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Slough Borough Council

Growing a place of opportunity and ambition

Date of issue: Tuesday 27 September 2022

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| **MEETING:** | **SLOUGH WELLBEING BOARD**<br><br>Councillor Pantelic, Lead Member for Social Care and Public Health<br>Dr Jim O'Donnell, East Berkshire Clinical Commissioning Group, Slough Locality<br>Andrew Fraser, Interim Executive Director of People (Children) / Slough Children First Chief Executive<br>Marc Gadsby, Acting Executive Director of People (Adults)<br>Adrian Davies, Partnership Manager, Department for Work and Pensions<br>Caroline Hutton, Frimley Health NHS Foundation Trust Representative<br>Sangeeta Saran, Slough CCG<br>Chris Holland, Royal Berkshire Fire and Rescue Service<br>Gavin Jones, Chief Executive, SBC<br>Ramesh Kukar, Slough CVS<br>Jonathan Lewney, Deputy Director of Public Health<br>Stuart Lines, Director of Public Health<br>Neil Bolton-Heaton, Healthwatch Representative<br>Aaryaman Walia, Slough Youth Parliament Representative<br>Supt. Lee Barnham, Thames Valley Police<br>Councillor Hulme, Lead Member for Children's Services, Lifelong Learning & Skills<br>Gavin Jones, Chief Executive, Slough Borough Council<br>2 Vacancies, Local Business Representatives |
| **DATE AND TIME:** | TUESDAY, 18TH OCTOBER, 2022 AT 5.00 PM |
| **VENUE:** | COUNCIL CHAMBER - OBSERVATORY HOUSE, 25 WINDSOR ROAD, SL1 2EL |
| **DEMOCRATIC SERVICES OFFICER:** | MANIZE TALUKDAR |
| **(for all enquiries)** | 07871 982 919 |

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

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| AGENDA ITEM | REPORT TITLE | PAGE | WARD |
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**GAVIN JONES**
Chief Executive

## AGENDA

## PART I

Apologies for absence.

## CONSTITUTIONAL MATTERS

| | | |
|---|---|---|
| 1. | Declarations of Interest<br><br>*All Members who believe they have a Disclosable Pecuniary or other Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Section 9 and Appendix B of the Councillors' Code of Conduct, leave the meeting while the matter is discussed.* | |
| 2. | Minutes of the last meeting held on 20 July 2022 | 1 - 6 |
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| 10. | Date of Next Meeting | |

**Press and Public**

**Attendance and accessibility:** You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before any items in the Part II agenda are considered. For those hard of hearing an Induction Loop System is available in the Council Chamber.

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In addition, the law allows members of the public to take photographs, film, audio-record or tweet the proceedings at public meetings. Anyone proposing to do so is requested to advise the Democratic Services Officer before the start of the meeting. Filming or recording must be overt and persons filming should not move around the meeting room whilst filming nor should they obstruct proceedings or the public from viewing the meeting. The use of flash photography, additional lighting or any non hand held devices, including tripods, will not be allowed unless this has been discussed with the Democratic Services Officer.

**Emergency procedures:** The fire alarm is a continuous siren. If the alarm sounds Immediately vacate the premises by the nearest available exit at either the front or rear of the Chamber and proceed to the assembly point: The pavement of the service road outside of Westminster House, 31 Windsor Road.

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**Slough Wellbeing Board – Meeting held on Wednesday, 20th July, 2022.**

**Present:-** Councillors Pantelic (Chair), Dr Jim O'Donnell (Vice-Chair), Supt. Lee Barnham, Adrian Davies, Andrew Fraser, Marc Gadsby, Chris Holland, Stuart Lines and Hulme

**Apologies for Absence:-** Neil Bolton-Heaton, Caroline Hutton, Gavin Jones, Ramesh Kukar and Jonathan Lewney

**PART 1**

**37. Declarations of Interest**

No declarations were made.

**38. Minutes of the last meeting held on 31 May 2022**

**Resolved** – That the minutes of the meeting held on 31 May 2022 be approved as a correct record.

**39. Public Health Annual Report 2021-22 - Part 1**

The SBC Joint Director of Public Health provided a brief overview of the Directors of Public Health Annual Report 2021-22.

He also shared the following link:

Berkshire Public Health Annual Report 2021/22 - Public Health Annual Report 2021/22

Following a question about whether the food sustainability initiatives were linked into the Council's and its partners' poverty initiatives, the SBC Joint Director confirmed this was the case, particularly in relation to healthy eating and food use schemes, which would be developed further.

Following a question regarding how school children and adults from deprived backgrounds would be encouraged to adopt new healthy behaviours, the SBC Joint Director advised that it would be important to take a holistic, system-wide approach and encourage children and young people to adopt healthy cooking and eating habits. This would be achieved by building on partnership working with schools and families to encourage the uptake of healthy cooking and healthy eating habits and by capitalising on any existing initiatives.

The Chair asked Board Members whether their organisations had taken on board the Council's climate change pledges.

The representative from the fire service responded that the service was looking at reducing its carbon footprint. For example, its fleet was being

assessed for conversion to electric vehicles but that this endeavour was in its early stages.

The representative from the police service advised that this fell within the remit of a central government department, which was looking at the service's fleet, estates, etc and had recently introduced hybrid working.

The SBC Joint Director stated that the NHS was taking a sustainable and green approach.

The Vice Chair stated GP practices were tackling this issue through mandatory training and changes in how practices were run, how materials were used and the disposal of clinical waste and recycling.

The representative from the DWP stated that the department operated within a national directive which oversaw operational delivery. It aimed to influence businesses to recruit staff locally, worked with local training providers to offer training and introduced a bicycle scheme in a bid to reduce car journeys. It was working with the Council and Heathrow airport to encourage local bus companies to lower their rates in a bid to reduce car journeys to and from the airport.

The SBC Interim Executive Director of People (children) stated that there was scheme where care leavers were provided with second hand bicycles in a bid to reduce car use.
Following a question regarding whether there any initiatives to educate those on benefits about climate change issues, the representative from the DWP advised that the majority of funding was aimed at aiding those fit for work, to gain employment. The service offered clients medium/high level online skills training focussed on employment. He would discuss the matter further with the vice chair outside the meeting.

**Resolved** – That the report be noted.

## 40. Update - Priority Two, Integration. Health and Social Care Partnership Board

The Integration Delivery Lead from Frimley introduced the report 'Update, Priority Two, Integration and Social Care Partnership Board'.

Following questions and comments, he advised that the sub-group was focussed on outreach work for children which was being scoped with the public health team, the school nursing service and the ICS maternity service lead. The BCF would support the SEND action planning and a new SEND officer would shortly be appointed. There was a co-production network, whereby all initiatives would be co-produced and co-designed with partners, relevant stakeholders and local residents.

Following a question from the Chair about arranging joint training with partners, he undertook to discuss the matter further with the Director of Operations.

The Vice Chair emphasised the importance of seeking evidence of co-production in all health related projects. He had recently attended the Frimley ICB integration workshop, where Slough had been strongly represented. A key phenomenon highlighted at the workshop was the fact that 20-25 of the most common chronic medical conditions, (ie those which cause the most problems to sufferers) were disproportionately prevalent in deciles 1 and 2, ie, among the most economically deprived groups. It was therefore imperative to tackle the causes of deprivation and provide funding to tackle these issues.

The Chair concurred that tackling the wider determinants of health was key, as was partnership work and increased funding to initiatives focussed on prevention in order to maximise the benefits to the community.

Action 1: The Board to encourage and promote the co-production and co-commission of services; and to encourage resident involvement in decision-making about service provision and how money was spent.

Action 2: Further explore joint training of staff with the aim of sharing information and good practice; and signposting residents to relevant information and services.

Action 3: The Vice Chair to feedback the Board's comments on integration to the ICS, emphasising the importance of tackling the wider determinants of health.

**Resolved** – That the report be noted.

## 41. Update - National & Local Policy

Councillor Hulme joined the meeting.

The SBC Strategy & Policy Lead tabled the following documents and provided a brief summary of each:

1. Census Data Release
2. Local & National Policy Update
3. Media Literacy Taskforce Fund
4. Youth Endowment Fund

Following questions, the SBC Strategy & Policy Lead advised that the 0-15 age group made up 22.5% of Slough's population. He added that the size of the 20-35 age group had decreased in recent years.

Following further questions, he confirmed that the Council was looking into a social value policy as part of its new corporate plan. He stated that he would confirm the percentage of the population in the 0-19 age range after the meeting.

He added that further briefings would be produced as additional census data sets were released in the autumn of 2022. This information could help inform the soon to be revised Wellbeing Strategy.

Following a question, the SBC Strategy & Policy Lead advised that the population density data related to England and Wales and not to Scotland.

**Resolved** – That the report be noted.

## 42. Children & Young People's Update

The SBC Interim Executive Director, People (Children) provided an overview of the report Children and Young People Update report. He added that there was an error on the report and that the CYPP would not be temporarily disbanded as stated in the report, but rather the focus would shift to early help, strategy and more frequent meetings of the task and finish group.

Board members concurred on the importance of strengthening partnership working and involving the community, and the development of an early help strategy for young people. The SBC Interim Executive Director stated that a task and finish group would evaluate how to deliver the outcomes set out in the report and that further update report would be submitted to the Board later in the year.

Following a question, the SBC Interim Executive Director advised that the early help would be available for all children. Support would be focussed on those areas of the borough with the greatest need, experiencing significant public health issues such as obesity, high infant mortality, tooth decay and other issues which continued to have an effect in adulthood.

**Resolved** - That the report be noted.

## 43. JSNA Update

The SBC Joint Director of Public Health provided an overview of the East Berkshire JSNA, progress to date, future direction of the JSNA and revised timescales.

He shared the link below to the JSNA website:

Berkshire East JSNA (berkshirepublichealth.co.uk)

Following a question, the SBC Joint Director responded that local councils and their partners had been asked to provide plans to improve their treatment and recovery systems and that the government would be providing additional funding for this.

**Resolved** – that the report be noted.

## 44. Forward Work Programme

The SBC Strategy & Policy Lead advised that 2 items listed on the work programme, namely the Strong Healthy & Attractive Neighbourhoods report and the update on the Slough equalities review had been deferred to the November 2022 meeting of the Board.

**Resolved** – That the report be noted.

## 45. Update ICS and Place

The Chair stated that the Board had received a fairly detailed update on ICS and Place at the previous meeting. The Associate Director, People, Adults advised that there was no specific update further to this. He advised that both he and the Director of Operations for Slough had weekly meetings where discussion was focused on key issues.

**Resolved** – That the verbal update be noted.

## 46. Date of Next Meeting

20 September 2022.

Chair

(Note: The Meeting opened at 5.01 pm and closed at 6.57 pm)

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**Slough Borough Council**

| | |
|---|---|
| **Report To:** | Slough Wellbeing Board |
| **Date:** | 20th September 2020 |
| **Subject:** | Better Care Fund Plan 2022/23 |
| **Chief Officer:** | Marc Gadsby, Executive Director People (Adults) interim |
| **Contact Officer:** | Mike Wooldridge, Integration Delivery Lead |
| **Ward(s):** | All |
| **Exempt:** | No |
| **Appendices:** | Better Care Fund Plan 2022/23 |

## 1. Summary and Recommendations

1.1 This report sets out present the Better Care Fund Plan 2022/23 to the Wellbeing Board the Board for final submission to government on 26th September 2022.

**Recommendations:**

The Wellbeing Board is recommended to note the content of the Better Care Fund Plan 2022/23. There may be minor changes and additions to the draft included with the agenda before of final submission to ensure that all Key Lines of Enquiry are met for assurance purposes.

Following submission the plan goes through a regional and national assurance process which involves representatives from NHS England and the Association of Adult Social Services (ADASS).

**Reason: for information**

## 2. Report

**Introductory paragraph**

The Better Care Fund programme is developed and managed between the local authority and CCG together with other delivery partners and aims to improve the health and wellbeing outcomes for the people of Slough. It directly supports delivery of integration; priority two of the Slough Wellbeing Strategy.

The BCF programme is guided by priorities set out within the Wellbeing Strategy and the Health and Wellbeing Plan for Slough place. It also supports the delivery of the Slough Corporate Plan (*'Doing Right by Slough'*) particularly around the effective implementation of integrated health and social care, increasing the effectiveness of reablement services and supporting delivery of some elements of the public health strategy and contributes to reducing health inequalities.

BCF also in this year includes support to the delivery of the SEND action improvements by investment to support SEND participation and engagement.

The plan also includes areas of integrated work between the partners that contribute directly towards addressing health inequalities identified in the Slough Joint Needs Assessment.

**Options considered**

None. Completion of a jointly agreed BCF plan between partners is a statutory requirement of local Wellbeing Boards and a condition to the pooling of funds.

**Background**

The government is committed to person-centred integrated care, with health, social care, housing and other public services working together to provide better joined up care. Enabling people to live healthy, fulfilled, independent and longer lives will require these services to work ever more closely together towards common aims.

The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

There are a number of upcoming reforms taking place to the health and social care system, including the Integration White Paper: Health and social care integration: joining up care people, place and populations, the Adult Social Care Reform White Paper, People at the Heart of Care; the Health and Care Act 2022 and reforms to the public health system which provide an important context for the BCF

The Better Care Fund programme is central to our integration approach within Slough and has provided vital investment for integration of health and social care, supporting people to stay well and live independently at home and supporting people to return home and recover after a spell in hospital. Along with the grant funding made directly to the local authority, the NHS contribution to the pooled budget protects funding to adult social care services and maintains investment in Intermediate Care, reablement, social work support for people leaving hospital and the voluntary sector role towards maintaining healthy communities.

## 3. Implications of the Recommendation

*3.1* Financial implications

The total size of the BCF pooled budget for 2022/23 is £15,732,772. This includes a minimum contribution of £10.6m from NHS Frimley, the improved Better Care Fund (grant funding to the Local Authority) of nearly £4m and Disabled Facilities Grant of £1.14m

| Funding source | Income |
|---|---|
| DFG | £1,140,680 |

| | |
|---|---|
| Minimum NHS Contribution | £10,602,678 |
| iBCF | £3,989,414 |
| Total | £15,732,772 |

The expenditure is across 37 schemes listed and described within the spend plan which are agreed and managed between the partners of the pooled budget under the section 75 agreement (NHS Act 2006). This is included in the background papers.

3.2 Legal implications

There is a legal implication in how funds are used, managed and audited within a Pooled Budget arrangement under section 75 of the NHS Act 2006.

The Care Act 2014 provides the legislative basis for the Better Care Fund by providing a mechanism that allows the sharing of NHS funding with local authorities.

3.3 Risk management implications

The Health and Social Care Partnership acts the Programme Board for the Better Care Fund and oversees and monitors risks in relation to the BCF programme. A risk register identifies, and scores risks of delivery of the programme together with actions to mitigate or manage those risks.

3.4 Environmental implications

None

3.5 Equality implications

The delivery of the Better Care Fund programme and the integration of health and social care services aims to improve outcomes and wellbeing for the people of Slough through effective protection of social care and integrated activity and to reduce emergency and urgent health demand.

Equality Impact assessments are undertaken as part of planning of any new scheme or investment proposal to ensure that there is a clear understanding of how various groups identified within the Equalities Act (2010) may potentially be affected.

3.6 Procurement implications

Within the BCF schemes are assigned to NHS or Local Authority as lead commissioners. Each follow their own procurement processes and financial regulations for the commissioning and procurement of services.

3.7 Workforce implications

There are potential future workforce implications as we move towards closer integration of health and social care service. The pooling of budgets and closer

collaborative working to deliver integrated care is creating new ways of working in partnership with others and BCF programme is therefore aligning together with other change programme activities happening across the wider Frimley Integrated Care Board as well as the local integration of services at place.

3.8 Property implications

None identified

## 4. Background Papers

Better Care Fund Narrative Plan 2022/23 – draft 15/9/2022
Better Care Fund metrics 2022/23
Better Care Fund expenditure plan summary 2022/23

# BCF narrative plan 2022-23

## *Draft 15th Sept 2022*

### Slough Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

- NHS Frimley
- Frimley NHS Foundation Trust
- Slough Borough Council
- Berkshire Healthcare Foundation Trust
- Slough Council for Voluntary Service
- Slough Coproduction Network

How have you gone about involving these stakeholders?

Local stakeholders are involved in planning and oversight of the BCF programme via the Health and Social Care Partnership and Place Based Committee. An outline of this 2022-23 plan was discussed at the meeting on Tues 23rd August. Our smaller BCF Delivery Group of health and adult social care partners has also discussed and reviewed the content of the plan.

Regular reports on the Slough BCF programme are produced and presented to the Partnership for key decisions, monitoring progress on schemes as well as finances and performance. The BCF plan along with the Annual Report(s) are also presented and discussed at the Slough Wellbeing Board.

Partners across the system are involved in setting metric ambitions i.e. local authority for ASCOF indicators and with Clinical Commissioning Team (analytics), Community Foundation Trust and Frimley Foundation NHS Trust for metrics relating to hospital discharge/admission avoidance as well as the Capacity and Demand Plan.

For the development of this year's BCF plan there has been early member engagement and discussion with lead members of the Slough Wellbeing Board (Wellbeing Board Chair, Cllr Natasa Pantelic, and Cllr Christine Hume) around the framework, local emerging priorities and ambitions of the Board.

The BCF programme in Slough is centre to the delivery of Integrated Care for Slough Place in partnership with the wider system. Our shared and agreed priorities were agreed and published last year (2021-22) in the Health and Social Care Plan and these still guide for prioritising the workplan, commissioning activity and investment decisions. Current and potential BCF funded schemes are therefore evaluated against the delivery of the plan. Any new business case for investment needd to identify not only how it meets the BCF criteria and contribution to performance against the metrics, but also how it contributes towards the local priorities in the H&SC Plan.

The H&SC Plan was developed together with all partners in the Partnership Board and Place based committee, including Primary Care Networks, Community and Acute Trusts and community and voluntary sector.

The Slough Wellbeing Board in this planning year is looking to how the Better Care Fund can be route through which investment can be made which will serve to further reduce health inequalities, particularly addressing wider determinants of health along with prevention, early intervention and the impact of poverty. In line with this there is a commitment to direct more investment to improving the healthy lives of Children and Young People in the Borough who represent 29% of the population of Slough. The Board is coming together as a workshop later in September (date to be confirmed) to discuss and agree the more detailed areas and approaches from which to develop business cases.

**Executive summary**

This should include:

- Priorities for 2022-23
- Key changes since previous BCF plan

Priorities for our BCF programme in Slough are still guided from the principles and priorities set out in our Health and Social Care Plan 2021-22. These being

- Better Access to Care
- More integrated and pre-emptive service offers
- Use of locality-based models
- Improved outcomes for mental health
- Improved outcomes for frailty
- Responding to changing demands and needs post covid-19

Last year saw some significant additional investment from BCF into social care services and supporting to improving discharge and flow from the acute hospital and the community and voluntary sector.

Key changes for BCF expenditure plan for this financial year of 2022/23 are as follows:

- Contract uplifts where applicable for staff pay increases/increments
- Additional investment into the OT/SALT service (to support young people with disabilities in Slough)
- Funding previously included for our digital telehealth programme supporting people with diabetes has been taken into our ICB digital programme allowing for the continuation of that work across the wider ICB and reinvestment of BCF
- Additional investment into Information and Advice services (now full year funding) through a contract held with Citizens Advice Bureau

New areas of spend (one-off) agreed:

- SEND Participation Officer – this is a 2 year post to support participation and engagement of young people with SEND and their parents/ families. Response to SEND inspection and one of areas of improvement identified.

- Homeless intensive support – Browns service are working directly with homeless people with chaotic lifestyles providing support work to access accommodation, health services, drug and alcohol treatment

- Interim care beds – additional capacity post-covid for discharge into step-down beds to support continued discharge and flow from hospital back to the community

In this year the Wellbeing Board is looking to BCF to support with wider health inequalities and areas of poverty, prevention and early intervention. A workshop event being held in September for Wellbeing Board members to come together and discuss how we invest to help address some of the wider determinants of health, particularly given the rising cost of living and inflation and the impact that this will have on our communities in this winter and beyond.

It has been agreed to hold current unallocated funding in this years BCF (£374k) in order for the Board to have this discussion and agree areas of investment that meet their priorities within the Wellbeing Strategy and help address the needs of the community in light of impact of inflation

and fuel poverty which likely to have deep and profound impact on households and communities across Slough. It is also likely that some contingency funding be held within this unallocated funding, as was the case in previous BCF expenditure planning rounds, to support with any additional demands that may occur within the local system over the winter period.

Of the current £374k CCG minimum contribution that remains uncommitted expenditure in this year, £141k will be invested to NHS commissioned out of hospital services to meet required minimum spend. Owing to the timescales between publication of BCF planning framework and deadline for plan submissions decisions on where this will be invested are still to be made and subject to completion of business cases. The Wellbeing Board has however given a direction of areas that it wishes to invest new BCF expenditure. These being areas of prevention, early intervention and wider determinants of health that will help toward reducing health inequalities in Slough.

## Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The governance of our BCF programme in Slough continues to be overseen by the Health and Social Care Partnership and CCG Place Based Committee. These were merged to a single partnership board in last year. This partnership is a formal sub-committee of the Slough Wellbeing Board and has membership of all our partners in the delivery of health and social care in Slough including local authority, CCG, acute trust, community trust, voluntary sector, Primary Care Networks, lay members and resident representatives from our co-production network.
The role of the partnership is to:

a) Agree strategic direction for the integration of health and social care within Slough.
b) Ensure commissioned services across the partnership are aligned to deliver efficient and effective services, designed to improve outcomes.
c) Consider any issue of health and social care strategic policy, public health strategy or general community concern within Slough
d) Deliver Priority Two – 'Integration' of the Slough Wellbeing Strategy 2020-2025 on behalf of the Slough Wellbeing Board.

The joining of the H&SC Partnership and Place Based Committee formed together in order to:

- strengthen the place approach for all Slough health and care partners
- to enable us to jointly oversee the delivery of our shared integration priorities through our Health and Care Plan
- to create a stronger connection with the Health and Wellbeing Board deepening the connections between CCG, PCN and member colleagues in the local authority
- make best use of stakeholder's time
- to help strengthen the relationships between primary care and the local authority
- to avoid duplication of time and effort

Regular reports (minimum quarterly) are presented to the H&SC Partnership on BCF and related integration development and activity. In support of the Programme Management function there is also a smaller Better Care Fund Delivery group which is the core group which drives forward the delivery of the Better Care programme on behalf of the partners to the pooled budget agreement. It coordinates and operationally manages the BCF on behalf of the Health and Social Care Partnership as well as ensuring that it operates within the policy and guidance framework set nationally.
The role of the delivery group is:

- To manage the delivery of the Better Care fund programme for Slough in line with the agreed plan, budget and timescales
- To receive and monitor performance reports on key performance indicators (KPI) and take appropriate actions
- To oversee and monitor financial expenditure and forecasts within the Pooled Budget
- To review progress in delivery and performance of projects and schemes within the programme
- To review and update the risk register for the programme and those from specific projects and to escalate risks to the Health and Social Care Partnership as appropriate
- To consider new ideas and proposals for Better Care Fund activities and guide and steer development of business cases for commitment of ongoing BCF investment before being presented to H&SC Board

In addition to the Health and Social Care Plan the Council in this year published a new Corporate Plan 2022-25 which includes the priority of achieving an environment that helps residents live more independent, healthier, and safer lives. It outlines key improvement areas of focus which are:

- *Reframing of public health strategy to achieve better outcomes for weight management, smoking prevalence, and substance misuse*

- *Work through the Health and Social Care Partnership to ensure effective implementation of integrated health and social care for outcomes*

- *Increase in the effectiveness of reablement services that enable people to live independently for longer*

In addition, the Slough Corporate Plan includes an ambition to be a borough where children and young people thrive. This includes that children and young people with SEND should have the same opportunities as non-disabled children and young people. To create a town for children and families to thrive, we must ensure that this is inclusive for children and young people with special educational needs and disabilities (SEND). Slough SEND approach must improve and will seek to ensure that children and young people with SEND can grow up happy and healthy, with a voice that is heard and the same opportunities to play, socialise and reach their full potential as other children and young people. The H&SC Partnership has representation from the Executive Director of Children's Service to ensure the scope of integration activity includes and aligns that of children and young people's services.

BCF has this year agreed investment to support the SEND participation work in support of the action plan developed following recent inspection and identified areas for development and improvement. There is ongoing discussion around investment in Children and Young People from within BCF to support longer term health outcomes and health and wellbeing. This needs to contribute to BCF metric outcomes but acknowledged that Slough has a comparatively young population, as identified within the JSNA. Slough has almost a third of its population aged under 18 (29%) compared with 21% nationally. Currently only small percentage of BCF investment is directly invested to CYP with most investment being into adults and older adults, specifically those with frailty and complex health needs.

**Overall BCF plan and approach to integration**

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2022-23
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2022-23.

The vision and principles for commitment to integration remains unchanged in our BCF Plan 2022-23 and is to continue to use our partnership, and the BCF investment, to achieve a shift from reactive to proactive health and social care to enable more people to have healthier, safer and more independent lives in their own home and community for longer, receiving the right care in the right place at the right time.

Our vision for being integrated is for the local delivery of a broad range of health and social care services to operate seamlessly, regardless of organisational boundaries. Working across a complex health and social care economy we continue to develop a proactive approach to the provision of health and social care and support in the community. This is delivered in partnership between

- Primary Care Networks and GP practices
- The acute trust
- integrated health and social care multi-disciplinary teams
- community-based health services
- adult social care services
- local care and housing providers
- community and voluntary sector
- Coproduction Network with Slough residents

Our joint priorities are laid out in our Health and Care Plan for Slough which was developed together in partnership and identifies where we are collectively aiming to promote good health and care outcomes and reduce inequality for the residents of Slough.

The plan is to develop, promote and maintain independence, because this is good for health, good for people, and good for the taxpayer and sustainability of services. This approach is achieved through:

- **Prevention and promoting self-care** through information and advice
- **Connecting individuals to their communities** to reduce the need to present in institutional settings
- When support is needed, **delivering care in a seamless and integrated way**

BCF funds a number of schemes which support the delivery of shared priorities and supporting integration of health and social care across. Key to our model of integrated care is the Integrated Care Decision Making (ICDM) which supports several additional posts creating capacity to do joint assessment, decision making and care planning. The ICDM consists of Social Workers, Mental Health practitioners (CPN), Occupational Therapists and physiotherapists. They meet together in monthly 'cluster' multidisciplinary team meetings with Community Matrons and GPs to discuss and case manage complex cases which require and benefit from multi-professional approach.

In addition to ICDM BCF has invested in the Slough Locality Access Point which a multi-professional single point of access operating Mon-Fri 9am -5pm for professional referral of cases for integrated health and social care response. This includes Social Worker, Mental Health and OT practitioner capacity to the LAP.

BCF also invests in several schemes that support in delivery of the High Impact Changes for Managing Discharge and Flow. These are outlined in the next section.

The Wellbeing Board has set its priorities within the Slough Wellbeing Strategy and integration is one of its 4 priorities. However, early engagement and discussion on BCF planning in this year has been how BCF can support and mitigate impact of the rising costs of living and the impact it will have on the health and wellbeing of Slough residents and its more vulnerable communities. The effect of fuel poverty and rising living costs will have impact on demand for local health and care services, and support of community and voluntary sector, comparable to that of the covid pandemic. Discussion is to take place at the Wellbeing Board around this and current uncommitted expenditure in BCF to be held further to agreed actions, areas for investment and development of accompanying business cases.

**Implementing the BCF Policy Objectives (national condition four)**

National condition four requires areas to agree an overarching approach to meeting the BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Please use this section to outline, for each objective:

- The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care
- How BCF funded services will support delivery of the objective

Plans for supporting people to remain independent at home for longer should reference

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level.

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to:

- Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support.
- Carry out collaborative commissioning of discharge services to support this.

Discharge plans should include confirmation that your area has carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Enabling people to stay well, safe and independent at home for longer and providing the right care in the right place at the right time are objectives that go hand in hand with the approach to integrated care within Slough. There are a range of services with the BCF programme that contribute directly to these national policy objectives.

As part of the response to the NHS long term plan the **Ageing Well** Programme is being led across the Frimley ICB and delivered at place. Includes:

- Urgent Care Response – providing 2 hr crisis response to people in need of urgent supporting running 8am-8pm Monday -Friday

- Establishing Virtual Wards providing medical care and treatment to people in their own home in need of enhanced clinical support
- Enhanced Healthcare to care Homes to enable homes to provide high quality care in care home settings and avoiding admission to hospital
- Anticipatory Care Planning to do proactive case finding of people with frailty risk factors, co-morbidities to provide early intervention and support to maximise independence and remain at home for longer.

**Falls forum and prevention work –** Slough BCF funds a Falls Free 4 Life service delivered by Solutions for Health. Takes self referrals and professional referral, completes comprehensive falls risk assessment and strength and balance classes to improve postural stability. The service also includes home safety assessments to reduce risk of falls.
There is an ICB forum of wide group of stakeholders sharing best practice and reviewing pathways ensuring falls prevention part of integrated support offer to people living with frailty in local place areas. Within the forum there is to be a focus on 'upstream' primary prevention as part of the 'Live Longer Better' programme approach promoting healthier lifestyles and activity that will maintain wellness and independence in the longer term.

**Integrated Care Decision Making** (ICDM) has been a key part of our integrated care approach. This is an ICS designed model which is delivered at place being jointly commissioned and funded through BCF. This is both a response (reactive) and proactive, community based integrated response that helps people to remain at home with integrated, personalised response to their health and social care needs. BCF investment has funding additional capacity into supporting this activity including that of social worker, MH practitioner, physiotherapy and OT together with input from PCNs (GP, paramedic, social prescribers) to have integrated and multi-disciplinary discussion and care planning to support people with complex health and social care needs. The MDT cluster meetings are coordinated and run at neighbourhood/locality level. There are therefore for Slough four 'cluster' meetings held per month aligned to Primary Care Network localities.

The Slough **Locality Access Point** operates Mon- Friday 9-5pm giving direct daily access for multi-disciplinary triage and assessment of referrals to support professionals working with complex cases. In this year this has also been extended to Care Home providers to help support them in care of their residents in the care home and avoid unnecessary admissions to hospital and this is being supported by the community consultant geriatrician. The LAP provides a point for referral for people with potentially rapidly escalating care and support needs to provide joint assessment and integrated response to help people remain at home and avoid unnecessary hospital admissions by a route to a multi-professional, integrated, same day response. BCF provides funding for the additional capacity needed for health and social professionals to operate the LAP throughout the week.

**Personalisation and person-centred care**
Frimley ICS has established a Personalised Care programme to support delivery of the NHS Long Term Plan commitments on personalised care. This includes the comprehensive model comprising of six evidence-based standard components intended to improve health and wellbeing outcomes and quality of care, whilst also enhancing value for money.
Implementation is taking place through local delivery partnerships between statutory health and social care partners, the voluntary and community sector and people with lived experience.
Deliverables of the programme include:

- Support and help train staff to have **personalised care conversations**

- Embedding **social prescribing link workers** to connect people to wider community support which can help improve their health and well-being and to engage and deal with some of their underlying causes of ill health.
- Further the roll out of **Personal Health Budgets** to give people greater choice and control over how care is planned and delivered.
- By rolling out training to help staff identify and support relevant patients, to introduce **proactive and personalised care planning** for everyone identified as being in their last year of life

Slough Borough Council been transforming its Adult Social Care Services supported by People Too in order to deliver **strength and asset-based approaches**. This is establishing new and innovate approaches to delivery of adult social care, coproduced with residents and staff. Asset based approaches seek to empower people to have greater choice and control over their care and support arrangements as well as giving high quality personalised support that gives greater flexibility and value for money. Initial conversation with new people seeking support is strength based and these first exchanges are key for some people who may be able to be more independent at home. The focus of this approach was initially via the customer contact centre but now also moving to the Adult Social Care duty system and in the development of the online portal.

Reviewing processes of care arrangements have been enhanced through the introduction of a Virtual Reviewing Team funded by BCF for two years providing a more strength-based discourse into the panel process along with clearer focus on outcomes achieved and ways to maximise independence.

To help monitor the impact of using these approaches, an Adult Social Care dashboard has been developed focusing on key performance areas.

**Links with housing in Slough**

As part of the Adult Social Care transformation the Slough commissioning team are continuing to look at a range of accommodation and care options to ensure that there is sufficient access to suitable housing provision in the borough in the future for those that need support. There is an established workstream taking forward an evidence-based approach to our local need for a range of accommodation with different models of provision. These include:

- Enhancing the accommodation with support offer with opportunities for people with learning disabilities, ensuring local access to appropriate placements for supported living as an alternative to residential care
- Re-procurement of extra care housing accommodation for older people in the borough
- establishing a 'Shared Lives' scheme in Slough
- The recommissioning of homeless hostels in Slough through the Housing Transformation Fund recognising that having access to appropriate housing for people who are homeless is vital in supporting with their health, mental health, substance misuse and pathways to employment.
- Exploring opportunities for block contract(s) for accommodation that can support people with more complex needs e.g. requiring high level of supervision and support

A comprehensive **review of reablement** (intermediate care services) has been conducted in this year and a new structure and framework for provision is currently out for consultation. The output of this review will be to re-focus the work of the RRR team on reablement and maintaining/maximising independence. Business case developed that will significantly increase the reablement offer to both community ('step-up' support) and hospital discharge providing

more universal offer to help people regain baseline, maintain and maximise independence and supporting to live at home.

**Discharge to Assess/ Home First** – there is continued investment in community capacity through BCF to support early transition out of hospital for recovery and assessment in the community, preferably at home, or in an interim care bed. This maximises people's potential to return and remain at home for longer term and avoid permanent placement in care home wherever possible.

The Slough **Hospital Social Work Team** is dedicated to supporting the timely flow of people being discharged to the community. Last year BCF secured ongoing investment to maintain capacity in the team to manage discharge and flow. The presence of social workers on site in the hospital and the daily multi-disciplinary meetings with discharge coordinators significantly improved the communication and coordination of information gathering and discharge planning for people to return home once they have become medically stable.

There is a collaborative of **Community Equipment Services** across Berkshire under a single contract. The rapid access to a wide range of aids and equipment is essential in helping people are supported to remain as independent as possible and can remain in their own home, reducing or avoiding higher levels, and associated costs, of direct care provision.

Slough Borough Council has well established **Care Provider forums** with representatives from both the local care home market and with domiciliary care providers. This forum has been valuable in sharing information and developments to support providers across the sector, it was particularly valued by providers to provide support throughout the covid pandemic and now on the Enhanced Healthcare to Care Homes framework (within the Ageing Well programme). There are regular meetings held as well as a newsletter published and circulated.

The **Slough Care Home** task and finish project group bringing together partners initially for the implementation of the Care Home DES (Direct Enhanced Service) and supporting the clinical model of dedicated GPs aligned to care homes and supported by local multi-disciplinary teams. The group continues to meet as a multi-agency group bringing together the PCN clinical lead, community nursing services, adult social care and CCG quality team. The group has continued to run to develop further the support to Care Homes within the Ageing Well programme and the Enhanced Healthcare in Care Homes framework, most recently with a focus on the digital element with the Remote Monitoring /digital management in care homes.

**High Impact Changes for Managing Transfers of Care**

There has been a review and self-assessment against the 9 changes within the HICM and there is continued investment in to the various aspects that ensure that we are addressing each aspect of the model.
These include investment in:

- Alamac (shared IT system to monitor flow)
- Multidisciplinary Teams to support discharge (IRIS), including the dedicated hospital social work team aligned to Wexham Park Hospital and providing weekend cover
- Discharge to Assess – additional capacity for SW, OT and interim packages of care
- Community beds for step down in community hospital and care homes
- System resilience – GP in ED for trusted assessment and coordination of complex discharges
- Enhanced Clinical Support to Care homes supporting people to remain living in the care home when acutely unwell

There is also now access though the Shared Care Record (Connected Care) to enable our practitioners in the Reablement service to identify Slough residents who have been admitted to hospital which provides real-time information and supporting with pre-emptive planning for discharge from the time of an (unplanned) admission.

**Supporting unpaid carers.**

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

Slough's Better Care Fund contributes £216k into the support for unpaid Carers. This includes the funding for the Carers Support Service hosted by the Slough Council for Voluntary Service (SCVS)

The Carers funds our Carers Support Service giving advice and support to all Slough unpaid carers and young carers. The service carries out Tier 1 assessments and produces wellbeing plans co-developed with carers identifying what support they need and how can be met. It also includes contingency planning for if/when the carer cannot provide their caring role. For those carers needing additional support and a social care led carer assessment the service makes onward referrals into Adult Social Care (Tiers 2 and 3).

The Slough Carers Support service runs and maintains a Carers network and forum across Slough providing unpaid carers with regular newsletters and information but also coordinates events through which for carers can come together. It also supports several local Carer Groups across Slough including the recently established Men's Carers group.

Carers funding from BCF invests in support to Young Carers through Aik Saath ('together as one') which is a local voluntary sector organisation for young people.

The funds also provide access to one-off Direct Payments for Carers which can help with access to short break or financial support to help continue carers in their caring role.

A revised Carers Plan was developed and coproduced in 2021/22 together with local carers in this last year in recognition of the impact of covid on many carers providing additional support to the people they care for as a result of some services reducing or closing. Carers needed additional help to stay connected, reduce social isolation and having support and recognition of the emotional, financial and physical impact of the covid crisis.

A Carers Discharge Support service pilot proposal has been developed looking at identifying carers of patients in hospital and supporting them through the discharge process and once back home with help and support. They may be new to caring or find themselves having additional caring responsibilities once the person leaves hospital.

A Working Carers Matter project was conducted last year funded by the NHS England Carers programme and looked at carer support within our own workforce across the ICS (now ICB). Findings and recommendations of that work have been taken forward into the newly established ICB and led to raising awareness of carers and the identification and recognition of carers in the workforce, harmonising carer related policies across partner organisations and establishing carer peer support group.

Carers representatives are part of coproduction network in Slough proving carer perspective and input to service development and the ASC transformation programme.

**Disabled Facilities Grant (DFG) and wider services**

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Through DFG funding Slough has been delivering a range of adaptations to a disabled person's property to ensure they can remain independent in their own home. This approach met both the legislative framework provided by HGCRA Act (1996) and the Care Act 2014, including ASC to assess and to arrange for appropriate assistance, including statutory entitlements to community equipment and minor adaptation.

However, following the national DFG Review (Feb 2018) we wanted to take some of the learning from the many examples of good practice, innovation and recommendations and in 2019/2020 commissioned Foundations UK to look at how DFG might can be further used to meet the wider health and social care needs of service users. The aim of this work was to produce a revised operating model, consider the future of how DFG should be delivered and develop pathways to further extend our offer to improve patient flows, promote independence and expand our assistive technology offer. The new policy also allows flexibility to support adaptations which breach the 30k limit increasing the reach of the grant.

There has since been updated guidance on DFG released in 2022 which has further informed our approach to DFG delivery. Through the proposed new Housing Assistance Policy our ambition is to transform these services from a fairly rigid DFG technical-based service to one which is more flexible and timely allows us to be more influential in terms of prevention, especially around hospital discharge and care home placement prevention to help disabled and vulnerable people to remain living independently at home for as long as they wish, and it is safe for them to do so.

Slough also wanted to be able to promote greater resident choice regarding the adaptations completed in their home and ensure they are happy with the service they receive. The service has been based upon technical surveyors with some support staff and provided very limited opportunities for individual support to those customers who needed help to navigate the often complex process of applying for a DFG. This led to delays and complaints from residents as well as increased work for the Occupational Therapy team who are trying to support customers without any clear remit or understanding of the DFG process.

The new DFG policy is currently going through internal governance routes and is planned to be presented at cabinet in November. Once implemented it will provide a more personalised approach to people who require adaptations that is based more individual needs and will remove barriers wherever possible. This moves away the traditional more 'technically-based' DFG service to that which is more customer focussed and personalised, whilst retaining the necessary core technical skills for more complex work such as those which require building adaptations.

The DFG capital grant allocation from Government for Slough in 2022-23 is £1,140,680 and this is expected to maintain this level of investment and possibly increase further in the future. The anticipated staffing requirements to deliver the full DFG spend within budget is approximately 2 full-time technical officers and 2 caseworker type roles along with administrative and management support. The 2008 Services and Charges Order allows the charging of fees for technical and OT services for preparing and delivery of DFG and therefore the proposal is that the posts should be capital funded from the DFG allocation on a fixed fee basis.

The current Independent Living Team is located within Adult Social Care, albeit as a separate team. This provides us with significant opportunity to more closely integrate social care and adaptation services and reduce overall delivery costs. A significant amount of the works will not require technical input and will be directly appointed/ordered by the assessing OT or appropriate support staff; including all stairlifts and hoists and ramp works. As Adult Social Care already provides support to residents those support roles will to be increased and enhanced to include support for the casework side of applying for a DFG. Technical skills will still be available for DFG work but these will also be within the Adult Social Care structure providing better response and outcomes for residents whilst still having oversight of standards and quality of work. To ensure a consistent, person-centred approach to the delivery of aids and adaptations we will also be moving toward both the clinical and technical side to DFG to sit within single manager under the OT service manager's remit.

**Equality and health inequalities**

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

In 2019 Frimley ICS established its strategy Creating Healthier Communities in which reducing Health Inequalities is at the heart of the approach and forms one of two overarching objectives for the programme. These are to increase overall life expectancy and reduce the differences in healthy lives lived of our residents.

This programme adopts a clear methodology using our shared population health data generated from the Connected Care platform looking at disparities of health outcomes for evidence of variation between social groups, populations with protected characteristics, geography within the system and comparisons with other healthcare systems. Within this methodology is the CORE20+5 approach looking for clinical areas requiring accelerated improvement within 20% of the most deprived cohort of our population.

Examples of health inequalities being addressed across Frimley ICB:

Living Well

- Our detection of known and unknown residents with hypertension is one of the lowest in the South East Region. If this variation is addressed, an estimated 147 heart attacks and 220 strokes could be avoided each year in the Frimley population as a whole. We have multiple projects and pilots underway in our Places with the greatest identified need to address this
- Ethnic minorities living in Britain are at higher risk of a number of smoking related diseases than white Britons. Those already more susceptible to these diseases further increase their chances of ill health if they smoke. On average, people of black African, black Caribbean and South Asian descent in the UK have strokes earlier on in their lives, with black people twice as likely to suffer a stroke overall. We are working with FHFT to implement a new smoking cessation service which will support 7,500 patients per year to give up smoking.

Starting Well

- Obesity rates in UK primary school children saw their ‘highest annual rise’ in 2020-21 with children living in ‘the most deprived areas’ more than twice as likely to be obese than those in more affluent locals. According to NHS Digital, the prevalence

of obesity is more than double for children living in 'the most deprived areas' at 20.3% versus those living in the 'least deprived' at 7.8%. To tackle this growing issue, we are investing in a childhood obesity programme which can be targeted at our communities which have children who would benefit most from this intervention.

The link between deprivation and challenging housing conditions with poor health is particularly true in Slough. Life expectancy is significantly below the national average and women on average can expect to live the last 24 years of their life in poor health (compared to 20 years on average in England), while men can expect to live the last 18 years of life in poor health (compared to 16 years in England).

Reducing health inequalities is central to the work of the Slough Wellbeing Board and also the newly published Slough Corporate Plan. Key health and wellbeing challenges for the borough include ensuring a healthy start to life, improving childhood obesity, oral health, smoking, physical inactivity, diabetes, TB, alcohol and substance misuse, mental health issues and early deaths from cardiovascular disease.

Locally a Health Inequalities group was formed following the covid pandemic and the BAME programme which highlighted the greater impact on communities and groups within Slough's diverse population. This group has recently taken forward work on Community Wellbeing Champions (understanding vaccine hesitancy and promoting vaccination take up), the mobile outreach to vulnerable group over the winter period as well as the population health work at PCN with our designated GP lead on health inequalities.

BCF contributes directly towards services that support people with weight management and offer an integrated cardio-wellness service identifying people at risk of cardio-vascular disease and hypertension

This year full investment into OT/SALT service supporting young people with disabilities in schools across Slough. There is significant delay in being able access SALT services in Slough which impacts on the children and family carers. The proposal adopts a whole school system approach to ensure earlier identification and intervention. Through adopting proactive practices, the child can be supported at a lower level by the school within a highly skilled and competent educational environment and reducing demand on statutory services. Schools will be trained to use a whole classroom approach so all children and young people have the best start in life. Where more individual focus is required, by working alongside Educational Psychologist and school SENCO leads. We anticipate stemming the demand on statutory service provision over the short to medium term.

Earlier this year we ran a Mobile Family Health Clinic pilot for two months supported with winter surge funds. This was an integrated approach and was successful in helping to reach into communities to provide health checks and information and advice to around 330 people, around 10% hadn't seen a GP for over 5 years. 30% of people were unaware of underlying medical conditions and encouraged them to have early diagnosis and treatment.

The next phase of this work is a roadshow/outreach model of support to young mothers, those who are pregnant or planning for a baby and proposal in development to run a series of outreach evenings in the community providing information and advice. Evaluation of this next phase will form part of the learning and evidence gathering for the children's hub to be established in the new year.

In this past year Slough piloted a Diabetes Telehealth monitoring programme working with an independent digital health management provider to support people with chronic diabetes to understand the manage their condition. Using a digital platform on a tablet the person would take and enter their daily readings to ensure that stayed within set thresholds and parameters. A regular telephone check in from a diabetic nurse provided personalised support. This has now been taken up across the wider ICB supported by the Digital programme. Working with new IT development partners, Docobo, to support patients using handheld tablets to provide remote monitoring to diabetes hub providing digital health management and support to help people better manage their diabetes

Digital support to Care Homes – as part of the enhanced healthcare in care home programme. A pilot project is being rolled out with Docabo healthcare technology to support care staff and clinical leads with digital health care management of residents.

