Slough

Clinical Commissioning Group

Annual Report 2017/18

Contents

Introduction by the Clinical Chair

Dr Jim O'Donnell

This Annual Report covers the CCG's fifth and final year as an independent CCG. From 1 April 2018 we will be part of East Berkshire CCG building on the strong relationship we have historically had with Bracknell and Ascot and Windsor, Ascot and Maidenhead CCGs. I am delighted to report that during this year we have been assessed as an 'Outstanding' CCG by NHS England – a far cry from the 'requires improvement' assessment we were given in our early years. Much of this success has been down to our collaborative commissioning with Bracknell and Ascot and Windsor, Ascot and Maidenhead CCGs, who have also been rated 'Outstanding', along with Frimley Health.

We originally created a CCG just for Slough to ensure that we developed excellent links with our member practices, Slough Borough Council, our local population and because of our familiarity with their health needs. The CCG has achieved this over the past five years. Our move to create one CCG for East Berkshire has been designed to make the most of working collaboratively as one organisation, whilst keeping a local focus. We have made a strong commitment to maintaining our engagement with local people, member practices, Slough Borough Council and other local organisations.

Our achievements have been made possible through the hard work of our member practices, Governing Body and CCG staff. We have improved the quality of services available to our population whilst remaining within the available financial envelope.

The CCG's partnership working with others has always been a strong theme. Over the past year this has developed even further as part of the Frimley Health and Care System which is considered as one of the most successful partnerships in the country. Working with our partners across the Sustainability and Transformation Partnership will bring the power of a larger system resource to give added focus on the health and care needs and inequalities of our population.

This past year has brought a greater GP focus on patients with several long term health conditions or other complexities, to keep them well and less likely to need an emergency admission.

During our time as a CCG, we have improved access to general practice and Slough CCG was the most improved CCG in the period between 2013 and 2016. We have continued to listen to patients and know that we still have more to do. The transformation of general practice has

continued during 2017/18 and the CCG has worked closely with practices to make the High Impact Changes for Primary Care a reality. This has resulted in a greater variety of health professionals available as part of the general practice team e.g. paramedics and pharmacists, 7 day access being provided and a pilot to provide online access to patient records.

In line with our population, we have focused on cardiovascular health. We have significantly increased the number of people identified with hypertension and atrial fibrillation – two important factors in monitoring cardiovascular health. The number of people having a stroke has also reduced over the last year – an indication that our preventative measures have been working. The CCG also successfully transferred the hyper acute and acute stroke service to High Wycombe where our patients are now receiving faster access to critical treatment.

Underpinning much of this work has been the development of our Connected Care programme. This programme has allowed community nurses access to patients' records so that they have information readily available when they visit patients in their homes, access to a summary care record when patients visit A and E and electronic prescribing to make the processing of prescriptions more efficient for patients, practices and pharmacies.

There are many more achievements to read about in the main body of this Annual Report. I would like to thank my Governing Body colleagues, local practices and CCG staff for the contribution they have made over the past five years to improve care for our local population. We will continue to 'think locally and work together' to ensure that the views and needs of our local population are taken into account in the future and that the new CCG effectively tackles the remaining challenges around health inequalities.

Dr Jim O'Donnell

Chair

Slough CCG

Review of the year

We have had a busy year full of challenges and achievements, building further on our decision to work more collaboratively with colleagues in Bracknell & Ascot and Windsor Ascot & Maidenhead CCGs. During the year we identified four key areas of focus:

Grip – ensuring we are on track to deliver what we set out to do and that we act quickly if anything starts to slip.

Transformation – our challenges ahead are significant and we are determined to make improvements that transform health and social care to meet the demands of our growing population consistently in the years ahead.

People – we can only deliver the improvements we want by ensuring we recruit the best people and retain them. This means investing in them and building strong organisations.

Money – our budgets are set for us and we must live within our means. This means making the most of every pound we spend to get good value for local residents and balance the books.

Integrated Care System

The Frimley Health and Care Sustainability and Transformation Plan (STP) is one of 44 plans in the country set up to deliver health's Five Year Forward View' (www.england.nhs.uk/ourwork/futurenhs/).

This plan has been developed in partnership with NHS organisations and local authorities across East Berkshire, Surrey Heath and North East Hampshire and Farnham, who together make up the catchment area for hospitals run by Frimley Health NHS Foundation Trust. The plan covers a population of 750,000 residents through nine councils (county, borough and district). It sets out how social care and health services delivered by councils and health authorities will become a more integrated system fit for the future. The plan runs from 2016 to 2021 and builds on the work already taking place to transform health and care provision in the region. The central role of the STPs is to support local plans, including achieving the changes that local people and local clinicians have told us they want.

The plan outlines how we aim to improve local services and was submitted to NHS England in October 2016. The CCG in partnership aims to prioritise good practice examples which make

the biggest difference to residents and will deliver them across the whole STP footprint for 750,000 population.

The five main priorities under the STP are:

Priority 1: Making a substantial step change to improve wellbeing, increase prevention, self-care and early detection.

Priority 2: Action to improve long term condition outcomes including greater self-management and proactive management across all providers for people with single long term conditions

Priority 3: Frailty Management: Proactive management of frail patients with multiple complex physical and mental health long term conditions, reducing crises and prolonged hospital stays.

Priority 4: Redesigning urgent and emergency care, including integrated working and primary care models providing timely care in the most appropriate place

Priority 5: Reducing variation and health inequalities across pathways to improve outcomes and maximise value for citizens across the population, supported by evidence

The document can be accessed at https://www.Eastberkshireccg.nhs.uk/about-us/sustainability-transformation-partnership/

Governance

During 2017/18, the three CCGs worked collaboratively and all the staff have worked as one team and each of the CCGs Council of Members approved to have one Governing Body in Common to ensure that the CCGs responsibilities were delivered appropriately

CCG Assurance

NHS England meets with the CCGs each month to assess their performance. Every three months they rate our performance, using a number of categories that together provide an overall assurance rating. We are delighted that all three CCGs were rated outstanding.

360 degree Stakeholders Survey

Overall, the 2017 360° survey was extremely positive, with all three CCGs outperforming national and cluster results in 19 out of 27 areas. Slough did particularly well, scoring higher than national and cluster averages in every single category.

All three CCGs demonstrated increases in positive responses compared with last year: in 21 areas for Bracknell & Ascot and Slough and in 10 areas for Windsor, Ascot & Maidenhead. Whilst Windsor, Ascot and Maidenhead had lower than expected results in 14 indicators, this was set against exceptional results in 2016.

Improvements in the following areas should result in improved results in the 2018 survey:

Slough CCG

- Encouraging more GP member practices to respond to the survey
- Encouraging more unitary authority stakeholders to respond to the survey

Operational Plans

We developed our commissioning plans for 2017-2019 following a health needs analysis for the CCG, using the joint strategic needs assessment, NHS Right Care (benchmarking outcomes, engaging with member practices and the public about our 2017/18 work programme. These fed into the 2017/19 operating plan, which was signed off in December 2016. During 2017/18 we have also refreshed our commissioning plans for 2018/19.

Primary Care

Delegated Primary Care Commissioning Function Transition

We have delivered our Delegation transition plan with NHS England for 2017/18, in partnership with our colleagues in NHS England Thames Valley. The CCG is working jointly with the other two CCGs, which has resulted in improvements in quality, communication, engagement and financial management all contributing to a successful first year with delegated responsibilities.

The CCGs in this year have successfully taken the role of delegated primary care responsibility for contracting, performance management and application for mergers within primary care medical services. Whilst transferring to delegated commissioning of general practice, more services have been commissioned into general practice with over £2 million invested in enhanced services in the first year of the General Practice Outcomes Framework (GPOF). Additional services for the GP Outcomes framework agreed for 2018/19 include pre-diabetes service, anticipatory care service to support patients with complex long term conditions and frailty.

General Practice Forward View: East Berkshire CCGs

The General Practice Forward View (GPFV) was published in April 2016, committing an extra £2.4 billion a year to support general practice services by 2020/21; through committing to improving patient centred care, access, and investing in new ways of providing general practice.

Investment in General Practice

The CCG has invested in General Practice transformation through GPFV allocations enabling practices to work differently together to develop services, such as;

- proactive care for patients who are housebound through the introduction of new roles and expanding skill mix
- reduced workload in practice through reducing the administration time for clinicians through technology and training of the practice team
- focus on self-care and prevention to reduce the demand on general practice and improve patient outcomes

These changes will benefit the patients as the clinicians will be able to focus on providing appropriate time to focus on complex patients and improve their health outcomes.

Workforce Development

A significant challenge to deliver high quality services can be identified in the workforce development plans, this is due to the predicted reduction in traditional GP and nurse roles with in future workforce in general practice. Through the Frimley Integrated Care System (ICS), there is a programme on GP transformation which has estimated the workforce gap for general practitioners. A number of initiatives have been identified for implementation in 2018/19. One such initiative is the Community Education Provider Network (CEPN) which went live in 2017/18. A training needs assessment was undertaken and it identified education and training that is aligned with education providers in order to provide a pipeline for future primary care services.

Workload Efficiency

The GPFV national policy has supported the delivery of the local strategic plans including support for practices to be more productive through programmes of quality improvement such as Time for Care and Productive General Practice (PGP).

The NHS England Time for Care programme works with networks of practices working together with quality improvement approaches, whereas PGP focuses on one practice at a time to implement small improvements. This programme has focused on the necessary change management skills in existing general practice teams, with the next initiatives prioritised as workforce development and self-care and prevention in general practice for 2018/19. The first cohorts for these programmes commenced in 2017/18 with 7 practices signed up for the Productive General Practices and 24 practices engaged through the development of the Time for Care programme.

Infrastructure

Together with NHS England the three CCGs have invested in premises and technology across local general practice through the Estates and Technology Transformation Fund (ETTF). This includes the co-location of two practices into the new Heatherwood Hospital development. The benefits of co-locating provides the strong emphasis on patient centred care, through services coming together suitable for the population and bringing the services closer to that population.

The CCGs have provided an additional £100,000 through minor improvement grants into general practices premises. This has led to improving standards in infection control and access to the premises across East Berkshire in 2017/18.

The Primary Care Strategy is committed to delivering a transformed and high quality sustainable model of general practice for the CCG. This will improve overall access to general practice services and realise the opportunities and benefits set out in the GPFV.

The Primary Care Strategy set out the following objectives for 2017/18:

Delivery Plan 2017 - 2021	**Progress in 2017/18 – Year one**
Secure the essential high quality general practice fit for our population	All practices have achieved good or above ratings with CQC by April 2018. Programme of Quality Improvement skills into general practice is in place through the Time for Care GPFV initiative. Continual work with all practices to support their resilience for sustainable healthcare supported with the development of a primary care performance dashboard.
Patient centred primary care at the heart of system transformation	Public conversation on the future of primary care services has been deferred to be included in the Primary and Community Care programme. This wider engagement programme will commence in May 2018.
Improve the patient experience of accessing general practice	The General Practice Patient Survey was reported in June with some areas of improvement: 4% improvement of overall experience for Slough CCG at 77%. There continues to be ambition to improve the levels of patient experience across general practice services.

Equitable extended hours and enhanced services available in general practice	100% of registered patients in each of the three CCGs in East Berkshire are able to access extended hours general practice services Monday to Friday until 8pm. 70% of registered patients are able to access extended hours general practice services on both Saturdays and Sunday All services commissioned for extended hours in general practice have delivered the required level of hours per 1,000 patients by March 2018.
Share information to support improved patient outcomes	Social Prescribing projects are now in all three CCGs to support patients in achieving their own well-being ambitions through accessing commissioned health and social care services, community and voluntary via their general practice. The three schemes vary across the three CCGs and unitary authorities. Shared medical records across general practice; a pilot in Slough has been delayed and should be implemented by July 2018. Online consultation (to improve patient access and supporting flexible options to promote self-care) is being piloted in one practice since February 2018. Following evaluation and more local engagement, implementation of online consultations is planned in 2018/19.
Increase capacity and reduce demand on general practice services	In addition to the extended hours available to East Berkshire patients, the three CCGs have been working collaboratively to transform GP services to work at scale. During the second quarter of delivery in 2017/18, the transformation plans are being implemented through practice networking together to transform general practices services. Schemes include those that improve efficiency in practice, to reduce demand through supporting patients and developing the roles in the General Practice team by March 2019.

Within the Integrated Care System (ICS) programme for general practice transformation, the three CCGs in East Berkshire have worked with their member practices as providers to develop Primary Care networks. These networks describe how practices will work together

across GP Federations and clusters to support transfer of care out of hospital and strengthen resilience in individuals and general practices.

Urgent and Emergency Care

In September 2017, we launched the new 111 with the implementation of the new integrated clinical hub. The CCG introduced direct booking into the out of hours service in East Berkshire which went live during October 2017 and plans are in place to extend this to urgent care centres and walk in centres during 2018/19.

The CCG has agreed contracts until March 2020 for the Slough walk in centre and extended the out of hours service, to work alongside the new NHS 111 service.

Emergency ambulatory care services were expanded to 7 days a week from October 2017 at both Frimley Park and Wexham Park Hospitals and this now means that more patients can be seen and treated on the same day without being admitted to hospital for urgent conditions either through referral by their GP or if they attend A&E. Additional resources were provided to the Frimley Health and Care Integrated Care System (ICS) to set up Frailty Units at Frimley Park and Wexham Park Hospitals which will continue to be progressed during 2018.

South Central Ambulance Services (SCAS) mobilisation of the Ambulance Response Programme (ARP) went live in October 2017. This has resulted in responses to 999 calls being reviewed in more detail once a call has been made. This is done to ensure that the most appropriate response is made to the patient and more patients are able to be treated at home instead of having to be sent into hospital.

Integrated Care and Better Care Fund

In line with our local priorities set out in the plan and in the context of the vision of the ICS, we are working in partnership with Bracknell Forest Council, Slough Borough Council and the Royal Borough of Windsor and Maidenhead to deliver plans to integrate health and social care services which improve the lives of local people.

We continued to work collaboratively through the Better Care Fund on system integration to support more people to live well at home and prevent unnecessary admissions to hospital. We achieved a significant reduction in unplanned hospital admissions from proactive and preventative work in areas such as falls, complex case management, children's' asthma, end of life care and enhancing support to care homes.

From April 2017, the CCG established a new end of life care and support service for people who are dying and their carers. The new service will support people to plan ahead about how they are cared for when they are coming to the end of their lives. Our practices are also

identifying patients nearing end of life so that plans can be made in advance with the involvement of the patient, carers and family that will support more people to die in their place of choice. The CCG has commissioned a 24/7 Rapid Response team from Thames Valley Hospice to provide advice and home based support 24/7/365.

The CCG has piloted a process for extending personal health budgets in partnership with the 3 Unitary Authorities. This has initially been in the area of Continuing Health Care and there are plans to broaden into other areas of mental health and learning disability.

The three CCGs have established an East Berkshire-wide care homes quality group to drive up standards and safety and develop meaningful relationships and innovative care with the homes. During 2017/18, the CCG appointed a Care Home Quality Lead to support the work of the steering group enhancing the support available to care homes and working with Registered Managers to improve education and training to staff.

The integrated care team are actively supporting and embedding with the ICS programme team to help shape the delivery of integrated care decision making hubs and the social care market development strategy. The CCG has developed a local model of integrated care decision making aimed at the improved management of those living with frailty or multiple complex physical and mental health long-term conditions.

The integrated decision making model includes the launch of a new anticipatory care commissioned service from primary care services which will build and extend the complex case management approach to proactively identify and manage people with multiple morbidities and support them through local multidisciplinary teams. The integrated approach will support and empower people to maintain independence and control, to manage their multiple health and care conditions locally, and provide wrap around care for people in or close to their own homes wherever possible. This model will begin to be implemented from April 2018.

Mental Health

The three CCGs in East Berkshire have continued to invest in developing local mental health services working with their population and providers as follows:

- Commissioned an improved service for psychiatric liaison and crisis at Wexham Park Hospital and reviewed the Crisis Response and Home Treatment Teams locally. This has increased the provision of the Street Triage service where a mental health clinician works with the police when they come into contact with people experiencing mental health problems, in order to avert crisis and get them the right support.

- Expanded Improved Access to Psychological Therapies (IAPT) services to work with people who have long term conditions.
- Commissioned Healthmakers, a group of volunteers who have long term conditions offering support to others.
- Commissioned a Young People with Dementia service improving the support available to people under 65 when they are initially diagnosed.
- Improved the Dementia diagnosis rates locally.
- Expanded Friends in Need services across all three boroughs to support people who are socially isolated.
- GP education – the CCGs' GP mental health lead has led education sessions for practice staff on a number of topics, including suicide prevention, dementia, children's mental health services and perinatal mental health.

Child and Adolescent Mental Health Service (CAMHS) Transformation

The three CCGs in East Berkshire and local Health and Wellbeing Boards have worked together to implement real improvements through the development of local plans for children and young people locally. The shared vision is:

- Children and young people will have good mental health and grow up being resilient.
- Children and young people will get the right support at the right time.

The transformation programme was set up to deliver recommendations made by Future in Mind and the CCG has:

- Received funding and commissioned a NICE compliant eating disorders service for children locally and a perinatal service.
- Commissioned a number of CAMHS transformation projects e.g. Kooth online, counselling services to support children wellbeing.
- Developed and published 'The Little Book of Sunshine' CAMHS resource.
- Reduced waiting times and improved access for CAMHS.

Learning Disabilities

The Berkshire Transforming Care Programme (TCP) has been running for almost two years now. This was set up to improve services for people with learning disabilities and/or autism, who display behavioural challenges, including those with a mental health condition. The aim is to enable more people to live in the community, with the right support close to home.

Progress in 2017/18 included:

- Commissioned a community intensive support services which has reduced the numbers of learning disability assessment and treatment beds
- Supported some people with learning disabilities to move into their own homes using the HOLD scheme and Transforming Care Partnerships
- Completed eight Care and Treatment reviews for people who are in hospital or at risk of going into hospital

Planned Care

The CCGs' strategy for planned care is to reduce unwarranted variation in both outcomes and activity using the Right Care programme methodology to identify priority specialties and to deliver Constitutional standards. This work stream is aligned to the ICS Reducing Clinical Variation work stream and shares the same priority areas.

The CCG identified the following areas for improvement in 2017/18:

- Cardiovascular
- Neurology
- Respiratory
- Gastrointestinal
- Musculoskeletal
- Diabetes
- Referral management and working towards 80% ERS utilisation
- Dermatology improvements in pathways
- Ophthalmology provision and improvements

The CCGs are working with GPs and providers to redesign the pathways and services and improve the care received by our population. In 2018/19 we will have a new integrated neurology service that bases as much of the service within the community as possible.

Cardiology

The CCGs has implemented a number of new pathways in cardiology this year including:

- Commissioning an IV diuretic lounge to support patients to access services without having to be hospitalised.
- Case finding for hypertension and Atrial Fibrillation to enable treatment and thus avoiding complications e.g. stroke and MI.

- Expanded our existing Heart Failure (HF) nursing team to accommodate larger caseloads thus avoiding unnecessary admissions.

The expanded services have been received well by our population and feedback has been positive from both staff and patients. We now look to share our models across the ICS as well as evaluate the scheme to learn from the successful implementation of these initiatives.

Musculoskeletal

During 2017/18, the CCG have focused on streamlining the MSK pathway and working with ICS partners to deliver a 100 day improvement project on the hip and knee osteoarthritis pathway. We also assessed the opportunity for whole service transformation. In 2018/19, the CCG will focus on implementing (across the ICS) the hip and knee improvements, implementing an acute clinical triage system and designing a locality wide integrated community service. The CCGs will also take forward a number of other projects across the ICS footprint including growing our ability to support self-management and shared decision making across multiple pathways.

Dermatology

In 2017/18, the CCG has developed a new model of provision which has been approved and been taken through our governance processes. This will be providing a GP specialist led provision for dermatology linked to key practices in each locality. Patients will access the service in a location close to their homes instead of having to attend a secondary care appointment for conditions that could be safely treated in a community setting.

The plan is based on utilising the skills and expertise we already have in our GPs who have undertaken specialist training and will be working closely with secondary care to ensure patients access this service seamlessly.

E-referral and DXS

GP practices have been supported in 2017/18 to increase utilisation of digital platforms e.g. DXS (referral pathway management tool) and the Electronic Referral System (ERS). These tools help practices and patients access treatment within secondary care where a GP deems it as clinically appropriate.

The CCG has supported practices and their staff through access to training, guides and a key contact person within the CCG to support practices to adopt this change.

E-referral utilisation rates have significantly improved across the practices with them achieving nearly 90% (excluding 2 week waits).

Additionally, we have supported practices to implement peer review of referrals as a tool to manage demand as well as to ensure clinicians learn from peers to adopt best practice care for our population.

The peer review methodology is now being shared across wider practice geography and in 2018/19 we plan to adopt the peer review process actively across all our practices, within a successful framework and process which is clinically lead.

Ophthalmology

In 2017/18, the CCGs successfully implemented a referral service for ophthalmology, which enables all optometry generated referrals to be triaged via a referral management service. The service enables patients to access their onward care in the most appropriate setting and in an easy to use systematic approach. It also advises patients to enable choice of provider, and has access to clinical advice if patients require it. The centre also manages adherence of referring optometrists to the quality of referrals as well as adherence to locally determined policies and procedures. We will use the information gained to inform our future commissioned pathways for ophthalmology.

Cancer

The CCGs planned to review and improve cancer services for our patients within 2017/18 as the first year of our three year improvement plans. We have undertaken work in early diagnosis as follows; most East Berkshire practices have implemented a locally commissioned service focusing on improving breast and bowel cancer screening. To deliver the service they have had to; appoint a practice cancer champion, deliver patient awareness events; achieve a best practice checklist of activities for supporting bowel screening uptake; complete a practice review with the CRUK Berkshire facilitators to identify an action plan to increase the uptake of screening; complete one audit activity to improve quality; and ensure 75% of practice staff have received cancer training (either clinical or non-clinical).

We have restarted the Macmillan funded Slough Bowel Screening project to provide additional resource to increase community engagement with the bowel cancer screening agenda. This project restarted in November 2017 and will run until March 2019.

The CCGs have reviewed the 2016 national cancer patient experience survey results for East Berkshire and are working with both primary care and secondary care to identify improvement activities.

The CCGs have worked with secondary care to support their pathway improvement projects and are ensuring through collaborative working that the primary care elements of the pathways

are agreed and implemented to support the secondary care work. As part of this we have joined an ICS cancer leads group to support better integration across the whole footprint of projects and improvement activities.

Finally, the CCGs have worked with the Thames Valley Cancer Alliance to support the roll out of transformation projects in line with their national award and full implementation of these projects will take place in 2018/19.

Diabetes

The CCGs have commissioned new services to support patients with diabetes to access structured education (lifestyle and dietary support), with an expanded evening, weekend offer and digital options. This will enable more of our diabetic population to have access to self-management and support thus preventing complications.

We have also put in place diabetes care and support care planning services, a diabetes foot care pathway, diabetes inpatient nursing services, digital access to structured education as well as commencement of a referral hub. There are new ambulance pathways in place for the management of hypoglycaemia. This means our patients and primary care professionals have access to a raft of new services to reduce complications associated with diabetes.

Operations and System Resilience

From April 2017 as part of the Frimley ICS the A&E delivery board, which is responsible for improvements, monitoring and management of urgent and emergency care became a joint board overseeing all the work across the Frimley system. Following the publication of the national Urgent and Emergency Care Strategy, which aims to strengthen and redesign the system to ensure that patients received the right care in the right place first time, the NHS and Social Care were asked to implement 7 ‘pillars’ of change and improvement. Some of the work was already taking place across East Berkshire but by joining up these initiatives the overall benefit to patients of these changes will be significant over the next few years.

The 7 pillars are:

- 111 online facilities that enable patients to enter their symptoms online and receive advice or a call back
- 111 telephone services increase the proportion of NHS 111 calls handled by clinicians
- GP access via improved 7 day access
- Establish Urgent Treatment Centres
- Improve ambulance response times to critically ill patients

- Improvements to hospital services to support screening in emergency departments to establish which patients need hospital care and who can be treated on the same day
- Use best practice to reduce the time people spend in hospital when they are medically fit to go home

Adult integrated respiratory service

The adult integrated respiratory (AIR) service pilot was extended to Slough in September 2017. The overall aim is to improve services by providing more care in the community and reducing hospital admissions.

Delivered by a multi-disciplinary team from Frimley Health and Berkshire Healthcare Foundation Trusts, it comprises medical, nursing, physiotherapy and admin staff. It provides comprehensive care to patients with chronic obstructive pulmonary disease, asthma, bronchiectasis and interstitial lung disease and who need to have oxygen at home.

Performance

Through 2017/18 performance in NHS Constitutional Standards for Slough CCG has been consistently strong. This is recognised by NHS England, which has throughout the year assessed the CCG as outstanding against the Improvement and Assessment Framework. This is the framework by which CCGs performance is assessed against 4 domains including;

- Better Heath
- Better Care
- Sustainability
- Leadership

https://www.england.nhs.uk/commissioning/ccg-assess/iaf/

Slough CCG has continued to work collaboratively with key providers, in particular Frimley Health Foundation Trust (for our acute hospital services), Berkshire Healthcare Foundation Trust (for mental and community health) and South Central Ambulance Service (for 999, 111 and patient transport services) to maintain this strong performance in NHS Constitutional Standards. In particular, 18 weeks referral to treatment waiting times consistently remained above the 92% standard and cancer waiting times at Frimley Health have consistently achieved the standard throughout the year. Dementia diagnosis rates have improved significantly for Slough CCG in the first half of the year; however this has not been sustained in Q3 and Q4 2017/18. Performance in A&E at Frimley Health has been less favourable due to

pressures resulting from increased demand and the higher acuity of patients presenting in Urgent Care.

The CCG meets regularly to review and challenge performance against key national indicators. Such forums provide partnership working with our providers, Local Authority partners, patient partners, and NHSE and HealthWatch partners. Such forums include:

- Clinical Quality Review meetings
- Contract Review meetings
- Joint CCG Quality Committee

These forums provide the CCG with assurance that action is being taken where performance is not achieved or has been identified as deteriorating. Action plans are agreed between partners when required and monitored closely to completion.

A performance report is compiled, along with a quality report, for the joint CCG Quality Committee and Governing Bodies. This report details performance against all NHS constitutional standards and other outcome metrics as required by exception.

Share Your Care

Share Your Care is a programme of work to link up health and social care systems across Berkshire and Frimley. It allows professionals involved in your care to have instant, secure access to your health and social care records. There are now 800 professionals accessing the system in any given month, with community and mental health professionals the main users. These professionals access the system after asking for the consent from the patient. This gives up to date information that would otherwise not be available, at the point of care.

Some of the benefits being described by the care professionals using the system include:

- Making them confident in decision making as they have more relevant information about the patient
- Aiding in discussions with patients around medication as they can see information from the GP system
- Reducing the time spent requesting information from other organisations which releases time to care

Over the past year, plans have been developed to extend the use of the system to benefit patients across the footprint. Some key planned developments are:

- To allow East Berkshire Out of Hours clinicians to access the system as they will significantly benefit from having access to information from the GP record

- To allow Frimley Health staff access to the system (particularly in ED), and for Frimley Health to provide information into the system
- For Berkshire Healthcare Foundation Trust to provide more clinically rich information into the system which will benefit care professionals in other settings
- To have a cohort of residents able to access a patient health record that will give them access to some of the information in Share Your Care

Further information about Share Your Care is available at https://www.shareyourcareberkshire.org

PERFORMANCE REPORT

John Lisle

Accountable Officer

Slough CCG

25 May 2018

Performance Overview

Statement from Accountable Officer

Slough Clinical Commissioning Group (CCG) is part of a collaboration of three CCGs with Bracknell and Ascot CCG and Windsor, Ascot and Maidenhead CCG. While retaining a local perspective on healthcare commissioning, we have a joint administrative structure, which brings consistency, reduces duplication of effort and allows us to benefit from economies of scale. WAM CCG is the employing organisation for the shared administration and management team.

We have 158,633 patients registered at our 18 GP practices. There are 15 dental surgeries, 32 community pharmacies and 10 community optometrists in the area.

Our services are commissioned from more than 300 providers, but our main providers are:

- Acute hospitals:
  - Frimley Health Foundation Trust
  - Royal Berkshire Foundation Trust
  - Ashford and St Peters Foundation Trust
- Mental health/community trust – Berkshire Healthcare Foundation Trust
- South Central Ambulance Service
- A range of private and other providers

The Slough Borough Council provides the majority of social care to the CCG's residents, but Buckinghamshire County Council also provide some services. In addition we have a vibrant voluntary and community sector.

