £33,000 was achieved.
In 2013-14, the CCG was permitted to spend £4,000,000 on specific revenue items, and spent this amount in full.

3 Other Operating Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Education, training and research	60	60	0	0
Non-patient care services to other bodies	2,390	100	2,290	3,727
Other revenue	604	28	576	498
Total other operating revenue	**3,054**	**188**	**2,866**	**4,225**

4 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
From rendering of services	3,054	188	2,866	4,225
From sale of goods	0	0	0	0
Total	**3,054**	**188**	**2,866**	**4,225**

5. Employee benefits and staff numbers

5.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	4,872	4,221	651	4,851	4,210	641	21	11	10
Social security costs	371	371	0	370	370	0	1	1	0
Employer Contributions to NHS Pension scheme	539	539	0	537	537	0	2	2	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	28	28	0	28	28	0	0	0	0
Gross employee benefits expenditure	**5,810**	**5,159**	**651**	**5,786**	**5,145**	**641**	**24**	**14**	**10**
Less recoveries in respect of employee benefits:	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**5,810**	**5,159**	**651**	**5,786**	**5,145**	**641**	**24**	**14**	**10**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**5,810**	**5,159**	**651**	**5,786**	**5,145**	**641**	**24**	**14**	**10**

PRIOR YEAR: 2013-14	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	5,123	3,843	1,280	5,123	3,843	1,280	0	0	0
Social security costs	348	348	0	348	348	0	0	0	0
Employer Contributions to NHS Pension scheme	492	492	0	492	492	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**5,963**	**4,683**	**1,280**	**5,963**	**4,683**	**1,280**	**0**	**0**	**0**
Less recoveries in respect of employee benefits:	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**5,963**	**4,683**	**1,280**	**5,963**	**4,683**	**1,280**	**0**	**0**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**5,963**	**4,683**	**1,280**	**5,963**	**4,683**	**1,280**	**0**	**0**	**0**

5.2 Average number of people employed

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**117**	**99**	**18**	110

None of those employed have been engaged on capital projects.

5.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	668	416
Total Staff Years	104	92
Average working Days Lost	**6**	**5**

This data represents the calendar year, 1st January 2014 to 31st December 2014.
No members of staff have retired early on ill health grounds (2013-14, 0)

5.4 Exit packages agreed in the financial year

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	1,872	1	1,872
£10,001 to £25,000	0	0	1	14,892	1	14,892
£25,001 to £50,000	0	0	1	33,585	1	33,585
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**3**	**50,349**	**3**	**50,349**

	Departures where special payments have been made	
	Number	£
Less than £10,000	0	0
£10,001 to £25,000	0	0
£25,001 to £50,000	0	0
£50,001 to £100,000	0	0
£100,001 to £150,000	0	0
£150,001 to £200,000	0	0
Over £200,001	0	0
Total	**0**	**0**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	1	28,181
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	2	22,168
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	**3**	**50,349**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of the standard NHS terms and conditions.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme, and are included in the tables.
Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.
The CCG has not agreed any early retirements during 2014-15
No non-contractual payments have been made to individuals during 2014-15

The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. During 2014-15, no exit payments have been made to senior managers.

The CCG did not approve any exit packages in 2013-14.

5.5 Pension costs

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

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

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

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:

5.5.1 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 2015, is based on valuation data as at 31 March 2014, updated to 31 March 2015 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) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

5.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the 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 2012.

The Scheme Regulations 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.

5.5.3 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 employer.

• 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.

6. Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	4,924	4,900	24	4,489
Executive governing body members	886	886	0	1,474
Total gross employee benefits	**5,810**	**5,786**	**24**	**5,963**
Other costs				
Services from other CCGs and NHS England	4,442	3,442	1,000	4,881
Services from foundation trusts	266,874	0	266,874	236,581
Services from other NHS trusts	91,508	0	91,508	115,363
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	84,593	0	84,593	77,996
Chair and Non Executive Members	524	506	18	126
Supplies and services – clinical	723	0	723	796
Supplies and services – general	284	262	22	173
Consultancy services	1,040	801	239	1,143
Establishment	745	328	417	526
Transport	8	8	0	6
Premises	357	318	39	394
Impairments and reversals of receivables	16	16	0	0
Inventories written down	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	250
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets	0	0	0	0
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	108	108	0	110
Other non statutory audit expenditure				
· Internal audit services	0	0	0	45
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	71,202	0	71,202	68,822
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	3,051	0	3,051	3,250
Other professional fees excl. audit	203	203	0	229
Grants to other public bodies	2,700	0	2,700	4,000
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	10	0	10	0
Education and training	82	78	4	46
Change in discount rate	0	0	0	0
Provisions	(93)	0	(93)	0
CHC Risk Pool contributions	751	0	751	0
Other expenditure	1	1	0	168
Total other costs	**529,130**	**6,072**	**523,058**	**514,906**
Total operating expenses	**534,940**	**11,858**	**523,082**	**520,869**