Population Health Management – a case study has been completed in SPINE PCN looking in detail of a PCN population and the correlation between deprivation and health. This looked at an age cohort with 2-3 chronic conditions living in area of high deprivation. Early insight is highlighting significant differences in levels of support with the population and looking at how we can work through local community champions to raise awareness, engage and understand experiences to address barriers to access and improve health outcomes.

A recent focus on improving healthchecks through Learning Disability recording on GP registers – practices have been working to review, improve and increase the recording of people with a learning disability or Autism on their registers. 156 new patients were coded, a 16% increase. This work is vital to ensure that that Learning Disability Annual Health Checks are reaching our population helping to reduce health inequalities, and that reasonable adjustments are made to enable this cohort to access timely and relevant health support as and when required.

Our Stroke support services commissioned with the national Stroke Association provide essential support to stroke survivors and their families. A particular strength of the service has been to support people to maintain or return to employment and/or access to benefits which promotes mental health and wellbeing and mitigating some of the impact of stroke on their lives.

BCF has supported Browns service locally with some one-off funding to help support homeless people. There has also been primary care funds to enhance the currently primary care clinical support we offer rough sleepers and homeless through a pilot project of a Mental Health dual diagnosis worker.

We have an integrated approach to the coordination and support to our asylum seeker hotel (temporary contingency accommodation) and to those dispersed into local housing accommodation in the borough working together with primary care, voluntary sector providing navigation support to local services and advice.

Mental Health research work is currently being carried through the Slough Council for Voluntary services (SCVS) on understanding the barriers to accessing mental health support services particularly across particular groups within the BAME community where numbers of people connecting to services are low.

There is a proposal for Dementia Care Coordinator role being scoped and developed currently and is aimed at improving diagnosis rates and reaching communities where there are lower rates compared with expected prevalence. It will also be a role bringing together partners across the

wider community looking at ways through which to promote the development of Slough as 'dementia friendly' town.

BCF investment was made into a AccessAble guide to Slough town which is an online resource giving detailed access information on a wide range of venues, site and locations. These include libraries, restaurants, health centres, leisure facilities, shops etc. This provides essential information to people with disabilities, sensory needs, wheelchair users enabling them to look at access information and plan their visit and facilities available before leaving home.

**Better Care Fund 2022-23 Template**

**Metrics**

Slough Wellbeing Board

**Avoidable admissions**

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000 population) | Rate per 100,000 | 113.0 | 107.0 | 111.0 | 90.2 | Ambition is modelling activity in last year through proactive work in community in Care Homes, LAP and ICDM looking to impact at least 3% improvement Q1 and Q2 and increasing to 5% Q3 and Q4. New pathways and services (Urgent Care Response and virtual wards) have come on line and will further impact through this year. Anticipatory care of people with chronic conditions helping proactive identification through Connected Care (risk stratification) and intervention in community MDTs. | Embedding the Urgent Care Response pathways and support in Slough.<br>Operation of the Local Access Point for coordinating same day integrated assessment and response.<br>Anticipatory Care Planning and proactive approach to people with people with moderate frailty<br>MDT cluster meetings in PCN localities for management of people with complex and chronic conditions<br>Increased capacity in Intermediate Care for step-up from community |
| | Numerator | 169 | 160 | 166 | 135 | | |
| | Denominator | 149,600 | 149,600 | 149,600 | 149,600 | | |
| | | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan | 2022-23 Q4 Plan | | |
| | Indicator value | 110 | 104 | 106 | 85 | | |

**Discharge to usual place of residence**

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence | Quarter (%) | 93.3% | 92.6% | 92.3% | 91.7% | Q1 taken from SUS data pack. Ambition reflects activity last year and anticipated increase from actual Q1 figures. Achieving a rate of 92.8% represents a stretch particularly with significant system pressure to maintain capacity and flow through the hospital and interim placements/step down to alternative care settings are being commissioned and used as part of the D2A pathway. However, the review of intermediate care services in this year presents opportunity for additional capacity and support more people back to their home with reablement and OT support | Plan to improve on 21-22 to achieve a minimum rate of 92.8% and be higher than the national average for Welbeing boards. Improve and extend reablement offer to support more people to return home. D2A packages of support people with Home First Approach. |
| | Numerator | 2,687 | 2,625 | 2,581 | 2,409 | | |
| | Denominator | 2,880 | 2,836 | 2,797 | 2,626 | | |
| | | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan | 2022-23 Q4 Plan | | |
| | Quarter (%) | 91.4% | 92.4% | 92.8% | 92.8% | | |
| | Numerator | 1,953 | 2,126 | 2,368 | 2,145 | | |
| | Denominator | 2,136 | 2,301 | 2,551 | 2,312 | | |

**Residential Admissions**

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and | Annual Rate | 488.5 | 478.5 | 478.5 | 469.0 | Maintain at previous plan rates against an increasing older population and increasing acuity of patients discharged from acute hospital. | Review and reconfiguration of reablement and intermediate care services creating more capacity and greater rehab focus. Integrated Care Teams, Local Access Point, virtual wards and |
| | Numerator | 76 | 76 | 76 | 76 | | |
| | Denominator | 15,557 | 15,884 | 15,884 | 16,205 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| nursing care homes, per 100,000 population | | | | | | | Urgent Care response supporting people with complex care needs |

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England: https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

## Reablement

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 76.6% | 65.2% | 78.9% | 78.2% | Slough's ambition to increase number of discharges into reablement services and enhance and extend the reablement capacity for both hospital discharges and step up support for referrrals from the community | Review of reablement services has been completed and in to consultation phase. Plan to go live from Nov 22. Will provide greater capacity and increase numbers into reablement on discharge and from community. |
| | Numerator | 36 | 43 | 56 | 61 | | |
| | Denominator | 47 | 66 | 71 | 78 | | |

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| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Area of Spend | Commissioner | Provider | Source of Funding | Expenditure (£) | New/ Existing Scheme |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Stroke Support Service | Stroke support service for stroke survivors and their families | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as anticipatory care | Social Care | LA | Charity / Voluntary Sector | Minimum NHS Contribution | £57,000 | Existing |
| 2 | Dementia Care Advisor | Post-diagnosis support for people with dementia and their carers | Community Based Schemes | Other | Mental Health | LA | NHS Community Provider | Minimum NHS Contribution | £30,000 | Existing |
| 3 | OT/SALT whole system transformation | OT/SALT support for children and young people | Enablers for Integration | Integrated models of provision | Community Health | LA | NHS Community Provider | Minimum NHS Contribution | £137,000 | Existing |
| 4 | Integrated Wellbeing Service | Range of primary prevention support for health and wellbeing inc. cardio and falls | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as anticipatory care | Social Care | LA | Private Sector | Minimum NHS Contribution | £241,000 | Existing |
| 5 | Telecare | Assistive Technology to maximise independence at home | Assistive Technologies and Equipment | Telecare | Social Care | LA | Private Sector | Minimum NHS Contribution | £72,000 | Existing |
| 6 | RRR service (Reablement, Recovery, Rehabilitation) | Intermediate Care | Reablement in a persons own home | Other | Social Care | LA | Local Authority | Minimum NHS Contribution | £2,858,239 | Existing |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 7 | Hospital Social Work Team | Discharge to Assess | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | Social Care | LA | Local Authority | Minimum NHS Contribution | £484,000 | Existing |
| 8 | Joint Equipment Service | Disability aids and mobility equipment | Assistive Technologies and Equipment | Community based equipment | Social Care | CCG | Private Sector | Minimum NHS Contribution | £710,802 | Existing |
| 9 | Joint Equipment Service | Disability aids and mobility equipment | Assistive Technologies and Equipment | Digital participation services | Social Care | LA | Private Sector | Minimum NHS Contribution | £130,000 | Existing |
| 10 | Nursing Care Home Placements | Nursing Care Home Placements | Residential Placements | Nursing home | Social Care | LA | Private Sector | Minimum NHS Contribution | £500,000 | Existing |
| 11 | Proactive frailty management | Anticipatory care planning and early intervention | Integrated Care Planning and Navigation | Care navigation and planning | Primary Care | CCG | CCG | Minimum NHS Contribution | £114,000 | Existing |
| 12 | Care Homes Programme Manager | Care Home quality programme | Enablers for Integration | Programme management | Community Health | CCG | CCG | Minimum NHS Contribution | £25,000 | Existing |
| 13 | Integrated Care Services / ICT | Community Health and Integrated Care Teams | Community Based Schemes | Multidisciplinary teams that are supporting independence, such as anticipatory care | Community Health | CCG | NHS Community Provider | Minimum NHS Contribution | £868,412 | Existing |
| 14 | Intensive Community Rehabilitation | Community Health led rehabilitation service | Reablement in a persons own home | Reablement to support discharge -step down (Discharge to Assess pathway 1) | Community Health | LA | NHS Community Provider | Minimum NHS Contribution | £82,000 | Existing |
| 15 | Intensive Community Rehabilitation | Community Health led rehabilitation service | Reablement in a persons own home | Reablement to support discharge -step down (Discharge to | Community Health | CCG | NHS Community Provider | Minimum NHS Contribution | £195,407 | Existing |

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|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Assess pathway 1) | | | | | | |
| 16 | Responder Service | First response service | Prevention / Early Intervention | Other | Social Care | LA | Private Sector | Minimum NHS Contribution | £130,000 | Existing |
| 17 | High Impact Change Delivery (D2A) | Discharge to Assess/ interim support | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | Social Care | LA | Local Authority | Minimum NHS Contribution | £284,200 | Existing |
| 18 | Systems reslience | Discharge to Assess - system monitoring and trusted assessment | High Impact Change Model for Managing Transfer of Care | Monitoring and responding to system demand and capacity | Acute | CCG | NHS Acute Provider | Minimum NHS Contribution | £97,016 | Existing |
| 19 | Community D2A beds (Windmill) | Community interim beds supporting discharge | High Impact Change Model for Managing Transfer of Care | Home First/Discharge to Assess - process support/core costs | Social Care | LA | Private Sector | Minimum NHS Contribution | £129,572 | Existing |
| 20 | Integrated Care Decision Making and Local Access Point (SBC) | Integrated Care - cluster, locality access point | Integrated Care Planning and Navigation | Assessment teams/joint assessment | Social Care | CCG | Local Authority | Minimum NHS Contribution | £283,656 | Existing |
| 21 | Integrated Care Decision Making and Local Access Point (BHFT) | Integrated Care - cluster, locality access point | Integrated Care Planning and Navigation | Assessment teams/joint assessment | Community Health | CCG | NHS Community Provider | Minimum NHS Contribution | £194,953 | Existing |
| 22 | Community Integration Manager | Management of Integrated Care Decision Making and Locality Access | Enablers for Integration | Integrated models of provision | Community Health | CCG | CCG | Minimum NHS Contribution | £83,430 | Existing |

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| | | Point | | | | | | | | |
| 23 | Disabled Facilities Grant | Aids and adaptations | DFG Related Schemes | Adaptations, including statutory DFG grants | Social Care | LA | Local Authority | DFG | £1,140,680 | Existing |
| 24 | Connected Care | Shared Care Records | Enablers for Integration | System IT Interoperability | Other | CCG | Private Sector | Minimum NHS Contribution | £200,000 | Existing |
| 25 | Winter Pressures (SBC) | Additional capacity SW and OT | Personalised Care at Home | Physical health/wellbeing | Social Care | LA | Local Authority | Minimum NHS Contribution | £180,000 | Existing |
| 26 | Carers Support | Carers support services | Carers Services | Other | Social Care | LA | Local Authority | Minimum NHS Contribution | £216,000 | Existing |
| 27 | End of Life Care Advice line | Advice and support to families and carers 24/7 | Personalised Care at Home | Physical health/wellbeing | Community Health | LA | Charity / Voluntary Sector | Minimum NHS Contribution | £148,206 | Existing |
| 28 | Paediatric Hotline | Telephone advice to GPs with paediatric consultant support | Personalised Care at Home | Physical health/wellbeing | Acute | CCG | NHS Acute Provider | Minimum NHS Contribution | £48,181 | Existing |
| 29 | End of Life nightsitting service | Night sitting as part of EOLC service | Carers Services | Respite services | Social Care | CCG | Charity / Voluntary Sector | Minimum NHS Contribution | £15,971 | Existing |
| 30 | Community Capacity (voluntary sector) | Support to the community and voluntary sector | Community Based Schemes | Integrated neighbourhood services | Social Care | LA | Charity / Voluntary Sector | Minimum NHS Contribution | £218,000 | Existing |
| 31 | Information and Advice service | Information and Advice | Community Based Schemes | Integrated neighbourhood services | Social Care | LA | Charity / Voluntary Sector | Minimum NHS Contribution | £140,000 | Existing |

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| 32 | Programme Management Office | Programme Management Office functions | Enablers for Integration | Programme management | Social Care | LA | Local Authority | Minimum NHS Contribution | £170,000 | Existing |
| 33 | Integration Delivery Lead | BCF and integration programme lead | Enablers for Integration | Programme management | Social Care | CCG | CCG | Minimum NHS Contribution | £90,000 | Existing |
| 34 | Care Act Funding | Supporting delivery of Care Act requirements | Care Act Implementation Related Duties | Other | Social Care | LA | Local Authority | Minimum NHS Contribution | £296,000 | Existing |
| 35 | Additional social care protection | Additional Social Care protection maintaining capacity | Personalised Care at Home | Physical health/wellbeing | Social Care | LA | Local Authority | Minimum NHS Contribution | £798,291 | Existing |
| 36 | Improved Better Care Fund | iBCF grant funds to LA | Enablers for Integration | Integrated models of provision | Social Care | LA | Local Authority | iBCF | £3,989,414 | Existing |
| 37 | Funds to be allocated | | | | | | | Minimum NHS Contribution | £374,342 | New |

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**SLOUGH BOROUGH COUNCIL**

**REPORT TO:** Slough Wellbeing Board

**DATE:** 20th September 2022

**CHIEF OFFICER:** Stuart Lines, Director of Public Health

**CONTACT OFFICER:** Jonathan Lewney, Deputy Director of Public Health
Author: Rebecca Willans, Consultant in Public Health

**PART I**

**FOR CONSIDERATION AND COMMENTS**

# FINAL PRESENTATION OF SLOUGH'S 2022-2025 'PHARMACEUTICAL NEEDS ASSESSMENT (PNA)'

## 1. Purpose of Report

The purpose of this report is to appraise the Slough Wellbeing Board (SWB) of the conclusions of the Slough Pharmaceutical Needs Assessment (PNA) 2022-2025. The report is also to ensure the Board acknowledged that sign off of the PNA has been delegated to Stuart Lines, Director of Public Health for Slough Borough Council and member of this Board to ensure the PNA was published by the statutory deadline of the 1st October 2022.

## 2. Recommendation(s)/Proposed Action

That the Slough Wellbeing Board (SWB):

2.1 Acknowledges the Slough PNA 2022-2025 has been signed off for publication by Stuart Lines, Director of Public Health for Slough Borough Council.

2.2 Notes that if significant changes occur during the lifespan of the PNA, the SWB will be notified.

## 3. The Slough Joint Wellbeing Strategy, the JSNA and the Five-Year Plan

The Slough Joint Wellbeing Strategy (SJWS) details the priorities agreed for Slough with partner organisations. The SJWS has been developed using a comprehensive evidence base that includes the Joint Strategic Needs Assessment (JSNA) 2016-2020.

## 3a. Slough Wellbeing Strategy Priorities

Since April 2013 local Health and Wellbeing Board has been given a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area.

Development of PNA across Slough will support and inform the Slough Joint Wellbeing Strategy (SJWS) priorities.

The SJWS priorities are:
1. Starting Well
2. Integration (relating to Health & Social Care)
3. Strong, healthy and attractive neighbourhoods
4. Workplace health

## 3b. Five Year Plan Outcomes

*Explain which of the Five-Year Plan's outcomes the proposal or action will help to deliver.*

PNA will particularly contribute to the following three outcomes laid in Slough's Five Year Plan:

- Outcome 1: Slough children will grow up to be happy, healthy and successful – through direct provision of national and locally commissioned services
- Outcome 2: Our people will be healthier and manage their own care needs– through direct provision of national and locally commissioned services
- Outcome 5: Slough will attract, retain and grow businesses and investment to provide opportunities for our residents - through the securing of appropriate services delivered through ongoing pharmaceutical businesses in the Slough area

## 4. Other Implications

(a) Financial

There are no financial implications of proposed action.

(b) Risk Management (Compulsory section to be included in **all** reports)

There are no risks as this report is for information only.

(c) Human Rights Act and Other Legal Implications (compulsory section to be included in **all** reports)

There are no Human Rights Act implication.

(d) Equalities Impact Assessment

An EIA is not necessary, but the result of PNA will augment and strengthen the SBC Equality duty through a refreshed needs assessment of pharmaceutical service provision in the area and the ability it affords to understand current population needs – including the needs of Slough residents with protected characteristics as set out in the Equality Act.

(e) Workforce

The Slough PNA 2022-2025 has been delivered by a commissioned provider, Healthy Dialogues, with support from a PNA steering group chaired by a Consultant in Public Health from the Berkshire East Public Health Hub. Slough Borough Council staff (public health and communications) have been engaged in the planning for and delivery of the public engagement survey and in the consultation but otherwise, delivery has had limited impact on workforce of the council.

Once the PNA is published, it is not anticipated that there will be demands on local public health or wider council involvement over and above existing contributions to work with primary care as part of the Integrated Care System.

There are therefore no workforce implications identified.

5. **Supporting Information**

**(a) *Background***

As outlined in the Health and Social Care Act 2012 – as of the 1st April 2013 every Health and Wellbeing Board (HWBB) has had statutory responsibility to publish, and keep up to date, a statement of the needs for pharmaceutical services in their area. This is referred to as the Pharmaceutical Needs Assessment (PNA). The first PNA had to be published on the 1st April 2015 and revised every three years after that, or sooner if a HWBB is made aware of a need to do so. Otherwise, supplementary statements may be published for small changes. This requirement was updated in statute in response to workforce capacity demands associated with the COVID-19 pandemic, allowing publication of the current revised PNAs by the 1st October 2022, rather than April 2022.

The PNA process is statutorily defined, including details such as when the PNA must be published, the PNA methodology and the requirement to undertake a 60-day consultation process. It is also strongly recommended that a PNA steering group is formed to support the HWBB in delivering the PNA.

**Management and delivery of Slough's PNA 2022-2025**

Typically, Directors of Public Health (DPH) are delegated as the lead HWBB member responsible for overseeing the PNA. In Berkshire, the two DPHs for the six local authorities in the area agreed to commission the production of the six Berkshire PNAs to a third-party provider. This was to ensure timely delivery, to a good standard, mitigating against the COVID-19 pandemic pressures on local public health teams. The provider was selected based on a three quotes process with a 60:40 quality: price ratio. Healthy Dialogues won the contract and have delivered the six Berkshire PNAs (including for SWB). The service specification that Healthy Dialogues delivered to included responsibility for undertaking the statutory PNA processes and writing of the PNAs.

Management of the contract with Healthy Dialogues was delegated to the Berkshire East Public Health Hub. There is also a Berkshire West Public Health Hub that supports Reading, Wokingham and West Berkshire local authorities, however for the purpose of managing the PNA provider, one of the hubs was nominated.

It is considered best practice to establish a PNA steering group early in the PNA process to advise on and quality assure the PNA production process and comment on draft versions of the PNA report, particularly pre consultation. Healthy Dialogues were therefore supported by a single Berkshire PNA steering group.

Members of the Berkshire PNA steering group included Thames Valley Local Pharmaceutical Committee (LPC), a Consultant in Public Health from the Berkshire East Public Health Hub; a regional representative from NHS England; Healthwatch (all six Healthwatch teams were invited to attend); a representative from Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS) and one from Frimley ICS, and a patient and public representative (a volunteer from one of the Healthwatch teams).

The Consultant in Public Health was the conduit between Healthy Dialogues and the local authority public health teams, responsible for updating the teams on the delivery and quality of the PNAs as they were developed. The Consultant also signposted Healthy Dialogues to staff in each local authority to ensure the public survey was appropriately targeted to the local community, especially local priority groups relevant to the PNA.

Healthy Dialogues produced a PNA delivery plan, which was signed off by the PNA steering group and the group met approximately once every six weeks to discuss the PNA assessment process at each stage. Key decisions of the steering group have included:

- A request for Healthy Dialogues to produce a public engagement survey relevant to each local authority's population.
- Approval for Healthy Dialogues to apply two commonly used measures to assess the adequacy of access to pharmacies within each local authority area, including a one mile walk and a 20-minute drive of a pharmacy. The former measure is typically used in urban areas and the latter is more often used in rural areas. There is no statutorily defined access measure, nor are any indicated in national guidance; the measures used need to balance the need at a population level for good access to pharmacy services, with the population size within a given radius to sustain a community pharmacy service.
- Approval of the draft PNAs to be published for their 60 day consultation, following a period of feedback from the PNA steering group to enhance the quality and accuracy of the reports.

In addition to this governance mechanism, the Health Intelligence leads for each of the Berkshire public health hubs reviewed the draft PNAs relevant to their local authority areas for accuracy of the population demographic and health needs.

It is under the oversight of these governance mechanisms that the Slough PNA was produced. The methodology applied by Healthy Dialogues followed the mandated stages for PNA development, including gathering of health and demographic data, public and contractor engagement, gathering information about pharmaceutical services currently in place in the local authority area, analysis and drafting of the PNA report, review by the PNA steering group and sign off as draft for the 60 day consultation, delivery of the consultation and, refining of the PNA based on consultation feedback to finalise for the SWB.

**(b) *Conclusions of the Slough PNA 2022-2025***

This process has led to the following conclusions in the Slough PNA:

- Slough is well served in relation to the number and location of pharmacies. There are 31 community pharmacies within the borough and 1 distance selling pharmacy. There are a further 7 community pharmacies located within a mile of Slough's border.
- There are no gaps in the provision of: essential, advanced (NHSE commissioned) and other pharmacy (locally commissioned) services in Slough.

## 6. Comments of Other Committees

NA

## 7. Conclusion

SWB's PNA 2022-2025 was delivered by a commissioned provider, Healthy Dialogues, with a Berkshire PNA steering group as the main governance mechanism to ensure the quality of the process and contents of the final PNA.

The Slough PNA 2022-2025 is complete and concluded that there are no gaps currently or foreseeable gaps in the lifetime of the PNA regarding access to essential, advanced (NHSE commissioned) and other pharmacy (locally commissioned) services in Slough.

The PNA required sign off and publication by 1st October 2022. This took place through delegated responsibility to the Director of Public Health for Slough and lead member of SWB for the PNA to ensure publication by 1st October 2022.

## 8. Background Papers

Slough PNA 2022-2025 Final (Appendix A)
Slough PNA Survey Engagement Plan (Appendix B)

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# SLOUGH PHARMACEUTICAL NEEDS ASSESSMENT SURVEY ENGAGEMENT PLAN

As part of the Pharmaceutical Needs Assessment for Slough, patient and public engagement in the form of a survey was disseminated. The survey helped us to understand how people use their pharmacies, what they use them for and their views of the pharmacy provision. The survey was approved for use with the local population by the Berkshire PNA Steering Group which included representation from Healthwatch, communications teams and a patient representative.

The survey was open from the 13th of January 2022 until the 4th of March 2022 and was published on the following channels:

- Berkshire Public Health webpage
- Slough Borough Council website
- Frimley Health & Care: Survey had been shared with PPG and the GP- ebulletin
- Frimley Health & Care engagement and survey webpage
- Social media posts were shared on Twitter and Facebook by Slough communications team
- One Slough Community Champions: survey was shared during a team meeting (10/2/21) and agreed to be included in community champions e-newsletter.
- Survey shared by the CVS communications team on socials (Facebook & twitter), and via an e-newsletter to residents.
- Survey was shared via Slough Faith Partnership on Facebook.
- Survey was circulated to Asian community group via WhatsApp

In addition, a targeted approach was agreed by the steering group to reach seldom heard groups and encourage their participation in the survey. The targeted approach is outlined below.

## Targeted approach

| Target population group | Approach |
|---|---|
| **Parents of children with SEND** | The survey had been shared on the 'Special Voices' forum and Facebook page.<br>The survey had also been shared on the Facebook page for Early Years parents. |
| **ESOL Groups** | The survey had been shared with the adult learning college in Slough and the RBWM. |
| **Young people** | Survey was sent to Aik Saath with wording. This was shared across their network. |

| | |
|---|---|
| | Slough for Youth had shared the survey to their members via text messaging and emails. |
| **Care home residents/ Older people's groups/digitally excluded** | Survey and wording had been sent to carers network (500 registered) and care home managers. The survey has also be put onto their fortnightly newsletter. |

A total of 131 responses were received. These responses were presented in Chapter 6 of the PNA.

**Slough Borough Council**

| | |
|---|---|
| **Report To:** | Slough Wellbeing Board |
| **Date:** | 20th September 2022 |
| **Subject:** | Strong, Healthy & Attractive Neighbourhoods update |
| **Chief Officer:** | Richard West – Executive Director Place and Community |
| **Contact Officer:** | Liz Jones – Group Manager Localities and Neighbourhoods |
| **Ward(s):** | |
| **Exempt:** | No |
| **Appendices:** | None |

## 1. Summary and Recommendations

This report sets out an update on the work to support the strong, healthy, and attractive neighbourhoods priority.

**Recommendations:**

Committee is recommended to note the contents of this update.

**Commissioner Review**

*[Sign off from the Commissioner(s) is required for all reports and any comments are to be recorded in the report. Commissioners must have reports one week before agenda publication to sign off. Legal and finance must have signed off reports before being sent to Commissioners.]*

## 2. Report

**Introduction**

The Wellbeing Board priority to support Strong, Healthy and Attractive Neighbourhoods helps the Council to meet one of the corporate priorities to have *an environment that helps residents live more independent, healthier, and safer lives*.

The corporate plan recognises that disparities in the length of life expectancy and healthy life expectancy between Slough's most deprived areas and the national average are perhaps the most serious impacts of poverty for our residents. We will aim to reduce these inequalities while also improving healthy life expectancy rates for everyone in the town, enabling our residents to live healthy lives and reach their full potential. Our approach will be to support residents to be as independent as possible whilst still ensuring we will be provider of services for the most vulnerable.

**Background**

Partnership work with, and to support our communities continues despite the financial challenges faced by Slough Borough Council. The strong partnerships forged to respond to the impact of Covid-19 on our neighbourhoods are the foundation for the work currently being delivered. A number of local organisations continue to work together under the #OneSlough umbrella, and this update describes the current priorities being delivered.

This partnership work extends to financially supporting the council officers who manage, deliver and co-ordinate these projects.

Although this work is not providing a statutory service (although the Safer Slough Community Safety Partnership is a statutory partnership), it supports the work of the council to empower and engage with individual residents and community groups. This empowerment and engagement aims to encourage self-help, deliver preventative programmes to reduce the need for acute interventions and develop self-reliance and resilience within Slough's communities to reduce their call on council services.

Strong, Healthy & Attractive Neighbourhood (SHAN) engagement
When the SHAN workstream began it was led by the council's Community Development Team from the community engagement stage through to implementation and delivery of neighbourhood action plans. Over the past year this model has changed, and the Community Development Team identify key neighbourhood stakeholders (for example, Parish Council, existing resident groups etc) to work with to deliver the initial engagement, analyse the results, develop an action plan to address the local priorities and then deliver these actions.

The first two SHAN areas were Chalvey and Colnbrook with Poyle. Both community action plans are now owned and delivered by local stakeholders (Chalvey Community Partnership and Colnbrook with Poyle Parish Council).

The Chalvey Community Partnership held a very successful "Chalvey Action Week" in July, which saw planters painted by the local schools and a Family Fun day at the Riverside Centre which included water safety education. The Partnership was awarded £2.5k to continue the allotment project which gives families advice and guidance on what seasonal vegetables and fruit to plant, grow and cook.

In Colnbrook with Poyle the Parish Council have funded the council's Community Youth Work team to work in the ward with groups of young people to reduce fear of crime and anti-social behaviour.

The second tranche of SHAN engagement was carried out in Britwell and Baylis & Stoke wards. In Britwell the focus of the engagement was around how residents would like to see the medical centre develop at the community hub. The new Britwell Community Forum met in mid-August to plan how they are going to work on the priorities resident's identified.

In Bayliss & Stoke ward there has been a successful Community Get Together event plus specific activities to encourage women to be physically active, a general introduction to using the Green Gym, 4 Health MOT check-up sessions delivered and a police/resident surgery.

SHAN engagement work with local residents and stakeholders has begun in four areas during 2022. These are Wexham Lea, Central, Cippenham (both Cippenham Green and Cippenham Meadow) and Langley (Foxborough, Langley Kedermister and Langley St

Mary's). This round of engagement work is focussed on social determinants of health inequality (e.g., low income, poor housing, social isolation etc.) to link with the pilot project between Primary Care Networks and Community Development (see below). Engagement responses will be analysed in early October 2022, and these will be used to co-produce action plans in each area.

Over the autumn and winter discussions will take place to identify a lead organisation to take ownership of the delivery of the action plan.

Primary Care Network health inequality reduction

Since April 2022 the council's Community Development Team and Slough's Primary Care Networks have been working together in a pilot scheme to reduce health inequality. This pilot has two workstreams; the first is the Community Development Officers receiving patient referrals from Social Prescribers so individual support and guidance can be offered, and the second is to share information about local support and networks with Social Prescribers.

To date over 20 individual referrals have been made to the Community Development Officers. The officers have been able to signpost and support residents with issues around housing, debt, social care, training & skills, social isolation, and loneliness. Work is progressing to allow the Community Development Officers to co-locate to the main GP surgeries to strengthen their relationship with GPs and Social Prescribers.

The work around sharing understanding of local community-based resources has resulted in the development of a #OneSlough online directory of resources. This is a free resource for residents, community groups, and health providers to access that brings all local support across a range of areas to one place. This is now live at OneSlough – Slough Directory or Services (sloughhealth.org) and the Community Development Officers will continue to develop and refine this with input from partner organisations.

This pilot project will end in March 2023 and negotiations have begun to explore continuing this work beyond this date.

Cost of living crisis

#OneSlough recognise that the most immediate and serious cause for concern for most residents is the cost-of-living crisis. A resource pack which brings together information about food, fuel, and financial support available locally will shortly be finalised and will be available on www.slough.gov.uk website. Community Development Officers will update this free resource every 12-weeks to ensure that it is up-to-date with any new initiatives at a local, regional, or national level.

The #OneSlough partnership also recognised that many organisations were offering support and help to alleviate the worst aspects of poverty in Slough. However, this wasn't well co-ordinated and there was an acknowledged risk that gaps in services could develop in addition to some duplication of effort. To mitigate this risk a new "Poverty Action Group" has been created. This group holds a monthly on-line forum and manages a mailing list of over 100 partner organisations. The forum and regular newsletters co-ordinate and communicate the support and help available to reduce the likelihood of unknown pockets of poverty in the borough with residents not receiving any help with fuel, food, or financial information. In addition, the council's Community Development Officers host a weekly drop-in service for any partner in the Poverty Action Group to either discuss proposals for new work, search out contacts and networks or seek advice about specific cases they are working on.

Examples of how the Action Group has brought about improved collaborative work include a wider appreciation from community groups about the workload of the council's Income and Benefits Team and the realistic timescales for cases to be taken on. Community groups also have better understanding of what support is currently available for residents and how it can be accessed (often this can be done directly without needing to wait for a council team to start the process). There is also improved visibility of the youth engagement work delivered by Aik Saath and other groups (including the small council team) to make sure that young people aren't left behind in receiving support.

The Community Development team have focussed specifically on developing programmes to alleviate food-poverty in the borough. Community Pantries are planned to open at a number of locations across the borough in the coming months. Some will also be offering warm spaces for residents to come and socialise or read the paper. During Covid lockdowns the Community Development team built a good relationship with the "Meals from Marlow" scheme that is able to provide free hot meals to community groups who can then distribute them through their own micro-networks. This scheme is being revitalised in Slough and the Community Development Team are working with their Primary Care Networks to investigate if GPs can refer patients who need emergency help with meals.

Community safety

The Council, in partnership with the Thames Valley office of the Police and Crime Commissioner, Aik Saath, and Lime, secured £513,940 in Home Office funding to help improve feelings of safety in public spaces, with a particular focus on women and girls. The Safer Streets project has focused on Chalvey, where statistically there was more of a need. The project worked with residents and community groups to understand fears and concerns and offer tangible solutions. The work focused on the physical environment, education of young people, and community groups as "capable guardians" in the community.

A new footpath was installed in Chalvey Recreation Ground with 16 solar lighting columns. It has created a circular walk linking the park's entrances and main features, which will encourage use of the park for exercise, increasing footfall and informal guardianship to protect women and girls. Vegetation has been cut back in several alleyways to improve light levels and lines of sight which have received very positive feedback from residents. New bins have been installed in three locations along Chalvey Road West where groups of men congregate. The new bins have a pitched lid making them uncomfortable to sit on and prevent anyone from being able to place drinks, food, and litter on top to discourage loitering. Street Guardians continued to work with community groups to set up a community led Street Guardian scheme, including training of community members and volunteers from Langley College, and the Chalvey Community Partnership has now taken over this scheme. Engagement work has also been done with local secondary schools to build behaviour change interventions to counter violence against women and girls.

The Safe Places Scheme was part of the Safer Streets Project and aims to offer vulnerable people a safe place to go when they need help. This includes women and girls, those who have learning disabilities, are elderly, have a physical disability, or have a mental health problem. The Council worked in partnership with the Chalvey Community Partnership, Thames Valley Police, and local community groups to set up the scheme. Local businesses are encouraged to sign up to the scheme and display a Safe Places sticker in their window to show that is a place where a vulnerable person can go in an emergency. Staff at the businesses will be trained on what to do and can offer a temporary safe haven or make a call to a carer or safe contact on the person's behalf. The Curve, Arbour Park and all other council buildings are already part of the Safe Places

Scheme. A full list of businesses that have already signed up is listed on the council's website and on Chalvey Community Partnership's social media.

In July, the Safer Slough Partnership met to consider the local crime and disorder challenges in Slough, against a background of significant challenge and change. Following a presentation of the local crime picture, the Partnership has agreed to focus on four priority areas, in addition to ensuring it meets its statutory obligations. The priorities chosen were; Violence (that is not Domestic Abuse), Domestic Abuse, Substance Misuse and Anti-Social Behaviour. These were selected on the basis of the significant threat, harm, and risk that each subject presents to Slough. Locally violence levels have increased, and the partnership recognised that with a younger than average population, we must build on our approach to prevention, in order to address future problems.

The partnership recognised that domestic abuse remains under-reported, and that the partnership working with communities can make a significant difference. The partnership recognises that the new 10-year drugs strategy, 'From Harm to Hope', presents a great opportunity to tackle a subject that is intrinsically linked and drives much of the reported and observed crime and disorder in Slough. ASB was selected in recognition that there is a need and opportunity to enhance the partnership approach to personal and environmental ASB (fly-tipping), that blights Slough.

New strategic leads for each priority have been identified, and over the next few months comprehensive partnership plans will be put in place to prevent crime, and tackle those who perpetrate crime.

## 3. Implications of the Recommendation

3.1 Financial implications

The project is funded by existing budgets from Community Development and Community Safety amounting to £0.090m and £0.339m respectively.

3.1.1 The costs of the two Community Development officers are currently 100% funded by the £0.090m grant via the Integrated Care Systems (Frimley) for 12 months up to March 2023. There is a risk that should the project continue beyond March 2023 there will be no available funding for these officers.

3.1.2 The Community Safety posts are funded from the Community Safety base budget of £0.339m and the activity of the project is effectively in-kind type of resource related to their core activities.

*3.2 Legal implications*

The partnership work described in the report assists the Local Authority in meeting its duty under s2 of the Care Act 2014 to prevent needs for care and assistance.

The Health and Wellbeing Board's terms of reference include "*to encourage persons who arrange for the provision of health and/or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the area*."

*3.3 Risk management implications*

| Risk | Mitigation |
|---|---|
| Reduced staff capacity in SBC results in SHAN project stopping. | Securing funding from PCN and demonstrating how SHAN projects assist in reducing health inequality has meant that a core staff resource has been retained.<br><br>The SHAN model has been revised so that at the beginning of each piece of work it is explicit that the implementation of the action plan must be led by a local group to reduce dependency on SBC teams to drive the implementation. Local stakeholders are encouraged and supported to take ownership of the SHAN work in their areas. This makes the work more sustainable as it is not reliant on SBC resource. |
| Community projects to help address issues linked to the cost-of-living crisis are un-coordinated leading to gaps in provision and duplications. | Co-ordination of work is undertaken by #OneSlough. The introduction of the Poverty Action Group, resource guide and weekly Community Development sessions ensures good co-ordination and clear identification of gaps. |
| Work of Community Development and Social Prescribers over-lap creating duplication and inefficiency. | Work is managed and co-ordinated jointly between SBC and Frimley ICS to ensure there is no duplication. Co-location of Community Development Officers in GP surgeries to work closer with Social Prescribers will reduce risk of duplication further. |
| Slough Community Safety Partnership does not address the key safety priorities for the borough. | The strategic review of data, intelligence, and analysis in summer 2022 provided an opportunity for all key stakeholders and statutory partners to contribute to setting new priorities for the next 3-years. |

*3.4 Environmental implications*

The work to prioritise strong, healthy, attractive communities has a number of environmental implications. Engagement with residents often highlights environmental improvements that can be made. In this particular update projects were delivered to improve the physical environment at specific locations in Chalvey. However, these workstreams have a more general impact of encouraging residents and businesses to be proud of their local areas and to use the facilities on offer in their community – parks, schools, businesses, and health provision – rather than travel to use facilities elsewhere. This will not only reduce car travel but encourage communities to care for their environment.

*3.5 Equality implications*

The Safer Streets project was implemented specifically to address the issue of intimidation, harassment, ASB and fear of crime amongst women and girls. This project was supported by analysis by the Thames Valley OPCC that identified that women and girls were disproportionately affected by street-based intimidation and harassment in Chalvey.

The range of resident engagement activity associated with all of these projects helps build a more informed understanding of communities in terms of protected characteristics. Anonymised equalities information about service users is shared among #OneSlough members to improve general understanding of the make-up of the vulnerable parts of our communities.

The pilot work between PCNs and Community Development is aimed to support residents who face of range of issues that result in them facing health inequalities. An Equality Impact Assessment based on the pilot scheme will be created as part of the planning to continue this work beyond 2022/23.

*3.6 Procurement implications*

There are no procurement implications from this report.

*3.7 Workforce implications*

There are no workforce implications from this report.

*3.8 Property implications*

There are no property implications from this report.

## 4. Background Papers

None

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**SLOUGH BOROUGH COUNCIL**

**REPORT TO:** Slough Wellbeing Board

**DATE:** 5th October 2022

**CONTACT OFFICER:** Tom Overend, Strategy & Policy Lead

**(For all Enquiries)** 07871982844

**WARDS:** All

**PART I**
**FOR COMMENT AND CONSIDERATION**

# DRAFT ANNUAL REPORT 2021-22

## 1. Purpose of Report

For the Slough Wellbeing Board to review its Draft Annual Report for 2021-22 (Appendix A)

## 2. Recommendations/Proposed Action

That the Board approve the annual report, subject to any amendments it wishes to make.

## 3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3.1 The work of the Slough Wellbeing Board aims to address the four priority areas outlined in the Slough Wellbeing Strategy 2020-2025:

- Starting Well
- Integration
- Strong, healthy and attractive neighbourhoods
- Workplace Health

3.2 The drat annual report summarises the activity taken by the board to deliver against these priorities in 2021-22.

## 4. Other Implications

(a) Financial

There are no financial implications of proposed action.

(b) Risk Management

There are no risk management implications of proposed action.

(c) Human Rights Act and other Legal Implications

There are no Human Rights Act implications arising from this report. Any specific activity undertaken by the Wellbeing Board which may have legal implications will be brought to the attention of Cabinet separately.

(d) Equalities Impact Assessment

There are no equalities implications arising from this report. Equalities Impact Assessments will be completed for any specific activity undertaken by the Wellbeing Board which may have equalities implications.

## 5. Supporting Information

5.1 The annual report outlines the work the Slough Wellbeing Board has been engaged in over the 2020/21 municipal year.

5.2 It includes updates against the Joint Wellbeing Strategy's four priority areas.

5.3 A short section has also been included covering the workshops that were undertaken with the support of the LGA.

5.4 It should be noted that, due to several disruptions, two of the Board's six planned sessions in 2021-22 were cancelled, so the annual report is more concise than would normally be the case.

## 6. Conclusion

This report is intended to provide the Slough Wellbeing Board with the opportunity to review the draft annual report and make any amendments it feels are required.

## 7. Appendices Attached

A – Draft Annual Report 2021-22

## 8. Background Papers

None.

## Cover page

Slough Wellbeing Board Annual Report

2021-2022

## Table of Contents

*(Showing page titles and page numbers)*

## What is the Slough Wellbeing Board Annual Report?

The Slough Wellbeing Board Annual Report outlines the work of the Slough Wellbeing Board over the previous municipal year. It describes the work the Board was involved in between May 2021 and April 2022.

### The Slough Wellbeing Board

The Slough Wellbeing Board is a partnership between organisations from the public, private and voluntary sector in Slough. The board brings together key organisations in the area to work together to improve the health and wellbeing of Slough residents.

The Wellbeing Board consists of senior representatives from:

- Slough Borough Council
- Berkshire Public Health
- Frimley Health Foundation Trust
- Frimley Collaborative Clinical Commissioning Group
- Slough Council for Voluntary Services
- Thames Valley Police
- Royal Berkshire Fire and Rescue
- Slough Youth Parliament
- The Department of Work and Pensions

In Slough, we have made the decision to widen membership beyond the minimum requirements. This allows us to engage with a greater range of partners and work on a wider range of issues. We have also called our partnership the ‘Slough Wellbeing Board’ rather than the Health and Wellbeing Board, to reflect our chosen focus on wellbeing and the broad impacts this has on a person’s life.

### Health and Wellbeing in Slough: The Context

Slough is a unique area, and as such, faces unique challenges.

The borough of Slough has a total population of around 158,500 people. This population is relatively young, with Slough’s average age estimated to be only 34.8 years. Since the 1930s, people from across the world have made Slough their home, making Slough one of the most diverse authorities in the country.

Located to the west of London, Slough is a densely populated urban area. High levels of personal car use mean there is significant congestion and poor air quality. However, despite the urban nature of the borough and its industrial history, Slough has more than 2.54 square kilometres of parks and open spaces. The council has also recently invested in new leisure facilities, including leisure centres, green gyms, swimming pools and an ice rink.

Slough has pockets of deprivation, and some neighbourhoods offer specific challenges. There are also inequalities in health, primarily between different areas of the borough and between different ethnic groups. Life expectancy in Slough is lower than the average for the rest of the South East, and physical inactivity, cardiovascular disease, obesity and diabetes are high. Slough also has high-rates of preventable ill health amongst children - including obesity, tooth decay and higher levels of hospital admissions for long-term conditions such as asthma.

This health and wellbeing context became even more significant during the COVID-19 outbreak, when Slough grappled with the impact of the virus on its population, including a significant impact on resident's mental health and wellbeing, with higher levels of reported stress and anxiety.

**About this Annual Report**

The impact of the COVID-19 pandemic continued to disrupt the Wellbeing Board's ability to meet in person, in accordance with the requirements for public meetings, resulting in the need to cancel two of the Board's six planned sessions. The work programme was therefore primarily focussed on meetings its statutory functions and overseeing the delivery of its four priorities. The board also received regular verbal updates regarding the Frimley Integrated Care System.

## The Work of the Slough Wellbeing Board: Our Priority Areas

At the start of the 2020 municipal year, the Slough Wellbeing Board adopted a new Wellbeing Strategy. The Wellbeing Strategy for 2020-2025 focuses on four main priority areas. These areas are:

- Starting Well
- Integration
- Strong, Healthy and Attractive Neighbourhoods
- Workplace Health

Two of these areas - Strong, Healthy and Attractive Neighbourhoods, and Workplace Health - represent areas where the Board directly shapes the work being done in this area. Starting Well and Integration are priority areas where the Board takes an influencing role, and the work is primarily delivered by other partnership boards which report to the Slough Wellbeing Board.

**Priority One: Starting Well**

Starting Well is one of the priority areas where the Slough Wellbeing Board has an influencing role in the work being done in this area. Tackling health and wellbeing issues at an early stage in life prepares our young people for their future.

The Children and Young People's Partnership Board directly was leading this work, and provided regular updates to the Slough Wellbeing Board on its activities to develop a new Children and Young People's Partnership Plan. Five specific priorities for Slough have been identified:

- Good physical health and an active lifestyle
- Positive mental health and wellbeing
- Supporting our children with SEND
- Continuing to achieve well as KS4 and KS5 and prepare for adulthood
- Safeguarding and protection from harm

In October, the Wellbeing Board also had the opportunity to review the East Berkshire Local Transformation Plan for Emotional Health and Wellbeing and Celebrating Neurodiversity, following a comprehensive overview of the services that are available and the plans that are going to be taken to bridge gaps in services.

**Priority Two: Integration**

Integration is one of the priority areas where the Slough Wellbeing Board has an influencing role in the work being done in this area. By working closely together, health and social care professionals can ensure that care and support services are aligned and integrated in order to provide better care for our residents.

The Health and Social Care Partnership Board directly leads this work, and provides regular updates to the Slough Wellbeing Board.

2021-22 has seen the HSCPB join up its work with Frimley CCG's Slough Place Based Committee, transacting business together to ensure more effective collaboration between colleagues.

In July 2021 the Wellbeing Board reviewed the draft HSCPB's draft Slough Health and Care Plan. The plan will seek to develop, promote and maintain independence, because this is good for health, good for people, and good for the taxpayer and sustainability of services. The plan has the following priorities:

- Better access to care
- Improved outcomes for mental health
- Responding to changing demands and needs post COVID-19
- More Integrated and Pre-emptive service offers
- Improved outcomes for frailty
- Use of locality based models

The Wellbeing Board was also updated on a number of further key priorities for integration, including:

- The Better Care Fund
- Anticipatory Care Planning
- The Ageing Well Programme
- Improving access to care
- Mental Health in Integrated Care Systems
- Neighbourhood and community work with the Primary Care networks
- Action being taken to reduce health inequalities

**Priority Three: Strong, Healthy and Attractive Neighbourhoods**

Strong, Healthy and Attractive Neighbourhoods is one of the priority areas where the Slough Wellbeing Board directly leads the work being done in this area.