We have worked hard, along with our partner organisations, to improve quality of care and our financial position while working towards delivering our vision.

We have monitored all the key areas of performance and any areas of concern have been brought to the attention of the governing body for action to be taken.

Statement of the purpose and activities of the organisation

Slough CCG was established on 1 April 2013 following the passing into law of the Health and Social Care Act 2012. This legislation resulted in a change in commissioning health services. Across England, CCGs took on many of the responsibilities of Primary Care Trusts. They are independent bodies run by GPs who plan, buy and oversee health services from a range of

NHS, voluntary, community and private sector providers. CCGs put clinicians, who are attuned and responsive to the health needs of local people, at the forefront of commissioning.

2017/18 has been a year of continued good progress for the CCG and the wider Frimley Health and Care System that we work within. Both the System and CCG have been classed as 'Outstanding' by national regulators. The effective joint working between the three CCGs (Slough, Bracknell & Ascot and Windsor, Ascot & Maidenhead) has helped us to commission effectively. The outstanding status recognises delivery of high quality services with good outcomes for patients, within the financial resources that we have available to us.

Our innovation and quality has also been recognised through numerous national and international awards, including:

- International recognition for Slough Complex Case Management – it won the John Hopkins Institute Starfield award
- National winner at the Primary Care Pharmacy Association Annual Care Homes Conference for hydration in care homes work. This project also gained a PrescQipp Gold award (and two others) for best innovation
- National winner of Nursing Times respiratory award for the Asthma bus initiative
- With Bracknell Forest Council, winner at the National Self Care Forum Awards for our Year of Self Care
- Short-listed for national award for improving young people's mental well-being
- Shortlisted for the Antibiotic Guardian awards for community engagement work in Antimicrobial Stewardship Network

We have also seen some of our work published

- National publication of our hypertension work: https://www.nice.org.uk/sharedlearning/systematic-case-finding-of-people-with-hypertension
- Further publications, e.g. https://link.springer.com/article/10.1007/s11096-017-0538-z

Despite huge pressures on emergency care, our system has performed significantly better on Accident and Emergency waiting times than many other areas nationally. We have also received a letter from the Health Secretary, Jeremy Hunt MP, commending our strong performance on cancer waiting times. We continue to meet national standards for elective care waiting times.

Partnership working has always been an important part of our approach as a CCG and I am delighted to report that in last year's Stakeholder Survey, all three CCGs performed well.

Across the 27 questions of the survey, Bracknell and Ascot were over 3 percentage points ahead of the highest benchmark, WAM 7 points ahead, and Slough 14 points ahead. Thank you to all those who support such strong relationships from within our Local Authorities, GP practices , public, community groups, provider trusts and many others.

Our commitment to engaging patients and the wider public has continued and we have involved local people in the development of services such as diabetes and end of life care. We have seen good attendance at the Community Partnership Forum and other public events, such as a series of discussion groups organised by Healthwatch.

This year has also seen great progress with shared care records and digitalisation, ensuring that health and care professionals have the right information about patient's to-hand when needed. This is starting to address one of the most common complaints – that the system isn't well joined up around the individual.

The foundations we have built as individual CCGs will stand us in good stead as we become a single East Berkshire CCG from 1 April 2018. I look forward to our continued success both as a CCG and the Frimley Health and Care System. We will achieve this by making the most of working collectively, but retaining strong engagement with local communities, our member practice localities, and the public.

Key issues and risks

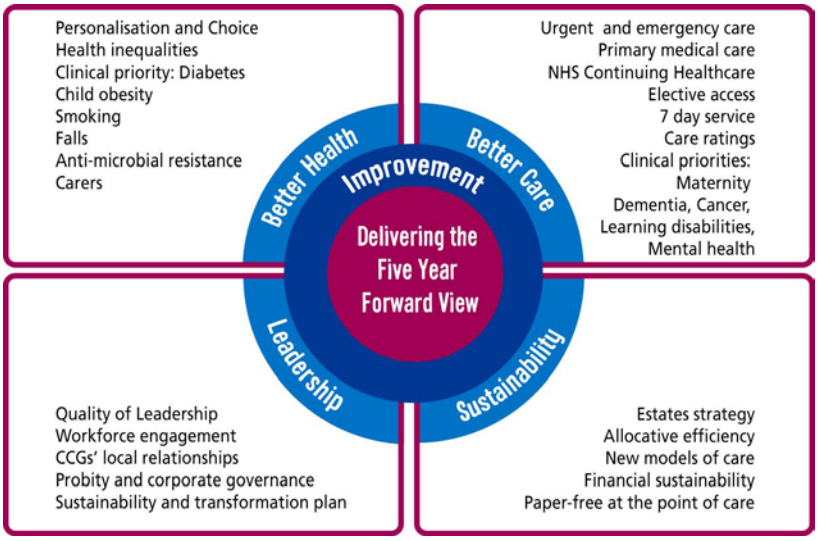
The CCG Governing Body regularly reviews its key risks and publishes an assurance framework which describes these and the mitigating actions in place. During the year key risks that were identified included:

- strategic relationships with CCG providers
- the right leadership skills, knowledge and capacity of the management team
- the right skills, workforce capacity in primary, social, community and secondary care
- having effective performance and quality governance structures in place
- effective corporate governance, decision making structures, member engagement and patient involvement in place
- acceleration and embedding adoption of technology and information sharing in clinical and corporate areas
- development and utilisation of the local health and local authority estate in the most effective way
- achievement of our QIPP savings and service transformation plans

- the right information to be assured we are meeting NHS constitutional standards, statutory standards and other key performance targets
- the right financial, activity and performance information
- anticipation of and response to future individual health needs
- having the right information about the impact of legislation and regulatory requirements on health and social care
- managing and stimulating the healthcare market
- partnership working arrangements to identify and uncover any threats to the financial sustainability of our local NHS providers and local authorities
- CCG does not have appropriate representatives on the delegated ICS groups and committees

Performance analysis

The Improvement and Assessment Framework (IAF) introduced during 2016/17 consists of 4 domains: Better Health, Better Care, Sustainability and Leadership. The CCGs are assessed against these 4 domains by NHS England (NHSE) in quarterly and year-end, face-to-face meetings. The CCGs' performance is published on myNHS and updated annually. Currently as at end of 2017/18 the CCG has been rated as outstanding by NHSE. This rating has remained unchanged in 2017/18.



In summary, the 4 domains in the IAF are as follows:

- Better Health looks at how the CCG is contributing towards improving the health and wellbeing of its population and bending the demand curve.

- Better Care principally focuses on care redesign, performance of constitutional standards and outcomes, including important clinical areas.
- Sustainability looks at how the CCG is remaining in financial balance and is securing good value for patients and the public from the money it spends.
- Leadership assesses the quality of the CCG's leadership, the quality of its plans and how the CCG works with its partners and the governance arrangements that the CCG has in place to ensure it acts with probity, for example, in managing conflicts of interest.

Link to myNHS where the latest IAF ratings (206/17) are reported for Slough CCG is:

NHS Choices Slough CCG IAF Published Rating 2016/17

The IAF indicators include many of the constitutional standards and our performance is outlined below. In addition, within the framework there are 6 clinical priorities including cancer, dementia, diabetes, maternity, learning disabilities and mental health.

Delivering NHS Constitutional Standards Slough CCG

NHS Constitutional Standards Performance

Our CCGs have continued to work with key providers, in particular Frimley Health Foundation Trust (FHFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Service (SCAS), to maintain strong performance. In particular, 18 weeks referral to treatment waiting times have consistently remained above the 92% standard and cancer waiting times at our main provider, FHFT, were achieved consistently throughout the year. This good performance is reflected in the published IAF indicators Better Care domain on myNHS.

Urgent and Emergency Care

A&E 4 Hours

Performance in A&E 4 hour waits during 2017/18 continued to be challenging, with increased demand, as 2016/17 winter pressures continued into 2017/18; increased acuity of patients and an increase in discharge delays for patients awaiting onward care. As a result, FHFT has struggled to maintain 95% of patients in A&E being seen within 4 hours. Cross-system working overseen by the A&E Delivery Board is proactive and robust underpinned by active operational groups and is attended by all system partners and NHSE. Challenging conversations are held

to address the factors that we believe are impacting performance. The Urgent and Emergency Care (UEC) plan has been developed in collaboration with all system partners and overseen by NHSE. This is now being implemented and progress is tracked and monitored at monthly A&E delivery Board meetings. The UEC comprises of 7 pillars focusing on:

1. *NHS 111 Online* – development of integrated Urgent Care Service
2. *NHS 111 Calls* – development of integrated Urgent Care Service
3. *GP Access* – enhanced access to evening and weekend appointments
4. *Urgent Treatment Centres* – improved access to same day urgent care services
5. *Ambulance* – improved response involving right treatment, right place, first time
6. *Hospitals* - right care for the patient, in the right place at the right time
7. *Hospital to Home* – "home first" to transfer patients to the right place with the right care without avoidable delays

A&E performance has been poor nationally throughout 2017/18. However, Frimley Health at both sites has maintained performance above the current national level and above other systems in the region, despite continuing challenges with increasing demand.

Fig: A&E 4hr Performance Frimley Health when compared to England 2017/18

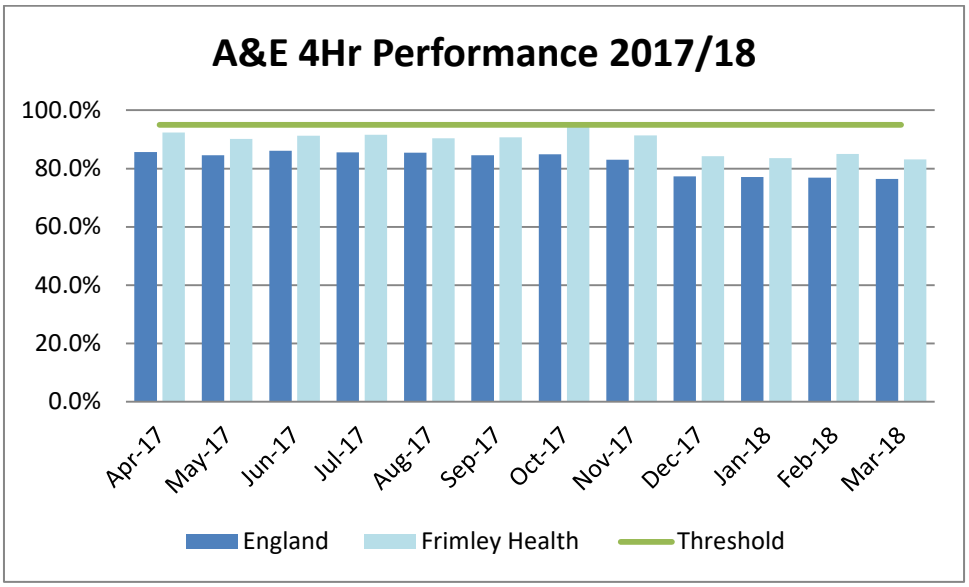
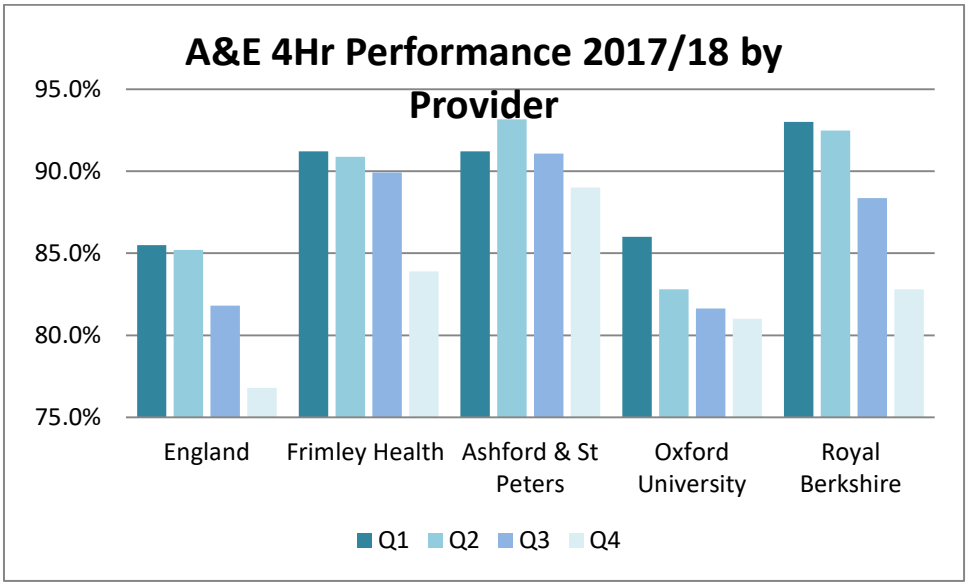


Fig: A&E 4hr Performance of Frimley Health when compared to other providers in area 2017/18



The A&E Delivery Board oversees the progress of actions identified to address the shortfall in A&E 4hr performance. Actions that have been identified year to date include:

- extended ambulatory care opening times at both Frimley sites

- ongoing recruitment drive for A&E middle grade doctors at both Frimley sites and focus on recruitment and retention for nursing staffing

- additional interim beds funded at Heatherwood site to ease winter pressures

- to support ambulance handover delays, an A&E Ambulance queue nurse is placed in A&E to support early assessment & intervention

- introduction of IRIS (Integrated Referral Information System) MDT model at Wexham site, designed to speed up discharge decision making between system partners

- daily system resilience calls and response to facilitate discharges

- launch of Frailty Unit at Wexham Park site with short stay ward and work with Community teams

- increased mental health and liaison and support in A&E

12 hour Trolley Waits

As a direct result of pressures in A&E, FHFT has reported two 12 hour trolley waits, both at Wexham Park site in 2017/18.

Both cases involved patients waiting for transfers to other hospitals for onward treatment. No harm to the patients was identified. They were moved into a bed within the A&E department whilst they waited transfer. All 12 hour trolley wait cases are reported as serious incidents and investigated accordingly.

Table: 12 Hour Trolley Breaches by Provider 2017/18

Indicator	Target	Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	YTD
A&E Trolley Waits: The Percentage of patients spending more than 12 hours from decision to admit to admission	**0**	Frimley Health	1	1	0	0	2
		Wexham Park	1	1	0	0	2
		Frimley Park	0	0	0	0	0

Mixed Sex Accommodation (MSA) Breaches

As a result of pressures and high demand in A&E at times it is not always possible to ensure single sex accommodation in bays especially in acute medical units whilst patients are waiting assessment prior to admission.

Royal Berkshire Hospital (RBFT) has reported a significant number of MSA breaches in 2017/18. Such breaches occur predominantly in the acute medical unit (AMU) and in observation areas in A&E at times of increased pressure. RBFT has implemented an action plan to reduce breaches but at times of severe pressure MSA breaches are authorised as clinical safety comes first. When breaches do occur, privacy and dignity of patients is maintained at all times.

At Frimley Health a relatively smaller number of breaches have been reported in the second half of the year, again as a result of increased pressure in A&E. The breaches in August occurred in the A&E Observation Unit at Frimley Park due to severe capacity issues compounded by the closure of A&E at Royal Surrey. Patients were informed of the situation and agreed to go into a mixed bay. Curtains and screens were used to maintain privacy and dignity.

Similarly in June cases occurred overnight in A&E Observation Unit at Frimley Park and Wexham Park as a result of capacity pressures.

Slough CCG reported 3 cases of mixed sex accommodation breaches in 2017/18 to January 2018. These cases would have primarily originated from Wexham Park hospital.

In response to pressure from CCGs regarding the disparity in reporting of MSA breaches across Providers, NHSE has recently issued updated guidance on mixed sex accommodation and the Trust and the CCGs are currently reviewing and updating processes in accordance with the revised guidance.

Table: Mixed Sex Accommodation (MSA) breaches by Provider and CCG 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
MSA: The Number of mixed sex accommodation breaches	**0**	Frimley Health	0	13	10	4
		Wexham Park	0	2	0	0
		Frimley Park	0	11	10	4
		Berkshire Healthcare	0	0	0	0
		Royal Berkshire	178	160	373	854
		Bracknell CCG	1	11	16	31
		Slough CCG	0	2	1	0
		WAM CCG	4	3	6	11

Ambulance Response Times – South Central Ambulance Service (SCAS)

In November 2017 the Ambulance Response Programme (ARP) went live following an extensive pilot study in Yorkshire Ambulance Trust. These new measures were varied into the NHS standard contract from 1st February 2018. Data is to be collected for 6 months in order to establish a baseline following which performance will be reviewed. If necessary, improvement trajectories will be set with agreement of all Commissioners.

To date variation is evident at CCG level but with limited data and at a time of increased winter pressures it is difficult to draw conclusions thus far on the impact of ARP.

CAT 1 performance for SCAS Thames Valley has been a little above the 7 minute mean with achievement of the 15 minute 90th percentile target year to date. This has been sustained at a time of increased winter pressure. For Slough CCG performance has been below the thresholds.

CAT 2 performance for SCAS Thames Valley and Slough CCG has been achieved year to date, with the exception of March 2018.

CAT 3 and CAT 4 performance is more challenged with longer waits reported both at SCAS and CCG level. Hospital handover delays impact the achievement of the response times considerably. During December to March hospital delays have increased due to ongoing winter pressures.

Achieving the standards, particularly at CAT3 and CAT4 is dependent on fleet reconfiguration, requiring reducing reliance on rapid response vehicles and adjusting the fleet to having more ambulances. SCAS are developing plans for 2018/19 to address this gap.

SCAS remain challenged in achieving the ambulance response time targets due to workforce pressures and shortages of trained paramedics. SCAS has put considerable effort into reversing the recruitment issue, with innovative ideas to overcome loss of specialist paramedics to other healthcare sectors. Progress against the recovery action plan is discussed by all Commissioners in the Thames Valley region with the Ambulance Trust at monthly contract and quality review meetings.

SCAS is ranked currently in the top third of Ambulance Trusts following five months of ARP data. In addition, when compared to England data, SCAS is performing well.

Table: ARP Performance to date November to March 2018

Indicator	Target	CCG/Provider	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Cat 1 7 min response time 15 mins 90th percentile response time ARP	**<=00:07:00**	**England Mean**	0:07:57	0:08:52	0:08:19	0:08:16	0:08:22	
	<=00:15:00	**England 90th Percentile**	0:13:48	0:15:25	0:14:29	0:14:17	0:14:36	
	<=00:07:00	SCAS TV Mean	0:07:15	0:07:38	0:07:10	00:07:19	00:07:26	0:07:22
	<=00:15:00	SCAS TV 90th Percentile	0:13:23	0:14:32	0:12:59	00:13:37	00:13:52	0:13:42
	<=00:07:00	Bracknell CCG Mean	0:07:37	0:07:34	0:08:00	0:07:39	0:07:15	0:07:38
	<=00:15:00	Bracknell CCG 90th Percentile	0:14:02	0:12:33	0:14:36	0:12:50	0:15:31	0:14:02
	<=00:07:00	Slough CCG Mean	0:06:04	0:06:20	0:05:55	0:06:06	0:06:53	0:06:15
	<=00:15:00	Slough CCG 90th Percentile	0:09:22	0:10:21	0:10:20	0:10:07	0:11:21	0:10:30
	<=00:07:00	WAM CCG Mean	0:06:47	0:07:20	0:07:46	0:09:50	0:07:17	0:07:38
	<=00:15:00	WAM CCG 90th Percentile	0:11:27	0:12:30	0:13:48	0:16:08	0:12:15	0:13:24

Indicator	Target	CCG/Provider	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Cat 2 18 mins mean 40 mins 90th percentile response time ARP	**<=00:18:00**	**England Mean**	0:22:50	0:29:41	0:26:05	0:25:34	0:27:07	
	<=00:40:00	**England 90th Percentile**	0:48:02	1:03:14	0:55:36	0:53:57	0:57:38	
	<=00:18:00	SCAS TV Mean	0:14:16	0:16:44	0:15:43	0:16:10	0:18:18	0:16:18
	<=00:40:00	SCAS TV 90th Percentile	0:27:31	0:33:31	0:31:36	0:31:36	0:37:32	0:32:30
	<=00:18:00	Bracknell CCG Mean	0:14:45	0:15:06	0:15:15	0:16:46	0:19:26	0:16:18
	<=00:40:00	Bracknell CCG 90th Percentile	0:28:22	0:29:24	0:29:29	0:30:33	0:36:25	0:31:24
	<=00:18:00	Slough CCG Mean	0:11:12	0:14:54	0:13:35	0:14:29	0:15:36	0:14:03
	<=00:40:00	Slough CCG 90th Percentile	0:20:51	0:30:55	0:29:53	0:31:21	0:32:32	0:29:51
	<=00:18:00	WAM CCG Mean	0:16:32	0:20:37	0:19:20	0:18:29	0:20:20	0:19:10
	<=00:40:00	WAM CCG 90th Percentile	0:27:19	0:41:22	0:34:34	0:35:48	0:41:24	0:35:52

Indicator	Target	CCG/Provider	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Cat 3 120 mins (2hrs) 90th percentile response time ARP	**2hrs**	**England 90th Percentile**	2:07:03	3:06:35	2:28:26	2:41:50	2:58:21	
	2hrs	SCAS TV 90th Percentile	1:48:52	2:36:52	2:17:25	2:17:40	2:34:43	2:18:06
	2hrs	Bracknell CCG 90th Percentile	1:59:21	2:28:40	2:28:56	2:34:08	3:02:04	2:30:39
	2hrs	Slough CCG 90th Percentile	1:44:07	2:59:10	2:32:00	2:41:23	2:40:27	2:31:16
	2hrs	WAM CCG 90th Percentile	1:49:30	2:52:41	2:44:06	2:54:58	3:01:31	2:43:09
Cat 4 180 minutes (3 hrs) 90th percentile response time ARP	**3hrs**	**England 90th Percentile**	3:06:56	4:07:35	3:15:32	3:29:16	3:39:18	
	3hrs	SCAS TV 90th Percentile	2:57:28	3:38:51	3:12:04	3:27:43	3:54:29	3:27:21
	3hrs	Bracknell CCG 90th Percentile	2:44:44	2:51:57	3:15:22	2:48:06	3:22:17	3:07:52
	3hrs	Slough CCG 90th Percentile	3:14:29	4:20:42	4:41:44	4:33:37	2:57:03	4:21:07
	3hrs	WAM CCG 90th Percentile	3:40:59	5:15:09	3:05:46	3:49:19	4:45:21	4:18:47

Planned Care

6 weeks Diagnostic Tests

Performance in 6 week diagnostic waits has also been very strong at Frimley Health, and thus reflected at CCG level. Performance at Wexham Park has consistently been at 0%, whereas at Frimley Park, with the exception of April 2017, the standard has been achieved but against a backdrop of continued pressures in delivery of endoscopy services due to staffing shortages. Slough CCG predominantly faces Wexham Park and this is reflected in the very good performance when compared to the other two CCGs in East Berkshire.

Table: 6 Week Diagnostic Tests by Provider and CCG 2017/18

Indicator	Target	CCG	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Diagnostic tests - the percentage of service users waiting 6 weeks or more from referral for a diagnostic test	**< 1%**	**Bracknell CCG**	0.53%	0.79%	0.30%	0.61%
		Slough CCG	0.2%	0.2%	0.2%	0.4%
		WAM CCG	0.21%	0.23%	0.13%	0.4%

18 weeks Referral to Treatment (RTT)

Performance in 18 weeks RTT has been strong at CCG level throughout 2017/18. Slough CCG has achieved the standard for the year at over 93%.

Our main provider, Frimley Health, has achieved the standard as a Trust in all but one month (December 2017). Pressure exists in trauma and orthopaedics, however 18 week RTT performance has been achieved for the remainder of 2017/18.

Table: 18 Weeks Referral to Treatment at Provider and CCG level 2017/18

Indicator	Target	CCG	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Incomplete RTT pathways (yet to start treatment) waiting 18 weeks or less from referral to hospital treatment	**92%**	**Bracknell CCG**	93.9%	93.3%	93.3%	93.1%
		Slough CCG	92.6%	93.1%	92.9%	92.8%
		WAM CCG	92.9%	92.9%	92.6%	93.1%

52 Week Waits

Slough CCG has reported 8 >52 week waits. All of these cases are from out of area Providers, in the main London Trusts and Oxford University. Once known, these cases are tracked to ensure treatment dates are planned at the earliest opportunity.

Frimley Health have reported 2 cases of >52 weeks waits at the Frimley Park site. Neither case was attributed to an East Berkshire CCG. Wexham Park have reported zero >52 week waits in 2017/18.

Oxford University Hospitals NHS Foundation Trust had reported significant numbers of >52 week waits throughout 2017/18, in particular in Gynaecology. NHSI are engaged with the Trust in developing and implementing a recovery action plan, but it will be some months before the numbers are reduced to zero.

Table : >52 Week Waits at Provider and CCG Level 2017/18

Indicator	Target	CCG/ Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	YTD
Incomplete RTT pathways (yet to start treatment) waiting 52 weeks or less from referral to hospital treatment	**0**	**Frimley Health**	1	0	0	1	2
		Bracknell CCG	1	0	1	3	5
		Slough CCG	1	0	2	5	8
		WAM CCG	1	5	3	1	10

Cancer Wait Times Performance

2 Week Waits

Performance in 2 week waits for suspected cancer and breast symptoms has been strong both at Provider and CCG level.

Slough CCG has achieved both standards at each quarter throughout 2017/18.

Table: 2 Week Wait Cancer Performance at Provider and CCG Level 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Cancer Waits - 2 Week Wait with suspected cancer by a GP waiting < 2 weeks for first OP appointment	93%	**Frimley Health**	96.2%	96.0%	96.5%	96.8%
		Bracknell CCG	96.1%	95.6%	96.5%	95.9%
		Slough CCG	96.0%	97.3%	96.8%	96.4%
		WAM CCG	96.2%	96.3%	95.7%	95.2%
Cancer Waits - 2 WW with breast symptoms (where cancer not initially suspected) waiting <2 weeks for first OP appointment	93%	**Frimley Health**	95.9%	96.5%	95.2%	96.0%
		Bracknell CCG	96.4%	97.5%	95.1%	92.9%
		Slough CCG	98.0%	97.2%	97.3%	96.5%
		WAM CCG	92.6%	97.9%	93.8%	96.6%

31 Days Cancer Waits

Performance in 31 day cancer waits has been strong at Provider and CCG level. Notable quarterly exceptions include:

Royal Berkshire Hospital did not achieve 31 days surgery in Q2 2017/18, although Slough CCG did achieve all quarters to date. This was primarily due to patient choice to delay treatment.

Slough CCG marginally failed to achieve the 31 day drug regimen in Q1 and Q3. This was due to 1 breach in each quarter. Both cases were delayed by only 1 day and received treatment at the earliest opportunity.

Slough CCG did not achieve in all 4 quarters in 31 day radiotherapy. This was due to breaches at both Royal Berkshire (RBFT) and East & North Hertfordshire Trust (ENHT). RBFT breaches were predominantly patient choice and ENHT was as a result of capacity issues and MRI scanner breakdowns. This was a theme for some months but resolved at the end of Q3 2017/18.

Table: 31 day Cancer wait times Performance by Provider and CCG 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Cancer Wait - 31 days % of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for **all cancers**	96%	**Frimley Health**	98.6%	99.9%	99.4%	99.7%
		Royal Berkshire	97.8%	98.2%	97.9%	97.2%
		Bracknell CCG	99.2%	97.2%	97.6%	98.8%
		Slough CCG	98.0%	98.1%	100.0%	97.8%
		WAM CCG	98.2%	100.0%	98.2%	100.0%
Cancer Waits - 31 days % of Service Users waiting no more than 31 days for subsequent treatment where that treatment is **surgery**	94%	**Frimley Health**	98.8%	100.0%	98.5%	100.0%
		Royal Berkshire	98.3%	90.5%	95.8%	100.0%
		Bracknell CCG	100.0%	100.0%	100.0%	100.0%
		Slough CCG	96.4%	100.0%	95.2%	95.2%
		WAM CCG	97.6%	100.0%	100.0%	100.0%
Cancer Waits - 31 days % of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an **anti-cancer drug regimen**	98%	**Frimley Health**	100.0%	99.3%	100.0%	100.0%
		Royal Berkshire	99.4%	100.0%	99.5%	99.5%
		Bracknell CCG	100.0%	100.0%	100.0%	100.0%
		Slough CCG	97.7%	100.0%	97.8%	100.0%
		WAM CCG	100.0%	98.6%	100.0%	100.0%
Cancer Waits - 31 days % of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of **radiotherapy**	94%	**Royal Berkshire**	96.9%	96.7%	94.7%	96.6%
		Bracknell CCG	93.9%	96.2%	98.0%	98.0%
		Slough CCG	89.7%	93.5%	92.5%	93.8%
		WAM CCG	96.0%	98.6%	94.5%	96.6%

62 Day Cancer Waits

Performance in 62 day cancer waits has been strong at Provider and CCG level. Notable quarterly exceptions include:

RBFT did not achieve 62 days wait for Q1, as a result of patient choice breaches in colorectal and urology pathways.