7.1 Better Payment Practice Code

Measure of compliance	**2014-15 Number**	**2014-15 £000**	**2013-14 Number**	**2013-14 £000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	8,920	71,390	7,665	61,063
Total Non-NHS Trade Invoices paid within target	8,802	70,765	7,518	59,603
Percentage of Non-NHS Trade invoices paid within target	**98.68%**	**99.12%**	**98.08%**	**97.61%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,841	358,735	2,550	339,327
Total NHS Trade Invoices Paid within target	3,801	357,875	2,521	338,895
Percentage of NHS Trade Invoices paid within target	**98.96%**	**99.76%**	**98.86%**	**99.87%**

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

In 2014-15, the CCG has not made any interest payments relating to the late payment of commercial debts (2013-14, nil)

8. Operating Leases

8.1 As lessee
NHS Wiltshire CCG occupies and pays rent on Southgate House, Devizes, a property owned by NHS Property Services Ltd. There is no signed lease in place, even though the nature of the transactions undertaken conveys the right for the CCG to use the property. Under paragraph 9 of IFRIC 4, these arrangements are a lease, and as such, they are accounted for in accordance with IAS17.

8.1.1 Payments recognised as an Expense

	Land £000	**Buildings £000**	**Other £000**	**2014-15 Total £000**	2013-14 Total £000
Payments recognised as an expense					
Minimum lease payments	0	332	8	**340**	373
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**332**	**8**	**340**	**373**

Whilst our arrangements with NHS Property Services Ltd fall within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently, this note does not include future minimum lease payments for the arrangements on Southgate House

8.1.2 Future minimum lease payments

	Land £000	**Buildings £000**	**Other £000**	**2014-15 Total £000**	2013-14 Total £000
Payable:					
No later than one year	0	0	5	**5**	6
Between one and five years	0	0	4	**4**	5
After five years	0	0	0	**0**	0
Total	**0**	**0**	**9**	**9**	**11**

8.2 As lessor
During 2014-15, the CCG has not acted a lessor.

9 Property, plant and equipment and Intangible non-current assets.

At 31st March 2015, the CCG did not hold any property, plant and equipment, nor any intangible assets.

In 2013/14, the CCG received £250,000 of IT equipment from the predecessor PCT. This was fully impaired in 2013-14 and the impairment charge reported in the Statement of Comprehensiuve Net Expenditure for that year.

9.1 Analysis of impairments and reversals

During 2014-15, the CCG did not charge any impairments, or reverse any impairments from prior years. This was because the CCG did not hold any property, plant and equipment, nor any intangible assets.

In 2013/14, an impairment charge of £250,000, classified as Other, was reported in the Statement of Net Comprehensive Expenditure. This related to the writedown of IT equipment transferred from the predecessor Primary Care Trust.

10 Inventories

As at 31 March 2015, the CCG does not hold any inventory (2013-14, nil)

11 Trade and other receivables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	2,429	0	1,195	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	294	0	3	0
Non-NHS receivables: Revenue	995	0	1,028	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	803	0	8	0
Provision for the impairment of receivables	(16)	0	0	0
VAT	43	0	137	0
Other receivables	0	0	0	0
Total Trade & other receivables	**4,548**	**0**	**2,371**	**0**
Total current and non current	**4,548**		**2,371**	
Included above:				
Prepaid pensions contributions	0		0	

The majority of the CCG's income is from other NHS organisations and from Wiltshire Council. As such, no credit scoring is considered to be necessary.

11.1 Receivables past their due date but not impaired	**2014-15 £000**	2013-14 £000
By up to three months	110	44
By three to six months	0	0
By more than six months	0	0
Total	**110**	**44**

£71k of the amount above has subsequently been recovered post the statement of financial position date.