Strong, healthy and attractive neighbourhoods are built around people, place, local pride and strong collaborative working between the community and its partners.

Significant activity has been undertaken with the Chalvey Community Partnership under the programme, including:

- The ‘Chalvey Can’ physical activity programme
- A community learning programme focussing on English for Speakers of Other Languages and Maths
- A new jobs club with the Department for Work and Pensions and local employers
- The Launch of the Chalvey Interfaith Partnership
- A project to improve safety for Women and Girls under the Safer Streets Fund

The SHAN team has also conducted an extensive consultation in Colnbrook and Poyle to identify the key priorities of the community – including challenges around the availability of local services, community safety and the public realm.

The team then worked with the community to co-create a Strong Healthy Attractive community plan for this neighbourhood, which is being delivered by Colnbrook Parish Council.

Further work has been undertaken throughout the year to strengthen community partnerships in Britwell and Haymill and Lynch Hill.

**Priority Four: Workplace Health**

Workplace Health is one of the priority areas where the Slough Wellbeing Board directly leads the work being done in this area, via a Task and Finish Group that meets regularly to rapidly progress work in this field.

Having a good job, with a reasonable wage, employment security and a safe working environment can support people to thrive. It can protect against poor health both while someone is working, and later in life.

A toolkit of resources and materials to support employers to promote workplace health in their workforce has been developed and is currently being promoted.

The group has conducted research on existing award and accreditation schemes running in Slough, including the awards scheme led by Slough CVS and the Early Years Kitemark Accreditation Scheme. The group has also been looking into the prevalence and impact of long COVID in the workplace, with a particular focus on BAME communities, and over 500 over people have responded either by telephone or by completing an online form so far.

## COVID Recovery

Responding to the COVID-19 crisis was the Wellbeing Board's primary area of focus in 2020-21. In June 2O21, the Wellbeing Board had the opportunity to review members' strategies as the emphasis moved from responding to the COVID-19 crisis to putting in place the necessary steps for Slough's recovery.

Members considered what more could be done to build on the effective partnership working that had developed during the crisis and to avoid duplicating measures between partners.

Looking ahead, the board identified a number of priority recovery areas where it could look to work together, including:

- *Workforce* – adapting to new, agile ways of working that had developed during the pandemic, rebuilding capacity and maintaining frontline staffing, as well as addressing unintended consequences of working from home, such as isolation and mental health challenges.

- *Vaccinations* - reiterating the message to Slough residents on the importance of being double vaccinated.

- *Needs analysis* – ensuring that the board fully understands the impact the pandemic had on Slough, and then putting the resources in the right place to respond.

- *Resilience* - both in volunteers and organisations, ensuring that the food bank was resilient, vulnerable charities had sufficient cash resources, providing training programmes for residents and volunteers and building new infrastructures for better service delivery.

- *Planning* – ensuring steps were taken to effectively prepare for the Autumn and Winter, when cases were expected to rise again.

- *Residents' views* - ensuring feedback measures were in place for residents to inform partners and the board about their priorities for COVID recovery.

## Strengthening our partnership and looking forward

In February and March 2022, the Wellbeing Board held a series of workshops to explore how it could improve the way it works as a partnership.

The sessions were kindly supported by the Local Government Association, and members of the Board had the opportunity to hear examples of good practice from Cllr Helen Holland, Co Chair of Bristol's Health and Wellbeing Board, and Jonathan McShane from the LGA's Community Wellbeing Board.

Key issues covered included:

- The need to respond to emerging policy and legislative changes
- The potential to expand the Board's work into other areas, such as deprivation, digital inclusion and early help when the Board comes to refresh the Joint Wellbeing Strategy
- The need to make better use of the JSNA and other sources of data
- Opportunities for making better use of all the partners on the board, and ensuring the Wellbeing Strategy is relevant to all
- The potential for further partners in Slough to join the board
- The need to improve the connectivity with the Board's sub groups, and other partnerships, such as the Safer Slough Partnership
- Opportunities for streamlining the 'formal' work programme and ensuring that the Board is asking the right questions and holding partners accountable where appropriate

The board also agreed to follow Bristol's example and schedule a series of informal sessions alongside of the boards' regular meetings, to provide a space for the board's development and to explore pressing issues in more detail. In 2022/23, these will explore:

- The relationship between the ICB, ICP, and Slough Wellbeing Board
- Tackling the cost-of-living crisis for local residents
- Understanding the health and wellbeing of our local population to inform a refresh of the Slough Wellbeing Board Strategy
- Delivering the 2023/2027 Slough Wellbeing Board Strategy

## Appendix One: Statutory Responsibilities of the Slough Wellbeing Board

The Health and Social Care Act of 2012 set out the statutory responsibilities of Health and Wellbeing Boards. These are:

- To prepare and publish a Joint Strategic Needs Assessment for Slough.
- To prepare and publish a Joint Health and Wellbeing Strategy for Slough.
- To give its opinion to the East Berkshire Clinical Commissioning Group (CCG) as to whether their Commissioning Plans adequately reflect the current Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.
- To comment on the sections of the CCG's Annual Report which describe the extent of their contribution to the delivery of Joint Health and Wellbeing Strategy.
- To give its opinion, as requested by the NHS Commissioning Board, on the CCG's level of engagement with the Board, and on the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.
- To encourage persons who arrange for the provision of health and/or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the area.
- To work with partners to identify opportunities for future joint commissioning.
- To lead on the signing off of the Better Care Fund Plan.
- To publish and maintain a Pharmaceutical Needs Assessment.
- To give its opinion to the Council on whether it is discharging its duty to have regard to any Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy prepared in the exercise of its functions.
- To exercise any Council function which the Council delegates to it.
- To ensure that strategic issues arising from Slough's Safeguarding Boards inform the work of the Board.
- To receive the annual reports from Slough's Safeguarding Boards and ensure that partners respond to issues pertinent to the Boar

NHS
Frimley
Clinical Commissioning Group

# Frimley CCG
# Annual report and accounts
# 2021-22

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Hampshire
GU11 1AY

# Contents

# PERFORMANCE REPORT

## 1. FOREWORD

The 2021-22 annual report and accounts for NHS Frimley CCG are remarkable.

They are the first such reports for the CCG, as the organisation only came into being on 1 April 2021 through the merger of East Berkshire, North East Hampshire and Farnham and Surrey Heath CCGs.

They may well also be the last such reports, as the CCG is due to be superseded by the Frimley Integrated Care Board within the next few months.

Aside from the structural changes, the content of the following pages is also extraordinary because it reflects our response to the greatest single challenge that health and care services in the UK have faced in generations: the continued coronavirus (COVID-19) pandemic. We have been adapting to the circumstances, flexing services and staffing to provide support where and when it has been needed most and to protect those most at risk. It has been an incredibly demanding time, yet our staff, our partners and the local population have risen to the challenge admirably.

When we created Frimley CCG, we did so with a vision for our new organisation: to deliver access to safe, sustainable, high quality, equitable, affordable and effective services, which we would achieve through working with our communities and our partners, leading to a health and care system where quality, co-production, financial sustainability and governance were all improved.

This vision is undaunted by the pandemic. If anything, the experiences of the past two years have strengthened our resolve, and amidst the darkness of COVID-19 there have been moments of light, areas where we have identified opportunities to improve services and systems, to work differently to the mutual benefit of local people, communities and health and care services.

We have transformed the way we use data – both NHS and population health – so that we are not only able to spot trends in the health of our population, but we are also able to identify people who may be at risk of ill health. This kind of pre-emptive approach is essential for the future wellbeing of our population, as by preventing health conditions from deteriorating it is better for the individual and those around them and it is also better for health services. This attitude is also supporting our efforts to reach more vulnerable members of our communities and to provide health promotion advice and screening in general. Our digital capabilities have increased dramatically during the pandemic. This can be seen in a number of areas, from the remote monitoring of COVID-19 patients through the COVID-19 Oximetry @ Home programme, to supporting GP practices with their websites.

Our ‘safe treatment pathways’ for local people and staff are a model which can be employed or adapted in the event of further COVID-19 infection rises, or other health emergencies, while our staffing arrangements, our communication processes and

many other internal functions now benefit from being both more flexible and robust as a result of their pandemic experiences.

The considerable strain of the past two years has had an impact on staff across the health and social care sectors. Demand for treatment has risen steeply, while at times staffing levels have fallen as a result of COVID-19 infection. The commitment and selflessness of staff and volunteers across our health and care system has been humbling, yet we must recognise that to operate at such a level for so long does take a toll. Increased use of technology has been helping clinicians and members of the administration workforce to support patients and we are supporting Primary Care Networks to increase efficiency and make general practice more resilient.

The health inequalities present across our communities have grown during the pandemic, with the difficulties brought by COVID-19 adversely affecting those who already struggled to stay well and to access health services. We know this and are doing what we can to understand what it means for those who are worst-affected so that we can put it right. Everybody has the same right to treatment, irrespective of their individual circumstances.

As the COVID-19 pandemic response has been scaled down we have been working to restore services which had been suspended. During this period waiting times for elective treatments have grown and we're putting considerable time, effort and resources into reducing delays. We and our partners are also providing support for those who are waiting so they are able to be in the best possible condition for their treatment, leading to faster and better recovery.

Despite the ongoing challenges posed by COVID-19, we are confident and optimistic about our future. In July 2021 the Government gave its backing to our health and care system to continue as it is. Less than four months later NHS England rated Frimley Health and Care as the number one system in the country (the only system to be 'consistently high performing'). Over the past 12 months we and our partners have been shortlisted for several awards, winning a number of them, demonstrating the innovative and targeted ways we have responded to the needs of our local population.

Both within the CCG and across our many partners we have attracted and retained extremely skilled, dedicated and creative staff, whose outstanding work is reflected in the pages of this report. Our task for the coming months and years is to build on the progress made so far, offering compassionate and kind leadership, promoting inclusion and continuing to attract high-calibre workforce as we move from the CCG to being an Integrated Care Board.

If we can do that, we will be in the best possible position to work with our partners to redefine the services we commission, to design our leadership and structures to suit the health and care needs of the people of East Berkshire, of North East Hampshire and of Surrey Heath and Farnham.

We've learned a lot about ourselves and our population over the past two years. We're now looking forward to putting that learning into practice as we face the challenges that lie ahead. We're eager to strengthen our relationships with our partners along the way, as well as forging new ones. We hope you will join us on our journey.

**Fiona Edwards**
Accountable Officer, Frimley CCG
Chief Executive Designate for the ICB

**Dr Huw Thomas**
Clinical Chair, Frimley CCG

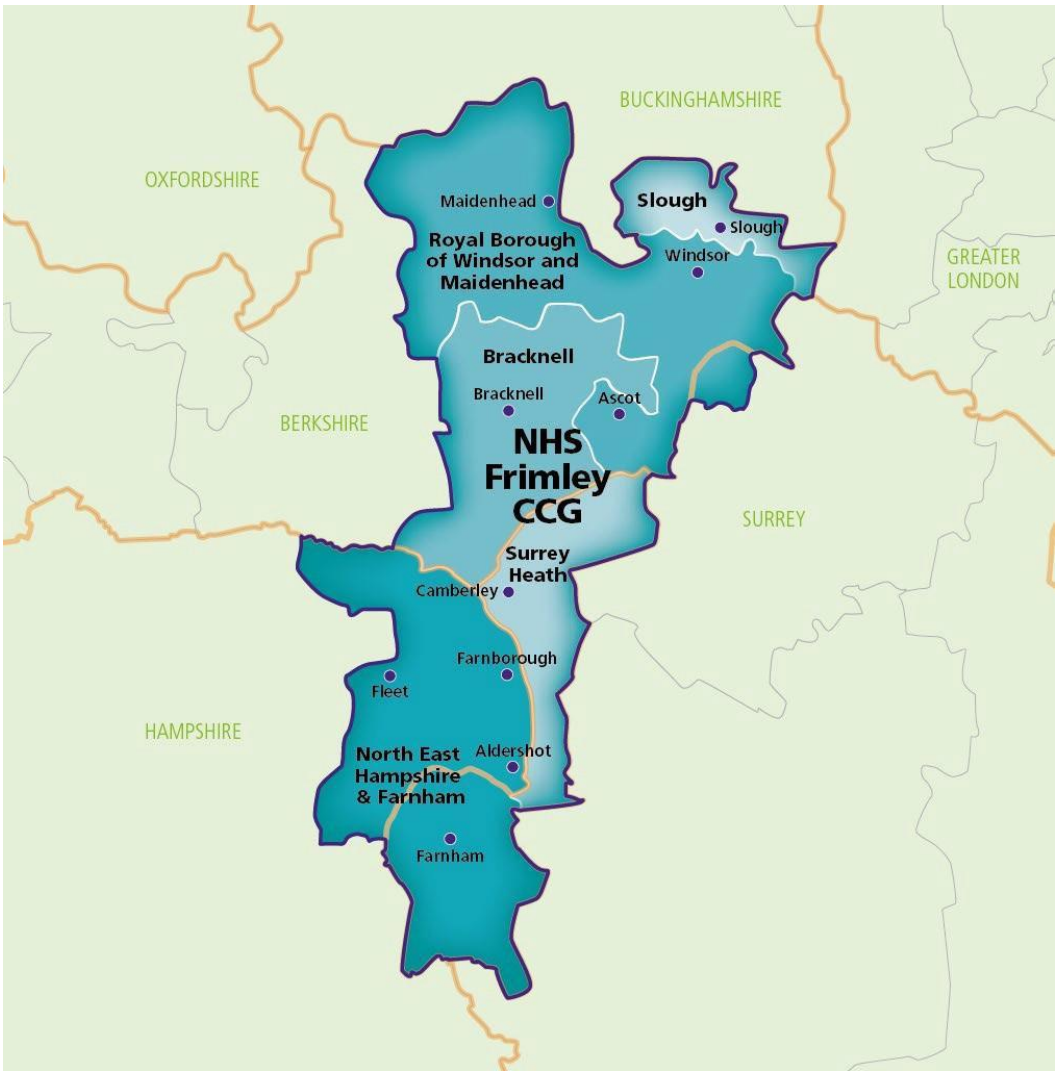
20 June 2022

## 2. PERFORMANCE OVERVIEW

The Performance Overview section of this Annual Report is designed to provide a short summary about the CCG, including our purpose, key objectives, achievements and any risks to achieving our objectives.

### Our purpose

Frimley CCG's purpose is to deliver the best possible health and wellbeing outcomes for our local community within the resources available. This is achieved through using the combined leadership of local GPs, independent lay people, public health, local authority and NHS commissioning staff to make informed decisions about local healthcare. The CCG serves a population of around 800,000 registered at 72 GP practices across five Places. These Places are: Bracknell Forest; Royal Borough of Windsor and Maidenhead; Slough; North East Hampshire & Farnham; and Surrey Heath.




The CCG is responsible for planning and commissioning healthcare services to meet the needs of our local population working in partnership with colleagues from NHS England, NHS trusts, CCGs, Health & Wellbeing Boards, public health, local

authorities and the voluntary sector. We are committed to understanding and responding to the needs of local people in our communities, co-designing services and working towards a 'Community Deal' as part of our ambitions.

The CCG has delegated responsibility from NHS England for commissioning sustainable primary care services and all the GP practices within our CCG area form part of our membership organisation, responsible for making sure that local people get the health services they need.

## Our activities

The CCG commissions:

- Primary care services (GPs);
- Out of hours primary medical services;
- Urgent and emergency care, including NHS 111, Accident and Emergency (A&E) and ambulance services;
- Elective (planned) hospital care, such as hip replacement surgery, hernia repairs and day surgery;
- Community health services, such as community nursing, physiotherapy, podiatry, speech & language therapy and rehabilitation services;
- Mental health services (including psychological therapies);
- Services for people with learning disabilities and autism;
- Maternity and newborn services (excluding neonatal intensive care);
- Children and young people's health services, such as community child health, therapists, acute care, child and adolescent emotional health and wellbeing; and
- NHS continuing healthcare for people with ongoing healthcare needs.

## Our organisational structure

Frimley CCG was established on 1 April 2021, following the merger of East Berkshire, North East Hampshire & Farnham and Surrey Heath CCGs who had been working closely together as a Collaborative since 2019. The new Frimley CCG is made up of the five Places and works across the same geography as our partner organisations in the Frimley Health and Care Integrated Care System.

### Our Vision as a single Clinical Commissioning Group

- To deliver access to safe, sustainable, high quality, equitable, affordable and effective services through innovative service models that consider national and international best practice, appropriately reflect local need and factor in the ability to manage future surge pressures (COVID-19, seasonal flu).
- To achieve the above through community collaboration, mutual decision making with people as partners, great teams, engaged and informed leaders.
- To create a health and care system that is materially higher in quality, more productive, financially sustainable and better governed.

Our experience tells us that it is relationships, not organisational boundaries, that determine the level of integration within systems and ultimately the ability to transform health and care outcomes. We have designed our organisation to build and develop these relationships at all levels – through individual and organisational values, neighbourhoods and relationships with our Primary Care Networks – with an emphasis on place, and structures which enable people to work flexibly across organisational boundaries and manage complexity.

The CCG also focuses on the importance of local insight and need, whilst recognising the strength of working as a system with a consistent core approach. This is in readiness for the establishment of a single Frimley Integrated Care System which will be made up of an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) effective July 2022.

Some services are commissioned on the new CCG (and Frimley ICS) footprint, others are secured at smaller Place footprints. Others may be jointly commissioned within local authority boundary footprints and/or health commissioners in other ICSs, while for rare disorders services need to be considered and secured nationally or regionally. We continue to be proud of the strategic commissioning model that has worked optimally across organisational and system boundaries.

## Our business model and environment

In 2021-22 the newly merged CCG managed itself through a number of business models from in-house, shared and bought-in services which enabled the CCG to retain ownership of statutory responsibilities while benefiting from economies of scale, working with partners across the CCG and ICS.

### In-house staff

Staff have very successfully adapted to remote working over the past two years and have responded to the challenges and opportunities it brings. Working together as a merged organisation has enabled better use of our people and our financial resources and to avoid duplication, making us more efficient and cost-effective. Thanks to working collaboratively prior to the pandemic, we have been able to maintain our close links and relationships whilst having to be based remotely.

The local leadership team in each Place includes GPs and other clinicians drawn from the local area, ensuring strong local clinical leadership and focus on all decision making. They work closely with local authority colleagues planning and making decisions jointly. The CCG has developed Place Based Committees that are partnership forums which recognise the role of local authorities and provider organisations in the planning and delivery of health and care improvements.

### Shared support services

These are provided by NHS South, Central and West Commissioning Support Unit (CSU). They support the CCG by providing expertise in a range of management areas such as information governance, HR, Freedom of Information, complaints, IT, procurement, finance and contracting. The CCG and its predecessors have benefited from using a variety of these services and have established a strong working relationship.

### Shared commissioning expertise

In 2021-22 the CCG continued to share expertise for services that need a high level of collaborative commissioning, for example: NHS Hampshire, Southampton & Isle of Wight CCG lead on NHS Continuing Healthcare, Funded Nursing Care and maternity and children's health services for our Hampshire residents. Whilst NHS Surrey Heartlands CCG, NHS Frimley CCG and Surrey Council fund a joint commissioning team to support improvements in children's services.

### Other partners

We work closely with a wide range of voluntary and non-statutory services locally and with our local authority partners at Surrey County Council, Hampshire County Council, Bracknell Forest Council, Slough Borough Council, Royal Borough of Windsor and Maidenhead, Rushmoor Borough Council, Hart District Council, Waverley Borough Council and Surrey Heath Borough Council.

We liaise closely with colleagues from the UK Health Security Agency (previously part of Public Health England) in Surrey, Hampshire and Berkshire who provide details about the health needs of our local population based on information from the Joint Strategic Needs Assessment (JSNA), which informs our local planning decisions.

There is also close working with NHS England who have specialised and primary care commissioning responsibilities for community pharmacy, dentistry and community optometry.

The CCG is a key partner on the Health and Wellbeing Boards in Hampshire, Surrey, Bracknell Forest, Royal Borough of Windsor and Maidenhead and Slough. In 2021 the Place Based Committees of the Frimley CCG worked closely with health and wellbeing partners to further align ways of partnership working. Further information can be found in the Health and Wellbeing section of the Annual Report.

## Frimley Health and Care Integrated Care System

There is a strong history of successful partnership working over a number of years in Frimley Health and Care ICS, demonstrated through the number one ranking in the system oversight framework (as an ICS) – the only system to be consistently high performing. During 2021-22 this ensured a strong, co-ordinated approach to the health response to the ongoing public health emergency caused by the COVID-19 virus.

The CCG is an integral part of the ICS and worked with system partners to focus on the rollout of the vaccination programme, elective recovery and to address health inequalities that have resulted from the pandemic.

## Frimley CCG's priorities and objectives

The CCG's main objectives in 2021-22 revolved around plans for recovery and restoration. The priorities in 2021-22 reflect the response to COVID-19 and the changing NHS landscape:

- Positively focus on levelling up models of care so that we can improve health outcomes, address inequalities, and deliver greater inclusion across the system
- Working with partners and local communities to support the recovery of health and care services, with a particular focus on addressing health inequalities and the impact of the pandemic
- Continue to focus on our staff and build a culture of inclusivity so that everyone feels heard, valued and empowered
- Effectively manage our resources together with our system partners to successfully deliver the system operating plan
- Lead well and inspire each other as we transition successfully into a new organisation

## Key issues and risks

The main risks and issues have been associated with the unprecedented and unplanned demand on health services as a result of the COVID-19 public health emergency. Despite the pressure on capacity, finance and resources the system has been able to work hard and consistently with health and local government partners to manage the impact on the quality of care as the surge for acute services took effect in 2021.

The COVID-19 pandemic has fundamentally changed the way we deliver care and carry out our routine business activities. A need to expand choice and modernise access to services has been a long-term ambition which the pandemic has helped to accelerate, driving a positive impact on people and the environment in which they live and work; both of which are key health and wellbeing priorities for our places over the next 12 to 18 months.

In 2021 the system was at risk of not being able to continue as an ICS and the CCG with partners worked hard to convince the Secretary of State that the Frimley system remain on its existing footprint. In July 2021 the Government confirmed that a single Frimley system could remain and develop in line with the updated Health and Care bill which received Royal Assent on 28 April 2022.

## Looking ahead

The CCG will cease to exist as the statutory commissioning organisation for Frimley and a new ICB will come into effect on the 1 July 2022 to take on its statutory functions.

Work is being undertaken to ensure a seamless transition to the new ICB as a fundamental part of the ICS. We have worked for a number of years with ICS ambitions setting the system direction and these will continue to form the core objectives for the new organisation. The ICB will continue to retain all the CCG functions but will have a board made up from a wider group of system partners, including wider health, local government and primary care.

## Performance Summary

We recognise the huge amount of work carried out by our staff, together with local people and our many partners, to respond to the COVID-19 pandemic.

In this year's annual report, we wanted to show the incredible work undertaken not just across the NHS, but also local authority, voluntary and private sectors. It is only by working together that we have been able to achieve so much and overcome so many challenges.

You will read many descriptions that describe quite complex ways of working. The wider relationships such as systems, partnerships and collaboratives enable the CCG to work at scale to 'fast-track' health improvements across a large area and implement them locally. This ensures that we use our resources wisely, as well as learn from those who may have already successfully implemented a service or programme from which we all can benefit.

Our local communities remain our principal focus and so we will continue to work with our patients and partners to design, develop and deliver services that our localities need. We do this by ensuring that the objectives we set form the basis for the priorities we identify in each local area. Again, the key to this is in working together, so that we can share capacity and skills and operate with greater consistency with all our local partners for the benefit of patients.

# 3. PERFORMANCE ANALYSIS

## Introduction

After another pandemic dominated year, the impact of months of lockdown measures combined with the rollout of the vaccination program is beginning to take effect. As progress continues, the number of people requiring urgent care for COVID-19 has continued to come down – in response to this Frimley CCG has been working hard to bring waiting times back down and continue to work through the backlog of unmet care. At the same time, we have been planning for our health services to be able to scale up COVID-19 services swiftly should this be required.

In May 2021 the CCG presented its Operating Plan for 2021-22 at the Governing Body meeting in public. This set out a system approach to developing healthier communities based on the Frimley Health and Care 5 year strategy:

- **Leadership and Governance**: Our System Recovery Network leading the delivery of our Operating Plan submission, strengthening cross system, place and partner alignment, underpinned by our agreed recovery activities and principles;
- **The System Recovery Network** supported by an Operational Planning Oversight Group enabling clear connectivity between the quality, delivery and financial aspects of the system plan;
- **Centralised and aligned ICS** activity and resource model which supports rapid appraisal of interdependencies and the assessment of the impact of improvement projects, covering activity, workforce and facilities, which are converted into a common currency.

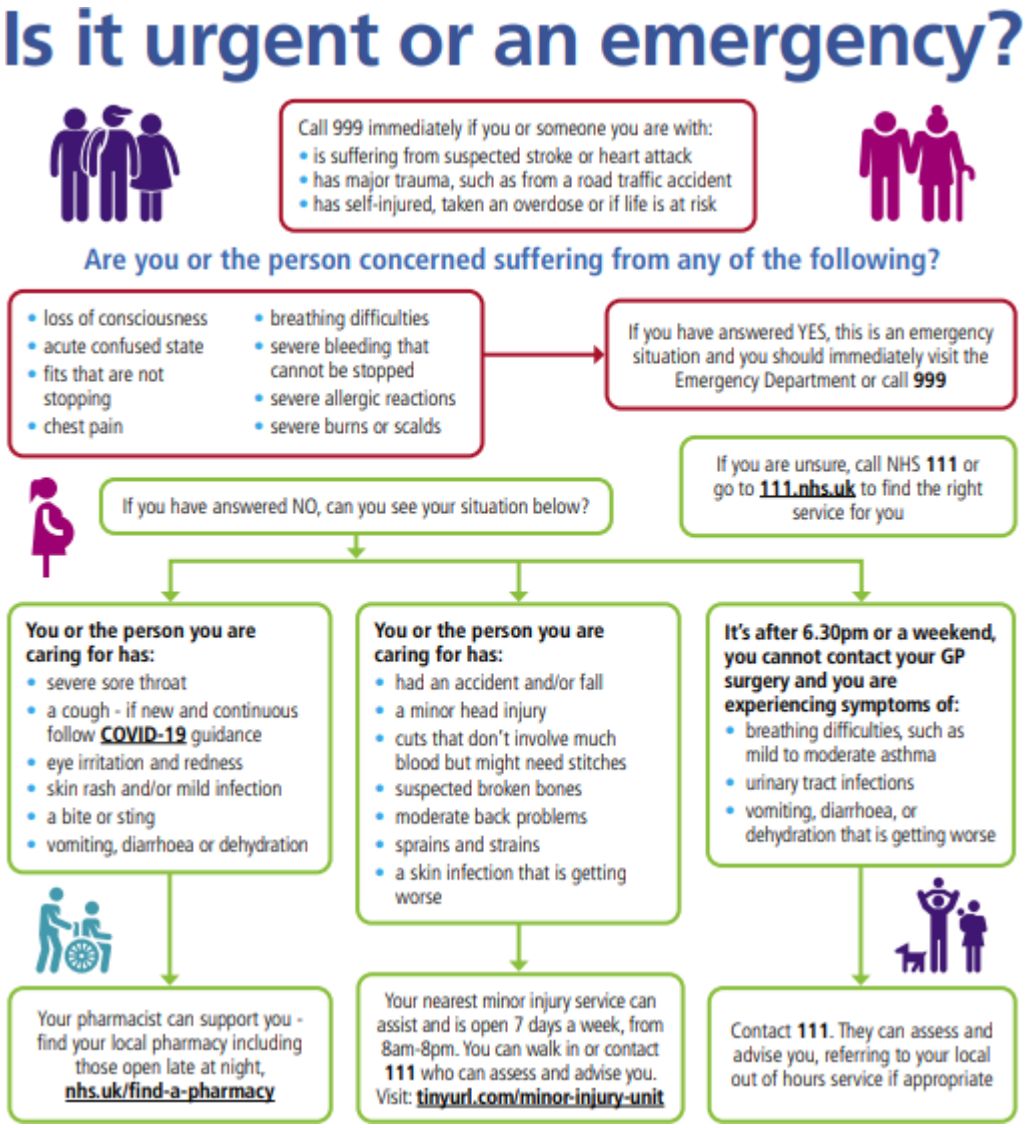
By June 2021 we were experiencing significant and increasing demand for non-COVID-19 related urgent and emergency care with general practice reporting increased same day demand up to 30% above peak winter levels. Even our community partners reported above normal caseload numbers with high acuity. Communication with the public has been vital to overcome some of these fears and remind the public what support is available to them.

This section shows some of the incredible work undertaken in the second year of the pandemic and focuses on:

- Improving access to services
- Supporting those most at risk
- Supporting our workforce

## Improving access

It is important that we all know where to turn when we or someone we care for needs help. As demand for NHS services increases, particularly when services are under considerable pressure, it is important that the public are seen and supported by the appropriate service. Frimley Health and Care ICS have produced this flow chart which can help the public determine which service they need.




**Additional capacity in primary care**, including face to face appointments, has been included in our winter pressures programme to support the increased demand we have seen for primary care services. As part of a national initiative, the General Practice Appointment Data (GPAD) mapping exercise was completed by all PCNs. This has helped drive a consistent approach for appointments and helped us understand demand and plan the right level of capacity for the future.

Spotlight

In December 2021 Slough practices delivered 1000 additional evening, weekend and twilight appointments per week and will maintain this increased capacity over the winter period.

In January 2022 East Berkshire Primary Care Out of Hours service were commissioned to deliver 100 additional primary care appointments per day via their Super Surge clinic which operates three days per week Sun/Mon/Tues.

A **new Community Pharmacy Consultation Service** has been rolled out across all practices to facilitate patients having a same day appointment with their community pharmacist for minor illness or an urgent supply of a regular medicine, improving access to services and providing more convenient treatment closer to patients' homes.

We have established a **centralised pulse oximetry at home service**, providing remote monitoring for patients with confirmed diagnosis of COVID-19 to ensure timely intervention to prevent unnecessary hospitalisation whilst facilitating timely and effective clinical involvement.

Based on feedback from local people we have been working with our PCNs and constituent member practices to shape, develop and mobilise an efficient digital front door to services, improving consistency in access and facilitating more timely responses to patient queries through deployment of VoIP (Voice over Internet Protocol) telephone systems, introducing population health segmentation, and streamlining of current processes.

## Supporting those at risk

Working with our ICS partners we have created 'insight' data reports that have helped us target those most at risk and those whose health has deteriorated over the past year or so for example people with uncontrolled long-term conditions and proactively managing those with a history of missing reviews.

Using population health managements tools, we have also been able to identify key priority areas such as cardiovascular disease, arrythmia and depression.

Using our COVID-19 vaccination sites we have been able to further address health inequalities through opportunistic health checks and co-administration of flu vaccinations. We have also created opportunities to improve population health by providing health promotion advice and offering health & screening checks where feasible.

To the end of March 2022 our system had given1,603,510 vaccinations to local people, with 594,508 first doses, 561,201 second doses, and 447,801 boosters (of

which more than 7,000 were co-administered with flu). The number of people receiving their boosters is over 88% of those eligible.

Through our outreach clinics we have engaged some of our most vulnerable population, offering health screening and advice, flu and COVID-19 vaccination.

Frimley has led the roll-out of anti-viral treatment for COVID-19 infection. Multiple organisations came together to successfully provide these brand-new treatments in the community for local people. Since going live in December 2021 the service has received over 3,300 patient referrals with over 700 patients successfully treated following triage making it one of the highest performing COVID-19 Medicine Delivery Units in the country and feedback from service users has been of a high standard.

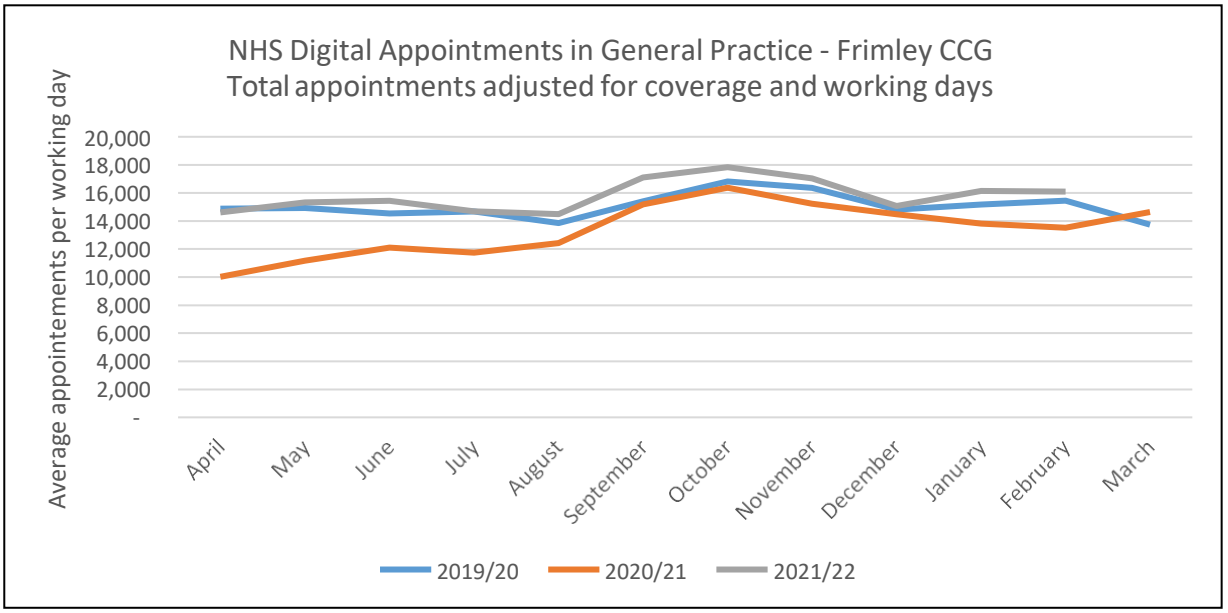
## Supporting our primary care workforce

Many of our practices have been significantly impacted by the pandemic, with staff suffering with exhaustion, long term sickness increasing, or staff leaving their current profession. Recruitment and retention of staff has been a particular challenge.

We have continued to work closely with practices and have re-established practice visits to facilitate a safe and transparent dialogue so that a robust resilience support offer can be developed and implemented.

All our practices have engaged in our Health and Wellbeing offer and we continue to meet with all practices via dedicated practice managers meetings. Supported by the national Winter Access Fund, a number of our PCNs have deployed telephony and eHubs, increasing working efficiencies, streamlining processes, and building resilience of individual general practices. PCNs have piloted urgent/same day telephony hubs, improving access, reducing waiting times and improving patient satisfaction.

We have seen a steady increase in appointments within primary care above levels reported in 2019/20 as shown in the graph below:



# 4. KEY PERFORMANCE MEASURES

The 2021-22 financial year saw the NHS transition from the Level 4 incident response regime for the COVID-19 Pandemic, the highest level of critical incident response, which requires NHS England National Command and Control to support the NHS response. Key priorities for the NHS were to:

- Support the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.

The system-wide structures established across the Frimley system during 2020/21 continued to support all system partners via our Incident Control Centre, which directs and manages our collective local resource and capacity to focus on our recovery, in line with NHS England directives. Continuing the approach in 2021-22, assurance and reporting requirements continued to be streamlined to essential activities to enable resources to be focused on the recovery priorities. To this end, much of the performance monitoring and reporting routinely undertaken was suspended this year and is therefore not included in our Annual Report. Where some has continued – referral to treatment times, cancer waits and ambulance response times for example – performance has been significantly below national targets as might be expected and does not reflect the extraordinary work and efforts of services over the last year.

Frimley CCG took a number of steps to provide information to support decision making and provide assurance around the quality of services during this extremely challenging period.

## System wide assurance of statutory functions

In line with the priorities set out by NHS England/Improvement we have focussed on Accident & Emergency and ambulance performance, referral to treatment (RTT) management, cancer referrals and treatment, and screening & immunisation. Weekly data has been reviewed by the performance team with exception reports escalated to

the executive team to agree corrective actions. The Quality Performance & Finance Committee has been stood back up to review performance on behalf of the Governing Body. The focus has been on system wide performance but with additional information for each our five places overseen by our Place Committees.

## Operational performance managementinformation;

A weekly operational dashboard is produced to support system oversight by the Frimley Incident Control Centre. The report has continued to adapt to reflect the emerging pressures or focus across the system. Place based insights included in the report focus on the following three priorities; vaccine roll out, reducing burden on acute services (both admissions & discharges) and supporting primary care resilience.

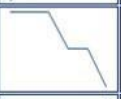
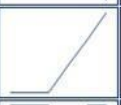
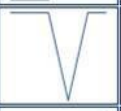
## Summary of key performance metrics

## Adult Mental Health

| Portfolio | Metric ID | Metric Description | Target | Data Range End | Previous five periods | | | | | Latest Data | Latest 6 period trend | Variation | Target assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adult Mental Health | E.A.S.1 | Estimated diagnosis rate for people with dementia | 67% | Mar-22 | 63.4% | 63.5% | 63.6% | 63.3% | 63.6% | 64.0% |  |  |  |
| Adult Mental Health | E.A.S.2 | IAPT recovery rate | 50% | Feb-22 | 51.2% | 51.6% | 51.3% | 51.9% | 50.0% | 50.6% |  |  |  |
| Adult Mental Health | E.A.S.3 | IAPT Roll-Out (rolling 3 month access rate) | 6.25% | Feb-22 | 5.1% | 5.0% | 5.5% | 5.1% | 5.1% | 4.8% |  |  |  |
| Adult Mental Health | E.H.21 | IAPT in-treatment pathway waits (hidden waits) | < 10% | Feb-22 | 5.1% | 3.7% | 6.9% | 4.6% | 11.7% | 11.0% |  |  |  |
| Adult Mental Health | EH1_A1 | IAPT Proportion of people that wait 6 weeks or less who finish treatment | 75% | Feb-22 | 97.4% | 98.3% | 96.9% | 94.6% | 96.4% | 96.1% |  |  |  |
| Adult Mental Health | EH1_A2 | IAPT Proportion of people that wait 18 weeks or less who finish first treatment | 95% | Feb-22 | 100.0% | 100.0% | 99.5% | 99.3% | 100.0% | 100.0% |  |  |  |
| Adult Mental Health | E.H.12 | Inappropriate adult acute mental health Out of Area Placement (OAP) bed days | 110 | Mar-22 | 365 | 420 | 455 | 510 | 516 | 692 |  |  |  |
| Adult Mental Health | E.H.13 | People with severe mental illness (SMI) receiving a full annual physical health check and follow up interventions | 60% | Mar-22 | 0.432 | 0.454 | 45.2% | 49.4% | 52.9% | 56.4% |  |  |  |
| Adult Mental Health | E.H.15 | Rate of women accessing specialist perinatal mental health services | 8.6% | Jan-22 | 4.1% | 4.2% | 4.3% | 4.2% | 4.3% | 4.4% |  |  |  |
| Adult Mental Health | EIP1 | Early Intervention Psychosis (EIP) - Percentage of people with first episode of psychosis who have accessed or are waiting for treatment | 60% | Jan-22 | 57.9% | 84.2% | 82.6% | 81.5% | 81.8% | 82.1% |  |  |  |

## Summary of key performance metrics

## Children & Young People and Learning Disabilities & Autism

| Portfolio | Metric ID | Metric Description | Target | Data Range End | Previous five periods | | | | | Latest Data | Latest 6 period trend | Variation | Target assurance |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CYP | E.H.10 | Waiting time for routine referrals to CYP eating disorder services | 95% | Dec-21 | 83.1% | 77.4% | 74.2% | 76.0% | 73.9% | 71.9% |  |  |  |
| CYP | E.H.11 | Waiting time for urgent referrals to CYP eating disorder services | 95% | Dec-21 | 86.2% | 83.3% | 84.6% | 86.0% | 84.2% | 73.8% |  |  |  |
| CYP | E.H.9 | Improve access to Children and Young People's Mental Health Services (CYPMH)<br>(% access target relates to being 35% of the prevelance rate of CYP with a diagnosed Mental Health condition based on 2004 esitmates). | 35% | Feb-22 | 37.9% | 39.1% | 40.2% | 41.3% | 42.2% | 41.6% |  |  |  |
| LD & A | E.k.1a | Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by CCG | 10 | Mar-22 | 10 | 10 | 10 | 9 | 9 | 8 |  |  | |
| LD & A | E.k.1b | Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by NHS England | 8 | Mar-22 | 8 | 8 | 8 | 9 | 10 | 11 |  |  | |
| LD & A | E.k.1c | Reliance on inpatient care for people with a learning disability and/or autism - Care for children | 2 | Mar-22 | 1 | 1 | 1 | 0 | 1 | 1 |  |  | |
| LD & A | E.K.3 | Learning disability registers and annual health checks delivered to patients 14yrs+ by GPs | 70.0% | Mar-22 | 33.9% | 41.3% | 46.9% | 54.4% | 66.1% | 79.1% |  |  |  |

## Summary of key performance metrics

## Planned Care

| Portfolio | Metric ID | Metric Description | Reporting Frequency | Target | Data Range Start | Data Range End | Previous five periods | | | | | Latest Data |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Care | E.B.26 | Diagnostic Test Activity | Monthly | #N/A | Apr-19 | Jan-22 | 14,439 | 15,482 | 15,250 | 16,682 | 15,031 | 16,062 |
| Planned Care | E.B.3a | RTT: Wait List size (incomplete) | Monthly | #N/A | Apr-19 | Jan-22 | 54,299 | 54,206 | 54,469 | 54,694 | 54,947 | 54,419 |
| Planned Care | RTT_03_04 | RTT: Number of patients waiting over 52 weeks (Incomplete) | Monthly | 0 | Apr-19 | Jan-22 | 1,145 | 1,309 | 1,435 | 1,420 | 1,569 | 1,565 |
| Planned Care | Diag_01 | Percentage of Patients waiting greater than 6 weeks for a diagnostic test | Monthly | 0% | Apr-19 | Jan-22 | 14.7% | 17.1% | 14.0% | 11.5% | 14.0% | 12.6% |
| Planned Care | E.B.30 | Numbers of patients seen in a first outpatient appointment following urgent referrals from GP | Monthly | #N/A | Apr-19 | Jan-22 | 2,462 | 2,290 | 2,452 | 2,827 | 2,168 | 2,183 |
| Planned Care | EB6 | Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer | Monthly | 93% | Apr-19 | Jan-22 | 86.1% | 83.1% | 81.1% | 72.3% | 78.2% | 72.6% |
| Planned Care | E.B.27 | Percentage of Patients receiving a diagnosis or ruling out of cancer, or a decision to treat within 28 days of an urgent referral for suspected cancer | Monthly | 70% | Apr-19 | Jan-22 | 82.2% | 76.5% | 75.2% | 74.4% | 70.4% | 64.2% |
| Planned Care | EB12 | Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer | Monthly | 85% | Apr-19 | Jan-22 | 78.4% | 79.5% | 80.4% | 79.2% | 76.8% | 64.7% |
| Planned Care | EB8 | Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis | Monthly | 96% | Apr-19 | Jan-22 | 98.1% | 95.5% | 95.5% | 95.2% | 95.7% | 91.5% |
| Planned Care | EB9 | Percentage of patients receiving subsequent treatment for cancer within 31-days (Surgery) | Monthly | 94% | Apr-19 | Jan-22 | 91.5% | 92.2% | 92.6% | 88.9% | 78.8% | 87.1% |

## Summary of key performance metrics

## Primary Care

| Portfolio | Metric ID | Metric Description | Reporting Frequency | Target | Data Range Start | Data Range End | Previous five periods | | | | | Latest Data |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Primary Care | E.D.19 | Appointments in General Practice | Monthly | #N/A | Apr-19 | Jan-22 | 304,129 | 375,891 | 374,371 | 374,564 | 316,533 | 322,593 |
| Primary Care | GP_ERs | GP e-Referrals (created) | Monthly | #N/A | Apr-19 | Feb-22 | 19,820 | 18,344 | 19,528 | 16,462 | 17,387 | 18,318 |
| Primary Care | Vaccine | COVID vaccination events | Monthly | #N/A | Dec-20 | Feb-22 | 53,089 | 119,162 | 139,261 | 227,031 | 60,450 | 23,764 |
| Primary Care | eConsult | Number of eConsults | Monthly | #N/A | Jan-21 | Feb-22 | 37,905 | 36,701 | 38,528 | 31,688 | 36,677 | 34,351 |
| Mental Health | E.A.S.1 | Estimated diagnosis rate for people with dementia | Monthly | 67% | Apr-20 | Feb-22 | 63.3% | 63.4% | 63.5% | 63.6% | 63.3% | 63.6% |
| LD & A/CYP | E.K.3 | Learning disability registers and annual health checks delivered to patients 14yrs+ by GPs | Monthly | 38.5% | Apr-21 | Feb-22 | 27.2% | 33.9% | 41.3% | 46.9% | 54.4% | 66.1% |
| Mental Health | E.H.13 | People with severe mental illness (SMI) receiving a full annual physical health check and follow up interventions | Monthly | 60% | Feb-21 | Jan-22 | 41.2% | 41.2% | 43.2% | 45.4% | 45.2% | 49.4% |

# 5. SUMMARY OF FINANCIAL PERFORMANCE

## Financial overview

Clinical Commissioning Groups are expected to manage expenditure within the resources allocated by NHS England and deliver a minimum of a break-even position in the financial year. This requires not only careful management of the finances but also strong internal control mechanisms to ensure the resources of the CCG are handled in a way which is up to public standards and can be sustained year on year.

