

## AGENDA for a Meeting of the Board

<b>Venue:</b>	Training Room 1, Chippenham Community Hospital and Dial In
<b>Date:</b>	Friday 25 <sup>th</sup> May 2018
<b>Time:</b>	10:00

WHC Board Members		
Carol Bode	Chair	CB
Douglas Blair	Managing Director	DB
Lisa Hodgson	Chief Operating Officer	LH
Annika Carroll	Head of Finance	AC
Sarah-Jane Peffers	Head of Quality	SJP
Cara Charles-Barks	SFT Board Representative	CC-B
Francesca Thompson	RUH Board Representative	FT
Carole Nicholl	Deputy GWH Board Representative	CN
Richard Barritt	Non Executive Member	RB
Celia Grummitt	Non Executive Member	CG
Adibah Burch	Non Executive Member	AB

In Attendance		
Lianna Bradshaw	Executive Assistant	LB
Katy Hamilton Jennings	Head of Legal and Corporate Governance II Board Secretary	KHJ
Apologies		
Nerissa Vaughan	GWH Board Representative	NV

Agenda Item		Lead	Paper	For Decision/ Discussion/ Information
<b>Part I</b>				
1	<b>Welcome, Apologies and Declarations of Interest</b>	CB	Verbal	Information
2	<b>Part I Minutes, Actions and Matters Arising</b>	CB	Attached	Approval
3	<b>Patient Experience: consideration of draft report from Healthwatch on Home First patient experience</b>	LH	Attached	Information
4	<b>Final accounts for 2017-18: presentation from KPMG</b>	AC	Attached	Approval
5	<b>Safeguarding Adult Reviews</b>	SJP	Attached	Information
6	<b>Exception Reporting on performance/quality/finance</b>	SJP/LH/AC	Attached	Information
<b>Part II</b>				
7	<b>Part II Minutes, Actions and Matters Arising</b>	CB	Attached	Approval
8	<b>Finance Summary</b>	AC	Attached	Information
9	<b>Community heart failure bid: update</b>	DB	Verbal	Information
10	<b>Any Other Business</b>	ALL	Verbal	
	<b>Date of Next Meeting: Friday 22<sup>nd</sup> June 2018</b>			

**WELCOME, APOLOGIES AND DECLARATIONS OF INTEREST**

**VERBAL ONLY**

## MINUTES Of a Wiltshire Health and Care Board Meeting Part I

<b>Venue:</b>	Training Room 1, Chippenham Community Hospital
<b>Date:</b>	10 <sup>th</sup> April 2018
<b>Time:</b>	14:00 – 17:00

<b>WHC Board Members</b>		
Carol Bode	Chair	CB
Douglas Blair	Managing Director	DB
Lisa Hodgson	Chief Operating Officer	LH
Annika Carroll	Head of Finance	AC
Lisa Thomas	Deputy SFT Board Representative	LT
Francesca Thompson	RUH Board Representative	FT
Nerissa Vaughan	GWH Board Representative	NV
Richard Barritt	Non-Executive Member	RB
Celia Grummitt	Non-Executive Member	CG
Adibah Burch	Non-Executive Member	AB

<b>In attendance</b>		
Lianna Bradshaw	Executive Assistant (minutes)	LB

<b>Apologies</b>		
Cara Charles-Barks	SFT Board Representative	CC-B
Sarah-Jane Peffers	Head of Quality	SJP
Katy Hamilton Jennings	Head of Legal and Corporate Governance II Board Secretary	KHJ

<b>Item</b>	<b>Title/Notes</b>	<b>Actions</b>
<b>1</b>	<p><b>Welcome, Apologies and Declarations of Interest</b></p> <p>Carol Bode welcomed everyone to the meeting and noted apologies from Cara Charles-Barks, Sarah-Jane Peffers and Katy Hamilton Jennings.</p> <p>Declarations of Interest – RB noted he is working with Southern Health NHS Foundation Trust on patient engagement.</p>	

2	<p><b>Part I Minutes, Actions and Matters Arising</b></p> <p>The minutes of the previous meeting held on 27<sup>th</sup> February 2018 were agreed as a true and accurate record.</p>	
3	<p><b>Chair's Report</b></p> <p>CB noted that she had attended the STP Sponsoring Board on 5<sup>th</sup> April 2018, which had discussed the developing priorities for the STP.</p>	
4	<p><b>MD's Report</b></p> <p>DB noted the following points:</p> <ul style="list-style-type: none"> <li>• The transfer of systems and TUPE transfer of staff had happened successfully on 1 April 2018, with no major issues. This had been a major undertaking for the Wiltshire Health and Care team.</li> <li>• Confirmation had been received that a new license had been issued by NHS Improvement, meaning that the LLP was now regulated directly by NHS Improvement as a 'NHS-Controlled Provider'.</li> </ul>	
5	<p><b>Patient Experience During Winter</b></p> <p>LH presented a review of the winter period and the impact that initiatives had on patient experience. This included the following key points:</p> <ul style="list-style-type: none"> <li>• The priorities for Winter 2017/18 were: <ul style="list-style-type: none"> <li>- prevent people from becoming unwell and needing to go to hospital</li> <li>- to support people to leave hospital as soon as fit to do so, delayed transfers of care to remain at 15-20%</li> <li>- to support as many people as possible in their own home</li> <li>- support our staff</li> </ul> </li> <li>• The Wiltshire Integrated Control Centre (WICC) was created to bring Wiltshire CCG, Wiltshire Council and Medvivo together with Wiltshire Health and Care.</li> <li>• The average length of stay (days), admission numbers and delayed transfers of care have decreased.</li> <li>• There were specific patient stories which showed the impact of greater coordination reducing delays for patients</li> <li>• There were lessons which needed to be taken from this experience and mainstreamed into day to day work.</li> </ul>	

	<p>It was agreed that LH will write up a short proposal to brief members in relation to the next steps that we need to take in relation to patient flow support.</p>	<p>LH</p>
<b>Scrutiny</b>		
<p>6</p>	<p><b>Quality, Finance and Performance Report</b></p> <p>The Board reviewed the quality, finance and performance report.</p> <p><b>Quality</b></p> <p>DB highlighted the following:</p> <ul style="list-style-type: none"> <li>• Overdue incidents are reducing (37 in March)</li> <li>• Short term sickness has risen, however this is being monitored closely</li> <li>• Vacancy rate is still high, however there are some data quality issues, which is expected to resolve once the new ESR is up and running. There will be no ESR data available during April and May</li> <li>• A backlog of statutory notifications has built up in the reporting to CQC. An approach to resolving this issue has been agreed with the CQC, which will focus on ensuring that the current process for completing all new notifications is robust.</li> <li>• Complaints 10% compliance in January 2018, however this is retrospective data and reflected some additional time taken on quality control in January. The position for March 2018 is 100% A Public and Patient Engagement Plan is in draft and the consultation is expected to commence shortly. This will include a workshop with Richard Barritt as patient voice non executive lead.</li> </ul> <p>It was noted that the dashboards do not provide clear evidence of the themes of complaints being reported to the Board. This needs to be shown.</p> <p><b>Performance</b></p> <p>LH highlighted the following:</p> <ul style="list-style-type: none"> <li>• An external review of Wilton community team had been commissioned.</li> <li>• Work has commenced on a re-design project for Ailesbury ward, given continuing and long running staffing vacancies and high agency usage and costs.</li> </ul>	<p>SJP</p>

	<p><b>Finance</b></p> <p>There were no issues to be highlighted to the Board in relation to the financial performance. AC noted that the LLP reports a year to date surplus of £61k as at M11, February 2018. The forecast outturn for the financial year remains a breakeven position as at M11. Due to the move to the new financial ledger, a financial report would not be produced for April 2018.</p> <p><b>Staff Survey Results</b></p> <p>The Board discussed the latest staff survey results. The broadly positive results were noted.</p> <p>There was a concern about the percentage decrease in personal development, as this was strategically important to get right.</p> <p>DB noted that staff forums were being organised for staff to discuss the results of the staff survey and staff will be asked to contribute to creating an action plan and to take a lead on implementing areas of the action plan.</p>	
7	<p><b>MIU Reporting</b></p> <p>The members reviewed the paper on reporting of MIU data. DB noted that from 1 April 2018, all data for Chippenham and Trowbridge MIU's will be reported as Wiltshire Health and Care LLP data. This means that the default position from April 2018 is that MIU reporting will not be able to be allocated towards any measurement of the 4 hour target across local geographies but included against the LLP as an entirely separate entry in national data.</p> <p>The members reviewed the following three options for allocation of data:</p> <ol style="list-style-type: none"> <li>1. Use the pattern of 'Type 1' attendances by postcode at RUH and GWH EDs as a proxy for the allocation of attendance by postcode at the two MIUs</li> <li>2. Use the balance of Wiltshire non elective admissions between RUH and GWH as proxy</li> <li>3. To split the units and allocate Trowbridge to RUH and Chippenham to GWH</li> </ol> <p>The Board agreed that Option 2 was the most appropriate option.</p> <p>DB will take papers to the A&amp;E Delivery Boards for information, and formally agree with NHSI and NHS England.</p>	DB

8	<p><b>MOU on Finance Sharing in STP</b></p> <p>The members reviewed the paper to seek Board agreement to sign an STP Memorandum of Understanding in relation to the sharing of financial information with an 'open book' approach.</p> <p>The Board agreed to sign the Memorandum of Understanding but noted that WHC should mirror the level of details provided by Virgin Care in relation to Bath and North East Somerset community services, to manage the risk of unfair use of commercially sensitive information.</p>	
9	<p><b>CQC Action Plan Update</b></p> <p>The members reviewed the paper relating to the CQC Action plan update.</p> <p>It was noted that good progress has been made towards the completion of the actions. This has been achieved through the agreement and appointment of a number of new governance and operational roles; Board Secretary, Medicines Governance Pharmacist, Safeguarding Lead for Children and a Chief Operating Officer to lead the delivery of all services.</p> <p>DB also noted the following:</p> <ul style="list-style-type: none"> <li>• WHC are now fully compliant with the Fit and Proper Persons regulations – KHJ will ensure future compliance</li> <li>• There is further work to do on some of the actions relating to Urgent Care</li> <li>• Steady progress was being made with the vast majority of 'must do's' now complete, and 'should do's' mostly green or amber</li> <li>• CQC are focussing on well-led in the future inspection regime, so this needed to be a continuing focus of Wiltshire Health and Care and the Board.</li> <li>• Current thinking on the vacant Clinical Director role was to put this together with broader clinical leadership for the system to create a shared role.</li> </ul>	
10	<p><b>Risks</b></p> <ul style="list-style-type: none"> <li>• <b>Board Assurance Framework</b></li> <li>• <b>Wiltshire Health and Care LLP Corporate Risk Register</b></li> </ul> <p>The members viewed the Board Assurance Framework (BAF), the Corporate Risk Register and the Service Delivery Risks.</p> <p>DB noted that proposed changes and a move to a new system (DATIX)</p>	

	<p>will mean a change to our risk system. Until this is developed, the similar format will be used. The BAF has largely unchanged with workforce still being the biggest risk. It was noted that a new Learning &amp; Development Lead position has been added to the structure to increase control of this strategic risk</p> <p>It was questioned how we are reviewing risks and DB noted that the Service Delivery Risks are reviewed in the Quality and Assurance Committee, and BAF and Corporate Risk Registers are reviewed by the Board Secretary before submission to Board.</p> <p>It was noted that there were gaps in terms of dates etc. and it was suggested that all risks are closed off before the new DATIX system is implemented so that we aren't transferring old risks over.</p>	
<b>Governance</b>		
<b>11</b>	<b>Delegation Framework</b>	
	<p>The Board reviewed the paper relating to the revised delegation framework that has been put in place from 1<sup>st</sup> April 2018.</p> <p>The Board members approved the revised delegation framework.</p>	
<b>12</b>	<b>Emerging Thoughts on Governance</b>	
	<p>The Board reviewed the paper relating to the draft proposal for developing WHC LLP's governance structure and noted that this is work in progress.</p> <p>The Board provided comments on the developing work. In particular it was questioned whether a Finance and Investment Committee was required. It was agreed that the revised structure should continue to be developed and updated following the upcoming members meeting on 9 May 2018.</p>	
<b>13</b>	<b>Any Other Business</b>	
	<p>There was no further business.</p> <p><b>Date of Next Meeting: 25<sup>th</sup> May 2018</b></p>	

Title	Assigned	Due date
Liaise re independent Audit and Assurance Committee Chair - CB/DB/CCB - In Progress - CB to update	Douglas Blair	10/04/2018
Estates Fire Safety: ensure that NHSPS prioritise safety and assurance; continue fire prevention and evacuation facilities improvement; make further inspections and take Fire Brigade advice - SJP/DB - Ongoing - 21.09.17 Further assurance work undertaken but further assurance being sought from NHSPS before being brought back to Board. 13.11.17 Meeting with fire lead at NHSPS taken place in early November - awaiting formal report in December of actions being and have been taken. Will report back to Board once received. Update 09.03.2018 Awaiting feedback from Jo Woodward. Update 15.03.18 further assurance has been provided by NHSPS, the risk register has been updated to reflect reduced risk, and fuller details will be provided in the annual reporting due in May.	Sarah-Jane Peffers / Douglas Blair	25/05/2018
DB will take papers relating to MIU reporting to the A&E Delivery Boards for information, and formally agree with NHSI and NHS England.	Douglas Blair	25/05/2018
Devise Board and Individual Development Plans - CB - Discussed on 25.07.17 - In progress - 1:1 meetings booked.	Carol Bode	31/05/2018
It was agreed that LH will write up a short proposal to brief members in relation to the next steps that we need to take in relation to patient flow support.	Lisa Hodgson	22/06/2018
Improvements to financial reporting should be made in line with the changes to new financial systems from April 2018. After initial improvements have been implemented for April 2018, a plan should be presented for further cost analysis and service line reporting.	Annika Carroll	22/06/2018
A strategic risk on financial information should be added to the Board Assurance Framework. Complete. upon establishment of the new clinical risk system (anticipated end of May/June 2018), the Board Secretary will review the format of risk registers and re-structure the approach. The Audit and Assurance Committee should review proposals for redesign of the risk management process.	Katherine Hamilton-Jennings	22/06/2018
Report back on physio waiting times - DB - Discussions with CCG ongoing, no decision made on future pathway. Waiting time position unchanged. Report back when commissioning decision/s reached. Update 25.07.17 No decision has been made so will bring back to September Board. Verbal update to be given.	Douglas Blair	27/07/2018
H&S, Fire and Security: Assess incidents of violence and aggression on patient to patient or patient to staff change categories in information - SJP - This change to categorisation will be taken forward as part of the planning for a new clinical risk system. Update 09.03.18 In line with DATIX build, to be carried out during 2018/2019.	Sarah-Jane Peffers	27/07/2018
Update Mandatory Training table and identify and implement training mechanisms. DB - 13.11.17 To be picked up by Board Secretary. Update 13.03.18 KHJ & LB to meet with HM/NS to discuss setting up mandatory training for Board	Katherine Hamilton-Jennings	27/07/2018
Board members would be interested to see an analysis of the relative costs of providing a higher intensity care intervention as opposed to inpatient care. DB to update Board in October. - DB - Further work to be done. Timescale has slipped.	Douglas Blair	27/07/2018
Re-design project for Ailesbury ward, given continuing and long running staffing vacancies and high agency usage and costs.	Sarah-Jane Peffers	27/07/2018

**Wiltshire Health and Care Board****For information****Subject: Healthwatch Wiltshire report into Home First****Date of Meeting: 25 May 2018****Author: Lisa Hodgson****1. Purpose**

To share with the Board a report from Healthwatch Wiltshire into Home First.

**2. Discussion**

Please find attached a near-final copy of a report from Healthwatch Wiltshire on Home First. This was carried out as part of a planned evaluation commissioned by the CCG. This is likely to be published shortly, and is being shared with the Board for information as part of our ongoing focus on assessing patient experience of our services.

**3. Conclusion**

The Board is invited to note the report and its intended publication and consider the themes highlighted by it.

**Better Care Plan  
engagement report:**  
Evaluation of Home First  
service in Wiltshire

6

Local health  
and care  
shaped by you

# Notes:

## Carers

Where we talk about carers in this report we are referring to unpaid carers:

“A carer is anyone who cares unpaid for a family member or friend who cannot always manage without their support. They might look after someone with a physical disability, long-term health condition, mental health issue or a problem with substance misuse.” (Carers Support Wiltshire<sup>1</sup>)

Where the report refers to paid care workers, we will make this clear, for example by stating “agency care worker.”

## References

<sup>[1]</sup> <https://carersinwiltshire.co.uk/are-you-a-carer>

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# Background

This report is part of Healthwatch Wiltshire's Better Care Plan work. Healthwatch Wiltshire is working with the Better Care Plan programme partnership (Wiltshire Council and the Clinical Commissioning Group) to assist in meeting its aim to see health and social care integrated by 2020. The vision for better care is based on the four priorities set out in Wiltshire's Joint Health and Wellbeing Strategy:

"I will be supported to live healthily, I will be listened to and involved, I will be supported to live independently and I will be kept safe from avoidable harm".

To be successful, services need to improve in these areas:

- admissions to residential and nursing care
- success of reablement and rehabilitation
- delayed transfers of care
- avoidable emergency admissions
- patient and service user experience

The Better Care Plan strategy is committed to reducing the number of delayed transfers of care and to increasing the independence of patients, particularly those over the age of 65. Once they are medically able to leave hospital or a care home, the timely transfer of patients from these settings to their own home or to a care home can be challenging for health and care systems.