Oxford did not achieve both Q1 and Q3. Under performance is due to ongoing issues with late tertiary referrals, staffing issues, theatre capacity and radiology equipment failures. OUH have appointed a new Cancer Lead role from Dec 2017 and is focusing on resolving this as a priority.

Slough CCG achieved this standard in Q1-Q3 2017/18, but did not achieve in Q4. This was as a result of breaches in January and February partly due to seasonal patient initiated delays over the Xmas period. In addition it was evident that numerous complex cases involving additional diagnostic tests and tertiary referrals to other cancer centres delayed treatment.

Table: 62 day Cancer wait times Performance by Provider and CCG 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Cancer Waits - 62 days % of Service Users waiting no more than two months (62 days) from **urgent GP referral** to first definitive treatment for cancer	85%	**Frimley Health**	91.9%	94.2%	93.6%	91.0%
		Bracknell CCG	95.8%	79.5%	92.1%	81.3%
		Slough CCG	92.3%	89.2%	95.0%	81.1%
		WAM CCG	97.2%	92.6%	86.3%	95.9%

Mental Health

Dementia Diagnosis Rate (DDR)

Slough CCG performance for DDR improved significantly up to and including November 2017. Since this time, a decline in performance is evident. Slough CCG is refreshing its existing action plans that had previously delivered improved dementia diagnoses rates. Slough CCG has many hard to reach groups resulting in identifying cases more difficult. Many initiatives have been undertaken to raise awareness in the various community groups as to the importance of dementia diagnosis and thus signposting patients to the help available.

Table: Dementia Diagnosis Rate (DDR) by CCG and Region 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Dementia Diagnosis rate	**67%**	**10G Bracknell**	67.1%	68.0%	70.1%	68.3%
		10T Slough	66.0%	65.9%	65.6%	63.0%
		11C WAM	70.5%	71.5%	73.1%	73.0%

Early Intervention Psychosis (EIP)

Our local Provider has sustained strong performance throughout 2017/18. Achievement is significantly above the 50% threshold both at Provider and CCG level.

Table: EIP Performance at Provider and CCG Level 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
EIP- Early Intervention of Psychosis People with first episode of psychosis started treatment with a NICE recommended package of care treated within 2 weeks of referral	50%	BHFT	79.0%	100.0%	89.5%	100.0%
		Bracknell CCG	100.0%	100.0%	100.0%	100.0%
		Slough CCG	81.8%	100.0%	100.0%	100.0%
		WAM CG	93.3%	100.0%	100.0%	100.0%

Improving Access to Psychological Therapies - IAPT

Sustained performance in provision of IAPT services by our Provider Berkshire Healthcare Trust (BHFT).

Notable exception for Slough CCG is IAPT Access in Q2/Q3/Q4 dropped due to expansion of IAPT to long term condition clients. Additional training was required of BHFT staff in order to roll out this expanded service, resulting in fewer clinics and a drop in performance. Recovery is expected in 2018/19.

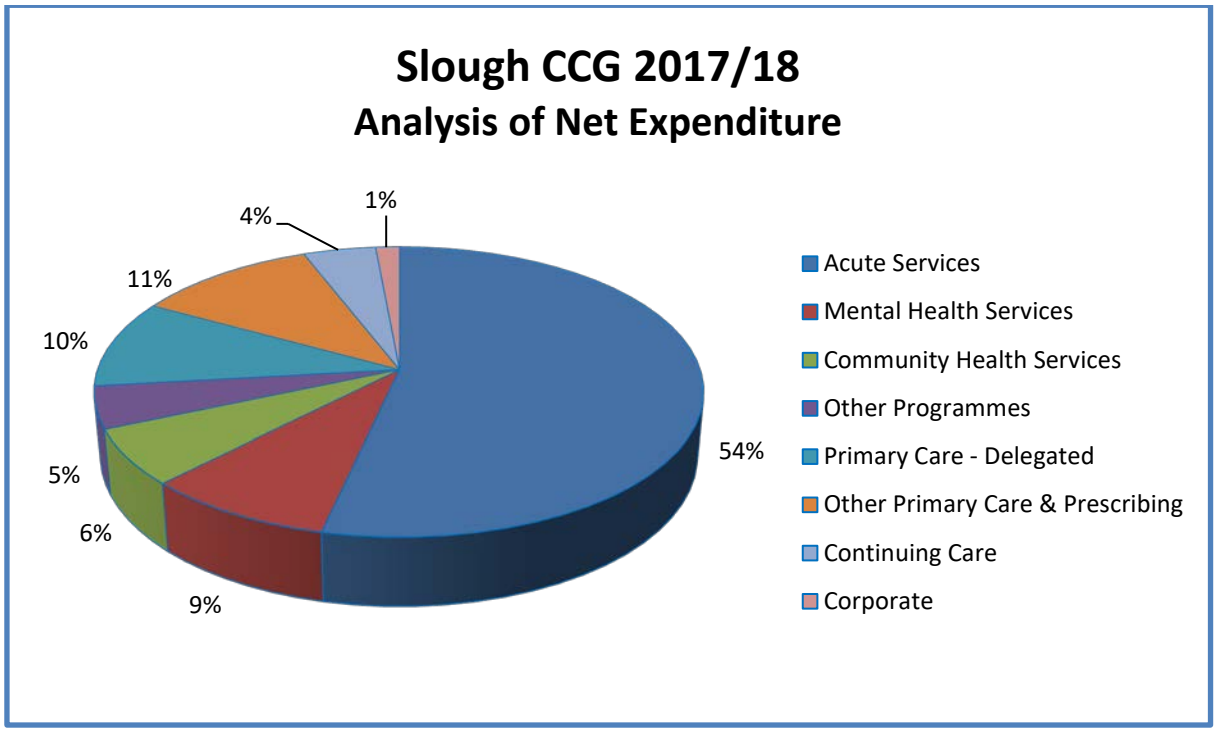
Table: IAPT performance at CCG level 2017/18

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
IAPT - Recovery rate The percentage of people who finished treatment within the reporting period; have attended at least 2 treatment contacts and are coded as discharged, who are assessed as moving to recovery	**50%**	Bracknell CCG	58.9%	59.6%	59.0%	57.8%
		Slough CCG	56.5%	57.9%	55.8%	58.6%
		WAM CCG	60.2%	58.3%	60.67%`	56.1%
Indicator	**Target**	**CCG/Provider**	**Q1 2017/18**	**Q2 2017/18**	**Q3 2017/18**	**Q4 2017/18**
IAPT - Access The proportion of people with depression and/or anxiety disorders that have entered psychological therapies	**16.8% (4.2% per Qtr.)**	Bracknell CCG	4.16%	4.45%	4.41%	4.48%
		Slough CCG	4.01%	3.69%	3.89%	3.94%
		WAM CCG	4.39%	4.05%	4.30%	4.81%
		Trajectory	4.00%	4.20%	4.20%	4.40%

Indicator	Target	CCG/Provider	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
IAPT - 6weeks The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment	**75%**	Bracknell CCG	99%	98.0%	98.0%	99.0%
		Slough CCG	99%	98.0%	97.0%	98.0%
		WAM CCG	99%	99.0%	98.0%	99.0%
IAPT - 18 weeks The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment	**95%**	Bracknell CCG	100%	100%	100%	100%
		Slough CCG	100%	100%	100%	100%
		WAM CCG	100%	100%	100%	100%

Financial Performance

Clinical Commissioning Groups are expected to manage expenditure within the resources allocated by NHS England, and deliver a minimum 1% surplus (which can be carried forward to future years). 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 CCG spent £203.6m in 2017/18 (net operating costs), which equates to £1,273 for every person registered with our practices. NHS Slough CCG have reported a surplus of £4.7m for the year. As set out in the 2017/18 NHS Planning Guidance, CCGs were required to set aside 1% of their allocation to be spent non recurrently. From within this budget CCGs were required to hold 0.5% percent as a system risk reserve uncommitted from the start of the year. The remaining 0.5% was made available for local investment.

The national position across the provider sector has been such that NHS England has requested CCGs to release the 0.5% risk reserve. Therefore, to comply with this requirement, NHS Slough CCG has released its 0.5% reserve to the bottom line, resulting in an additional surplus for the year of £0.9m. This additional surplus will be carried forward for drawdown in future years. In addition, further savings from nationally negotiated drugs prices (referred to as Category M savings) has also been reflected in the year end surplus, amounting to £0.2m.
Over half of our expenditure (£109m) is spent on acute services. Our main provider is Frimley Health NHS Foundation Trust. In 2017/18 we spent £85m with Frimley Health. Our next largest provider is the Royal Berkshire NHS Foundation Trust (£5.3m), who provide ophthalmology services from the King Edward VII Hospital in Windsor. Then there are range of smaller contracts with other hospitals such as Ashford & St Peters, Buckinghamshire Healthcare and Oxford University Hospitals. This category of expenditure (acute services) also includes Ambulance costs. The majority of our community and mental health services are provided by Berkshire Healthcare NHS Foundation Trust £24.8m.

In 2017/18 the CCG assumed full delegated responsibility for Primary Care (GP) commissioning and received an allocation of (£19.8m) from NHS England. The majority of GP costs are funded through contracts held directly by NHS England and administered by Slough CCG. We also meet the cost of drugs prescribed by our local GPs (£17.7m) and pay for the GP ‘out of hours’ service (£1.5m). The CCG has received £0.9m of additional funding to provide improved access to primary care.

In common with many CCGs across the country during 2017/18 Slough CCG experienced significant financial pressure on its acute hospital contracts, particularly in the cost of emergency admissions. Other cost pressures included expenditure on independent acute hospital contracts, additional costs of Mental Health packages of care and Continuing Healthcare (CHC) for clients awaiting assessment, appeals and joint funded learning disability

clients. These financial pressures and unexpected costs have been funded from the financial contingencies the CCG established at the start of the year.

NHS England adopted a new funding formula for CCGs in 2014/15 which allocated the overall national funding based on the needs of the local population, and calculates a 'target' allocation. Over time actual funding levels will be moved closer to the 'target' (this is sometimes referred to as the 'pace of change'). Slough CCG is funded at this target level, and for 2017/18 the CCG received an increase of £4.1m in its programme funding allocation.

Looking to 2018/19, Slough CCG merged with Bracknell and Ascot CCG and Windsor, Ascot & Maidenhead CCG to form NHS East Berkshire CCG with effect from 1 April 2018. East Berkshire CCG has received programme growth of £12.6m to cover inflation, population growth, a range of new national policy pressures and local service developments. In addition the CCG has received additional NHS revenue funding of £4.2m for 2018/19, which will increase funding for emergency & urgent care and elective surgery. The CCG also has to create the contingency budgets. It has therefore been necessary to develop a QIPP (Quality, Investment Productivity and Prevention) programme looking to mitigate the impact of these pressures by £10.3m. We have approached this through using the NHS Right Care approach to identify opportunities where evidence indicates unwarranted variation in outcomes and/ or financial value. We have used this approach to drive a robust plan of clinical and wider stakeholder engagement in the generation and development of new ideas for QIPP projects.

These include projects for respiratory services, neurology and end of life care.
About £8.4m of the CCG's funding allocation will be spent in partnership with the Slough Borough Council via the Better Care Fund. This is supporting greater integration across health and social care services. We are also planning to continue our scheme for extended access to primary care (GP) services.

Since the formation of the CCG in 2013, we have been working in close partnership with the other two CCGs in the East of Berkshire, and this includes sharing the financial risks on some areas of our budget. As already mentioned elsewhere in this Annual Report, we are also part of the Frimley Health and Care Integrated Care System (ICS), formerly referred to as the Sustainability and Transformation Partnership (STP), which includes East Berkshire CCG, Surrey Heath CCG, North East Hampshire & Farnham CCG, local health providers and our local authorities. In the year ahead we will be working together to tackle the challenges of

increasing demand for healthcare caused by an ageing population, ensuring that acute services are configured in the most clinically and cost effective way, and that where appropriate patients are cared for at home or in community settings rather than in expensive hospital beds. Over the medium term the increases in CCG funding only covers the costs of inflation, not the demographic impacts – so effectively we have to "meet tomorrow's demand with today's funding".

Further details about our expenditure in 2017/18 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 for 2017/18 costs us £31,667 plus VAT.

Sustainable Development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supercede this target by reducing our carbon emissions 34% by 2019/20 using 2014/15 as the baseline year.

Modelled Carbon Footprint: The majority of the environmental and social impacts are through the services we commission, with an estimated total carbon footprint of 2 tonnes of carbon dioxide equivalent emissions (tCO_2e)

Policies: In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Procurement (environmental & social aspects)	Yes
Suppliers' impact	Yes
Business Cases	Yes
Travel	Yes

One of the ways in which we as an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). We will be putting one together in the near future for consideration by the Governing Body.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business via direct effects on healthcare estates and patient health. Examples include heat waves and prolonged periods of cold, floods and droughts. The organisation has identified the need to develop a board-approved plan to include adaptation for future climate change.

We have not assessed social and environmental impacts for the CCG.

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

The CCG evaluates the environmental and socio-economic opportunities during procurement process through the use of the standard NHS contract and have a business case template for all projects and programmes.

Adaptation: Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that the CCG would continue to meet the needs of our local population during such events we have developed business continuity plan in partnership with other local agencies to use in such incidences.

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

Strategic partnerships are already established with the following organisations and the table below shows the sustainability comparator for our main providers:

Organisation Name	SDMP	On track for 34% reduction	GCC	Healthy travel plan	Adaptation	SD Reporting score
Berkshire Healthcare NHS Foundation Trust	Yes	2. Target included but not on track to be met	No	Yes	Yes	Excellent
Frimley Park Hospital NHS Foundation Trust	Yes	2. Target included but not on track to be met	Yes	Yes	No	Good
Royal Berkshire NHS Foundation Trust	No	4. No Sustainable Development Management Plan	No	Yes	No	Minimum
Ashford and St. Peters Hospital NHS Foundation Trust.	Yes	2. Target included but not on track to be met	No	Yes	Yes	Good

Organisation Name	SDMP	On track for 34% reduction	GCC	Healthy travel plan	Adaptation	SD Reporting score
Oxford Health NHS Foundation Trust.	No	4. No Sustainable Development Management Plan	No	Yes	Yes	Minimum
Surrey and Borders Partnership NHS Foundation Trust	Yes	1. On track to meet target	No	No	No	Good

More information on these measures is available here: www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Performance: As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supercede this target by reducing our carbon emissions 34% by 2019/20 using 2014/15 as the baseline year. Here's how we have done for our commissioned activity:

Organisation Name	Building energy use	Building energy use per FTE	Water	Water use per FTE	Percent high cost waste	Waste cost increase
Berkshire Healthcare NHS Foundation Trust	>10% increase	1.2	0-20% increase	11.1	>89% high cost	>20% decrease
Frimley Park Hospital NHS Foundation Trust	0-10% decrease	3.1	>20% increase	50.2	>89% high cost	>20% increase
Royal Berkshire NHS Foundation Trust	>10% decrease	3.2	>20% decrease	53.5	>97% high cost	0-20% increase

Organisation Name	Building energy use	Building energy use per FTE	Water	Water use per FTE	Percent high cost waste	Waste cost increase
Ashford and St. Peters Hospital NHS Foundation Trust.	0-10% increase	3.9	0-20% increase	42.7	>89% high cost	Data not available
Oxford Health NHS Foundation Trust.	>10% decrease	1.3	>20% increase	30.7	>75% high cost	0-20% decrease
Surrey and Borders Partnership NHS Foundation Trust	>10% increase	1.7	>20% decrease	22.0	<=75% high cost	Data not available

More information on these measures is available here: www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff, through our providers and to patients and public who use the services we commission. Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reduction. We support a culture for active travel to improve staff wellbeing and reduce sickness. The CCG manages business travel, encouraging staff to use technology for meetings, travel by public transport, or travel together to meetings.

Energy

The CCG encourages staff to reduce energy consumption wherever possible. It has a single headquarters at King Edward VII Hospital. The table below shows energy usage by the CCG in 2016/17 as data was not available for 2017/18.

Resource		2016/17
Gas	Use (kWh)	3,098
	tCO_2e	1
Electricity	Use (kWh)	29,134
	tCO_2e	15
Total Energy CO_2e		16
Total Energy Spend		£ 5,780

Waste

The CCG supported and encouraged staff in recycling paper waste and other consumables.

Waste		**2017/18**
Recycling/ reuse	(tonnes)	0
	tCO_2e	0.01
Other	(tonnes)	3
	tCO_2e	0.06
Landfill	(tonnes)	0
	tCO_2e	0.00
Total Waste (tonnes)		3
% Recycled or Re-used		9%
Total Waste tCO_2e		0.06

Engaging people and communities

The CCG has a commitment to community and patient engagement that runs through everything we do. We encourage patient and public involvement and listen to people to understand our local communities better and commission high quality services. Effective communication and engagement plays a central role in many CCG projects and programmes.

For each individual project or stream of work, the CCG individually evaluates requirements for engagement and communication and sets out an action plan using the most appropriate methodologies. This may include public meetings, workshops, surveys, focus groups and online channels. Our engagement principles are available on our website, and underpin all that we do. We believe that practice based patient groups are vital to our developing our approach to involvement and we have actively supported networks of these groups to develop and in turn support one another to be the best that they can.

We work closely to support our partners, both formal and informal, and communicate via each other's networks to ensure consistent messaging with our local population. Local community groups and leaders are a key asset to reaching those who are generally seldom heard.

Below is a summary of the key activity during the year.

Frimley Health and Integrated Care System (ICS)

The CCGs in East Berkshire have been represented on the ICS Communications Network from the outset and have taken the lead on the communication plan for the Integrated Decision Making workstream. The Network has focused primarily on communications rather than engagement. Whilst Network members encourage patient and public involvement through all of the workstreams, the majority of engagement takes place at a local level as it is local geographical areas that people identify with.

Communications leads from across the ICS footprint have been assigned to seven core work streams. An action plan for each work stream has been developed, together with mapping of communication and engagement opportunities for system leaders and members.

The Health and Wellbeing Alliance consists of the Chairs and Vice Chairs of Health and Wellbeing Boards across the ICS area and has a role in agreeing key messages and the overall communication strategy.

Community Partnership Forum (CPF)

The Community Partnership Forum is our main engagement forum across East Berkshire and has been key to engaging on developments both across the CCGs and the wider ICS footprint. The Terms of Reference were updated and approved by the group and are now available on the website. The CPF is open to everyone and meeting venues are rotated to provide access to different populations. The CPF has a Lay Chair. This year, a forward plan has been developed with input from commissioning colleagues, the CCG Executive Team and the CPF Chair. The agenda and planned topics are promoted in advance of each meeting by the CCG, through a variety of media, as well as by HealthWatch and other local partners.

Over the past year, CPF meetings have taken a workshop style approach, with opportunities for group work, feedback and in-depth discussion. We trialled a new approach to the CPF in January 2018 with a single agenda item, more time for discussion, a briefing note in advance of the meeting and the use of audience interaction software. This received positive feedback from attendees and is the format we will continue with. The meeting is live streamed in an attempt to attract a wider audience that might not normally attend a meeting and comments and questions can be raised remotely. Key topics discussed have included:

- Urgent and emergency care
- Cardiology
- Mental Health
- Sustainability and Transformation Plan
- Local review of national consultations

Meetings are open to the public and invitations are sent to all members of Health Connect, Healthwatch and GP practice patient groups. Web copy, social media messages and images are shared with key partners who then promote this through their own digital channels. The CPF mailing list consists of those who have attended meetings, partner organisations and members of the public forms a part of our stakeholder list. Regular attendees include CCG Clinical Chairs, HealthWatch, and representatives from local Get Involved groups, Older People's Advisory Forum and members of the wider public, patients and carers.

The CPF has influenced our commissioning work. For example, the discussions around urgent and emergency care highlighted to the local team how simple the urgent care offering needs to be if people are to understand it and use the NHS appropriately. The language used by the public and personal experiences that were shared and heard first-hand, all helped to feed into the development of the urgent and emergency care strategy. CPF provided the opportunity for colleagues to hear directly from local people and to develop innovative approaches.

CPF meetings are held in easily accessible venues with free parking and strong public transport links. The meetings are held alternately in each CCG area and attendees can claim via our 'Volunteer Expenses Policy' if required. All venues provide a hearing aid loop system and we have never been requested to provide translation services.

Patient Panel

To support the New Vision of Care and the ICS, a Patient Panel for East Berkshire was established in 2015.

Projects the Panel supported in 2017/18 include:

- End-of-life care – feeding into the review of the strategy, service specification and implementation of the new Rapid Response Service working closely with Thames Valley Hospice
- Connected Care (Share Your Care) – supporting the delivery of this project, starting with governance arrangements and data sets to be included in the first phase
- Website and digital communications – providing feedback on website functionality and information for the public
- Carers – contributing towards a joint ICS wide carer's event.

Patient transport can be offered for meetings and transport costs are reimbursed via the 'Volunteer Expenses Policy'. In the past, Patient Panel members have included those with learning disabilities, highlighting how this group was going beyond the normal boundaries of people we tend to reach.

Behaviour change

A behaviour change project was undertaken in Ringmead Medical Practice Bracknell to encourage patients to use the NHS appropriately. Pilot interventions were developed with staff and patients and were tested over a period of 6 months, with the practice leading discussions with their patients.

Practice staff and the patient group supported the development of a local, practice specific flyer, explaining the access points to NHS care, how and when to use them and how much they cost. HealthWatch Bracknell Forest were also involved in the co-production of the leaflet, and were able to provide the costs that were used in the final print run. This leaflet was then distributed to every household with a patient registered with the practice and via local voluntary sector and community groups. Other interventions also included practice staff visiting school assemblies to explain when to use 999 and NHS111 and a competition to encourage school children to take the messages home.

The evaluation will determine to what extent this project has had an impact with a view to extending this approach in the future. The learnings are to be shared across the three CCG areas and wider via the A&E Delivery Group. Evaluation data sets include practice level data, 111 calls, out of hours, urgent care and A&E usage.

HealthMatters – review of the year for each CCG

HealthMatters is the name of the publication launched at the AGM which summarises key information from the approved and already published Annual Report, and is part of our efforts to make the annual report accessible.

Through this publication, we share our local achievements with residents in East Berkshire and explain how and where NHS money was spent.

Digital Communication and Engagement

The CCG has spent the last year working to align its online presence so that with the merger of the three CCGs, a single website is ready for launch with the public.

The new website e launched on 2 April 2018 and is designed to provide useful CCG and NHS information for patients, residents, GPs and other health care professionals, key stakeholders and partners in East Berkshire.

The new site is more convenient for local residents, putting the public and patients at its heart. It continues to provide health information to assist in influencing and changing patient behaviours, to encourage them to take action to improve their health now and for the future. Consistent messaging across one platform should lead to better outcomes.

The website was designed using the previous year's analytics from the existing three CCG websites to see what information people were accessing our sites for and how they were using them. We also conducted online user testing to test our website design, layout and navigation and seek feedback/comments about how the pages were set out.

We invited a number of stakeholders to test the website including:

- Experts by experience user group (link through Healthwatch)
- Deaf Positive
- Local Healthwatch in the 3 localities
- Representatives from the visually impaired community
- Youth parliament
- Council for Voluntary Services in all 3 localities – to support with reaching out to diverse communities and local voluntary organisations
- PRG/ Patient Assembly/ PPG chair WAM, Slough & B&A
- Local Authority Public Health Teams x3
- Lay members
- Representative from Slough Seniors Group
- Representative from the Learning Disability community
- Dyslexia Association
- Family members / friends
- HealthMakers

We encouraged these groups to share the links with the wider community.

There were 24 users who took part in our online user testing. Analysis of the results showed that participants were clicking on the parts of the site we would expect them to click on. We will continue to ensure that web pages use a strong call to action approach so we encourage users to view related pages/content. We will continue to use Google Analytics to understand what people are looking for and ensure information is easy to find and access.

The "East Berkshire CCGs" Facebook account is gathering momentum, and all major campaigns are promoted via this channel. The same account is also used for live streaming events such as Annual General Meetings, (AGM) and the Community Partnership Forum. In preparation for the merger of the three CCGs, a single twitter account was created and is building up an online presence.

Health Connect

Health Connect allows people to share their views with the CCG online. Anyone can join. It can help us target information more effectively so people are invited to participate in events and surveys that will be of interest to them. It also helps us to analyse the results of feedback to identify differences in responses from different groups and ensure we are reaching all sectors of the community. Health Connect is shared by the three East Berkshire CCGs and to date 1047 people have registered as members.

Over the past year, the CCG has used Health Connect to consult the public on areas such as end of life care.

Regular emails are sent out to all members with details of future meetings and links to where the papers can be found online. We are also using Health Connect to encourage people to sign up to be involved with the ICS and Patient Panel.

Internal communications and engagement with member practices

One of the biggest achievements for 2017/18 was the launch of the new member practice extranet. This was only possible due to extensive engagement with practice managers and clinical staff to understand what they needed from an extranet and what functionality it needs to have. This open dialogue and two way communication resulted in the successful launch and ongoing use of the extranet.

In 2016/17, CCG specific, weekly Bulletins were published and sent to all member practices. This year, communication with our member practices has been even further streamlined, and a single weekly newsletter is now sent to all member practice staff with links to the extranet. This has been well received and will be regularly evaluated to ensure practices continue to be happy with the messaging, frequency and content.

CCG leaflet accompanying council tax letters

The CCG has a positive relationship with the local authority, and for the second year running, has developed a leaflet which has been distributed to all households with council tax notices. This year the leaflet focused on promoting NHS 111 and detailing how to access local primary care extended hours services. There was also information about how the CCG spent its funds in 2016/17. These leaflets hit doorsteps in March 2018 and initial feedback from member practices seems to indicate an impact, with the demand increasing for these extended hours appointments.

Safeguarding

Following child safeguarding concerns, the CCG developed and published an animated video to warn parents about the dangers of getting distracted while caring for babies and toddlers in the bath or by water generally. The launch took place in July, in line with summer holidays and was received very well by members of the public as well as stakeholders and partner organisations. The video had 54,000 shares on the CCG Facebook page alone. It was also promoted in the GP Bulletin and on practice website and was shown in public waiting areas in maternity units across both Trust sites. This is one example of how joint working with our community and partner organisations can really reach into the community.

Standing together against violence and exploitation

In November, more than 250 front line practitioners and leads from across the country met to attend the East Berkshire against Violence and Exploitation conference. The CCG together with partners ensured that the event was well publicised and filmed. The film will be used for training professionals to recognise signs of child exploitation. A social media hashtag #EBAgainstViolence was established and was seen trending across various platforms.

Communications and engagement to support commissioning

The communications and engagement team worked to support more than 20 different projects over the year, across the three CCG areas. Details of a few of these follows:

Connected Care/Share Your Care public engagement

Work continues across Berkshire to engage around this important project, both via the Patient Panel, but also via other engagement opportunities such as Patient Assemblies and Patient Groups. Discussions include creating films and patient stories.

NHS111

A communications plan supported all elements of the procurement and service delivery of the improved NHS 111. This included local press releases, social media activity and sharing updates with patient groups both face to face and via channels such as HealthConnect.

Mental Health

East Berkshire Young People's Survey

As part of the Child and Adolescent Mental Health Service Transformation work a survey was created to gain feedback from our young people about the services that are currently commissioned across East Berkshire to support mental wellbeing. The survey received over a

1000 responses and the comments formed the foundation of focus groups within the community to gain a further understanding of what commissioners need to take into account for any future services for children and young people.

Little Book of Sunshine

The Little Book of Sunshine booklet was written by a group of local young people for young people about emotional wellbeing and mental health. It explores issues that may affect young people and provides them with handy and helpful tips on how to cope, as well as signposting them to local and national agencies that can help. The booklet was written as a result of the East Berkshire CAMHS Transformation Programme, and the communications and engagement team supported its publication and promotion via social media and internal communications.

Brighter Berkshire 2017 Year of Mental Health

Brighter Berkshire is an initiative driven by a group of people from a range of communities and organisations in Berkshire who want to help make a difference to mental health by reducing stigma. The aim is to combine existing work and identify what can be done differently to raise awareness and make a significant impact locally. The CCG supported this with pledges from the Accountable Officer and individuals within the CCG with members of staff raising awareness among the communities with which we work, including a presentation and workshop at CPF.