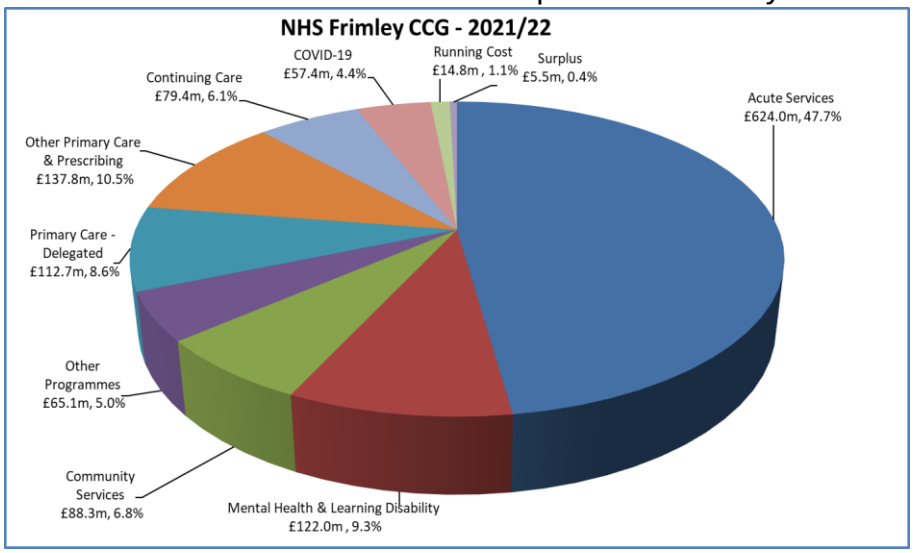
The 2021-22 financial regime was a transitional year as the NHS began to revert to the historical funding arrangements rather than the temporary flows established in response to covid. Funding settlements were split into two 6-month periods, the first from 1st April 2021 to 30th September 2021 and the second from 1st October 2021 to 31st March 2022. Arrangements continued to be based upon nationally calculated funding flows with further discretionary funds available to the system to support local recovery needs.

Additional covid funding continued to be available to CCG's and Trusts to ensure that all services were adequately resourced for the additional costs of staff and facilities. The CCG has also been reimbursed for costs incurred in ensuring faster discharge from hospital for patients who required ongoing support but could be safely discharged from an acute setting.

## Review of the financial year

The CCG spent £1.3bn in 2021-22, which equates to approximately £1,444 for every person registered with our practices. NHS Frimley CCG has reported a surplus of £5.5m for the year bringing the cumulative surplus to just over £31.1m. The surplus this year has arisen primarily due to the CCG receiving transformation funding which was not fully spent in year because of the continued impact of COVID-19. In line with the Group Accounting Manual, the CCG cannot carry forward this unspent resource which has been allocated to them in year and has declared the surplus as a result.

The chart shows the breakdown of expenditure in the year across the main categories:



Approximately half our expenditure, £624.0m, is for acute services. Our main provider is Frimley Health NHS Foundation Trust (FHFT), with whom we spent £491.3m in 2021-22. Other main providers of acute services for our population include Royal Berkshire NHS Foundation Trust (£30.1m), Royal Surrey County Hospital Foundation Trust (£12.8m) and Ashford St Peters NHS Foundation Trust (£10.3m). We also spent £16.7m with a range of London Trusts for specialist services. Acute expenditure also includes the cost of emergency ambulance services (£28.4m)

Most of our mental health services are provided by Berkshire Healthcare NHS Foundation Trust (£59.7m) and Surrey & Borders Partnership Foundation Trust (£34.7m).

Community services are provided mainly by Berkshire Healthcare NHS Foundation Trust (£39.1m) and Frimley Health NHS Foundation Trust and Health (£19.5m).

Under full delegated responsibility for Primary Care (GP) commissioning, the CCG received an allocation of £112.9m from NHS England in 2021-22. Most GP costs are funded through contracts held directly by NHS England and administered by Frimley CCG. We also meet the cost of drugs prescribed by our local GPs of £95.8m and pay for the GP 'out of hours' service at a cost of £6.0m. The budget was underspent by £0.2m overall.

The CCG spent £58.5m with our local authority partners under the Better Care Funds with Bracknell Forest Council, Slough Borough Council, Surrey County Council, Royal Borough of Windsor & Maidenhead and Hampshire County Council, supporting greater integration across health and social care services.

The CCG has spent a total of £57.4m on Covid related services, £42.3m of which went to Frimley Health NHS Foundation Trust with £8.2m being spent on placements and home-based care, including equipment for use at home, under the hospital discharge scheme, which was run in conjunction with Bracknell Forest Council, Slough Borough Council, Surrey County Council, Hampshire County Council and the Royal Borough of Windsor & Maidenhead. The scheme enabled patients to be safely discharged from hospital as soon as possible to either a nursing or residential care setting or with additional support at home. This supported the flow of patients through the acute hospitals and freed up bed capacity and nursing resource for Covid patients and those who were more acutely unwell.

The CCG is required to invest in mental health services over and above the growth increase it receives each year as part of its allocation. During the year, we have maintained this enhanced investment across both our core services and for some specific investments, including in our eating disorders services and for safe havens. Our expenditure on mental health services for 2021-22 will be reviewed by our auditors later in the year to verify that we have achieved the mental health investment standard as required.

## Running Costs

The CCG receives a separate allocation for the costs of running the organisation based on the size of the population and it must not overspend against this amount. In 2021-22, we received and spent £14.9m.

## Financial plan 2022-23

NHS England has set out their priorities for the 2022-23 and it is within this context that financial plans are being developed by the CCG and our system partners. The ten national priorities we have been asked to focus on are as follows:

1. **Invest in our workforce** – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

2. **Respond to COVID-19** ever more effectively - delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

3. **Deliver significantly more elective care** to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

4. **Improve the responsiveness of urgent and emergency care** (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.

5. **Improve timely access to primary care** – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

6. **Improve mental health services and services for people with a learning disability and/or autistic people** – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

7. **Continue to develop our approach to population health management, prevent ill health and address health inequalities** – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

8. **Exploit the potential of digital technologies to transform the delivery of care and patient outcomes** – achieving a core level of digitisation in every service across systems.

9. **Make the most effective use of our resources** – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

10. **Establish ICBs and collaborative system working** – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

The new financial year sees the national financial framework transitioning back to historical funding arrangements based on a per head of population allocation. With the establishment of ICBs in year, the ICS is the key planning unit, with Frimley Health NHS Foundation Trust formally aligned to the system. This combined planning unit needs to deliver a balanced financial plan within the £1.3bn funding envelope allocated.

There are a number of key variables within the position that need to be managed by the system; including pressures arising from increased energy costs, ongoing covid costs and making reductions to these as IPC restrictions are released, delivering the operational requirements for our population including increased elective activity to reduce our waiting lists, all whilst delivering an ambitious efficiency plan in part to make up for efficiency plans that were rightly delayed during the pandemic.

The CCG will continue to be scrutinised in terms of delivering value for money against the backdrop of delivering transformation to services in line with the NHS Long Term Plan and the continued recovery from the impact of the Covid pandemic.

Further details about our expenditure in 2021-22 are available in our Financial Statements. These statements have been prepared in accordance with the Directions issued by NHS England under the National Health Service Act 2006 and are audited by KPMG LLP. Our external audit fees in 2021-22 were £150k plus VAT.

## 6. SUSTAINABLE DEVELOPMENT

Sustainability means spending public money well, with smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term. Spending money well and considering the social and environmental impacts is covered in the Public Services (Social Value) Act (2012).

The CCG is committed to environmental and social sustainability through our actions as a corporate body as well as a commissioner. This section covers the work undertaken across our five places and includes how the CCG is:

- **Optimising the use of medicines**
- **Sustainable models of care: Making sure people don't need to go into hospital**
- **Digital transformation: Creating sustainable digital solutions**
- **Improving how we use our buildings**

### Optimising the use of medicines

There are real opportunities to reduce the carbon emissions related to the prescribing and use of medicines and medical products. The CCG has a dedicated team that work to optimise medicines, reduce waste, and look at alternative medicines that have a lower carbon footprint. The 2021-22 NHS Standard Contract also set out two key areas for early action in this area - inhalers and anaesthetic gases. Inhalers account for 3% of the total NHS carbon emissions. The CCG's approach to inhaler prescribing is mentioned below.

**Lowering of the carbon footprint of inhaler prescribing**

The CCG's medicines optimisation team have led the sustainable agenda locally and regionally, with engagement from all system partners, on ways to reduce the carbon footprint and environmental impact of prescribing and help improve the provision of medication.

Joint working with specialist respiratory teams and PCNs has led to the development of guidance and support tools to aid clinicians and individuals in reaching shared decisions about inhalers and whether to use low carbon inhalers in preference to higher carbon options. All PCNs across the ICS are showing significant progress in moving to prescribing of lower carbon inhaler devices.

The work undertaken in Frimley has received national recognition and is cited as an example of good practice by the Royal College of Paediatrics and Child Health: https://qicentral.rcpch.ac.uk/resources/systems-of-care/reducing-the-environmental-impact-of-inhaler-use-and-disposal-within-the-paediatric-department-at-wexham-park-hospital/ *Roome C, Bush O, Steinbach I, Langran T, Patel S. Reducing the environmental impact of inhaler use and disposal within paediatrics and the local community.* Archives of Disease in Childhood 2021;106:A41-A42 https://adc.bmj.com/content/106/Suppl_1/A41.2

## Sustainable models of care: Making sure people don't need to go into hospital

Embedding net zero principles across all clinical services is a critical ambition for many NHS organisations. The CCG continues to develop and improve how services provide care closer to home to support this ambition.

**Integrated community health and care services**

Heathlands is part of our joint vision with Bracknell Forest Council to create integrated community health and care services for our Bracknell Forest residents; services that are essential to local communities, are close to home, family and friends and services that we hope our residents feel familiar with and are seamless with the care they receive at home.

Heathlands will have 66 single en-suite rooms. Windsor Care has been appointed to provide residential care for those experiencing the challenges of dementia and Frimley Health Foundation Trust will manage a 20-bed intermediate care facility. The intermediate care facility opened to the public in March 2022 closely followed by the residential service in April.

The intermediate care beds are part of our wider ambition to support those living with frailty. Frimley Health Foundation Trust and community staff will work closely together to provide joined up care to local residents. Heathlands will provide a local alternative to hospital where people need support to get back on their feet following illness or injury. This may include being 'stepped up' from home to intermediate care or 'stepped down' from hospital to intermediate care, where people need extra support before going home.

These intermediate care beds will help patients avoid being admitted to hospital and reduce hospital stays, in favour of being cared for in their local community by a dedicated team focused on helping them achieve their personal rehabilitation goals. Freeing up hospital beds, reducing length of hospital stay and transfers of care will contribute positive benefits to the wider Frimley system releasing hospital bed capacity for those that need it most.

**Same day urgent care**

Our aim is to provide primary and community integrated same day urgent care that is responsive and focused on meeting the needs of the local community. The model will offer clear and timely access to advice, assessment and where required appropriate intervention for individuals who require support to manage their urgent health needs.

The ambition is to improve patient care outcomes and satisfaction by navigating patients to the right place, to see the right person, at the right time and to reduce patient confusion whilst improving access to same day primary and urgent care assessment and management. We have worked with our analytics team to understand the right capacity of the same day model to support the urgent care demand requirements. For example, some people with more complex needs and long-term conditions have a greater need for continuity of care from the same clinician or team of clinicians, whereas people who are generally well with an urgent health problem may be suitable for an appointment with any clinician.

The changes underway in Bracknell Forest provide a good example of what we are working towards across the whole ICS footprint. Changes have been made to our already well established integrated urgent care services to meet demand throughout 2021-22, in particular, provision of additional dedicated clinics made as part of the Bracknell Forest winter surge response.

**Improving access to gastroenteritis medication for children**

The CCG and ICS partners have introduced a new service improving access to gastroenteritis medication for children across all localities within the ICS. Gastroenteritis is among the leading causes for local people accessing urgent care and this service will support treatment closer to home as well as relieving pressure on urgent care services.

## Digital transformation: Creating sustainable digital solutions

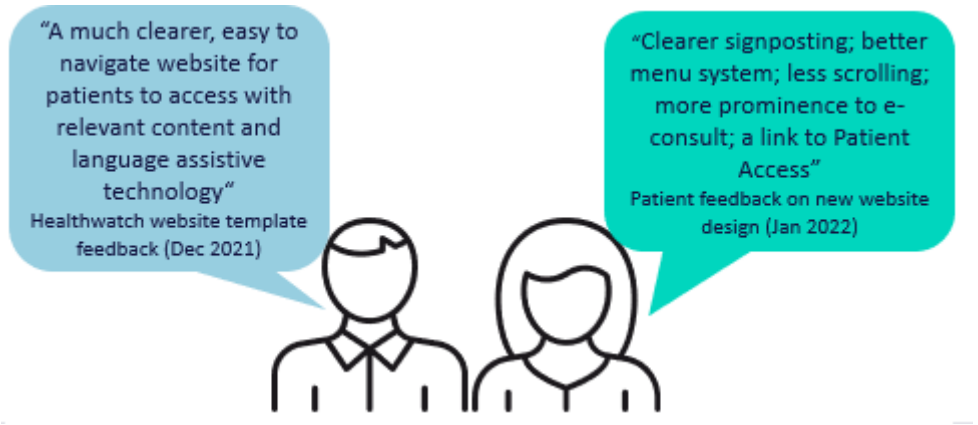
The CCG has continued to work with system partners to harness new digital technology and systems to help transform how GPs deliver services and at the same time help reduce carbon emissions.

**Access to primary care**

With infection prevention and control measures placing continued restrictions on the level of face-to-face appointments during 2021-2022, phone, online and video communication was the norm for initial appointments, with patients invited to see a clinician in person if appropriate.


We know that every individual has their own preferred method of contacting health services and that the switch to an increased number of virtual appointments during the pandemic has not been to everyone's liking. In October and November 2021 the CCG ran a survey specifically on access to primary care, to identify how people felt and what issues needed to be addressed.

There were 603 responses to the survey, providing feedback on people's confidence in using certain digital communication tools, their experience of using those tools and their willingness or reluctance to recommend them to others. When combined with the respondents' ages and genders, and with a wealth of other data and insights from other areas of work, the information serves as a valuable asset to help us make positive changes to the way local people can access health and care services. This feedback is now being used to help the CCG create consistent access to services in a variety of ways including telephone, online and face to face.




Other improvement areas include:

- **Training for practice receptionists** and wider staff in holding 'positive conversations' and training for GPs and managers to support engagement with patients, carers and local communities are both underway.
- **Patient information** have been created to help the public better understand the tools and technology available to support wellbeing. These are being produced

and updated regularly - please visit www.frimleyhealthandcare.org.uk for more information.

- A number of **new GP practice websites** have now launched, with more to follow throughout 2022. These have been developed to ensure a consistency of design that makes navigating GP websites much easier for our residents and supports people knowing the best source of support for their needs.

- There is also a focus in 2022 on the development of **digital champions** to raise awareness of services available, develop further training and improve access to digital services.

**Supporting the management of long-term conditions**
Since November 2021, we have been working with Healthy.io to enable smartphones to be used to support how patients record their urine tests. Increasing the number of tests taken by patients with diabetes is particularly important as early markers of kidney damage can be assessed using these specialist tests.

Patients who had not had a test in the previous 12 months were encouraged to test their urine at home and use their smartphone to submit test results. In one practice alone 109 patients were identified as not having had a test in the previous 12 months. Over half responded to the request, helping the practice focus on patients who were most at risk of chronic kidney disease.

**Prescribing decision support software**
This year saw the successful introduction of computer software that helps clinicians make safe and cost-effective prescribing decisions. In a single year the software created safety messages 122,186 times that then resulted in savings of over £400,000 in prescribing costs.

**Use of technology - Therapeutic gaming apps**
Our staff in Surrey Heath worked with BfB Labs, a company that designs therapeutic digital technology gaming applications, to support children and young people waiting for the Children's Mental Health Service (CAMHS) treatment. In addition, this application can also be used to help children who would not be eligible for CAMHS but require support with their mental health. Working with three GP practices, we have trialled Champions of the Shenga; which trains young people in diaphragmatic breathing (utilising a heart rate sensor) which helps them to regulate their emotions and become more resilient.

Children and young people that have used the game provided positive feedback:

"*This app has made a seeable deference to X. And I would be more than happy to take part in any other apps or programs that may help him as he is now in home education and I am looking to get him tested/ for autism adhd. Thanks very much for your help and for adding us to this program. Many thanks*" – Parent of a young person aged 14.

We have continued to use and build on relationships with local schools through the 'Link' workshop and, more specifically, we developed a special gaming app with three Primary Schools to support years five and six. Lumi Nova is an immersive mobile game to help build lifelong skills and manage worries.

## Improving how we use our buildings

In January 2018 the ICS was awarded £28.4m to support the implementation of an Estates Investment Programme to develop local **Integrated Care Hubs (ICH) within the Frimley ICS footprint, with eight** projects identified across the Frimley area.

These Integrated Care Hub are designed to ensure that primary and community care services have sufficient and suitable capacity, in the right places, to meet future demand. The aim is also to enable staff to work in the most efficient way by utilising the estate and digital capability to maximise impact.

The CCG is working with our partners across health and care to design the clinical model and the space requirements, to provide an integrated care model designed around the needs of our population.

The integrated care model programme aims to:

- deliver a sustainable model of primary care by providing premises that are fit for purpose, with capacityfor future growth. Premises must support the use of digital technology for consultations which increased enormously during the pandemic and now forms a real alternative to face to face consultations;
- allow for co-location of professional teams, supporting integration and delivering joined-up services designed to meet local need;
- create capacity and improve recruitment and retention of the extended clinical workforce, including new roles for clinical pharmacists, physiotherapists, mental health practitioners and extended nursing roles, and;
- provide greater patient choice by offering more appointments locally with a wider range of health and care professionals available to ensure more appropriate and timely intervention – the right person, in the right place at the right time.

**In Binfield, for example,** the design of the Binfield Surgery building will support the development of a shared service model that provides enhanced wraparound services that will not only meet the needs of the local patient population of Binfield Surgery but will provide additional services for patients across the local Primary Care Network.

## Using our buildings more efficiently

**Blue Mountain, Bracknell Forest**

Binfield and Warfield are within one of Bracknell Forest Council's Major Areas for Growth and are next to planned Strategic Development locations in the neighbouring Borough of Wokingham.

The CCG and Bracknell Forest Council have worked throughout 2021/2022 to redevelop the former Blue Mountain Golf club to build a community and health centre. The centre will open early 2023.

The new facility will enable health and care services to be delivered locally, provide much needed accommodation to house an extended and integrated multi-disciplinary workforce, deliver modern facilities that are designed to support new ways of working and create capacity to meet growth in future demand.

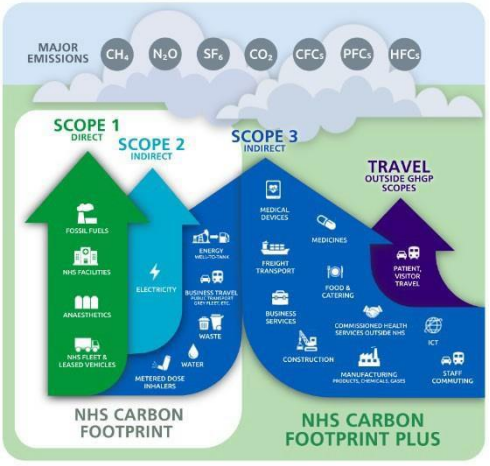
**Brook House**

In spring 2021 Ascot Medical Centre and Green Meadows Surgery moved to a modern, fully refurbished building at the Heatherwood Hospital site in Ascot, called Brook House. The site has allowed a mixed workforce to provide additional services to patients, enabling more appointments and supporting patients to be seen more quickly.

The move to a digital working model using laptops enables flexible working for staff, increasing wellbeing and retention at a particularly difficult time for all in primary care. Staff and patients using the new building reported feeling better and more social andrecruitment has been more successful, partly due to the new modern facilities. The practices are working together on supporting staff resilience and retention, developing a Same Day Urgent Care service and ensuring the use of the new space matches the needs of the local population.

As well as Brook House, planning permission has been granted for the Sunningdale Health Hub development which will locate Kings Corner Surgery and Magnolia House Surgery within facilities which are suitable for the future. The site will also be key to the delivery of community services for practice patients.

## Sustainable Development Summary




As the CCG transitions into becoming an ICB there will be a wider view on how the system can help meet the NHS targets to deliver a net zero National Health Service:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

There are many opportunities to meet these targets including:

- our care: By developing a framework to evaluate carbon reduction in new models of care being considered and implemented as part of the NHS Long Term Plan;

- our medicines and supply chain: By working with our suppliers to ensure they meet or exceed our commitment on net zero emissions before the end of the decade;
- our transport and travel: By supporting road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet;
- our innovation: By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service, and actively seeking out future innovations that support this ambition;
- our hospitals: By supporting the construction of 40 new 'net zero hospitals' as part of the Government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard;
- our heating and lighting: By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort and save over £3 billion over three decades;
- our adaptation efforts: By building resilience and adaptation into the heart of our net zero agenda with the third Health and Social Care Sector Climate Change Adaptation Report and;
- our values and our governance: By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme for a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, demonstrating that this is a key responsibility for us all. *Reference to 'delivering a net zero national health service* https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf

## 7. IMPROVING QUALITY

Local people have the right to high quality patient care; as stated by the NHS Constitution and the CCG continues to be responsible for ensuring continual quality improvement of all locally commissioned NHS services.

Quality care is the level of care we would expect our families and loved ones to experience, should they need it. Quality is what matters most to people who use our services and what motivates and unites everyone working in health and care. It is intrinsically linked to finance and performance as one of the three key pillars.

Frimley CCG has adopted the National Quality Board definition and vision of quality for those working in health and care systems. It uses Lord Darzi's definition of high-quality care as being safe, effective, and providing a positive experience, with a greater emphasis on population health and health inequalities.


**Safe -** delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports, and enables people to make safe choices and protects people from harm, neglect, abuse, and breaches of their human rights; and ensures improvements are made when problems occur.

**Effective -** informed by consistent and up-to-date high-quality training, guidelines, and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking, and clinical audit.

**Positive Experience -** responsive and personalised - shaped by what matters to people, their preferences, and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable. Caring - delivered with compassion, dignity, and mutual respect.

**Well-led -** driven by collective and compassionate leadership, which champions a shared vision, values, and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.

**Sustainable use of resources -** focused on delivering optimum outcomes within financial envelopes, reducing impact on public health and the environment.

**Quality Care is equitable -** everybody should have access to high-quality care and outcomes, whatever their background or circumstances, and those working in health and care must be committed to understanding and reducing variation and inequalities.

## COVID-19 Quality Response

As a system, the quality impact of COVID-19 on services remains a key focus of the Frimley ICS Executive Quality and Response Group. Through Quality Impact Assessments, System Leaders can understand the change and impact on services and give consideration on the effect to the whole system. They also give the opportunity to highlight and reduce health inequalities.

Many members of the quality team come from clinical backgrounds including nursing, physiotherapy, and paramedics. This has meant during peaks of the pandemic in 2021-22, the team was able to offer clinical support to vaccination centres, the acute hospital and community services to help our partners when workforce shortages were impacting on the delivery of patient care.

## Frimley ICS COVID-19 Vaccination Programme

The Frimley COVID-19 vaccination programme continued to enact government-endorsed Joint Committee on Vaccination and Immunisation (JCVI) guidance throughout 2021-22, operating flexibly to respond to changing requirements, and providing localised vaccination sites. The programme was expanded during the year to include oversight of the flu vaccination programme, which gave an opportunity to explore the co-administration of flu and COVID-19 vaccinations where possible.

As of 31 March 2022, Frimley ICS has delivered 1,603,510 vaccinations to local people, with 594,508 first doses, 561,201 second doses, and 447,801 boosters. . This has been a huge and successful effort involving all parts of the system, including the NHS, Local Authorities, the Police, volunteer services, charities, and community groups.

Booster vaccination uptake in those eligible aged 16 years and over is currently 84% which is similar to the South East regional average. 64% of children aged 12-15 years have received their first vaccination, and 92.7% of eligible immunosuppressed people have taken up the third dose vaccination.  Frimley ICS has delivered first doses to 82% of pregnant women at the end of their second trimester, and second doses to 74%. Frimley has consistently featured in the top ten systems nationally for Learning Disabilities vaccination uptake. Ensuring good outreach, information, and support to all vulnerable and hard-to-reach groups within the community remains a key priority for our programme.

## Infection Prevention and Control

The Infection Prevention and Control (IPC) Team spans the ICS and has undertaken a wide-ranging programme of work,  including:

- providing support for all adult and social care organisations across Frimley ICS, ensuring IPC principles were implemented and upheld to safeguard both staff and those receiving care;
- training in Infection Prevention and Control/Personal Protective Equipment use for staff in care homes, supported living organisations and primary care ;

- providing support for primary care with the ‘stepping up’ of services, such as vaccination sites, ‘hot’ hubs and specialist treatment centres;
- carrying out infection, prevention and control reviews of vaccine sites;
- providing outbreak management support to social care organisations and primary care
- ‘fit-testing’ care home staff needing to undertake aerosol generating procedures upon a resident and requiring the use of FFP3 (Filtering Face Pieces) respirators.
- working with care homes to support discharge of residents from hospital

Throughout the pandemic the IPC Team has continued to undertake post infection reviews, with a focus on sharing learning across the system.

## Serious Incidents

Serious Incidents and Never Events are well-defined by the NHS England Serious Incident (SI) Framework and by the Never Events Policy and Framework. The CCG’s serious incident management process allows providers to be held to account and seeks assurances over their investigation, in order to ensure learning from serious incidents and Never Events has taken place and mistakes are not repeated.

The CCG holds serious incident panels with our providers. This gives us an opportunity to identify any themes and discuss larger pieces of work aimed at minimising systemic risks

Never events are considered to be red flags as they highlight potential weaknesses in how an organisation manages fundamental safety processes.

| | Frimley CCG |
|---|---|
| Never Events 2021-22 | 3 |

## Complaints

The CCG welcomes feedback via complaints, concerns, and compliments from members of the public as part of efforts to continually improve commissioned services.

The CCG can provide advice to patients and/or carers about help available if they are unhappy with the NHS care they have received. This includes assisting in a discussion with the care provider at the time a concern is identified (whenever possible) and providing advice about independent advocacy services and the Parliamentary Health Service Ombudsman (PHSO) as appropriate.

Complaints and concerns raised to the CCG help to inform future service improvements. The CCG ensures individual quality leads are informed of complaints or concerns relating to the providers they work with.

The table below shows the number of complaints and concerns that have been received over the financial year 2021-22:

| 2021-22 | Frimley CCG |
|---|---|
| Complaints | 78 |
| Concerns | 520 |

## Clinical Feedback

During 2021-22 Frimley CCG continued to provide a platform for GP practices and other health professionals to report patient and process specific concerns across our local healthcare system. Through the clinical feedback process resolutions are sought and investigations opened into quality matters. The clinical feedback system is a valuable tool to respond to and monitor quality issues. It gives an opportunity for Frimley CCG to identify themes among concerns raised and to bring about positive changes to patient experience.

## Learning Disabilities Mortality Review Programme (LeDeR)

The Learning Disabilities Mortality Review Programme (LeDeR) was established following a national Confidential Inquiry into Premature Deaths of People with learning disabilities, which reported that people with learning disabilities are more likely to die from causes of death that could have been avoided with good quality healthcare.

Changes to national structures caused a temporary suspension of case work between April and June 2021, while the new national platform was readied. Case reviews resumed in June 2021.

At system-level, the LeDeR Programme is managed by the CCG, and since the formation of Frimley CCG in April 2021 there has been a single Frimley ICS programme. The LeDeR Steering Group meets on a quarterly basis to review investigations, to act on lessons learnt and to facilitate improvements which can be shared across organisations.

The CCG has ensured that the vaccination of people with Learning Disabilities has remained a priority across the system (with reasonable adjustments and support put in place) and highlighted the need for vigilance for people showing atypical symptoms after vaccination.

## Mortality Review Group

The CCG convenes an ICS Mortality Review Group, meeting quarterly. This group is chaired by the Executive Director of Quality and Nursing and includes executive and operational leads from all main providers, including Royal Berkshire NHS Foundation Trust. The group meets to share learning from provider mortality reviews, and initiatives / responses to key risk areas identified. Through this forum providers have been able to share their practice in relation to key topics such as early detection of deterioration, frequent attenders to Accident & Emergency units, substance misuse, mental health risk assessments, and psychiatric liaison. The group also discusses and shares progress with the planned widening of the Medical Examiners system to cover community and primary care services.

## End of Life Care

There has been rapid pace of change in end-of-life (EOL) care within Frimley ICS in response to the challenges during the pandemic. The ICS EoL Steering Group has continued to meet and prioritise areas of development. One area that supports this is

the introduction of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment), which had a soft launch in July 2021. Training commenced in primary, secondary and voluntary sectors, including care homes. The medicines optimisation team has continued to work on electronic end-of-life prescribing drug charts, which was nearing completion.

ReSPECT is a long-term project to ensure that training is delivered at different levels across the system to ensure understanding and competency in completing the ReSPECT forms.

The Steering Group is in the process of developing guidance in relation to homeless pathways and videos which could help to support health inequalities in Frimley ICS.

## Quality at Place

Each of the five Places within Frimley CCG has a dedicated Place quality lead to ensure high quality of care is brought closer to home. Whilst the CCG recognises there will be variation of approaches, there will be a continued focus on:

- empowering and educating people to make informed decisions about their health and to manage and take responsibility for their care;
- developing services that place the person at the centre of the care process, and;
- developing integrated services that deliver the right care, first time.

Place-Based quality lead roles were created to embed quality in everything that is done at Place. The roles have evolved over the past year and are becoming firmly integrated within Place-Based teams at operational and strategic levels.

The CCG Place quality leads work closely with the Care Quality Commission (CQC) to ensure that any areas of concerns or quality issues are known. Support can then be offered to patients and providers, promoting best practices and identifying opportunities to make improvements or positive changes.

## Care Home

Care Home quality leads have been working together to support local care homes during the COVID-19 pandemic. The team has provided support on issues such as infection control advice, discharge issues and vaccination hesitancy.

Care home support forums were introduced in March 2021, providing an opportunity to share the latest guidance changes, to update on local support and training offers and to provide a question-and-answer opportunity.

During the pandemic virtual training and education packages were offered on a wide range of topics. These packages included both older adults and learning disability care homes in the Frimley ICS area.

The Care Home quality leads were innovative in their support to care homes. The CCG provided laptops to homes where they did not have sufficient equipment and

supported the roll out of iPads from the national programme. The team worked with nursing homes on enabling them to be connected with the shared care records (Connected Care) and are piloting remote monitoring for at-risk residents.

Place based quality leads have enabled close partnership working with local authority colleagues and the development of strong local relationships.

## Safeguarding

2021-22 has seen ever-closer collaboration of safeguarding partnerships across the Frimley system and has allowed the development of shared ICS and ICB Ambitions for 2022/23:

- establishment of a Safeguarding model within the ICB;
- implementation of a collaborative portfolio model for organisations across the ICS;
- development of one ICS training resource, and;
- development of an ICS Safeguarding Annual Report for the health system

Streamlined governance and reporting arrangements were established for the newly formed CCG - the Executive Director of Nursing for the CCG acting as the Chair for the Strategic Safeguarding Group and the named and designated safeguarding leads for the CCG and the Providers meeting together on a regular basis to ensure aligned system working. This has fostered close working relationships, embedded best practice and allowed the development of system-wide reporting, which is cascaded to each of the Five Places within the CCG footprint.

NHS England has indicated it's satisfaction with the CCG's progress to establish appropriate safeguarding systems in readiness for the establishment of the ICB.

Collaboration has allowed for joint learning from live cases in each area; for example, the prevention of violence and abuse to babies and children, early detection of and improving the response to abuse by neglect and self-neglect. In addition, closer collaboration has supported care and residential homes where a health-coordinated response is essential and a need was identified for increased communication, particularly for organisations which are positioned close to county borders. We have learned that issues with violence – especially knife crime – must be reported quickly. There has been a positive response to the creation of a new health navigator position in the acute trust.

The Safeguarding Team has been working with Surrey and Hampshire Children in Care Teams to improve the provision of health care to children and young adults, including care leavers. One example of their work was ensuring improved access to dentists and the creation of a specialist children in care Children and Adult Mental Health (CAMHs) role worker. We have been working with multi-agency partners to arrange health provision for people who are seeking asylum or are part of resettlement programme and are housed in hotels and other placements. Based in Slough and

Rushmoor, the safeguarding staff liaise with the Home Office and ensure the risks for these individuals are highlighted continually.

Primary care is fully supported with safeguarding responsibilities by the safeguarding team – level 3 safeguarding training has been delivered to over 500 primary care practitioners. The use of virtual on-line training has improved the attendance rates and this model has been permanently adopted. The team works with specialist named GPs for safeguarding to continuously improve the safeguarding response across primary care.

## Medicines Safety

This year a new Medicines Safety Pharmacist post was created and an ICS Medicines Safety Group established.

The medicines optimisation team supported local practices with training and guidelines to support some key medicines safety priorities: anticoagulants, medications that can cause dependence and National Patient Safety Alert Steroid Emergency Cards. These priorities have all brought about positive progress in prescribing patterns.

The medicines optimisation team and NHS Surrey and Borders Partnership Foundation Trust were nominated for a Health Service Journal Award for their innovative work on PRISM (Pathway Redesign for the Improvement of Safer Valproate Medication prescribing) which ensures that women prescribed valproate (for example for epilepsy) are supported appropriately to reduce the risk that this medication brings during pregnancy.

The team also undertook a project with Berkshire Healthcare NHS Foundation Trust to review the prescribing of psychotropic medication (that includes anti-depressants, anti-anxiety, anti-psychotic, and mood stabilisers) for children with learning disabilities. As a result of the review, the medicines optimisation team made recommendations to improve practice.

## Workforce development

The medicines optimisation team has developed and delivered a huge amount of training over the year for different groups of staff, for example practice clinical staff and Care Home Staff and PCN Pharmacists, Pharmacy Technicians, GP Trainees, Nurses and Prescription Managers

This year has also seen the creation of system-wide Early Careers Pharmacy development groups to form strategy and deliver change to pharmacy career pathways and placements within the ICS. We aim to create more cross-sector placements and posts that will not only recruit and retain staff better but also create a workforce that is truly system-wide and understands what we are all trying to achieve together.

## Medicines Optimisation in Care Homes (MOCH)

The MOCH Team has continued throughout the pandemic to provide guidance and support to care homes on safe medicines use. This has been in the form of written guidance, webinars, phone calls and answering queries. The team has led the roll out of a system which streamlines prescription ordering and reduces workload at both care homes and GP practices.

The team also had a crucial role in providing information to care home staff on COVID-19 vaccinations in order to support them to make decisions about having the vaccine. They have attended multi-disciplinary team meetings to provide expert pharmaceutical advice and supported community pharmacists with reviews of complex cases and with training to develop local capability and quality of structured medication reviews.

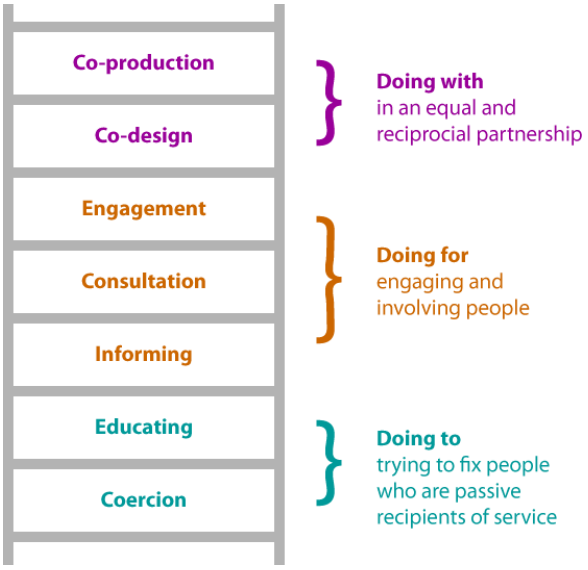
## 8. ENGAGEMENT WITH PEOPLE AND COMMUNITIES

Involving local people and communities in the work that we do is essential to our success as an organisation. Patients, communities, and local people not only have the right to participate in plans and decisions around their own health and care, but they should also be able to play a role in shaping the services available. For services to be truly effective we need to raise awareness among our residents of the choices available to them, to allow them to make informed decisions and get the treatment they need, when they need it.

Working in partnership with patients, carers, families and local people within their own communities brings a different perspective to our understanding and can challenge our view of how we think services are received and should be delivered in the future.

Through our experiences of working with local people in recent years, we know that collaboration and developing trusting relationships with our communities leads to better decisions and better results. We are committed to keeping the patient and public voice at the heart of everything we do.

By supporting projects and approaches that are community focused we can continue to co-design an approach that tackles broader inequalities that affect our health. Our ambition is to work together as communities, voluntary sector, health, care and local government to deliver change as part of our local communities.




www.thinklocalactpersonal.org.uk/

### The COVID-19 pandemic

Throughout 2021-22 the COVID-19 pandemic has continued to have a serious impact on all activities of the CCG. Lockdowns and other infection prevention measures have particularly affected our ability to engage with our local communities in the way we did before the pandemic.

Despite the restrictions we have nevertheless been determined to continue to connect with our residents and with our many other partners in a meaningful and constructive way wherever and whenever possible.

The pandemic has presented opportunities as well as challenges, including the increased use of data to transform services more quickly to adapt to changing circumstances and to address inequalities. Technology has also changed the way many people interact with health services and how NHS staff work together and with partners. These developments are key elements of the recovery from COVID-19.

Face-to-face engagement activity has continued to be on hold, particularly given the emergence of the omicron variant of COVID-19 towards the end of 2021, when restrictions were tightened again, and many health and care staff were redeployed to support COVID-19-related activity. As part of this, in December 2021 the CCG took the difficult decision, in line with advice from the Government and NHS England, to postpone even online meetings as a result of the national return to emergency response level 4. This temporary measure was removed as soon as circumstances allowed.

## Our legal duties and principles of engagement

The CCG has a duty, under Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012, to involve the public in commissioning (planning, decision-making and proposals for change that will impact individuals orgroups and how health services are provided to them).

This section of the annual report provides an overview of the consultation and engagement activities that have taken place over the year from April 2021 to March 2022.

We know from experience that engagement with patients, carers and our local communities can result in:

- better outcomes and patient experience;
- improved services - gathering and using patient experiences can help the CCG commission (buy) and deliver services more effectively;
- reduced demand - informing and engaging people can increase self-care, improve take-up rates for healthy options, and reduce inappropriate service use;
- deliver change - involving people in discussions and decisions about service changes can make it easier to manage risks and deliver difficult change successfully.

We are continuing to drive a real culture change across the health and social care system, to put engagement and co-production at the heart of everything that we do, helping residents to actively participate in design and delivery of services – now and in the future.

Until 1 April 2021, the three communications and engagement teams from East Berkshire, North East Hampshire and Farnham and Surrey Heath CCGs had been working together as a joint team to support the Frimley Collaborative of CCGs. With the CCG merger, the three teams were united to create a single Frimley-wide communications and engagement team within the new NHS Frimley CCG.

We continue to work to a set of principles for engagement with people locally, which all staff at the CCG aim to use in everything that they do:

- be open and honest about what is possible and what is not possible;
- communicate clearly in easy-to-understand language;
- listen and act on patient and carer feedback at all stages of decision makingand identify how that feedback has changed what we do;
- be accessible – the way we engage people should be tailored to the needs of the people we are trying to engage – ask people what is best for them and in places and times that meet their needs;
- involve people as early as possible and make sure our engagement is representative to the piece of work we are engaging on;
- base relations on equality and respect – patients and the public have an equal voice to professionals;
- work hard to seek the views of people and communities who experience the greatest health inequalities and the poorest health outcomes, making it easier for people to take part, identify barriers and remove them;
- allow plenty of time for people to receive information, read itand respond to it;
- review, evaluate and publish the impact of patient, carer and public engagement, and;
- allocate appropriate resources and support so that engagement can be effective

## Engagement across the Frimley Health and Care System


Working in partnership, our intention is to implement the ambitions of the Frimley Health and Care Integrated Care System for the benefit of the communities we serve and our staff.

Our shared ambitions are:

- Starting Well: We want all children to get the best possible start in life.
- Focus on Wellbeing: We want all people to have the opportunity to live healthier lives, no matter where in our system they live.
- Community Deals: We will agree with our residents, families and carers how we work together to create healthier communities.
- Our People: We want to be known as a great place to work and live, and to make a positive difference.
- Leadership and Culture for Improvement: We will work together to build collaboration at every level across the system.
- Outstanding use of resources: We will offer the best possible care and support where it is most needed, in the most affordable ways.

The ambitions were developed through high levels of engagement and they reflect local needs, issues and priorities, are rooted in evidence and aim to tackle health inequalities and the wider determinants of health and wellbeing for our population.

All of our engagement activity is based around the above ambitions and is focused on supporting one or more of the above goals. We continue to work with our local residents, families, volunteers and carers to agree how we collectively (as organisations, individuals and families) create healthier communities, supporting healthy choices and designing and delivering new ways of working to improve the health and wellbeing of our local population.

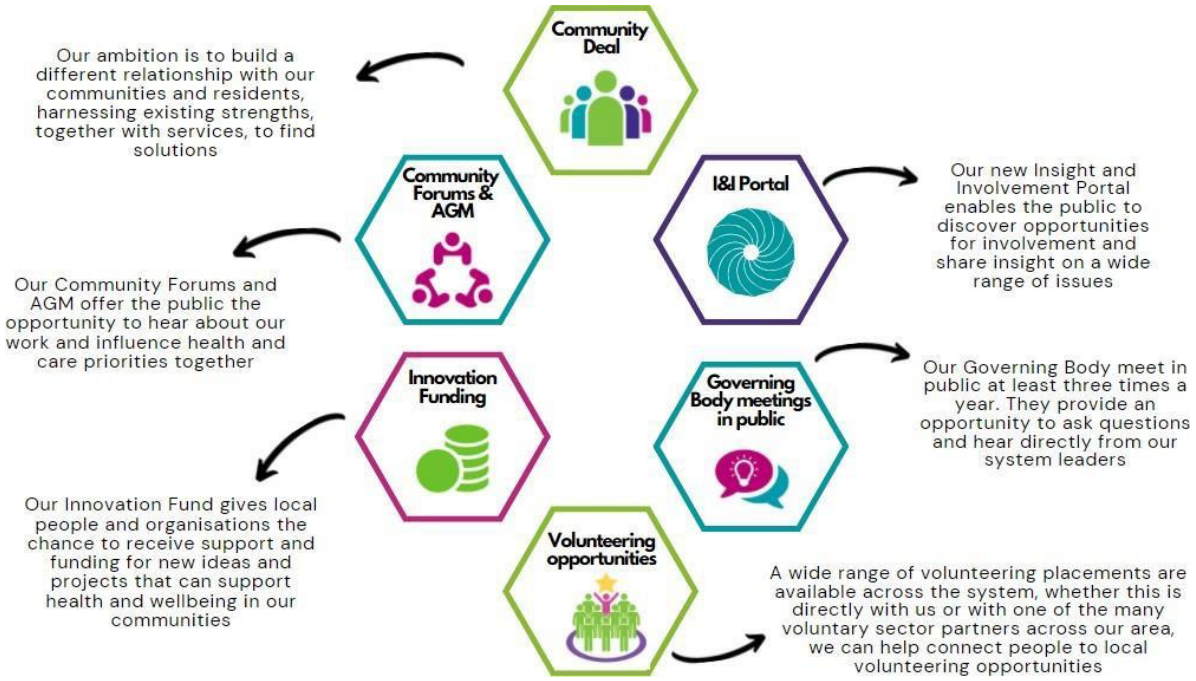
## Join the Conversation

We have a number of ways in which people can engage with us, because we understand that everyone is different and what suits one of our residents will not work for another.

These different channels come together under our Join the Conversation programme. The simple brand reflects our belief as a CCG that our population is involved in what we do, and that any individual, group or organisation can play a part.

Over the years we and our predecessors have increased the involvement of our population in our activities. The pandemic has affected our interaction with local people, but we are still able to engage with them and with the relaxing of infection control measures we are looking forward to meeting with people once again.

There are a wide range of ways that people can get involved and share their views:




## The Insights & Engagement Portal

We are committed to being an organisation that delivers the best possible health and wellbeing outcomes for people who live within our local communities. This means adapting to new ways of working, ensuring a local focus but with the additional benefits of support, sharing good practice and learning across the Clinical Commissioning Group (CCG) and the wider Frimley Health and Care Integrated Care System (ICS).

We know that health and care services can be improved if we can learn more about the views, experiences and concerns of local people and communities. The introduction of restrictions on everyday activities and face to face activities has mean that we have had to rethink how we reach out to people. We recognise a continued and critical need to talk to and hear local people and patients throughout this time.

As part of a wide reaching engagement programme this year we launched our new Insight and Involvement Portal and made developments to our online Community Panel.

The portal:

- offers local people the opportunity to explore a wide range of projects and work where we are seeking their input and involvement;
- improves access with a variety of tools including surveys, quick polls, Q&As, maps, document sharing and ideas boards;
- is a space to share experiences, hear from others, build networks and share feedback, and;

- allows sign up to our Community Panel to take part in regular surveys and hear about other opportunities to support us in creating healthier communities.

Our Community panel is now embedded within the new portal. Recruited in 2019 and still growing, our online Community Panel of over 1,500 people support us to better understand our local communities. Panel members may also be invited to take part in project work, focus groups and face to face opportunities. This year we have also been successful in securing additional funding from NHS England to further develop the panel.