11.2 Provision for impairment of receivables	**2014-15 £000**	2013-14 £000
Balance at 1 April 2014	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(16)	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2015	**(16)**	**0**

	2014-15 %	2013-14 %
Receivables are provided against at the following rates:		
NHS debt	0%	0
Non NHS debt	1%	0

12 Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	(21)	0
Net change in year	67	(21)
Balance at 31 March 2015	**46**	**(21)**
Made up of:		
Cash with the Government Banking Service	46	0
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**46**	**0**
Bank overdraft: Government Banking Service	0	(21)
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**(21)**
Balance at 31 March 2015	**46**	**(21)**
Patients' money held by the clinical commissioning group, not included above	0	0

13 Trade and other payables	**Current 2014-15**	**Non-current 2014-15**	Current 2013-14	Non-current 2013-14
	£000	**£000**	£000	£000
Interest payable	0	0	0	0
NHS payables: revenue	8,203	0	6,258	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	144	0	73	0
Non-NHS payables: revenue	2,569	0	2,426	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	19,436	0	16,546	0
Social security costs	54	0	52	0
VAT	0	0	0	0
Tax	63	0	59	0
Payments received on account	0	0	0	0
Other payables	477	0	211	0
Total Trade & Other Payables	**30,946**	**0**	**25,625**	**0**
Total current and non-current	**30,946**		**25,625**	

Other payables include £82,000 outstanding pension contributions at 31 March 2015 (£73,000 at 31 March 2014)

14 Borrowings	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Bank overdrafts:				
· Government banking service	0	0	21	0
· Commercial banks	0	0	0	0
Total overdrafts	**0**	**0**	**21**	**0**
Total Borrowings	**0**	**0**	**21**	**0**
Total current and non-current	**0**		**21**	

15 Provisions

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	71	0	168	0
Other	0	0	0	0
Total	**71**	**0**	**168**	**0**
Total current and non-current	**71**		**168**	

	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 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**168**	**0**	**168**
Arising during the year	0	0	0	0	0	0	0	12	0	12
Utilised during the year	0	0	0	0	0	0	0	(5)	0	(5)
Reversed unused	0	0	0	0	0	0	0	(104)	0	(104)
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**71**	**0**	**71**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	71	0	71
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**71**	**0**	**71**

Continuing Care - This provision relates to existing retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) which 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 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 Wiltshire CCG was established. The total value of legacy NHS continuing healthcare provisions accounted for by NHS England on behalf of Wiltshire CCG at 31 March 2015 is £2,741k (31/3/2014, £3,148k).

From 2014/15, all CCGs contribute to a risk-sharing pool to be used by NHS England for legacy payments. During 2014-15, Wiltshire CCG contributed £751k.

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them.

16 Contingencies

The CCG has no contingent assets or contingent liabilities at 31 March 2015 (2013-14, nil)

17 Commitments

17.1 Capital commitments

At 31 March 2015, the CCG has no capital commitments (31/3/14, nil)

17.2 Other financial commitments

The CCG has not entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) during 2014-15.

18 Financial instruments

18.1 Financial risk management

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

Because NHS Wiltshire 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 clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

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

18.1.1 Currency risk

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

18.1.2 Interest rate risk

Wiltshire CCG has not borrowed during 2014-15 and has no plans to do so. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of the CCG's revenue comes from parliamentary funding and other NHS organisations, the organisation 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.

18.1.3 Liquidity risk

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

18 Financial instruments cont'd

18.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,429	0	2,429
· Non-NHS	0	996	0	996
Cash at bank and in hand	0	46	0	46
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**3,471**	**0**	**3,471**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,195	0	1,195
· Non-NHS	0	1,028	0	1,028
Cash at bank and in hand	0	0	0	0
Other financial assets	0	0	0	0
Total at 31 March 2014	**0**	**2,223**	**0**	**2,223**

18.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	8,347	8,347
· Non-NHS	0	22,483	22,483
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**30,830**	**30,830**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	6,330	6,330
· Non-NHS	0	18,972	18,972
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	21	21
Other financial liabilities	0	0	0
Total at 31 March 2014	**0**	**25,323**	**25,323**

18.4 Maturity of financial liabilities

	2014-15			2013-14		
	Payable to DH	Payable to Other Bodies	Total	Payable to DH	Payable to Other Bodies	Total
	£000	£000	£000	£000	£000	£000
In one year or less	0	30,830	30,830	0	25,323	25,323
In more than one year but not more than two years	0	0	0	0	0	0
In more than two years but not more than five years	0	0	0	0	0	0
In more than five years	0	0	0	0	0	0
Total CCG at 31 March 2015	**0**	**30,830**	**30,830**	**0**	**25,323**	**25,323**

19 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare	534,940	(3,054)	531,886	4,594	(31,017)	(26,423)
Total	**534,940**	**(3,054)**	**531,886**	**4,594**	**(31,017)**	**(26,423)**

Reconciliation between Operating Segments and SoCNE

	31-Mar-15 £'000
Total net expenditure reported for operating segments	531,886
Reconciling items:	0
Total net expenditure per the Statement of Comprehensive Net Expenditure	531,886

Reconciliation between Operating Segments and SoFP

	31-Mar-15 £'000
Total assets reported for operating segments	4,594
Reconciling items:	0
Total assets per Statement of Financial Position	**4,594**