Latent TB

The communications team worked on new and innovative ways of targeting relevant audiences, including a jingle on Asian Star radio in Hindi / English which played through the month of March. There were also radio interviews on Asian Star radio and BBC Berkshire which talked about the high prevalence of TB in Slough. To mark World TB Day The Curve in Slough was lit up in red as part of a global initiative to raise awareness of TB and a series of events were hosted in the community.

Diabetes

The communications team worked with Diabetes UK to support practices in Slough during Ramadan, by providing leaflets about safely fasting with this condition. This was helpful for clinical staff as well as the public. The leaflets were also available to practices from the other CCG areas who requested them to support their local patients.

The CCG has also worked with Diabetes UK to recruit volunteers from within high-risk areas of Slough to act as “Diabetes Champions” within the local community to dispel myths and help people to live well with diabetes. The volunteers went through a rigorous training programme to equip them with the knowledge and information they would need to do their role. This Champion scheme has a robust evaluation methodology including using practice data to record any change in the number of newly identified diabetic patients as well as change to number of patients with better blood sugar levels.

This project was approved to go ahead by the ICS work stream and pending the evaluation, similar initiatives may be implemented in other diabetes high-prevalence areas within the ICS. Through such ground level projects, we are able to reach diverse population groups, especially those who are potentially excluded and disadvantaged.

Primary Care

The communications team has supported primary care over the past year, including the move to delegated commissioning and signing the Memorandum of Understanding with NHSE for Communications and Engagement. All websites have been updated with information on Delegated Commissioning, as well as links into primary care and the ICS.

The team has supported primary care to plan and/or secure engagement and involvement when proposed changes are predicted to have an impact on services. Other support to the primary care agenda includes practices moving location, closures, CQC inspections and a change to the provider at the Slough walk-in centre. Through positive patient and media engagement, most of this occurred smoothly, with the team providing practice specific support and guidance on both engagement and media relations, as well as providing support to the practices involved with regards to key messages for their patients and community members.

Primary Care and Out of Hospital Care

The team have supported communications and engagement for the new medical centre on the Ben Lynwood Care Village Site in Ascot, which is planned to open in early 2019. Plans were submitted to the Council following consultation with patients, patient representation groups, members of the Council, GPs and others. The public meeting was run by the two practices involved supported by the CCG and people were invited to an open session to view the detailed plans, followed by a formal presentation by practice doctors.

Cardiology

There has been a strong focus on proactive work to promote key messages around Cardiology, including a local campaign which was supported with the development of a new logo and strapline which was used internally and externally - Protect your heart: prevent, detect, and treat.

The communications team supported internal communications and training by attending the GP training event, and filming the session on Cardiology. This was then shared via the extranet and promoted in the CCG newsletter to practice staff. This made sure that those who could not attend the training session, were still able to access the content. An awareness raising event was held in the Tesco Superstore in Slough.

Media

The Communications and Engagement Team continue to work with the media as an important stakeholder and have had press releases well-received and published. This includes news of the three CCGs receiving “Outstanding” ratings from NHSE and stroke services. The media also covered the various changes and closures of primary care services such as Princes Street as well as routine press releases ahead of bank holidays with pharmacy opening hours etc.

Press releases have also been part of local campaigns such as around cardiology, where social media also played into the channel mix. The team has worked jointly with partners to do joint press releases where appropriate e.g. End of Life in conjunction with Thames Valley Hospice and with local authorities around the award winning Asthma Bus. In addition, an unlocking variation in Slough case study was included in an article in Healthcare Finance magazine, while a diabetes article in GP Online also included a Slough case study.

All press releases are available on the website and an analysis of six months coverage showed that 97% of coverage was positive or balanced, with only 3% coverage to be negative.

Campaigns

We continue to publicise health campaigns via our digital platforms to encourage people to get involved in local campaigns and support the behaviour change agenda. Campaigns covered this year include:

- Stay Well this Winter / flu
- Stay Well Pharmacy
- Cancer awareness
- Mental Health Awareness Week
- World Mental Health Day

- World Suicide Prevention Day
- Children's Mental Health Week
- Dying Matters
- Diabetes Week
- Keep Antibiotics Working
- Carers Week
- Self-care week
- Kids Jabs
- STOMP – Transforming care for people with a learning disability, autism or both
- Alcohol Awareness Week
- Dry January
- Act FAST Campaign
- Cervical Screening Awareness Week
- Cover up Mate Campaign
- Drowning Awareness
- Urinary Tract Infections awareness campaign
- Sexual Health Awareness Week
- Herbert Protocol – Keeping people with dementia safe
- E-prescriptions campaign
- In the event of an acid attack what to do
- Standing together against violence and exploitation

We continue to share and promote messages and campaigns from our local partners.

Winter pressures

The CCGs heavily supported the 'Stay Well This Winter' campaign with a strong social media campaign, media releases and heightened activity around the Christmas and New Year period and cold weather spells.

Flu

This year we promoted the national flu campaign strongly to persuade patients and staff to have the flu jab. There was a strong local social media campaign and media activity. Internally, the CCG offered the flu vaccination free to all staff, and uptake was positive.

The new stroke pathway

Efforts have continued to ensure stakeholders are aware of the new service, building on communication and engagement work that was carried out for the interim arrangements between January and May 2017. Work focused on planning for the 1 May launch of the permanent service and included a follow-up press release for local media, as well as internal messages that were circulated to all providers and GP practices.

End of Life Care

The End of Life Care Patient Panel was reconvened to discuss the revision of the end of life care strategy and an online questionnaire sought views from local clinicians and the public.

Patient Groups

The CCGs believe that Patient Groups in practices are key to our engagement work and also to provide an additional channel of communication to patients.

We have actively supported the development of Patient Group Networks in the three CCG areas. Over the past year we have provided them with facilitation to review their purpose and terms of reference. We have also provided support to create a forum for sharing best practice and mutual support. Representatives at these Networks are asked to discuss topics of interest with their own Patient Group and provide feedback either directly to the CCG or via other methods e.g. in the case of national consultations. The Networks receive regular updates on key topics from the CCG including the merger of the CCGs, ICS developments and individual projects. Patient Group representatives at these Networks are then asked to cascade information back through their own groups and more widely to registered patients via methods such as their newsletters. The CCGs provide administrative support to these Networks and fund the venues. We have trialled a monthly Bulletin to these groups with key information so that they can share information more widely between meetings without overwhelming these volunteers with a variety of emails.

Equality and Diversity

The CCG is committed to equality of opportunity for all people and to eliminating unlawful discrimination. We recognise and value the diversity of the local communities and believe that equality is central to the commissioning of modern, high quality health services, particularly in relation to the protected characteristics as set out by the Equality Act 2010. We have set our objectives through patient and staff consultation. The key objectives are:

1. We will make sure information is accessible.
2. We will develop an inclusive workforce that reflects our local communities and provide appropriate levels of equality and diversity training and development to all staff and members of the Governing Body

The CCGs' Equality & Diversity (E&D) strategy was used to inform a work plan undertaken in 2017/18; the plan was monitored and reviewed by the Equality & Diversity (E&D) Steering Group, which met five times during 2017/18.

Using the Equality Delivery System 2 (EDS) template the E & D Steering Group drafted the annual declaration. This was approved by the CCGs Quality and Constitutional Standards Committee and was published on the CCGs' websites in January 2018.

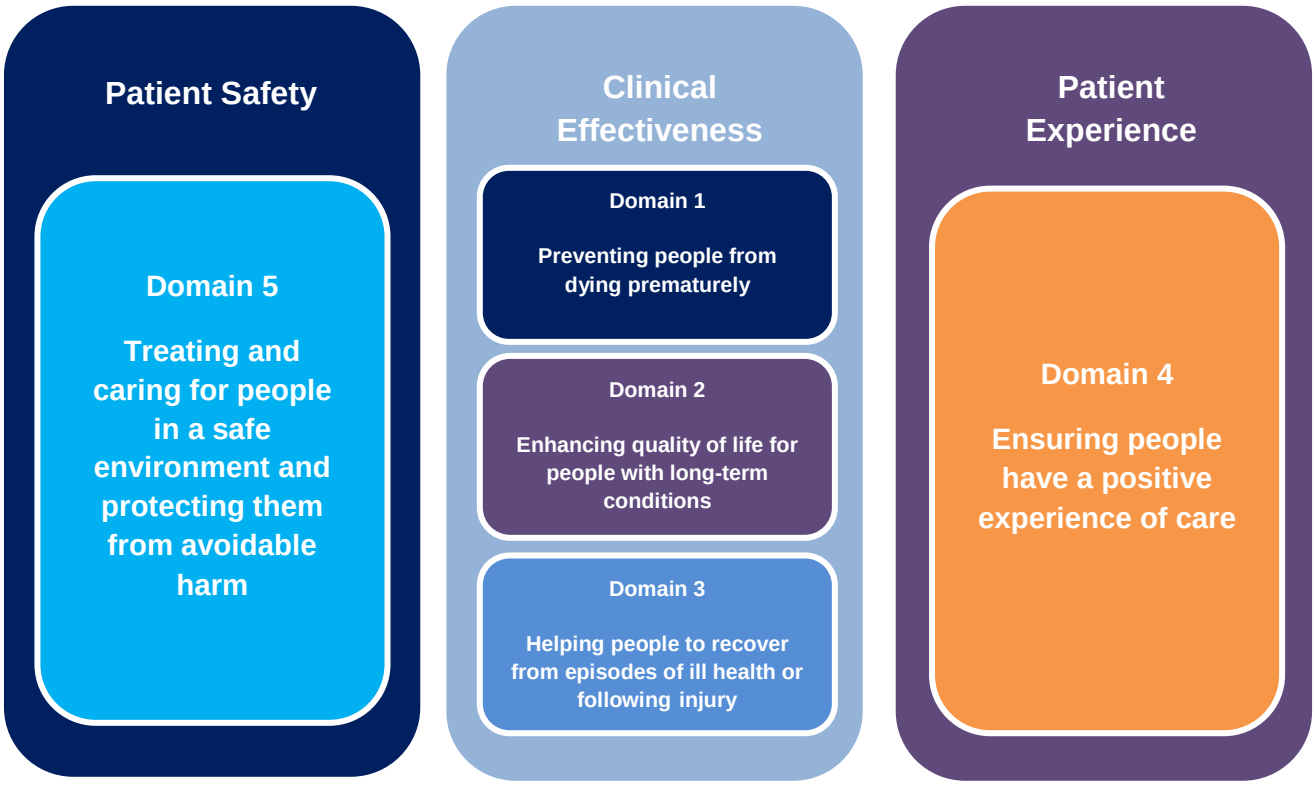
The CCG continues to work closely with partners in understanding the health needs of the different communities, including those that may otherwise be hidden. The CCG has worked with community groups and developed joint plans with the local authority to improve outcomes and reduce inequalities. The communications team ensures that any additional requirements when hosting events or any form of consultation are taken into account. This could be in the form of interpreters, easy read documents or any other area that needs additional support.
The key outcome achieved in 2017/18 included:

- The introduction of an E&D session on the core staff induction.
- Delivery of an E&D awareness session for the Governing Body in October 2017
- Delivery of an interactive session for CCG staff at the December 2017 away day covering deaf awareness and an introduction to basic British Sign Language.
- A business case audit to review E&D consideration in CCG project work. The following recommendations were made:
    - Training on the required standards for completing business cases.
    - Earlier involvement of relevant teams (e.g. Quality, Finance and Communications and Engagement) to support the development of business cases.
    - Audit to be reviewed by the relevant teams and actions developed to support improvements.
    - Re-audit of the standards in 6-12 months (dependent on having a reasonable sample size) to measure improvements.
- Established a local Learning Disabilities Mortality Review (LeDeR) Programme with the aim of reducing inequalities in the standards of care received by patients with learning disabilities, particularly at end of life.

The Equality Delivery System 2 (EDS2) declaration is available on the CCG website.

Improving Quality

The CCG works collaboratively with providers to ensure high quality and safe care is provided across all commissioned services and that patients and their carers experience is exceptional. The model below illustrates the three components of quality and when quality is discussed throughout the document each of the 3 are considered. There has been closer working in the year on a number of quality initiatives across the Integrated Care System (ICS).



These outcomes have been the key drivers for the CCGs' local priorities for ensuring quality in commissioning. Each indicator is captured in a document called a Quality Schedule which was agreed for 2017-19. All providers of services commissioned by the CCGs have a quality schedule that is mapped against the 5 Domains. The Quality Schedule indicators are standards to support the monitoring of safety, effectiveness and patient/carer experience. Quality is reviewed at the regular Clinical Quality review meetings for each Provider with a Standard NHS Contract. There are a number of contractual levers that can be used if the Provider does not meet the standard the CCG has commissioned; one of these levers is called a Contract Performance Notice (CPN). A contract performance notice is a tool that allows the commissioner and the provider to work together to meet the standard of care commissioned. In

2017/18, contract performance notices were issued to a number of Providers with a positive impact; the quality of care improved following implementation of agreed specified actions.

Sign up to Safety

Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. The CCG is committed to action the five Sign up to Safety pledges that it agreed from a Commissioner's perspective. The CCG has been making a commitment to bringing them to life. The commitments can be found on the CCG website https://www.eastberkshireccg.nhs.uk/about-us/policies/sign-up-to-safety/.

The CCG's approach to quality concentrates on the following key areas:

Patient experience: The aim is to have measurable ambitions that help to reduce poor patient experience and to understand and assess the quality of care experienced by vulnerable groups of patients. The evidence base is information gathered from the friends and family test, complaints, safe staffing levels, incidents and NHS choices. The CCG strives to ensure that providers deliver on the NHS Constitution, patients' rights and commitments given to patients (more details of this in the performance section). All these areas are monitored and reported to the CCG Quality and Constitutional Standards Committee. .

Safety of clinical services: the CCG has worked with providers to increase the reporting of harm to patients, targeting areas of concern raised by external or local intelligence including proactive assurance of performance against national standards and ensuring that actions from lessons learned were taken effectively and monitored for example through the Clinical Quality Review Meeting, Integrated Care System (ICS) Mortality Review Group and the Learning Disabilities Mortality Review Steering Group (LeDeR).

A new ICS Mortality Review Group (also including Berkshire West CCGs and Royal Berkshire Foundation Trust (RBFT) was formed during the year and has met twice and received updates from providers, most of whom submitted their Q2 mortality reports. The group has had good engagement to date, extending the membership to include representation from the Coroner's office.

A key part of the LeDeR Programme supported by Bristol University is to support local areas to review the deaths of people with learning disabilities aged 4 years and over, irrespective of whether the death was expected or not, the cause of death or the place of death. This will enable the CCG working with local partners to identify good practice and what has worked

well, as well as where there may need to be improvements to the provision of care for people in the future. The LeDeR programme became live in the CCG from September 2017, following training of local reviewers. East Berkshire LeDeR Reviewer and Steering Group meetings were set up to support the process. Some of the learning and key points include:

- Sourcing examples of easy-read guidance on 'Do Not Attempt Resuscitation' orders, and for suggesting adoption within local providers.
- Promotion of learning disabilities in end of life care planning and linking with the commissioners' End of Life Steering Group.
- Overseeing work to draft a process regarding care staff continuing to provide care for individuals who are admitted into hospital.

There have been 12 reviews identified so far that need to be carried out since September 2017. Of these 1 has been completed and the other 11 are in progress. The CCG is working with local partners so that there is a range of people who can carry out a LeDeR review. So far 26 people have been trained in carrying out a review.

Heatherwood and Wexham Park Hospital (HWPH) have been reporting a notably higher number of Serious Incidents (SI) per quarter than Frimley Park Hospital (FPH) and, for the first two quarters, RBFT. In Q3 and Q4, RBFT SI numbers rose and in Q4 were notably higher than both HWPH and FPH, although just lower than FHFT collectively.

In comparison with the previous year, all three hospitals are reporting more serious incidents. Incident reporting is important as it supports clinicians/organisations to learn about why patient safety incidents happen within their own service and organisation, and what they can do to keep their patients safe from avoidable harm. Commissioners also hold Serious Incident Panels at which all serious incident investigation reports are scrutinised and signed-off. This involves the agreement and monitoring of action plans for each case, along with thematic reviews and overarching action plans where required by the provider.

"Never Events" are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. The National guidance was

revised in January 2018. https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-summary-of-january-2018-revisions. Never Events include incidents such as:

- •wrong site surgery
- •retained instrument post operation
- •wrong route administration of chemotherapy

Total Never Events by Provider					
Trust	**No. of Never Events 16/17**	**No. of Never Events Q1 17/18**	**No. of Never Events Q2 17/18**	**No. of Never Events Q3 17/18**	**No. of Never Events Q4 17/18**
BHFT	0	0	0	0	0
FPH	3	1	2	1	3
HWPH	1	1	1	2	3
RBFT	1	1	1	0	0
SCAS	0	0	0	0	0
Other	0	0	0	0	0

HWPH and FPH have reported a notably higher number of Never Events than RBFT and in comparison with their own figures from the previous year. Due to the categories acute Trusts are more likely to have never events than other Trusts.

One of the HWPH Never Events may be downgraded and if so the numbers for HWPH and FPH will be equal. National benchmarking shows Frimley Health to be a relatively higher reporter of Never Events. All serious incidents including Never Events are thoroughly investigated and the reports and action plans are reviewed by the CCG. People affected by a serious incident are supported by the Trust to deal with the consequences and offered for the findings and actions from the investigation to be shared with them.

FHFT Never Events 2017/18									
Type	**Total Cases**	**FPH**				**HWPH**			
		Q1	**Q2**	**Q3**	**Q4 (to 28/3)**	**Q1**	**Q2**	**Q3**	**Q4 (to 26/3)**

Wrong site Surgery	7	1	2	-	1	1	-	1	2
Retained foreign object post procedure	3	-	-	-	1	-	-	1*	1
Wrong implant/prosthesis	1	-	-	1	1	-	-	-	-
Administration of medication by the wrong route	1	-	-	-	-	-	1	-	-
TRUST TOTAL	**14**			**FPH Total**	**7**			**HWPH Total**	**7**

*HWPH reported a retained foreign object Never Event in Q3 but this is likely to be downgraded.

An internal audit report on learning and implementation of actions from Never Events is scheduled to come to the FHFT SI Panel in early 2018/19, along with an annual analysis of cases being submitted to the Clinical Quality Review Meeting.

Good clinical practice: The CCG works with providers to ensure that clinicians and services are systematically working to accepted best practice guidelines, and that there are systems of clinical communication which are timely, accurate, relevant and systematic. At the Clinical Quality Review Meeting providers are requested to undertake a deep dive into different services either showcasing good practice or where there have been concerns raised. For example the End of life team provided information on the work they have been doing to improve the experience of patients at the end of their life.

Agreed pathways of care: The CCG has worked with primary, community and secondary care services ensuring effective adoption of agreed care pathways with indicators which measure the quality of a whole pathway of care and are evidence based. When new care pathways are being developed following the agreed CCG commissioning intentions there is a quality review. A quality impact assessment is used as part of the project management process. An example of this work carried out by the Quality team is a review of the lower limb care pathway, as there was an inequity of service across East Berkshire CCG's. The business case outlines a number of opportunities for improvement in the way that lower limb conditions can be managed in the community following pathway development with the CCG and providers; :

- Improved patient experiences and health outcomes
- Care provided more appropriately, in a local environment and with a defined pathway
- Reduced health system costs and pressures on the acute sector
- Improved access times to health services
- Better, more efficient use of the limited resources of the NHS
- Reduced costs to the NHS through inappropriate or delayed care
- Reduced burden of disability and social care costs
- Reduced variation

Staff satisfaction is an important indicator of quality and there is a good evidence base which supports that happy, well-motivated staff deliver better care and that their patients have better outcomes. NHS staff work very hard, often under great pressure and the CCG has worked with providers of NHS services to make it possible for them to do the best job they can. The CCG used the results from the staff surveys and the staff Friends and Family Test to improve the quality of services being commissioned. The CCG has also surveyed its own staff to have an understanding of the needs of its workforce. There is considerable pressure on the local workforce with a number of providers experiencing high staff vacancy rates in all professions. At HWPH, they have experienced high vacancy and turnover rates in the last year. The Trust has shared a number of initiatives to reduce the vacancies.

Safeguarding: The CCG publishes a separate mandatory safeguarding annual report; this will be published on the CCG website later in the year.

Nursing developments: The CCG has continued to work with Providers on a variety of initiatives to support shared learning and knowledge for nurses. There have been a number of learning summits organised on End of life care. These have been well received and a programme of events is being considered for the future. This work is becoming aligned with the Community Education Provider Network (CEPN) which is focusing on education in Primary Care.

A Thames Valley collaborative was successful in bidding to pilot the training of Nursing Associates, and they started their training in April 2017. This is a 2 year course with the trainees working the equivalent of 3 days a week in their place of work, university for 1 day and at an external placement for the other day. The introduction of this new role will ensure a highly trained support role to help Registered Nurses deliver effective, safe and responsive care. The Nursing Associate will also play a key part of the multi-disciplinary workforce that is needed to respond to the future needs of the public and patients. Once they have completed and passed

their 2 year training they will be registered with the Nursing and Midwifery Council. The CCG has been supporting one trainee in Primary Care who works in a Slough Practice. There have been a number of challenges which are not easily unravelled and the Associate Director of Nursing – Quality and Safety has been working nationally to look at ways to resolve these issues. We are hoping to support more Nursing Associates in General Practice in the future.

During the year there has been a project looking at the community nursing service and how it can be developed for the future. From January 2018 there has been some significant progress, with some guiding principles being set out and discussed with stakeholders, with areas for discussion on new ways of working, case load reviews and care pathway co-redesign with partners. The review is also a key component of the future integrated care delivery model.

Assurance Visits: The Quality team has worked closely with locally commissioned providers in ensuring that the quality of care is of a good standard. Mechanisms are in place for regular monitoring of these providers allowing the CCG to quickly identify areas of poor performance and quality and either working collaboratively with the provider or in some instances sanctions are issued and focussed improvement initiatives are implemented. This can be through a contract performance notice or a financial penalty. The CCG can also offer support particularly to those new providers who have not had a Standard NHS Contract before. An example of this is a Nursing home who was commissioned to deliver packages of care for re-ablement and discharge to assess where they needed support with improving the quality of their medicines management.

The Quality team with the CCG lay members have undertaken a number of observational visits to our local providers and are able to provide feedback to the provider on what was observed. If any actions are required to be taken these are monitored through the Clinical Quality Review meetings. The observational visits are based on the key lines of enquiry that are the basis for Care Quality Commission inspections. Following Primary Care delegation, the Quality team have also undertaken Assurance visits in Primary Care. There have been 13 visits to practices during the year.

Assurance visits carried out.

April	Spire Thames Valley
April	BMI Princess Margaret Hospital
April	Berkshire Healthcare NHS Foundation Trust - Complaints

May	Active Solutions
June	British Pregnancy Advisory Service
June	Bracknell Urgent Care Centre
July	Shreeji Ophthalmology
July	Eye Academy
September	Frimley Park Hospital – Theatres
October	RBH Ophthalmology (King Edward V11 Hospital)
December	Wexham Park Hospital -Theatres
March	Berkshire Healthcare NHS Foundation Trust – CRHTT
March	Berkshire Healthcare NHS Foundation Trust – CPE

National Commissioning for Quality and Innovation (CQUINS): For the first time, the CQUIN scheme is over two years which will provide greater certainty and stability on the CQUIN goals leaving more time for health providers to focus on implementing the initiatives. The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. A number of the CQUINS require providers to work together and the Quality team have supported this by facilitating workshops from this are seeing some positive outcomes. Below is a table of the CQUINS for 2017/19 and which Provider they are aimed at.

CQUIN	**Indicator**	**Goal**	**Provider**
CQUIN 1a	Improvement of health and wellbeing of NHS staff	Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.	FH, BHFT RBFT and SCAS Adapted version for Spire Thames Valley and BMI- Princess Margaret hospital
CQUIN	Healthy food for NHS staff,	As above	As above

CQUIN	**Indicator**	**Goal**	**Provider**
1b	visitors and patients		
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	As above	As above

	Indicator	**Goal**	**Provider**
CQUIN 2a	Timely identification of sepsis in emergency departments and acute inpatient settings	Timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.	FH and RBFT
2b	Timely treatment of sepsis in emergency departments and acute inpatient settings	As above	As above
2c	Antibiotic review	As above	As above
2d	Reduction in antibiotic consumption per 1,000 admissions	As above	As above

	Indicator	**Goal**	**Provider**
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with	Assessment and early interventions offered on lifestyle factors for people admitted with serious mental illness (SMI).	BHFT

	psychoses	.	
CQUIN 3b	Collaboration with primary care clinicians.	As above	As above

	Indicator	**Goal**	**Provider**
CQUIN 4	Improving services for people with mental health needs who present to A&E.	Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.	BHFT, RBFT, FH

	Indicator	**Goal**	**Provider**
CQUIN 5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services	BHFT

	Indicator	**Goal**	**Provider**
CQUIN 6	Offering advice and guidance	Improve GP to access consultant advice prior to referring patients in to secondary care.	FH and RBFT

Only for 17/18	**Indicator**	**Goal**	**Provider**
CQUIN 7	NHS e-referrals	All providers publish all of their services and make all first outpatient appointment slots available on e-referral service by 31 March 2018.	FH and RBFT

Only 17/18	**Indicator**	**Goal**	**Provider**
CQUIN 8	Supporting pro-active and safe discharge	Enabling patients to get back to their usual place of residence in a timely and safe way.	BHFT, RBFT FH

	Indicator	**Goal**	**Provider**
CQUIN 9	Preventing ill health by risky behaviours – alcohol and tobacco	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco	BHFT (Acute Providers have this CQUIN for 18/19) Adapted version for Spire Thames Valley and BMI Princess Margaret Hospital
CQUIN 9a	Tobacco screening	As above	As above
CQUIN 9b	Tobacco brief advice	As above	As above
CQUIN	Tobacco referral and	As above	As above

	Indicator	Goal	Provider
9c	medication offer		
CQUIN 9d	Alcohol screening	As above	As above
CQUIN 9e	Alcohol brief advice or referral	As above	As above

	Indicator	Goal	Provider
CQUIN 10	Improving the assessment of wounds	To increase the number of full wound assessments for wounds which have failed to heal after 4 weeks	BHFT

	Indicator	Goal	Provider
CQUIN 11	Personalised Care and Support Planning	To identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.	BHFT

	Indicator	Goal	Provider
CQUIN 12	A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or	To support the ambulance service to become a community-based provider of mobile urgent and emergency	SCAS

	type 2 A&E Department.	healthcare.	

	Indicator
Local CQUIN for SCAS	An increase in the number of nursing/care homes with access to Live Link

	Indicator
Local CQUIN Bracknell Urgent Care Centre	Sepsis Screening
	Identifying and treatment of URTI (upper respiratory tract infection)

Infection Prevention and Control Provision

The Infection Prevention & Control Nurse (IPCN) (10 hours a week) is working to a plan improving and developing communication networks across provider organisations, CCG settings, and Primary Care. The Infection Prevention & Control Nurse raises awareness and profile of the IPC agenda and develops relationships and networks across the whole health economy in east Berkshire. Education support and advice is given to Primary Care on infection control measures to ensure compliance with Care Quality Commission regulation and to reduce the Health Care Acquired Infections impact in the community. The IPCN and members of the quality team have visited a number of practices for Infection Prevention & Control compliance visits.

There have been 18 practice IP&C audits. The IPCN audits have focused on Practices who;

- had previously had infection control issues raised in a CQC report
- and / or where a CQC inspection was imminent
- and / or the Practice or CCG sought such an audit.

The audit scores ranged from 67% to 98%.

The IPCNs responsibilities include leading all the post-infection reviews for the CCGs (on *Clostridium difficile* infections [CDI], MRSA bacteraemia and Gram Negative bacteraemias).

The IPCN is part of the established infection prevention and control and microbiology networks across Thames Valley and the Frimley Health footprint.

Antimicrobial Prescribing and resistance rates: The IPCN has been working closely with the medicine optimisation and public health team on the antimicrobial prescribing and resistance rates. There is a local Antimicrobial plan to improve antibiotic prescribing within primary and secondary care.

Any lapses and learning or trends seen from post-infection reviews are communicated by the IPCN to the relevant GP Practice and then summarised in the quarterly newsletter which is sent to all Practice staff via the weekly east Berkshire Bulletin. Such information is also included in training sessions provided by the IPCN.

The IPCN is a member of the pan-Berkshire antimicrobial resistance group which meets quarterly and the Thames Valley Infection Prevention group (6-monthly meetings). The IPCN also attends the Infection Control Committee meetings at Frimley Park and Wexham Park hospitals. Issues linking Healthcare Associated Infections (HCAIs) and antimicrobial resistance are reviewed and actions decided at each of these forums.