Over the course of 2022 we are particularly keen to:

- support the Integrated Care Partnership and other stakeholders in the system and increase the use of the community panel to engage with people and communities on services that impact on their health and wellbeing;
- test how the community panel can best reach the most excluded and/or vulnerable groups, for example ethnic minority groups, people who are rough sleeping, homeless or insecurely housed, people with a diagnosis of dementia and/or their carers, Gypsies and travellers;
- use the community panel as part of the wider engagement and consultation process in relation to major service change and reconfiguration of services, and;
- support other insight and intelligence gathering across the system such as population health management data or redesigning outpatients.

More information about the panel, including examples of previous surveys, can be found on the portal: insight.frimleyhealthandcare.org.uk

## Engagement response to the COVID-19 pandemic

### Vaccination

The COVID-19 vaccination programme has been the largest and most intensive vaccination programme ever mounted by the NHS. With so much riding on its success, it has required considerable communication and engagement resource throughout.

In addition to supporting national vaccination messaging – on vaccine safety, eligibility, access, phases of the rollout etc. – on our website, our social media channels and in information shared with the media, we have taken part in specific activity. This has included facilitating national and regional media visits to vaccine services, supporting and promoting the introduction of the ‘vaccine bus’ initially in East Berkshire, but later shared this best practice to areas in Surrey Heath and Aldershot to tackle variation in uptake, continuously updating details of local vaccine clinics to be a single source of information to be accessed by local people and shared by our partners, and assisting community vaccine initiatives i.e. with local mosques to respond to local need.

#LetsTalkCovidVaccines has linked together all our communications and engagement, with continued efforts to make information assessable to all communities across the system. This includes pregnant women, those in deprived communities as well as those for whom English is not a first language.

Additional funding has been secured by the system from the regional team for focused work determined by the equalities impact assessment, and the submission recognised as one of the best in the region, based on the fact that communications and engagement interventions were data driven, recognising the demographics in communities as well as the variation in vaccine uptake.

In Slough for example, there was exceptionally low uptake for the 12-15 year old cohort. Acting on community feedback, we knew we needed to do something different and test new ways of engaging our population. This population are familiar with, and actively use YouTube to livestream local language content. It is a trusted channel, which does not need login or subscription to watch content. We identified well recognized local GPs to form a panel, who took live questions from the public via YouTube comments, text message and email. The session was promoted to young people and anyone working with young people including parents, teachers etc with the objective to de-mystify the vaccination programme for this cohort, and instil confidence in vaccines.

A key strength of the communications for this programme has been its agility. Insights from vaccination sites are shared via the programme board, and communication messages are designed to facilitate the staff on the ground, for example, when hesitancy was felt for Moderna, local comms was strengthened re vaccine confidence and materials made available to all sites.

In December when the programme was asked to step up vaccinations ahead of the new year to protect against Omicron, our communications and engagement efforts doubled too. From local ‘gold tickets’ issued to residents in neighbourhoods where vaccination rates were really low, to targeted messages into local residents social media groups, our communications made clear when, where and how people could get vaccinated.

The Frimley Health and Care ICS Communications Group has representation from all local authorities and provider organisations. This enables effective consistent and effective message sharing across the system, as well as good use of all communication resources – both people and assets.

The communications and engagement team has also supported local vaccine services to highlight the excellent work they have been carrying out and covering the plaudits they have received from Government and the Royal Family, including phone calls to a GP practice from the Duke of Cambridge and the Secretary of State for Health and Social Care, as well as a visit by the Earl of Wessex to a vaccination service.

## Working with our partners

Healthwatch are the independent national champion for people who use health and social care services. They are there to find out what matters to people and help make sure their views shape the support they need. There is a local Healthwatch in every area of England working to find out what people like about services, and what could be improved, and they share these views with those with the power to make change happen. Healthwatch also help people find the information they need about services in their area.

Nationally and locally, they have the power to make sure that those in charge of health and social care services hear people's voices. As well as seeking the public's views themselves, they also encourage health and social care services to involve people in decisions that affect them.

Frimley CCG work closely with our local Healthwatch organisations to better understand what they are hearing and how we can make changes as a result. We also hold regular network meetings with all of our local Healthwatch to share feedback and learn from each other. We will also regularly commission Healthwatch to undertake independent work on our behalf, particularly when we want to ensure independence and capture anonymous or impartial feedback.

## Voluntary & Community Sector

Frimley CCG also works closely with the Voluntary sector in a range of different ways. The vast majority of small charities and voluntary groups are supported by their local Council for Voluntary Services (CVS). We meet regularly with CVS colleagues to understand shared priorities, share ideas and develop new ways of working. We also commission a wide range of voluntary sector organisations to provide services for the local population. As we move through 2022, we will also be working closely with voluntary sector colleagues to develop a Voluntary Sector Alliance to strengthen these relationships and improve our ability to work in partnership as the ICS develops.

Case Study: Living Well in Farnham – A partnership approach

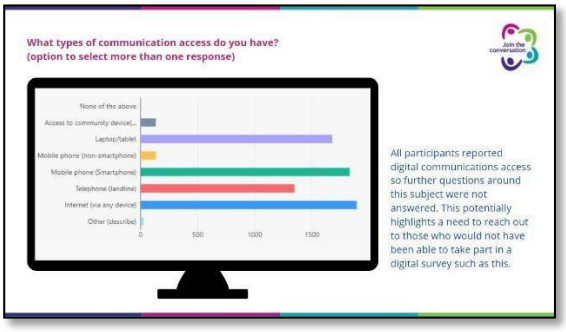
In order to better understand the needs of people in Farnham, we teamed up with local partners, ranging from small community groups to the county council and the police. The aim was that by working together we can build stronger relationships and tackle issues that one organisation on its own cannot solve.

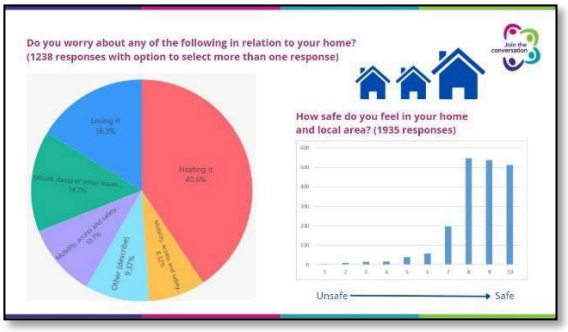
As part of this work we ran a survey between December 2021 and January 2022 to learn what mattered to Farnham residents as far as their health and wellbeing were concerned. Live Well partners shared the survey at community events and online and GP practices sent text messages to patients. The survey had an impressive response, with 1,937 people completing it.

The survey provided valuable insights into patient demographics, access to services, general fitness and health satisfaction, as well as any housing issues. It also enabled participants to suggest changes required to address their issues.

It was particularly interesting to note that although the vast majority of respondents said that they were able to access the internet to access information about local health, care and wellbeing services, most were using the national NHS website or search engines and were not aware of more local information and resources. The survey also highlighted a real concern for local people around the cost of living and the impact this would have on heating their homes and feeding their families.

As a result, the group created a page on our 'Insight and involvement portal' that shared the feedback received alongside a wide range of local resources and information that has been shared directly with those that took part. Over time, this site will be used to continue to the conversation with local residents. You can access the page, including a complete summary of results, here:
https://insight.frimleyhealthandcare.org.uk/livingwellinfarnham




## Urgent and Emergency Care system pressures

One area of healthcare that has been hit particularly hard by the COVID-19 pandemic is urgent and emergency care.

Disruption to routine health and care services, combined with people's reluctance to come forward with health problems at an early stage in the way they previously would have done, has led to an increase in the numbers of people requiring urgent and emergency care. Some urgent care services have also had to be suspended in order to reduce the risk of infection to other service users and staff at certain sites.

At Frimley CCG we are looking at these areas of work as part of our Urgent and Emergency Care system pressures plan. From late December 2021 to early January 2022 we ran a short survey to gauge people's awareness of urgent and emergency care provision and to gain insight on their behaviours.

As part of the broader work around urgent and emergency care and supporting our population to access the right treatment at the right time, we have also been using our various communications and engagement channels to promote our Know Where to Go campaign. We have developed a range of graphics and short videos and used these on our websites and social media channels and have issued press releases, all aimed

at raising awareness among our population of which service to use when, in order to get the appropriate treatment.

Developing meaningful ways to engage the local community and staff is a key element of the delivery of the Urgent and Emergency Care (UEC) system pressures plan. To further embed and extend the current engagement work, we are reviewing audiences' responses to the recently produced materials, and messaging to better understand what resonates and what has reached key target groups. By gaining further insights about whether our current approach is working, and how the messaging has been received, we can then adjust or refine our materials and/or channels to better meet the needs of our target groups. We are now in the second phase of testing public and staff awareness and response to the current key messages, materials and the best channels to reach them. This was done via a dedicated online space, created on our Insight and Involvement Portal, with links to information and materials: https://insight.frimleyhealthandcare.org.uk/frimleywinter

Participants were invited to take part in a short survey to give their thoughts on those materials and where they had seen them, as well as responding to some scenarios to test which service they would choose in certain circumstances. Respondents were also asked if they would like to take part in further focus groups to further explore and develop more insight into their attitudes and reasons for their behaviours.

With the increase in attendances at hospital A&E departments, in February 2022 we provided communications support to our primary care and Frimley Health NHS Foundation Trust colleagues with the design and printing of patient leaflets explaining the new pilot primary care service at Wexham Park Hospital, including versions in English, Urdu and Polish.

Depending on the pandemic response continuing to scale down, we will be looking to carry out more engagement work to determine the future shape of local urgent and emergency care provision.

## Public meetings

Social distancing and other infection control measures have prevented us from holding face to face meetings in public, yet we have continued to hold them online whenever possible.

During 2021-22 we have held our Governing Body meetings in public, as well as our Primary Care Commissioning Committee meetings in public. These are promoted using our website and our social media accounts and we have seen higher numbers of external attendees than when the meetings were held face-to-face in the past.

The meetings were temporarily suspended in late 2021 when the Government announced an escalation to Level 4 Incident Response as a result of the emergence of the omicron variant of COVID-19 and the redeployment of staff as part of the enhanced vaccination booster drive. The suspension was lifted as soon as possible in 2022.

On 21 September we held the first ever Annual General Meeting of NHS Frimley CCG. We are committed to engaging with residents and partners and were determined to stage the showcase event despite the pandemic, although in line with our other meetings at the time, it was held online. The meeting was well-attended and was an opportunity to share the many ways in which local NHS and social care services had adapted to continue to support residents.

A key focus of the meeting was to share some of the key community projects that have been supported or funded by the CCG as part of the innovation fund and NHS charities funding. Both schemes offered local people and communities the chance to apply for funding that supports health and wellbeing in the community. Projects had a particular focus on supporting priority areas that were identified to reduce inequalities, many exacerbated by the impact of the pandemic. You can see a short film highlighting these projects HERE.

The meeting was recorded and the recording uploaded to our website along with our Annual Report and Summary documents so that anyone unable to attend the meeting itself did not miss out. A full summary is available HERE.

## Innovation Conference

The Innovation Fund was established in 2017. Starting as an idea from a volunteer Community Ambassador in North East Hampshire and Farnham, the Innovation Fund, and supporting conference aims to give communities the opportunity, support, courage and seed funding to suggest and progress innovative projects that could have a big impact on the health and wellbeing of local people.

Over 45 projects have now been supported and the impact on local communities has been clear to see. By providing opportunities for our community to find the solutions to local health and care issues, we are able to develop models from the ground up alongside local people, supporting gaps in health inequalities in a different and more impactful way.

The Innovation Fund has always aimed to create a safe space for individuals, local community groups or established charities to bring new ideas or ideas that can take an existing project to the next level and benefit from the input, knowledge and connections of local people and organisations in developing and shaping the project further. Alongside this fantastic networking opportunity, this year thrilled to have opened up the process to a much wider audience.

At the beginning of 2021 funding was made available to people and communities across North East Hampshire and Farnham and Surrey Heath. This was followed by an opportunity for residents across Slough, The Royal Borough of Windsor and Maidenhead and Bracknell Forest (East Berkshire). We invited anyone to get in touch with an idea that could help with the physical or mental health of children, young people and/or families, in any way - No idea was too small or too large.

## Committed to addressing inequalities within our local communities.

The impact of COVID-19 has been felt by everyone. We wanted to hear from those who had ideas which could support people most in need. Listening to our communities over the course of 2020 and 2021 highlighted a number of priority areas for consideration including:

- oral health, healthy eating and nutrition;
- loneliness and social isolation;
- digital exclusion and accessibility;
- family, carer and parent support;
- anxiety and managing change and transition;
- physical health and mental wellbeing;
- opportunities for young people not in employment, education or training, and;
- 5 ways to wellbeing

Projects had the opportunity to apply for funding from £500 to £5000.

35 projects were funded this year, reaching a wide range of different communities. You can access the full list of projects and find out about their work HERE.

## CCG website and social media

Our website provides information about the work of the CCG, showcasing projects, highlighting the impact of local community involvement, and signposting engagement opportunities. We use the website to inform the public of our plans toengage, raise awareness of any consultation activity and also to provide opportunities to become involved. The website is updated regularly so we can report on the outcomes of all consultations and what we have done as a result of our activity.

The website can be found here: https://www.frimleyccg.nhs.uk/

Our social media accounts have grown as a result of a renewed focus and a more strategic approach to the way in which we use them. From simply using Twitter and Facebook before, we now have a presence on Instagram and LinkedIn as well.

We have also switched to a different account management tool which better suits our needs and enables us to improve how we use our social media accounts to reflect and promote the work of the CCG and partners.

Our messages, including content, imagery and the quantity and timing of posts, are more carefully planned and targeted and we have seen a greater level or response as a result.

We have also used paid campaigns as and when we need to reach a greater audience or to target specific sectors of our population.

## Engagement summary

Engagement with our population and our partners is an essential factor in making up who we are as an organisation. By collaborating with those we serve and our health and care colleagues, we combine our talents, knowledge and experience to improve the health of everyone in our communities.

Our aim is that everyone within the Frimley CCG area can feel part of the process of creating healthier communities. Whether someone is actively involved in our planning and decision making, or they are simply acting on information that we are sharing, it all adds up to improving their health and that of their family and community around them. Our relationships with individual residents, local groups and statutory partners may differ but we are all part of the process, with important roles to play in ensuring positive changes take place across our communities.

Together we will design and deliver new models of care and different ways of working that are making a real difference to people and their local communities. People will be supported to innovate and make improvements where they live andwork. We will work collaboratively across local authority, health, and voluntary sector to understand and build our communities, maximising the collective impact we can have on the health of our population.

This approach will provide strength and equality of opportunity, with the freedom and flexibility to respond in the most effective way to local needs, regardless of structures.

## 9. REDUCING HEALTH INEQUALITY

Equality, diversity and inclusion underpins all our work and is at the heart of who we are and what we do. Our commitment is driven by the principles enshrined in the NHS Constitution and goes beyond the legal requirements of legislation such as the Human Rights Act 1998, the Equality Act 2010 and the Health and Social Care Act 2012 (section 14T).

These include:

- Give 'due regard' to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- 'Have regard' to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

The CCG plays key roles in addressing equality and health inequalities for our local population: as commissioners, as employers and as local and national system leaders, in creating high quality care for all.

The CCG has two separate key duties, one on equality and one on health inequalities. Both require informed consideration by decision makers, but it is important to appreciate that they are two distinct duties.

The specific duties of the Equality Act 2010 require public bodies such as the CCG to have due regard to the aims of the Public Sector Equality Duty (PSED) in exercising their functions, such as when making decisions and when setting policies. In addition, they require public bodies to set specific measurable equality objectives every four years.

As a statutory public body, we must ensure we meet these legal obligations and, by publishing annual equality information, demonstrate how the organisation has used the PSED as part of the process of decision making in relation to service delivery, provision of information and communication and engagement.

The overall aim of the PSED is to make sure that the CCG take equality into account as part of their decision making process. It is not possible to consider equality issues retrospectively and comply with the PSED.

This section shows the following:

- Our commitment to EDI through setting **Strategic Equality Objectives**.
- How we **organise ourselves to deliver** the equality objectives.
- **Impact of COVID-19** and our approach in addressing inequalities and vaccine hesitancy.

## Our Equality and Diversity Objectives

Our equality objectives are closely aligned to the CCG's vision, values and corporate objectives, as well as its statutory and regulatory obligations, and align to the ambitious five ICS equality objectives which have been recently developed. More information can be found on our website https://www.frimleyccg.nhs.uk/about-us/equality-diversity-and-inclusion

### Our ambition

As an NHS organisation we aim to:

- Ensure staff fully understand equality, diversity and inclusion issues;
- Feel empowered to challenge prejudice and make reasonable adjustments in their own work areas;
- Include equality and diversity training for all staff;
- Ask managers to promote the cultural and behavioural changes to ensure equality, diversity and inclusion is demonstrated in all aspects of the CCG's work;
- Provide an environment for our staff which is free from unlawful discrimination; and
- Work with staff and use anonymous questionnaires to ascertain staff opinions.

### Our objectives

- To create an environment where staff feel valued, respected and included;
- To improve staff awareness, understanding and implementation of EDI including their legal obligations;
- To provide equality of opportunity in our employment practices;
- To provide learning and development opportunities for staff; and
- To continually improve what we do based on equality.

## How we organise ourselves to deliver the equality objectives

The CCG established an EDI working group (the Group) to address an identified gap on a renewed focus and harmonised approach on equalities work. The Group meets on a monthly basis and has broad membership from across the CCG including programme leads by place, staff network(s) and staff side. In addition, the meetings are co-chaired by the Executive Director of Nursing and/or the EDI System Lead, who have overall responsibility and accountability for equalities and health inequalities.

The role of the Group, which reports to the Quality, Performance and Finance Group and the Frimley CCG Governing Body, is to keep under review the CCG's progress in meeting its equality responsibilities; to provide assurance that these are being

managed effectively and in accordance with statutory, regulatory and relevant guidance; and to make recommendations to the Governing Body for remediation if required.

## Impact of the COVID-19 pandemic

The impact and challenges of COVID-19 has been felt by everyone and has been unprecedented. It is important that the CCG understand the difficulties people, families and communities are facing whether they be related to health (including mental health), housing, finances or bereavement. Staff from Black, Asian and Minority Ethnic (BAME) backgrounds are crucial to the NHS and care sectors, making up over one-fifth of the workforce.

The health and care services have responded with the support of both staff and communities. However, there needs to be recognition that the emerging data and themes associated with the pandemic magnified existing health inequalities, and it has had a disproportionate adverse impact on some groups of staff and communities who have been hit particularly hard. For example:

- The Kings Fund highlighted the disproportionate impact of COVID-19 both in terms of prevalence, mortality and also in the context of NHS staff who have died from the pandemic, at the time 64% who had died were from an ethnic minority background.

- While people from BAME backgrounds are more likely to be affected by COVID-19, there are not always the same proportion in terms of impact. People of Black ethnicity are four times as likely to die from COVID-19 compared to people of White ethnicity.

The CCG took a proactive approach in improving access to vaccines and addressing vaccine hesitancy, as well as providing pulse oximeters, for all groups of people and to share lessons.

## Focus on improving access and outcomes for people with Learning Disabilities

Utilising a wealth of population health data, the CCG has been able to understand health inequalities for people with a learning disability, and this in turn has helped us focus our efforts to improve the uptake and quality of health checks; support for weight, diet and exercise; prescribing; epilepsy and collaborative working.

Working directly with the Surrey Heath Primary Care Network and partners, the CCG has seen early achievements including (1) a bespoke database for practices to enable them to more easily access vital patient information; (2) which has enabled them to develop a process to more accurately review antipsychotic medications; (3) the ability to share regular cancer screening data to ensure equality of access.

As part of the COVID-19 vaccination programme, we have ensured that people with learning disability, living in their own homes, are able to access the vaccination service

closer to home with suitable adjustments, and home visits are ongoing. Working in collaboration with the Surrey County Council the CCG has helped support the needle desensitisation service and ensured it has been offered to those who need it – with many able to have vaccinations in less stressful locations such as GP surgeries and in some cases in the person's homes.

## Building stronger relationships with our community

In the last year we have built up excellent relations with our Nepali Community to ensure uptake of the COVID-19 vaccination. Working with Surrey Minority Ethnic Forum and local Nepali networks information and updates have been shared via Nepali community champions and Ghurkha Radio. Additional work with our large Gypsy Roma Traveller community in Ash Vale has ensured access to vaccination via the outreach service, Lakeside Vaccination Centre and mobile units. Excellent relations have been built up via the PCNs Care Co-ordinator and Practice Manager, with the community now accessing health services at practice more than previously.

## Mental Health postcards

We heard feedback from our Community Representatives that communities were struggling following the first year of the pandemic, and whilst there were mental health and wellbeing services available, these were not widely known about, and accessing existing directories of services could be difficult due to illiteracy, oracy issues and digital poverty. We worked with our Community Representatives to develop a postcard setting out the key adults mental health services with an icon, simple description and phone number to allow ease of access, and did a mail drop to every postal code in our area. The postcard was also distributed to key partners working with communities such as the Free Food Stall, Hope Hub and practices as we recognised a conversation in addition to the postcard could be more valuable.


## Health Inequalities Board

Following on from the successful BAME programme in Slough, working to try and reduce disproportionate impact on our communities of COVID-19, we are continuing to build on the insights and learning by establishing a local Health Inequalities Board with partners and representatives across the sector. The group is identifying health inequalities with greater insights and analysis of our population health and using this to deliver improvements in physical and mental health outcomes, promoting wellbeing

and reduce or mitigate these inequalities. This group also supports the delivery of the ICS ambitions around Living Well.

### Community Champions #OneSlough and the support of NHS charities

During the pandemic the #OneSlough Community Champions network was established to enable residents and communities across Slough to keep up to date with latest, trusted information about COVID-19. It provided trusted and reliable advice and guidance direct from the Public Health team to communities across Slough. It was supported with interactive online sessions initially once a week with two sessions but adapted to review frequency depending on changes to guidance, COVID-19 climate and feedback from communities.

Through a bid for support from NHS charities funding we've now been able to recruit to a Community Champions Coordinator role to develop and sustain this network beyond COVID-19 and use to engage and share on promoting wider health and wellbeing into communities.

There are now over 2000 people who have registered as community champions and continued to have many regularly tune in to attend presentations and Q&A sessions with guest speakers, alongside COVID-19 updates. Recent examples are the work of #OneSlough volunteers, hypertension and blood pressure monitoring as well as changes happening in primary care services.

## Reducing health inequality in summary

As demand for health and care becomes more complex, it is essential that our services are people based. We have worked across diverse stakeholder groups and through our clinical leaders to establish a culture of continual learning. We know that our clinicians feel engaged in the conversations and approach we are taking to address health inequalities and inequities. As we evolve as a CCG we will continue to work with a broader partnership of organisations to tackle inequalities effectively together.

## 10. HEALTH AND WELLBEING STRATEGY

The CCG plays an active role on the Health and Wellbeing Boards for Slough, Bracknell Forest, Royal Borough of Windsor and Maidenhead, Hampshire, and Surrey County Councils – as shown in the diagram below:


Statutory Health and Wellbeing Boards bring together partners from local government, the NHS, other public services, and the voluntary and community sector. The Boards aims to ensure that organisations plan and work together to improve the health and wellbeing of local residents.

In the second year of the COVID-19 pandemic the CCG has continued to strengthen joint working arrangements, demonstrating what can be achieved through taking a combined approach to supporting people stay well at home, improving access to

mental health and wellbeing services and improving health outcomes for the community.

Closer working can be seen in the CCG's Place Committees which are starting to align their meetings with local councils. The aim in many areas is to meet together to conduct shared business. These new collaborative working arrangements have in turn helped to create stronger connections with the Health and Wellbeing Boards to ensure we collective build the most appropriate services for local people and benefit from a combined understanding, connection and expertise of all partners involved.

This section covers the work undertaken across all our places and includes 'case studies' and 'real stories' to help bring our work to life and for the public to see the impact the CCG by working with our partners across health, social care, communities and the voluntary sector.

This section describes the following topic areas:

- **Community Deal**
- **Supporting the mental health and emotional wellbeing - adults**
- **Supporting the mental health and emotional wellbeing of Children and Young People**
- **Restoration - Supporting people to stay well at home**
- **Working with communities to support the COVID-19 vaccination programme**

**Community Deal** - *programme of work to support the community to be as healthy, independent and resilient as possible whilst delivering cost effective and sustainable services.*

Throughout 2021-2022 the CCG have worked on developing our approach to implementing the ICS "Community Deal" ambition through partnership working at Place. Considering how we build a different relationship with communities, residents and staff to design and deliver solutions together and working together to realise wider public health opportunities presented by COVID-19 as part of "Community Deal" conversations.

Our joint ambition is to support the community to be as healthy, independent and resilient as possible whilst delivering cost effective and sustainable services. This means that our focus for expanding the range and scale of joint working will be in understanding the priority needs of our community. This shared understanding will guide how the next steps are delivered and embody the principles of joint working that we have agreed to.

**NHS Charities Community Partnership Grant**

Through the NHS Charities Community Partnership Grants which aims to support early intervention, reducing inequality with a focus on preventative health and social care within our diverse population a range of place-based initiatives fosters the concept of community/voluntary sector support to build a stronger co-production approach which will assist the most vulnerable in our local communities to improve their outcomes and their ability to maintain or return to health as well as breaking down the barriers in communities and developing local leadership and champions to support making the most difference to individual people's health and wellbeing.

Frimley Health and Care ICS was allocated £356,426 from NHS Charities to support several projects across the system working with communities.

Several initiatives are being implemented across the five places in the ICS, where work is being undertaken to explore and pilot new ways of working that include the following:

- Community Champions to support the BAME population
- Support Safe Discharges using Wellbeing Circles
- Reaching Out Project to the hard-to-reach communities
- Creating an Older Peoples New Opportunities Consortium
- Supporting communities through the Innovation fund
- Keep Well & Stay Connected improving digital connectivity

The initiatives support the ICS systemwide Community Deal ambition and its focus on population health, working closely with our communities to improve people's lives.

**Reaching Out Project**

The Reaching Out Community Project aims to contribute to reducing health inequalities by focusing on the communication of health messages to support our BAME communities. Engaging with voluntary organisations, community and faith leaders and community members to help to develop culturally appropriate and targeted communication and engagement on a range of health, wellbeing, advice and guidance through English and multilingual platforms.

A local Community Insight study has been completed through a programme of engagement and consultation with underserved communities. Several key Public Health priorities have been identified to direct further engagement with and support unserved communities including the new and emerging communities.

A Community Engagement and Communications Plan has been developed to identify and engage with underserved communities, build local networks and new relationships across communities. This has facilitated the development of ongoing organisational insights, and knowledge to help co designing community exercises.

A network of community leaders and volunteers has been established including representative from across the different communities within Bracknell Forest. The network has been involved in consultation exercises and co-designing health and wellbeing interventions and activities.

## Supporting the mental health and emotional wellbeing - adults

This year new Mental Health practitioners have been employed through the funding Additional Roles Reimbursement Scheme (ARRS) and have begun working in each Primary Care Network. They are experienced and registered mental health practitioners who will provide triage, assessment and mental health advice in a timely way, working as part of the GP surgery Multi-Disciplinary Team. The roles will provide an opportunity to support primary care and alleviate suffering and distress in a timely way for patients. The roles will enhance patient journeys and create better joint working across primary care and adult secondary care mental health systems and will make it easier for patients to obtain the help they need.

> ***Real Stories*** *I requested an appointment with the GP due to persistent low mood over a long period of time and I was given an appointment with Thandi. I was made to feel comfortable quickly to discuss my mental health in a safe and supportive environment. During my first appointment, we discussed why I might be feeling low using the stress bucket method and explored problem-solving.*
>
> *This method has proved effective in me getting a better understanding of why I felt the way I did, and how I can make little steps to improve my mood. I have taken the problem-solving steps forward and have seen a positive impact on my mood within two weeks, and I now feel I am on the right track to continue to improve long term.*
>
> *I appreciated being given steps I could take before medication, and the open discussion around how I felt about taking medication, being given the opportunity to get referred to talking therapies. I felt Thandi showed great empathy and care towards my situation and I am very grateful for her support, it has been invaluable in me improving my personal situation."*

**New integrated models of care to support adults at risk of admission to secondary mental health services:**

The new Mental Health Integrated Care Service model has now expanded to cover the whole of the CCG. The team includes Mental Health Practitioners, a pharmacist, Community Connectors employed by Catalyst, an Assistant Psychologist and is currently developing a model to include those with lived experiences to focus on drug and alcohol and Gypsy Roma Traveller communities as identified by local clinicians. The service supports adults experiencing a wide and potentially complex range of mental health difficulties and who have historically fallen between available services.

*"I really can't thank you enough for what you have done , even on our last session I was told that you are only a phone call away if I felt I needed more sessions just call. This made me feel reassured as talking to people was a big step for me and helped me no end..."*

**Suicide prevention**

We have worked closely with Surrey County Council's Public Health lead for suicide prevention to increase our knowledge and understanding of the suspected/suicides in Surrey Heath and are developing a dashboard to ensure we are well-informed of these and any possible patterns that we can identify and target. Currently working in partnership with the hospital psychiatric liaison team to improve the timeliness of post-discharge information reaching practices in order to mitigate risks of those attending Accident and Emergency Departments – unfortunately this learning resulted from a suicide earlier this year, but we are using the learning to make changes for our population.

**Other Mental Health service improvements**

- Planned roll out of the Mental Health Integrated Community Service across all Primary Care Networks in Slough
- Safe Haven is a Crisis Alternative community care service for adults living in East Berks. This service will be operating from Slough and is due to commence May 2022.
- Mapping exercise being done to explore/improve Voluntary community sector services that can support Slough residents with acute mental health needs.
- Berkshire East Wellbeing Service- The wellbeing service is available for anyone 18+ registered to a GP in East Berkshire with low level needs driven by a social or environmental determinant that is affecting their mental wellbeing. Recent evaluation of this service has shown good uptake figures from Slough.

## Supporting the mental health and emotional wellbeing of Children and Young People

There has been a focus throughout the year on improving the access and available support for children and young people and their mental health. This has built on work in the previous year and will continue into the next. More still needs to be done but significant steps have been made to ensure when a request for support is made that there is something available quickly and appropriate to the need.

**Surrey Mindworks**

The new Children and Young People's Emotional Wellbeing and Mental Health Service, recently renamed as Surrey Mindworks, went live in 2021. The service supports Children and Young People across Surrey, including Surrey Heath and Farnham. It has a focus on the importance of early intervention and is working closely with schools to provide a more robust offer, particularly in areas that don't have a Mental Health Support Team. The service continues to see an increased demand for

support, and the strengthened approach to partnership working in the alliance of providers is working hard to meet this demand.

**Mental Health Support Teams in Schools**
The Surrey Heath Mental Health Support Team has recently expanded into additional schools, following completion of the Education Mental Health Practitioners' (EMPH) qualification. Activity in Surrey Heath shows a high level of need, but also a good level of engagement with the schools, pupils and parents.

**Schools Link programme**
Surrey Heath was successful in being accepted to the national Link Programme, funded by NHS England and delivered by the Anna Freud Centre. Bringing together education and mental health professionals to improve joint working and communication with the aim to ensure children and young people get the help and support they need, when they need it. Over two workshops held in spring 2021, schools and mental health professionals in Surrey Heath came together virtually to discuss children and young people's mental health, share experiences and most importantly, make links with each other. The workshops consisted of education professionals, representatives from children and young people's mental health services (then known as CAMHS/MHST), educational psychology, primary care, voluntary sector and the Police. Following the workshop, we created a central online platform for schools to use as a way of communicating with each other and a central portal to access information and documents.

**Children and Young People**
Following the increase of children and young people attending and being admitted to our acute hospital during 2021, a weekly discharge team was established in summer of 2021 to support hospital staff who were struggling with the complexity of some patient groups. The meetings acted as a great support mechanism for the hospital and provided an opportunity for staff from social care, CAMHS, hospital and commissioners to have a holistic discussion around individuals and work together to find the most appropriate route for them out of hospital in a more time-focussed way. It also highlighted some key themes and gaps in provision (disordered eating, neurodevelopmental support, self harm, parental support) that are now being feedback into service development and future redesign with our local providers. Additionally it has strengthened and improved relationships between providers and with CCG staff, demonstrating our commitment to working in partnership to support partners and our young people.

> **Real stories** - An 18-year-old boy has been working with Social Prescribers after recently being 'kicked out' of his family home due to drug use. He struggles with anxiety and cannot leave his property alone. Due to his drug use, counselling through talking therapies would not be beneficial to him. He had limited access to the internet and his anxiety about leaving his home, made accessing community resources difficult.

However, a sick note from his GP enabled him to access support from the job centre without having to leave his property. A collaborative approach was taken with New Hope, CMHT and Social Prescribers. Social Prescribers worked closely with him to develop a trusting relationship and personalise his care.
Now, he is much more confident and slowly making steps to overcome social anxiety when leaving the property and is currently abstaining from drug use. Support is ongoing to help his progress continue and hopefully be sustained to help him live his life to its full potential.

## Restoration - Supporting older people to stay well at home

In 2021 every Integrated Care System were asked to draw up plans with partners to ensure all hospitals maximised their capacity to do as many non-urgent operations as possible. In response to this the CCG working in partnership with its social care partners offered additional support to enable older people to stay well at home. Examples are given here:

**Bracknell Forest** - Across Bracknell Forest there are several charities offering care, support and information to older people focussed on wellbeing, prevention of deterioration and retaining independence at home. They also are supporting carers with information to ensure a positive experience.

Two national Age UK reports undertaken since COVID-19 spoke of the considerable impact the pandemic has had to the physical and social wellbeing of older people. In understanding this, alongside local insights and consultation with Frimley ICS, Public Health and the Local Authority, saw the forming an alliance incorporating 7 charities that seeks to challenge the negative impact of the virus. Enabled by 12-months of funding, the consortium has been able to form an offer in which older people can be digitally enabled, assisted to build confidence to go back out into the community by skilled volunteers, offered telephone support and signposting to informal carers, and can access their local day centre for bespoke social activity. To date, approximately 350 residents have been supported through the consortium's offer. We are anticipating this to double by the end of the year 1. Considerable insight is being developed and shared by partners which will be used to build upon the legacy of the initial funding.

**Slough** place has actively worked with Wexham Park Hospital to assist in the discharge home of its residents. Working with our GP's we have been able to identify residents with mild or moderate frailty who have not seen their GP for over six months and offered them to work with the integrated care team on an anticipatory care plan. This is aimed at working with residents to prevent deterioration in their health and wellbeing. Slough has successfully trailed a pilot aimed at admission avoidance, for residents who were at risk of admission to hospital, by providing an Occupational Therapist to visit them at home to provide targeted care support and equipment to keep them at home.

**Real stories** A 90-year-old Bracknell Forest resident fell and fractured her hip. In hospital she contracted COVID-19 that prolonged her hospital stay. She lived on her own, was fiercely independent but frightened of falling again preventing her leaving the house. Her daughter was helpful but what was important to her, was walking to the shops herself and meeting people face-to-face. A social prescriber trained in using the community map worked with her at home to identify local groups that would help her improve her strength and balance whilst at the same time provided the company she wanted. She enrolled in a local sitting Tai Chi class and Age UK befriending service.

**Working with local councils to encourage physical inactivity**

**Surrey Heath** Borough Council are leading the Whole Systems Approach to Obesity programme, which was launched with a face-to-face Obesity Summit for stakeholders to share health data and local population survey results. This has helped to inform stakeholders approach to identifying local issues and solutions to meet the needs of our diverse communities. (similar whole system approach now across Frimley CCG)

Diabetes Walks for Health, led by Surrey Heath Borough Council and supported by the CCG and partners including Camberley Health Centre and our community diabetes nurse specialist. This initiative runs every Monday morning at a local Surrey Heath Park and aims to help Type 2 diabetics improve their condition through meeting with peers and discussing healthy living with health professionals.

**We CAN do it – Rushmoor physical activity campaign -** because it has been a long, tough year for many people, both physically and mentally, it can be difficult to encourage people to get out and about again and taking part in physical activity.


Rushmoor Borough Council, which covers the Aldershot and Farnborough areas, has launched a campaign aimed at promoting existing facilities, clubs and societies to reinvigorate the local community.

**Living with long term conditions**

<u>Diabetes</u>

GP practices in Surrey Heath continue to be part of the new ground-breaking pilot which provides a low-calorie diet programme for people who are overweight and living with type 2 diabetes. The pilot supports people to improve their diabetes control, reduce diabetes-related medication and even achieve remission (no longer have diabetes).

All GP Practices in Surrey Heath have made a referral to the programme and outcomes for patients will be formally evaluated, however patient feedback is

encouraging and we are delighted to share a case study of a Surrey Heath resident – see links below:

- https://xylahealthandwellbeing.com/case-study/low-calorie-diet/timothys-low-calorie-diet-journey/
- https://player.vimeo.com/video/561388522

Starting in December 2021, we have employed two Frimley ICS diabetes engagement officers. Working across Frimley ICS, they have focussed on supporting practices to increase referrals, uptake and retention to the Healthier You: National Diabetes Prevention Programme. For any patients who are pre-diabetic, this programme is designed to empower them to take charge of their health and wellbeing and prevent them developing Type 2 diabetes. The engagement officers are currently working with all practices in Surrey Heath and in the first practice they contacted and successfully referred over 70 patients to the National Diabetes Prevention Programme.

Hypertension

Hypertension remains a high priority for the CCG and is now an ICS wide programme currently running to address need, which includes:

- Supporting practices to enable them to text patients with hypertension who have not had a blood pressure check over the past 18 months.
- Work with Community Pharmacists to roll-out Hypertension Service that is part of national community pharmacy contract.
- Public Health commissioned health check team to enable mobilisation of BP checks and promote Know your numbers campaign
- Vaccine centres - all patients to have opportunistic BP measurement offered. Community Groups and engagement various BP measurement avenues in the communities.
- Communication Campaign socialising our plan to all community groups e.g. clinician talking to our community champions meetings to promoting Know your Numbers amongst all community groups and social channels.

## Working with communities to support the COVID-19 vaccination programme

Uptake of the COVID-19 vaccine in **Slough** has been lower than other Frimley CCG areas and the national average and we have been working closely with partners in Slough to address this. Work that has taken place to reduce hesitancy and improve uptake includes:

- Vaccination Bus – working in partnership with Solutions for Health the mobile bus in Slough was able to provide an outreach vaccination service targeted to areas of the borough with communities and harder to reach groups where take up was lower and to those who would not otherwise visit the vaccination

centres. This proactive outreach approach was successful in providing easier access to vaccinations and boosters across Slough.

- Vaccination up take was also supported through targeted Enhanced Call and recall by GP practices, based on the successes achieved by one practice with the highest uptake in Slough. The focus being on those people aged 12-49 who have not had their first vaccination.
- Webinar for school aged children and their parents.
- Combining home vaccinations with health checks to maximise primary care workforce when carrying out the 15 minute observation period.

**Slough: working with community champions**

Slough suffers from a lower uptake of immunisations across a range of vaccines including Influenza, Measles, Mumps and Rubella (MMR) and Human Papillomavirus (HPV). Research suggests that vaccine myths remain prevalent in Slough. For some parts of the community, cultural reasons present a challenge to vaccination uptake.

In September 2020, the OneSlough partnership, led by Slough Borough Council, the Slough CVS (Council for Voluntary Services) and the East Berkshire CCG established a network of 'Community Champions'. Their role is to support the COVID-19 response in communities that have been disproportionately hit by the virus. By the end of 2020, there were 600 community champions.

At the beginning of December 2020, the champions' role developed to become 'vaccine champions' to ensure as many residents as possible are vaccinated, whilst at the same time helping dispel any vaccine myths and disinformation.

Since then, the partnership has provided training and information sessions to the champions on how to talk about the vaccine and mitigate the impact of disinformation, produced tailored social media resources and created a bespoke local FAQ guide on the vaccine (which is given to everyone receiving a rapid COVID-19 test in the borough).

The partnership has also trained some champions as volunteers at vaccination centres themselves to support logistics and community engagement on the ground. Virtual information supported by champions and delivered by public health and CCG experts, for example with the University of the Third Age cover vaccine hesitancy. Sessions like this are being offered to all local community groups.

**Oximetry at Home**

Pulse oximetry is the monitoring of a person's blood oxygen levels, which is normally done by a simple device that clips onto a fingertip. It has long been recognised as an easy and effective way of detecting potentially serious health conditions and during the pandemic it has become a vital tool in protecting people infected with COVID-19.

Prior to 2021-22 each CCG was required to put in place arrangements to support those with COVID-19 to monitor their blood oxygen levels themselves at home.

Patients, or those caring for them, report the oxygen levels to their GP practice, where staff respond accordingly, escalating the response in line with any deterioration in a patient's condition.

Patients over 65, or under 65 and in an at-risk group, within the NHS Frimley CCG area have access to COVID-19 Oximetry @ Home, with access through referral by GPs, the Out of Hospital service and the COVID-19 hot site.

Oximetry at home has been very well received by patients who appreciate being able to have active support within their own homes and are reassured that any deterioration in their conditions will be detected and acted upon.

## Summary

The new Integrated Care Board will have much stronger links to the local councils with the Integrated Care Partnership acting as a joint committee of health and social care; and three members of the ICB Board will be selected one from each sector:

- Surrey and Hampshire County Council;
- Slough, Bracknell Forest and Royal Borough of Windsor and Maidenhead unitary councils; and
- Borough and district councils.

Each of our five places will continue to work in partnership with our local authority partners – aligning health and care priorities to create stronger connections to ensure we collectively build the most appropriate services for local people.

## 11. SOCIAL MATTERS, HUMAN RIGHTS, ANTI-CORRUPTION AND ANTI-BRIBERY

The CCG is committed to making progress on all social and environmental matters, human rights and their associated regulations & guidance. The CCG is responsible for planning, commissioning and designing many of the health services needed by the population in its own area. It makes decisions about health services based on the feedback received from patients and carers, which ensures the services we commission and re-design are the ones local residents inform us that they need and are able to access.

The CCG is also committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and maintaining it at that level. By doing this, valuable resources can then be used where they should be, delivering better patient care.

This section covers the following:

- **Social Matters, Human Rights**
  - Care home Support
  - Asylum Seekers and Refugee Support
  - Homelessness
  - The Surrey Homeless Multi-Agency Group (MAG)
  - Create Hope
- **Anti-corruption and bribery**
  - Counter Fraud Specialists
  - Fraudsters and COVID-19
  - Cyber Fraud


### Social Matters, Human Rights

Respecting diversity, promoting equality and ensuring human rights helps to make sure that everyone using health and social care services receives good quality care. We also have legal duties to consider equality and human rights in our work.

**Care Home Support (Enhanced Health in Care Homes)**
Building on the COVID-19 response to care homes throughout 2020-2021, we have continued to work closely with our care homes to ensure vulnerable residents have the best access possible to health, social care and well-being services. Our relationship with care home staff is going from strength to strength and helping to collectively improve our knowledge about the needs of care home residents and finding out what is important to them. We are currently in the process of testing care models that offer a wider variety of knowledge and skills to care home residents with complex needs focusing on prevention and proactive care through collaborative working across local community health and care organisations.

We will use the feedback from these care models to shape our future ambition of having a dedicated Care Home teams across the CCG area that are passionate about working with care home staff and residents to improve health and wellbeing outcomes, supporting individuals to achieve their goals in the context of their whole life experience, family and close friends.

**Asylum Seekers and Refugee Support**
Slough has been host to one of a number of hotels in the Thames Valley who have provided accommodation for new asylum seekers arriving in the UK whilst applications are processed and onward dispersal accommodation is organised. With East Berkshire Primary Care Out of Hours service we have been registering patients on arrival and providing testing, health checks and vaccinations. Slough also has many asylum seekers and refugees living in the Borough. Aware that these groups have additional barriers and challenges to access local health and support services we have been working together with voluntary sector partners to help with navigating services.

Slough Refugee Support

**Homelessness**
We continue to reach out to our homeless population throughout the pandemic, initially providing GP clinics in temporary hotel accommodation and through weekly drop-in clinics in many of our practices. Our GPs were quick to provide COVID-19 vaccination to our homeless as a group that could be particularly vulnerable.

**The Surrey Homeless Multi-Agency Group (MAG)**
The MAG was established to better support Surrey's homeless population during the pandemic and continues in the longer term. A wide network of partners continue to come together to reduce the impact of COVID-19 on people who are homeless or at risk of being homeless as well as provide the wrap around support needed to allow people to get and retain newly acquired accommodation. A key achievement of the Homeless MAG has been the successful funding of nearly £3m for the Changing Futures programme, which will run until 2024. The programme covers the whole of

Surrey and aims to deliver improvements for people who face multiple-disadvantage. This is a large project but partners in Surrey Heath remain engaged including housing and voluntary sector.

Homelessness and Rough Sleeping Strategy 2019- 2023 is located on the Surrey Heath Borough Council website
https://www.surreyheath.gov.uk/sites/default/files/Strat%20doc.pdf

**Create Hope** is based in Bracknell Forest and offers emotional support to children, young people and families. The CCG continues to work closely with the Hope Hub, a local charity working to prevent homelessness. We have funded in collaboration with Surrey Heath Borough Council a Mental Health Outreach worker at the Hope Hub, this role works closely with clients and provides support to people who have a mental health need. The case worker is able to support, empower and encourage people by listening, coaching as well as assist with access to appointments, activities and communicating with other agencies such as employment or housing. This is fundamental in helping people who are homeless or at risk of homelessness access the support they need.

The CEO, Catherine Hockley, recognised a greater need for therapeutic services through her work with families, schools, voluntary and statutory services. Funding from the CCG through the Innovation Fund will support a programme of family therapeutic support days.

Catherine said '*We support families impacted by different environmental issues such as domestic abuse, family separation, bereavement, bullying etc offering therapeutic services, which include play therapy, family support, and therapy for parents delivered at our centre in Bracknell Forest and through work with local schools. We have identified the importance of working with the whole family and try to make that the case with all we do*.'