The Home First service is a new initiative aiming to support early discharge of patients who are medically able to leave hospital or care home. Wiltshire Health and Care provide the service and have employed rehabilitation support workers to work alongside therapists to support people on discharge from hospital. They provide care for up to 10 days before transferring the service to a home care agency if needed.

This work aims to evaluate the effectiveness of the Home First service from the point of view of patients, relatives, staff and stakeholders. It has involved gathering and analysing people's experiences of using or providing the service as well as asking for their views about it.



# What we did

- We prepared information leaflets and surveys for patients and professionals.
- We visited the community teams across Wiltshire and held focus group discussions with staff involved with the Home First service.
- We provided surveys for staff members who were unable to attend the meetings.
- We asked Home First staff members to talk to their current patients about our evaluation and ask them if they would be prepared to talk to us about their experience.
- We distributed information and surveys for Home First teams to send out to any other patients who had used the service.
- We carried out one-to-one interviews with patients who had agreed to speak to us.
- We contacted acute hospitals and asked them to share their experiences with us.
- We spoke to staff from Medvivo who are involved in processing referrals for Home First.



# Who we spoke to



A total of **34** patients and/or their unpaid carers shared their experiences of using the service:

- 22 patients or carers had 1-1 interviews that involved an informal discussion and completion of a survey
- 12 patients or carers completed our survey

A total of **76** professionals shared their views of the service:

- 61 people took part in our focus group discussions
- 10 people completed our survey
- 5 people took part in telephone interviews

# Our volunteers

Healthwatch Wiltshire has a team of trained volunteers. Twelve of our volunteers were involved and contributed a total of 40 hours of their time. They supported the engagement by:

- supporting the visits to community teams and focussed discussions
- writing up focus group notes
- carrying out some of the one to one interviews with patients
- inputting the surveys
- proof reading and commenting on the report



# The key messages

The Home First service was regarded as a high quality, useful service.
Patients and carers were not consistently given accurate information about the Home First service prior to coming home.
The rehabilitation and reablement aspect of the service was thought to be particularly valuable.
Patients and carers thought staff were professional, respectful, kind and caring.
Patients were not given much information about other organisations that were available.
Staff and patients thought that the service enabled people to return home more quickly, and that it could reduce the need for some ongoing care visits.
Staff thought Home First was a good service and were committed to it.
There were some concerns about the administrative tasks associated with Home First and their impact, particularly on the roles of therapists.
The Home First service sometimes extends well beyond its 10-day remit when other care services are not available to take over.
Staff felt the service could be improved with greater capacity for care visits. This was from rehabilitation support workers and home care agencies, once Home First is no longer needed.

# Patients' views about Home First

In our surveys and 1-1 interviews, we asked patients and their carers to tell us about their experiences of the Home First service at different stages: prior to discharge; the initial set up; while the service was being provided; and when the service finished.

## 1. Prior to discharge



We found that there was considerable variation in what people had been told about the service prior to returning home. This ranged from a few who had been given accurate information, some who had been given some information, for example just being told someone would be visiting, and a few who said that they were not told about the service at all and were surprised when someone turned up. Some patients said they didn't think that they would have been able to take this information in as they were still feeling poorly and/or disorientated following treatment. There was a similar variation in what patients' families and carers had been told.

The majority of patients (88%) we spoke to said that they felt ready to come home. Some said that they had concerns about coming home. All but one of these said that they were able to talk to someone about these concerns, and that they were given answers.

On discharge, most patients and their families were not aware of the name of the service or team who would be visiting them, or how to contact them. Hospital staff told us that this sometimes meant that people would telephone the ward if Home First staff didn't arrive when the patient expected them.

Patients and staff felt that a leaflet that gave a brief overview of what to expect from the service would be useful to give to patients and/or their families before they are discharged from hospital.

## 2. Initial set up of service

All but one of the people we interviewed said that a member of the Home First team arrived to carry out an initial assessment when they expected them to. The one exception was a patient who said that they were discharged on a Friday evening and that no one arrived until Monday.

People told us that during the assessment a therapist made sure that they had all the equipment that they needed, ordered anything necessary, and assessed what therapy and care visits they would need. Everyone we spoke to said that they were happy with what was agreed as a result of this assessment process. Most of the patients we spoke to said that they felt safe being back home.

“I was discharged on Friday and arrived home between 7 - 8pm. No carer arrived till Monday so me and my wife just had to manage. I wasn't given the time that the first visit was expected, when to expect people or a contact number.”

“A physio came straight away after my husband came home. It was reassuring to have this from the first day. I was told who would be visiting. It is a fantastic set up as they have got a bit of everything there.”  
**(carer from Devizes)**

Most patients told us that the service was well explained to them by the Home First team once they reached home. However, 62% of those we spoke to said they didn't know which team member was coordinating their care. All but one said that they were given contact details for the team and knew how to get in touch with them if necessary. People told us that if they did need to get in touch with the team, they were responsive and sorted out any issues or concerns.

### 3. Provision of Home First service

In general, the feedback we had from patients about the Home First service was extremely positive. In particular they praised the provision of equipment, staff attitude and the reablement approach.

Patients told us that, following an assessment, staff organised for a variety of equipment to be delivered. This included frames, trolleys, grabbers and specialist chairs and beds. Some equipment was arranged prior to discharge so that it was there before the person arrived home. Several people we spoke to were also complimentary about the company, Medequip who delivered and collected the equipment and said that they were friendly and helpful. People said that they found the assessment and equipment very useful in supporting them to become more independent. For example, one lady told us that by having a trolley she could now prepare her own meals and had therefore been able to stop having a care worker visit at lunchtime.

Patients and carers praised the Home First staff teams, including therapists and rehabilitation support workers. They said that staff were professional, reliable and came when they were expected. 100% of patients and carers we surveyed said that they were treated with respect and dignity when receiving care from the Home First teams. People described Home First staff as being polite, kind, caring and friendly.

“Medequip was brilliant. They provided bed, commode and cushion and then collected it – really good service, really nice people.” **(carer from Malmesbury area)**

“They were all lovely and it was good to have a chat.” **(patient from Malmesbury)**

“The girls were brilliant, I knew they were coming. There was nothing I could say that I didn't have that I needed.” **(patient from Devizes)**

“Care staff were absolutely brilliant.” **(patient from Trowbridge)**



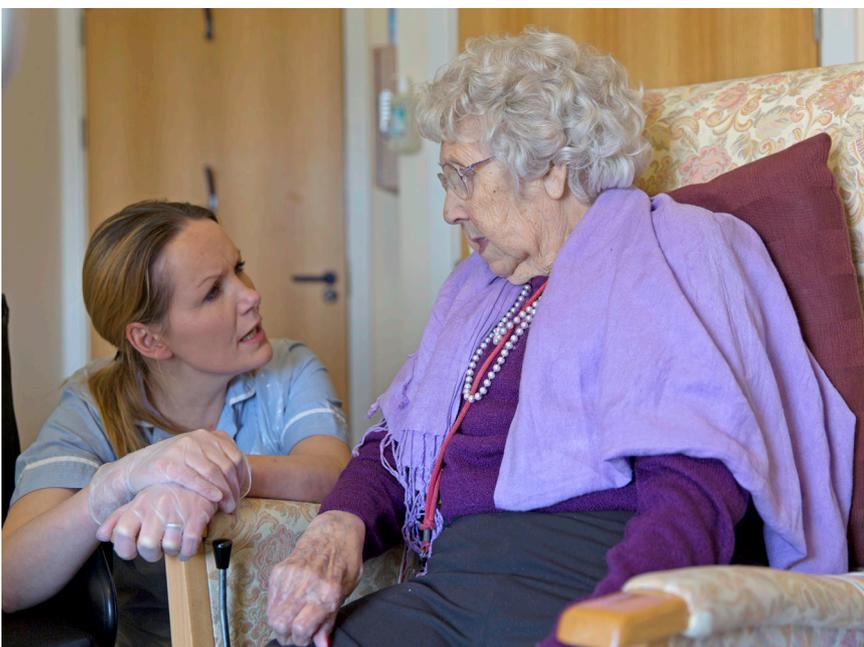
“They said to me: ‘There’s no time limit, we spend what we need to spend with each person’ – that is what I liked.” (patient from Trowbridge)

“I’d forgotten how to use my microwave and washing machine, they sorted me out and got me using them again.” (patient from Devizes)

People talked about the rehabilitation and reablement aspects of the service and said that they found this very useful and well delivered. They told us about visits from the physiotherapists and being given exercises, and visits from occupational therapists who gave advice and organised equipment. Some told us that the rehabilitation support workers helped them with keeping up these exercises. Many people said that they were encouraged to try to do personal care tasks themselves and that as they became more able, the team would stand back and only step in when needed. They said this helped them to build confidence that they would be able to do things on their own. We were also told by some people that they had been supported with tasks such as preparing meals and other domestic tasks and that they had been supported to ‘re-learn’ tasks. Examples included using the washing machine, microwave and making an omelette. We were told that this support made people more independent, and often meant that one of their care visits could be stopped.

## 4. Experiences when the service finished

We asked patients what happened when Home First finished. Everyone we spoke to said that this had been discussed with them and that they understood this. Of those we spoke to 13 people told us that their care transferred to another organisation and 15 said that their home care finished as it was no longer needed. All of these people agreed that this was the right decision and several of them told us that they had been advised that they could contact the team again if they felt they needed further visits. One of these patients and their family told us that delays in accessing other health care services meant that they had not been able to keep as active as they would have liked and that due to this they had now had to ask the Home First team to become involved again.



Of the 13 patients whose care was transferred to another home care agency, 10 patients told us that there were no problems with this and 3 said that there were some problems. The problems people described concerned changes in timings of visits and late visits. Overall 69% of patients told us that they were very satisfied with the transition and 31% said that they were satisfied.

In our survey we asked people if the support they received from the Home First service had done what they wanted it to do, 91% responded 'Yes, completely' and 9% responded 'Yes, to some extent'. People felt the service had given them confidence and enabled them to be more independent. Some people told us that their quality of life was now much better than it had been for some time due to the Home First team being involved.

We asked patients whether they were told about other services that might be available to them. 31% said that they were, 50% said they were not and 19% said they were not sure. We talked about this in our interviews with patients and found that they had different levels of awareness of other support organisations. This is an area that could be developed further.



"I was in a bad way before I went into hospital. I'm better now because I can use my Zimmer frame to get out in the garden and my wheel chair to get out - I couldn't do this before." (Patient from Warminster)

## Carers' views about Home First



Ten of our interviews and surveys included the views of patients' unpaid carers. Their feedback about the service was consistent with that described by patients.

In addition, carers told us that they had been involved in discussions about the Home First service from the point of the assessment visit at home. They said that the care visits from the team were individually tailored to the times that they needed. This meant that unpaid carers could support with care at times when they were available, and the Home First team would support when they had fixed commitments. Carers told us that this worked well for them.

Carers told us that they thought that the 'confidence building' aspect of the service was particularly useful. They said that it meant that their relative became more able to manage tasks themselves and, as carers, they felt more comfortable with them doing these.

Some carers of people with quite complex needs told us that they had been concerned about whether they would be able to manage when

the person came out of hospital. They told us that they felt well supported by the team. For example, one carer told us that they were initially allocated 4 visits a day. Once they found that they didn't need all of these, they were gradually reduced, by mutual agreement. This carer told us that they found this reassuring.

Carers told us that they felt staff from the Home First service were polite, respectful and considered their individual needs as a carer in terms of how the Home First service was delivered. However we found that carers were not given information about other organisations that might be able support them.

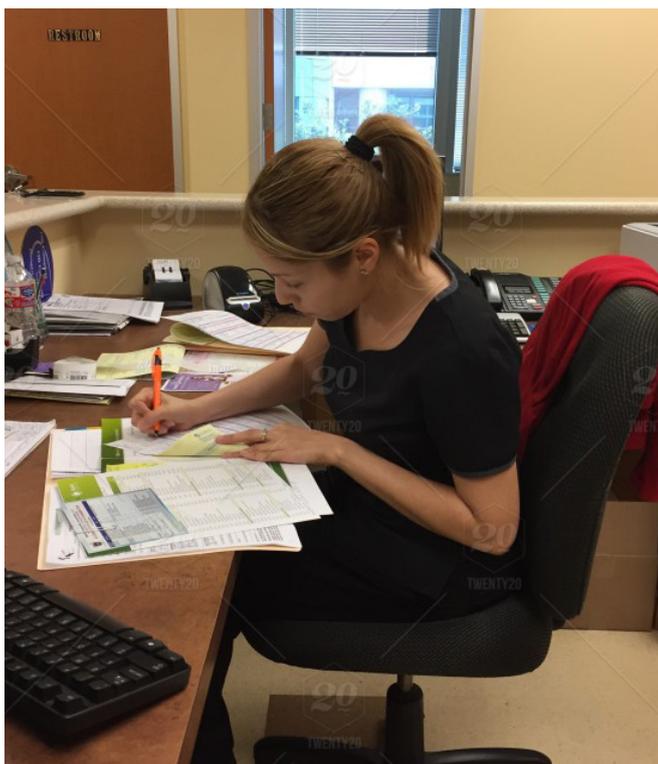
“They encouraged my husband to be able to do as much as he could before. They also helped me as a carer.” (carer from Devizes)

“The team came every day in the mornings but not on the weekends as I could do this. They did whatever was needed. Once Mum could do things they would stand back. This was exactly the type of support needed in terms of confidence building.” (carer from Malmesbury)

## Staff views about Home First

We spoke to staff who were providing the Home First service as well as those involved with it. This included physiotherapists, occupational therapists, rehabilitation support workers, customer coordinators from Wiltshire Council, and staff from home care agencies, Medvivo and acute hospitals.

### 1. Roles and organisation of Home First teams



We found that there was variation between the teams in how the Home First service is organised. For example, some teams had designated one of the therapists to lead on the service including coordinating referrals, others alternated who was responsible on a day by day basis and others just managed things between them.

In general staff members said that some of the administration associated with Home First presented them with challenges and could be time consuming. This primarily included managing staff rotas and liaising with hospitals and home care agencies about discharge and follow on care as well as completing forms and records specific to Home First.

We were told that when Home First started staff took on new responsibilities, for example rotas. They said they were not given much guidance on how to go about this. We found

“Much more admin, scheduling and management of staff than expected which impacts on other areas of physiotherapy.” (Home First team staff member)

that rotas are mostly being prepared by therapists, though in some teams they are prepared by one of the rehab support workers. Covering the rota presented a challenge for many of the teams, particularly on occasions where there was staff absence. Some teams that were not yet fully staffed were using home care agencies through the Help to live at Home service to cover some of the visits. Some staff members said that they sometimes didn't get much notice of their shifts and that they would like the rota to be prepared further in advance.

Staff also talked about teething problems with some of the electronic systems. They said that they had reported these but that they had not always been resolved promptly. This had meant that they had to be particularly careful to be sure that visits were not missed.

Staff told us that they spent a lot of time on the phone liaising with hospitals about discharge arrangements and home care agencies about onward care. They said that it was often difficult to get through to the person they needed to speak to and get the information they needed. Finding out the time that a patient was likely to return home from hospital was highlighted as being particularly difficult. In particular therapists felt that the administration they were now involved in meant they had less time to spend with patients. Several therapists said that, in concentrating on Home First, their other therapy work had been affected, for example, by increased waiting times for other patients requiring routine therapy.

Staff members we spoke to had some ideas about how this could be overcome and suggested that a designated person to lead on Home First management and administration would be useful. Some teams felt that this should be a senior therapist while others saw this more as an administrative role.



## 2. What is good about the service

Staff we spoke to from the acute hospitals, Medvivo and the Home First teams all thought that the service is valuable and a positive new initiative for patients. They thought that the service enabled people to leave hospital more quickly and they felt that they could ensure that the right support was in place for people.

Staff valued the rehabilitative and reablement approaches that are an integral part of the service. They said that they felt that the service actively encouraged and supported people to be as independent as possible. They thought that this meant that people's ongoing care needs were reduced. They also said that they thought patients gained personal satisfaction from making progress and being

“I have not had any issues with the referral process - we refer them when they are medically fit. They are usually quick but occasionally there might be a delay in Home First being ready. This might be 2-3 days.” (staff member from acute hospital involved in discharges)

more independent.

Staff felt that the rehab support workers were a great asset in ensuring that the service kept the ethos of supporting patients to become more independent. They thought this was one of the successes of the service. It was felt that this was due to the fact that the rehab support workers are inducted, trained and supervised by therapists.

Staff felt that having the rehab support workers as part of the team helped with continuity. The therapists said that this meant that they could get quick and accurate feedback as to how their patients were progressing. As a result, any changes to care could be implemented promptly.

Staff told us that they felt the confidence building aspect of the service was really important and beneficial. Those involved in hospital discharges thought this reassured patients and their families and facilitated prompt discharge because it alleviated patients and carers worries, if they know that someone would be coming in to make sure they could manage initially.

Staff we spoke to demonstrated a positive 'can do' attitude, said that they worked well as a team and showed a commitment to the service.