HCAI statistics: Results of mandatory reporting

MRSA bacteraemias/bloodstream infections (BSIs) for 2017/18:

Month	**Bracknell & Ascot CCG**	**Slough CCG**	**WAM CCG**	**Frimley Health**
April	**1**	0	0	0
May	0	0	**1**	0
June	0	0	0	1
July	0	0	0	0
August	0	0	0	1
September	**1**	0	0	0
October	0	0	0	0
November	0	0	0	0
December	0	0	0	0
January	0	0	0	0
February	0	0	0	1
March	0	0	0	0
TOTAL	**2**	0	**1**	0

***Clostridium difficile* infection (CDI).**

CDI cases by CCG 2017/18:

	B&A CCG (pre-72hr cases)	B&A CCG (post-72hr cases)	Slough CCG (pre-72hr cases)	Slough CCG (post-72hr cases)	WAM CCG (pre-72hr cases)	WAM CCG (post-72hr cases)
Apr-17	1	1	0	1	0	1
May-17	1	0	0	0	3	1
Jun-17	1	0	1	1	1	3
Jul-17	1	0	1	0	1	0
Aug-17	2	0	0	2	2	0
Sep-17	0	0	1	1	1	0
Oct-17	1	0	1	0	0	1
Nov-17	2	0	0	0	2	0
Dec-17	0	2	1	0	1	2
Jan-18	2	0	0	0	3	2
Feb-18	2	0	0	1	0	0
Mar-18	2	0	2	0	2	1
Total	15	3	7	6	16	11
Year total	**18**		13		27	
Objectives	18		22		33	

There were 7 lapses of care identified involving patients from the CCGs from the 2017/18 cases. However it should be noted that there has been a reduction in the numbers reported against the target set.

Local Acute Trust CDI Objectives and CDI Cases 2017/18:

	CDI Objectives 2017/18	CDI ACTUAL cases 2017/18
Ashford & St Peters hospitals NHS Foundation Trust	17	14 figures at end of Feb18)
Frimley Health Foundation Trust	30	44
Royal Berkshire NHS Foundation Trust	26	19

Escherichia coli (E.coli) BSI

Analysis of *E.coli* bacteraemias has been required by CCGs from 1st April 2017 as part of the 2017/18 Quality Premium on gram-negative bacteraemia.

The objective was for a 10% reduction in cases (based on 2016 incidence) in the financial year 2017/18. Table 5 shows the incidence by CCG in 2017/18 against the objectives has risen from the previous year's baseline. Quality team have carried out significant work on reviewing all the bacteraemias and providing feedback and learning to the practices.

E.coli-bacteraemia incidence and objectives 2017/18 by CCG:

Public Health England

Counts or Rates of Infection Episodes

Organisation Name	Code	Apr-2017	May-2017	Jun-2017	Jul-2017	Aug-2017	Sep-2017	Oct-2017	Nov-2017	Dec-2017	Jan-2018	Feb-2018	Mar-2018	Total
NHS BRACKNELL AND ASCOT CCG	10G	4	5	10	8	9	10	7	11	9	12	2	6	**93**
NHS SLOUGH CCG	10T	8	14	10	13	14	6	22	9	9	9	4	9	**127**
NHS WINDSOR, ASCOT AND MAIDENHEAD CCG	11C	10	4	9	11	10	14	13	10	11	14	6	11	**123**
Total		**22**	**23**	**29**	**32**	**33**	**30**	**42**	**30**	**29**	**35**	**12**	**26**	**343**

Summary of findings: An action plan to reduce gram-negative bacteraemias was agreed across the ICS and work on this will continue in the coming year as reductions have not been made in 2017/18. The main focus during the year has been on the reduction in urinary tract infections with patients with or without catheters.

Training activities: Practices must have a robust system in place for ensuring that all their staff attend or complete mandatory infection prevention & control training. Many practices opt to use the on-line updates.

Some Practices requested such an update be provided by the IPCN (mainly to give staff an opportunity to ask questions and get an update that is focused on Primary Care issues; as some of the on-line updates remain quite acute hospital focused).

The IPCN/Quality Team staff provided 13 face-to-face training sessions in 2017/18, training 216 staff. Six of these were at protected learning times and the rest were at individual practices.

Influenza Campaign: Seasonal influenza (Flu) is a key factor in NHS winter pressures. The National Flu Plan aims to reduce the impact of flu in the population through a series of complementary measures. Flu vaccination is commissioned by NHS England for groups at increased risk of severe disease or death should they contract flu.

Key aims of the immunisation programme in 2017-18 were to;

- Actively offer flu vaccine to 100% of people in eligible groups.
- Immunise 60% of children, with a minimum 40% uptake in each school
- Maintain and improve uptake in over 65s clinical risk groups with at least 75% uptake among people 65 years and over and 75% among health and social care workers

The CCG is responsible for quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines. The CCG worked very closely with all partners to support the flu campaign holding regular meeting to understand any gaps, how the campaign was going and sharing of good practice. Additionally, the CCG in 2017/18 was given responsibility for commissioning appropriate primary care clinicians to respond to flu outbreaks, by assessing exposed persons for the antiviral treatment or prophylaxis and completing a patient specific direction for this purpose. The circulating flu was higher this year and there were some outbreaks in care homes. A learning event was held following an outbreak to understand good practice and any learning for future outbreaks. A stakeholder workshop was held in June 2017 which was jointly delivered by CCGs, Screening and Immunisation Team NHS England South, South Central and Berkshire local authority public health teams. Participants from a range of stakeholder organisation attended.

The table below shows that not all areas improved from the previous year and that there still needs to be further work during the yearly campaign to increase the uptake with those people who are at risk.

Flu vaccine uptake among GP registered patient by CCG - Sept 1 2017 to Jan 31 2018 in comparison to 2016-17 time-point.*

CCG	Summary of Flu Vaccine Uptake %					
	65 and over	Under 65 (at-risk)	All Pregnant Women	2 Years old	3 Years old	4 Years old
NHS BRACKNELL AND ASCOT 2017-18	73.5	53.8	55.8	47.0	51.9	n/a
2016-17	70.9	54.0	51.1	49.5	50.5	41.0
2016-17 Variation	2.6	-0.2	4.7	-2.5	1.4	n/a
NHS SLOUGH 2017-18	69.9	47.5	35.9	26.3	28.1	n/a
2016-17	68.2	50.6	40.8	26.7	33.2	25.4
2016-17 Variation	1.7	-3.1	-4.9	-0.4	-5.1	n/a
NHS WINDSOR, ASCOT & M'HEAD 2017-18	70.8	47.5	49.4	44.1	44.5	n/a
2016-17	68.4	47.0	44.5	37.0	44.2	32.3
2016-17 Variation	2.4	0.5	4.9	7.1	0.3	n/a
Thames Valley Total 2017-18	**74.0**	**50.0**	**50.4**	**46.8**	**48.8**	n/a
2016-17	72.1	50.7	47.2	43.3	47.0	38.1
2016-17 Variation	1.9	-0.7	3.2	3.5	1.8	n/a
England Total 2017-18	**72.6**	**48.9**	**47.2**	**42.8**	**44.2**	n/a
	70.4	**48.7**	**44.8**	**38.9**	**41.5**	**33.9**
	2.2	**0.2**	**2.4**	**3.9**	**2.7**	n/a

Data source: **Seasonal influenza vaccine uptake amongst GP Patients in England**

* includes those GP-registered patients who were vaccinated through national community pharmacy scheme or by hospital midwives

In Berkshire, the children's' quadrivalent live attenuated intra-nasal vaccine (LAIV) was delivered in primary schools by a team of school immunisation nurses from Berkshire Health Foundation Trust. The team arranged and carried out visits at around 300 schools across Berkshire, including special schools where all year groups were offered vaccine The BHFT school immunisation team delivered over 40,000 doses of vaccine and succeeded in reaching and exceeding the 40% overall uptake target in every Berkshire Local Authority.

Uptake for school years R, 1, 2, 3 and 4 children[$], by local authority 2017-18

		Bracknell Forest	Reading	Slough	West Berks	RBWM	Wokingham	NHS South Central	England
Reception (age 4-5)	Estimated no. eligible children	1402	1906	2164	1981	1665	1974	42,971	656,251
	Estimated no. of children vaccinated	1110	1330	1157	1575	1370	1820	30,923	410,565
	% influenza vaccine uptake	79.2	69.8	53.5	79.5	82.3	92.2	72.0	62.6
Year 1 (age 5-6)	Estimated no. eligible children	1610	2094	2504	2026	1944	2400	45,617	680,602
	Estimated no. of children vaccinated	1179	1297	1132	1620	1325	1799	31,064	414,317
	% influenza vaccine uptake	73.2	62.2	45.2	80.0	68.2	75.0	68.1	60.9
Year 2 (age 6-7)	Estimated no. eligible children	1557	2081	2515	2098	1963	2282	46,019	682,256
	Estimated no. of children vaccinated	1159	1314	1177	1627	1309	1756	31,339	411,375
	% influenza vaccine uptake	74.4	63.1	46.8	77.6	66.7	77.0	68.1	60.3
Year 3 (age 7-8)	Estimated no. eligible children	1598	2036	2495	2051	1989	2373	45,564	674,105
	Estimated no. of children vaccinated	1093	1206	1079	1539	1275	1745	29,335	387,648
	% influenza vaccine uptake	68.4	59.2	43.2	75.0	64.1	73.5	64.4	57.5
Year 4 (age 8-9)	Estimated no. eligible children	1624	1995	2452	2010	1975	2262	44,119	668,153
	Estimated no. of children vaccinated	1081	1155	1031	1492	1222	1606	27,662	371,927
	% influenza vaccine uptake	66.6	57.9	42.0	74.2	61.9	71.0	62.7	55.7

Data source: Seasonal influenza vaccine uptake for children of primary school age, Provisional monthly data for 1 September 2017 to 31 January 2018 by Local Authority

[$] Data is provisional and represents 100% of all Local Authorities (LAs) in England responding to the January 2017 survey. Where a total for England is quoted (e.g. sum of number of patients registered and number vaccinated) this is taken from the 100% of all LAs and is therefore NOT an extrapolated figure for all of England.

Latent tuberculosis infection screening in Slough

The CCG has continued to build upon its collaborative working with Slough Borough Council and the local voluntary and community sector to raise awareness of latent tuberculosis infection and screening. In addition to raising awareness the ambition for 17/18 was to increase the number of people screened for latent tuberculosis by delivering screening services that were local and accessible. This was supported by a successful funding opportunity from NHSE with the objective for increasing the number of people screened.

The prevalence of TB is reducing but remains high in the UK with Slough having the highest incidence rate in the South East and the highest incidence rate outside of London. A high percentage of TB in England originates from people who unknowingly have latent TB otherwise

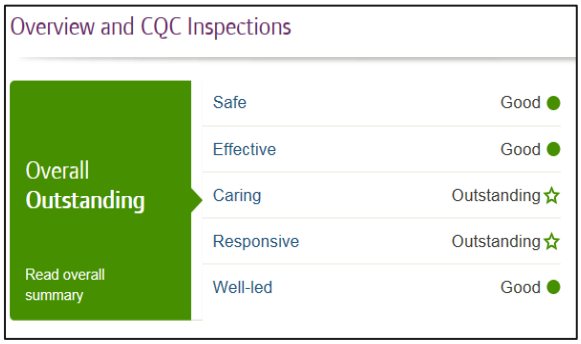
known as sleeping TB. Latent TB has no symptoms and therefore a person may unknowingly have the latent TB infection for many years before the infection activates and becomes active TB. The challenge in Slough is to work with the community most at risk to raise awareness, and encourage people to self-care by having the latent TB screening test so as to treat any latent infection before it becomes active. Early detection and treatment of latent TB is paramount to support better health outcomes and the reduction of TB incidence.

The latent TB service has screened 1070 people this year [April 17-Feb 18] which is a significant increase from the previous 2 years and can be attributed to the expansion of local community based screening clinics, changes to a personalised approach to invitation to screening and improved communication to raise awareness.

In March 2018, the CCG, Frimley Health and Slough Local Authority joined to host a number of events to mark World TB day and of note Slough joined the global “Light up the World for TB” campaign. This included lighting up the Curve. The CCG has also been successful in bidding for support from TB alert to assist in raising awareness through community engagement. This project will be continuing throughout 2018.

Care Quality Commission (CQC) inspections: All the Practices in the CCG are rated as Good or above at the end of March 2018, this is a significant achievement. From 2018 there will be a new inspection regime for General Practice.

RBFT was also inspected by CQC and the report was published in February 2018. Overall they were rated as Good but the Royal Berkshire Hospital was rated as outstanding as shown in the table below:



BHFT also had a number of services inspected by CQC and these service reports can be found on the CQC website.

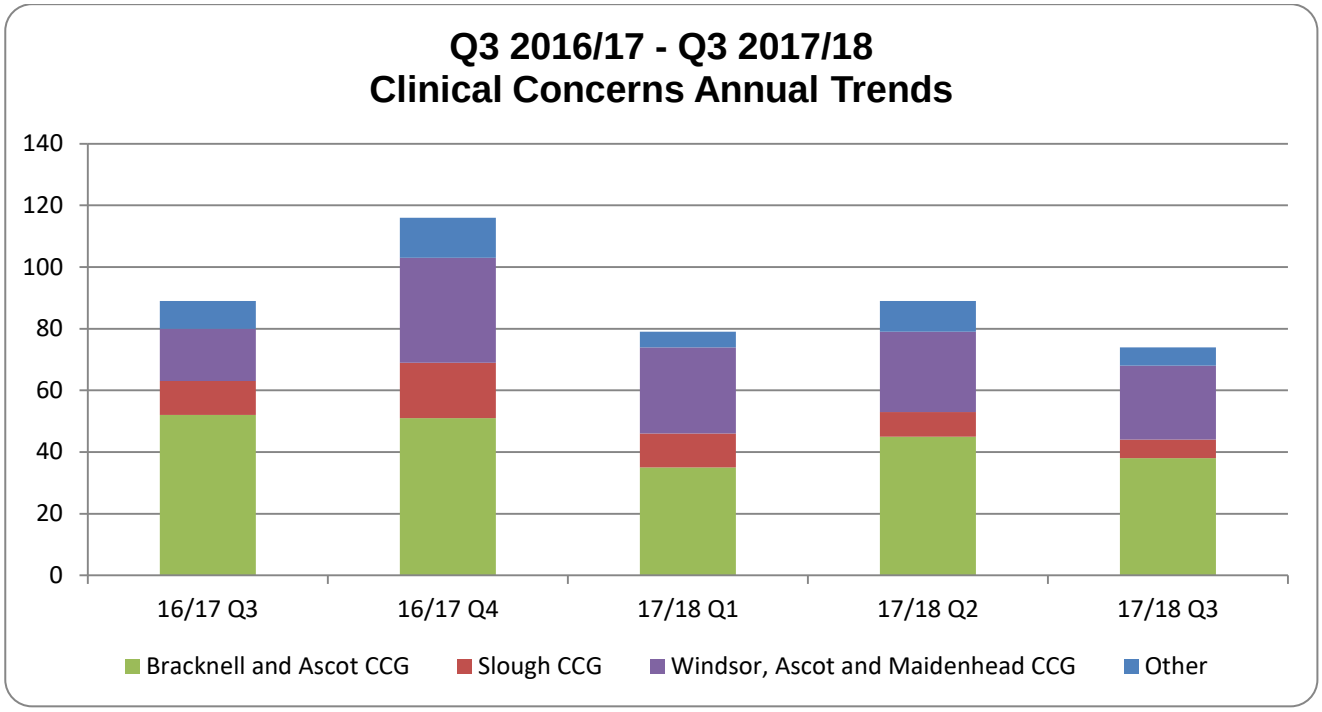
Ashford and St Peter's Hospitals NHS Foundation Trust (ASPHFT) had a CQC unannounced inspection of Medical Wards at St Peter's Hospital which took place in September 2017. The report was published in January 2018. As it was a focused inspection, it did not result in any new domain or service ratings.

Clinical Concerns: The CCG actively encourages GP's reporting of clinical concerns regarding Providers. These concerns are collated on a database and themes identified. The concerns are then raised with Providers and where appropriate actions identified. Some of the themes identified for example in quarter 3 were;

Key themes identified:

- Delay/failure to communicate results to GP
- Quality/content of discharge summary

There has been some key learning through the year from the reporting of clinical concerns.



Patient Experience: the CCG monitors patient experience from our Providers by review at Clinical Quality Review Meetings. There are quarterly patient experience reports from providers that include complaints with themes by Specialty and actions arising, Family and Friends Test outcomes, compliments, Patient Advice and Liaison Service, NHS Choices summary, covering what you said we did. Robust scrutiny by CCG is given to Providers to ensure that there is learning and improvement in the experience of patients. A collated summary report of Provider patient experience including CCG Patient Advice and Liaison Service and complaints is presented at the CCG Quality and Constitutional Committee in order to review Provider performance across East Berkshire.

Friends & Family Test: The NHS Friends and Family Test was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements needed to be made. It is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS.

The Family and Friends Test has been rolled out across most NHS services, including community care, hospitals, mental health services, maternity services, GP and dental practices, emergency care, patient transport and more.

The CCG monitors the Family and Friends Test on a monthly basis via Quality Schedule submission and the review of nationally published data. This is reported quarterly to the CCG

Quality and Constitutional Standards Committee. There is also a staff Family and Friends Test if staff would recommend the service.

Primary Care is also taking part in the Family and Friends Test and this is reported to the Primary Care Quality Improvement Meeting monthly. Practices can use a texting service to patients after they have had their appointment and this has increased the uptake. It is recommended to Practices that they feedback to patients on what they changed following the responses.

Subject Access Requests (SAR): The CCG has responded to a number of Subject Access Requests in the last year. A Subject Access Request is where an individual asks to see a copy of the information an organisation holds about them. This request has to be made in writing and a fee paid. The CCG has 40 calendar days to respond to the request but in some cases a timescale can be negotiated with the requester. The numbers of requests are below

Bracknell and Ascot – 1

Slough – 1

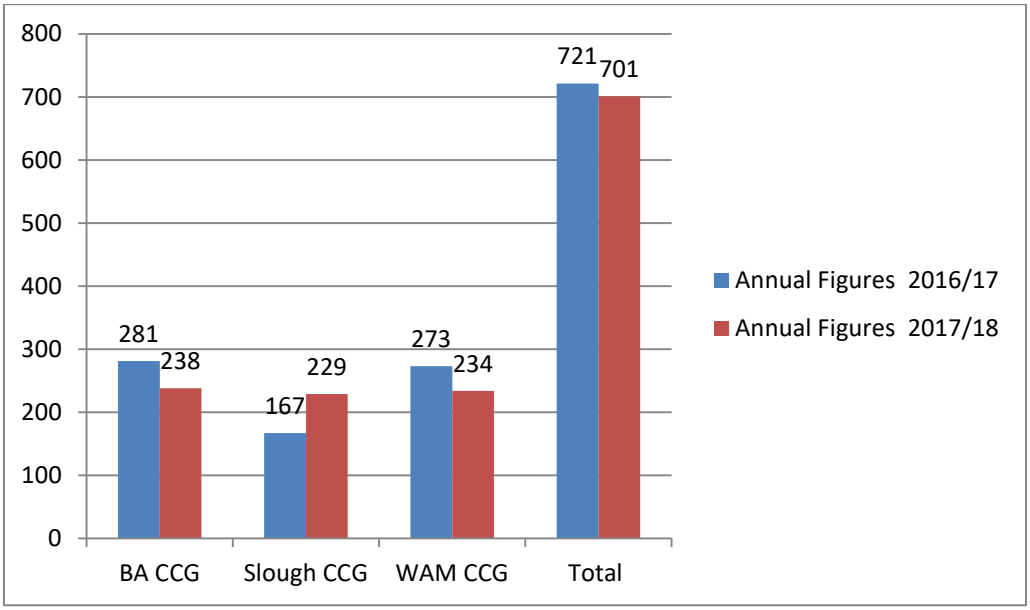
Windsor, Ascot & Maidenhead – 6

Freedom of Information Requests (FOI): Under the Freedom of Information Act and the Environmental Information Regulations a member of the public has the right to request any recorded information held by a public authority, such as a government department, local council or the NHS.

The public can ask for any information they think a public authority may hold. The right only covers recorded information which includes information held on computers, in emails and in printed or handwritten documents as well as images, video and audio recordings.
When making a request the requester should identify the information they want as clearly as possible, however this is not always the case and clarification may be sought from the requester.

The authority does not have to answer a question if this would mean creating new information or giving an opinion or judgment that is not already recorded.
Some information may be withheld because it is exempt, for example because it is commercially sensitive or is scheduled to be published at a future date. Some exemptions are subject to a Public Interest Test.

Providing information under the Freedom of Information (FOI) Act is a frontline statutory requirement and Public Authorities (including CCGs) are required to answer FOI requests within 20 working days. Failure to answer within 20 working days constitutes a breach of the Act.



End of Life Care (EoLC)

The CCG is committed to providing the highest quality care to all of our patients at the end of their lives, as well as supporting their families and carers, to achieve the death that all of us would want: peacefully, with dignity, having our wishes met and being cared for with compassion and respect.

A two-year locally commissioned service for end of life care was launched in April 2017 supporting GP practices in the planned management of the last months/ weeks/ days of a person's life to ensure that they and their family have their dignity and wishes respected. The service aims to identify people likely to be in the last 12 months of life earlier so that they are given the opportunity to have thoughtful, timely conversations with their GP and to plan their care. The patient's advance care plan can be shared and discussed with other health care professionals, allowing their preferences to be known by all those providing their care and facilitating care to be delivered in the place of patient choice, and for more deaths to occur in their preferred place. The end of life locally commissioned service also focuses on the importance of on-going quality supportive education for primary care teams, and encourages continual reflection on areas of good practice and service development in the delivery of end of life care.

In May 2017, an innovative new service provided by the locally-based Thames Hospice was launched. Its aim is to provide advice and guidance to any patient in their last year of life across east Berkshire, for their families and carers, and for other professionals involved in delivering care. This service is also linked to a rapid response nursing team who will visit any patient at the end of their life who is in need of symptom control, crisis management, emotional support or reassurance for them and their family. Both the telephone advice line and the rapid response nursing team are available 24 hours a day, 7 days a week, and 365 days a year. The service is delivered in partnership with other key providers of end of life care such as a patient's GP, district nurse and the community and hospital palliative care teams.

Since its launch, we have seen an increasing number of calls to the advice line and rapid response patient visits. The service is receiving excellent feedback; families feel supported to care for their family member at home to enable the wishes of family members wanting to die at home. The service has contributed to a reduction in unnecessary 999 call outs, avoidable A&E attendances and in unplanned hospital admissions.

An active and engaged steering group meets regularly to provide strategic leadership on EoLC issues and collaborate with providers of EoLC and other stakeholders. The steering group drives forward service and system improvements, taking into consideration wider issues, national strategy, guidance and recommendations.

Since January 2018, a steering sub-group comprising a wide range of stakeholders, including commissioners and providers from the community, hospital and voluntary sectors, has been working towards refreshing east Berkshire's End of Life Care Strategy. Members of the public have the opportunity to get involved in a number of different ways, such as by attending a Patient Panel and responding to surveys that have been set up to inform the strategy. Future plans for the continued development and improvement of end of life care in east Berkshire include the drive towards better systems for information sharing and care pathways to enable integrated working across the Integrated Care delivery model.

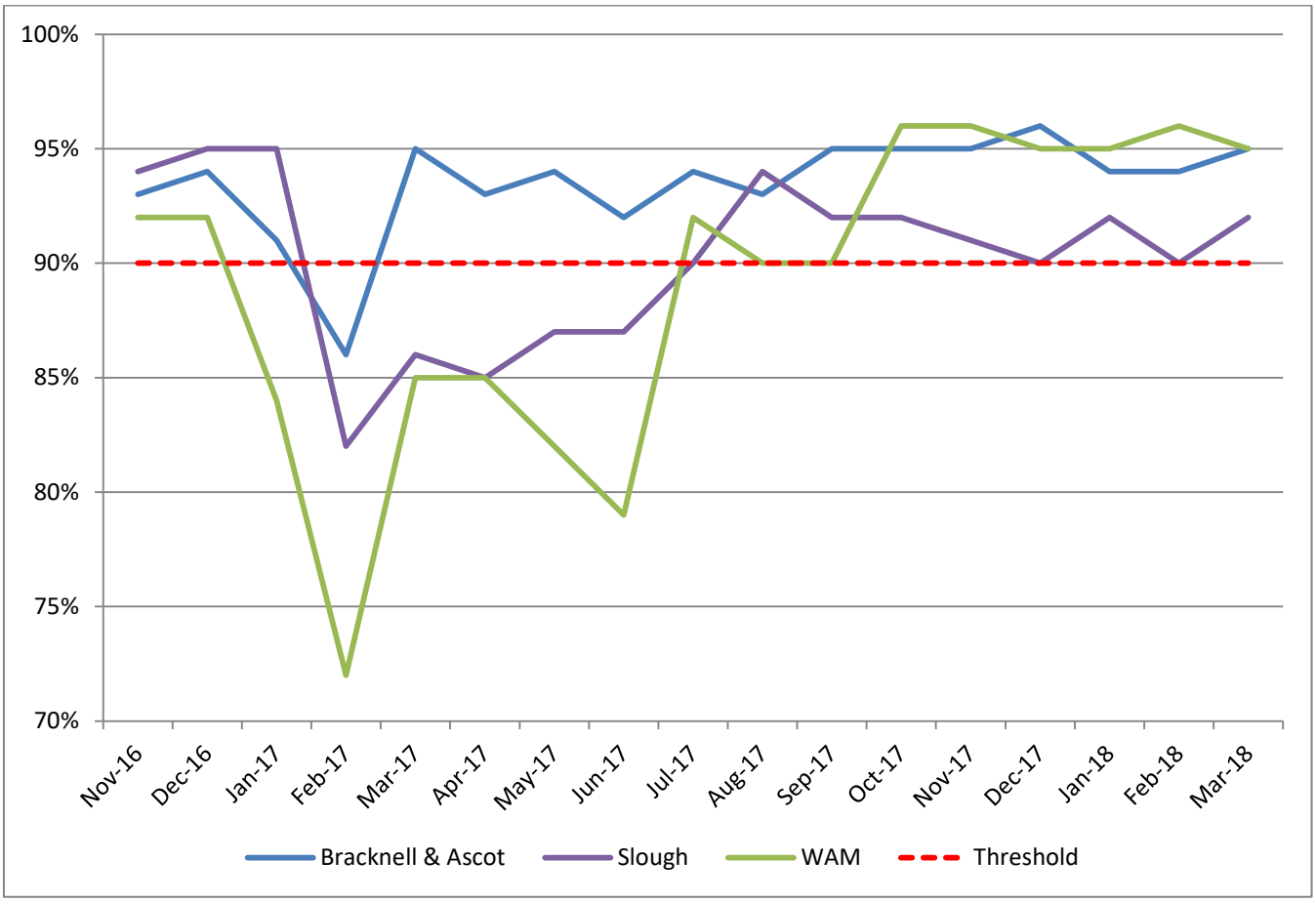
Non Acute Trusts

Berkshire Healthcare NHS Foundation Trust (BHFT)

The Crisis contingency planning for patients on the care programme approach (CPA) have been reviewed at the Clinical Quality Review meeting. The graph shows that the Trust has

been performing under the threshold since January 2017 across the 3 areas in east Berkshire. This is due to a change that was made to the CPA. The change was implemented in order to improve the quality of the CPA and ensure that the information within it is more meaningful.

It was anticipated that there would be a drop in performance whilst improvements were made to the Safety Plans. The Trust has been working very hard to improve the results on a monthly basis. Bracknell & Ascot has maintained 94%-96% for several months. WAM has seen a significant improvement in October and November with 96% for both months and have maintained the high result for the previous three months. Slough is the only area that is still just over the 90% threshold.