## Anti-corruption and bribery


The CCG has a zero-tolerance policy of any fraud, bribery or corruption and aims to eliminate all such activity as far as possible. The Local Area Counter-Fraud Team is active in the prevention and deterrence of fraud, bribery and corruption through its attendance at the Audit and Risk Committee, involvement in policy-setting, awareness training and sharing of information through their website and attendance at CCG meetings. Counter fraud work has been undertaken in each of the four strategic areas. These set out the requirements in relation to:

- Strategic Governance - The organisation's strategic governance arrangements. The aim is to ensure that counter fraud measures are embedded at all levels across the organisation.
- Inform and Involve - Raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of fraud and bribery affecting the NHS.
- Prevent and Deter - Discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for fraud to occur are minimised.
- Hold to Account - Detecting and investigating economic crime, obtaining sanctions and seeking redress.

**Counter Fraud Specialists**

Every NHS organisation is required to appoint the services of a Local Counter Fraud Specialist (LCFS). The LCFS is a professionally accredited criminal investigator, who will undertake a range of duties to minimise the impact of fraud on the organisation. The LCFS will investigate allegations of fraud and, where evidence of criminal offences exists, can refer the case to solicitors for consideration of further criminal action. The LCFS will also liaise with HR and other professional bodies if a suspected breach of conduct is identified.


Fraudsters and COVID-19

There has been a spike in scams aro und the COVID-19 Passes. The pressures of the pandemic continue to be felt across the NHS, with its staff and resources continuing to deliver services under increasing demands. Fraudsters are taking advantage of this strain, and have created fake websites claiming to sell COVID-19 Passes. These sorts of scams target NHS patients, especially people who may be vulnerable. Staff were asked to remember:

- The NHS App is free
- The NHS COVID-19 Pass is free
- The NHS will never ask for any financial or payment details

The CCG's Fraud and Security Management Service website provides a useful resource of information for CCG employees. The website can be viewed at https://www.nhsfraudandsecurity.co.uk An information and guidance page was also set up in respect of COVID-19 fraud and security risk and can be found at https://nhsfraudandsecurity.co.uk/covid-19-2/

In 2021-22 there have been a number of key risks affecting the CCG but most significant was the increased risk of a cyber-attack.

The National Cyber Security Centre (NCSC) advised all UK organisations that '*the threat of a cyber attack has heightened following Russia's attack on Ukraine (which began in February 2022). While the NCSC was not aware of specific threats they produced guidance to encourage organisations to follow actionable steps that reduce the risk of falling victim to an attack*.' In response to this advice the CCG reminded staff to:

- Make sure passwords are strong and unique, and that any which are not are changed immediately. This applied to all desktops, laptops and other mobile devices.
- Be vigilant for phishing emails. Think before clicking on a link which could download malware or ransomware, sabotage systems or result in data theft.

<u>Cyber Fraud</u>

The NHS Counter Fraud Authority website has been updated to include fraud prevention guidance on financially motivated cybercrime which results in fraud. Cybercrime continues to rise in scale and complexity at an alarming pace, and affects businesses and individuals alike, costing the UK billions of pounds. The aim of the cyber criminals is to obtain personal and sensitive data for financial gain. Staff bulletins covered advice on 'How to Protect Yourself From Fraud':

- Don't use public Wi-Fi when working remotely. Work offline and connect to a secure network later.
- Do not open email attachments from unknown senders or click on suspicious links, as these could be infected with malware
- Update your devices as out of date software, applications and operating systems contain weaknesses
- Never leave equipment unattended and never allow anyone else to access your device for personal use such as internet browsing.

## 12. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The CCG plans for, and responds to, a wide range of incidents that could impact on health or patient care. These could be anything from a prolonged period of severe pressure on services, extreme weather conditions, an outbreak of an infectious disease, a major transport accident or industrial action.

We work together with partners across the Frimley Health and Care Integrated Care System to deliver the CCGs' responsibilities as 'Category 2' responders under the Civil Contingencies Act 2004. We have 24/7 on call rotas and incident response plans which has been formally agreed by each organisation. We are required to self-assess against the NHS core standards, including Business Continuity Plans, and this report forms part of our formal reporting process.

The CCG is required to put in place Emergency Preparedness, Resilience and Response (EPRR) Teams to enable the CCG to maintain an effective response to a Major, Critical or Business Continuity Incident, mitigating their effects and ensuring that critical services are maintained. The CCG's response, irrespective of the nature of incident, should be one that is proportionate, coordinated with health and multi-agency partners and which is managed through an effective Command, Control, Coordination and Communications structure.


This section sets out how the CCG has prepared for and responded to emergencies in 2021-22:

- **Introducing the Team**
- **COVID-19**
- **Vaccination Programme**
- **Working across the Frimley System**
- **Regional and system working**
- **Looking ahead**

### Introducing the Team

The System Resilience Team are made up of a unique set of highly trained individuals led by the Accountable Emergency Officer and Director who are able to step up to manage any type of incident at any time of the day or night.

The team now works using a cyclical process throughout the year to provide Frimley CCG with a robust and effective workplan, to accomplish full compliance with the annual EPRR assurance process and to ensure that our legal duties are met.

Over the past two years, the Team has not only responded to the COVID-19 pandemic but to array of incidents affecting the Frimley system. In 2021-22 these include managing the health response for:

- The Duke of Edinburgh's funeral (10 day response) and Trooping the Colour, both held in Windsor;
- The Fuel Crisis;
- Storms Arwen, Eunice and Franklin;
- The Major Incident declared by Portsmouth Hospital following a site flood, where an eight hour ambulance divert was put in place across the South East and South West regions;
- The Critical Incident declared at Frimley Health Foundation Trust due to a suspected Chlorine leak;
- Avian Flu outbreaks;
- The increase in terrorism threat level following the Liverpool Women's Hospital bomb;
- The South East Coast Ambulance Service IT outage and critical incident declaration.

Key Initiatives

Over the past year the System Resilience Team have created some key initiatives recognised and seen as good practice by our health and multi-agency partners across the South East. As example of these are:

- A series of Checklists and Action Cards to support actions decision making;
- MS Teams On Call Page to support Frimley CCG on call managers access to key documents 24/7;
- Quarterly On Call Updates to share experience, best practice, and receive formal updates on developments;
- Coordinating and managing risk management;
- Creation of specific checklists to aid the out of hours management of key procedures that may need coordination, for example mutual aid for critical care, ambulance diverts and the management of a critical incident. These have proved to be invaluable for our on call teams;
- The creation of Business Continuity Champions for each place and each main workstream in order to attain to our Business Continuity responsibilities as a CCG.

## COVID-19

In light of the COVID-19 pandemic, the CCG started to work in new and different ways. CCG staff have had critical roles in leading and supporting the wider health and

care system for the challenges we faced together. The priorities during the pandemic are to:

- Lead and resource the Frimley ICS COVID-19 Incident Coordination Centre which all manages the Vaccination Programme;
- Focus on our business critical activities, refocus our leadership and resource to ensure we deliver and support the system to meet demand;
- Plan for business continuity and maintain these during challenging times;
- Work with all our health partners in their response to COVID-19;
- Work alongside our multi-agency partners in their response to COVID-19;
- Take part in the debriefs to date and any future debriefs to ensure we capture any lessons learned;
- Update any relevant plans or processes accordingly;
- Support to recovery and restoration to normal activities;
- Support the health and wellbeing of our communities.

## Vaccination Programme

Our response to the COVID-19 pandemic has been in line with our statutory Emergency Preparedness Resilience and Response duties.

During the pandemic the Frimley ICS created a single overarching coordination role across all health partners within Frimley system. To reflect this, a single Incident Coordination Centre (ICC) was set up and has been functioning for two years.

The ICC also manages the operational aspect of the Vaccination Programme in conjunction with the Frimley Vaccination Project Management Office.

The ICC has a legal requirement to maintain an electronic audit trail of all information in and out of the ICC which may be used in the Public Inquiry.

The ICC has been flexed up and down when required to reflect demand and can fully function 7 days a week. The ICC team also support, when required, the On Call teams at the weekend. It liaises directly with the South East Regional Incident Coordination Centre, now known as the Regional Operational Centre, and out to all the health and multi-agency sectors.

The Incident Coordination Centre is also responsible for receiving information from and reporting into the relevant Strategic Coordination Groups and Tactical Operations Groups of the Local Resilience Fora.

## Working across the Frimley System

Frimley CCG delivers a 24/7 on call rota of Gold and Silver Commanders.

Staff receive specific training for this role including Strategic Leadership during Emergencies and Managing the NHS Response to Incidents, training on the national information sharing platform Resilience Direct, Cyber Security training, Business Continuity training, and Strategic/Tactical Coordination Group training.

On Call Managers are invited to take part in any planned exercises when they are on call; this area is to increase in 2022-23, by ensuring that the on-call manager is invited as standard to any exercise being run by a Local Resilience Forum (LRF) and Local Health Resilience Partnerships (LHRPs) within Frimley's footprint.

On Call Managers take part in quarterly on call updates where they share their experiences and identify any training needs. Any queries can also be answered by the EPRR/Systems Resilience Team.

The On Call Teams are supported by a series of documents, checklists, plans and procedures all saved on a newly developed MS Team On Call Page. Key documents are the newly designed On Call Pack and On Call Directory. To maintain resilience documents on Microsoft Teams are also duplicated on the Frimley CCG shared drive.

The Systems Resilience Team also manage the On Call Rota ensuring a 24 hour, seven days a week on-call system.

On call updates are now shared with system partners including tactical and strategic ambulance trust leads, enabling a full oversight off the whole system after the weekend and on a Friday.

Plans and Checklists

All EPRR Plans for Frimley CCG were updated in 2021 and are having an administration review for 2022 until we become an ICB; post July, the plans will be reviewed again to reflect the new duties. They are all saved onto our newly created Frimley CCG Resilience Direct page which is the national information sharing portal and the Frimley CCG MS Teams On Call page. Completion and testing of these plans is part of the Annual EPRR assurance process.

These plans are supported by a series of "Checklists" to aid a quick response to an incident. These have been very well received and have been seen as "good practice" across the ICSs in the South East and have been shared accordingly.

EPRR Assurance

On an annual basis the CCG is required to self-assess against the NHS England EPRR Core Standards, including Business Continuity Management and this assessment forms part of our formal EPRR Assurance processes.

Reports on the outcome of this process go to the three LHRPs, the Frimley CCG Internal Resilience Group and Non-Executive Director, The Governing Body and the UEC Board. A full report is submitted to NHS England and NHS Improvement.

In 2021 Frimley CCG were fully compliant with all the EPRR Core Standards.

## Regional and system working

Frimley CCG provides resilience oversight across all of the system providers and updates regional teams and system executives daily this is achieved through:

- Daily System Resilience calls. Resilience Calls are held on Mondays, Wednesdays, and Fridays as standard, with further escalation calls stood up as required to address increasing risks or specific areas of pressure. To further support the format of these calls and sharing of information from the system calls a new reporting format has been agreed to support chairs and present information in a fluid, logical format tracking agreed actions;

- Gold and Silver calls are now in place during times of heightened pressure. These have been reviewed with new terms of reference and agendas agreed to ensure Gold and Silver calls are appropriately focused for maximum efficiency and to ensure that robust command and control processes are adhered to;

- The Frimley ICS Surge and Escalation Protocol has been reviewed in line with the NHS ENGLAND National Escalation Framework and the SE Regional Operational Pressures Escalation Levels (OPEL) Framework. This was a detailed review and was carried out with full system partner input and consultation, agreeing system wide OPEL triggers and actions. In light of anticipated pressures over winter 2021-22 an OPEL 4+ action card has been created to support super surge and “system reset” actions in response to extraordinary pressures. Additional work is underway to capture primary care and diagnostics OPEL status and actions.

- Planning and assurance continue for Bank Holiday periods, Winter, and key areas of identified or anticipated high system pressures. These plans take a whole system approach to identifying services available, risks and mitigations over any set time period and have proven useful additions to standing plans and procedures by system tactical and strategic managers. Identifying that pressures normally peak the week after the Bank Holiday, planning has expanded to cover actions to release capacity on the week leading up to the Bank Holiday and actions to maximise flow to absorb forecast increases in patient activity, the week after a Bank Holiday.

<u>Interface with the three Local Health Resilience Partnerships (LHRPs) and three Local Resilience Forums (LRFs)</u>

Frimley CCG interfaces with three LHRPs. These are strategic emergency planning meetings bringing together all the NHS organisations from across the Thames Valley, Surrey, and Hampshire/Isle of Wight systems.

Frimley CCG also interfaces with three LRFs from across the Thames Valley, Surrey and Hampshire/Isle of Wight systems. These are made up of all our multi-agency partners.

Having the unique role of working with three LHRPs and three LRFs we are able to influence a more joined up approach by sharing good practice and stopping duplication.

We participate in training and exercising events with the LRFs which are used to test response plans relating to our local, regional, and national risks and this enable us to work alongside, and forge good working relationships with our multi-agency partners.

The team also attend LRF working days where subject matter experts share in depth knowledge and lessons learnt on key situations expands the teams' oversight and knowledge on LRF members capabilities.

## Looking ahead

The Health and Care Bill, currently going through the Parliamentary process, contains the legal amendment to the Civil Contingencies Act 2004. This change, Schedule 4, Section 80 of the Health and Care Bill, amends Schedule 1 by adding Section 4B, which incorporates Integrated Care Boards to the list of Category 1 Responder agencies. This change upgrades the ICS from the CCG position as a Category 2 responder, and also makes clear that the ICB is seen as equivalent in stature and responsibility to that of NHS England and NHS Improvement. The change will also increase the responsibilities of the EPRR Team through them having to discharge the full duties of an NHS Body under Category 1 status.

**Fiona Edwards**

Accountable Officer

20 June 2022

# ACCOUNTABILITY REPORT

## Corporate Governance Report

## 13. MEMBERS REPORT

This section of the report contains information about our membership, the way we work as a CCG and some of our legal responsibilities.

### Our Membership

NHS Frimley CCG covers a population of approximately 800,000 people registered at 72 GP practices across five Places. These are: North East Hampshire and Farnham; Surrey Heath; Royal Borough of Windsor, Ascot and Maidenhead; Bracknell Forest; and Slough.

### Member practices of the CCG in 2021-22

**North East Hampshire and Farnham Place (19 practices)**

| Practice Name | Address |
|---|---|
| **Alexander House Surgery** | 2 Salisbury Road, Farnborough, Hampshire, GU14 7AW |
| **Branksomewood Healthcare Centre** | Branksomewood Road, Fleet, Hampshire, GU51 4JX |
| **Crondall New Surgery** | Redlands Lane, Crondall, Farnham, Surrey GU10 5RF |
| **Downing Street Group Practice** | 4 Downing Street, Farnham, Surrey, GU9 7PA |
| **Farnham Dene Medical Practice** | Farnham Centre for Health, Hale Road, Farnham, Surrey, GU9 9QS |
| **Farnham Park Health Group** | Farnham Centre for Health, Hale Road, Farnham, Surrey, GU9 9QS |
| **Fleet Medical Centre** | Church Road, Fleet, Hampshire, GU51 4PE |
| **Giffard Drive Surgery** | 68 Giffard Drive, Farnborough, Hampshire, GU14 8QB |
| **Holly Tree Practice** | 42 Boundstone Road, Wrecclesham, Farnham, Surrey, GU10 4TG |
| **Jenner House Surgery** | 159 Cove Road, Farnborough, Hampshire, GU14 0HQ |
| **Mayfield Medical Centre** | Croyde Close, Farnborough, Hampshire, GU14 8UE |
| **North Camp Surgery** | 2 Queens Road, Farnborough, Hampshire, GU14 6DH |
| **Oakley Health Group** | 51 Frogmore Rd, Blackwater, Camberley, Surrey, GU17 0DB |
| **Princes Gardens Surgery** | 2A High Street, Aldershot, Hampshire, GU11 1BJ |
| **Richmond Surgery** | Richmond Close, Fleet, Hampshire GU52 7US |
| **The Cambridge Practice** | Aldershot Centre for Health, Hospital Hill, Aldershot, Hampshire, GU11 1AY |
| **The Border Practice** | Blackwater Way, Aldershot, Hampshire, GU12 4DN |
| **Voyager Family Health** | Farnborough Centre for Health, Apollo Rise, Southwood Business Park, Farnborough, Hampshire, GU14 0NP |

| Practice Name | Address |
|---|---|
| **Wellington Practice** | Aldershot Centre for Health, Hospital Hill, Aldershot, GU11 1AY |

## Bracknell Forest Place (10 practices)

| Practice Name | Address |
|---|---|
| **Binfield Surgery** | Terrace Road North, Binfield, Berkshire, RG42 5JG |
| **Crown Wood Medical Practice** | 4A Crown Road, Bracknell, Berkshire, RG12 0TH |
| **Easthampstead Surgery** | 23 Rectory Lane, Bracknell, Berkshire, RG12 7BB |
| **The Evergreen Practice** | Skimped Hill Health Centre, Skimped Hill Lane, Bracknell, RG12 1LH |
| **Forest Health Group** | Ringmead, Birch Hill, Bracknell, RG12 7PG |
| **The Gainsborough Practice** | Warfield Green Medical Centre, 1 County Lane, Warfield, Bracknell, RG42 3JP |
| **Great Hollands Practice** | Great Hollands Square, Bracknell, Berkshire, RG12 8WY |
| **Ringmead Medical Practice** | Birch Hill Medical Centre, Leppington, Bracknell, RG12 7WW |
| **The Sandhurst Group Practice** | 1 Cambridge Road, Owlsmoor, Sandhurst, Berkshire, GU47 0UB |
| **The Waterfield Practice** | Ralphs Ride, Harmanswater, Bracknell, RG12 9LH |

## Royal Borough of Windsor and Maidenhead (20 practices)

| Practice Name | Address |
|---|---|
| **Ascot Medical Centre** | Brook House, Brook Avenue, SL5 7GB |
| **Cookham Medical Centre** | Lower Road, Cookham Rise, Maidenhead, Berkshire, SL6 9HX |
| **Cordwallis Road Surgery** | 1 Cordwallis Road, Maidenhead, Berkshire, SL6 7DQ |
| **Claremont and Holyport Practice** | 2 Cookham Road, Maidenhead, Berkshire, SL6 8AN |
| **Clarence Medical Centre** | Vansittart Road, Windsor, Berkshire, SL4 5AS |
| **Datchet Health Centre** | Green Lane, Datchet, Berkshire, SL3 9EX |
| **Green Meadows Surgery** | Brook House, Brook Avenue, Ascot, SL5 7GB |
| **Kings Corner Surgery** | Kings Road, Sunninghill, Ascot, Berkshire, SL5 0AE |
| **Lee House Surgery** | 84 Osborne Road, Windsor, SL4 3EW |
| **Linden Medical Centre** | 9a Linden Avenue, Maidenhead, Berkshire, SL6 6JJ |
| **Magnolia House Surgery** | 15 Station Road, Sunningdale, Berkshire, SL5 0QJ |
| **Redwood House Surgery** | Cannon Lane, Maidenhead, Berkshire, SL6 3PH |
| **Rosemead Surgery** | 8a Ray Park Avenue, Maidenhead, SL6 8DS |
| **Ross Road Medical Centre** | 85 Ross Road, Maidenhead, Berkshire, SL6 2SR |
| **Runnymede Medical Practice** | Newton Court Medical Centre, Burfield Road, Old Windsor, Berkshire, SL4 2QF |

| Practice Name | Address |
|---|---|
| Sheet Street Surgery | 21 Sheet Street, Windsor, Berkshire, SL4 1BZ |
| South Meadow Surgery | 3 Church Close, High Street, Eton, Berkshire, SL4 6AP |
| The Cedars Surgery | 8 Cookham Road, Maidenhead, Berkshire, SL6 8AJ |
| The Symons Medical Centre | 25 All Saints Avenue, Maidenhead, Berkshire, SL6 6EL |
| Woodlands Park Surgery | 15 Woodlands Park Road, Maidenhead, Berkshire, SL6 3NW |

## Slough Place (16 practices)

| Practice Name | Address |
|---|---|
| Bharani Medical Centre | 16-18 Lansdowne Avenue, Slough, SL1 3SJ |
| Cippenham Surgery | 261 Bath Road, Slough, Berkshire, SL1 5PP |
| Crosby House Surgery | 91 Stoke Poges Lane, Slough, SL1 3NY |
| Dr Sharma's Surgery | The Surgery, 240 Wexham Road, Slough, SL2 5JP |
| Farnham Road Practice | 301 Farnham Road, Slough, Berkshire, SL2 1HD |
| Herschel Medical Centre | 45 Osborne Street, Slough, Berkshire, SL1 1TT |
| Kumar Medical Centre | 59 Grasmere Avenue, Slough, Berkshire, SL2 5JE |
| Langley Health Centre | Common Road, Langley, Slough, Berkshire, SL3 8LE |
| Manor Park Medical Centre | 2 Lerwick Drive, Slough, Berkshire, SL1 3XU |
| Ragstone Road Surgery | 40 Ragstone Road, Chalvey, SL1 2PY |
| Shreeji Medical Centre | 22 Whitby Road, Slough, Berkshire, SL1 3DQ |
| The Avenue Medical Centre | Wentworth Avenue, Britwell Estate, Slough, Berkshire, SL2 2DG |
| The Chapel Medical Centre | Upton Hospital, Albert Street, Slough, SL1 2BJ |
| The Orchard Surgery | Willow Parade, 276 High Street, Langley, Slough, SL3 8HD |
| Upton Medical Partnership | The Village Medical Centre, 45 Mercian Way, Cippenham, SL1 5ND |
| Wexham Road Surgery | 242 Wexham Road, Slough, Berkshire, SL2 5JP |

## Surrey Heath Place (7 practices)

| Practice Name | Address |
|---|---|
| Bartlett Group | Frimley Green Medical Centre, 1 Beech Road, Frimley Green, Surrey, GU16 6QQ |
| Camberley Health Centre | 159 Frimley Road, Camberley, Surrey, GU15 2QA |
| Lightwater Surgery | 39 All Saints Road, Lightwater, Surrey, GU18 5SQ |
| Park House Surgery | Park Street, Bagshot, Surrey, GU19 5AQ |
| Park Road Group Practice | 143 Park Road, Camberley, GU15 2NN |
| Station Road Surgery | 4 Station Road, Frimley, Surrey, GU16 7HG |
| Upper Gordon Road | 37 Upper Gordon Road, Camberley, GU15 2HJ |

## Our Governing Body

The Governing Body is constituted in accordance with the Health and Social Care Act 2012 and is the principle decision-making body in the commissioning and contracting of high-quality healthcare for our local community. It comprises of clinical, lay and executive directors with a variety of backgrounds, with a wide range of skills and experience. These include members overseeing elements of governance and patient and public engagement.

On 1 April 2021 NHS East Berkshire CCG, NHS North East Hampshire and Farnham CCG and NHS Surrey Heath CCG merged to become a single statutory organisation NHS Frimley CCG. This decision was taken in line with The NHS Long Term Plan published by NHS England with the view of forming a single statutory Integrated Care System (ICS) with placed based partnership working between health and local authorities.

The Governing Body of NHS Frimley CCG is comprised of the following voting members: five elected GPs known as Place Based Clinical Leads; four Lay Members, one Secondary Care Clinician, four executive directors. In addition to the voting members, there is also non-voting membership comprised of the following roles: the Executive Director of Development and Improvement and five Executive Place Managing Directors. Between 1 April and 30 June, the Independent Lay Member for Bracknell Forest (Dr Ed Palfrey) acted as the Independent Chair of the Frimley CCG. Following an election process Dr Huw Thomas, the Place Based Clinical Lead for the Royal Borough of Windsor and Maidenhead was appointed to the role of Clinical Chair for the CCG on 1 July 2021. Details of the Governing Body can be found on the website https://www.frimleyccg.nhs.uk/about-us/our-governing-body

The five Places which make up NHS Frimley CCG are comprised of (i) Bracknell Forest (ii) North East Hampshire and Farnham (iii) Surrey Heath (iv) Slough (v) Royal Borough of Windsor and Maidenhead. Each of the five Places has an Executive Managing Director, Lay Member and Clinical Lead who form part of the leadership team to manage the place-based delivery plans. Stakeholders and local authority colleagues work alongside each of the leadership teams, meeting regularly together at their local Place Committees. Details of the five Places can be found on the website https://www.frimleyccg.nhs.uk/about-us/our-places

The CCG's leadership changed to support the transition of the commissioning functions of NHS Frimley CCG to the Integrated Care Board. Dr Andy Brooks, Clinical Chief Officer for the Frimley CCG was seconded to NHS England in April 2021 to undertake a wider national role and Fiona Edwards, the Frimley ICS Lead and Chief Executive of NHS Surrey and Borders Partnership Foundation Trust was seconded to the Frimley CCG as its Accountable Officer. On 1 December 2021 Fiona Edwards was appointed as the Chief Executive Designate for the Frimley ICB.

The Frimley CCG Governing Body makes decisions on matters that are common to the five Places taking into account the needs of local people. Following its formation,

the Frimley CCG Governing Body met in public on the following occasions: 11 May 2021, 13 July 2021, 14 September 2021, 9 November 2021, 8 March 2022.

The voting membership for NHS Frimley CCG is set out below:

## Membership in 2021-2022

| Name and role | |
|---|---|
| **Voting Members** | |
| **Governing Body GP members** | |
| **Dr Huw Thomas, Clinical Chair (1 July 2021 – 31 March 2022) and Place-based Clinical Lead (Royal Borough of Windsor and Maidenhead)** | 1 April 2021 – 31 March 2022 |
| **Dr John Fraser, Place-based Clinical Lead (Surrey Heath)** | 1 April 2021 – 31 March 2022<br>On Sabbatical during the months of September and October 2021 |
| **Dr Jim O'Donnell, Place-based Clinical Lead (Slough)** | 1 April 2021 – 31 March 2022 |
| **Dr Steven Clarke, Place-based Clinical Lead (North East Hampshire and Farnham)** | 1 April 2021 – 29 October 2021 |
| **Dr Gareth Robinson, Place-based Clinical Lead (NEHF)** | 1 November 2021 – 31 March 2022 |
| **Dr Martin Kittel, Place-based Clinical Lead (Bracknell Forest)** | 1 April 2021 – 31 July 2021 |
| **Dr Annabel Buxton, Place-based Clinical Lead (Bracknell Forest)** | 6 September 2021 – 31 March 2022 |
| **Secondary Care Consultant** | |
| **Dr Amanda Wellesley** | 1 April 2021 – 31 March 2022 |
| **Lay Members** | |
| **Dr Ed Palfrey, Independent Lay Member (Bracknell Forest), Independent Chair (Frimley CCG Governing Body, 1 April 2021 until 30 June 2021)** | 1 April 2021 – 31 March 2022 |
| **Kathy Atkinson, Lay Member for North East Hampshire and Farnham and Patient and Public Engagement, Chair of the Remuneration Committee, and Freedom to Speak Up Guardian (Staff)** | 1 April 2021 – 31 March 2022 |
| **Arthur Ferry, Lay Member for Slough, RBWM, and Audit and Risk, Chair of the Audit and Risk Committee, and Conflicts of Interest Guardian** | 1 April 2021 – 31 March 2022 |

| Name and role | |
|---|---|
| **Tony Fitzgerald, Lay Member (Surrey Heath) and Chair of the Primary Care Commissioning Committee** | 1 April 2021 – 8 October 2021 |
| **Andrew Lloyd, Interim Lay Member (Surrey Heath) and Chair of the Primary Care Commissioning Committee, Chair of the Frimley ICS Partnership Board (April 2021 – December 2021)** | 8 October 2021 – 31 March 2022 |
| **Executive Medical Director** | |
| **Dr Lalitha Iyer** | 1 April 2021 – 31 March 2022 |
| **Executive Directors** | |
| **Andy Brooks, Chief Clinical Officer** | 1 April 2021 – 18 April 2021<br><br>19 April 2021 – 15 December 2021 on secondment to NHSE<br><br>16 December 2021 – 31 March 2022 on secondment to The Kings Fund |
| **Fiona Edwards, Accountable Officer** | 19 April 2021 – 31 March 2022<br><br>Appointed Chief Executive-designate of the Frimley Integrated Care Board on 1 December 2021 |
| **Sarah Bellars, Executive Director of Quality and Nursing, Caldicott Guardian, and Freedom to Speak Up Guardian (Primary Care)** | 1 April 2021 – 31 March 2022 |
| **Rob Morgan, Executive Director of Finance** | 1 April 2021 – 31 March 2022 |
| **Non-voting members** | |
| **Emma Boswell, Executive Director of Development and Improvement** | 1 April 2021 – 31 March 2022 |
| **Fiona Slevin-Brown, Executive Place Managing Director (Bracknell Forest) and Frimley ICS COVID-19 Executive Director** | 1 April 2021 – 31 March 2022 |
| **Daryl Gasson, Executive Place Managing Director (NEHF)** | 1 April 2021 – 31 March 2022 |
| **Nicola Airey, Executive Place Managing Director (Surrey Heath)** | 1 April 2021 – 31 March 2022 |
| **Tracey Faraday-Drake, Executive Place Managing Director (Slough)** | 1 April 2021 – 31 March 2022 |
| **Caroline Farrar, Executive Place Managing Director (RBWM)** | 1 April 2021 – 31 March 2022 |

| Name and role | |
|---|---|
| **Regular Attendees – between 1 April 2021 and 31 March 2022** | |
| **Sharon Ward, Director of Communications and Engagement** | 1 April 2021 – 31 March 2022 |
| **Caroline Corrigan, National Director of People Strategy, Nursing Directorate** | 1 April 2021 – 31 March 2022 |
| **Jane Hogg, Frimley ICS Transformation Director** | 1 April 2021 – 31 March 2022 |
| **Sam Burrows, Frimley ICS Programme Director** | 1 April 2021 – 31 March 2022 |

## Other related appointments

| | |
|---|---|
| **Dr Emma Whitehouse, Interim Clinical Lead for Surrey Heath Place while Dr John Fraser was on Sabbatical** | 1 September 2021 – 31 October 2021 |

For details of **declared conflicts of interest** published on our website please click here on the Civica Declare link. https://nhsfrimleyccg.mydeclarations.co.uk/home

During 2021-22 NHS Frimley CCG continued to respond to the COVID-19 health pandemic and worked to achieve system priorities on recovery, tackling inequalities and the vaccination programme. In December 2021 NHS England and NHS Improvement announced a Level 4 National Incident in response to the COVID-19 Omicron variant and national directives to free up capacity to prioritise the COVID-19 vaccination programme resulted in a significant number of changes to how the Governing Body operated.

The CCG responded in line with its Constitution and approved the following steps at its Governing Body on 11 January 2022 and agreed to:

- Suspend all non-essential meetings for a three-month period with exception of the Governing Body; Audit and Risk Committee; Remuneration Committee; Primary Care Commissioning Committee; Quality, Performance and Finance Committee; Equality, Diversity, and Inclusion Working Group. Additionally, all meeting times were reduced to free up capacity, and meetings in public were cancelled during this period.
- Approve the delegation of emergency / extra-ordinary powers to Fiona Edwards in her capacity as Accountable Officer and Rob Morgan as Chief Finance Officer
- Continue Emergency Preparedness Resilience and Response (EPRR) arrangements

## Table showing Governing Body Attendance:

| Name and designation | 1 April 2021 | 13 April 2021 | 11 May 2021 | 8 June 2021 | 13 July 2021 | 14 Sep 2021 | 12 Oct 2021 | 9 Nov 2021 | 14 Dec 2021 | 11 Jan 2022 | 8 Feb 2022 | 8 Mar 2022 | No of meetings attended |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Voting members:** | | | | | | | | | | | | | |
| **Dr Andy Brooks** | ✓ | ✓ | | | | | | | | | | | 2/2 |
| **Fiona Edwards** | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| **Sarah Bellars** | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11/12 |
| **Rob Morgan** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12/12 |
| **Dr Lalitha Iyer** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12/12 |
| **Dr Steven Clarke** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | | | | 6/6 |
| **Dr Gareth Robinson** | | | | | | | ✓ | A | ✓ | ✓ | A | ✓ | 4/6 |
| **Dr Ed Palfrey** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | A | A | ✓ | ✓ | ✓ | ✓ | 10/12 |
| **Dr Huw Thomas** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12/12 |
| **Kathy Atkinson** | ✓ | ✓ | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11/12 |

| Name and designation | 1 April 2021 | 13 April 2021 | 11 May 2021 | 8 June 2021 | 13 July 2021 | 14 Sep 2021 | 12 Oct 2021 | 9 Nov 2021 | 14 Dec 2021 | 11 Jan 2022 | 8 Feb 2022 | 8 Mar 2022 | No of meetings attended |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dr Jim O'Donnell | A | A | ✓ | A | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 8/12 |
| Arthur Ferry | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12/12 |
| Dr Amanda Wellesley | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11/12 |
| Tony Fitzgerald | ✓ | ✓ | ✓ | ✓ | A | ✓ | | | | | | | 5/6 |
| Andrew Lloyd | | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6/6 |
| Dr John Fraser | ✓ | ✓ | A | ✓ | ✓ | A | A | A | ✓ | ✓ | ✓ | ✓ | 8/12 |
| Dr Emma Whitehouse | | | | | | D | D | | | | | | 2/2 |
| Dr Martin Kittel | A | ✓ | ✓ | ✓ | A | | | | | | | | 3/5 |
| Dr Annabel Buxton | | | | | | A | ✓ | ✓ | ✓ | ✓ | A | ✓ | 5/7 |
| **Non-voting members:** | | | | | | | | | | | | | |
| Emma Boswell | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11/12 |
| Fiona Slevin-Brown | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ A | | A | 9/12 |
| Daryl Gasson | ✓ | ✓ | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11/12 |
| Tracey Farraday-Drake | ✓ | ✓ | ✓ | A | ✓ | ✓ | A | A | ✓ | ✓ | ✓ | ✓ | 9/12 |
| Caroline Farrar | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12/12 |
| Nicola Airey | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12/12 |

✓Attended **A** Absent **D** Deputy present

In 2021-22 the Governing Body met on twelve occasions –Meetings in public were held four times over the course of the year: 11 May 2021, 13 July 2021, 9 November 2021, and 8 March 2022.

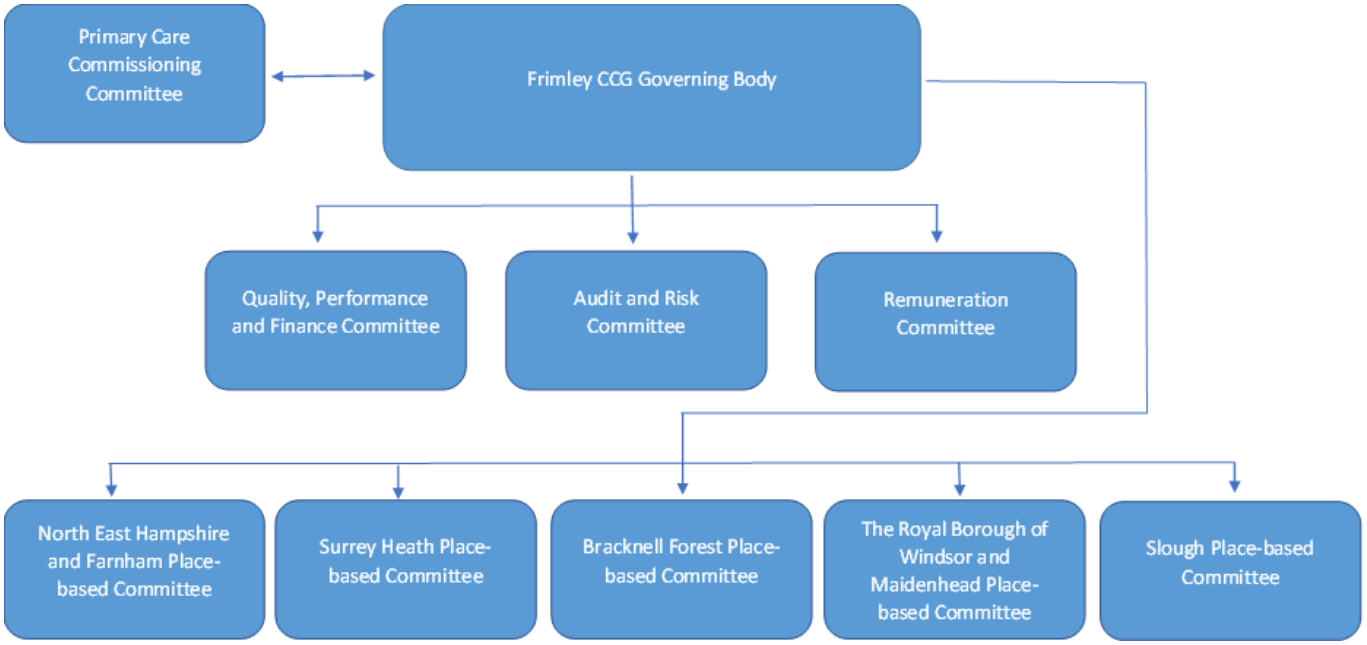
## Transition to Integrated Care Board

The introduction of the Health and Care Bill that was due to come into effect on 1 April 2022 was delayed through parliament for three months until 1 July 2022.

The legislative changes will result in the formation of a single statutory unitary Integrated Care Board (ICB) – this Board will be comprised of providers, commissioners and local authority members and also a partnership board (ICP) these two bodies will work side by side in the Frimley System to deliver health and care services to its local population. To support this integration the commissioning functions of the Frimley CCG will transition to the Frimley ICB from 1 July 2022.

The result of the delay in the enactment of the legislation has meant that the Lay Members and elected Place Based Clinical Leads whose terms of office were due to end on 31 March 2022 have been offered an extension until 30 June 2022.

## 13.1. Frimley CCG Governing Body Structures




### Committees of the Governing Body

### Audit and Risk Committee April 2021 – March 2022

The role of the Frimley CCG Audit and Risk Committee is to provide assurance to the Frimley CCG Governing Body that NHS Frimley CCG is operating effectively and meeting its respective statutory and strategic objectives.

The Committee considers the reports and opinions from a variety of sources, including internal and external audit and Counter-Fraud Services. It acts as the senior assurance committee to the Governing Body. It has a crucial role to play in scrutinising the risks and controls affecting every aspect of the CCG, as well as maintaining its focus on finance and financial management.

Key pieces of work included: reviewing and agreeing the 2020-21 Annual Reports for NHS East Berkshire CCG, NHS North East Hampshire and Farnham CCC and NHS Surrey Heath CCG. The Committee also received regular assurance on progress with the establishment of robust risk management arrangements for the CCG and the rollout of an online Conflicts of Interest, gifts and hospitality declarations system for

staff. The Audit and Risk Committee also received regular briefings on the change and transition work that was taking place at system level ahead of the transition of the Frimley CCG to the Frimley ICB on 1 July 2022.

During 2021-22 the Frimley CCG Audit and Risk Committee met on 6 occasions. The voting members and their attendance are listed in the table below:

**Table showing Audit and Risk Committee membership and attendance between April 2021 – March 2022**

| Name and designation | 11 May 2021 | 9 June 2021 | 23 Sept 2021 | 6 Dec 2021 | 18 Jan 2022 | 24 March 2022 |
|---|---|---|---|---|---|---|
| Arthur Ferry, Lay Member for Slough, RBWM, and Audit and Risk, Chair of the Audit and Risk Committee, and Conflicts of Interest Guardian | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Tony Fitzgerald, Lay Member (Surrey Heath) and Chair of the Primary Care Commissioning Committee | ✓ | ✓ | ✓ | n/a | n/a | n/a |
| Andrew Lloyd, Interim Lay Member (Surrey Heath) | n/a | n/a | n/a | ✓ | ✓ | ✓ |
| Amanda Wellesley, Secondary Care Consultant, NHS Frimley CCG | ✓ | A | ✓ | ✓ | ✓ | ✓ |

✓Attended **A** Absent

## Committees of the Governing Body

## Remuneration Committee April 2021 – March 2022

The Remuneration Committee oversees and monitors matters relating to CCG staff and their development. A more detailed breakdown of the work of the Remuneration Committee can be found within the Remuneration Report.

The Frimley Remuneration Committee met on 12 occasions during 2021-22. Following the secondment of Dr Andy Brooks, Clinical Chief Officer for the Frimley CCG to NHS England and the subsequent appointment of Fiona Edwards as the Chief Executive of the Frimley CCG in order to ensure that it complied with its constitution in the event that a non-GP was appointed to be the Accountable Officer, the Frimley CCG was required to directly elect a Clinical Leader to become the CCG Chair.

The Remuneration Committee reviewed and approved the job description and the time commitment for the Clinical Chair. The Remuneration Committee also agreed the Case for Change for the incumbent Frimley CCG Executive Team and provided its input to the development of the five Chief Officer roles for the Frimley ICB. To ensure

continuity during the transition phase, the Remuneration Committee agreed that where applicable fixed term contracts could be extended until September 2022 – remaining staff groups would be TUPE transferred to the new organisation.

The Committee received regular briefs on national and system HR and OD technical change workstreams to support the transition of the CCG to the Frimley ICB.

According to the Terms of Reference, at least three members are required for quoracy, however, due to capacity issues the meetings in June, September and October 2021 were not quorate. On the occasions when the meetings were not quorate the Chair of the Remuneration Committee sought a decision directly from the member who had not been able to attend and their decision was communicated via email to all members. The decisions were recorded in the minutes of the meeting to ensure transparency.

The Remuneration Committee agreed to strengthen its capacity in January 2022: the Independent Lay Member for Bracknell Forest joined the Committee as a voting member, and the Clinical Chair was also given a standing invitation to attend the meeting.

The Committee is comprised of both voting members and non-voting attendees. Membership and attendance is shown below:

**Table showing Remuneration Committees interim membership and attendance between April 2021 – March 2022**

| Name | 6 April 2021 | 28 April 2021 | 18 June 2021 | 8 July 2021 | 5 August 2021 | 9 September 2021 | 6 October 2021 | 3 November 2021 | 26 November 2021 | 14 December 2021 | 26 January 2022 | 23 March 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Members** | | | | | | | | | | | | |
| Kathy Atkinson (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Amanda Wellesley | | ✓ | ✓ | A | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ |
| Tony Fitzgerald | ✓ | ✓ | ✓ | ✓ | ✓ | A | | | | | | |
| Andrew Lloyd | | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Dr Ed Palfrey | | | | | | | | | | | ✓ | ✓ |

✓Attended **A** Absent

## Table showing Remuneration Committee non-voting attendees between April 2021 – March 2022

| Name | 6 April 2021 | 28 April 2021 | 18 June 2021 | 8 July 2021 | 5 August 2021 | 9 September 2021 | 6 October 2021 | 3 November 2021 | 26 November 2021 | 14 December 2021 | 26 January 2022 | 23 March 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Non-voting attendees** | | | | | | | | | | | | |
| Fiona Edwards | | ✓ | | | | | | | ✓ | | ✓ | ✓ |
| Arthur Ferry | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Dr Ed Palfrey | | ✓ | | | | | | | | | | |
| Emma Boswell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| Caroline Corrigan | ✓ | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Huw Thomas | | | | | | | | | | | | ✓ |

✓Attended A Absent

## Committees of the Governing Body

## Primary Care Commissioning Committee April 2021 – March 2022

On April 1 2016, CCGs assumed responsibility for commissioning local primary care services. The delegation of this role from NHS England to NHS Frimley CCG is an extremely important development in the planning of healthcare services provided to the local population. As the commissioner for local primary care the CCG works more closely with its member practices on planning the services provided to local people.

The Primary Care Commissioning Committee operates as a Meeting in Public, and members of the public are invited to submit questions in advance of each meeting. During 2021-22, the Committee received presentations on the Frimley Digital First Primary Care Programme as well as Supporting Effective Communication and Engagement in General Practice. Due to the emergence of the COVID-19 Omicron variant in December 2021 and the subsequent guidance by NHS England to free up capacity where possible, the decision was made to cancel Meetings in Public in January and March 2022. On these dates, the Primary Care Commissioning Committee ran in Private only and at a shortened runtime of one hour.

In accordance with its Terms of Reference, the Primary Care Commissioning Committee extended standing invitations to representatives from Health Watch, Local Medical Committees, and local Health and Wellbeing Boards.

At its meeting held on 1 March 2022, the Committee received assurances that the CCG's Primary Care finance internal audit had received a low-risk score of 2, consistent with its previous review in 2020-21.

Tony Fitzgerald was the Chair of the Primary Care Commissioning Committee from 1 April 2021 until 8th October 2021, after which Andrew Lloyd assumed the role until 31 March 2022.

The Primary Care Commissioning Committee met six times between April 2021 and March 2022.

## Tables showing membership and attendance at the Primary Care Commissioning Committees held between April 2021 and March 2022

| Name | 18 May 2021 | 20 July 2021 | 21 Sept 2021 | 2 Nov 2021 | 4 Jan 2022 | 01 March 2022 | No of meetings attended |
|---|---|---|---|---|---|---|---|
| **Members** | | | | | | | |
| Tony Fitzgerald | ✓ | ✓ | ✓ | | | | 3/3 |
| Andrew Lloyd | | | | ✓ | ✓ | ✓ | 3/3 |
| Arthur Ferry | ✓ | ✓ | ✓ | A | ✓ | ✓ | 5/6 |
| Caroline Farrar | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6/6 |
| Sarah Bellars | A | ✓ | ✓ | ✓ | ✓ | ✓ | 5/6 |
| Rob Morgan* | D | D | D | D | D | D | 0/6 |
| Veronica Lowthian, deputising for Rob Morgan* | ✓ | ✓ | ✓ | ✓ | A | ✓ | 5/6 |
| Richard Buckley, deputising for Rob Morgan* | | | | | ✓ | | 1/1 |
| Steven Clarke | ✓ | ✓ | A | | | | 2/3 |
| Gareth Robinson | | | | ✓ | ✓ | ✓ | 3/3 |
| Huw Thomas | ✓ | A | A | A | A | A | 1/6 |
| Jim O'Donnell | ✓ | A | A | ✓ | ✓ | ✓ | 4/6 |
| Martin Kittell | ✓ | A | A | | | | 1/3 |
| Annabel Buxton | | | | ✓ | A | A | 1/3 |
| John Fraser | A | ✓ | D | ✓ | ✓ | ✓ | 5/6 |
| Emma Whitehouse | | | ✓ | ✓ | | | 2/2 |
| **In attendance** | | | | | | | |
| Health Watch | ✓ | ✓ | ✓ | ✓ | A | A | 4/6 |
| Health and Wellbeing Board | ✓ | A | ✓ | ✓ | A | A | 3/6 |
| LMC | ✓ | ✓ | ✓ | ✓ | A | ✓ | 5/6 |

* "Executives may appoint an appropriate deputy (who must be an employee of the CCG) to attend a meeting. For the purpose of a quorum, the deputy shall be counted as a member and shall have full voting rights on that occasion)."