	31-Mar-15 £'000
Total liabilities reported for operating segments	(31,017)
Reconciling items:	0
Total liabilities per Statement of Financial Position	**(31,017)**

20 Intra-government and other balances

	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	69	0	278	0
· Local Authorities	1,431	0	2,508	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	2,080	0	155	0
· NHS Trusts and Foundation Trusts	643	0	8,192	0
Total of balances with NHS bodies:	**2,723**	**0**	**8,347**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	325	0	19,813	0
Total balances at 31 March 2015	**4,548**	**0**	**30,946**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	0	0	231	0
· Local Authorities	524	0	1,595	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	505	0	255	0
· NHS Trusts and Foundation Trusts	693	0	6,076	0
Total of balances with NHS bodies:	**1,198**	**0**	**6,331**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	649	0	17,468	0
Total balances at 31 March 2014	**2,371**	**0**	**25,625**	**0**

21 Related party transactions

Details of related party transactions with individuals are as follows:

Name of related party	Nature of relationship	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
White Horse Health Centre	Dr Debbie Beale, GP Vice Chair WWYKD Group (April to October 2014), is a senior partner within this practice	968	0	49	0
The Porch Surgery	Dr Simon Burrell, GP Chair NEW Group, is a partner within this practice.	235	0	17	0
Pewsey Surgery	Dr Anna Collings, GP Vice Chair NEW Group, is a partner within this practice.	117	0	0	0
The Castle Practice	Dr Toby Davies, GP Chair Sarum Group, is a senior partner	157	0	1	0
Morley Manor Ltd	Dr Toby Davies, GP Chair Sarum Group, is a director of Morley Manor Ltd.	50	0	0	0
Bourne Valley Practice	Dr Celia Grummitt, GP Vice Chair Sarum Group (April to September 2014) is a partner.	32	0	0	0
Cross Plain Surgery	Dr Celia Grummitt, GP Vice Chair Sarum Group (April to September 2014) is a partner.	195	0	26	0
Rainbow 2 Ltd	Dr Celia Grummitt, GP Vice Chair Sarum Group (April to September 2014) is the owner of this company.	66	0	0	0
Courtyard Surgery	Dr Helen Osborn, GP Chair WWYKD Group, is the owner of this practice.	125	0	0	0
Market Lavington Surgery	Dr Richard Sandford-Hill, GP Vice Chair WWYKD Group, is a partner of this practice.	174	0	5	0
Salisbury Walk In Centre	The practice which Dr Toby Davies, GP Chair Sarum Group, belongs to, is a shareholder in Salisbury Walk In Centre. The practice which Dr Peter Jenkins, GP Medical Advisor, is a partner in, is a shareholder in Salisbury Walk In Centre	954	0	11	20
St Ann Street Surgery	Dr Chet Sheth, GP Vice Chair Sarum Group, is a partner of this practice.	279	0	0	0
CS Medical Consultancy Services Ltd	Dr Chet Sheth, GP Vice Chair Sarum Group, is a director of this company.	50	0	0	0
Royal United Hospitals NHS Foundation Trust	Simon Truelove, Chief Financial Officer, is married to the Director of Finance of the Trust	82,623	0	2,272	0
McLaren Perry Ltd	Lynn Talbot, Interim Director of Transformation, is a director of this company.	123	0	11	0
Wiltshire Council	James Roach, Director of Integration, is jointly employed with Wiltshire Council.	16,885	1,193	2,508	1,431
JCC Partnership Ltd	Jacqui Chidgey Clark, Director of Quality and Patient Safety, is a director of this company.	8	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 involvespaying 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 CCGs strict governance and accountability arrangements. Material transactions are disclosed appropriately in the accounts.

The Department of Health is considered to be a related party. During 2014-15, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities include:
- NHS England
- Salisbury NHS Foundation Trust
- Great Western Hospitals NHS Foundation Trust
- Royal United Hospitals NHS Foundation Trust
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South Western Ambulance Service NHS Foundation Trust

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

22 Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local heatlh services.

NHS Wiltshire CCG will assume responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2015 but these will be discharged under joint decision making processes through a Joint Committee of NHS England and the CCG. Accountability, and the associated income and expenditure, remain with NHS England.

The accounts were authorised for issue by Simon Truelove, Chief Financial Officer, on 19 May 2015

23 Losses and special payments

23.1 Losses

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Administrative write-offs	1	15	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**1**	**15**	**0**	**0**

23.2 Special payments

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	1	1	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	3	50	0	0
Total	**4**	**51**	**0**	**0**

24 Third party assets

The CCG does not hold any assets on behalf of third parties (2013-14, £nil)