Serious incidents

BHFT – 68 Serious Incidents reported 2017/18	
Reported in Q1	15
Reported in Q2	15
Reported in Q3	21
Reported in Q4	17

Never Events	0

Types of Incidents	
Abuse/alleged abuse of adult patient by staff	2
Abuse/alleged abuse of adult patient by third party	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1
Apparent/actual/suspected homicide meeting SI criteria	2
Apparent/actual/suspected self-inflicted harm meeting SI criteria	26
Commissioning incident meeting SI criteria	1
Confidential information leak/information governance breach meeting SI criteria	19
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	3
Medication incident meeting SI criteria	1
Pending review (a category must be selected before incident is closed)	3
Pressure ulcer meeting SI criteria	1
Slips/trips/falls meeting SI criteria	7
Treatment delay meeting SI criteria	1

South Central Ambulance Service NHS Foundation Trust (SCAS)

999 Service

SCAS was issued a Contract Performance Notice (CPN) during January 2017 in the 2016/17 contract relating failure to refer patients to the falls services. A CPN was also issued in the same month for failing to respond to complaints and clinical concerns within the specified timeframe. Since the CPNs were issued, the response times to complaints and clinical concerns has significantly improved. SCAS still remain under the threshold for referring patients to the falls service however; there is an action plan in place to make this a mandatory electronic referral which should then improve the results.

Non-Injury Falls

The Trust has completed a piece of work to look further into those patients who are reporting non-injury falls in order to strengthen the utilisation of other services, such as fire services, to facilitate the growing demand. These are people that have fallen, in their own home and

require assistance in getting up but do not require medical treatment. There are on average 1220 of these types of calls that occur within the SCAS catchment area which equates to approximately 3% of the SCAS demand. In comparison to this time last year, there has been an increase in the number of these calls coming through. The most common times for these calls are between the hours of 07:00-10:00 and the highest numbers of calls are from those patients aged over 81; however there does not appear to be any correlation in the month, the day of the week, or gender.

Patient Transport Service (PTS)

There has been a significant increase in the number of incidents reported by Health Care Professional feedback (HCPF) since April 2017 although these have started to decline again since December 2017.

Current HCPF status

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	**Mar-18**	**Total**
New	62	96	142	92	139	195	195	232	170	153	148		**1573**
Open	0	0	0	0	0	0	0	0	0	3	1		**45**
Closed	**62**	**96**	**142**	**92**	**139**	**195**	**195**	**232**	**170**	**150**	**147**	**66**	**1602**

There is some work that is currently underway to improve the quality of the responses to the HCP feedback forms. Whilst most of the forms are responded to within the specified timeframe, there are a large number that have a standard response which is limiting the learning that can be gained from these incidents. SCAS is currently working with commissioners on an action plan in order to make the responses more meaningful to the providers that are submitting the forms.

HCPF - by Category

	Total for the year
Delay/Non-Attendance	**1513**
Other	**77**
Communication	**78**
Patient Care/Handling/Property	**41**
Staff Attitude	**17**
Driving Standards	**2**
Total	**1728**

An action plan has been developed to help mitigate the delay/non-attendance incidents and work has begun to address the 4 main root causes which have been identified as resources, communication, planning and managing expectations.

Serious incidents

SCAS – 14 Serious Incidents reported 2017/18 (11 for Ambulance Service and 3 for 111)	
Reported in Q1	3
Reported in Q2	3
Reported in Q3	1
Reported in Q4	7
Never Events	0

Types of Incidents	
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1
Maternity/Obstetric incident meeting SI criteria: mother only	1
Medication incident meeting SI criteria	1
Slips/trips/falls meeting SI criteria	1
Sub-optimal care of the deteriorating patient meeting SI criteria	4
Treatment delay meeting SI criteria	5

Site of Incident	
Patients Home	10
Public Place/Street	3
Unknown	1

Acute Trusts

Frimley Health

There have been a number of areas that the CCG has been working closely with Frimley Health on.

- **Cardiology**: The concerns arose following several serious incidents involving surgical procedures in Cardiology, complaints, mortality reviews. The Trust initiated an internal

review of the department and identified a number of areas for improvement which they have been working on during the year

- **Maternity**: The ICS has implemented a "Local Maternity System Better Births Implementation Plan" linked to the recommendations of the national maternity review, 'Better Births' - Improving Outcomes of Maternity Services in England: A Five Year Forward View for Maternity Care'. This is overseen by an ICS Local Maternity System Board, supported by a subsidiary Maternity Safety Task and Finish Group
- **Pathology:** There have been concerns raised by GPs about the performance of the pathology service run by Berkshire and Surrey Pathology Service (BSPS), a joint enterprise which comes under the governance of FHFT. The Quality Team looked at two strands of information which showed differing pictures: A quality assurance visit and meeting with all providers using the service and commissioners is to be held to understand the concerns and if appropriate an improvement plan.

Serious Incidents

Year	FPH				HWPH				FH Financial Year Total
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
2015/16	6	6	11	8	9	12	12	9	**73**
2016/17	11	5	10	16	9	5	8	10	**74**
2017/18	9	14	14	12	18	21	17	19	**124**

There has been an increase in Serious Incident (SI) reporting during 2017/18. Some of this has come from enhancements to the Trust's incident identification processes, particularly their mortality review process which complies with the guidance issued by NHS England in March 2017. The Trust's overall engagement with incident reporting has also increased as shown by an improved position in the national benchmarking data produced from the National Reporting and Learning System. The implementation of the National Early Warning Score (NEWS) and enhanced protocols for the escalation of deteriorating patients has also led to an increase in the reporting of 'deteriorating patient' SIs at the Wexham Park site; the higher standard set by these new protocols has served to expose cases where deficiencies in the management of a patient may not previously have been identified. There has been a series of Maternity SIs at the FPH site and the Trust is currently awaiting the outcome of an external thematic review of these cases.

Royal Berkshire NHS Foundation Trust (RBFT)

The CCG has been working closely with the RBFT on

- **Ophthalmology:** Failures in the process for scheduling clinical follow-up were identified in Serious Incidents and an observational quality visit was undertaken by the Quality Team in October 2017. This concluded that routine assurance would continue to be needed on this issue. There have since been two further Serious Incidents in March 2018. A special focus on Ophthalmology was included in the March.

Serious Incidents (SIs)

RBFT SIs	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
No.	2	4	5	5	1	3	3	7	8	11	8	9	**65**

The largest numbers, by category of SI, have been:

Maternity/Obstetric incident meeting SI criteria: mother only	13
Slips/trips/falls meeting SI criteria	16
Treatment delay meeting SI criteria	16

Ashford and St Peter's Hospitals NHS Foundation Trust (ASPHFT)

Serious Incidents (SIs)

Oversight of SIs is undertaken by the co-ordinating commissioners (North West Surrey CCG), who liaise with us directly on cases involving East Berkshire CCG patients. There were three cases in 2017/18 involving EBCCG patients:

- 2017/14327 (June 2017) Allegation of abuse of adult patient by a member of staff. Case under Police investigation
- 2017/24536 (Oct 2017) Patient fall resulting in fractured neck of femur.
- 2017/30701 (Dec 2017) Pressure ulcer category 3

There has recently been a series of SIs reported about post-procedure infections in Ophthalmology; while it does not look like these cases involve East Berkshire patients, we are in contact with the co-ordinating commissioners for further emerging detail and assurances around the quality and safety of this service.

Reducing Health Inequality

The CCG is committed to address inequalities in outcome and achieve fair and equitable access to health services. The CCG is committed to upholding the NHS Constitution which outlines a number of commitments and pledges to uphold patient dignity, equality and diversity and human rights on all aspects of commissioning, employment practice, and engagement and involvement.

The CCGs population profile differs from the national picture with a larger proportion of children aged 0 to 14 and younger adults aged 25 to 44, but a smaller proportion of adults aged 45 and over. 29% of the CCG's total registered population are under 19.
The CCG's resident population is 147,181 people and estimated to increase to 162,100 by 2039, which is a 5% percentage increase. The most significant population change is in older adults aged 65 to 84 and 85 and over.

Life expectancy at birth for men is 78.5 years, which is significantly worse than the national figure of 79.2 years. Life expectancy at birth for women is 82.7 years, which is similar to the national figure of 83.0 years.
The prevalence of cardiovascular diseases, cancer, respiratory diseases, diabetes, chronic kidney disease, dementia and depression is lower than the national prevalence rates. The prevalence of diabetes is higher.

The CCG had 8,144 potential years of life lost (PYLL) considered amenable to healthcare on 2012-14. This is a rate of 2,460 PYLL per 100,000 registered population, which is significantly higher than the national rate. Ischaemic heart disease is the main cause of PYLL in the CCG at 36.0% in 2012-14

The CCG has worked closely with public health in understanding the health needs of the different communities, including those that may otherwise be hidden. The CCG has worked with community groups and developed joint plans with local authority to improve outcomes and reduce inequalities. Details are in the table below.

Strategy	Local Theme	CCG plan	BCF Plan
Slough Wellbeing Strategy	Protecting vulnerable Children	Safeguarding of vulnerable people, care homes, carers	Care Home Quality Project across East Berkshire BCFs; Carers' service (Signal)
	Increasing life expectancy by focusing on inequalities	Cancer, Cardiology, diabetes	Integrated cardio prevention scheme, Memorandum of understanding for Carers across East Berks BCFs
	Improving mental health and wellbeing	Mental health and prevention services	Dementia care advisors, support to carers, community capacity building/wellbeing prescription
	Housing		Disabled Facilities Grants

Health and Wellbeing Strategy

In 2017/18 the CCG contributed £8.4m towards the pooled budget in support of the Slough Better Care Fund programme. The Better Care Fund Plan 2017-19 sets out the finance and activity to be undertaken by the CCG to deliver to objectives of the health and wellbeing strategy, within the agreed NHSE framework.

The plan is signed off by the Slough Wellbeing Board, and progress is reviewed regularly through the Health Partnership Delivery Group, and quarterly updates to the Board. In 2017/18, the CCG's contribution supported delivery of the programme by funding schemes across Slough including the falls prevention programme, short term rehabilitation and reablement services, integrated cardio wellness services, telehealth and telecare schemes, a

responder service, enhanced support to care homes, support for carers and for residents diagnosed with dementia.

This investment is also helping to deliver the aims of the Slough Wellbeing Strategy which include improving health and wellbeing, reducing gaps in life expectancy and the commissioning of better, more integrated and efficient health and social care services. The Strategy is focussed on four key priorities to improve the health and wellbeing of the people in Slough:

1. Protecting vulnerable children
2. Increasing life expectancy by focusing on inequalities
3. Improving mental health and wellbeing
4. Housing

It support the Council in objectives set in its 5 year plan which include:

- Slough children will grow up to be happy, healthy and successful and
- Our people will be healthier and manage their own care needs

Slough 5 year plan	Slough children will grow up to be happy, healthy and successful	CAMHs services	Children's community asthma service
	Our people will be healthier and manage their own care needs	Diabetes prevention programme, , physical inactivity project, smoking cessation, weight reduction, Personal health budgets	Integrated cardio wellness service, complex case management, telehealth, telecare, wellbeing prescribing

ACCOUNTABILITY REPORT

John Lisle

Accountable Officer

Slough CCG

25 May 2018

Corporate Governance Report

Members Report

Dr Jim O'Donnell has been a full time GP in the area and is the Clinical Chair of the CCG. The Accountable Officer, John Lisle has been in post since 3 May 2016.

Clinical Chair Dr Jim O'Donnell	Dr O'Donnell qualified at the National University of Ireland, Galway, in June 1978 and completed his General Practice training in Portsmouth in 1982. He worked in tertiary referral medicine in Baghdad, Iraq from 1984 to 1988 followed by a cardiology research post at Wexham Park Hospital (UK) involving the first use of thrombolysis in acute myocardial infarction. This led to a career in the pharmaceutical industry involving novel treatments for ischaemic heart disease. He continued as a GP and was involved in the development of new medicines up to 1998 at which time he returned to full-time general practice in Slough and had a key interest in clinical governance and education in primary care. In 2007 he became the Slough Locality Lead and shortly after in 2008 he became Chairman of the Clinical Executive Committee at Berkshire East PCT. Jim is also a member of the NHS Commissioning Board "Sounding Board" and has been involved in drawing up plans for the Commissioning Assembly.
Lay Member for Primary Care Professor Clive Bowman	Professor Clive Bowman CSci FRSM FRSS FLS moved to Slough in 1979. He is married with one adult daughter and shares full-time caring for an 85 year old living in Maidenhead, where he ran a medical business for more than 10 years. He is Lay Chair for the Primary Care Co Commissioning Committee Meetings. He is a research scientist being a Royal Society Industrial Fellow at Mathematical Institute University of Oxford. He has

	held a variety of UK and EU senior pharmaceutical industry, government regulation, academic body and governance committee posts. An unusual fact is that he is an enthusiastic motorcycle rider.
GP member Dr Sivakumary Sithirapathy April 2017- 30th June 2017	Dr Sivakumary Sithirapathy has been working as a GP at Wexham Road Surgery since 1999. Prior to this, she worked mainly in Obstetrics and gynaecology, sexual health and family planning, and paediatrics and was awarded MRCOG in 1996. She was involved with a redesign of East Berkshire maternity services in 2010, and was involved in community gynaecology services. She is the Slough clinical commissioning lead for dermatology and plastic surgery. Interested in the care of the elderly, she is the lead for care homes, including intermediate care, to ensure a smooth transition from acute to the community by being involved in the discharge work team. She is the Slough commissioning lead for end-of-life patient care.
GP member Dr Nithya Nanda 1st July 2018 – to date	Dr. Nithya Nanda graduated from Bangalore Medical college, India in 2000 and underwent extensive medical rotational training in various specialties in the UK from 2001 till 2006, attaining MRCP (UK) in 2006. Having worked clinically in Cardiology, Diabetes and other allied medical specialties in Heatherwood and Wexham Park hospital NHS trust, he started General Practice training, and qualified as a MRCGP (UK) in 2008. He is currently a GP Principal in Farnham Road Practice, Slough, and represents Slough as the GP Governing Body member. Nithya is also a Clinical Lead GP for Diabetes and Cardiology for the East Berkshire CCG. He actively contributes to various commissioning projects i.e. Diabetes Transformation program, National Diabetes prevention program and Reducing variation in Cardiovascular work stream across the Frimley STP.

Local Authority Member Director of Adult Social Services, Slough Borough Council Alan Sinclair	Alan Sinclair is a non-voting member of the Governing Body**.** He has a wealth and depth of experience working and leading across all aspects of adult social care. Extensive experience in senior management roles leading on operational and commissioning responsibilities. An excellent track record of successfully managing change, budget control and improving outcomes for people. Delivered improved performance, efficiency savings and excellent experience in working in partnership particularly with the NHS and with people who use services November 2014 to date
Accountable Officer John Lisle	John Lisle joined the NHS in 2007 as a Non-Executive Director with Buckinghamshire PCT and later as Head of Operations for Imperial College NHS Trust. Prior to this he had a commercial career in the pharmaceutical industry, initially with AstraZeneca, then with GSK where he was UK National Business Director, and more recently as CEO of two medicines/devices companies. He graduated in Natural Sciences and has maintained an interest in the scientific developments within healthcare ever since. He lives in Chalfont St Peter with his partner and two children. Joined the CCG from 3 May 2016 to date
Director of Finance and Performance Nigel Foster	Nigel has been working in the NHS since 2002, originally with Wokingham PCT and then NHS Berkshire West where he held a variety of senior finance roles. From March 2012 he led the formation of Central Southern Commissioning Support Unit (CSCSU) and became their Chief Finance Officer. He joined the CCGs in East Berkshire in November 2013. In August 2017 he was appointed by Frimley Health NHS Foundation Trust to be their Director of Finance, but he continues to have strategic oversight of the of the CCG's finances in his new role and is formally seconded to East Berkshire CCG as our Director of

	Finance on a part-time basis. Nigel is a CIPFA qualified accountant who started his career with Oxfordshire County Council before a spell in the private sector working for the business process outsourcing firm Liberata, where amongst other things he managed a pan-European shared service centre for a subsidiary of ICI. He is now heavily involved in working with colleagues across the Frimley Health Integrated Care System, and also leads the 'Connected Care' IT interoperability project in East Berkshire which is enabling the sharing of patient records between primary, secondary and social care.
Director of Nursing Sarah Bellars	Sarah has worked in the NHS for nearly thirty years and the majority of which has been in Berkshire. Sarah trained at St Bartholomew's Hospital in London and worked on the HIV ward after qualifying. She spent the next 10 years of her career working in women's health and acute medicine at the Royal Berkshire Hospital. During her time in the acute setting she trained to be an Infection Prevention and Control Nurse and developed tissue viability skills. Sarah then moved to a community provider as Specialist Infection Prevention and Control Nurse. During this period she set up a community tissue viability service and developed the community Intravenous therapy team. Whist working with the community provider she moved in into senior nursing leadership and quality governance. Following a merger between the community provider and the mental health trust Sarah worked for Berkshire Health Foundation Community and Mental Health Trust focussing on patient safety and quality governance. She then moved to South Central Strategic Health Authority as Deputy Director of Nursing and Safeguarding, before taking up her current role as Director of Nursing and Quality for the CCG in February 2013.
Director of Strategy and	Fiona has over 25 years' experience in the NHS in Berkshire working as a Podiatrist and more recently in range of senior

Operations Fiona Slevin-Brown	leadership roles. She has worked at Director and Executive level in a range of NHS Commissioning and Provider organisations including the independent sector. Fiona brings passion and energy to her role in the CCG and to improving health outcomes for local people. Her wealth of knowledge and experience combined with a commitment to effective collaboration with partners has resulted in the successful delivery of transformed models of care in East Berkshire.
Medical Director Dr Lalitha Iyer	Dr Lalitha Iyer has been working as a GP Partner at the Farnham Road Practice in Slough since 2007. She has a special interest in Obstetrics and Gynaecology and is the Women's Health lead for Slough CCG. She is also the GP lead for FGM in East Berkshire. Initially qualifying as a gynaecologist, she worked in the gynaecology department at Wexham Park Hospital (Frimley Trust) for 10 years with a special interest in Colposcopy and cervical screening programmes. Following this, she trained to be a general practitioner. She has been the Paediatric lead for Slough CCG and was involved in the paediatric asthma project to improve the health of children with asthma. She has led on various cancer related projects for Slough and was involved with Macmillan cancer in their project on promoting increased screening uptake in Slough. Her passion for reducing health inequalities is reflected through her involvement in community health events with local charities in the population served, including ethnic minorities. She was involved in starting the first cancer support group for ethnic minorities in East Berkshire jointly with Macmillan and a local charity. Working for many years in the NHS hospital environment and

	then within the community gives her a unique advantage in understanding the issues in both these settings and provides her with the ability to contribute to the improvement of patient care and health outcomes.

Members profiles

1. 40 Ragstone Road
2. 240 Wexham Road
3. 242 Wexham Road
4. Avenue Medical Centre
5. Bharani Medical Centre - Lansdowne Avenue
6. Bharani Medical Centre - Bath Road
7. Slough Walk-In Centre – include The Chapel Medical Centre
8. Crosby House Surgery
9. Farnham Road Practice - Farnham Road
10. Farnham Road Practice - Weekes Drive
11. Cippenham Surgery
12. Herschel Medical Centre
13. Kumar Medical Centre
14. Langley Health Centre
15. Manor Park Medical Centre - Lerwick Drive
16. Manor Park Medical Centre – Princes Street- closing on the 15th December 2017
17. The Orchard Practice – Willow parade require a map identifier
18. Shreeji Medical Centre
19. Upton Medical Partnership- Sussex Place- due to close in April 2018
20. The Village Medical Centre

Committee(s), including Audit Committee

The CCG has a Joint Federated Audit Committee. The Committee has the responsibilities to ensure that the activities relating to NHS Bracknell & Ascot CCG; NHS Slough CCG and NHS Windsor, Ascot & Maidenhead CCG are managed in accordance with the law and regulations governing the NHS by carrying out specified duties.

The Committee comprises of at least three lay members, one from each CCG who have responsibility for governance from the Governing Body in Common. Whilst not mandatory, the Governing Body Chair from each CCG will be invited to attend meetings of the Committee to review the annual accounts, but shall not be members of the Committee.

The Director of Finance and Performance and or their Deputy of the three CCGs will be invited to attend meetings of the Committee, as and when required by the Committee, but shall not be a member of the Committee.

The Accountable Officer is invited. The Committee comprised of three lay members who have responsibility for governance (or their deputy) from each of the CCGs.

The lay members are:

- Arthur Ferry (Chair and Lay Member for Governance of Windsor, Ascot and Maidenhead CCG)
- Sally Kemp (Vice Chair and Lay Member for Governance of Bracknell and Ascot CCG)
- Clive Bowman (Lay Member for Governance Slough CCG)

Register of Interests

All governing body members, senior managers and General practitioners who are involved in the CCGs business are required to declare their interests. The Registers of Interests are maintained and published on the https://www.eastberkshireccg.nhs.uk/

Personal data related incidents

The CCG has investigated 10 incidents which have been assessed using the HSCIC's Checklist for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incident Requiring Investigation. Eight incidents were assessed as SIRI Level 1 incidents which were non-reportable. Two incidents were assessed as SIRI Level 2 incidents which were reported externally via the CCGs IG Toolkit which automatically notifies the HSCIC, Department of Health and the Information Commissioners Office

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 needed 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

Slough CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not met the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

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 John Lisle to be the Accountable Officer of Slough CCG since May2016.

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 accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with 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 financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and

fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (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

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Governance Statement

Introduction and context

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

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

As at 1 April 2017, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 / is subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 and is licensed without any conditions.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in managing public money. I also acknowledge my responsibilities as set out 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 CCG is a clinically led organisation with strong clinical engagement from GPs through its Assembly of Members, which had been in place in 'shadow form' and operating successfully well before the licencing of the CCG. The Assembly of Members was selected and then appointed its Governing Body and delegated to it the power to develop the strategic direction of the CCG and to conduct the overall management of the CCG. The Governing Body has been in place since its inception on 1st April 2013 and has provided the leadership and stewardship of the CCG, including a governance framework which ensures transparency, accountability and probity. The CCG has worked on a coordinated plan to create the CCG's vision, values and priorities and to develop the governance framework, financial plan and five year strategic plan.

GP Assembly (Assembly of Members)

As a clinical led membership organisation 'Members' participate in the work of the CCG through the GP Assembly. Practices have selected appropriately qualified and competent Members to represent their practice at the GP Assembly meetings. The GP Assembly is the forum for Member practices to give direction, inform and approve the commissioning and financial plans for the population of Slough.

Meetings of the GP Assembly are held on a monthly basis and are well attended; a register of attendance is taken at every meeting to ensure that the high level of practice engagement established is maintained. Member practices actively participate and contribute to shaping commissioning intentions and plans, as well as using their clinical expertise and experience to inform the development of clinical pathways and the delivery of services. Their Clinical leads for key service redesign work such as Dementia, Dermatology and Cardiology etc. The need for the clinical lead is identified at the GP Assembly meetings. The post is then advertised and then

an individual is selected; this ensures that there is a broad and inclusive approach across member practices in the work of the CCG.

The GP Assembly's remit and responsibilities are clearly defined in the CCG Constitution; there are a number of matters that are reserved for decision by the Assembly. A decision can only be carried when 75% of votes are cast at a meeting of the GP Assembly. When a vote is taken it is formally recorded in the minutes of the meeting, which are distributed to all member practices.

The matters reserved to the GP Assembly cover:

- applying to NHS England to amend the CCG Constitution, except to the extent that such amendments are required by law or regulations
- change the vision or values of the CCG or doing anything that is inconsistent with them
- change the geography
- change the name of the CCG
- merge with any other clinical commissioning group
- remove any Member for any reason (for example a Member breaching the policy for managing conflicts of interests, for failing to comply with decisions of the Governing Body or for consistent and/or flagrant breaches of the CCG Constitution)
- Approval of the annual operational plan and the commissioning strategy/plan which are recommended by the Governing Body
- Entering into certified externally financed development agreements
- Extension of terms of members of Governing Body in exceptional circumstances

Governing Body

The three CCGs (Bracknell & Ascot CCG, Slough CCG and Windsor Ascot & Maidenhead CCG) in January 2017 undertook governance review and had subsequent discussions at the Joint Governing body meeting on 8 February 2017 and 26 April 2017, where it was agreed to have a single Governing Body in Common for all three CCGs. This decision was subsequently shared and presented at each of the CCG membership meetings in February 2017 and was consequently approved to

have Governing Body in Common form April 2017. The purpose of the Governing Body in Common is to work collaboratively to ensure that the CCGs commission services to improve the health of the population in its geography and for patients registered with Members' practices as cited in each of the CCGs Constitution.

Each CCG has agreed to operate a single Governing Body in Common to which it delegates the power to develop the strategic direction of the CCGs, provide assurance and conduct the overall management of the CCGs, having taken account of all relevant statutory requirements and Department of Health and NHS England guidance. The Governing Body in common will ensure there is quality and value for money for the commissioned services for the population in its geography. The single Governing Body in Common was established in April 2017 and the role is as follows:

- To work collaboratively to ensure that the CCGs commission services to improve the health of the population in its geography and for patients registered with Members' practices as cited in each of the CCGs Constitution
- Each CCG has agreed to operate a single Governing Body in Common to which it delegates the power to develop the strategic direction of the CCGs, provide assurance and conduct the overall management of the CCGs, having taken account of all relevant statutory requirements and Department of Health and NHS England guidance
- Will ensure there is quality and value for money for the commissioned services for the population in its geography so as to improve the overall health outcomes

The Governing Body in common has established a Clinical Leadership team. This is a forum for clinical GP Governing Body members and other clinical leads to review the current and future clinical issues affecting local people in the context of the CCG and wider collaborative priorities. It will also provide an opportunity for clinicians to explore and make recommendations to the Business Planning and Clinical Commissioning Committee on opportunities to adopt new and emerging innovations. The objective of the group is not only to directly inform the CCGs commissioning plans, but also to make formal recommendations to the Business Planning and Clinical Commissioning Committee. The forum will provide the Committee with supporting information used to inform these recommendations and will provide

assurance on its actions to deliver the objectives of the individual CCG.

The CCG has continued to develop and improve the organisational structures through its organisational development initiatives which have focused on the CCG's committee, risk and governance structures, as well as collaborative work across the three CCGs in East Berkshire (i.e. Bracknell & Ascot CCG, and Windsor Ascot & Maidenhead CCG), and with key stakeholders (Slough Borough Council , The Royal Borough Windsor and Maidenhead, Frimley Health NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust etc.) including patients and the public.

The constitution for the CCG is available on the organisation's website: https://www.eastberkshireccg.nhs.uk/

The CCG's governance arrangements, agreed by the membership GP practices and set out in the CCG's constitution, gives the Governing Body the power to lead and manage the CCG on the members' behalf. The Governing Body has a responsibility to ensure there are appropriate healthcare services for the resident population.

As the Accountable Officer, I work closely with governing body members on delivering the strategy and objectives of the CCG and much of this work is coordinated by the Governing Body and Clinical Leadership & Innovation Forum. Importantly, the strong partnership working with The Slough Borough of Council has been in place for a number of years and provides a solid basis for integrating health and social care, by using the Better Care Fund (BCF) policy framework and funding, alongside the Health and Wellbeing Board to strategically drive greater integration. This collaborative working is further enhanced through representation of the Director of Adult Social Care (Slough Borough Council) on the Governing Body. In conjunction with the CCG Chairman, an annual work programme is developed and the agenda for each meeting is agreed between us.

The Governing Body membership is predominantly clinical:

- Three GPs (including the Chairman)
- Secondary Care Consultant
- Director of Nursing & Quality (joint post)

- Accountable Officer (joint post)
- Director of Finance and Performance (joint post)
- Director of Strategy & Operations (joint post)
- Lay Member for Governance
- Lay Representative and Chair Primary Care Co-Commissioning (co-opted)
- Director of Adult Social Care (non-voting rotation -one representative from each of the local authorities)

The scope of the Governing Body's accountabilities and responsibilities are clearly articulated in the CCG's Constitution. The Governing Body met in public on 3 occasions during 2017/18 to consider; debate and agree commissioning and financial plans, service developments and policies amongst many other business matters. Over the past year, there has been good attendance at all the meetings. The quoracy is as follows:

- six clinical representatives with at least one clinical representative from each CCGs
- two lay member representatives
- two Executive members (Medical Director and the Director of Quality and Nursing are Executive as well as Clinical for quoracy purposes)

Collaborative working

The three CCGs (Bracknell and Ascot CCG, Slough CCG and Windsor, Ascot and Maidenhead (WAM) CCG) have agreed to work together in a collaborative model to successfully deliver their accountabilities through joint arrangements. They will focus on key shared priorities for example the 5 year System wide Sustainability Transformation Plan, negotiating provider contracts and large scale transformational change initiatives (such as New Vision of Care (NVOC) which is reviewing care for frail citizens). This allows for the three statutory organisations to operate as separate entities (i.e. each as the commissioning leader of the local health system), whilst enjoying the benefits of cooperation and support provided by the collaborative arrangement.