✓Attended **A** Absent **D** Deputy present

## Quality Performance and Finance Committee April 2021 – March 2022

The Quality, Performance and Finance Committee ensures reporting and assurance functions are fulfilled and allowing the Governing Body to retain its strategic focus.The Committee met five times between April 2021 and March 2022 and included representation from each of the five places in addition to executive and non-executive directors.

Throughout the year the Committee has focused its discussions on how best to develop its approach to monitoring performance across the CCG, ensuring that it avoided duplication with other assurance bodies. Business as usual covered monthly updates on system finance as well as quality and safeguarding. The Committee also received regular updates on the development of the ICB as well as key Governance assurance arrangements for the transition to the ICB.

In accordance with its Terms of Reference, the Quality, Performance and Finance Committee is considered quorate with the following member representation:

- Chair - Secondary Care Specialist
- Executive representative (Finance or Quality)
- One representative from each of the five Places

## Table showing membership and attendance at meetings held between April 2021 and March 2022

| Name | 25 May 2021 | 27 Jul 2021 | 28 Sept 2021 | 30 Nov 2021 | 15 Feb 2022 | No of meetings attended |
|---|---|---|---|---|---|---|
| **Members** | | | | | | |
| **Chair*** | ✓ | ✓ | ✓ | ✓ | D | 4/5 |
| **Executive Director of Finance** | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| **Executive Director of Quality and Nursing** | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| **Medical Director** | ✓ | A | A | A | ✓ | 2/5 |
| **Bracknell Forest Place-based representative** | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| **NEHF Place-based representative** | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| **RBWM Place-based representative** | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| **Slough Place-based representative** | ✓ | ✓ | ✓ | ✓ | ✓ | 5/5 |
| **Surrey Heath Place-based representative** | ✓ | ✓ | A | ✓ | ✓ | 4/5 |

✓Attended **A** Absent **D** Deputy present

*Amanda Wellesley was the Chair of the Committee for the May, July, September and November meetings. The February meeting was chaired by Arthur Ferry, Lay Member.

## Additional notes

### Personal data related incidents

In 2021-22, there were no reported Serious Untoward Incidents relating to data security breaches.

### Statement of Disclosure to Auditors

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

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

### Modern Slavery Act

NHS Frimley CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website.

## 14. STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

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

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of Accountable Officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

For the year 2021-22 NHS Commissioning Board (NHS England) appointed Fiona Edwards as the Accountable Officer for the merged NHS Frimley CCG.

The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper records and for safeguarding NHS Frimley CCG's assets, are set out in Managing Public Money published by the HM Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Frimley CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

To the best of my knowledge and belief I have properly discharged the responsibilities set out under the National Health Services Act 2008 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

**Fiona Edwards**

Accountable Officer

20 June 2022

# 15. GOVERNANCE STATEMENT

## Introduction and context

*'NHS Frimley CCG is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).*

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

*As at 31 March 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.'*

During 2021-22 the CCG worked in a complex and emerging healthcare environment and it continued its work to develop a single commissioning function for the Frimley ICS.

## Scope of responsibility

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

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

## Governance arrangements and effectiveness

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

The Governing Body is constituted in accordance with the Health and Social Care Act 2012 and is the principle decision-making body in the commissioning and contracting of high-quality healthcare for our local community. It comprises of clinical, lay and executive directors with a variety of backgrounds, with a wide range of skills and experience. These include members overseeing elements of governance and patient and public engagement.

The Frimley CCG and its systems partners have continued to experience extraordinary and unprecedented challenges as a result of the COVID-19 health pandemic.

During the course of 2021-22 the CCG has worked collaboratively with system partners to focus on the rollout of the vaccination programme, elective recovery and to address health inequalities that have resulted from the pandemic.

Following the announcement in December 2021 by NHS England of the Level 4 Public Health Emergency in response to rising COVID-19 numbers - the Frimley CCG enacted its Emergency Preparedness Resilience and Response (EPRR) arrangements and worked with system partners in a “command and control” structure in a single Frimley ICS Incident Co-Ordination Centre. Some members of staff in the Frimley CCG were redeployed to support the fast-paced rollout of the vaccination programme and a number of non-urgent activities were suspended between December 2021 and March 2022, including meetings to free up capacity for staff to support the vaccination centres (both clinical and non-clinical) and also primary care colleagues.

I confirm that the CCG has been able to maintain the functions of the Governing Body through these arrangements and has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

I can confirm that the CCG ensures a strong focus on effective governance is maintained through the observance of the governance framework which is set out in the CCG’s constitution.

The constitution requires that the CCG will at all times observe the principles of good governance in the way it conducts its business. These principles include the Good Governance Standard for Public Services, the Nolan Principles, the seven key principles of the NHS Constitution and the Equality Act 2010.

Embedded within the constitution are the CCG’s Standing Orders. These Standing Orders, combined with the Scheme of Delegation and Prime Financial Policies, form the procedural governance framework. They set out the structure and arrangements for conducting the business of the CCG, the appointment of member practice representatives, and the procedures to be followed at meetings of the CCG, the process to delegate powers and the declaration of interests and standards of conduct.

Information about the Governing Body and its sub-committees, membership and attendance records can be found in the Member’s Report.

The membership, attendance records and highlights of the work undertaken by the Frimley CCG Governing Board and its sub-committees the (i) Audit and Risk Committee (ii) Remuneration Committee (iii) Primary Care Commissioning Committee and (iv) Quality Finance and Performance Committee for 2021-22 are described separately in the Membership Report.

## UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

## Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

The CCG has restated how it would discharge its responsibilities and functions. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

## Risk management arrangements and effectiveness

The Governing Body Assurance Framework (GBAF) and the system of internal control are significant parts of the risk and control framework and are designed to manage risk and to provide reasonable assurance of effectiveness. The Governing Body Assurance Framework and the system of internal control are based on an on-going process to identify and prioritise the management of risks which could impact upon the achievement of the CCG's strategic objectives and to evaluate the likelihood of those risks being realised showing the impact should they be realised.

I can confirm that the Governing Body of the Frimley CCG approved a single Risk Management Framework in April 2021 which aligns all the predecessor risks and sets out new risk management processes.

Risks from the three legacy CCGs East Berkshire; North East Hampshire and Farnham and Surrey Heath were transitioned to the newly merged Frimley CCG on 1 April 2021 and undertook a review and close down process for these risks. This legacy closedown work took place alongside the development of new organisational risks. In line with its Risk Management Framework and throughout 2021-22 the CCG has worked hard to develop and align processes for managing risks across each of its five places.

I can confirm that risk management has been one of the priorities for the newly merged CCG and risk management processes have been rolled out across the organisation to embed best practice. I note the internal auditors points on the CCG's risk management processes in its corporate governance report and I am assured through regular updates to the Audit and Risk Committee that the CCG has taken onboard these comments and improved processes over the past year.

It is important for every employee and clinical lead to understand the Governance Framework, the Risk Management processes and the benefits of on-going identification and management of risk issues. To support staff and improve how the staff record and report on risk the CCG has successfully rolled-out 4Risk which has supported new risk management reporting processes. I also note the bespoke risk management training schedule for all staff including my executive team delivered by our internal audit partner through the mid part of the year.

In September 2021-22 the CCG agreed five strategic objectives to support the transition to becoming a single Integrated Care System (ICS) on 1 July 2022 - the short-term strategic objectives map to those of the NHS England and to partners in the Frimley system and supports the ongoing work to address the impact of the COVID-19 health pandemic. These five strategic objectives have enabled the CCG to develop and agree a single aligned Governing Body Assurance Framework which the Governing Body approved at its meeting in October 2021.

The CCG reviews any impact that a project or programme of work will have on local people. This includes an assessment of risk that helps the CCG to identify mitigating actions. Engaging with local people and stakeholders is one of the actions taken to reduce potential risks. The CCG listens to patients and makes sure local people are engaged throughout the design process, helping to develop new ideas and improve existing services. These actions are described in the Engaging People and Communities section of this report.

The CCG has continued to receive assurance on risk from Local Counter Fraud Specialist and Security Management Specialists who have provided an evaluation on potential cyber risks during the pandemic. The Audit and Risk Committee receives these assurances on behalf of the Governing Body.

## Capacity to Handle Risk

The risks faced by the CCG against its strategic objectives are identified through various means, including risks assessments, audits, incident reports, complaints, through self-assessment and by NHS England.

From June 2021 the Executive Team received assurances on the new corporate risks including corporate, place and system risks.

The Audit and Risk Committee have been briefed throughout the year on the development of risk management in the CCG and a summary of progress was made at its meeting in March 2022.

The Quality, Performance and Finance Committee received key assurance reports at its meetings which include an Integrated Performance Report, Quality and Safeguarding Reports alongside the relevant risk reports.

## Risk Assessment

The Governing Body has agreed five significant risks. The risks are aligned to the strategic priorities and also correlate to the five national priorities set out by NHS England and system ambitions for the Frimley ICS:

- **Strategic Objective 1**: Positively focus on levelling up models of care so that we can improve health outcomes, address inequalities, and deliver greater inclusion across the system

  **Risk**: With the ongoing impact of COVID-19 on the financial regime and allocation for the system; in addition to being able to finalise a workable financial framework for the ICS, means that the system will not be able to successfully deliver its operating plan and the CCG may not meet its statutory duties.

- **Strategic Objective 2**: Working with partners and local communities to support the recovery of health and care services, with a particular focus on addressing health inequalities and the impact of the pandemic

  **Risk:** If we do not take decisive and continuous action to improve health outcomes and deliver greater inclusion for our local communities then, if unchecked, could potentially lead to a widening of the health gap and worsening health outcomes for people living in the most disadvantaged areas.

- **Strategic Objective 3** -Continue to focus on our staff and build a culture of inclusivity so that everyone feels heard, valued and empowered

  **Risk**: If we do not show through action our commitment to supporting our staff and having a culture of inclusivity then we will not be able to attract and develop a diverse workforce that reflects the communities we service

- **Strategic Objective 4**: Effectively manage our resources together with our system partners to successfully deliver the system operating plan

  **Risk**: If we do not coordinate our approach with system partners and use insights and intelligence in how we recover health and social care then we will not effectively address the health impact of COVID-19 on our communities.

- **Strategic Objective 5**: Lead well and inspire each other as we transition successfully into a new organisation

  **Risk**: If the CCG is unable to maintain robust CCG governance arrangements while developing new ICS governance then this may lead to poor decisions, increasing the likelihood of challenge and reputational damage.

The CCG continues to keep NHS England aware of all strategic risks as part of the regular dialogue and reporting arrangements.

## Other sources of assurance

### Internal Control Framework

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

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

The external auditors provide me with their opinion through their letter of representation.

Internal audit has provided reasonable assurance in their head of internal audit opinion (included at the end of this section of the report).

### Annual audit of conflicts of interest management

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

In April 2021 the CCG agreed its updated Conflicts of Interest Policy for the newly merged organisation which aligned management of conflicts of interest processes to ensure that the CCG is compliant with statutory guidance. The online Civica Declare system procured at the beginning of 2021 was rolled out to all CCG staff and system partners who attend CCG meetings from April 2021 onwards. The system provides the public with access to the declarations of interest for Governing Body members and decision makers in line with NHS England guidance. Staff are regularly reminded about the need to complete and maintain their conflicts of interest and to complete their mandatory training.

I am pleased with the progress made and the internal audit of conflicts of interest has given the CCG low risk rating for conflicts of interest. Their report notes that the CCG's procedures for identifying and mitigating conflicts of interest were well documented in each of the terms of reference reviewed, including the Audit Committee; Remuneration Committee; Quality, Performance and Finance Committee; and each of the Place Based Committees. Conflicts of interest were a standing agenda item in all meeting minutes reviewed and in the majority of cases, where a conflict was declared, the actions taken to mitigate the conflict were clearly documented.

I can confirm there have been no conflict of interest breaches reported between 1 April 2021 and 31 March 2022.

## Data Quality

High quality data underpins every step of the commissioning cycle. It is only through the analysis of high-quality data that the CCG can move towards safe, effective, and equitable care for all.

The CCG ensures data quality throughout the commissioning process and, although we rely on other NHS organisations and the CSU, we gain direct assurance from these organisations on a monthly basis and gain independent assurance from Internal Audit reports. No significant issues relating to data quality have been reported to the CCG.

## Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. In 2021-22 the CCG received a low-risk rating from the Internal Audit on the review of the Data Security and Protection Toolkit. The auditors noted several areas of good practice during the review:

- All relevant training for the SIRO and Caldicott Guardian have been completed, and 97% of all staff have completed their Data Security Awareness Training;
- Clear and concise guidance is available for how to perform Data Protection Impact Assessments;
- The DATIX incident reporting and management system is in place for reporting IT incidents;
- All 10 High severity alerts raised this year have been addressed within 24 hours of being raised;
- The Information Governance Policy, Password Policy, and Patch Management Policy were noted to be comprehensive, including clear guidance and version control.

This provides the assurance that the CCG has established an information governance management framework and developed robust information governance processes and procedures in line with the Data Security and Protection Toolkit. All staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

In 2021-22 no serious untoward incidents relating to data security breaches needed to be reported to the regulators.

## Response to COVID-19

The CCG responded appropriately to the COVID-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002. In line with the requirements set out by Secretary of State and NHS Digital this allowed action to be taken to share confidential patient information amongst health organisations and other appropriate bodies for the purposes of protecting public health, providing healthcare services to the public and monitoring and managing the outbreak. Further information can be found on NHS Frimley CCG's website https://www.frimleyccg.nhs.uk/policies-and-documents/information-governance-policies/149-covid-privacy-notice/file

## Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business-critical models, in line with the recommendations in the Macpherson report. The business-critical models of the CCG primarily rely on activity and finance data produced by the Commissioning Support Unit (CSU) which is assured through their own processes.

The work of the CSU and the validity of its data is subject to further independent internal audit scrutiny. As Accountable Officer, I receive assurance through the CSU service auditor reports that relevant controls are in place and have been operating throughout the year. NHS England undertakes a quarterly assurance review which covers the output from these business critical models. All business-critical models have been identified and information about quality assurance processes for those models has been provided to Audit and Risk Committee.

## Third party assurances

The CCG business critical-models primarily rely on activity and finance data produced by the CSU which is assured through the CSU own processes. As Accountable Officer, I receive assurance through service auditor reports that relevant controls are in place for business-critical models and have been operating throughout the year. For the reporting period 2020-21 a number of reports were qualified, and I have received sufficient assurance via the Audit and Risk Committee over processes for each of the respective service organisations. The Audit and Risk Committee did not consider any of the control deficiencies identified in the reports to be significant to the CCGs control environment.

The CCG receives assurance reports from the following organisations:

- From the CSU for some or all services provided (as agreed between the CCG and CSU annually);
- From NHS Shared Business Services for the provision of Financial and Accounting Services and Primary Care Payments services;
- From IBM on the operation of the Electronic Staff Record (ESR) Payroll infrastructure and service;

- From NHS Digital on the operation of GP payments services;
- From NHS Business Service Authority on the operation of prescription services and dental services.

These are Service Auditor Reports which typically set out the following:

- Respective responsibilities in the Service end to end process;
- A high level description of the governance and assurance arrangements in place at the Service Organisation including arrangements for effective risk management and assurance;
- A high level description of the Service control environment;
- An assertion by the Service Organisation management regarding the design of internal controls over the process; and,
- A low level description of the Service's control objectives and supporting key controls.

Service Auditor Reports are an internationally recognised method for Service Organisations to provide details of controls and their operation in a specified period to their clients and are prepared to internationally recognised standards (typically ISAE 3000 and 3402).

In drawing a conclusion on third party assurances, no control issues have been raised via the Service Auditor Reports that would have an impact on the CCG's control environment for the period 2021-22.

## Control Issues

During the year, Internal Audit issued a number of advisory audit reports which identified governance, risk management and/or control issues. The Head of Internal Audit Opinion is informed by these reports and is set out within this annual report. I am pleased to have received an overall reasonable assurance rating.

I can confirm that the CCG did not receive any limited assurance opinions.

No significant control issues have been identified by the auditors that might prejudice or undermine the integrity or reputation of the CCG and/or wider NHS.

## Review of economy, efficiency & effectiveness of the use of resources

I am confident the CCG actively promotes economy, efficiency & effectiveness in all aspects of the CCG's business. The Executive Team and the Quality, Performance and Finance Committee provide critical oversight on investments from both a clinical and financial perspective. All of the achievements of the CCG have been performed within resource limits set by NHS England.

Recruiting the right people to the right posts has been a fundamental approach the CCG has taken forward as part of managing its resources throughout 2021-22. It has maintained its strong leadership with clinical leadership central to the areas that the CCG is responsible for commissioning.

CCGs are statutory organisations responsible to their Governing Body for the delivery of both their statutory and constitutional duties and improvements in the health outcomes of their population. NHS England approaches assurance from the assumption that CCGs will deliver against these requirements.

The process uses information derived from a variety of sources including, where necessary, face-to-face visits. The nature of the oversight, including the expected frequency of assurance meetings, is agreed between NHS England and individual CCGs.

The assurance process introduces a more risk-based approach which differentiates high performing CCGs, those whose performance gives cause for concern, and those in between. It consists of the following components:

- well-led organisation;
- performance: delivery of commitments and improved outcomes;
- financial management;
- planning; and
- delegated functions.

For 2021-22 NHS Frimley CCG has received a low risk rating on all domains assessed.

## Delegation of functions

On April 1 2021 the CCG assumed responsibility for commissioning local primary care services. The delegation of this role from NHS England to the CCG is an extremely important development in the planning of healthcare services provided to the local population.

As the commissioner for local primary care the CCG works more closely with its member practices on planning the services provided to local people.

No control issues have been raised by the auditors or NHS England during 2021-22 and previous legacy CCG's had all received low risk or substantial assurance on effectiveness of the arrangements put in place to exercise the primary medical care commissioning functions of NHS England as set out in the Delegation Agreement.

## Counter fraud arrangements

Following the merger of the three former CCGs (East Berkshire, North East Hampshire and Farnham and Surrey Heath) in April 2021 the Fraud and Security Management Service for the Frimley CCG was aligned to a single provider TIAA – an effective handover of responsibilities was undertaken between the outgoing Hampshire and Isle of Wight Team and TIAA to ensure continuity.

The Fraud and Security Management Service provide an active role in the prevention and deterrence of fraud, bribery and corruption through their attendance at the Audit and Risk Committee, involvement in policy-setting and sharing of information through

attendance at CCG meetings and alerts, bulletins and articles published through the dedicated Fraud and Security Management website.

The emergence of the COVID-19 global pandemic has created unprecedented challenges and across the NHS fraud referrals have increased compared to the same period in 2019-20. A bespoke COVID-19 Fraud and Security Risk Assessment was designed to include emerging risks specific to the pandemic and undertaken across the CCG which provided support for all key functions to mitigate fraud risk, and identified areas of risk to target for fraud risks.

In 2021-22 the CCG's Counter Fraud Specialist reported on five allegations to the Audit and Risk Committee. Four remain under investigation at year end (two from previous years). No other significant losses are reported.

On 1 April 2021 the NHS Counter Fraud Services transitioned its compliance with the NHS Standards to the Government Functional Standards. The Fraud and Security Management Team has worked closely with the CCG to support this transition process and evidence compliance - the Frimley CCG submitted an overall "Amber" rating ahead of the first submission deadline date of 31 May 2021.

The CCG has established a positive training and awareness culture to ensure all staff receive regular training in person, virtually and through the dedicated online e-learning package. Awareness articles produced by the Local Counter Fraud Team have been disseminated to all staff and published online for all staff to access. A staff survey was also carried across the CCG by Counter Fraud.

The Local Counter Fraud Specialist attended the Audit and Risk Committee meetings and reported on progress against the Annual Plan and achievement of the new Government Functional Standards.

No significant control issues have been raised by the Counter Fraud Team.

## Review of the Effectiveness of Governance, Risk Management and Internal Control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their Auditor's Annual Report and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised and given assurance on the effectiveness of internal controls throughout the year through the work carried out by the following:

- Governing Board;
- Incident Control Centre;
- Audit and Risk Committee;
- Quality Performance and Finance Committee; and
- Internal audit.

Our board assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

Conclusion: No significant internal control issues have been identified.

**Fiona Edwards**

Accountable Officer 20 June 2022

## Interim Head of Internal Audit Opinion (HoIA)

### Head of internal audit opinion

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

### Opinion

**Generally satisfactory with some improvements required**

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and/or effectiveness of the framework of governance, risk management and control.

### Basis of opinion

Our opinion is based on:

- All PwC internal audits undertaken during the year.
- Any follow up action taken in respect of PwC audits from previous periods.
- The effects of any significant changes in the organisation's objectives or systems.
- Any limitations which may have been placed on the scope or resources of internal audit.
- NHSE requires that the assurance rating for each review of delegated commissioning needs to be included in Frimley CCG's annual report and governance statement and discussed at a Governing Body meeting in public. We reviewed Primary Care Finance with an overall assurance rating of Full in line with NHSE classifications.

### Commentary

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

- Of our 4 reviews completed in the year, one has been rated as high risk overall, two have been rated as low risk overall and our follow-up review was not risk rated. We have not raised any critical risk rated reports in 2021/22. The 4 reports included 1 high, 1 medium and 11 low risk findings, with no critical rated issues identified within those reports.
- The number of high, medium and low risk rated reports, the nature of the issues raised within them, has led us to conclude that the internal controls in place at the CCG are generally satisfactory with some improvements required. We have highlighted in section 2 specific findings which have contributed to this overall assessment, and the CCG should consider whether these findings are reflected within the Annual Governance Statement.

### Acknowledgement

We would like to take this opportunity to thank Frimley CCG staff for their cooperation and assistance provided during the year.

# 16. REMUNERATION REPORT AND STAFF REPORT

## REMUNERATION REPORT

### Definition of senior manager

The definition of 'senior managers' as per NHS England Annual Reporting guidance is: *"Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the clinical commissioning group."*

This means those who influence the decisions of the clinical commissioning group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory or lay members.

For the purpose of this remuneration report, 'senior managers' constitute both voting and non-voting members of the CCG Governing Body.

### Remuneration Committee

It is a statutory requirement that a CCG's governing body has a remuneration committee to determine and approve remuneration packages for the Accountable Officer, Chief Finance Officer, Executive Directors and Board members. It will also approve policies relating to remuneration and the terms and conditions of employment for all CCG staff.

Their role is to provide advice, guidance and workforce related data as required by the Committee. No committee member is present for discussions about their own remuneration or terms of service.

For further details about the Remuneration Committee, please see Member report.

### Remuneration of Very Senior Managers

For any senior manager who is paid in excess of £150,000 on a full-time annualised basis, the remuneration is agreed and discussed with the CCG Non-Executives at the Remuneration Committee. Some individuals, including the Clinical Chief Officer of the Frimley Collaborative, have expanding and more complex portfolios covering multiple systems and geographies, and this has been strongly taken into consideration when agreeing the remuneration values. The Salary and Allowances table that follow contain further disclosures on the remuneration of the CCG's senior managers.

### Statement of Policy

The Remuneration Committee has the responsibility to maintain awareness of statutory requirements, national guidance and directions in relation to remuneration and workforce matters and to ensure appropriate weight is given in its deliberations to the need to conserve public resources and deliver value for money.

### Senior Managers Service Contracts

There have been no payments made for loss of office to any senior manager who was a member of the Governing Body during 2021-22.

## Salaries and allowances

The table below shows the salaries and allowances paid to senior managers during 2021-22.

| This table is subject to Audit | | | 2021/22 | | | |
|---|---|---|---|---|---|---|
| Name | Title | Note | Full Salary & Fees (Bands of £5,000) £000 | Full Performance Pay & Bonuses (Bands of £5,000) £000 | All Pension-related benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 |
| Nicola Airey | Executive Place Managing Director for Surrey Heath | | 110-115 | 0 | 30-32.5 | 140-145 |
| Kathy Atkinson | Lay Member for North East Hampshire and Farnham and Patient and Public Engagement, Chair of the Remuneration Committee, and Freedom to Speak Up Guardian (Staff) | | 15-20 | 0 | 0 | 15-20 |
| Sarah Bellars | Executive Director of Quality and Nursing, Caldicott Guardian, and Freedom to Speak Up Guardian (Primary Care) | | 115-120 | 0 | 22.5-25 | 135-140 |
| Emma Boswell | Executive Director of Development and Improvement | | 95-100 | 0 | 15-17.5 | 110-115 |
| Dr Andy Brooks | Chief Officer (Accountable Officer) | *i* | 5-10 | 0 | 0 | 5-10 |
| Dr Annabel Buxton | Place Based Clinical Lead for Bracknell Forest | *ii* | 15-20 | 0 | 0-2.5 | 15-20 |
| Dr Steven Clarke | Place Based Clinical Lead for North East Hampshire and Farnham | *iii* | 25-30 | 0 | 0 | 25-30 |
| Fiona Edwards | Chief Officer (Accountable Officer) | *iv* | 190-195 | 0 | 0 | 190-195 |
| Tracey Faraday-Drake | Executive Place Managing Director for Slough | | 110-115 | 0 | 25-27.5 | 135-140 |
| Caroline Farrar | Executive Place Managing Director for Royal Borough of Windsor and Maidenhead | | 110-115 | 0 | 57.5-60 | 165-170 |
| Arthur Ferry | Lay Member for Slough, Royal Borough of Windsor and Maidenhead and Audit and Risk, Chair of the Audit and Risk Committee, and Conflicts of Interest Guardian | | 15-20 | 0 | 0 | 15-20 |
| Tony Fitzgerald | Lay Member for Surrey Heath and Chair of the Primary Care Commissioning Committee | *v* | 5-10 | 0 | 0 | 5-10 |
| Dr John Fraser | Place Based Clinical Lead for Surrey Heath | *vi* | 40-45 | 0 | 0 | 40-45 |
| Daryl Gasson | Executive Place Managing Director for North East Hampshire and Farnham | | 110-115 | 0 | 0 | 110-115 |
| Lalitha Iyer | Executive Medical Director | *vii* | 105-110 | 0 | 20-22.5 | 125-130 |
| Dr Martin Kittel | Place-based Clinical Lead for Bracknell Forest | *viii* | 10-15 | 0 | 0 | 10-15 |
| Andrew Lloyd | Interim Lay Member for Surrey Heath, Chair of the Primary Care Commissioning Committee | *ix* | 5-10 | 0 | 0 | 5-10 |
| Rob Morgan | Executive Director of Finance | | 130-135 | 0 | 27.5-30 | 160-165 |
| Dr Jim O'Donnell | Place Based Clinical Lead for Slough | *x* | 60-65 | 0 | 0 | 60-65 |
| Dr Ed Palfrey | Lay Member for Bracknell Forest, Independent Chair for Frimley CCG Governing Body | *xi* | 15-20 | 0 | 0 | 15-20 |
| Dr Gareth Robinson | Place Based Clinical Lead for North East Hampshire and Farnham | *xii* | 20-25 | 0 | 0 | 20-25 |
| Fiona Slevin-Brown | Executive Place Managing Director for Bracknell Forest | | 115-120 | 0 | 22.5-25 | 140-145 |
| Dr Huw Thomas | Clinical Chair and Place Based Clinical Lead for Royal Borough of Windsor and Maidenhead | *xiii* | 65-70 | 0 | 25-27.5 | 95-100 |
| Amanda Wellesley | Interim Secondary Care Specialist | | 15-20 | 0 | 0 | 15-20 |
| Emma Whitehouse | Interim Place Based Clinical Lead for Surrey Heath | *xiv* | 5-10 | 0 | 0 | 5-10 |

## NOTES Salaries and allowances

There are no values included in the remuneration report for 2020-21 as recommended because NHS Frimley CCG was formed on 1 April 2021 following the merger of NHS East Berkshire, North East Hampshire & Farnham and Surrey Heath CCGs.

i. Dr Andy Brooks (Accountable Officer) was seconded to another role from 19 April 2021. Fiona Edwards was seconded to the Accountable Officer role from 19 April 2021.
ii. Dr Annabelle Buxton was the Place Based Lead for Bracknell Forest from 6 September 2021.
iii. Dr Steven Clarke was the Place Based Lead for North East Hampshire and Farnham from 1 April 2021 to 29 October 2021.
iv. Fiona Edwards was seconded to the Accountable Officer role from 19 April 2021.
v. Tony Fitzgerald was the Lay Member and Chair of the Primary Care Commissioning Committee from 1 April 2021 to 8 October 2021.
vi. Dr John Fraser was on a sabbatical from 1 September 2021 to 31 October 2021. His role was undertaken by Dr Emma Whitehouse on an interim basis during this time. See note xiv.
vii. The salary and fees for Dr Lalitha Iyer include payments relating to her clinical role in addition to those for her Medical Director role.
viii. Dr Martin Kittel was the Place Based Lead for Bracknell Forest from 1 April 2021 to 31 July 2021.
ix. Andrew Lloyd was Interim Independent Member and Chair of the Primary Cre Committee from 8 October 2021 to 31 March 2022.
x. The salary and fees for Dr Jim O'Donnell include payments relating to his ICS role in addition to those for his Place Based Clinical Lead role for Slough.
xi. Dr Ed Palfrey was the Independent Chair for Frimley CCG from 1 April 2021 to 20 June 2021. He became the Independent Member of the Governing Body from 21 June 2021 to 31 March 2022.
xii. Dr Gareth Robinson was the Place Based Lead for North East Hampshire and Farnham 1 November 2021 to 31 March 2022.
xiii. Dr Huw Thomas was the Place Based Clinical Lead for Royal Borough of Windsor and Maidenhead from 1 April 2021 to 31 March 2022 and elected as Clinical Chair from 1 July 2021 to 31 March 2022.
xiv. Dr Emma Whitehouse acted as Place Based Clinical Lead for Surrey Heath between 1 September 2021 and 31 October 2021.

## Pension Benefits

| Pension Benefits 2021-22 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name and Title | Real increase in pension at pension age<br>£000<br>(bands of £2,500) | Real increase in pension lump sum at pension age<br>£000<br>(bands of £2,500) | Total accrued pension at pension age at 31st March 2022<br>£000<br>(bands of £5,000) | Lump sum at pension age related to accrued pension at 31st March 2022<br>£000<br>(bands of £5,000) | Cash Equivalent Transfer Value at 1st April 2021<br>£000 | Real increase in Cash Equivalent Transfer Value<br>£000 | Cash Equivalent Transfer Value at 31st March 2022<br>£000 | Employers contribution to stakeholder pension<br>£000 |
| Nicola Airey, Executive Place Based Managing Director for Surrey Heath | 2-2.5 | 0-2.5 | 35-40 | 65-70 | 647 | 47 | 693 | 16 |
| Sarah Bellars, Executive Director of Qaulity and Nursing, Caldicott Guardian and Freedom to Speak Up Guardian (Primary Care) | 2-2.5 | 0 | 35-40 | 70-75 | 646 | 39 | 685 | 17 |
| Emma Boswell, Executive Director of Development and Improvement | 0-2.5 | 0 | 30-35 | 55-60 | 473 | 25 | 498 | 14 |
| Dr Amanda Buxton, Place Based Clicial Lead forBracknell Forest) | 0-2.5 | 0-2.5 | 0-5 | 5-10 | 81 | 3 | 85 | 2 |
| Fiona Edwards, Accountable Officer | 0 | 0 | 40-45 | 120-125 | 49 | 1 | 50 | 2 |
| Tracey Faraday-Drake, Executive Place Based Managing Director for Slough | 0-2.5 | 0 | 5-10 | 0 | 49 | 31 | 80 | 16 |
| Caroline Farrar, Executive Place Based Managing Director for Royal Borough of Windsor, Ascot and Maidenhead | 2.5-5 | 0 | 15-20 | 0 | 169 | 59 | 228 | 16 |
| Daryl Gasson, Executive Place Based Managing Director for North East Hants and Farnham | 0-2.5 | 0-2.5 | 45-50 | 100-105 | 919 | 25 | 944 | 16 |
| Lalitha Iyer, Executive Medical Director | 0-2.5 | 0-2.5 | 20-25 | 55-60 | 467 | 38 | 504 | 11 |
| Rob Morgan, Executive Director of Finance | 0-2.5 | 0 | 20-25 | 0 | 244 | 36 | 280 | 19 |
| Fiona Slevin-Brown, Executive Place Based Managing Director for Bracknell Forest | 0-2.5 | 0 | 45-50 | 100-105 | 845 | 54 | 899 | 17 |
| Dr Huw Thomas, Clinical Chair and Place Based Clinical Lead for Royal Borough of Windsor and Maidenhead | 0-2.5 | 0-2.5 | 25-30 | 65-70 | 434 | 37 | 470 | 10 |

There are no values included in the remuneration report for 2020/21 as recommended because Frimley CCG was formed on 1st April 2021 following the merger of East Berkshire, North East Hants and Farnham and Surrey Heath CCGs

## Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

## Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

## Fair Pay Disclosure

## Percentage change in remuneration for the highest paid director

The percentage change in remuneration for the highest paid director from the previous financial year and the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole are not available as the CCG was only formed in 2021/22 as a result of the merger of East Berkshire, North East Hants and Farnham and Surrey Heath CCGs on 1st April 2021.

## Pay Ratio Information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/member in Frimley CCG in the financial year 2021/22 was £195,000 - £200,000 (mid-point £197,500) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

| 2021-22 | 25th percentile | Median | 75th percentile |
|---|---|---|---|
| Total remuneration (£) | 39,431 | 50,219 | 79,504 |
| Salary component of total remuneration (£) | 39,431 | 50,219 | 79,504 |
| Pay ratio information | 5.01 : 1 | 3.93 : 1 | 2.48 : 1 |

No staff were in receipt of non-consolidated performance related pay during the year and the benefits in kind (related to travel expense mileage payments) were minimal due as staff were working from home during the year due to the pandemic. No prior year comparatives are available as Frimley CCG is a newly formed organisation in 2021-22 following the merger of East Berkshire, North East Hants and Farnham and Surrey Heath CCGs on 1st April 2021.

In 2021-22, no employees received remuneration greater than the highest-paid director/member

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

Remuneration of Frimley CCG's CCG staff is shown in the table in the Staff Report section.

## Staff Report (subject to audit)

Under the Equality Act 2010, it is essential that the CCG collects and reports on its current relevant workforce information. To do this, it is updated on a regular basis to ensure that current policies, practices and support mechanisms remain relevant to the needs and requirements of the workforce.

The CCG employs permanent staff and also uses a limited amount of agency staff, classified as 'other'. It also buys in services from Commissioning Support Units and other CCGs. The following table sets out the staff costs for the permanent and agency staff for 2021-22:

*Note: This only reflects the headcount of staff on the CCG's Payroll as at 31st March*

**Number of Senior Managers**

| Band | Permanent | Other |
|---|---|---|
| **Very senior Manager** | 37 | 0 |
| **Senior Manager** | 71 | 26 |
| **Total** | 108 | 26 |

Very Senior Managers includes Executive Directors and also non-executives and all clinical leads. Senior managers include all other managers Band 8b and above.

**Staff numbers and costs**

| Employee Benefits | Permanent employees | Other | Total |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Salaries and wages** | 12,105 | 1,921 | 14,026 |
| **Social security costs** | 1,284 | - | 1,284 |
| **Employer Contributions to NHS Pension scheme** | 2,181 | - | 2,181 |
| **Other pension costs** | - | - | - |
| **Apprenticeship Levy** | 44 | - | 44 |
| **Other post-employment benefits** | - | - | - |
| **Other employment benefits** | - | - | - |
| **Termination benefits** | 24 | - | 24 |
| **Gross employee benefits expenditure** | 15,639 | 1,921 | 17,560 |

## Staff numbers (headcount)

| Description | Permanent | Other |
|---|---|---|
| **Very senior Managers** | 37 | 0 |
| **Senior Managers** | 59 | 5 |
| **Manager** | 67 | 8 |
| **Clerical and Administrative** | 56 | 0 |
| **Nurse** | 28 | 32 |
| **Senior Manager - Pharmacy** | 6 | 0 |
| **Pharmacist - trained** | 8 | 0 |
| **Pharmacy Technician** | 5 | 0 |
| **Total** | 265 | 45 |

The above Includes executive directors, clinical leads, agency and temporary staff at 31st March 2022. It excludes non-executive directors and staff who have left the organisation before 31st March 2022.

## Staff Sickness Absence

Staff sickness absence is provided by NHS Digital and is set out in the table below. The CCG continues to develop systems and policies for the reporting of staff sickness and absence. Sickness absence is higher than targeted this year due to the continued impact of COVID 19.

| Average FTE | Average Annual Sick Days per FTE | Total FTE Days Sick | Sum of FTE Days Available |
|---|---|---|---|
| **200** | **5.2** | **1,257** | **54,739** |

## Cost Allocation and Setting of Charges for Information

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

## Principles for Remedy

The Parliamentary and Health Service Ombudsman's six Principles for Remedy (below for information) are embedded into the Complaints Policy and Procedure in use by the CCG to ensure that the approach taken to complaints handling is reasonable, fair and proportionate and meets the needs of individuals. As commissioners, the CCG is committed to ensuring high-quality, clinically effective services, treatments and interventions that meet the needs of patients and that through the highlighting of complaints and concerns the CCG can make improvements to these services.

The six Principles for Remedy are:

1. Getting it right
2. Being customer-focused

3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

The Lay Member for Patient and Public Engagement has the role of the Freedom to Speak Up Guardian in 2021 to give independent support and advice to staff who want to raise concerns.

The Director of Quality and Nursing has the role of the Freedom to Speak up Guardian in 2021 to give independent support and advice to anyone from primary care who want to raise concerns.

## Employee Consultation

The CCG believes that by working in partnership with staff we can learn about peoples' experiences and views, to help prioritise the best ways to support and work together, ultimately acting as a good employer, with strong, supported teams who share organisational learning to shape the delivery of high-quality care for all.

As in previous years, the CCG continues to regularly communicate and engage with staff through weekly staff updates and monthly team briefs – a meeting where staff are informed of organisational change and are invited to be engaged and involved. Staff are also involved and invited to stakeholder events, where CCG priorities are debated and shaped, and regular communications are sent to staff via emails and one-to-one meetings are held with line managers on a frequent basis. Objective settings and personal development plans are written for staff to follow as part of their performance management plans each year too.

## Staff Partnership Forum

The Staff Partnership Forum was established to improve communication between managers and staff, as well as to improve the working environment within the CCG and thereby staff morale. The forum is made up of representatives nominated by each team within the CCG. It is chaired by the CCG's Governing Body Lay Member for Patient and Public Engagement and is also attended by the CCG's HR Manager.

The forum is the CCG's primary means of consulting staff on a range of work-related issues, such as:

- Health and Wellbeing Activities
- Organisational Development
- Health and Safety
- Equality Act
- Organisational Policies

Forum members also consider suggestions made by colleagues on any aspect of working conditions or environment and take decisions or make recommendations to senior management accordingly.

Forum meeting notes are shared with CCG colleagues by the nominated team representatives. The representatives also consult their team members on issues raised at the forum and feed their views back to the forum, as well as supporting and encouraging colleagues to put forward suggestions or ideas.

## Staff policies

During the course of 2021-22 the CCG has continued to develop a range of policies and procedures that we apply to govern our approach to staff recruitment and development. These include:

- Appeals Policy
- Career Break Policy
- Disciplinary Policy
- Volunteering Policy
- Flexible Working Policy
- Freedom to Speak Up Policy
- Grievance and Procedure Policy
- Learning and Development Policy
- Lone Working Policy
- Organisational Change Policy
- Pay Protection Policy
- Professional Registration Policy
- Recruiting Ex-Offenders Policy
- Retirement Policy
- Secondment Policy
- Special Leave Policy
- Temporary Promotion Policy
- Working Time Directive Policy

## Staff training

All staff are required to undertake statutory and mandatory training on a variety of topics to keep standards high, ensure compliance with regulations, and to keep you safe at work.

The training staff are required to do will be specific to their role. Some training is required to be completed annually and others every three years. Training includes but is not limited to:

- Display Screen Equipment
- Fire Safety

- Information Governance
- Equality and Diversity
- Health Safety and Wellbeing
- Safeguarding Adults
- Safeguarding Children
- Fraud awareness
- Moving and Handling

## Equality

The role of equality and diversity is central to the CCG's values, processes and behaviours. As a public body the CCG has a duty to eliminate discrimination and promote equality of opportunity - this duty applies to staff, service users, patients, carers and members of the general public that the CCG comes into contact with.

The CCG is committed to developing, supporting and sustaining a diverse and inclusive workforce that is representative of the community it serves. Equally, we are committed to commissioning (buying) a health service that respects and responds to the diversity of the local population.

In 2021-22 the CCG appointed a dedicated Equality, Diversity and Inclusion (EDI) Lead and established a EDI Working Group to ensure that it meets its statutory duties to comply with key legislation including: the NHS Constitution, the Equality Act 2010, the Human Rights Act 1998 and the Health and Care Social Care Act 2010. The CCG uses the NHS Equality Delivery System 2 (EDS2) to help us to meet the requirements of the Public Sector Equality Duty which is set out in the Equality Act 2010. There are three strands to the Public Sector Equality Duty. These are to:

- eliminate unlawful discrimination, harassment, victimisation and other conduct prohibited by the Equality Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

The CCG self-assesses itself against dedicated Equality Objectives and publishes this information on the website it also undertakes annual analysis of the indicators in the NHS Workforce Race Equality Standard. The CCG has an Equality, Diversity and Inclusion Policy Statement which provides guidance to staff.

The newly appointed EDI Lead has supported the staff induction programme for new starters and has promoted awareness of equalities work and activities by attending a range of staff meetings. This close collaborative working helps to ensure that equality, diversity and inclusion is considered and integrated in all aspects of the CCG’s work,

and at an early stage. The CCG also has a BAME Network which provides a forum for staff to work together to embed equalities work.

The CCG has marked a number of equality events for staff, partners and the wider community. The South East Asian Heritage Month was celebrated in July – August 2021 and brought different and diverse members of the community and staff together. Other events included, Black History Month, Disability History Month, Holocaust Memorial Day, LGBT+ History Month and Race Equality Week. A series of EDI events are being planned for the year ahead which will support the development of a more inclusive culture in the Frimley ICS.

## Freedom to speak up

In accordance with the duty of candour the CCG is committed to conducting its business with openness, honesty and integrity and staff are encouraged to raise concerns about any suspected wrongdoing either via the Counter Fraud Team or with one of the two Freedom to Speak Up Guardians.

The role of the Freedom to Speak Up Guardian is to act as an independent and impartial source of advice at any stage of raising a concern, with access to anyone in the organisation, including the Accountable Officer. Sarah Bellars, Executive Director of Nursing and Quality is the designated Freedom to Speak Up Guardian for Primary Care and Kathy Atkinson, Lay Member for Patient and Public Engagement and Lay Member for North East Hampshire and Farnham Place is the Freedom to Speak Up Guardian for staff. The CCG has a Freedom to Speak Up Policy (formerly the Whistleblowing Policy) which is published on the website https://www.frimleyccg.nhs.uk/policies-and-documents/corporate-policies

Staff are able to access information on the intranet about how to independently contact a member of the Counter Fraud Team – staff also have access to a range of Counter Fraud resources which promote how to raise concerns about any suspected wrongdoing.

## Disabled Employees

Recruitment by the CCG is carried out in accordance with its recruitment policy. All candidates' application forms are shortlisted anonymously and all applicants considered according to the same criteria. The organisation adheres to the Two Tick scheme in that the CCG guarantees to interview all applicants with a disability who meet the essential criteria for a job vacancy and to consider them on their abilities. Where an individual identifies a disability the CCG will make reasonable adjustments throughout the recruitment process.

Employees who become disabled in the course of their employment will have a regular review with their manager to consider how to best utilise and develop their abilities. Any adjustments which are deemed reasonable, to their employment or working conditions that would assist them in the performance of their duties should be considered.

## Trade Union

Public sector organisations are required to report on trade union facility time, which is the paid time off for union representatives to carry out trade union activities. In 2021-22 the CCG only had one member of staff who acted as a Trade Union official. The CCG has agreed flexible time to carry out trade union duties.

## Expenditure on Consultancy

As detailed in note 5 of the financial statements, the CCG's total expenditure on consultancy service for 2021-22 is £1,489,000.

## Off Payroll Engagements

It is a Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and National Insurance arrangements. In addition, payments to GP practices for the services of employees and GPs are deemed to be "off-payroll" engagements.

As a newly formed organisation, all Frimley CCG's off payroll engagements are deemed to be new this year and under 1 year duration.

## Length of all highly paid off-payroll engagements

**For all off-payroll engagements as of 31 March 2022, for more than £245 per day:**

| | |
|---|---|
| No. of existing engagements as of 31 March 2022 | 61 |
| Of which the number that have existed: | |
| For less than one year at the time of reporting | 61 |
| For between one and two years at the time of reporting | 0 |
| For between two and three years at the time of reporting | 0 |
| For between three and four years at the time of reporting | 0 |
| For four or more years at the time of reporting | 0 |

## Off-payroll workers engaged at any point during the financial year

**For all off-payroll engagements between 1st April 2021 and 31 March 2022, for more than £245 per day**

| | |
|---|---|
| No. of temporary off-payroll workers between 1 April 2021 and 31 March 2022 | 61 |
| Of which: | |
| No, not subject to off-payroll legislation | 0 |
| No. subject to off-payroll legislation and determined as in-scope of IR35 | 61 |
| No. subject to off-payroll legislation and determined as out of scope of IR35 | 0 |
| No. of engagements reassessed for consistency / assurance purposes during the year | 0 |
| Of which: no. of engagements that saw a change to IR35 status following the consistency review | 0 |

## Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st April 2021 and 31st March 2022.

| | |
|---|---|
| No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. | 1* |
| Total no. of individuals on payroll and off-payroll that have been deemed "board members", and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on-payroll and off-payroll engagements. | 25 |

*Note 1 Gareth Robinson was appointed Place based clinical lead for North East Hants and Farnham on 1 November 2021. He received off-payroll payments whilst his remuneration was being finalised and is now on the payroll.