“I think it’s a very good thing that people are assessed at home rather than in hospital. I think the service is good, but it would be amazing if there was a full capacity of trained staff.” (Home First Team member)



“It has been successful in reducing care needs and enabling patients.” (Home First team member)



“We are positive about the Home First service, I believe it has made a difference to patients who avoid being de-conditioned or institutionalised and that mostly, patients and families end up positive about the service.” (Home First team member)

### 3. What could be improved

Staff involved in Home First thought that it couldn't always operate to its full potential due to lack of capacity both in the Home First service and in the onward home care. Staff involved in hospital discharge and the Home First teams felt that they could take more patients if there were more rehab support workers employed. This was exacerbated in areas where recruitment was being undertaken to fill vacancies, although it was felt that in general more rehab support service would improve the ability to be responsive.

We were told that difficulties sourcing ongoing care when the service was supposed to finish sometimes meant that it couldn't stop when it was supposed to. This varied across different areas of Wiltshire with rural areas highlighted as being more challenging to source home care.

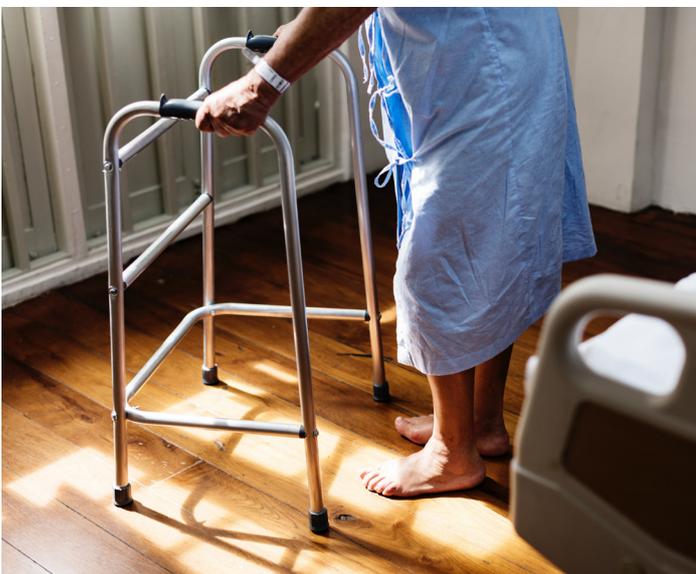
“The difficulty is in finding care that can take over Home First, which means that often Home First exceeds 10 days. This means there is a knock-on effect on our capability to pull patients out of hospital or support an unwell person at home.” (Home First team staff member)



We were told that patients often had not been given much information about the service prior to discharge and that some patients had unrealistic expectations. The most common of these was that home care would always be provided free of charge for 6 weeks, and that Home First staff would be doing tasks for the patient, including domestic tasks. Staff felt that, often, during the first few days of Home First they spent a lot of time establishing with the patient what would be provided. Staff felt that there should be a Home First leaflet which was given to patients and/or their families before the start of the service.

Staff said that, on occasions, health and social care services were not working well together. For example, we were told of one patient who ended up having 7 visits a day from several different agencies because staff providing social care visits would not support them with eye drops. This was very confusing for the individual and had led to medication errors. We were told that this had been taken up by staff and raised as a case study but that the situation was not yet resolved.

“Some patients expect us to do everything for them, we have to explain that we are here to help them back on their feet.” (Home First team staff member)



Although, in general, staff felt that the referral system to Home First worked smoothly some things were mentioned that could be improved. Not all hospital staff were clear what they needed to know about the patients to make a referral, and staff who managed the referral process, felt that hospital staff didn't always make the best use of the service. We were told about some instances where patient information on the referral differed from what the hospital discharge team told them. There were occasions when Home First teams felt that the patients referred to them were not appropriate either because they were too ill and/or not suitable for rehabilitation.

# Recommendations

Despite some of the challenges highlighted, the Home First service is clearly valued and well regarded by the patients and carers we spoke to. Staff involved in providing the service were committed and positive and felt that the service was largely achieving its aims.

These recommendations may help develop the service further:

1. Develop a short leaflet or information sheet which describes the Home First service in Wiltshire and give this to the acute hospitals, patients and/or family members. Healthwatch Wiltshire could support with this.
2. Carry out an audit of administrative and/or management tasks and identify any that could be done centrally, for example induction training, to make this as efficient as possible.
3. Provide opportunities for staff involved in Home First to meet as a forum to share ideas and experiences of how they manage the service.
4. Ensure that all hospital staff are clear about the information needed and the process by which to make a referral.
5. Monitor the impact of delays in transferring care to other home care agencies and continue dialogue with colleagues from Adult Social Care about this.
6. Continue to raise any issues arising from health and care services not working well together, with the aim of addressing these.
7. Consider how Home First staff can provide patients and carers with information about other organisations that might be able to support them, for example, by providing rehabilitation support workers with information sheets or packs that they can pass on as appropriate.
8. Continue to recruit rehabilitation support workers into any vacant posts to ensure that the service can run at full capacity.

## Next steps

We know that it is important to people to know what has happened as a result of them sharing their experiences with us. We will be working with commissioners to respond to the issues raised during this engagement. In due course we will publish an ***Evaluation of the Home First service - you said, we did*** report which will bring together the key messages from this work and the action that is underway to address our recommendations.

# Thank you

Healthwatch Wiltshire would like to thank everyone who took the time to contribute their views and experience through the engagement activities. Thanks to staff Wiltshire Health and Care for sharing their views and promoting the engagement to patients, and to staff from Medvivo and the acute hospitals for sharing their views with us.



Thanks also to our dedicated volunteers who helped to support the engagement activity. Without them we would not have been able to reach the numbers of people that we did.

## Response from Wiltshire Health and Care

The report was shared with Wiltshire Health and Care and Douglas Blair, Managing Director has given us this response:



Wiltshire Health and Care appreciates the review carried out by Healthwatch. Staff enjoyed being part of the assessment and having the opportunity to talk about Home First and how it is delivered. Home First was implemented last year as a new initiative designed to improve the way support is offered to people when they are discharged from hospital, and where possible, helping them back to their usual routine. It is gratifying to see that positive feedback from patients and their carers is in line with the outcomes that we are seeing in our daily practice and in our performance reports.

The report highlights some areas where improvements are required, particularly information on Home First (both pre and post discharge) and the current administrative procedures. We will be addressing these areas as a matter of priority and include a staff forum in this process.

We accept the recommendations and will be working with our partners in order to implement them.

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## Why not get involved?



[healthwatchwiltshire.co.uk](http://healthwatchwiltshire.co.uk)



[info@healthwatchwiltshire.co.uk](mailto:info@healthwatchwiltshire.co.uk)



01225 434218



Unit 5, Hampton Park West, Melksham, SN12 6LH



HealthwatchWiltshire



@HWWilts



healthwatchwiltshire

**Wiltshire Health and Care Board****For decision**

**Subject:** External Audit Report – Financial Statements 2017/18 Wiltshire Health and Care LLP

**Date of Meeting:** 25 May 2018

**Author:** Douglas Blair/Annika Carroll

**1. Purpose**

1.1 To present the draft external audit report and financial statements for 2017/18 to the Board

**2. Background**

2.1 The draft audit report from KPMG is attached. KPMG will be present at the meeting to present their findings. As this is a draft report, there are a few minor remaining aspects being finalised. As such the Board is being asked to delegate authority for the signing of the final accounts.

In relation to evidence of a going concern, the fact that a commitment was given for the life of the contract to the CCG by Member organisations has been used by the auditors in the previous year as evidence to satisfy the requirements around a going concern. We therefore need to confirm that these commitments remain unchanged.

**3. Discussion**

3.1

**4. Recommendation**

4.1 The Board is invited to:

- (a) Note and discuss the report from the auditors;
- (b) Delegate authorisation to the Managing Director to finalise the Letter of Representation and financial statements and to sign both, for and on behalf of the Members, subject to any material changes being referred back to the Board
- (c) Member representatives are asked to confirm that there are no changes in circumstances which would mean that the commitment given to the CCG at the start of the contract around continuity of services cannot be used as evidence of a going concern

## Impacts and Links

Impacts	
<b>Quality Impact</b>	Click here to enter text
<b>Equality Impact</b>	Click here to enter text
<b>Financial implications</b>	Click here to enter text
<b>Impact on operational delivery of services</b>	Click here to enter text
<b>Regulatory/ legal implications</b>	Click here to enter text
Links	
<b>Link to business plan/ 5 year programme of change</b>	Click here to enter text
<b>Links to known risks</b>	Click here to enter text
<b>Identification of new risks</b>	Click here to enter text



# External Audit Report

**Wiltshire Health & Care LLP**

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**May 2018**

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2017/18 financial statements for Wiltshire Health & Care LLP. This document was discussed and approved by the Board Meeting on 25 May 2018.

.....  
Rees Batley

Director for and on behalf of KPMG LLP,  
Chartered Accountants  
66 Queen Square, Bristol, BS1 4BE

[~~xx~~] June 2018

Our audit opinions and conclusions:

Financial Statements: unqualified

# Content

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## Important notice

### 1. Summary

### 2. Financial Statements Audit

## Appendices

- 1 Recommendations raised and followed up
- 2 Audit Differences
- 3 Audit Independence
- 4 Audit Quality

## Page

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# Important Notice

This report is presented under the terms of our audit engagement letter. This report is addressed to Wiltshire Health & Care LLP and has been prepared for your use only. Circulation of this report is restricted. The content of this report is based solely on the procedures necessary for our audit. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the LLP. External auditors do not act as a substitute for the LLP's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

**Basis of preparation:** We have prepared this External Audit Report (Report) in accordance with our responsibilities under the terms of engagement letter dated 25 April 2017.

**Purpose of this report:** This Report is made to the LLP's Board in order to communicate matters as required by International Audit Standards (ISAs) (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report. This Report is subject to disclosure restrictions.

**Limitations on work performed:** This Report is separate from our audit opinion included in the LLP's Annual Reports and Accounts and does not provide an additional opinion on the LLP's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors reporting. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this Report. The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

**Status of our audit:** Our audit is not yet complete and matters communicated in this Report may change pending signature of our audit report. The following work is still outstanding:

- Review of the final financial statements after feedback on version one;
- Final consistency check between the consolidation schedules and the financial statements



# Summary

# Summary

## Audit focus areas

These are the risks and other focus areas we identified in our audit plan.

### Audit risk

Revenue recognition  
Management override of controls

### Risk change

No change Page 9  
No change Page 9

### Other focus area

There were no other focus area's identified in our audit plan.

## Audit misstatements

Page 11

There are no corrected or uncorrected audit misstatements.

We have agreed minor presentational changes to the financial statements, mainly related to compliance with the FRS 102 LLP SORP .

## Controls findings

We have not undertaken a controls approach on our audit given the financial environment in which the LLP operates. However, we note the expected changes to the organisation in 2018/19 and will perform necessary additional procedures as part of the audit process.

## Outstanding matters

- Review of adjustments made to AoB differeneeces
- Review of summarisation schedules
- Final review of statutory accounts
- Receipt of member letters to support the going concern assessment made by management.

## Other matters

We are required to report on differences over £300,000 between the financial statements and the consolidation schedule to the NAO, as well as reporting on differences over £1 million between FRS 102 LLP SORP and IFRS DH GAM to the Department of Health and Social Care. We are no expecting and differences to report.



# Financial Statements Audit

## Section Two

# Financial Statements Audit

We audit your financial statements by undertaking the following tasks:

Work Performed	Accounts production stage		
	Before	During	After
<b>1. Business Understanding:</b> review your operations	✓	✓	–
<b>2. Controls:</b> assess the control framework	✓	–	–
<b>3. Prepared by Client Request (PBC):</b> issue our prepared by client request	✓	–	–
<b>4. Accounting standards:</b> agree the impact of any new accounting standards	✓	✓	–
<b>5. Accounts Production:</b> review the accounts production process	✓	✓	✓
<b>6. Testing:</b> test and confirm material or significant balances and disclosures	–	✓	✓
<b>7. Representations and opinions:</b> seek and provide representations before issuing our opinions	✓	✓	✓

We have completed the first six stages shown above and report our key findings below:

1. Business Understanding	In our audit plan we assessed your operations to identify significant issues that might have a financial statements consequence. We confirmed this risk assessment as part of our audit work. We have provided an update on each of the risks identified later in this section.
2. Assessment of the control environment	We have assessed the design of the key financial system controls that prevent and detect material fraud and error. However other than those designed to prevent management override of control we did not deem it appropriate to test the operating effectiveness of the control systems given the limited activity in the financial year. We note as the LLP takes full control of services in 2018/19 the financial control environment will come under more scrutiny, which should be considered as the LLP continues to develop.
3. Prepared by client request	We produced this list to summarise the working papers and evidence we ask you to collate as part of preparation of the financial statements. We discussed and tailored our request with Matt Lowe, Head of Financial Services, RUH NHS Foundation Trust. The quality of documentation was of a high standard and the majority of working papers were available at the start of the audit.
4. Accounting standards	We have worked with you to understand the changes to accounting standards and other technical issues. The LLP has applied FRS 102 LLP SORP for which we have provided account templates and have fed back comments on the first draft.
5. Accounts Production	We would like to commend the finance staff at the LLP and RUH who were available throughout the audit visit to answer our queries and thank the finance team for their co-operation throughout the visit which allowed the audit to progress and complete within the allocated timeframe.

## Section Two

# Financial Statements Audit

6. Testing	We have summarised the findings from our testing of significant risks and areas of focus on the following pages. During the audit we identified <b>KUL8</b> one audit adjustment which has been updated within the financial statements.
7. Representations	You are required to provide us with representations on specific matters such as your going concern assertion and whether the transactions in the accounts are legal and unaffected by fraud. We draw your attention to the requirement in our representation letter, table at the Board meeting on 25 May 2018 for you to confirm to us that you have disclosed all relevant related parties to us.

We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest. We have not identified any other matters to specifically report.

To ensure that we have provided a comprehensive summary of our work, we have set out over the next pages:

- The results of the procedures we performed over the required risks of the fraudulent risk of revenue recognition and management override of control, which were identified as significant risks within our audit plan.;

### Independence **KUL5** and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

### Audit Fees

Our fee for the audit was £9,000 plus VAT (£ 9,000 in 2016/17). This fee was in line with that highlighted within our audit plan agreed by our Audit Plan in March 2018. We have not completed any non-audit work at the LLP during the year.

## Slide 8

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**KUL5**

Could we add something in here on going concern to highlight that net liabilities etc and need confirmation of ongoing support?

KPMG UK LLP, 22/05/2018

**KUL8**

We say 0 adjustments elsewhere

KPMG UK LLP, 22/05/2018

## Section Two

# Financial Statements Audit

### Results of our testing on areas of high audit risk

In our External Audit Plan 2017/18, presented to you in March 2018, we identified the areas assessed as significant risks in terms of their impact on our financial statements audit opinion. We have now completed our testing of these areas and over the next pages set out:

- The results of the procedures we performed over revenue recognition and management override of controls which were identified as significant risks within our audit plan;
- The results of our procedures to review the required risks of the fraudulent risk of revenue recognition and management override of control; and
- Our view of the level of prudence you have applied to key balances within your financial statements.

Risks that ISAs require us to assess in all cases	Why	Our findings from the audit
<p><b>Fraud risk from management override of controls</b></p>	<p>Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.</p> <p>We have not identified any specific additional risks of management override relating to this audit.</p>	<p>Our audit methodology incorporates the risk of management override as a default significant risk.</p> <p>We carried out controls testing and substantive procedures, including those over journal entries, accounting estimates and significant transactions that are outside the Organisation's normal course of business, or are otherwise unusual.</p> <p>We substantively testing the recognition of income received in the year, part of this work is pending the outcome of discussions with country parties from the Agreements of Balance exercise.</p>
<p><b>Fraud risk from revenue recognition</b></p>	<p>Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant audit risk. We did rebut this risk.</p> <p>We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk.</p> <p>The bulk of the Organisations income, at £45m for 2017/18, is through a block contract with Wiltshire CCG, although there is no incentive to misreport income we have not rebutted the presumption.</p>	<p>Our work focused on the completeness, existence and accuracy of the balances recorded within the financial statements. We are currently working through variances on the income lines to contract.</p> <ul style="list-style-type: none"> <li>■ We tested the income recorded in your financial statements to the signed contracts that you have in place with Wiltshire CCG to remittance and bank statement.</li> <li>■ We have tested income recognition around year end to ensure that income is recognised in the correct period,</li> <li>■ We have review income received against the agreement of balances exercise, although this work is still underway.</li> </ul>

**Slide 9**

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**KUL6**

Is this supposed to be in the revenue box? Duplicates last bullet there?

KPMG UK LLP, 22/05/2018



# Appendices

## Appendix 1

# Audit Differences

Under UK auditing standards (ISA (UK&I) 260) we are required to provide the Board with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK&I) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate. As communicated previously with the Board, details of all adjustments greater than £40K are shown below.

Under UK auditing standards (ISA UK&I 260) we are required to provide the Board with a summary of adjusted audit differences (including disclosures) identified during the course of our audit. The adjustments below have been included in the financial statements.

We are pleased to report that there were no adjusted or **KUL7** stated audit differences.

### Presentational Issues

We identified a small number of minor presentational issues during our audit and these have all been amended by the LLP. We are awaiting the revised set of financial statements for a final review.

### Other Matters

There are no other matters to be brought to the Board's attention.