A Memorandum of Understanding (MOU) was produced and incorporated into each CCG's constitution, which describes how the three CCGs work together to fulfil their

statutory duties in an effective, efficient and economical way. The MOU also explains the arrangements for the CCGs appointing a joint management team such as Accountable Officer, Director of Finance and Performance, Director of Nursing & Quality and Director of Strategy & Operations as well as other key management roles. This is to enable efficient and economical use of resources, and expertise to be shared across the three CCGs.

Similar principles of shared resources and expertise underpin the establishment of the joint committees and working groups which cover CCG responsibilities in relation to quality of services, financial audit and service improvement. The following committees and groups are shared across the three CCGs:

- Joint Federated Audit Committee
- Joint Remuneration Committee
- Information Management and Technology (IM&T) Committee
- Quality and Constitutional Standards Committee
- Business Planning and Clinical Commissioning Committee
- Finance, Quality Innovation Productivity and Prevention Committee

Partnership forums

- Accident & Emergency Delivery Board (previously known as System Resilience Group and urgent care sub-groups (system wide arrangements)
- System Leaders Group (system wide group)
- Health and Wellbeing Boards (partnership board chaired and organised by The Royal Borough of Windsor and Maidenhead)
- Community Partnership Forum
- Joint Co-Commissioning Committee for Primary Care

Joint Federated Audit Committee

The Joint Federated Audit Committee comprises the Lay Member for Governance and the Lay Member for Patient and Public Involvement (PPI) from each of the three CCGs. The Lay Member for Governance (WAMCCG) is the Chairman. The Committee met on 6 occasions throughout the year and the quoracy is to have at least one CCG representative in attendance at each meeting (including via conference call), this was met on 4 occasions. The quoracy was not met on 5th May

2017 and 8 September 2017. On these occasions email approval was sought by the absent CCG lay member for decisions taken at the meeting.

The Joint Federated Audit Committee is responsible for ensuring the adequacy of:

- All risk and control related disclosure statements (in particular the Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Governing Body
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud Authority

Joint CCG Remuneration Committee

See section under Remuneration report page 142

Joint Quality & Constitutional Standards Committee

The Joint Quality & Constitutional Committee oversees the clinical quality of commissioned services across the three CCGs.

The Committee met on 6 occasions during 2017/18 and is chaired by the Secondary Care Consultant and deputised by the Director of Nursing & Quality (for the three CCGs). The meeting is well attended with representation from all three CCGs, and was quorate on 5 occasions. The meeting was not quorate on 22nd November and it was agreed that the Director of Nursing would liaise and get feedback from the absent member and this was minuted. The Director of Nursing is responsible for monitoring and reporting risks relating to clinical quality that are reviewed and discussed at the Committee and thereafter reported to the Governing Body in Common. She is supported in this work by the CCG's Quality Improvement Team.

The Committee is responsible for ensuring the adequacy of controls relating to:

- Quality of commissioned services according to service specifications and contracts.
- Performance reports relating to quality KPIs.
- Risk identification, management and mitigation of quality risks.
- the Committee's risk register is part of the Audit Committees 'deep dive' process of cyclical risk assessment.

The Committee is accountable to the Governing Body and minutes are reported on a bi-monthly basis. At each Governing Body in Common meeting the following reports are considered:

- Quality Dashboard, which provides an overview of performance against key quality targets.
- Quality Committee minutes.
- Exception risk reports.
- Quality risks incorporated in the Assurance Framework.

Business Planning and Clinical Commissioning Committee

The Business Planning and Clinical Commissioning Committee is a joint committee of the three CCGs. It is chaired by the Accountable Officer. The Committee met 12 occasions during 2017/18. There is good attendance at each meeting with representation from the three CCGs, and the meeting was quorate on all occasions.

The Business Planning and Clinical Commissioning Committee is responsible for ensuring that there is a strategic approach to commissioning across the three CCGs. The committee approves proposals for new commissioning activities and recommends the Annual Operating Plans to the Governing Body in Common. It ensures that controls are in place for:

- Development and delivery of clear and consistent Annual Operating Plan and five year system wide Sustainability Transformational Plans for high quality, safe services.
- Development of a collaborative partnership approach to planning health and social care service changes; and the integration of health and social care (Better Care Fund, BCF).
- Provision of strong leadership and transparent accountability for delivery of any

joint strategic plans where joint action is appropriate and agreed by the three CCG governing bodies.

- Links to regional collaborative commissioning arrangements and clinical networks in areas such as cancer, cardiovascular, maternity and trauma and influencing and approving commissioning plans as appropriate.
- Monitoring, managing and reporting risks relating to the delivery of planned change programmes e.g. NVOC, BCF and other Transformational Plan associated with Frimley Health;
- The Business Planning and Clinical Commissioning Committee**'s** risk register is part of the Audit Committee's 'deep dive' process of cyclical risk assessment.

The Committee is accountable to the Governing Body in Common and minutes are reported on monthly basis to the Governing Body in common.

Finance, Quality Innovation Productivity and Prevention Committee

The Finance and QIPP Committee acts as a formal sub-committee for Bracknell & Ascot, Slough, and Windsor Ascot & Maidenhead CCG Governing Body in Common The role of the Finance and QIPP Committee is to advise and support the Governing Body in Common in scrutinising and tracking delivery of key financial and QIPP priorities as specified in the CCGs' Strategic and Operational Plans. It is chaired by Director of Finance & Performance. The committee met 12 times during 2017/18. The meeting was not quorate for 8 occasions and only one of these occasions there was a decision taken on March 2018. On this occasion it was agreed to send the information to that representative in advance to the meeting so that the decision can be finalised at the next meeting.

The Committee acts as a co-ordination group and provides the opportunity for discussions about financial issues to enable decisions to be shaped for approval by the individual CCG Governing Bodies. It has specific delegated authority to:

- Develop the annual financial strategy for Governing Body and membership approval
- Review the delivery of CSU services and make recommendations to the Governing Bodies in respect of service delivery and cost

The Committee is a formal sub-committee of each CCG's Governing Body.

The agreed minutes of Committee meetings are formally recorded and submitted to the CCG Governing Bodies.

Information, Management and Technology (IM&T) Committee

The IM&T Committee works to develop the strategic direction and planning for IM&T across the three CCGs. The IM&T Committee is chaired by the IM&T leads from each of the three CCGs on a rotating basis; there is good representation from all three CCGs. The Group meet on a monthly basis throughout the financial year 2016/17 and they met on 11 occasions and were not quorate for 3 occasions. The quoracy was not met in on 26th October, 23 November and 15th December. On these occasions email approval was sought from the CCG representative for decisions taken at the meeting. The committee is accountable to the Governing Body in Common.

The IM&T Committee is responsible for ensuring the adequacy of controls in place:

- To manage operational risks relating to IM&T including CCG IT and data quality, GP IT programme, information governance (IG), IG risks and incident reporting.
- To assure the CCGs that there is a robust information governance framework in place that ensures the security and management of data both patient and corporate information.
- Develop the strategic vision and priorities for the three CCGs, and seek to work collaboratively across the three CCGs where priorities are shared such as interoperability (Connected Care); GP IT equipment / training and support / projects in video conferencing, social media, data management (technology to assist care pathways planning and risk stratification).
- To provide risk report from the IM&T Committee to Governing Body in Common by way of the IM&T risk register, interoperability reports and updates on the IG Toolkit, high and extreme risks are included in the Assurance Framework.

Compliance with the UK Corporate Governance Code

The CCG is not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

For the financial year ending 31 March 2018, and up to the date of signing this statement, the CCG complied with best practice guidance on leadership, effectiveness, accountability. The CCG Constitution, approved by NHS England, defines the accountability structure of the CCG, along with the roles and responsibilities of the Assembly of Members, and of the Governing Body and its membership.

The remuneration (the terms of reference of the CCG Remuneration Committee are set down in the Constitution) and relations with shareholders (the Constitution specifies the responsibilities for engagement with the public and other stakeholders, including those of the lay member for patient and public engagement).

The Governing Body in Common receives regular reports from the Chairs of its delegated committees.

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. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

The CCG recognises that risk management is an integral part of good management practice and that to be most effective it should be embedded as part of the CCG's overall culture and ways of working. The CCG has a web based incident reporting system called Datix and a web based risk management tool for recording the CCG risks called "4risk" for staff to use. Risk training is delivered to staff following the introduction of the new risk management system and as part of the induction for new joiners. The Associate Director of Nursing/Quality & Safety holds the responsibility of coordinating the management of CCGs risks and has attended risk management and assurance framework training in 16/17.

Capacity to handle risk

Since 2016/17, the CCG have moved to a new management structure so that staff work in a more collaborative approach where there is a collective of individuals working on behalf of the three CCGs and work into one unified structure grouped into four Directorates. Some staff have retained a specific focus on one CCG, but the overarching principle has been that the teams operate to consistent standards and processes, and are able to provide cover and support across all the three CCGs. This has enabled a much more streamlined way of working, with a governance structure that has facilitated a clearer route to decision making and accountability.

The CCG's Risk Management Framework sets out the organisation's attitudes to risk and defines the structures for the management and ownership of risk throughout the organisation. The strategy describes the risk management processes in place within the CCG including the key stages of risk identification, risk analysis and evaluation, risk control and reduction, and processes for ongoing monitoring and review. Each risk has a delegated risk owner who has responsibility for determining the inherent risk, identifying the controls and the mitigating actions.

Risk Management is embedded within the CCGs activities in several ways:

An Assurance Framework, described in more detail below, has been approved by the Governing Body together with an action plan to address gaps in controls and

assurance. The Assurance Framework is reported to the Governing Body on a quarterly basis along with a summary analysis of the key changes to the risks during that period (increase or decrease in risk rating, updates on actions and controls etc.).

Each of the Governing Body's sub-committees have a risk register; the committee is responsibility for identifying new risks, evaluating and reviewing current risks, and the controls and assurances in place to effectively manage and mitigate those risks.

The Joint Federated Audit Committee regularly reviews the CCG's risk management systems, including the risk registers held at committee level as well as the Assurance Framework.

All incidents are now being reported on the Datix incident reporting system. All serious incidents including those concerning data security are reported using the national reporting system and are fully investigated, with an accompanying set of actions that are implemented. This is in accordance with the CCG's Serious Incident Reporting policy and procedures.

Prevention of risk

The CCG recognises that risk management is an integral part of good management practice and that to be most effective it should be embedded as part of the CCG's overall culture and ways of working.

The CCG has in place a robust governance framework and system of internal control that seeks to proactively prevent risks, manage, mitigate and report identified risks. This is delivered through the system of internal control which is summarised as follows:

- CCG Constitution, Standing Orders and Terms of Reference (ToR) of committees that set out respective responsibilities, duties, delegated authority and scope of decision making of the Governing Body, executive team, committees and groups
- Prime Financial Policies and Financial Scheme of Delegation that clearly sets out the financial approval limits of the CCG Chairman, executives and staff (CCG and CSU)

- Policies and procedures that articulate the legislative and national / local policy requirements that CCG staff must adhere to including (HR policies, information governance policies, corporate and financial policies)
- The CCG has a whistleblowing policy in place and there is a named lay governing body member who is the freedom to speak up guardian. The CCG is committed to the principle of public accountability and welcome the opportunity to investigate genuine and reasonable concerns expressed by an individual or groups of staff relating to malpractice. As laid down by the Public Interest Disclosure Act 1998 (PIDA) and Bribery Act 2010, no one will be discriminated against or suffer a detriment as a result of making such a disclosure. This policy applies to everyone who works in the organisation. This policy is supported in conjunction with our policies covering Grievance, Disciplinary, Health & Safety Policies and Incident Reporting
- Standards of Business Conduct policy and related procedures on declaring interests, gifts and hospitality, which is closely aligned to the Counter Fraud policy
- Risk reporting is through the risk registers and the Assurance Framework, with risk scrutiny and analysis undertaken by the Audit Committee and reported to the Governing Body
- The CCG has a robust Incident reporting and learning system and any learning from incidents are shared with all staff
- Training in risk management is available to all staff, and mandatory training covering Information Governance, Fire Safety, Equality and Diversity, Safeguarding and Moving and Handling. Staff have also been trained on the 4Risk management tool
- An internal audit programme that aligns to the CCG's risks; the programme has been designed to respond and adapt to the CCG's changing risk profile. Internal Audit also work with the Local Counter Fraud Service (LCFS), external audit and other stakeholders, as appropriate and produces risk reports that concentrate on the key risks to the CCG
- An external audit plan to review the year end accounts and governance arrangements

- Local Counter Fraud Services proactively responds to potential fraud and raising fraud awareness within the CCG

Management of current risk

The Assurance Framework enables the Governing Body to be properly informed about the principal risks to the achievement of the organisation's key objectives and the controls which are in place, which are intended to manage these risks. There has been improvement to the Assurance Framework this year with each risk aligned to the organisations objective and timescales for the actions to be completed. The framework document comprises:

The organisation's strategic priorities and financial plans and correlates with the CCG's Operational Plan and Commissioning Intentions.

The principal risks associated with achieving these priorities. The criteria for evaluating these risks are:

- financial / value for money issues
- quality of services from commissioned providers
- operational risks
- impact of that risk on the organisation / stakeholders / partners – reputational risks
- equality and quality impact assessments are carried out on all new business cases

There are key controls/systems in place to minimise the risks and potential sources of assurance on the effectiveness of the controls.

There is critical challenge and questioning of risk mitigation and management from the Governing Body in Common, the Joint Federated Audit Committee on the Assurance Framework. In addition the membership of the Governing Body in Common includes local authority representatives, provider organisations and in public meetings, patients and the public who provide critical challenge. Other committee members and executives also have a responsibility to challenge and critically question the risk registers.

The positive assurances available to the Governing Body, in the form of internal and external assessments and reports; including risk based board reports which are highlighted in the Assurance Framework.

The Assurance Framework provides evidence that the effectiveness of controls to manage the risks to the organisation achieving its strategic goals have been regularly reviewed. This work has highlighted some gaps in controls during the year that have therefore enabled the CCG to find additional ways to address these which are documented in the risk assessment section.

The 4risk management centre supports a methodology which is consistently applied to the evaluation of all risks.

Risk assessment

The risk management tool “4risk” is available to the CCG and its members of staff to enable them to identify, document, assess and report risks associated with the activities of the CCG. Among these are:

- risk registers, project/operational and corporate, which document and enable understanding of the CCG’s risk profile
- risk rating matrix (based on the Australian and New Zealand Risk Model), the use of which enables the CCG and its members of staff to evaluate appropriately and consistently the likelihood and impact (severity or consequence) of a given risk
- risk rating/acceptability matrix which identifies responsibility for the management or risks at different levels, e.g. low/green, moderate/yellow, high/amber and very high/red

The controls, both in place and required, and the actions taken to mitigate the risks, are documented in the Assurance Framework which has undergone regular review by the Joint Federated Audit committee and by the Governing Body. In 2017/18, there is only one risk with a residual risk rating of ≥ 15 at year end included:

RS08: If Quality Innovation Productivity & Prevention, (QIPP) savings and service transformation plans are not achieved. THEN we will be unable to meet our financial

challenges and the rising demand for services (see section Assurance Framework). The controls in place for this risk are;

- Process for planning achievable QIPP schemes and transformation plans in line with commissioning intentions
- All QIPP and investment programs have detailed plans, which where appropriate have been agreed with providers
- Robust processes in place to ensure delivery of the financial outturn including the QIPP Plan Budgetary control system and QIPP Tracker

It is anticipated QIPP will remain an “extreme” risk for the foreseeable future given the demographic and financial pressures across the system.

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.

Each committee and directorates have a risk register which has controls described for every risk entry. The controls are reviewed on a monthly or quarterly basis (depending on their risk level) along with progress for reducing the risk to ensure they are still effective. Each risk has mitigating actions to reduce the risk which have a named lead to undertake the task.

The objective of the Governing Body Assurance Framework is to provide assurance against the key strategic risks and controls that the Governing Body must consider when seeking internal and external assurance.

The system of internal control has been in place in the CCG for the entire year, from 1st April 2017 to 31st March 2018 and up to the date of the approval of the Annual Report and Accounts.

Internal Audit Programme for 2017/18

The CCG has commissioned assurance reviews from the Internal Auditors (PwC) on issues that the CCG working collaboratively with the internal auditors have identified as requiring strengthening and performance improvement. The internal audit reports for 2017/18 are as follows:

Review	**Report classification and period**	**Number of findings**			
		Critical	High	Medium	**Low**
Primary Care Commissioning	**Medium risk** Quarter 2	-	-	2	1
Sustainability Transformation Partnership Governance	No risk rating awarded Quater2/Quarter 3	Internal Audit Advisory			
Corporate Governance and Compliance	**Low risk** Quarter 3			1	2
Stakeholder Engagement	**Low risk** Quarter 3	-	-	1	
Core Financial systems	**Low risk** Quarter 2	-	-	2	-
Estates Strategy	**Low risk** Quarter 2	-	-	1	-
Patient Experience	**Medium risk** Quarter 2	-	-	2	1
	Total	-		**9**	**4**

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.

The CCG has carried out their annual internal audit of conflicts of interest following NHS England's statutory guidance on managing conflicts of interest for CCGs (published in June 2017). The audit identified the following areas of good practice:

- The conflict of interest policy has been updated to reflect NHS England guidance and changes are approved by the Governing Body in Common
- The policy is easily accessible on the staff intranet
- The CCGs recruiting documents for permanent staff and short term contract were reviewed and did not identify any issues related to conflict of interest

Data Quality

The CCG's Governing Body and sub-committees are provided with data / information that has been processed and analysed by the Business Intelligence Team (CSU). This information supports the CCG's strategic and financial plans (Two Year Operating Plan and Five Year Sustainability & Transformational Plans and Better Care Fund plans).

The CCG continues to work with provider organisations on the data / information that is reported as part of the contractual process, to ensure that it is of the quality and standard required. There are improvement plans in place with provider organisations to achieve this. The CSU Business Intelligence Team is working on on-going improvements and developments; including self-service information management tools and systems, alongside bespoke CCG reports. The CSU works to national data quality standards which are incorporated in the National Contract.

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. The IG Toolkit Version 14.1 was submitted by 23rd March 2018 evidencing that Level 2 or above has been achieved for each requirement.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing / have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff is aware of their information governance roles and responsibilities.

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

Business Critical Models

Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place in line with Requirement 14-346 IG Toolkit Version 14.1.

Third party assurances

The CCG ensures that all third party providers with access to the organisations information assets have been identified and NHS Standard Contracts are in place which include compliance with information governance requirements and are reviewed on an annual basis.

Control Issues

There were nine issues identified via the Month 9 Governance Statement return and these were related to the following areas:

Information Governance Breaches: The CCG has experienced 6 SIRI Level 1 - non-reportable information governance breaches. All incidents were investigated using

HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incident Requiring Investigation as per IG Toolkit Requirements. All incidents were assessed as SIRI Level 1 incidents and did not require reporting via the IG Toolkit. As part of the internal process reports were produced for all incidents and reported to the IG Lead, SIRO and Caldicott Guardian and IM&T Board. These reports will include any lessons learnt and actions identified. Two separate incidents related to patient information being released in error in which both patients were sent a letter of apology.

Review of economy, efficiency & effectiveness of use of resources

The Governing Body in Common has overall responsibility for the use of the CCG's resources. This includes establishing systems and processes for planning, budgeting, procurement, implementation, monitoring, review and evaluation of all commissioned services.

The Accountable Officer is responsible for providing assurance to the Governing Body that these systems and processes are in place, particularly (although not exclusively) through the development of annual and medium term plans.

The Governing Body is also supported in fulfilling this responsibility by the work of the following Committees:

- Joint Collaborative Audit Committee
- Joint Remuneration Committee
- Business Planning and Clinical Commissioning Committee
- Quality and Constitutional Standards Committee
- Finance & QIPP Committee
- Information & Management Committee

The CCG has a responsibility to ensure its expenditure does not exceed the funding allocation for the financial year. This is achieved through the drafting of the annual budget (setting out the deployment of resources within allocations and the approach to delivery and risk mitigation) and regular budget monitoring. The CCG's Scheme of Delegation and Prime Financial Policies ensure that expenditure is incurred in

accordance with agreed plans and legislative requirements.

Monitoring of the financial plan has been delegated to the Director of Finance and Performance, who is the Governing Body's professional expert on finance and ensures through robust systems and processes the regularity and propriety of expenditure, is fully discharged. The Director of Finance and Performance is also responsible for:

- making arrangements to support, monitor and report on the CCG's finances
- overseeing robust audit and governance arrangements leading to propriety in the use of CCG resources
- advising the Governing Body in Common on the effective, efficient and economic use of its allocation to remain within that allocation and deliver required financial targets and duties
- producing the financial statements for audit and publication in accordance with statutory requirements to demonstrate effective stewardship of public money and accountability to tax payers
- overseeing all financial systems and internal controls
- maintaining relationships with external professional advisors and managing relationships with Internal and External Audit

Delegation of functions

The CCG has a complex risk profile due to the diversity of organisations that services are commissioned from (acute, community, primary care and private providers) and risk sharing arrangements with Bracknell & Ascot and Windsor Ascot & Maidenhead CCG. These risks cover quality, financial, operational and reputational risks.

New risks identified for inclusion in organisational risk registers are assessed for the their likelihood and consequence using 5x5 risk matrix in accordance with the Risk Management Strategy. In addition, high Scoring and high impact risks are reviewed by each committee and the Joint Federated Audit Committee. They are reported to the Governing Body in Common on the Assurance Framework. The Joint Federated Audit Committee ensures that the Assurance Framework is fit for purpose and

reviews risk reports from each of the committees.

The Governing Body in Common considers whether new risks have been identified and / or existing risks have increased or have been effectively mitigated. Each of the Governing Body in Common sub-committees has a risk register aligned to that business area; risk owners are appointed for each risk register. The risk register is reported to the relevant committee on a regular basis and high and extreme risks are reflected in the Assurance Framework which is reported to the Governing Body, bi-monthly meetings held in public.

Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. All staff including Governing Body in Common members and clinical leads are required to complete mandatory and statutory training covering information governance, fire safety, moving and handling etc. Governing Body in Common have attended specifically designed risk workshops to enhance their understanding of identifying, managing and reporting risk.

Service Auditors Report- Commissioning Support Unit

In addition to the reporting by Internal Audit, the CCG has also received a number of Service Auditor Reports for the CSU during the year. NHS England has chosen to follow this approach as the method of providing assurance to CCGs over the services provided by CSUs.

The objective of this is to provide assurance in a cost effective manner for the NHS through reducing the duplication which would likely arise from multiple CCG internal and external auditors separately assessing CSU controls.

There are two types of Service Auditor Report. A “Type I” report assesses the suitability of the design of the controls that are necessary to achieve the control objectives specified whereas the “Type II” report assesses the suitability of the design and the operating effectiveness of the controls.

In effect the “Type I” report looks at controls at a point in time whereas “Type II”

looks at controls in place for a defined period. All the reports received have been "Type II" reports.

For both the period of 1st March 2017 to 31st August 2017 and 1st September 2017 to 31st March 2018 the CCG received reports covering: payroll, financial ledger, accounts payable, accounts receivable, financial reporting, non-clinical procurement, and treasury and cash management

The CSU's auditors (Deloitte) issued a qualified opinion because of the number of control objectives which were not operating with sufficient effectiveness. Table below shows the details for the period of 1st March 2017 to 31st August 2017.

Service Area	**Number of Control Objectives**	**Number of exceptions noted**	**Number of no relevant exceptions noted**
Payroll	14	3	11
Accounts Payable	4	0	0
Accounts Receivable	4	0	0
Financial Reporting	5	0	0
Financial Ledger	5	1	4
Non Clinical Procurement	5	1	4
Total	37	5	19

The table below shows the details for the period of 1st September 2017 to 31 March 2018. The CSU's auditors (Deloitte) issued a qualified opinion because of the number of control objectives which were not operating with sufficient effectiveness.

Service Area	**Number of Control**	**Number of exceptions noted**	**Number of no relevant**

	Objectives		exceptions noted
Payroll	6	0	6
Accounts Payable	5	0	5
Accounts Receivable	4	0	4
Financial Reporting	2	0	2
Financial Ledger	5	1	4
Non Clinical Procurement	6	2	4
Treasury and cash Management	3	0	3
Total	31	3	28

As the reports provided by the CSU's auditors cover all its CCG customers, we do not know whether the specific control issues relate to services provided to this CCG, but they could be indicative of generic weaknesses in the control environment operated by the CSU. Whilst ideally there shouldn't be any weaknesses in controls, it is not uncommon to have some weaknesses particularly given the geographical size and operational scope of the CSU. But the number of control objectives not operating effectively is a concern. The report, and the associated management action plan produced by CSU, was considered by the Joint Federated Audit Committee on 9th February 2018.

The CSU have provided action plans which sets out mitigating actions to improve the control environment, and the control procedures operated by South, Central and West CSU during the period 1st March 2017 to 31st August 2017, and for the period 1 September 2017 till the 31st March 2018.

South, Central and West CSU can confirm that:

- There have not been material changes in our control environment for the period 1 March 2017 to 31 March 2018, which would adversely affect the Service Auditors Opinion reached in the most recent issuance of any of the reports for the two periods
- That the controls detailed within the most recent issuance of the Service Auditor Report, have operated effectively. Where controls have not operated effectively within the period, there is an action plan in place

The CSU have taken steps to confirm this through the following mechanisms:

- Management Assertions received from service leads; and
- Sample testing performed by service leads or their nominees.

Counter fraud arrangements

The CCG has procedures in place that reduces the likelihood of fraud, corruption and/or bribery occurring. These include the CCG Standing Orders and Constitution, Prime Financial Polices and Financial Scheme of Delegation and other documented policies and procedures, a system of internal control, and a system of risk assessment.

The CCG Governing Body seeks to ensure that a risk awareness culture exists in the CCG (which includes fraud, corruption and bribery awareness), and has complied with the NHS Protect (NHSP) Standards for Commissioners; fraud, bribery and corruption, which require the CCG to employ or contract in an accredited, nominated person (or persons) to undertake the full ranges of counter fraud, bribery and corruption work. TIAA Ltd have been contracted to provide this service.

The Director of Finance & Performance (CFO) has overall responsibility for ensuring compliance with the NHS CFS Standards. The CFO ensures that fraud and corruption is prevented, detected and investigated and is assisted in this respect by the Local Counter Fraud Specialist (LCFS).

The LCFS is responsible for managing and delivering all counter fraud work within the CCG in accordance with an agreed annual work plan that is monitored by the Joint Federated Audit Committee. Under the NHSP Standards for Commissioners, CCG's Standing Orders and Constitution and Prime Financial Policies, the LCFS is

responsible for investigating allegations of fraud, bribery and corruption within the CCG.

When a referral of fraud is made to the CFO they ensure that the LCFS responds proactively to any risks and occurrences of fraud and corruption that are identified, by providing a robust and effective prevention, detection and investigation function.

The LCFS reports to the CFO, but staff within the CCG are actively encouraged to speak to and ask for advice from the LCFS. The CCG has ensured that the Counter Fraud policy, leaflets and posters are made available to all staff through the intranet and email communication; risk awareness training is provided to staff to raise awareness of potential fraud and the work of the LCFS (through e-learning).

The LCFS is authorised to receive reports of suspected fraud from anyone, whether an employee of the CCG, independent contractors, patients or other third party. All staff have been informed that it is their responsibility to raise their genuine concerns of fraud to the LCFS, CFO and / or their manager.

The CCG has a work plan in place to meet the guidance provided by NHSP. This plan is agreed by the CFO and the Joint Federated Audit Committee. The plan is a live document and is adapted to reflect the Standards for Commissioners and any emerging or identified risks. Performance reports are presented to the Joint Federated Audit Committee and LCFS has regular contact with CFO and Deputy CFO.

Any corrective action as a result of recommendations made by NHSP is overseen by the Chief Finance Officer and Joint Federated Audit Committee.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that

assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

Opinion

Our opinion is as follows:

Satisfactory	**Generally satisfactory with some improvements required**	Major improvement required	Unsatisfactory

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 effectiveness of the framework of governance, risk management and control. Please see our Summary of Findings in Section 2.

Commentary

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

- Of our seven reviews completed in the year, two have been rated as medium risk overall and four as low risk, for one review no risk rating was given as this was an internal audit advisory review. We have not raised any high risk rated reports in 2017/18. The seven reports included 9 medium risk and 4 low risk findings, with no high or critical rated issues identified within those reports.
- In addition to the findings raised in the 2017/18 reviews, our follow up procedures performed in December 2016 identified that of the 59 findings followed up 52 had been completed. Whilst this demonstrates progress by management in completing actions to mitigate identified risks, further action is required in order to remediate previously identified findings.

- The number of medium 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 below specific findings which have contributed to this overall assessment, and the CCG should consider whether these findings are reflected within the Annual Governance Statement.