## Exit packages, including special (non-contractual) payments

| Exit package cost band (inc. any special payment element) | Compulsory redundancies | | Other departures agreed | | Total | | Number of departures where special payments have been made | Cost of special payment element included in exit packages |
|---|---|---|---|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** | **Number** | **£** | **Number** | **£** |
| Less than £10,000 | - | - | - | - | **-** | **-** | - | - |
| £10,000 - £25,000 | 1 | 24,443 | - | - | **1** | **24,443** | - | - |
| £25,001 - £50,000 | - | - | - | - | **-** | **-** | - | - |
| £50,001 - £100,000 | - | - | - | - | **-** | **-** | - | - |
| £100,001 - £150,000 | - | - | - | - | **-** | **-** | - | - |
| £151,001 - £200,000 | - | - | - | - | **-** | **--** | - | - |
| > £200,000 | - | - | - | - | **-** | **-** | - | - |
| **Total** | **1** | **24,443** | **-** | **-** | **1** | **24,443** | **-** | **-** |

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Agenda for Change Terms & Conditions. Exit costs in this note are accounted for in full in the year of departure. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

## Parliamentary Accountability and Audit Report

Frimley CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements.

**Fiona Edwards**

Accountable Officer

20 June 2022

# INDEPENDENT AUDITOR'S REPORT

## INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS FRIMLEY CLINICAL COMMISSIONING GROUP

### REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

#### Opinion

We have audited the financial statements of NHS Frimley Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2021/22.

#### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

#### Emphasis of matter – going concern

We draw attention to the disclosure made in note 1 to the financial statements which explains that on 1 July 2022, NHS Frimley CCG will be dissolved, and its services transferred to NHS Frimley Integrated Care Board. Under the continuation of service principle, the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

#### Going concern basis of preparation

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the CCG will continue in operation.

#### Fraud and breaches of laws and regulations – ability to detect

*Identifying and responding to risks of material misstatement due to fraud*

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit as to the CCG's high-level policies and procedures to prevent and detect fraud as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition.

We did not identify any additional fraud risks.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual accounts combinations and other unusual journal characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Agreeing a sample of year end accruals to relevant supporting evidence.
- Identifying expenditure invoices recognised in the period 1 March 2022 to 31 May 2022, to determine whether the expenditure is recognised in the correct accounting period, in accordance with the amounts billed to the corresponding parties.
- Assessing the outcome of the NHS agreement of balances exercise with CCGs and other NHS providers and investigating the cause of the variances identified.

*Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations*

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the CCG's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

*Context of the ability of the audit to detect fraud or breaches of law or regulation*

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

**Other information in the Annual Report**

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information;
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements; and
- in our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22.

***Annual Governance Statement***

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22. We have nothing to report in this respect.

***Remuneration and Staff Reports***

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

**Accountable Officer's responsibilities**

As explained more fully in the statement set out on page 99, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

**Auditor's responsibilities**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

**REPORT ON OTHER LEGAL AND REGULATORY MATTERS**

**Opinion on regularity**

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

***Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources***

As explained more fully in the statement set out on page 99, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

**Statutory reporting matters**

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

**THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES**

This report is made solely to the Members of the Governing Body of NHS Frimley CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or

assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

**CERTIFICATE OF COMPLETION OF THE AUDIT**

We certify that we have completed the audit of the accounts of NHS Frimley CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Dean Gibbs
**for and on behalf of KPMG LLP,**
*Chartered Accountants*
15 Canada Square

21 June 2022

**Statement of Comprehensive Net Expenditure for the year ended 31 March 2022**

| | Note | 2021-22 £'000 |
|---|---|---|
| Income from sale of goods and services | 2 | (6,655) |
| Other operating income | 2 | 19 |
| **Total operating income** | | **(6,636)** |
| Staff costs | 3 | 17,560 |
| Purchase of goods and services | 4 | 1,290,546 |
| Depreciation and impairment charges | 4 | 53 |
| Provision expense | 4 | (308) |
| Other Operating Expenditure | 4 | 273 |
| **Total operating expenditure** | | **1,308,125** |
| **Total Net Expenditure for the Financial Year** | | **1,301,489** |
| **Other Comprehensive Expenditure** | | |
| Net loss on Absorption in respect of assets transferred from closed NHS bodies | | 102,637 |
| **Comprehensive Expenditure for the year** | | **1,404,126** |

The notes on pages 140 to 163 form part of this statement

**Statement of Financial Position as at 31 March 2022**

| | Note | 2021-22 £'000 | 01-April-2021 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 8 | 54 | 106 |
| **Total non-current assets** | | 54 | 106 |
| **Current assets:** | | | |
| Trade and other receivables | 9 | 2,965 | 9,291 |
| Cash and cash equivalents | 10 | 163 | 46 |
| **Total current assets** | | **3,128** | 9,337 |
| **Total assets** | | **3,182** | 9,443 |
| **Current liabilities** | | | |
| Trade and other payables | 11 | (126,846) | (104,492) |
| Borrowings | 12 | - | (1,992) |
| Provisions | 13 | (4,026) | (4,846) |
| **Total current liabilities** | | **(130,872)** | (111,330) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(127,690)** | (101,887) |
| **Non-current liabilities** | | | |
| Provisions | 13 | (790) | (750) |
| **Total non-current liabilities** | | **(790)** | (750) |
| **Assets less Liabilities** | | **(128,480)** | (102,637) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (128,480) | (102,637) |
| **Total taxpayers' equity:** | | **(128,480)** | (102,637) |

The notes on pages 140 to 163 form part of this statement

The financial statements on pages 136 to 163 were approved by the Governing Body on 14th of June 2022 and signed on its behalf by:

Fiona Edwards
Chief Accountable Officer

Date: 20 June 2022

**Statement of Changes In Taxpayers Equity for the year ended 31 March 2022**

| | General fund £'000 |
|---|---|
| **Changes in taxpayers' equity for 2021-22** | |
| **Balance at 01 April 2021** | 0 |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | (102,637) |
| **Adjusted NHS Clinical Commissioning Group balance at 31 March 2021** | **(102,637)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22** | |
| Net operating expenditure for the financial year | (1,301,489) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year** | **(1,301,489)** |
| Net funding | 1,275,646 |
| **Balance at 31 March 2022** | **(128,480)** |

The notes on pages 140 to 163 form part of this statement

**Statement of Cash Flows for the year ended 31 March 2022**

| | Note | 2021-22 £'000 |
|---|---|---|
| **Cash Flows from Operating Activities** | | |
| Net operating expenditure for the financial year | | (1,301,490) |
| Depreciation and amortisation | 8 | 53 |
| Decrease in trade & other receivables | 9 | 6,326 |
| Increase in trade & other payables | 11 | 22,354 |
| Provisions utilised | 13 | (472) |
| Decrease in provisions | 13 | (308) |
| **Net Cash (Outflow) from Operating Activities** | | **(1,273,537)** |
| **Net Cash (Outflow) before Financing** | | **(1,273,537)** |
| **Cash Flows from Financing Activities** | | |
| Grant in Aid Funding Received | | 1,275,646 |
| **Net Cash (Outflow) from Financing Activities** | | **1,275,646** |
| **Net Increase in Cash & Cash Equivalents** | 10 | **2,109** |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **0** |
| Cash & Cash Equivalents on Absorption transferred from closed NHS bodies | | **(1,946)** |
| **Cash & Cash Equivalents at the End of the Financial Year** | | **163** |

The notes on pages 140 to 163 form part of this statement

**Notes to the financial statements**

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statemen ts have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the exte nt that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Gro up Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis**.**

The Health and Care Act received royal assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and will abolish CCGs. ICBs will take on the commissioning functions of CCGs. As a result the functions, assets and liabilities of the CCG will therefore transfer to NHS Frimley Integrated Care Board.

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

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern. If services will continue to be provided the financial statements are prepared on the going concern basis. As the CCG's functions will continue to be delivered by the ICB the CCG has therefore assessed that it remains a going concern as at 31 March 2022.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector . Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs. Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries

1.4 **Pooled Budgets**

The clinical commissioning group has entered into pooled budget arrangement with Local Authorities including Hampshire County Council, Bracknell Forest Council, Slough Borough Council, Royal Borough of Windsor & Maidenhead and Surrey County Council in accordance with section 75 of the NHS Act 2006. Under these arrangements, funds are pooled for joint health and social care provision under the Better Care Fund, and with additional arrangements for the purchase of Child and Adolescent Mental Health Services, Community Equipment and integrated health and social care initiatives (community nursing and mental health services, adult social care services and commissioning staff). Note 18 provides details of the income and expenditure.

The pools are hosted by the Local Authorities. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 **Operating Segments**

The CCG has one operating segment, commissioning of healthcare services, as reported in the Statement of Comprehensive Net Expenditure and the Statement of Financial Position.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

**Notes to the financial statements**

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **Other Expenses**

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

1.9 **Grants Payable (where relevant)**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Leases**

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

1.10.1 **The Clinical Commissioning Group as Lessee**

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

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

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hour s. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and t hat form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

**Notes to the financial statements**

1.15 **Contingent liabilities and contingent assets**

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

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

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.16 **Financial Assets**

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

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in I FRS 9, and is determined at the time of initial recognition.

All CCGs Financial assets are classified as loans and receivables.

1.16.1 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

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

1.18 **Value Added Tax**

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

1.19 **Losses & Special Payments (where reported in financial statements)**

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

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

1.20 **Critical accounting judgements and key sources of estimation uncertainty**

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

1.20.1 **Critical accounting judgements in applying accounting policies**

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

The CCG has adopted, for hosted services, where a lead CCG acts as a payment body on behalf of other CCG's a Net Accounting Agreements. This applies to the service element only and charges for administering the hosted services have been shown gross.

The Net Accounting Agreements cover the following areas :-

Continuing Healthcare managed via NHS Surrey Heartlands CCG and NHS Hampshire, Southampton and Isle of Wight CCG.

Mental Health placements managed via NHS Surrey Heartlands CCG and NHS Hampshire, Southampton and Isle of Wight CCG.

Children's placements and CAMHS managed via NHS Surrey Heartlands CCG and NHS Hampshire,Southampton and Isle of Wight CCG.

Wheelchair Services managed via NHS Surrey Heartlands CCG.

The CCG hosts the London Focus Group, a collaboration of 7 CCGs which commissions activity at 15 London Trusts and the collaboration has agreed to net account the arrangement.

There is a small number of other low value net accounting arrangements.

1.20.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

**Notes to the financial statements**

**Prescribing accruals:**
There is a time lag between when the clinical commissioning group's patients receive drugs and certain other medical consumables prescribed by our GPs and when the Group pays the NHS Prescription Services for their issue. At the balance sheet date the Clinical Commissioni ng Group has estimated the value of this lag in relation to drugs and goods issued but not paid for to be £15,706k

**Continuing Care Accrual**
The Clinical Commissioning Group holds its approved care packages, Personal Health budgets (PHB), funded nursing care and additional associated charges to care in a Continuing Healthcare database which provides a forecast of annual costs. An accrual is made between the current year invoices received in year and the forecast of the annual costs

**Accruals**
For goods and/or services that have been delivered but for which no invoice has been received/sent, the CCG has made an accrual based upon known commitments, contractual arrangements that are in place and legal obligations. the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The estimates and associated assumptions are based on historical experience and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.
During 2021/22 the CCG paid for it's NHS secondary healthcare activity on a block basis and therefore no accruals as at 31 Ma rch 2022.

**Continuing Care Provision**
An amount of £4,816k has been included in the NHS Continuing Healthcare (CHC) provisions relating to the following items:
• Continuing Health Care (CHC) Waiting List clients awaiting assessment at 31 March 2022 Nil
• Appeals against earlier CCG decisions of non-eligibility for CHC funding £3,599k
• Previously Unassessed Periods of Care (PUPoC) claims awaiting assessment £1,167k
(these relate to claims in respect of clients who have died and other clients requesting an assessment for a past period of t ime)
• Provision for Redundancy Costs for carers employed by Personal Health Budget holders £50k
The final outcome has yet to be determined therefore the resultant financial effects remain uncertain at the year end. The total cost of all outstanding CHC Waiting List clients' claims would be calculated using the average local current nursing home and homecare package weekly costs for NHS CHC Adult Fully Funded clients.
The CHC Appeals provision has been calculated on an individual basis for each client appealing against the CCG's decision of non-eligibility. The provision is based on the time period from the start-date of the claim up to 31 March 2022 (or date client died) using the current average local nursing home and homecare package weekly costs. The majority of the provisions have been made at 42% for Local appeals and 20% for the Independent Review Panels (IRPs), 38% for PUPoC and those appeals that are successful are provided at 100%.
The Redundancy Costs in respect of PHB clients has been estimated on a notional basis. As per national guidance, the CCG is financially responsible for bearing the redundancy costs of carers of Third Party and Direct Payment PHB clients and hence it is probable that the CCG will have to incur some expenditure of this type during 2022/23. However, at present the timings and amounts are unclear and therefore a provision has been set up to act as a reserve.

1.21 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.22 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard.
IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The clinical commissioning group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the clinical commissioning group will apply the standard retrospectively without re statement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the clinical commissioning group's incremental borrowing rate. The clinical commissioning group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the clinical commissioning group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

The application of the Standards (IFRS 17 and IFRIC 23 (Uncertainty over Income Tax Treatment)) as revised would not have a material impact on the accounts for 2021-22, were they applied in that year.

## 2 Other Operating Revenue

| | 2021-22 Total £'000 |
|---|---|
| **Income from sale of goods and services (contracts)** | |
| Education, training and research | 122 |
| Non-patient care services to other bodies | 5,791 |
| Prescription fees and charges | 202 |
| Other Contract income | 540 |
| **Total Income from sale of goods and services** | 6,655 |
| | |
| **Other operating income** | |
| Charitable and other contributions to revenue expenditure: non-NHS | 10 |
| Other non contract revenue | |
| **Total Other operating income** | (29) |
| | |
| **Total Operating Income** | 6,636 |

## 3. Employee benefits and staff numbers

### 3.1. Employee benefits

| | Tota | | 2021-22 |
|---|---|---|---|
| | Permanent Employees £'000 | Other £'000 | Total £'000 |
| **Employee Benefits** | | | |
| Salaries and wages | **12,105** | **1,921** | **14,026** |
| Social security costs | **1,284** | **-** | **1,284** |
| Employer Contributions to NHS Pension scheme | **2,181** | **-** | **2,181** |
| Apprenticeship Levy | **44** | **-** | **44** |
| Termination benefits | **25** | **-** | **25** |
| **Gross employee benefits expenditure** | 15,639 | 1,921 | 17,560 |

The full staff cost note is in the staff report in the annual report

**3.2 Average number of people employed**

| | 2021-22 | | |
|---|---|---|---|
| | Permanently employed Number | Other Number | Total Number |
| **Total** | **202.66** | **17.10** | **219.76** |

There were no ill health retirements in 2021-22.

**3.3 Exit packages agreed in the financial year**

The CCG has one exit package agreed in 2021-22

| | 2021-22 Compulsory redundancies | |
|---|---|---|
| | Number | £ |
| £10,001 to £25,000 | 1 | 24,443 |
| **Total** | **1** | **24,443** |

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change and the provisions set out in Section 16 of the NHS Terms and Conditions of Service Handbook.

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

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

### 3.4 Pension costs

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

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

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:

#### 3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

#### 3.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

For 2021-22, total employers' contributions of £2,209,995 (CCG: £1,546,530 and NHSE: £663,465) were payable to the NHS Pensions Scheme at the rate of 20.6% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2016 and was published on the Government website. These costs are included in the NHS pension line of note 3.1. The value included in note 3.1. £2,181,106 varies from the total employers' contribution of £2,209,995 largely as a result of net recharges to other organisations.

**4. Operating expenses**

| | 2021-22 Total £'000 |
|---|---|
| **Purchase of goods and services** | |
| Services from other CCGs and NHS England | 8,649 |
| Services from foundation trusts | 826,045 |
| Services from other NHS trusts | 9,424 |
| Purchase of healthcare from non-NHS bodies | 212,721 |
| Prescribing costs | 99,219 |
| Pharmaceutical services | 8 |
| General Ophthalmic services | (1) |
| GPMS/APMS and PCTMS | 120,772 |
| Supplies and services – clinical | 472 |
| Supplies and services – general | (348) |
| Consultancy services | 1,489 |
| Establishment | 3,640 |
| Transport | 4 |
| Premises | 7,233 |
| Audit fees | 187 |
| Other non statutory audit expenditure | |
| · Other services | (7) |
| Other professional fees | 1,053 |
| Legal fees | 119 |
| Education, training and conferences | (133) |
| **Total Purchase of goods and services** | **1,290,546** |
| **Depreciation and impairment charges** | |
| Depreciation | 53 |
| **Total Depreciation and impairment charges** | **53** |
| **Provision expense** | |
| Provisions | (308) |
| **Total Provision expense** | **(308)** |
| **Other Operating Expenditure** | |
| Chair and Non Executive Members | 204 |
| Grants to Other bodies | (89) |
| Clinical negligence | (1) |
| Other expenditure | 159 |
| **Total Other Operating Expenditure** | **273** |
| **Total operating expenditure** | **1,290,564** |

During 2021-22, the national financial regime remained in place, to manage flows of funding to NHS Trusts and other healthcare providers ensuring resource continued to be available to respond to the COVID pandemic in the most effective way and with additional funding being provided for COVID related activities.

Audit fees - statutory audit services excluding VAT is £150k, amount shown £187k is inclusive of VAT, £180k relates to 21-22 and £7k to 20-21 legacy organisation.

The CCG has provided £15k excluding VAT for the fee for 21-22 compliance review of the Mental Health Investment Standard. The 20-21 compliance review did not take place therefore the £22k accrual from the legacy CCGs has been released to give an overall credit value of £7k.

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the contract with our Auditors provides for a £0.5m limitation of their liability.

**5.1 Better Payment Practice Code**

| Measure of compliance | 2021-22 Number | 2021-22 £'000 |
|---|---|---|
| **Non-NHS Payables** | | |
| Total Non-NHS Trade invoices paid in the Year | 26,924 | 245,402 |
| Total Non-NHS Trade Invoices paid within target | 25,671 | 235,646 |
| **Percentage of Non-NHS Trade invoices paid within target** | **95.35%** | **96.02%** |
| | | |
| **NHS Payables** | | |
| Total NHS Trade Invoices Paid in the Year | 963 | 909,365 |
| Total NHS Trade Invoices Paid within target | 918 | 906,121 |
| **Percentage of NHS Trade Invoices paid within target** | **95.33%** | **99.64%** |

The Better payment practice code requires the CCG to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

## 6. Net (loss) on transfer by absorption

| | 01-April-2021 £'000 |
|---|---|
| Transfer of property plant and equipment | 106 |
| Transfer of cash and cash equivalents | 46 |
| Transfer of receivables | 9,291 |
| Transfer of payables | (106,484) |
| Transfer of provisions | (5,596) |
| **Net loss on transfers by absorption** | **(102,637)** |

## 7. Operating Leases

### 7.1. Payments recognised as an Expense

| | Buildings £'000 | Other £'000 | 2021-22 Total £'000 |
|---|---|---|---|
| **Payments recognised as an expense** | | | |
| Minimum lease payments | 5,793 | 1 | **5,794** |
| **Total** | **5,793** | **1** | **5,794** |

### 7.1.2 Future minimum lease payments

| | Buildings £'000 | Other £'000 | 2021-22 Total £'000 |
|---|---|---|---|
| **Payable:** | | | |
| No later than one year | 42 | - | **42** |
| Between one and five years | 25 | - | **25** |
| **Total** | **67** | **-** | **67** |

NHS Frimley CCG occupies properties owned and managed by NHS Property Services (NHSPS) and Surrey Heath House managed by the Council. Whilst our arrangement with the NHSPS and the Council falls within the definition of an operating lease, including void spaces, the rental charge for future years has not yet been agreed with NHSPS. Consequently, the NHSPS arrangement does not include the future minimum lease payments.

## 8. Property, plant and equipment

| 2021-22 | Information technology £'000 | Total £'000 |
|---|---|---|
| **Cost or valuation at 01 April 2021** | 762 | 762 |
| **Cost/Valuation at 31 March 2022** | **762** | **762** |
| **Depreciation 01 April 2021** | 655 | 655 |
| Charged during the year | 53 | 53 |
| **Depreciation at 31 March 2022** | **708** | **708** |
| **Net Book Value at 31 March 2022** | **54** | **54** |
| Purchased | 54 | 54 |
| **Total at 31 March 2022** | **54** | **54** |
| **Asset financing:** | | |
| Owned | 54 | 54 |
| **Total at 31 March 2022** | **54** | **54** |

### 8.1 Economic Lives

| | Minimum Life (Years) | Maximum Life (Years) |
|---|---|---|
| **Information Technology** | **3** | **3** |

**9.1 Trade and other receivables**

| | **Current 2021-22 £'000** | Current 01-April-2021 £'000 |
|---|---|---|
| NHS receivables: Revenue | 342 | 2,354 |
| NHS prepayments | 0 | 3 |
| NHS accrued income | 957 | 4,328 |
| NHS Contract Receivable not yet invoiced/non-invoice | 101 | 131 |
| NHS Non Contract trade receivable (i.e pass through funding) | 5 | - |
| Non-NHS and Other WGA receivables: Revenue | 299 | 625 |
| Non-NHS and Other WGA prepayments | 900 | 670 |
| Non-NHS and Other WGA accrued income | 335 | 597 |
| Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding) | 5 | 103 |
| Non-NHS Contract Assets | - | 226 |
| Expected credit loss allowance-receivables | (3) | (3) |
| VAT | 24 | 257 |
| **Total Trade & other receivables** | **2,965** | **9,291** |
| **Total current and non current** | **2,965** | **9,291** |
| Included above: | | |
| Prepaid pensions contributions | - | - |

**9.2 Receivables past their due date but not impaired**

| | **2021-22 DHSC Group Bodies £'000** | **2021-22 Non DHSC Group Bodies £'000** | 01-April-2021 DHSC Group Bodies £'000 | 01-April-2021 Non DHSC Group Bodies £'000 |
|---|---|---|---|---|
| By up to three months | 72 | 21 | 329 | 67 |
| By three to six months | - | - | 72 | 95 |
| By more than six months | - | 190 | 149 | 139 |
| **Total** | **72** | **211** | **550** | **301** |

**9.3 Loss allowance on asset classes**

| | **Trade and other receivables - Non DHSC Group Bodies £'000** | **Total £'000** |
|---|---|---|
| Balance at 31 March 2022 | (3) | **(3)** |

**10. Cash and cash equivalents**

| | 2021-22<br>£'000 |
|---|---|
| **Balance at 01 April 2021** | (1,946) |
| Net change in year | 2,109 |
| **Balance at 31 March 2022** | **163** |
| | |
| Made up of: | |
| Cash with the Government Banking Service | **163** |

A BACS payment run was processed on 31 March 2021 as part of preparations for the CCG merger on 1 April 2021. This was posted to the 2020-21 ledger, however, the cash did not clear the bank account until April 2021. This resulted in a 'technical' bank overdraft at the 1 of April 2021.

| **11. Trade and other payables** | **Current 2021-22 £'000** | Current 01-April-2021 £'000 |
|---|---|---|
| NHS payables: Revenue | 7,425 | 2,149 |
| NHS accruals | 5,087 | 2,712 |
| Non-NHS and Other WGA payables: Revenue | 33,132 | 22,183 |
| Non-NHS and Other WGA accruals | 47,195 | 49,651 |
| Non-NHS and Other WGA deferred income | 446 | 158 |
| Social security costs | 208 | 172 |
| Tax | 174 | 156 |
| Other payables and accruals | 33,179 | 27,311 |
| **Total Trade & Other Payables** | **126,846** | **104,492** |
| Total current and non-current | **126,846** | **104,492** |

Other payables include £265k outstanding pension contributions at 31 March 2022

| 12 Borrowings | Current 2021-22 £'000 | Current 01-April-2021 £'000 |
|---|---|---|
| **Bank overdrafts:** | | |
| · Government banking service | - | 1,992 |
| **Total Borrowings** | **-** | **1,992** |
| **Total current and non-current** | **-** | **1,992** |

A BACS payment run was processed on 31 March 2021 as part of preparations for the CCG merger on 1 April 2021. This was posted to the 2020-21 ledger, however, the cash did not clear the bank account until April 2021. This resulted in a 'technical' bank overdraft at the 1 of April 2021.

**13 Provisions**

| | Current 2021-22 £'000 | Non-current 2021-22 £'000 | Current 01-April-2021 £'000 | Non-current 01-April-2021 £'000 |
|---|---|---|---|---|
| Continuing care | 4,026 | 790 | 4,846 | 750 |
| **Total** | **4,026** | **790** | **5,596** | **750** |
| **Total current and non-current** | **4,816** | | | |
| | (820) | | | |
| | **40** | | | |

Continuing Care provision relates to amounts set aside at 31 March 2022 for appeals against previous CCG decisions of non-eligibility for Continuing Care funding.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the Clinical Commissioning Group. However, the legal liability and the responsibility for processing and assessing the claims remains with the CCG. The total value of legacy NHS Continuing Healthcare contingent liability legally accounted for by NHS England on behalf of this CCG at 31 March 2022 is £5k.

| | Continuing Care £'000 | Total £'000 |
|---|---|---|
| **Balance at 01 April 2021** | **5,596** | **5,596** |
| Arising during the year | 3,513 | **3,513** |
| Utilised during the year | (472) | **(472)** |
| Reversed unused | (3,821) | |
| **Balance at 31 March 2022** | **4,816** | **(3,821)** |
| **Expected timing of cash flows:** | | |
| Within one year | 4,026 | **4,026** |
| Between one and five years | 790 | **790** |
| **Balance at 31 March 2022** | **4,816** | **4,816** |

## 14 Contingencies

| | 2021-22 £'000 | 01-April-2021 £'000 |
|---|---|---|
| **Contingent liabilities** | | |
| Continuing Healthcare | 144 | 138 |
| **Net value of contingent liabilities** | **144** | **138** |

## 15 Commitments

### 15.1 Other financial commitments

The NHS clinical commissioning group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

| | 2021-22 £'000 |
|---|---|
| In not more than one year | 41,980 |
| **Total** | **41,980** |

The clinical commissioning group has reviewed its contracts that extend over more than one financial year. All of these contracts have break clauses, however included above are the value of those contracts where early termination would result in a significant financial impact on the clinical commissioning group.

## 16 Financial instruments

### 16.1 Financial risk management

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

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

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

#### 16.1.1 Currency risk

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

#### 16.1.2 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note 9.2.

#### 16.1.3 Liquidity risk

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

#### 16.1.4 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

**16 Financial instruments cont'd**

**16.2 Financial assets**

| | Financial Assets measured at amortised cost 2021-22 £'000 | Total 2021-22 £'000 |
|---|---|---|
| Trade and other receivables with NHSE bodies | 778 | 778 |
| Trade and other receivables with other DHSC group bodies | 703 | 703 |
| Trade and other receivables with external bodies | 563 | 563 |
| Cash and cash equivalents | 163 | 163 |
| **Total at 31 March 2022** | **2,207** | **2,207** |

**16.3 Financial liabilities**

| | Financial Liabilities measured at amortised cost 2021-22 £'000 | Total 2021-22 £'000 |
|---|---|---|
| Trade and other payables with NHSE bodies | 6,109 | **6,109** |
| Trade and other payables with other DHSC group bodies | 14,873 | **14,873** |
| Trade and other payables with external bodies | 105,035 | **105,035** |
| **Total at 31 March 2022** | **126,017** | **126,018** |

**17 Operating segments**

The CCG has one operating segment, commissioning of healthcare services, as reported in the Statement of Comprehensive Net Expenditure and the Statement of Financial Position.

**18 Joint arrangements - interests in joint operations**

The CCG has a pooled budget arrangement with Local Authorities (LA) including Royal Borough of Windsor and Maidenhead (RBWM), Slough Borough Council (SBC), Bracknell Forest Borough Council (BFBC), Hampshire County Council (HCC) and Surrey County Council (SCC) for the Better Care Fund (BCF). The Pool is hosted by the Councils. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for joint commissioning arrangements.

| | | | Amounts recognised in Entities books ONLY |
|---|---|---|---|
| | | | 2021-22 |
| **Name of arrangement** | **Parties to the arrangement** | **Description of principal activities** | **Expenditure** |
| | | | **£'000** |
| BCF Pooled budget arrangement with the Royal Borough of Windsor and Maidenhead | NHS Frimley CCG and the Royal Borough of Windsor and Maidenhead | Commissioning of Health and Social care | 12,130 |
| BCF Pooled budget arrangement with Bracknell Forest Borough Council | NHS Frimley CCG and Bracknell Forest Borough Council | Commissioning of Health and Social care | 9,525 |
| BCF Pooled budget arrangement with Slough Borough Council | NHS Frimley CCG and Slough Borough Council | Commissioning of Health and Social care | 10,785 |
| BCF Pooled budget arrangement with Surrey County Council | Surrey County Council and NHS Frimley CCG | Commissioning of Health and Social care | 11,364 |
| Child and Adolescent Mental Health Services | Surrey County Council and NHS Frimley CCG | Targeted (Tier 2) CAMHS services (including school based services, HOPE service, children in care services and youth support services) Behaviour pathway for children with neurodevelopmental disorders. | 204 |
| Integrated Community Equipment Store | Surrey County Council and NHS Frimley CCG | Purchase of community equipment across Surrey | 172 |
| BCF Pooled budget arrangement with Hampshire County Council | Hampshire County Council and NHS Frimley CCG | Commissioning of Health and Social care | 14,669 |

**19 Related party transactions**

**Details of related party transactions with individuals are as follows:**

| | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
|---|---|---|---|---|
| Royal Borough of Windsor and Maidenhead - (Dr Huw Thomas-Clinical Chair and Place based Clinical Lead for Royal Borough of Windsor and Maidenhead) | 8,352 | 41 | - | 11 |
| Claremont & Holyport Practice - (Dr Huw Thomas-Clinical Chair and Place based Clinical Lead for Royal Borough of Windsor and Maidenhead (GP Partner )) | 2 | - | - | - |
| East Berkshire Out of Hours - (Dr Huw Thomas-Clinical Chair and Place based Clinical Lead for Royal Borough of Windsor and Maidenhead (GP)) | 14,379 | - | - | - |
| Rosemead Surgery - (Dr Huw Thomas-Clinical Chair and Place based Clinical Lead for Royal Borough of Windsor and Maidenhead (Patient)) | 885 | - | - | - |
| Farnham Road Surgery - (Dr Lalitha Iyer-Executive Medical Director (GP Partner)) | 3,145 | - | - | - |
| Dr V Sharma Surgery - (Dr Lalitha Iyer-Executive Medical Director (Patient)) | 802 | - | - | - |
| Solutions for Health - (Dr Lalitha Iyer-Executive Medical Director) | 120 | 15 | - | - |
| Farnham Road Practice - (Dr Jim O'Donnell-Place Based Clinical Lead for Slough (GP Partner)) | 3,145 | - | - | - |
| Hampshire, Southampton and Isle of Wight CCG - (Ed Palfrey-Lay Member for Bracknell Forest Place and Independent Chair) | 26,519 | 2,595 | 1,224 | 78 |
| Thames Valley Vasectomy Services (TVVS) - (Dr Martin Kittel-Place Based Clinical Lead for Bracknell Forest) | 63 | - | - | - |
| Forest End Medical Centre - (Dr Martin Kittel-Place Based Clinical Lead for Bracknell Forest (GP & Partner)) | 2,371 | - | - | - |
| Downing Street Surgery - (Andy Brooks-Clinical Chief Officer (Patient)) | 1,566 | - | - | - |
| Park Road Group Practice - (Andy Brooks-Clinical Chief Officer (GP Partner)) | 2,480 | - | - | - |
| Surrey Heath Community Providers Ltd- (Andy Brooks-Clinical Chief Officer (Practice (GP Partner) is a member of this GP Federation) | 1,566 | - | - | - |
| Gordon Road surgery - (John Fraser-Place based Clinical Lead for Surrey Heath (Part owner)) | 2,415 | - | - | - |
| Surrey Heath Primary Care Network - (John Fraser-Place based Clinical Lead for Surrey Heath) | 2,788 | - | - | - |
| Lightwater Practice - (Andrew Lloyd-Interim Lay Member for Surrey Heath (Patient)) | 1,255 | - | - | - |
| Lightwater Practice - (Tony Fitzgerald- Lay Member for Surrey Heath (Patient)) | 1,255 | - | - | - |
| Oakley Health Group - (Gareth Robinson-Place based Clinical Lead for North East Hampshire and Farnham(GP Partner and Managing Partner)) | 457 | - | - | - |
| Salus Medical Services - (Gareth Robinson-Place based Clinical Lead for North East Hampshire and Farnham (Director)) | 6,275 | - | - | - |
| Jenner House Surgery - (Emma Boswell-Executive Director of Development and Improvement) | 961 | - | - | - |
| Surrey and Borders Partnerships NHS Foundation Trust - (Fiona Edwards-Accountable Officer) | 38,209 | - | - | - |
| Hollytree Practice - (Steven Clarke (patient)) | 1,241 | - | - | - |

GP practices within the area have joined other professionals in the Clinical Commissioning Group in order to plan, design and pay for services. Under these arrangements some services are designed to be delivered in a primary care setting. This involves paying GP practices for the delivery of these services. A GP is also paid by the CCG for taking a lead role on clinical services.

The Clinical Chief Officer was seconded to another role and a new Chief Officer was seconded to the Accountable officer role in April 2021. The place based clinical lead for North East Hampshire and Farnham came in to post in November 2021 and the Place-based clinical lead for Bracknell Forest stepped down at the end of July with a new Place-based clinical lead for Bracknell Forest starting in September 2021. The Independent Chair stepped down at the end of 30 June 21 and the new Clinical Chair started 1 July 2021. There was a change of Surrey Heath Lay member in October 2021.

All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. Material transactions are

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are: In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transact ions have been with Royal Borough of Windsor and Maidenhead, Bracknell Forest Council, Slough Borough Council and Surrey County Council in respect of joint commissioning arrangements.

The Department of Health is regarded as a related party. During the year, the clinical commissioning group has had a signific ant number of material

Ashford & St Peter's Hospitals NHS Foundation Trust
Berkshire Healthcare NHS Foundation Trust
Frimley Health NHS Foundation Trust
NHS Business Services Authority NHS Resolution
NHS England
NHS South, Central And West Commissioning Support Unit
Oxford University Hospital NHS Trust
Royal Berkshire NHS Foundation Trust
Royal Surrey County NHS Foundation Trust
South Central Ambulance Service NHS Foundation Trust
NHS Surrey and Borders Partnership NHS Trust

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Royal Borough of Windsor and Maidenhead, Bracknell Forest Council, Slough Borough Council, Hampshire County Council and Surrey County Council in respect of joint commissioning arrangements.

**20 Events after the end of the reporting period**

On 28 April 2022 the Health and Care Act received royal assent. This confirms the establishment of Integrated Care Boards in England. As a result of this the CCG expects to be wound up on 30 June 2022 and NHS Frimley Integrated Care Board to be formed on 1 July 2022. As explained in note 1.1 the CCG's accounts are still prepared on a going concern basis due to the continued provision of the CCG's commissioning functions by the ICB.

**21 Financial performance targets**

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

| | 2021-22 Target | 2021-22 Performance | 2021-22 Surplus/ (Deficit) | 2021-22 Target Met |
|---|---|---|---|---|
| Expenditure not to exceed income | 1,313,665 | 1,308,125 | 5,540 | Y |
| Capital resource use does not exceed the amount specified in Directions | - | - | - | Y |
| Revenue resource use does not exceed the amount specified in Directions | 1,307,029 | 1,301,489 | 5,540 | Y |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | - | Y |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | - | Y |
| Revenue administration resource use does not exceed the amount specified in Directions | 14,887 | 14,849 | 38 | Y |

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**SLOUGH BOROUGH COUNCIL**

**REPORT TO:** Slough Wellbeing Board

**DATE:** 5th October 2022

**CONTACT OFFICER:** Tom Overend, Strategy & Policy Lead

**(For all Enquiries)** 07871982844

**WARDS:** All

**PART I**
**FOR COMMENT AND CONSIDERATION**

# SLOUGH WELLBEING BOARD - WORK PROGRAMME 2022/23

## 1. Purpose of Report

For the Slough Wellbeing Board to discuss its work programme for the 2022/23 year.

## 2. Recommendations/Proposed Action

That the Board review the work programme and potential items listed for inclusion.

## 3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3.1 The work of the Slough Wellbeing Board aims to address the four priority areas outlined in the Slough Wellbeing Strategy 2020-2025:

- Starting Well
- Integration
- Strong, healthy and attractive neighbourhoods
- Workplace Health

3.2 The priorities in the Wellbeing Strategy are informed by evidence of need contained in the Joint Strategic Needs Assessment. Therefore, the work outlined in the work programme is built upon the evidence outlined in the JSNA.

3.3 The work of the Slough Wellbeing Board also contributes to the second priority of the council's Corporate Plan: an environment that helps residents live more independent, healthier and safer lives

## 4. Other Implications

(a) Financial

There are no financial implications of proposed action.

(b) Risk Management

There are no risk management implications of proposed action.

(c) Human Rights Act and other Legal Implications

There are no Human Rights Act implications arising from this report. Any specific activity undertaken by the Wellbeing Board which may have legal implications will be brought to the attention of Cabinet separately.

(d) Equalities Impact Assessment

There are no equalities implications arising from this report. Equalities Impact Assessments will be completed for any specific activity undertaken by the Wellbeing Board which may have equalities implications.

## 5. Supporting Information

5.1 This work programme outlines some of the work the Wellbeing Board will be involved in over the next year.

5.2 In particular, some of the statutory responsibilities of the Board have been scheduled into the work programme, in order to make sure these pieces of work are addressed at the most suitable time of year. This scheduling has taken place by drawing on conversations with officers from the appropriate organisations, as well as conversations with the Chair and Vice-Chair of the Wellbeing Board.

5.3 In addition to these items, regular updates on the work being done to address the priorities of the Wellbeing Strategy have been scheduled across the year. The work programme has been updated following training sessions provided by the LGA and includes provision for offline workshops, to support the Board's activity between formal meetings.

5.4 The work programme is a flexible document which will be continually open to review throughout the municipal year.

## 6. Conclusion

This report is intended to provide the Slough Wellbeing Board with the opportunity to review its upcoming work programme and make any amendments it feels are required.

7. **Appendices Attached**

A - Work Programme – 2022/23.

8. **Background Papers**

None.

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# Slough Wellbeing Board Work Programme 2022/2023

** Subject to ongoing review and change by the Slough Wellbeing Board**

## Early September 2022 (Date TBC)

**Informal Session 2**

**Title:** Exploring the Relationship between the ICB, ICP, and Slough Wellbeing Board

**Overall Aim of the Session:** Support improved integration, alignment, and join-up, with the new Integrated Care System Arrangements, preventing duplication and wasted resource.
**Session Details:**

- Overview of the implications of the Health & Social Care Act 22, and the Health & Social Care White Paper, and how they apply to the Slough Wellbeing Board.
- Overview of the role of Integrated Care Partnerships (ICP), Integrated Care Boards (ICB), the role of place, and provider collaboratives.
- Begin exploring/mapping the relationship between the ICP, ICB, and Slough Wellbeing Board - how do the different structures and strategies work together, noting that the Frimley ICB and ICP expand beyond Slough.

**Attendance:** Participation to be broader than the core Slough Wellbeing Board members.
**Location:** To be confirmed (Microsoft Teams or in person at the Council Chambers)

## Provisional date: 28th October (Friday afternoon)

**Informal Session 3**

**Title:** Tackling the Cost-of-Living Crisis for Local Residents
**Overall Aim of the Session:** Identify activity at a local level to support residents facing unprecedented challenges due to the cost-of-living crisis, building on the work of the local poverty action group.

**Session Details:**

- Overview of local data and insight for Slough to inform local profile re: cost-of-living crisis (fuel poverty / food poverty etc.) and local need.
- Overview of what we are currently doing/what is currently in place to support local residents, and gaps in local provision to address need.
- Breakout groups to explore what as a group of partners, we can do collectively to support in addressing identified gaps → ideas to be incorporated within the local poverty action group delivery plan. Delivery of work by the Local Poverty Action Group to be monitored by the Slough Wellbeing Board under the Strong, Healthy, Attractive Neighbourhoods priority.

**Timing of the Session:** The timing of this session is in line with an anticipated 2nd phase of energy price increases, and will look to build on activity already underway to support local people.
**Attendance:** Membership for the session to be broader than Slough Wellbeing Board members.
**Location:** To be confirmed (Microsoft Teams or in person at the Council Chambers)

## 24th November 2022

**Formal Meeting**

- Update – ICS and Place (verbal update)
- Update – Priority One, Starting Well. Children and Young People Partnership Board
- Update – Priority Four, Workplace Health Task and Finish Group
- Update on Adult Social Care Reform
- Update on Adult Social Care Transformation Programme and Savings Plan
- Safeguarding Partnership Annual Report
- Update – Slough Equalities Review
- Update – National & Local Policy
- Slough Wellbeing Board Work Programme

**Attendance:** Slough Wellbeing Board Members
**Location:** Session to be held in person at the Council Chambers

## December 2022 (Date TBC)

**Informal Session 4**

**Title:** Understanding the Health and Wellbeing of Our Local Population to Inform a Refresh of the Slough Wellbeing Board Strategy
**Overall Aim of the Session:** Generate a collective understanding of what local data and insight tells us about the need of our local population, to steer the focus of the 23-27 Slough Wellbeing Strategy, recognising the impact of factors including Covid-19, the cost-of-living crisis, and the Ukraine conflict etc.

**Session Details:**

- Overview of local data and insight for Slough re: local profile and need.
- Discussion re: the priorities for the Wellbeing Board given local profile & need – consideration to be given to the interplay with the Integrated Care Strategy.
- Following session 3, the strategy will be developed, and a draft compiled for the November 22 informal session.

**Timing of the Session:** The timing of this session in December 22 allows for inclusion of the most recent census data to support in informing the priorities of the partnership. Furthermore, it is timely, with the Frimley Integrated Care Strategy anticipated to be complete by the end of December 22; government guidance states: *"Upon receipt of an integrated care strategy, the Health and Wellbeing Board must prepare a 'joint local health and wellbeing strategy' that sets out how the local authorities, integrated care board and NHS England will meet population needs in that area. However, if the Health and Wellbeing Board does not need to prepare a new joint local health and wellbeing strategy if, having considered the integrated care strategy, they consider that their existing joint local health and wellbeing strategy is sufficient".* Integrated care partnership (ICP): engagement summary - GOV.UK (www.gov.uk)

**Attendance:** Membership for the session to be broader than Slough Wellbeing Board members.
**Location:** To be confirmed (Microsoft Teams or in person at the Council Chambers)

## 18th January 2023

**Formal Meeting**

- Update – ICS and Place (verbal update)
- Update – National & Local Policy
- ICB Commissioning Plan
- Update – Priority Two, Integration. Health and Social Care Partnership Board
- Update – Priority Three, Strong, Healthy and Attractive Neighbourhoods
- Slough Wellbeing Board Work Programme

**Attendance:** Slough Wellbeing Board Members
**Location:** Session to be held in person at the Council Chambers

## February 2023 (Date TBC)

**Informal Session 5**

**Title:** Delivering the 2023/2027 Slough Wellbeing Board Strategy
**Overall Aim of the Session:** Review and update the refreshed strategy to enable official sign-off, identifying the delivery mechanisms needed to ensure progression aligned to the revised priorities.

**Session Details:**

- Review of the draft strategy which has been worked up from the December 22 Slough Wellbeing Board informal session; consideration of the following:
    - Does the strategy capture the desired direction/priorities of the board?
    - What delivery mechanisms does the board need in place to deliver the strategy?
    - What is the operating model / structure that will deliver the strategy?
    - How does the refreshed strategy and required operating model / structure influence the role of the Slough Wellbeing Board and its members?
- Feedback from the session to be used to update the strategy prior to the March 2023 meeting where official sign-off will take place; terms of reference to be revised in line with the strategy ahead of the March 2023 meeting. The refresh of the 2023/2027 Strategy will likely influence the work programme moving forward.

**Attendance:** Slough Wellbeing Board Members
**Location:** To be confirmed (Microsoft Teams or in person at the Council Chambers)

## 15th March 2023

**Formal Meeting**

- Update – ICS and Place (verbal update)
- Sign-Off - Slough Wellbeing Strategy 2023 – 2027
- Sign-Off - Slough Wellbeing Board Terms of Reference
- Update – Priority One, Starting Well. Children and Young People Partnership Board
- Update – Priority Four, Workplace Health Task and Finish Group
- Update – National & Local Policy
- Slough Wellbeing Board Work Programme

**Attendance:** Slough Wellbeing Board Members
**Location:** Session to be held in person at the Council Chambers

## April 2023 (Date TBC)

**Informal Session 6**

- To be confirmed later in the year following the refresh of the Slough Wellbeing Board strategy; informal sessions to also consider emerging risks.

- Ideas suggested to date by SWB members include:
    - Tackling Local Child Poverty
    - Children and Young People – Intervening Earlier to Reduce Statutory Crisis Intervention
    - Improving the Lives of Children and Young People in Slough
    - Digital Access and Inclusion
    - Tackling Local Inequality
    - Tackling Worklessness to Address Poverty

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