**Slide 11**

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**KUL7**

We say earlier that there was one? Can you check for consistency

KPMG UK LLP, 22/05/2018

## Appendix 2

# AOB Differences

We are required to report any inconsistencies greater than £300,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions regardless of whether a LLP is a sampled or non-sampled component. We have provided details of the inconsistencies that we are reporting to the NAO as follows:

Counter party	Type of balance/ transaction	Balance as per LLP (£'000)	Balance as per counter party (£'000)	Difference (£'000)	Comments on Difference
Great Western Hospitals NHS Foundation LLP	Expenditure	£41,733	£42,487	£(754)	This variance arose due to errors in the submissions of Wiltshire Health and Care. GWH omitted accrued income in their submission whilst Wiltshire Health and Care did not reflect accruals in their in their submission expenditure submission. WH&C LLP have updated their side of the submission. We have reviewed the correct balances as included within expenditure in the financial statements , therefore no adjustments are required.
NHS Property Services	Creditor	£949	£1,933	£984	Explanation is outstanding at time of writing this report. Management are working with the counter party to provide an explanation of the difference. The impact on the financial statements will need to be considered upon the conclusion of the difference.

## Appendix 3

# Audit Independence

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance*.

### **Integrity, objectivity and independence**

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the LLP for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

### **General procedures to safeguard independence and objectivity**

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Governors.

### **Audit matters**

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the LLP's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the LLP's financial statements.

## Appendix 3

# Audit Independence

- Material uncertainties related to event and conditions that may cast significant doubt on the LLP's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the LLP's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our meetings with management, attendance at Audit Committee/Board where required, commentary and reporting and, in the case of uncorrected misstatements, through our request for management representations.

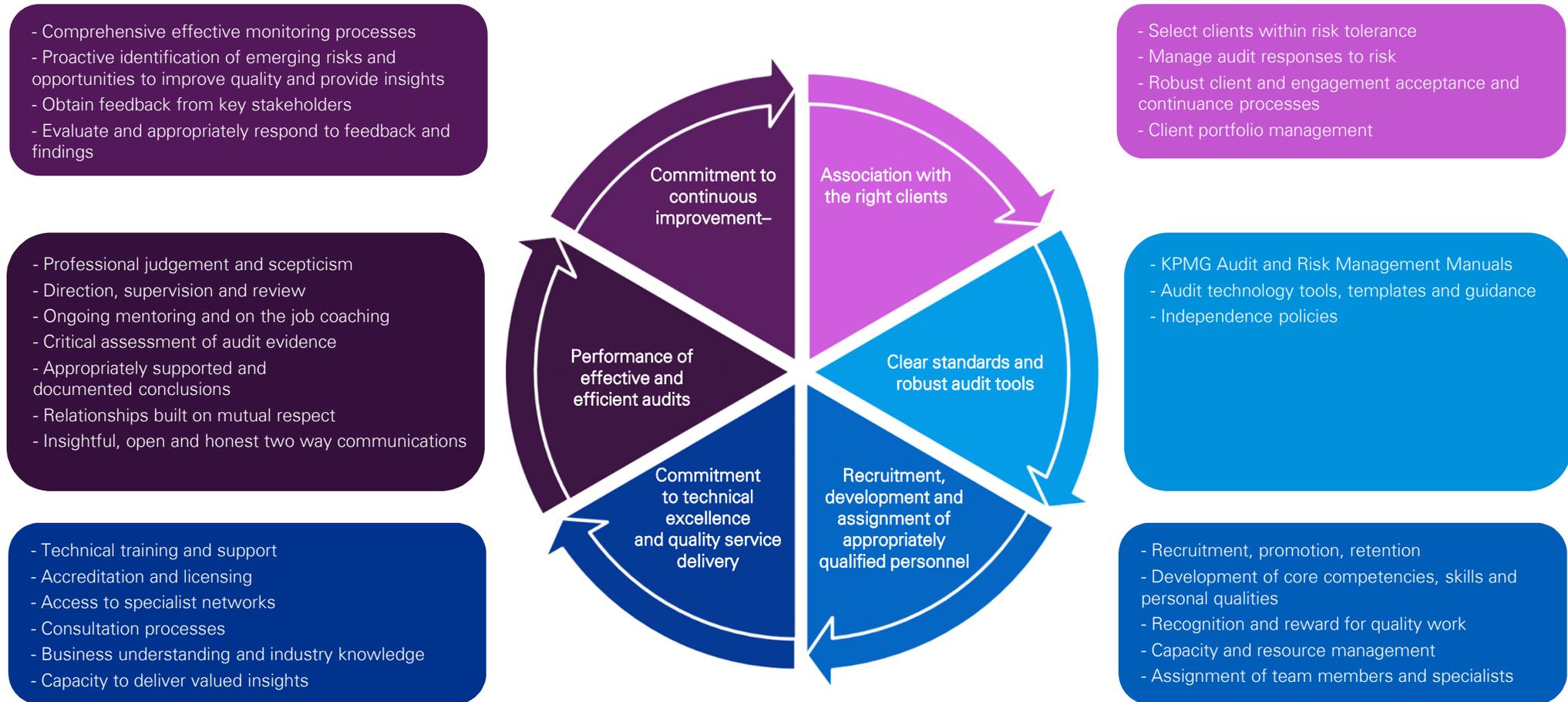
### Auditor Declaration

In relation to the audit of the financial statements of the LLP for the financial year ending 31 March 2018, we confirm that there were no relationships between KPMG LLP and the LLP, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.

## Appendix 4

# KPMG's Audit quality framework

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. To ensure that every partner and employee concentrates on the fundamental skills and behaviours required to deliver an appropriate and independent opinion, we have developed our global Audit Quality Framework





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The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.

Wiltshire Health and Care LLP  
Annual Report and Accounts 2017 to 2018

Presented to Parliament pursuant to Schedule 7, paragraph  
25 (4) (a) of the National Health Service Act 2006

Ordered by the House of Commons to be printed 5 July 2018

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**Officers and Professional Advisers**

**Designated Members**

Great Western Hospitals NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation  
Trust

Salisbury NHS Foundation Trust

**Registered Office**

Chippenham Community Hospital,  
Rowden Hill,  
Chippenham,  
SN15 2AJ

**Independent Auditor**

KPMG LLP  
66 Queen Square  
Bristol  
BS1 4BE

**Bank**

Lloyds Bank plc  
Chippenham Branch  
PO Box 1000  
BS1 1LT

The members are pleased to present their report and the audited financial statements for the year to 31 March 2018

## **Members' report**

### **Principal Activity**

Wiltshire Health and Care LLP is a public benefit entity whose principal activity is the provision of adult community health services across Wiltshire.

### **Results**

The results for the year are an overall breakeven position, as outlined on page 6.

### **Business Review**

The LLP has continued to deliver adult community services for the people of Wiltshire during the financial year 2017/18. This has involved responding to increased demand for services and continuing to improve the way in which community services support the needs of the population. The LLP was assessed as 'Good' by the Care Quality Commission during 2017/18.

2017/18 was the first full year of operational delivery and the LLP continued to break even at the financial year and grew its income base in a sustainable manner related to development of additional commissioned services.

In terms of risks and uncertainties, the LLP's highest strategic risk is related to continued supply of adequate workforce to deliver commissioned services. Whilst overall vacancy levels have reduced during the financial year, there are specific services or geographic areas in which workforce challenges are a risk to sustainable service delivery, in common with similar services in other areas of the country.

### **Designated Members**

The designated members who served during the year and to the date of this report are set out on page 1.

### **Charitable Donations**

The staff made a number of donations during the year, although the LLP itself did not directly contribute.

### **Policy regarding Members' Drawings and Capital**

All contributions of Capital made by a Member shall be recorded by the LLP. No interest shall be payable on any Capital Contribution unless the Members agree otherwise. There have been no contributions made to date.

Should any Member provide any services to the LLP, the Member shall not make any profit on any elements of those services with all risks managed in line with the relevant regulatory framework. Arrangements subject to periodical review by the Board.

**Members' report**

In the event that the LLP makes any Profits a reserve shall be formed and will only be divided and converted into a debt to the Members if and when the Board (acting on behalf of the Members) has agreed to distribute those Profits among the Members as per section 8 of the Members Agreement.

The amounts transferred in the year was £0 (2016/17: £0).

**Disclosure of information to auditor**

The members who held office at the date of approval of this members' report confirm that, so far as they are each aware, there is no relevant audit information of which the LLP's auditor is unaware; and each member has taken all the steps that they ought to have taken as a member to make themselves aware of any relevant audit information and to establish that the LLP's auditor is aware of that information.

**Auditor**

The independent auditors of WH&C LLP are KPMG LLP.

Pursuant to section 487 of the Companies Act 2006, the auditor will be deemed to be reappointed and KPMG LLP will therefore continue in office.

Approved by the Members  
and signed on behalf of the Members

Douglas Blair

Managing Director

Registered office address: Chippenham Community Hospital, Rowden Hill, Chippenham, Wiltshire, SN15 2AJ

**Statement of members' responsibilities in respect of the Members' report and the financial statements**

The members are responsible for preparing the financial statements in accordance with applicable law and regulations and have elected to prepare a Members' Report.

The members are responsible for the maintenance and integrity of the corporate and financial information included on the LLP's website.

The Limited Liability Partnerships (Accounts and Audit) (Application of Companies Act 2006) Regulations 2008 require the members to prepare the financial statements for each financial year. Under that law the members have elected to prepare the financial statements in accordance with United Kingdom Accounting Standards and applicable law (United Kingdom Generally Accepted Accounting Practice), including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*.

Under Regulation 8 of the Limited Liability Partnerships (Accounts and Audit) (Application of Companies Act 2006) Regulations 2008 the members must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of affairs of the LLP and of the profit or loss of the LLP for that period. In preparing these financial statements, the members are required to:

- select suitable accounting policies and then apply them consistently;
- make judgments and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the LLP will continue in business.

Under Regulation 6 of the Limited Liability Partnerships (Accounts and Audit) (Application of Companies Act 2006) Regulations 2008, the members are responsible for keeping adequate accounting records that are sufficient to show and explain the LLP's transactions and disclose with reasonable accuracy at any time the financial position of the LLP and enable them to ensure that its financial statements comply with those regulations. They have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the LLP and to prevent and detect fraud and other irregularities.

## **Independent Auditor's report to the members of Wiltshire Health and Care LLP**

We have audited the LLP's financial statements ("the financial statements") of Wiltshire Health and Care LLP ('the LLP') for the year ended 31 March 2018 set out on pages 6 to 16. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland*.

This report is made solely to the members of the LLP, as a body, in accordance with Chapter 3 of Part 16 of the Companies Act 2006, as required by Regulation 39 of the Limited Liability Partnerships (Accounts and Audit) (Application of Companies Act 2006) Regulations 2008. Our audit work has been undertaken so that we might state to the LLP's members 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 LLP and the LLP's members as a body, for our audit work, for this report, or for the opinions we have formed.

### **Respective responsibilities of members and auditor**

As explained more fully in the Members' Responsibilities Statement set out on page 3, the members are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors.

### **Scope of the audit of the financial statements**

A description of the scope of an audit of financial statements is provided on the Financial Reporting Council's website at [www.frc.org.uk/auditscopeukprivate](http://www.frc.org.uk/auditscopeukprivate).

## **Independent Auditor's report to the members of Wiltshire Health and Care LLP (continued)**

### **Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the state of affairs of the LLP as at 31 March 2018 and of its profit for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Companies Act 2006, as applied to limited liability partnerships by the Limited Liability Partnerships (Accounts and Audit) (Application of Companies Act 2006) Regulations 2008.

### **Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Companies Act 2006 as applied to limited liability partnerships requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Rees Batley  
**Senior Statutory Auditor**  
**for and on behalf of KPMG LLP, Statutory Auditor**  
Chartered Accountants  
66 Queen Square,  
Bristol,  
BS1 4BE,  
United Kingdom

Date: \_\_\_\_\_ June 2018

**Statement of comprehensive income  
For the year ended 31 March 2018**

	Note	31 March 2018 £000	31 March 2017 £000
<b>Turnover</b>	1	45,228	31,288
Operating Expenses	2	(45,229)	(31,290)
<b>Operating loss</b>		<u>(1)</u>	<u>(2)</u>
Net interest receivable	5	1	2
<b>Profit for the financial year available for discretionary division among members</b>		<u>0</u>	<u>0</u>
Other comprehensive income		0	0
<b>Total comprehensive income</b>		<u>0</u>	<u>0</u>

All results relate to continuing activities.

Notes on pages 9 to 16 form part of the financial statements

**Statement of financial position  
As at 31 March 2018**

	Note	31 March 2018 £000	31 March 2017 £000
<b>Current assets</b>			
Debtors	9	978	459
Cash at bank and in hand	10	2,659	498
		<hr/>	<hr/>
Creditors: amounts falling due within one year	11	(3,637)	(957)
<b>Net current assets</b>		<hr/> <b>0</b>	<hr/> <b>0</b>
<b>Total assets less current liabilities</b>		<hr/> <b>0</b>	<hr/> <b>0</b>
<b>NET ASSETS ATTRIBUTABLE TO MEMBERS</b>		<hr/> <b>0</b>	<hr/> <b>0</b>
 <b>REPRESENTED BY:</b>			
<b>Equity</b>			
Members' other interests – other reserves classified as equity	12	0	0
<b>TOTAL MEMBERS' INTERESTS</b>		<hr/> <b>0</b>	<hr/> <b>0</b>

The financial statements of Wiltshire Health and Care LLP, registered number OC399656, were approved by the Members on 25 May 2018

Signed on behalf of the Members

**Douglas Blair**  
Managing Director

Date: \_\_\_\_\_ June 2018

Notes on pages 9 to 16 form part of the financial statements

**Statement of cash flows**  
**Year ended 31 March 2018**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
<b>Net cash inflow from operating activities</b>	<b>0</b>	<b>0</b>
Profit for the financial year after members profit shares charged as an expense	0	0
Adjustments for:		
Increase in creditors	2,680	957
Increase in debtors	(519)	(459)
<b>Net cash flows from operating activities before transactions with members</b>	<b>2,161</b>	<b>498</b>
<b>Net cash from investing activities</b>	<b>0</b>	<b>0</b>
<b>Net cash from financing activities</b>	<b>0</b>	<b>0</b>
<b>Net increase in cash and cash equivalents</b>	<b>2,161</b>	<b>498</b>
Cash and cash equivalents at 1 April	498	0
<b>Cash and cash equivalents at 31 March</b>	<b>2,659</b>	<b>498</b>

Notes on pages 9 to 16 form part of the financial statements

**Notes to the Financial Statements**  
**Year ended 31 March 2018**

**1. Accounting policies**

The principal accounting policies used in the preparation of the financial statements, which have been consistently applied in the current and preceding financial years, are as follows:

**1.1 Basis of preparation**

These financial statements were prepared in accordance with Financial Reporting Standard 102 *The Financial Reporting Standard* applicable in the UK and Republic of Ireland ("*FRS 102*") and The Statement of Recommended Practice, 'Accounting by Limited Liabilities Partnerships' with the consideration that the LLP is a public benefit entity. The presentation currency of these financial statements is sterling. All amounts in the financial statements have been rounded to the nearest £1,000.

Due to the LLP not having recorded any losses or profits, the statement of changes in equity has not been included in the financial statements given that it would not provide any additional information.

The accounting policies set out below have, unless otherwise stated, been applied consistently to all periods presented in these financial statements.

Judgements made by the members, in the application of these accounting policies that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 1.7.

**1.2 Going concern**

The LLP is funded by the cash flow that it generates from trading activities and robust working capital management.

The LLP is reliant on group support for the year ending 31 March 2018. Trading projections have been prepared for the next twelve months that take account of reasonable possible changes in trading performance and demonstrate that the LLP expects to be able to operate within its available financial facilities for the foreseeable future. Accordingly the members believe it is appropriate to prepare the financial statements on the going concern basis.

In the event that the LLP expenditure cannot be covered by current, or any agreed adjustments, to Commissioning income the Board shall notify the Members who shall make a decision on the next steps in line with the Members Agreement.

**1.3 Turnover**

Turnover represents amounts chargeable to customers for services provided during the year excluding Value Added Tax.

**Notes to the Financial Statements  
Year ended 31 March 2018**

**1. Accounting policies (continued)**

**1.4 Employee benefits**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable public bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the public body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

**1.5 Cash and cash equivalents**

Cash and cash equivalents comprise all cash balances.

**1.6 Financial instruments and financial liabilities**

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the LLP’s normal sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made. These assets and liabilities are categorised as fair value through income and expenditure and loans and debtors.

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

The LLP’s loans and receivables comprise: cash; debtors; and creditors.

**Notes to the Financial Statements  
Year ended 31 March 2018**

**1. Accounting policies (continued)**

**1.7 Critical Accounting estimates and judgements**

Provisions, including legal claims and restructuring, are considered and reviewed periodically to ensure that it accurately reflects the current position in providing for potential future costs from past events at each balance sheet date. There are no provisions at 31 March 2018 (31 March 2017: £0).

Fixed assets would be accounted for as per FRS 102, with the useful lives of property, plant and equipment being reviewed at least annually to assess the impact of usage; anticipated wear and tear; and technical or commercial obsolescence. The assets would be depreciated on a straight-line basis over the determined useful life.

**Notes to the Financial Statements  
Year ended 31 March 2018**

**2. Total operating expenditure**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Staff costs (note 4)	273	148
Chair and Non-Executive Costs	38	14
Commissioned Service Costs	44,774	31,048
Other operating charges	144	80
	45,229	31,290

**3. Operating profit**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
<b>Operating profit is after charging :</b>		
Auditor's remuneration		
Audit of these financial statements	9	9

**Notes to the Financial Statements  
Year ended 31 March 2018**

**4. Staff costs and employee information**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Employee costs during the year amounted to:		
Wages and salaries	205	144
Social security costs	23	2
Pension costs (note 13)	25	2
Temporary staff	20	0
	<u>273</u>	<u>148</u>

The staff costs consist entirely of amounts relating to key management personnel, the highest paid of which was the Managing Director £148k (2016-17: £118k)

<b>Average Headcount Numbers</b>	<b>31 March 2018 No</b>	<b>31 March 2017 No</b>
Support staff	4	2
	<u>4</u>	<u>2</u>

**5. Net interest receivable**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Bank interest receivable	1	2
<b>Net interest receivable</b>	<u>1</u>	<u>2</u>

**6. Members' share of profits**

The average number of members during the year was 3 (2016-17: 3).

No profits were distributed to members for the year to 31 March 2018.

**7. Members' remuneration charged as an expense**

Members did not receive any remuneration in respect to Wiltshire Health and Care LLP.

**8. Profit of the Limited Liability Partnership**

The profit for the year available for discretionary division among members reflected in the individual profit and loss account of the LLP for the year ended 31 March 2018 was £0 (2016/17: £0).

**Notes to the Financial Statements  
Year ended 31 March 2018**

**9. Debtors**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Trade debtors	50	174
Accrued Income	928	284
Prepayments	0	1
	<b>978</b>	<b>459</b>

All amounts are due within one year.

**10. Cash and cash equivalents**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Cash at bank and in hand	2,659	498

**11. Creditors: amounts falling due within one year**

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Other taxes and social security	48	9
Accruals and deferred income	3,601	948
	<b>3,649</b>	<b>957</b>

**12. Total members' interests**

On the creation of the LLP and during the 12 months to 31 March 2018 no Member made any financial investment into the LLP. Members have not received any revenue or capital remuneration.

## Notes to the Financial Statements Year ended 31 March 2018

### 13. Employee benefits

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows.

#### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018 is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, 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. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

#### b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

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

**Notes to the Financial Statements**  
**Year ended 31 March 2018**

**14. Related parties**

Expenditure with Great Western Hospitals NHS Foundation Trust was £41,409k (£30,901k 2016/17) in respect to community healthcare services provided on behalf of the LLP.

Expenditure with Salisbury NHS Foundation Trust was £152k (£124k 2016/17) in respect to lymphoedema and geriatric services provided on behalf of the LLP

Expenditure with Royal United Hospitals Bath NHS Foundation Trust was £172k (£23k 2016/17) for financial services and dietetics services.

Expenditure with NHS Property Services Ltd for £1,934k (£0k 2016/17) for rent.

Income of £44,907k (£31,082k 2016/17) was received from Wiltshire CCG, £139k (£101k 2016/17) from BANES CCG, £127k (£13k 2016/17) from South Gloucestershire CCG.

Payments were made to NHS Business Services in relation to NHS Pensions of £25k (£3k 2016/17), with tax and NI creditors totalling £23k (£5k 2016/17).

There are no transactions with management.

**15. Financial instruments**

**Carrying amount of financial instruments**

The carrying amounts of the financial assets and liabilities include:

	<b>31 March 2018 £000</b>	<b>31 March 2017 £000</b>
Assets measured at fair value through profit or loss	62	174
Liabilities measured at fair value through profit or loss	(48)	(8)
	<b>14</b>	<b>166</b>

The LLP has no derivative financial instruments.

**16. Events after the reporting period**

As from the 1<sup>st</sup> April 2018 1031 number of staff TUPE from Great Western NHS Foundation Trust.

KPMG LLP  
66 Queen Square  
Bristol  
BS1 4BE

XX May 2018

Dear Sirs,

This representation letter is provided in connection with your audit of the financial statements of Wiltshire Health & Care LLP (“the LLP”), for the year ended 31 March 2018, for the purpose of expressing an opinion:

- i. as to whether these financial statements give a true and fair view of the state of the LLP’s affairs as at 31 March 2018 and of the LLP’s position at the financial year then ended;
- ii. whether the financial statements have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland* (“FRS 102”); and
- iii. whether the financial statements have been prepared in accordance with the requirements of the Companies Act 2006.

These financial statements comprise the Balance Sheet, the Profit and Loss Account and Other Comprehensive Income, the Cash Flow Statement and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Members confirm that the LLP meets the definition of a qualifying entity and meets the criteria for applying the disclosure exemptions with FRS 102.

The Members confirm that the representations they make in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Members confirm that, to the best of their knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing themselves:

### **Financial statements**

1. The Members have fulfilled their responsibilities, as set out in the terms of the audit engagement dated 25 April 2017, for the preparation of financial statements that:
  - i. give a true and fair view of the state of the Company’s affairs as at the end of its financial year and of its position for that financial year;
  - ii. have been properly prepared in accordance with UK Generally Accepted Accounting Practice (including FRS 102); and
  - iii. have been prepared in accordance with the requirements of the Companies Act 2006.

The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Members in making accounting estimates, including those measured at fair value, are reasonable.
3. All events subsequent to the date of the financial statements and for which section 32 of FRS 102 requires adjustment or disclosure have been adjusted or disclosed.
4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. A list of the uncorrected misstatements is attached to this representation letter.

### **Information provided**

5. The Members have provided you with:
  - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
  - additional information that you have requested from the Board for the purpose of the audit; and
  - unrestricted access to persons within the LLP from whom you determined it necessary to obtain audit evidence.
6. All transactions have been recorded in the accounting records and are reflected in the financial statements.
7. The Members confirm the following:
  - i) The Members have disclosed to you the results of their assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatements arising from fraudulent financial reporting and from misappropriation of assets.

- ii) The Members have disclosed to you all information in relation to:
  - a) Fraud or suspected fraud that they are aware of and that affects the LLP and involves:
    - management;
    - employees who have significant roles in internal control; or
    - others where the fraud could have a material effect on the financial statements; and
  - b) allegations of fraud, or suspected fraud, affecting the LLP's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Members acknowledge their responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Members

acknowledge their responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Members have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
9. The Members have disclosed to you and have appropriately accounted for and/or disclosed in the financial statements, in accordance with section 21 of FRS 102 all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.
10. The Members has disclosed to you the identity of the LLP's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with section 33 of FRS 102.

Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in FRS 102.

11. The Members confirm that:

- a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Company's ability to continue as a going concern as required to provide a true and fair view.
- b) No events or circumstances have been identified that may cast significant doubt on the ability of the Company to continue as a going concern.

This letter was tabled and agreed at the meeting of the Members on [date].

Yours faithfully,

Douglas Blair

Managing Director

## **Appendix to the Board Representation Letter of Wiltshire Health & Care LLP: Definitions**

### **Criteria for applying the disclosure exemptions within FRS 102**

- The LLP discloses in the notes to its financial statements:
  - a) A brief narrative summary of the disclosure exemptions adopted; and
  - b) The name of the parent of the group in whose consolidated financial statements its financial statements are consolidated, and from where those financial statements may be obtained

### **Financial Statements**

A complete set of financial statements (before taking advantage of any of the FRS 102 exemptions) comprises:

- *a Balance Sheet as at the end of the period;*
- *a Profit and Loss account for the period;*
- *a statement of other comprehensive income for the period;*
- *a statement of changes in equity for the period;*
- *a cash flow statement for the period*
- *notes, comprising a summary of significant accounting policies and other explanatory information.*

FRS 102 permits an entity either to present (i) separately a Profit and Loss account and a Statement of Other Comprehensive Income or (ii) a combined Profit and Loss Account and Other Comprehensive Income.

### **Material Matters**

Certain representations in this letter are described as being limited to matters that are material.

FRS 102 states that:

Omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or combination of both, could be the determining factor.

## **Fraud**

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

## **Error**

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

- a) was available when financial statements for those periods were authorised for issue; and
- b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

## **Management**

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

## **Qualifying Entity**

A member of a group where the parent of that group prepares publicly available consolidated financial statements which are intended to give a true and fair view (of the assets, liabilities, financial position and profit or loss) and that member is included in the consolidation by means of full consolidation.

## **Related Party and Related Party Transaction**

### **Related party:**

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in FRS 102 as the "reporting entity").

- a) A person or a close member of that person's family is related to a reporting entity if that person:
  - i. has control or joint control over the reporting entity;
  - ii. has significant influence over the reporting entity; or
  - iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.
- b) An entity is related to a reporting entity if any of the following conditions apply:

- i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).
- ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).
- iii. Both entities are joint ventures of the same third party.
- iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.
- v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.
- vi. The entity is controlled, or jointly controlled by a person identified in (a).
- vii. A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).
- viii. The entity, or any member of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity.

**Related party transaction:**

A transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.



Ted Wilson  
Group Director  
Wiltshire CCG  
Southgate House  
Pans Lane  
Devizes  
SN10 5EQ

**Directors' Office**

Royal United Hospitals Bath  
NHS Foundation Trust  
Combe Park  
Bath  
BA1 3NG

Tel: 01225 824308  
Email: [sarahtruelove@nhs.net](mailto:sarahtruelove@nhs.net)

22<sup>nd</sup> June 2016

Dear Ted

**Wiltshire Health and Care contract with Wiltshire CCG**

I understand that the discussions about the new contract with Wiltshire Health and Care LLP to deliver adult community services have touched upon the issue of what would happen if, for whatever reason, the LLP was not able to continue to deliver services.

My Board have discussed and agreed the position of this Trust, as a member of the LLP, in these circumstances.

In the unlikely event that Wiltshire Health and Care LLP has a need to cease delivery of adult community services outside of the normal contract notice period of 12 months, the three members of the LLP will ensure that service delivery can be continued for a maximum interim period of 6 months, to allow the CCG sufficient time to find an alternative provider of the services.

I hope that this letter clarifies the position of the Royal United Hospitals Bath NHS Foundation Trust in relation to this issue.

Yours sincerely



**Sarah Truelove**  
**Deputy Chief Executive and Director of Finance**

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SN3 6BB

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Ted Wilson  
Group Director  
Wiltshire CCG  
Southgate House  
Pans Lane  
Devizes  
SN10 5EQ

22<sup>nd</sup> June 2016

Dear Ted

### **Wiltshire Health and Care contract with Wiltshire CCG**

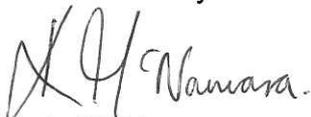
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I hope that this letter clarifies the position of Great Western Hospitals NHS Foundation Trust in relation to this issue.

Yours sincerely



Kevin McNamara  
Director of Strategy

Peter Hill  
Chief Executive  
Salisbury NHS Foundation Trust  
Salisbury  
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SP2 8BJ

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Ref: PH/EA/TW

22<sup>nd</sup> June 2016

Ted Wilson  
Group Director  
Wiltshire CCG  
Southgate House  
Pans Lane  
Devizes  
SN10 5EQ

Dear Ted

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In the unlikely event that Wiltshire Health and Care LLP has a need to cease delivery of adult community services outside of the normal contract notice period of 12 months, the three members of the LLP will ensure that service delivery can be continued for a maximum interim period of 6 months, to allow the CCG sufficient time to find an alternative provider of the services.

I hope that this letter clarifies the position of Salisbury NHS Foundation Trust in relation to this issue.

Yours sincerely



Peter Hill  
Chief Executive

## Wiltshire Health and Care Board Meeting

For information

**Subject:** Safeguarding Adult Reviews  
**Date of Meeting:** 25 May 2018  
**Author:** Sarah-Jane Peffers/ Kat Hitch

### 1. Purpose

To update the Board on the publication (May 22<sup>nd</sup> 2018) of Safeguarding Adult Review (SAR) of Adult A and Adult B and the associated action plans for Wiltshire Health and Care.

### 2. Background

Wiltshire Safeguarding Adult Board (WSAB) commissioned two SARs in 2107; Adult A and Adult B.

A SAR was commissioned by WSAB following a coroner's report into the death of Adult A. The death of Adult A occurred whilst care provision was managed by Great Western Hospitals Foundation Trust. However, as Wiltshire Health and Care (WHC) is now the current provider of therapy provision to the Intermediate care beds, it was essential to be involved in the process. The report was compiled by Kat Hitch (WHC Safeguarding Adults Lead) and Jules Irlam (WHC Clinical Services Manager), using the Significant Incident Learning Process (SILP).

A SAR was commissioned following a Section 42 Safeguarding Enquiry into the events leading up to Adult B's death. At the time of death Adult B received services from a primary care based Clinical Care Co-ordinator employed by Wiltshire Health and Care. Wiltshire Health and Care's report was compiled by Kat Hitch (WHC Safeguarding Adults Lead) and Heather Kahler (Community Services Manager), using the Significant Incident Learning Process (SILP).

Section 44 of The Care Act (2014) states:

*“SAB to conduct a Safeguarding Adults Review (SAR) into certain cases; where there is reasonable cause for concern about how the SAB, it's members with relevant functions involved in the case, worked together and either the adult has died or experienced serious harm and the SAB knows or suspects that the death or harm resulted from abuse or neglect.”*

The purpose of any review is to; establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk, what those lessons are, how they will be acted upon, and what is expected to change as a result, and to improve inter-agency working and better safeguarding of adults at risk including the review of procedures where there may have been failures.

## Background of Adult A:

Adult A was found in a 'situation of serious self-neglect' in her flat having activated her lifeline. She had been discharged from Intermediate Care bed the day before. Paramedics transported her to hospital, where she died. Her cause of death was Hypothermia and Bronchopneumonia

Adult A was admitted to Intermediate Care bed from ED following a 'non injurious' fall at home. She was admitted for 'rehabilitation' and concerns about her living conditions at home.

She reported concerns of financial abuse to the ambulance staff who admitted her to ED.

Adult A's case review must be considered against the wider backdrop of the challenges of working with adults who exhibit self-neglecting behaviours and/or lifestyle choices. There is growing evidence base (from research and SCR/SAR reviews) of best practice with people who self-neglect. Current Health and Social Care system does not readily support best practices recommendations.

The investigation found the following notable practice; Weekly MDTs- regular, timely review of Adult A whilst in ICT Care, focus on functional independence- behaviour modification strategies, attempt to identify life history- link to potential underlying triggers for self-neglecting behaviour and recognition of potential mental health concerns and need for assessment and review.

The following areas of concern were also noted:

- This case only became evident to WHC safeguarding lead and the Head of Quality when the outcome of the coroner's report was known
- A lack of cohesive, collaborative and co-ordinated multi-disciplinary working, lack of Information sharing/flow/recording, segregation of roles/assessment/planning (Therapy/social work/nursing/care) and leadership.
- Continued 'one dimensional' decision making- primarily focussed on continence management and resolving long term issues of this self-neglecting behaviour.
- Discharge recommendations overly focussed on meeting long term needs and not on potential short term needs to facilitate safe discharge and re-establishment of former coping strategies/routine. Lack of alternatives considered beyond formal paid care and funded' deep clean
- Lack of explicit application/recording of the Principles of the MCA- 'informed decision making'/ risk and consequences/cognition v mental health (mood disorder)
- Lack of formal discharge/transfer of care procedures in place, led to a fragmented and unconfirmed plan- basic and immediate needs (physical health, heat, food/drink, medication) not assessed or clearly planned for post discharge
- ICT isolated/ less connected to WHC- lack of incident reporting and therefore decreased escalation via WHC operational and quality structures.

This incident occurred at a time when the therapists were based in Wiltshire Council offices at Monkton Park and recorded information in paper records or on Care First (Adult Social Care record). Whilst MDT meetings were held, nobody was assigned to manage individual cases. Since the incident there have been a number of key changes in daily operational management; WHC clinical staff are situated in the care homes and using SystemOne to record information, however, this is a different care record to social care and the care home, although Wiltshire Council do have read only

access to SystmOne, however, there is limited assurance of its usage by social care colleagues. All patients referred for ICT management are assigned a case manager, dependent on their needs and pathway of care. Alongside these cases, there are now regular meetings between senior health and social care managers to support improved management of the service. In some instances, social care staff are more visible in the care homes and this is helping continual dialogue and supportive discharge planning, although this is not consistent across all commissioned beds.

### **Background of Adult B:**

Adult B was an individual with dementia living alone in sheltered accommodation. He died as a result of a road traffic accident where he was walking at a significant distance from his home. He had been found wandering in previous weeks in a deserted army village in a state of undress.

During the reported period Adult B received support from both statutory and provider agencies and his needs were met within the limitations of the commissioning and role responsibility of those allocated to work with Adult B at that time. This meant that Adult B did not receive robust support at the right level at the right time to assess risk and apply the relevant legal frameworks.

The absence of a clear decision making process and a single lead for this (the decision maker) meant that decisions that may have enabled more robust management of the risk taking behaviour that ultimately contributed to the unique set of circumstances of the incident that led to his death did not happen.

The report highlighted that the Clinical Care Co-ordinator involved provided the following areas of good practice;

- Face to face contact with Adult B on a regular basis throughout the 12 week episode
- Attempted a good level of interface and liaison with the main agencies
- Provided a timely response to all enquiries and developments
- Monitored and reviewed Adult B's clinical care needs

The following were areas of concern:

- There was a lack of recognition of the complexity of Adult B's needs across all agencies; major support during this period came from two "care co-ordinators": one with a social care role (WC) and the other clinical care (WHC) both with limited scope and responsibility to their roles.
- The WHC Primary Clinical or Care Co-ordinator role is limited in scope and responsibility where the presenting needs of a patient such as Adult B are overwhelmingly social care related and as a practitioner the CCC is not linked into that management or commissioning structure, limiting the role to one of 'sign poster or monitor'.
- Lack of formal risk assessments and management of escalating risk across all agencies
- Lack of explicit application of the legal framework of the Mental Capacity Act

- CCC role isolated/ less connected to WHC- Reduced management control/oversight re cases allocated, co-location and/or alignment of WHC staff to GP Practices and their systems
- Lack of incident reporting and therefore decreased escalation via WHC operational and quality structures.
- Lack of a clearly defined Multi- agency decision making process in relation to a patient with risk taking behaviours and a single lead for this process

### **3. Recommendation**

The Board is invited to:

1. Note the content of the Safeguarding Adult Reviews and action plans
2. Recognise and note the full report published by WSAB

## Impacts and Links

Impacts	
<b>Quality Impact</b>	The Safeguarding Adult Review process has highlighted a number of areas requiring further development to ensure safe and effective care is delivered to all patients in Wiltshire Health and Care
<b>Equality Impact</b>	All recommendations should be consider across WHC and not only where the incident occurred
<b>Financial implications</b>	This paper has not highlighted any financial impact
<b>Impact on operational delivery of services</b>	The focus of the recommendations for WHC is to improve the daily operational delivery and partnership working with all agencies
<b>Regulatory/ legal implications</b>	<p>CQC Fundamental Standards:</p> <p><b>Person-centred care-</b> You must have care or treatment that is tailored to you and meets your needs and preferences.</p> <p><b>Safety-</b> You must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Providers must assess the risks to your health and safety during any care or treatment</p> <p><b>Safeguarding from abuse-</b> You must not suffer any form of abuse or improper treatment while receiving care.</p>
Links	
<b>Link to business plan/ 5 year programme of change</b>	Develop and Strengthen partnerships
<b>Links to known risks</b>	None currently reported
<b>Identification of new risks</b>	Risk associated with the care co-ordinator model in primary care-On risk register

SAR Adult A

Recommendation made in single agency SAR report	SMART Action / Change in Practice / Procedure:	Target date	How has action been implemented (monitoring and evaluation)	Lead Person	Date completed	RAG/status
Therapy staff based in Intermediate Care Teams will be confident and able to apply the Mental Capacity Act to their practice and include good practice around self-neglect and high risk behaviours	<ul style="list-style-type: none"> <li>Bespoke case specific half day session on the MCA in the context of self-neglect for NEW ICT</li> <li>Development of bespoke MCA support programme for ICT Therapy staff</li> <li>Following this bespoke session a Quality Team (QT) and Ops discussion on how to transfer the learning across all bed based care models and/or appropriate services</li> </ul>	<p>30<sup>th</sup> June 2018</p> <p>30<sup>th</sup> Sept 2018</p>	<ul style="list-style-type: none"> <li>Attendance list and robust learning plan</li> <li>Measurement via self-evaluation pre and post training</li> <li>Quality improvement audit using S1 MCA tools</li> <li>Minuted discussion with development of long term sub-actions and cross referencing with other developing quality improvement plans</li> </ul>	WHC Safeguarding Lead Adults		amber
Wiltshire Health and Care to develop and implement a safe transfer/discharge of care policy- Policy to reflect relevant NICE guidance (NG 74)	<p>Policy to be reflective of community health service requirements (including inpatients and ICT) and evidence current best practice guidance</p> <ul style="list-style-type: none"> <li>QT and Ops lead to review current admission, transfer and discharge policy, to include format and domains of an appropriate discharge summary and checklist which applies to all WHC services supporting people to be discharged from bed based care.</li> </ul>	31 <sup>st</sup> Dec 2018	<ul style="list-style-type: none"> <li>Published policy</li> </ul>	CSM for ICT and inpatient services manager		red

Recommendation made in single agency SAR report	SMART Action / Change in Practice / Procedure:	Target date	How has action been implemented (monitoring and evaluation)	Lead Person	Date completed	RAG/status
<p>WHC to contribute to the review across all relevant agencies the structure and functioning of the Intermediate Care bed service Improved collaborative working across ICT and MDT WHC to review current record keeping arrangements for health based staff in ICT. WHC to investigate the practice employed for the storage and archiving of paper based health records</p>	<ul style="list-style-type: none"> <li>Review of the pathway and the multi-disciplinary functioning of the service</li> <li>Strengthening of the MDT with clear identification and role alignment for the management, care, treatment and discharge of the patient</li> <li>All ICT partners to explore and agree an appropriate shared recording system of patient notes</li> <li>Ensure that the current electronic recording system meets the requirements of WHC and that of the multi-disciplinary service</li> <li>WHC to fully establish an outcome in relation to Adult A's 'missing therapy records' establish accountability and develop actions and recommendations accordingly</li> </ul>	<p>Quarterly monitoring</p>	<ul style="list-style-type: none"> <li>Multi-agency training plan</li> <li>Triangulation with quality matrix</li> </ul>	<p>Head of Operations</p>		<p>amber</p>
<p>Improved identification of clinical risk and incident reporting</p>	<ul style="list-style-type: none"> <li>Incident risk management training</li> <li>Earlier internal identification and escalation of risk to enable support of staff in managing practice of challenging situations.</li> <li>Enable the identification and tracking of trends and themes to target practitioner/team level training/support wider internal</li> </ul>	<p>30<sup>th</sup> June 2018</p>	<ul style="list-style-type: none"> <li>Triangulation with the quality matrix</li> </ul>	<p>Risk and Complaints Manager</p>		<p>amber</p>

Recommendation made in single agency SAR report	SMART Action / Change in Practice / Procedure:	Target date	How has action been implemented (monitoring and evaluation)	Lead Person	Date completed	RAG/ status
	governance actions and/or external reporting requirements					
Implement WSAB self-neglect and high risk behaviours good practice guidance when available	<ul style="list-style-type: none"> <li>In the interim, Safeguarding lead to develop a SOP based on the SCIE good practice evidence base</li> </ul>	Pending publication of WSAB guidance	<ul style="list-style-type: none"> <li>WHC adoption of the guidance when published</li> <li>Continued development of the S1 tools to support practice</li> <li>Quality improvement audit of the S1 tools</li> </ul>	WHC Safeguarding Lead Adults		amber

SAR Adult B

Recommendation made in single agency SAR report	SMART Action / Change in Practice / Procedure:	Target date	How has action been implemented (monitoring and evaluation)	Lead Person	Date completed	RAG/status
<p>WHC to escalate their concern regarding the current care coordinator model and for Wiltshire CCG consider a review to achieve a clear identifiable process and equitable model that meets the needs of Wiltshire's patient population</p> <p>In the interim; WHC to review current management and supervision processes for primary care coordinators</p>	<ul style="list-style-type: none"> <li>WHC to raise this with the WCCG via the contractual reporting route.</li> <li>Risk assessment in relation to the current care coordinator model to be completed by WHC</li> <li>Review and consultation with clinical and care coordinators and WHC line managers to explore best practice for management and supervision for these practitioners specific development and supervision needs</li> </ul>	15 <sup>th</sup> May 2018	<ul style="list-style-type: none"> <li>Outcome of the commissioning review</li> <li>Monitoring through the risk register</li> <li>Supervision logs, staff appraisal and application of the WHC safety culture tool</li> </ul>	<p>WHC COO</p> <p>WHC Risk and complaints manager</p> <p>Community service managers</p>		amber
Implement WSAB self-neglect and high risk behaviours good practice guidance when available	<ul style="list-style-type: none"> <li>In the interim, Safeguarding lead to develop a SOP based on the SCIE good practice evidence base</li> </ul>	Pending publication of WSAB guidance	<ul style="list-style-type: none"> <li>WHC adoption of the guidance when published</li> <li>Continued development of the S1 tools to support practice</li> <li>Quality improvement audit of the S1 tools</li> </ul>	WHC Safeguarding Lead Adults		amber

Recommendation made in single agency SAR report	SMART Action / Change in Practice / Procedure:	Target date	How has action been implemented (monitoring and evaluation)	Lead Person	Date completed	RAG/status
WHC to review risk management policy	<ul style="list-style-type: none"> <li>For this policy to include procedures, training, documentation and compliance</li> </ul>		<ul style="list-style-type: none"> <li>Publication of policy and compliance of its effectiveness</li> </ul>	WHC Risk and complaints manager		amber

**Wiltshire Health and Care Board**

**For information**

**Subject: Quality, performance and finance monthly report**

**Date of Meeting: 25 May 2018**

**Author: Sarah-Jane Peffers, Lisa Hodgson, Annika Carroll**

**1. Purpose**

1.1 To provide an overview of the main issues arising from review of information about the quality and performance of Wiltshire Health and Care services and alert and advise the Board to issues by exception.

**2. Issues to be highlighted to Board**

2.1 The quality and performance dashboards are attached for the Board's information. The following issues are highlighted to the Board in relation to the quality of services:

<b>ADVISE</b>	<ul style="list-style-type: none"> <li>Continued Improved position with the completion of IR1's within expected timeframe.</li> <li>In month improvement in sickness rates, vacancy factor and retention</li> </ul>
<b>ALERT</b>	No alerts to be reported to the board
<b>ACTION</b>	There are no issues on which Board action is required.

2.2 There are no issues to be highlighted to the Board in relation to the maintaining performance against required performance standards.

2.3 Issues to be highlighted to the Board in relation to the financial performance:

<b>ADVISE</b>	<ul style="list-style-type: none"> <li>Delay in implementation of financial systems, particular concern around access for requisitioners and budget managers to upgraded software - Unit 4 (Financial Ledger) from July 2018. Particular issues relating to creating of financial reports due to financial systems experts being the limiting factor. Risk register to be updated and to mitigate the risk Wiltshire Health and Care are seeking direct consultancy support with Unit 4 to support the in-house reporting expertise.</li> <li>Increased estates costs due to transfer of estates. A final financial summary of costs have been shared with commissioners. There would be financial consequences if commissioners would fail to meet their obligations.</li> </ul>
<b>ALERT</b>	No alerts to be reported to the board
<b>ACTION</b>	There are no issues on which Board action is required.

**3. Recommendation**

3.1 The Board is invited to note the contents of this report.

**Wiltshire Health and Care LLP  
Financial Position M12, March 2018**

<u>WH&amp;C LLP Profit and Loss Account - March 2018</u>	<u>WH&amp;C LLP Balance Sheet as at March 2018</u>	<u>WH&amp;C LLP Statement of Cashflows</u>
M12 (March 2018) £'000	M12 (March 2018) £'000	M12 (March 2018) £'000
<b>Turnover</b> 45,229	<b>Current Assets</b>	Profit/(Loss) 0
Staff (291)	Debtors 534	Movements in:
Contracted Services (42,476)	Cash at Bank 2,659	Debtors (75)
Other Administrative Exps (2,462)	Creditors (3,193)	Creditors 2,236
<b>Total Expenses (45,229)</b>	Net Current Assets 0	Net in/(out)flow 2,161
	Net Assets 0	Opening Cash Balance 498
Profit/(Loss) 0	Profit and Loss Account 0	Closing Cash Balance 2,659

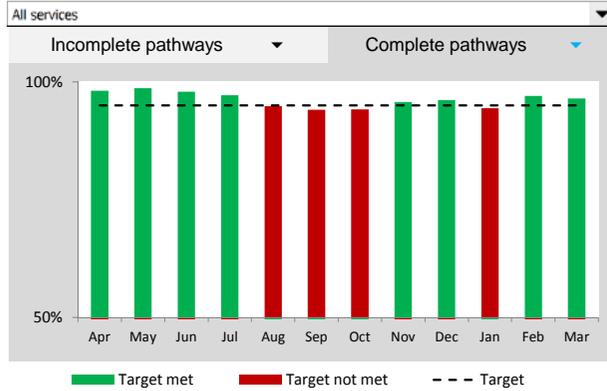
The LLP reports a breakeven position for the year ending March 2018.

The year-end position includes estimated provisions for outstanding estates and VAT related liabilities as at March 2018. The favourable cashflow is due to unpaid estates lease charges, for which final values are currently being finalised.

The turnover reflects contracted values with commissioners for 2017/18 adjusted for CQUIN risk for Quarter 4 performance, yet to be finalised and a provision for funding to cover the confirmed additional VAT liability and the estimated increased estates costs following the estates transfer in July 2017 to NHS Property Services.

The contracted services value includes a risk provision relating to the transfer of services from April 2018.

RTT

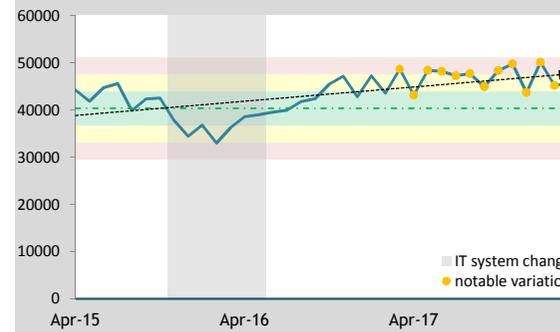


Incomplete pathways month end position

	% under 18 weeks	Breaches
Community Teams	89%	114
Continence - Adult	100%	1
LD	75%	13
Outpatient Physio	99%	44
Podiatry	99%	7
Wheelchair service	91%	20
WON	98%	10

LD service remains an area of concern - previously flagged to commissioners. There are 2 LD breaches over 52 weeks - these are Psychology referrals and are receiving care by other members of the team so are not being treated as breaches by the CCG.

Activity



Category	Change
Referrals	↑ 13%
Contacts	↑ 8%
Bed Based Intermediate Care	↑ 92%
Diabetes	↑ 52%
Speech and Language Therapy	↑ 24%
MIU	↓ -11%
Fracture Clinic	↓ -9%
Dietetics	↓ -7%

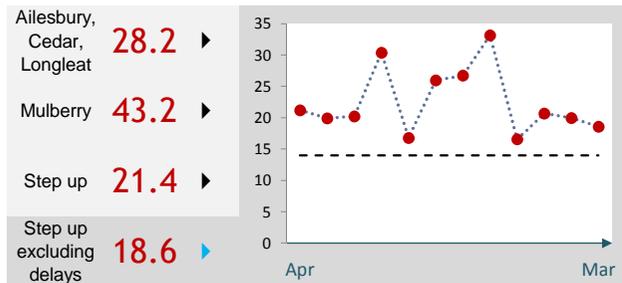
LD and Wheelchair services data excluded in this view of overall activity as not comparable pre and post system migration. Old Wheelchair service system recorded each work request as a separate referral. See explanatory notes for notable variation guidance. No longer reporting Inpatient therapy contacts as agreed with commissioners.

Inpatient assessments

Assessment	Completion Rate
MRSA	99%
VTE	100%
VTE prophylaxis	100%
MUST	98%
PURAT	92%
Falls	95%
Dementia	100%

PURAT - Unusually low performance. Some missed the target time by a small margin. All were completed. Performance will be monitored.

Mean Inpatient Length of Stay

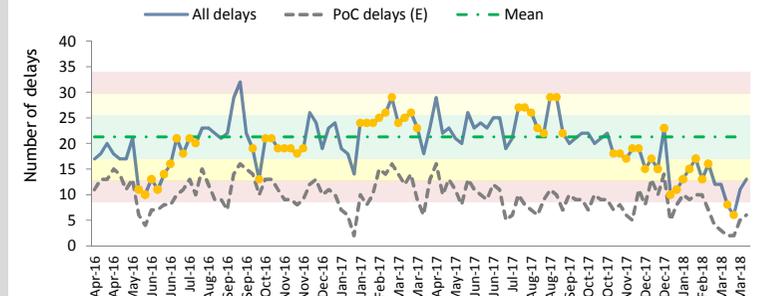


Improvement in our DToC position is not yet evident in the length of stay data. For more detail around our LoS see the inpatient data sheet.

Discharge timings

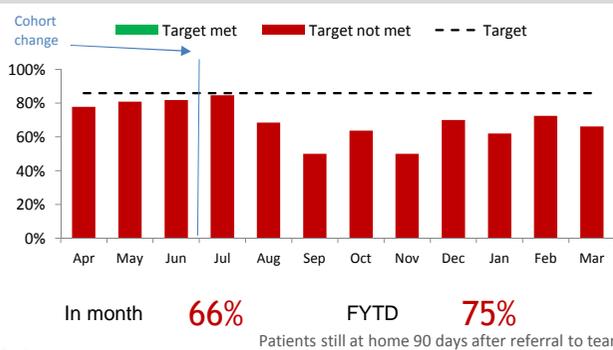


Delayed Transfers of Care



Recent improvement in DToC position. See explanatory notes Activity for notable variation guide.

Community teams 90 day reablement



Data quality concerns. It is an ongoing challenge to identify the correct cohort for this data - now looking at Home First patients. Very low numbers since cohort change - slow to increase, System change is needed to support this in future.

End of life support

In month	FYTD
89%	93%
17 of 19 patients were supported by the community teams to die in their place of choice	

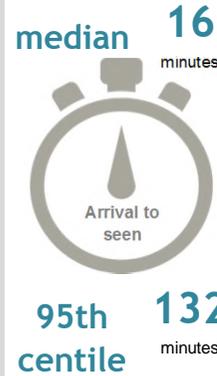
Strong performance year to date

Funding reviews\*

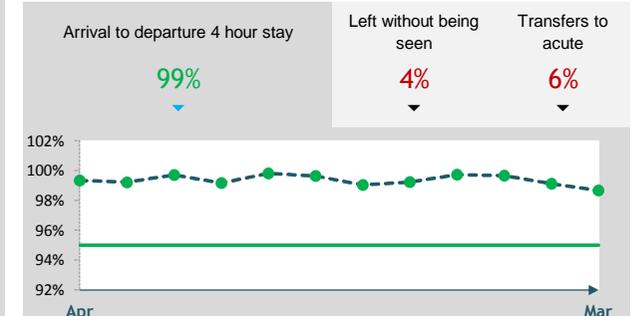
In month	FYTD
CHC 3 month	
Completed 0	N/A
Due 0	
CHC Annual	
Completed 6	86%
Due 7	
FNC	
Completed 0	N/A
Due 0	

No list received from CCG re CHC/FNC reviews due

MIU waiting times

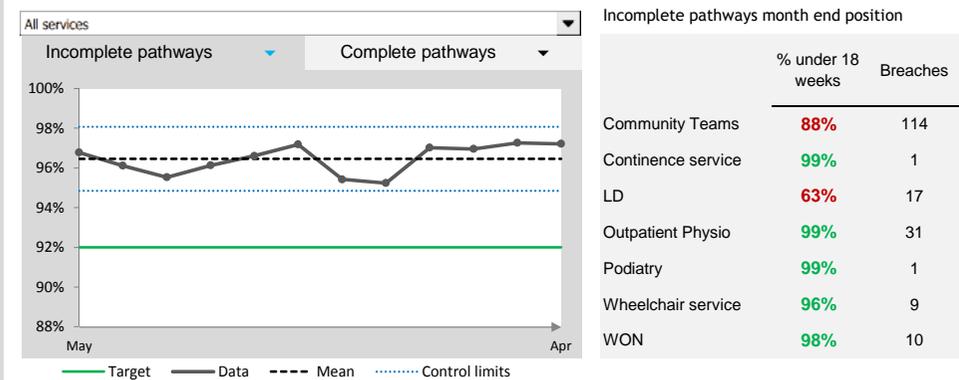


MIU performance



Performance on 4 hour stay and patient feedback remains strong. Data challenges remain around patients left without being seen and transfers to acute. Significant operational pressures are not reflected in the data.

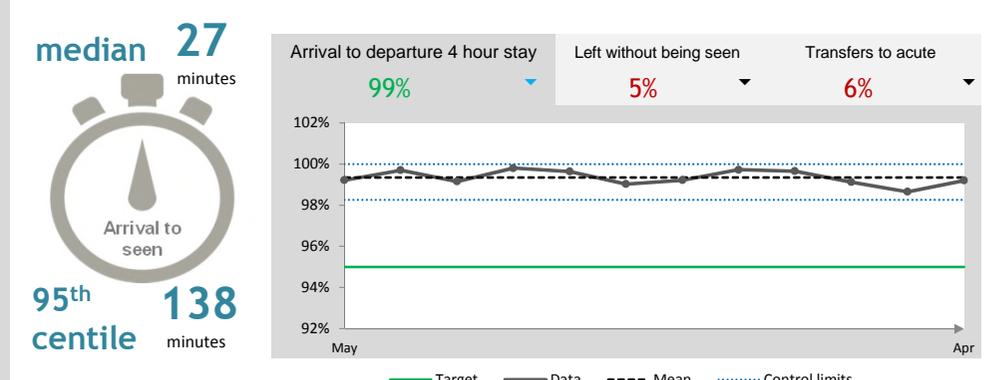
RTT



**In Control**  **On target**  **Action**  No action needed

LD service remains an area of concern - previously flagged to commissioners. Community Teams flagging as not in control with declining performance - likely to include some data quality errors - system design work ongoing to lessen likelihood of this in future.

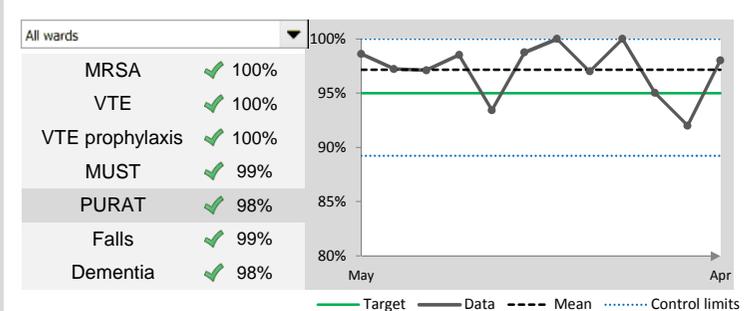
MIU



**In Control**  **On target**  **Action**  No action needed

Performance on 4 hour stay and patient feedback remains strong. Data challenges remain around left without being seen and transfers to acute - action to put MIU on SystmOne to address this; project ongoing. Significant operational pressures are not reflected in the data.

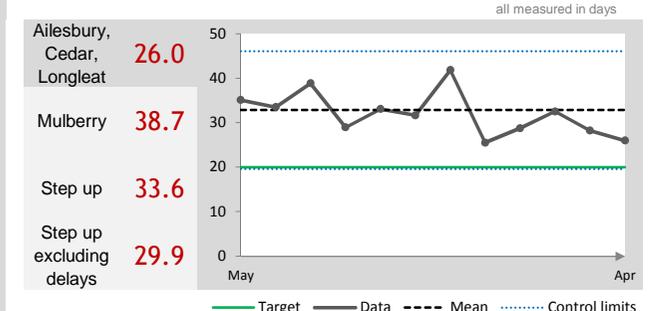
Inpatient assessments



**In Control**  **On target**  **Action**  No action needed

All overall targets in control and on target.

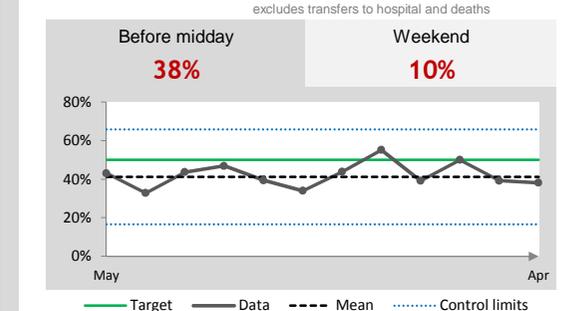
Mean Inpatient Length of Stay



**In control**  **On target**  **Action**  Action needed

Progress on DTocS has not yet translated into significant LoS reduction. Action ongoing - focus to incorporate stranded patients.

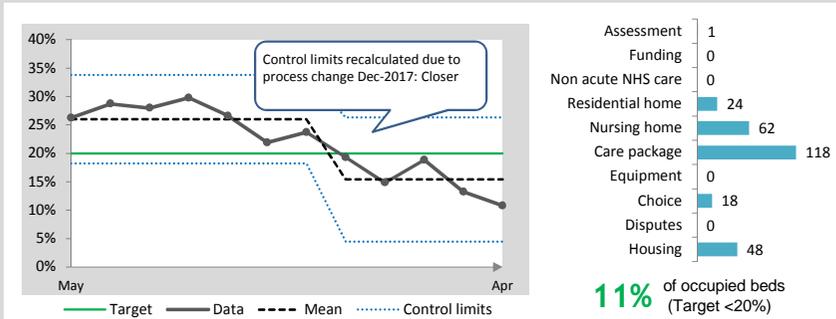
Discharge timings



**In control**  **On target**  **Action**  Action needed

Continuing challenge - Care homes reluctant to take in morning and at weekends.

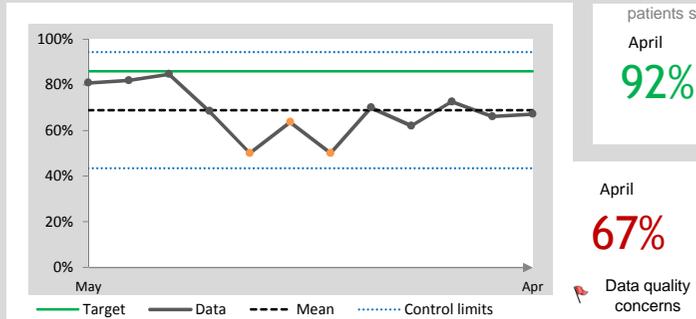
Delayed Transfers of Care - bed days lost



**In Control**  **On target**  **Action**  No action needed

Process changes in December 2017 have had a significant impact on the number of days lost to delays each month. Care package delays continue to be the biggest cause of lost days each month.

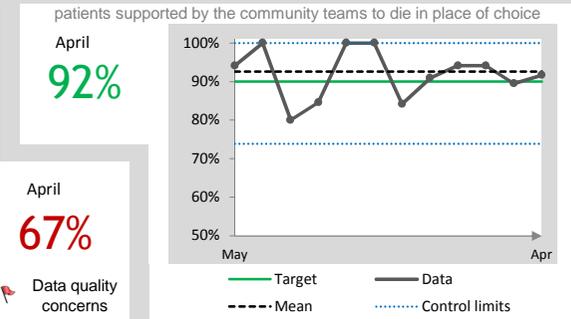
Community teams 90 day reablement



**In Control**  **On target**  **Action**  Action needed

Significant data quality concerns affecting both cohort and performance. Action: System project underway to address cohort concerns and to allow transparent performance review.

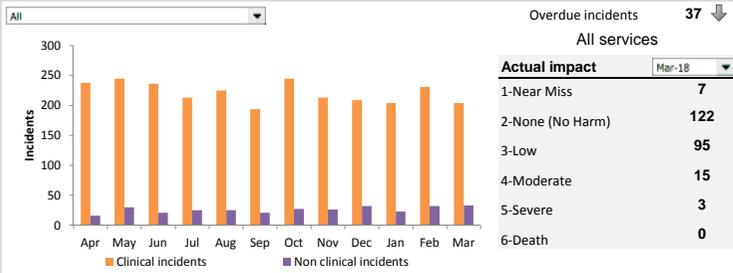
End of life support



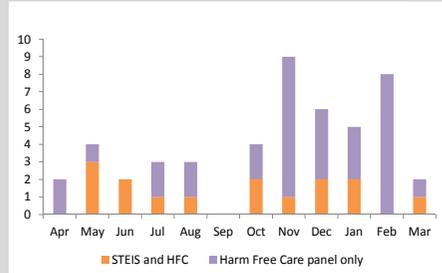
**In control**  **On target**  **Action**  No action needed

Excellent performance continues.

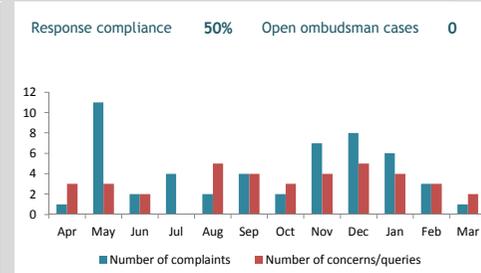
Incidents



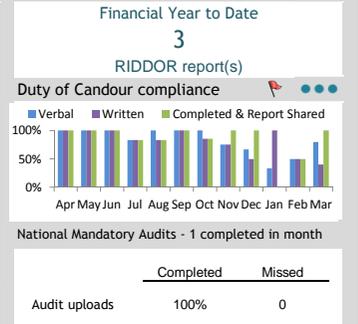
Incidents Requiring Further Investigation



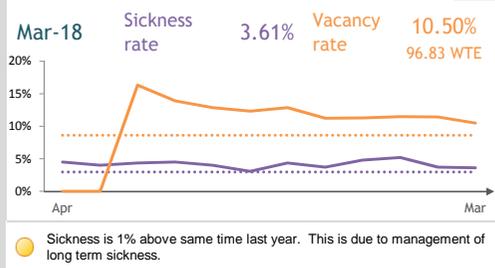
Complaints/Concerns



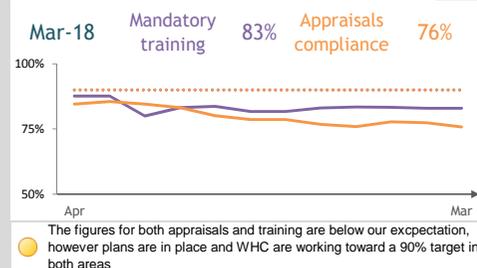
RIDDOR



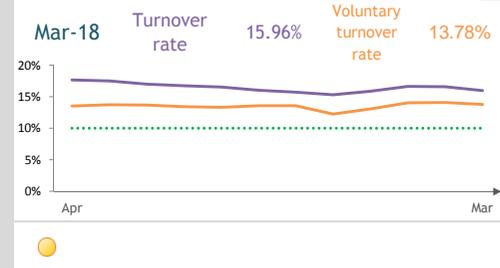
Sickness/Vacancy



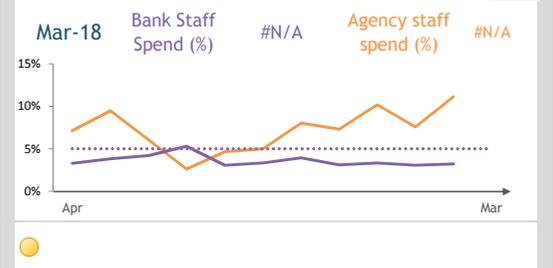
Training/Appraisals



Turnover



Bank/Agency spend %



Infection Prevention & Control

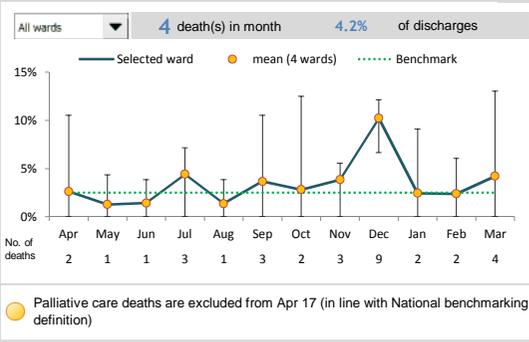
All wards

Prev 12 months

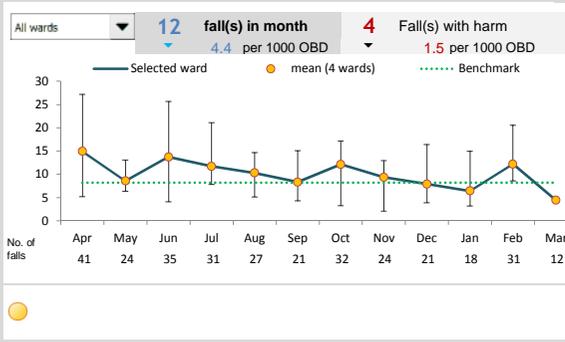
MRSA incidence	0	0
C diff incidence	0	2
E coli incidence	0	0
Bed days lost to norovirus	0	0

The patient was recorded as C.difficile colonisation in Aug 17 whilst in RUH, however they were asymptomatic and did not require isolation or treatment

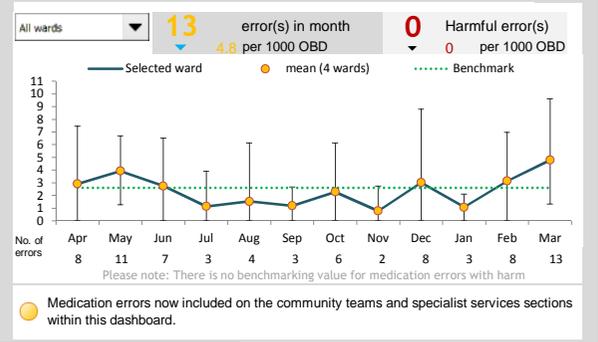
Deaths



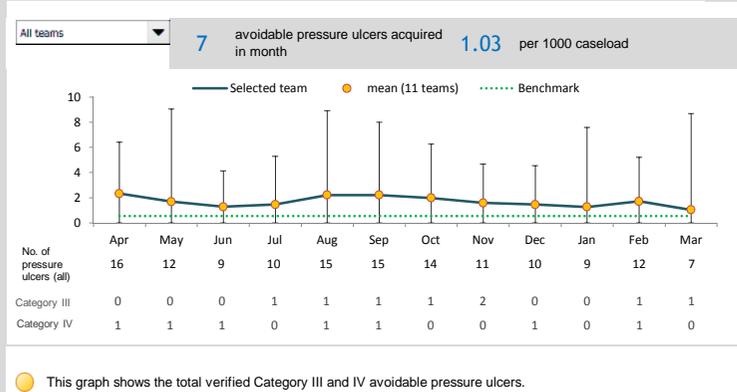
Falls



Medication errors



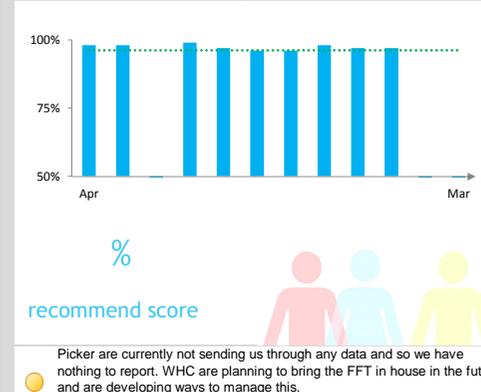
Avoidable Pressure Ulcers



Safety Thermometer



Friends and Family Test



Inpatient assessments

All wards

	Feb-18	Mar-18
Early Warning Score	100%	100%
VTE assessment	99%	100%
VTE prophylaxis	100%	100%
Hospital Acquired Thrombosis	0	0
Falls assessment	98%	98%
MUST assessment	96%	98%

## MINUTES

### Of a Wiltshire Health and Care Board Meeting Part II **CONFIDENTIAL**

<b>Venue:</b>	Training Room 1, Chippenham Community Hospital
<b>Date:</b>	10 <sup>th</sup> April 2018
<b>Time:</b>	14:00 – 17:00

<b>WHC Board Members</b>		
Carol Bode	Chair	CB
Douglas Blair	Managing Director	DB
Lisa Hodgson	Chief Operating Officer	LH
Annika Carroll	Head of Finance	AC
Lisa Thomas	Deputy SFT Board Representative	LT
Francesca Thompson	RUH Board Representative	FT
Nerissa Vaughan	GWH Board Representative	NV
Richard Barritt	Non-Executive Member	RB
Celia Grummitt	Non-Executive Member	CG
Adibah Burch	Non-Executive Member	AB

<b>In attendance</b>		
Lianna Bradshaw	Executive Assistant (minutes)	LB

<b>Apologies</b>		
Cara Charles-Barks	SFT Board Representative	CC-B
Sarah-Jane Peffers	Head of Quality	SJP
Katy Hamilton Jennings	Head of Legal and Corporate Governance II Board Secretary	KHJ

<b>Item</b>	<b>Title/Notes</b>	<b>Actions</b>
<b>1</b>	<p><b>Welcome, Apologies and Declarations of Interest</b></p> <p>Carol Bode welcomed everyone to the meeting and noted apologies from Cara Charles-Barks, Sarah-Jane Peffers and Katy Hamilton Jennings.</p> <p>Declarations of Interest – RB noted he is working with Southern Health NHS Foundation Trust on patient engagement.</p>	
<b>2</b>	<b>Part II Minutes, Actions and Matters Arising</b>	

	The minutes of the previous meeting held on 27 <sup>th</sup> February 2018 were agreed as a true and accurate record.	
<b>Scrutiny</b>		
<b>3</b>	<b>Detailed Finance Report</b>	
	<p>The members reviewed the finance report and noted the following key points:</p> <ul style="list-style-type: none"> <li>• Agency spend continues to be high – this is due to the escalation beds on Ailesbury ward being staffed by agency nurses and HCA's from Thornbury Nursing Agency</li> <li>• There will be no reporting for April due to the new ledger being set up</li> <li>• The initial move will be to a basic ledger, full functionality will be dependent on a planned upgrade, due by the end of June.</li> </ul> <p>The collation of final additional estates costs due to the transfer of estates was almost complete, and would be shared with the CCG. Provisions had been made by WHC and the CCG for 2017-18.</p>	
<b>Strategy</b>		
<b>4</b>	<b>Draft Business Plan</b>	
	<p>The members reviewed the draft business plan.</p> <p>DB noted that agreement had not yet been reached on the contractual value for 2018-19 with the CCG. This, coupled with substantial draw on resources related to the change in delivery structure from 1 April, had meant that the preparation of the Business Plan had been delayed from its normal timescale. The early draft set out the main content that had been completed and noted the gaps that remain to be filled. The main sections of the plan were:</p> <p>Section A, the Organisational Development Strategy, DB noted the following strategic objectives:</p> <ul style="list-style-type: none"> <li>• Transforming adult community health services</li> <li>• Integration of health and social care provision</li> <li>• A role in an Integrated Care Alliance for Wiltshire</li> </ul> <p>Section B included a proposed update to the 2 year delivery plan.</p> <p>Section C shows an updated delivery structure, which noted the changes that had been made on 1 April.</p> <p>Section D will include a resources plan – this is yet to be completed.</p>	

	<p>Section E shows the updated corporate risks from the Board Assurance Framework and Corporate Risk Register.</p> <p>The Board agreed that:</p> <ul style="list-style-type: none"> <li>• The strategic objectives remained pertinent</li> <li>• A more detailed timeline for delivery should be included in the refresh of the delivery plan, with a clearer sense of expected deliverables</li> <li>• A revised plan should return to the Board once contractual finances had been resolved.</li> </ul>	
<b>5</b>	<p><b>18/19 Contract Update</b></p> <p>DB noted that the contract variation for 2018/19 had not been signed, as there were ongoing discussions about reaching a more strategically-aligned financial settlement. The latest response from the CCG was not acceptable, and negotiations would continue. DB said that it was hoped the contract will be in place by end of April.</p>	
<b>6</b>	<p><b>Provider Partnership Proposal</b></p> <p>The Board reviewed the paper seeking views on a proposed creation of a Wiltshire Provider Partnership. Concern was expressed that the proposal strayed too far from original thinking on the purpose of the LLP.</p> <p>It was agreed that a discussion would be had at the members meeting on 9 May 2018 to discuss this. The focus needs to be on primarily on what we want to deliver and what the outcome looks like.</p>	
<b>7</b>	<p><b>Any Other Business</b></p> <p><b>Date of Next Meeting: 25<sup>th</sup> May 2018</b></p>	

## Wiltshire Health and Care (delivery arm within GWHFT) Financial Performance Summary M12 (March 2018) – CONFIDENTIAL

### Summary of in-month and year end financial position as at March 2018

2017-18 Plan		In-Month M12 (March 2018)			YTD M12 (March 2018)		
Income & Expenditure	Annual Plan £'000	M12 Plan £'000	M12 Act £'000	M12 Var £'000	YTD M12 Plan £'000	YTD M12 Act £'000	YTD M12 Var £'000
Income	44,169	3,685	3,742	57	44,169	43,808	(361)
Pay	(31,368)	(2,525)	(2,716)	(192)	(31,368)	(31,538)	(169)
Non Pay	(12,801)	(1,238)	(1,104)	134	(12,801)	(12,270)	530
Total	0	(78)	(78)	(0)	0	(0)	(0)

The Wiltshire Health and Care (GWHFT) delivery arm reports a break-even in-month and year end position as at M12, March 2018.

Corporate services report a favourable in month variance of £185k and a favourable year end variance of £431k which in main is driven by additional income in the month for six escalation beds on Ailesbury Ward (now closed), and continuing lower than planned non pay due to the estates transfer in July 17. These favourable variances are partly offset by lower than planned income. Operations Specialist Services report a full year adverse variance of (£451k); the in-month adverse variance is in main driven by higher than planned non pay within Orthotics and Diabetes services where a provision for FP10 expenditure was increased in the month. The favourable variance for Operational Services reduced in month from £62k in February to £20k in March, which in main was driven by agency spend in the month exceeding the budget available from vacancies across the wards.

### Financial position by service group - March 2018

Financial position by service group - YTD M12 (March 2018) £000k									
Service	Funded WTE	Contracted WTE	Paid WTE	In Month Budget £000	In Month Actual £000	In Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income				3,573	3,625	52	42,822	42,391	(432)
Non Pay				(689)	(587)	102	(6,670)	(5,998)	672
Pay	25.5	23.9	23.0	(135)	(105)	31	(1,612)	(1,422)	190
<b>Corporate Services Total</b>	<b>25.5</b>	<b>23.9</b>	<b>23.0</b>	<b>2,749</b>	<b>2,934</b>	<b>185</b>	<b>34,541</b>	<b>34,971</b>	<b>431</b>
Income				2	(20)	(22)	29	120	91
Non Pay				(321)	(137)	184	(3,390)	(3,273)	117
Pay	643.1	575.7	641.1	(1,641)	(1,845)	(204)	(20,825)	(21,013)	(188)
<b>Operations - Community, Inpatient and Tissue Viability Total</b>	<b>643.1</b>	<b>575.7</b>	<b>641.1</b>	<b>(1,959)</b>	<b>(2,001)</b>	<b>(42)</b>	<b>(24,186)</b>	<b>(24,166)</b>	<b>20</b>
Income				110	136	26	1,318	1,297	(21)
Non Pay				(229)	(381)	(152)	(2,741)	(3,000)	(259)
Pay	254.0	234.5	236.1	(748)	(767)	(19)	(8,931)	(9,103)	(172)
<b>Operations - Specialist Services Total</b>	<b>254.0</b>	<b>234.5</b>	<b>236.1</b>	<b>(867)</b>	<b>(1,012)</b>	<b>(144)</b>	<b>(10,354)</b>	<b>(10,806)</b>	<b>(451)</b>
<b>Grand Total</b>	<b>922.5</b>	<b>834.0</b>	<b>900.2</b>	<b>(78)</b>	<b>(78)</b>	<b>(0)</b>	<b>0</b>	<b>(0)</b>	<b>(0)</b>

## Financial position by service line - March 2018

YTD M12 (March 2018) - Financial position by service line £000k										
Service Line	Funded WTE	In Month Worked WTE	In Month Paid WTE	In Month Contract WTE	In Month Budget £000	In Month Actual £000	In Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
PN3114 Management	16.3	14.5	14.5	15.4	2,788	2,960	173	35,003	35,408	405
PN3121 Quality & HR	9.2	8.5	8.5	8.5	(39)	(26)	13	(463)	(437)	26
<b>Corporate Services Total</b>	<b>25.5</b>	<b>23.0</b>	<b>23.0</b>	<b>23.9</b>	<b>2,749</b>	<b>2,934</b>	<b>185</b>	<b>34,541</b>	<b>34,971</b>	<b>431</b>
PN3104 Specialist Services Admin	16.8	16.4	16.4	18.4	(29)	(29)	(1)	(345)	(340)	4
PN3105 Continence	7.9	6.9	6.9	6.7	(25)	(24)	1	(305)	(312)	(7)
PN3107 Diabetes	16.2	14.1	14.1	14.1	(44)	(85)	(42)	(520)	(522)	(2)
PN3108 Dietetics	23.9	21.7	21.7	22.4	(63)	(99)	(37)	(750)	(771)	(21)
PN3112 Learning Disability	34.1	34.4	34.4	38.4	(122)	(213)	(91)	(1,463)	(1,464)	(1)
PN3115 MIU	34.1	33.1	35.8	27.9	(112)	(143)	(31)	(1,341)	(1,830)	(489)
PN3117 Orthotics	1.0	1.0	1.0	1.0	(25)	(39)	(14)	(305)	(476)	(171)
PN3118 Outpatients Physio	58.3	52.2	52.4	52.8	(193)	(202)	(10)	(2,295)	(2,267)	29
PN3119 PACE and Oxygen	8.3	8.1	8.1	8.0	(27)	(23)	4	(325)	(326)	(0)
PN3120 Podiatry	22.0	18.2	18.2	17.8	(80)	(83)	(3)	(956)	(876)	80
PN3123 SLT	8.7	8.8	8.8	8.8	(29)	(29)	0	(316)	(301)	15
PN3125 Wheelchairs	16.9	14.2	14.2	14.2	(101)	(23)	78	(1,212)	(1,010)	202
PN3128 Specialist Services Management	6.0	4.0	4.0	4.0	(18)	(18)	0	(220)	(311)	(91)
<b>Operations - Specialist Services Total</b>	<b>254.0</b>	<b>233.2</b>	<b>236.1</b>	<b>234.5</b>	<b>(867)</b>	<b>(1,012)</b>	<b>(144)</b>	<b>(10,354)</b>	<b>(10,806)</b>	<b>(451)</b>
PN3110 Inpatients	164.2	171.0	192.6	136.5	(526)	(559)	(33)	(6,312)	(7,390)	(1,079)
PN3111 Intermediate Care	0.0	0.0	0.0	0.0	0	(0)	(0)	0	(1)	(1)
PN3116 North Community	158.3	137.2	143.3	143.5	(466)	(451)	15	(5,847)	(5,558)	289
PN3122 South Community	137.1	122.3	127.2	122.6	(374)	(397)	(23)	(5,021)	(4,681)	339
PN3124 Tissue Viability	5.5	5.8	5.8	5.7	(26)	(37)	(11)	(313)	(330)	(17)
PN3126 West Community	165.9	155.0	162.4	157.5	(483)	(520)	(37)	(6,112)	(5,772)	340
PN3127 Operations Management	5.6	5.2	5.2	5.2	(68)	(24)	43	(374)	(282)	92
PN3135 Community ESD	6.5	4.7	4.7	4.7	(17)	(13)	4	(208)	(152)	56
<b>Operational Services Total</b>	<b>643.1</b>	<b>601.1</b>	<b>641.1</b>	<b>575.7</b>	<b>(1,959)</b>	<b>(2,001)</b>	<b>(42)</b>	<b>(24,186)</b>	<b>(24,166)</b>	<b>20</b>
<b>Grand Total</b>	<b>922.5</b>	<b>857.3</b>	<b>900.2</b>	<b>834.0</b>	<b>(78)</b>	<b>(78)</b>	<b>(0)</b>	<b>0</b>	<b>(0)</b>	<b>(0)</b>

**Income** – reports a favourable variance in month, £57k, and an adverse year end variance of (£361k). The reported favourable in-month variance is due to the additional income received for the escalation beds on Ailesbury Ward, which is offset by expenditure. The adverse year end variance is in main due to lower than planned income drawn down from the LLP following the estates transfer on 1<sup>st</sup> July. This is partly offset by additional income for escalation beds open earlier on Ailesbury ward.

**Pay** – reports an adverse variance in-month of (£192k) and an adverse year end variance of, (£169k).

YTD Pay M12 (March 2018) - Breakdown by Pay Group, WTE and £000									
Pay Group	Funded WTE	Contracted WTE	Paid WTE	In Month Budget £000	In Month Actual £000	In Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Agency	0.0	0.0	24.6	(34)	(268)	(234)	(36)	(2,178)	(2,142)
Bank	0.0	0.0	27.2	0	(71)	(71)	0	(1,102)	(1,102)
Permanent	922.5	834.0	848.4	(2,491)	(2,377)	113	(31,332)	(28,258)	3,075
<b>Grand Total</b>	<b>922.5</b>	<b>834.0</b>	<b>900.2</b>	<b>(2,525)</b>	<b>(2,717)</b>	<b>(192)</b>	<b>(31,368)</b>	<b>(31,537)</b>	<b>(169)</b>

Wiltshire Health and Care Delivery Arm (GWHFT) Actual Pay for the 12 month period April 2017 - March 2018 by Pay Type												
Pay Group	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Agency	(192)	(277)	(27)	(40)	(138)	(139)	(205)	(177)	(266)	(152)	(297)	(268)
Bank	(87)	(107)	(89)	(132)	(80)	(87)	(105)	(85)	(89)	(81)	(89)	(71)
Perm	(2,318)	(2,420)	(2,242)	(2,284)	(2,370)	(2,371)	(2,348)	(2,441)	(2,318)	(2,403)	(2,365)	(2,377)
<b>Grand Total</b>	<b>(2,597)</b>	<b>(2,804)</b>	<b>(2,357)</b>	<b>(2,456)</b>	<b>(2,588)</b>	<b>(2,596)</b>	<b>(2,658)</b>	<b>(2,703)</b>	<b>(2,673)</b>	<b>(2,637)</b>	<b>(2,751)</b>	<b>(2,716)</b>

\*The permanent staffing values include RUH dietetics to March 17 and medical secretaries to June 17. These staff have subsequently transferred.

The adverse in-month variance continues to be driven by temporary staffing spend above vacancy levels, particularly on Ailesbury Ward where the six escalation beds remained open for part of March.

The overall reported vacancy rate reduced in month by 1% to 9.6%. Although high vacancy levels remain on Ailesbury Ward, this reduced by 3.4% in the month to 30.2%, with Cedar ward reporting a vacancy level of 18.4% in March. This is as per March payroll, which therefore excludes any vacancy pipeline.

The community teams and corporate services continue to report a underspend due to vacancies not being covered by temporary staffing. Recruitment is on-going.

### Temporary Staffing Spend

Overall temporary staffing spend reduced in the month, however, the spend continues to exceed vacancy levels across the wards and minor injury units. The number of close support shifts decreased slightly in the month, with 105 shifts in total being filled, down from 112 shifts in February. 61 of the close support shifts in the month were used on Longleat ward.

Spend with Thornbury nursing agency continued on the wards and MIUs in March.

Agency Nursing and HCA spend YTD Month 12 (March 2018) - spend by framework and off framework agencies				
Cost Centre	Agency spend - within framework £000	Expenditure - Agencies OFF Framework £000	Grand Total	Comments - OFF Framework spend
Ailesbury Ward	(318)	(442)	(759)	Vacancy cover, Escalation Beds (April-May 2017, January-March 2018), Close Support, Sickness cover
Minor Injury Units	(81)	(52)	(133)	Acuity and critical cover - mostly due to vacancies - cover from Thornbury and Evergood in main for ENPs
Longleat Ward	(110)	(31)	(141)	Vacancy, sickness and close support cover
Mulberry Ward	(181)	(72)	(252)	Vacancy, sickness and close support cover
Cedar Ward	(110)	(652)	(762)	Vacancy, sickness and close support cover
<b>Total</b>	<b>(799)</b>	<b>(1,248)</b>	<b>(2,047)</b>	
% of Total Agency Spend	39%	61%		

**Non-Pay** – reports a favourable in-month variance of £134k and a favourable year end variance of £530k against plan. The in-month and year end underspend is in main driven by lower than planned estates lease charges within the delivery arm from July 2017 (offset by reduced income) and lower than planned provider to provider expenditure due to transfer of medical secretary services to RUH earlier in the financial year. This underspend is partly offset by an overspend against Orthotics services, as well as bed hire charges on Cedar and Mulberry ward.

**Savings** – The full year savings target of £1,074k was achieved, with 'Improved MIU Roster Management', 'Travel' and 'Drugs Cost Reduction' being the schemes that did not deliver the planned savings for the year. Non recurrent savings covered the short fall against these schemes and any unidentified saving targets in the financial year.

**COMMUNITY HEART FAILURE BID**

**VERBAL ONLY**

**ANY OTHER BUSINESS**

**VERBAL ONLY**