Integrated Care System (ICS) Governance

This was an advisory piece looking at the governance arrangements the ICS has put in place in order to both fulfil the requirements of the Memorandum of Understanding but also to promote transparency, collaboration and independent challenge across the system. No risk ratings were given.

The key observations were:

- Ensuring appropriate involvement of Lay Members / NEDs and GP provider representatives on the ICS Board, leading and facilitating integrated working between Executives, Lay Members, and NEDs from across the ICS. Establishing membership and quoracy in terms of reference.
- Successfully engaging with, and achieving buy-in from, the workforce, stakeholders, and the general public as to the ICS's strategy – without this transparent, collaborative and risk sharing approach the vision for the ICS may not be achieved. This will be especially important when agreeing system control totals for the ICS to work towards and the sharing of activity and financial risk that this will entail.
- Development of clear lines of sight across the ICS, and constituent members, for independent scrutiny of ICS only funds (mainly transition funds at the moment) and activities (i.e. ICS wide "QIPP" schemes") that could cause a real or perceived conflict of interest. To be supported by clear intra-ICS protocols around conflicts of interest, conflict resolution, and information sharing with scrutiny and oversight provided by the CCGs Joint Federated Audit Committee and assurance provided by internal audit (with further guidance on this anticipated from NHSE).
- Monitoring of potential leakage of ICS funds outside of the system and the

establishment of clear processes for the management of business cases that impact multiple members. Robust and trusted performance data from across the ICS constituent members is vital to understanding financial and activity impact of money flows and business cases.

- Ensuring that constituent members have sufficient capacity to deliver against both the ICS's priorities and their own business as usual activities.
- Finally, as the ICS develops and takes on greater responsibility for the management of individual budgets and projects it may require the development of its own non-executive / lay scrutiny committee, for example an "ICS Assurance Group / Committee" made up of majority Lay and non-executive membership.

Core Financial Systems

Given the move towards the STP there has been a significant level of procurement at the CCGs. This review therefore considered the CCGs' compliance with procurement policy including a focus on single tender waivers to ensure that they were being appropriately used, as well as identifying any thematic trends in their usage. As part of the review we also undertook a high level review of how out of hours and extended access primary care services have previously been procured and reviewed these in light of industry best practice.

We raised two medium risk findings:

- Incidences of approval outside of the scheme of delegation. The results of our sample testing of orders of goods and services placed in year showed that 3/25 invoices did not gain the approval required by the scheme of delegation. This was due to changes in roles, responsibilities and team structures not being reflected in the scheme of delegation.
- There is no procurement register in place. The procurement policy requires that a list of all current and known future procurements is maintained, to be reviewed on a regular basis. The CCGs are working towards the implementation of a procurement register, but there is currently no such list maintained.

Estates Strategy

This review looked at the CCGs' Strategic Estates Plan and a sample of associated Statement of Operating Needs and applicable minutes and papers in order to understand and assesses how well CCG estates plans have been aligned with the STP and the Five Year Forward Plan, and also how this alignment is monitored and reported.

We raised one medium risk finding:

- A lack of formalised reporting and monitoring of estates projects. In particular, there are indistinct and limited reporting lines in-place to monitor the implementation of significant estates projects undertaken by commissioned providers.

Patient Experience

This review looked at how the CCGs incorporate Patient and Public Involvement (PPI) and Patient Experience in their commissioning and reporting processes.

We raised two medium and one low risk findings. The medium rated issues were in relation to:

- Limited evidence of Patient and Public Involvement (PPI) in Business Planning. The CCGs' Business Plan template has a limited amount of detail on PPI, with just an open text response box for information to be included in the Plan. As a result there is a lack of guidance on what is expected of staff in-order to achieve adequate PPI, and add value to service design.
- There is limited promotion to patients and public regarding service transformation and also of planned service changes, via the CCGs' social media. This includes, to a lesser extent, information on how patients and the public can become involved in the development of future services.

Primary Care Commissioning

Primary care commissioning is now fully delegated to the CCGs and our review raised two medium and one low risk findings. The medium rated issues were in relation to:

- Improvements required over the completeness and level of detail for reporting on projects to the Primary Care Commissioning Committee in Common (PCC) - Highlight reports, both the summary presented to the PCC and individual project reports to the Primary Care Commissioning Operational Group (PCOG), could be clearer regarding RAG ratings to enable the PCC and PCOG to focus on the key risks to non-delivery. The information contained in the highlight reports, especially those for individual projects presented, was incomplete or contradictory.
- Delays in the approval for payment of primary care invoices. For six out of 20 invoices and credit notes reviewed relating to primary care expenditure authorisation was received more than a month after it had been received. This was due to invoices being incorrectly coded to the Continuing Healthcare team for action on their initial receipt.

Corporate Governance, Committee Structures, Board Reporting and Risk Management, Compliance and Information Governance

Our focus was: 1) To review the revised Assurance Framework to understand if the revised framework is consistent with the GP and Mental Health Five Year Forward View and whether it has been embedded throughout the CCGs' risk management processes; 2) To establish if conflicts of interest guidance has been updated to reflect the latest guidance from NHS England (no issues were noted); 3) To assess the adequacy of the CCGs controls for monitoring and completing statutory and mandatory training; and 4) That appropriate controls are in place to enable the accurate completion of the Information Governance Toolkit.

We raised one medium and two low risk findings. The medium rated issue was in relation to:

- There was a 21% non-compliance rate with statutory and mandatory training requirements. Of this, two business units stood out; non-executive directors formed 52% of outstanding modules, and continuing healthcare 21%.

Stakeholder Engagement

This review looked at how the CCGs have engaged with and obtained feedback from GPs and whether action plans have been developed off the back of this. We

also looked at how action plans are monitored and timescales adhered to.

We raised one medium finding; the medium rated issue was in relation to:

- The CCGs were unable to locate any actions plans put in place after the 360 degree feedback tool was completed in 2017.

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 annual audit letter 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 on the implications of the result of this review by:

- Governing Body in Common
- Joint Federated Audit Committee
- Joint Remuneration Committee
- Business Planning and Clinical Commissioning Committee
- Quality and Constitutional Standards Committee
- Finance & QIPP Committee
- Information & Management Committee
- Head of Internal Audit opinion;
- Detailed reports from both Internal Auditors and the external auditors;
- Reports and minutes to the Governing Body
- Joint Co-Commissioning Primary Care Committee

The assurance framework highlights the major risks to the successful achievement

of the CCGs' strategic objectives. It has been strengthened by use of a central data system to capture all the risks and can be easily updated and risks can be linked together. The Assurance Framework provides details of each of the risk scenarios, the risk owner, the risk rating and the controls and assurance that are in place; along with a risk mitigation plan.

All risks are evaluated with the NHS Constitution standards and other statutory and regulatory obligations in mind. Risk evaluation includes:

- compliance with the Equality, Diversity and Human Rights agendas
- financial implications associated with specific risk scenarios are taken into consideration in evaluation of the "rating", and is supported by a Finance risk register
- quality implications associated with specific risk scenarios are taken into consideration in evaluation of the "rating", and is supported by a Quality Risk Register

Clinicians are involved in a number of areas where risks have been identified and particularly through consideration of risks at Quality Committee.

There are 16 risks on the Assurance framework at the end of March 2018. 12 of the risks have remained at the same level of risk rating throughout the year 4 have reduced and none have increased. There have been 2 new risk identified in the year. There is 1 extreme risks identified, 9 high and 6 medium. Each of the risks has management action plans which are updated and monitored on a quarterly basis.

There are 1 extreme risks identified, 9 high and 5 medium. Each of the risks has management action plans which are updated and monitored on a quarterly basis.

The table below is a summary of the risk scoring as at 31st March 2018:

Assurance Framework Snapshot

Ref	Risk Scenarios	Risk Owner	Gross Risk Exposure	Gross Risk Exposure Rating	Net Risk Exposure	Net Risk Exposure Rating	Risk Movement
RS01 GB_16 Linked to CO 2	IF we do not maintain good strategic relationships with providers, practices, local authorities, NHS England, other CCGs and the voluntary sector THEN we may not be able to deliver the necessary transformational charge to meet the aspirations of the Five Year Forward View whilst remaining in financial balance	**AO**	12	H	8	H	⇔
RS02 GB_20 Linked to CO 1, 2	IF we do not have the right skills, knowledge and capacity in our leadership, management teams and our commissioning support services THEN we may not be able to manage both our day to day operations and the delivery of our strategic objectives	**AO**	16	E	6	M	⇩
RS03 GB_13 Linked to CO 2, 3	IF we do not have the right skills, workforce capacity in primary, social, community and secondary care THEN this may impact on the ability of our local health and social care system to deliver both current services and the necessary transformational change resulting in poorer care for our citizens and dissatisfaction amongst staff	**Dir. Strategy & Op.**	8	H	8	H	⇔
RS04 GB_08 GB_11 Linked to CO 1, 2, 3	IF we do not have effective performance and quality governance structures in place THEN we will be unable to assure ourselves of the quality of commissioned services and that any emerging quality are identified and appropriately mitigated	**Director of Nursing**	16	E	6	M	⇔
RS05 Linked to CO 1, 2, 3	IF we do not have effective corporate governance, decision making structures, member engagement and patient involvement in place THEN we may not make the most appropriate decisions for our citizens and may be open to legal challenge	**Accountable Officer**	15	E	6	M	⇔
RS06 Linked to CO 2	IF we do not accelerate and embed the adoption of technology and information sharing in clinical and corporate areas THEN we will be unable to transform services and deliver the best possible care for our citizens	**Director of Finance & Performance**	8	H	6	M	⇔
RS07 GB_23 Linked to CO 2	IF we do not develop and utilise the local health and local authority estate in the most effective way THEN there may be unacceptable financial and service consequences	**Director of Strategy and Operations**	12	H	12	H	⇔
RS08 GB_02 Linked to CO 1, 2, 3	IF we do not achieve our QIPP savings and service transformation plans THEN we will be unable to meet our financial challenges and the rising demand for services; we may also not be able to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	**Director of Strategy and Operations**	20	E	16	E	⇔
RS09 GB_03 GB_04 GB_05 GB_10 Linked to CO 1	IF we do not have the right information to be assured we are meeting the NHS constitutional standards, statutory standards and other key performance targets THEN this will impact on the CCGs quality premium and the quality of the services we commission for our citizens and on our reputation	**Director of Strategy and Operations**	20	E	8	H	⇔
RS10 Linked to CO 1, 2	IF we do not have the right financial, activity and performance information THEN we may not be commissioning value for money services and will be unable to meet our financial challenges	**Director of Finance & Performance**	20	E	12	H	⇩

Assurance Framework Snapshot

Ref	Risk Scenarios	Risk Owner	Gross Risk Exposure	Gross Risk Exposure Rating	Net Risk Exposure	Net Risk Exposure Rating	Risk Movement
RS11 Linked to CO 1	IF we do not anticipate and respond to future individual health needs THEN we may not commission the right services to meet those needs, reduce health gaps and prevent ill health	**Director of Strategy and Operations**	8	H	8	H	⇔
RS12 Linked to CO 1,2	IF we do not have the right information about the impact of legislation and regulatory requirements on health and social care THEN we may not commission the right services to meet these requirements	**Accountable Officer**	9	H	6	M	⇔
RS13 Linked to CO 1,2	IF we do not appropriately manage and stimulate the healthcare market THEN the social, voluntary and commercial providers may not be able to effectively respond to our commissioning intentions and therefore we may not be able to transform services in the way we intend	**Director of Strategy and Operations**	12	H	8	H	⇔
RS14 Linked to CO 1, 2	IF the CCG partnership working arrangements fail to identify and uncover any threats to the financial sustainability of our local NHS providers and local authorities, THEN we may not be able to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	**Accountable Officer**	15	E	8	H	⇔
RS15 Linked to CO 1,2	**IF** the CCG does not have appropriate representation on and delegated to STP/ACS groups and committees **THEN** we may not be able to discharge our statutory responsibilities to commission the right services in the right settings with the right outcomes for our patients, at an affordable price.	**Accountable Officer**	15	E	6	M	⇔

Conclusion

In conclusion, my review acknowledges the gaps in controls relating to those risks identified by the CCG and reported in the Assurance Framework and risks that have been identified by Internal Audit reviews. All of the risks have current action plans that are closely monitored by the relevant committee and reported to the Governing Body. I conclude that the CCG has a generally sound system of internal control that supports the achievement of its policies, aims and objectives

Remuneration and staff report

Remuneration Committee (not subject to audit)

The core membership of the Remuneration Committee comprises Governing Body lay members with responsibility for governance from each of the three CCGs. Other individuals such as the Chair of Governing Bodies, Accountable Officer, Director of Finance and Performance and HR Officer may at the invitation of the Chair attend part of the meeting. However, no officer shall be in attendance for discussions about their own remuneration/terms of service.

Policy on the remuneration of senior managers (not subject to audit)

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

Senior managers' remuneration is set through a process that is based on a consistent framework and independent decision making based on accurate assessment of the weight of roles and individuals' performance in them.

This ensures a fair and transparent process via bodies that are independent of the senior manager whose pay is being set. Pay relating to GPs, Practice Nurses and Practice Managers working for the CCG is set out in the CCG's Remuneration Policy. No individual is involved in deciding his or her own remuneration.
The framework and processes followed for determining pay is in accordance with:

- Clinical Commissioning Groups: Remuneration Guidance for Chief Officers and Chief Finance Officer
- CCG Remuneration Policy.

Executive senior managers are on permanent NHS contracts. The length of contract and terms and conditions are set out in the Agenda for Change, NHS Terms and Conditions of Service Handbook.

Governing body in Common GPs members and lay members are on office holders contract. The practice managers and practice nurses are on a secondment agreement and are appointed for a set period as detailed in the CCG's constitution for 2017/2018 which is approved by Member Practices/ Governing Body and are as follows:

a) Chair – 1 year renewable
b) Deputy Chair –1 year renewable
c) Lay members – 1 year renewable
d) General Practitioners (one of whom will be the Chair) – 1 year renewable

A 1% pay award was given for those staff members on Agenda for Change Band 8c and above or for those on VSM contracts. This was agreed by the Joint Remuneration Committee. There was no performance bonuses paid to any staff or governing body member during 2017/18.

There were no changes to the Governing Body membership during the year.

Membership and attendance (not subject to audit)

The Remuneration Committee met on 4 occasions in 2017/18. The quoracy was not met on the following two occasions as the Slough Lay member was not present. It was agreed that an email approval will be sought from the lay member:

5th May 2017 - approval of previous minutes and the Very Senior Managers (VSM) pay increase

8th September 2017- Approval of previous minutes and CHC re-structure required

The recommendations from this meeting are reported to the Governing Body In Common.

Remuneration of Very Senior Managers (not subject to audit)

No senior managers were paid more than £150,000 per annum.

Salaries and Allowances of Senior Managers 2017-18 (subject to audit)

Name	Title	2017-18			
		Federation Salary & Fees (Bands of £5000) £000	Slough CCG Salary & Fees (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Slough CCG (Bands of £5000) £000
Dr Jim O'Donnell ①	GP Chairman	0	85-90	12.5-15	105-110
Dr Siva Sithirapathy ①②	Co-opted GP Governing Body Member	0	0-5	0	0-5
Dr Nithya Nanda ①③	GP Governing Body Member	35-40	20-25	197.5-200	215-200
Dr Michael Hoskin ①④	GP Governing Body Member	0	10-15	132.5-135	140-145
Alan Sinclair ⑥	Local Authority Member	0	0	0	0
John Lisle	Accountable Officer	135-140	45-50	37.5-40	85-90
Nigel Foster ⑤	Director of Finance & Performance	40-50	10-15	97.5-100	110-115
Lalitha Iyer ①	Medical Director	50-55	25-30	107.5-110	130-135
Sarah Bellars	Director of Nursing	95-100	30-35	60-62.5	95-100
Fiona Slevin-Brown	Director of Strategy & Operations	105-110	35-40	30-32.5	65-70
Debbie Fraser ⑤	Deputy Director of Finance	55-60	20-25	22.5-25	40-45
Anne Stebbing	Secondary Care Consultant member	15-20	5-10	0	5-10
Arthur Ferry	Lay member for Governance/Vice Chair	15-20	5-10	0	5-10
Clive Bowman	Co-Opted Lay Member for Primary Care	5-10	0-5	0	0-5
Sally Kemp	Lay member for Governance/Vice Chair	10-15	0-5	0	0-5

See notes on following page

- ① Payment for the Governing Body element of the salary is via the payroll the remaining salary is invoiced directly from the GP practice or the individual.
- ② Dr Siva Sithirapathy resigned as a GP Governing Body member on 30th June 2017.
- ③ Dr Nithya Nanda was appointed GP governing Body member on 1st July 2017.
- ④ Dr Michael Hoskin was appointed GP Governing Body member on 1st September 2017.
- ⑤ As of the 8th August 2017, Nigel Foster was appointed to be Director of Finance and IM&T for Frimley Health Foundation Trust. He continues his role as Director of Finance under an honorary contract with no cost to the CCG. The Deputy Director of Finance undertakes day to day operations and all the relevant statutory responsibilities where the Director of Finance is conflicted.
- ⑥ Local Authority Representatives do not receive any payment form the CCG.

The Governing Bodies of NHS Bracknell and Ascot CCG, NHS Slough CCG and NHS Windsor, Ascot and Maidenhead CCG meet as a governing body in common from the 1st April 2017. As a result of this Susan Bowden and Mike Connolly no longer attend the Governing Body meetings and have therefore not been included in the salaries & allowances table for 2016-17.The Amount disclosed in the All Pensions related Benefits column is the full amount and not the Clinical Commissioning Groups proportion.

Name	Title	2016-17			
		Federation Salary & Fees (Bands of £5000) £000	Slough CCG Salary & Fees (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Slough CCG (Bands of £5000) £000
Dr Jim O'Donnell ⑧	GP Chairman	0	95-100	0	95-100
Dr Asif Ali ⑧	GP Governing Body Member	0	45-50	0	45-50
Dr Ajaz Nabi ⑦⑧	GP Governing Body Member	0	20-25	0	20-25
Dr Siva Sithirapathy ⑧	Co-opted GP Governing Body Member	0	40-45	0	40-45
Alan Sinclair ⑨	Local Authority Member	0	0	0	0
Susan Bowden	Local Nurse	0	0-5	0	0-5
John Lisle ②	Accountable Officer	120-125	40-45	100-102.5	140-145
Paul Sly ①	Interim Accountable Officer	35-40	10-15	0	10-15
Nigel Foster	Director of Finance & Performance	115-120	40-45	20-22.5	60-65
Lalitha Iyer ⑤	Medical Director	30-35	10-15	0	10-15
Sarah Bellars	Director of Nursing	95-100	30-35	27.5-30	60-65
Niki Cartwright ③	Interim Director of Strategy and Commissioning	55-60	15-20	0	15-20
Fiona Slevin-Brown ④	Director of Strategy & Operations	75-80	25-30	55-57.5	80-85
Mike Connolly	Lay member for Public and Patient Involvement	0	10-15	0	10-15
Nasreen Bhatti ⑥	Lay member Governance/Vice Chair	0	0-5	0	0-5

See notes on following page

- ① Paul Sly was Interim Accountable Officer for the period 1st April to 29th April 2016. His last working day was the 13th May 2016. For the period 30th April to 13th May 2016 he provided a handover and support to the new Accountable Officer. The salary disclosure for Paul Sly includes VAT and agency fees.
- ② John Lisle was appointed as Accountable Officer on the 3rd May 2016.
- ③ Niki Cartwright was Interim Director of Strategy and Commissioning for the period 1st April to 10th July 2016. The salary disclosure for Niki Cartwright includes VAT and agency fees.
- ④ Fiona Slevin-Brown was appointed Director of Strategy and Operations on 27th June 2016.
- ⑤ Lalitha Iyer was appointed Medical Director on 22nd August 2016.
- ⑥ Nasreen Bhatti resigned as Lay member Governance/Vice Chair as of 9th September 2016.
- ⑦ Dr Ajaz Nabi resigned as GP Governing Body Member as of 21st March 2017.
- ⑧ Payment via GP practice or directly to the individual not via the CCG's payroll.
- ⑨ Local Authority Representatives do not receive any payment form the CCG.

The Clinical Commissioning Group undertook a restructure which was implemented in April 2016. As a result of this Mary Purnell, Viki Wadd and Rachel Wakefield no longer attend the Governing Body meetings and have therefore not been included in the salaries & allowances table for 2017-18.
The amount disclosed in the All Pensions Related Benefits column is the full amount and not the Clinical Commissioning Groups proportion.

Pension Benefits as at 31 March 2018

Name	Title	2017/18							
		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr Jim O'Donnell	Gp Chairman	0-2.5	0-2.5	0-5	0-5	16	16	0	0
Dr Nithya Nanda	GP Governing Body Member	5-7.5	17.5-20	Oct-18	25-30	128	96	0	0
Dr Michael Hoskin	GP Governing Body Member	2.5-5	05-Oct	Oct-18	15-20	111	64	0	0
John Lisle	Accountable Officer	0-2.5	0-2.5	20-25	0-5	305	253	49	0
Nigel Foster	Director of Finance & Performance	0-2.5	0-2.5	25-30	60-65	448	386	35	0
Lalitha Iyer	Medical Director	0-2.5	12.5-15	10-15	40-45	286	175	109	0
Sarah Bellars	Director of Nursing	2.5-5	0-2.5	25-30	60-65	406	273	130	0
Fiona Slevin-Brown	Director of Strategy & Operations	2.5-5	5-7.5	35-40	90-95	577	516	56	0
Debbie Fraser	Deputy Director of Finance	10-12.5	30-32.5	10-15	50-55	341	0	220	0

- This disclosure is only for senior managers disclosed in the Salaries and Allowances table, where the Clinical Commissioning Group makes contributions direct to a pension scheme (i.e. as employer or a sharing arrangement is in place which is being disclosed as if the person were employed). Other persons paid via an invoice to their employer and those where no pension contributions are being made will not be included in the table.
- The Senior Managers disclosed are not on the CCG payroll they, are on the Windsor, Ascot and Maidenhead CCG payroll. The amount disclosed is their full amount not just the Slough CCG portion of their pension benefits.
- Lay members do not receive pensionable remuneration therefore there are no entries in respect of pensions for Non-Executive members.
- The pension disclosures have been made in full and not apportioned for any period where the senior manager may have held the post for part of the year.

Name	Title	2016/17							
		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
John Lisle	Accountable Officer	5-7.5	0-2.5	20-25	0-5	253	174	79	0
Nigel Foster	Director of Finance & Performance	0-2.5	0-2.5	20-25	55-60	386	356	30	0
Lalitha Iyer	Medical Director	0-2.5	0-2.5	5-10	25-30	175	170	5	0
Sarah Bellars	Director of Nursing	0-2.5	0-2.5	20-25	60-65	273	250	23	0
Fiona Slevin-Brown	Director of Strategy & Operations	2.5-5	2.5-5	30-35	85-90	516	461	55	0

- This disclosure is only for senior managers disclosed in the Salaries and Allowances table, where the Clinical Commissioning Group makes contributions direct to a pension scheme (i.e. as employer or a sharing arrangement is in place which is being disclosed as if the person were employed). Other persons paid via an invoice to their employer and those where no pension contributions are being made will not be included in the table.
- The Senior Managers disclosed are not on the Clinical Commissioning Group payroll, they are on the Windsor, Ascot and Maidenhead CCG payroll. The amount disclosed is their full amount not just the Slough CCG portion of their pension benefits.
- Lay members do not receive pensionable remuneration therefore there are no entries in respect of pensions for Non-Executive members.
- The pension disclosures have been made in full and not apportioned for any period where the senior manager may have held the post for part of the year.
- The Clinical Commissioning Group undertook a restructure which was implemented in April 2016. As a result of this Sangeeta Saran, Viki Wadd and Rachel Wakefield no longer attend the Governing Body meetings and have therefore not been included in the Pension Benefits table for 2016-17.

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).

Compensation on early retirement of for loss of office (subject to audit)

No payments were made for compensation on early retirement or for loss of office.

Payments to past members (subject to audit)

No payments were made to past directors.

Pay multiples

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

The banded remuneration of the highest paid director in the CCG in the financial year 2017-18 was £70 to £75k (2016-17: £95k to £100k). This was 1.7 times (2016-17 2.6 times) the median remuneration of the workforce, which was £42,089 (2016-17: £36,890). It should be noted that a number of the senior Governing Body roles are shared between the three CCGs in East Berkshire, so the actual costs incurred by the CCG was approximately one third of this amount. It is the cost to the clinical commissioning group that identifies them as 'highest paid' and not the total of that members remuneration.

In 2017/18, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £1,000 to £73,000 (2016/17: £1,000 to £97,000)

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

Staff Report

Slough CCG employs a total of 7 employees. However, senior managers employed by the CCG in Collaborative roles are' shared' across Bracknell and Ascot CCG, Slough CCG and Windsor, Ascot and Maidenhead CCG. Therefore a proportion of the whole time equivalent is shown in the calculation below.

Number of Senior Managers

Senior Manager Banding	Number of Employees
Band 8b	1
Total	**1**

*****Please note – VSM (4 employees), Band 7 and below (2 employees) total headcount including figure above for Slough CCG as at 31st March 2018 – 7 employees.

Staff numbers and costs (subject to audit)

Employee benefits	2017-18	Total			Admin			Programme	
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	1,855	1,506	349	1,011	955	56	844	551	293
Social security costs	166	166	0	112	112	0	54	54	0
Employer contributions to the NHS Pension Scheme	211	211	0	142	142	0	69	69	0
Apprenticeship Levy	3	3	0	3	3	0	0	0	0
Gross employee benefits expenditure	**2,235**	**1,886**	**349**	**1,268**	**1,212**	**56**	**967**	**674**	**293**

NHS Windsor, Ascot and maidenhead CCG host all the shared management teams for the Berkshire East CCGs (NHS Bracknell and Ascot CCG, NHS Slough, NHS Windsor, Ascot and Maidenhead CCG) The Figures in the table include staff directly employed by the Clinical Commissioning Group and an apportionment for the shared teams hosted by NHS Windsor, Ascot and Maidenhead CCG.

Employee benefits	2016-17	Total			Admin			Programme	
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	1,672	1,178	494	1,088	789	299	584	389	195
Social security costs	133	133	0	91	91	0	42	42	0
Employer contributions to the NHS Pension Scheme	158	158	0	110	110	0	48	48	0
Gross employee benefits expenditure	**1,963**	**1,470**	**494**	**1,290**	**990**	**299**	**674**	**479**	**195**

Average Number of staff employed (subject to audit)

	Total Number	2017/2018 Permanently employed Number	Other Numbers	2016/2017 Total Number
Total	37	35	2	33
Of the above: Number of whole time equivalent (WTE) people engaged on capital projects	0	0	0	

Staff Composition (not subject to audit) numbers are as at 31st March 2018

The below table outlines the gender breakdown of staff:

	Female Headcount	Male Headcount	Total Headcount
Governing Body	0	3	3
Very Senior Managers (VSM)	0	1	1
All other Employees	2	1	3
Total Employees	2	5	7

Please note (all other employees are those with the AfC banding)

Staff sickness absence data (not subject to audit)

Below outlines Slough CCGs sickness absence data from 1ST April 2017 to 31st March 2018.

	2017 – 18	**2016 - 17**
Total Days lost	10	11
Headcount (Yearly Average)	2	7
Average Working days Lost	4	2

There were no ill health retirements in 2017-18 (2016-17 nil)

The staff sickness absence figures only include staff on the payroll of Slough CCG; no apportionment has been made for the shared management teams on the payroll of NHS Windsor, Ascot & Maidenhead CCG. Note is based on calendar year January to December 2017.

Total days lost is the full time equivalent sickness days divided by the proportion of working time available in a year for a full time employee to give the total days lost. The Total Staff Years represents the total amount of time that could be worked by the workforce if they all worked full time without any sickness.

The full time equivalent total days lost due to sickness is then divided by the total staff years available to give an average number of days lost due to sickness absence

Sickness absence is managed in a supportive and effective manner by CCG managers, with professional advice and targeted support from Human Resources, Occupational Health and Staff Support services which are appropriate and responsive to the needs of our workforce. The CCG's approach to managing sickness absence is governed by a clear HR policy and this is further reinforced by the provision of HR support, regular provision of data and training sessions for all line managers on the effective management of sickness absence. As the size of the organisation is relatively small, cases of long term sickness can have a significant effect on the organisations absence calculations.

We also proactively promote the health and wellbeing of staff through the provision of annual flu jabs and the provision of an Employee Assistance Programme which also promotes key themes each month and staff have access to a 24/7 helpline. We will seek to further our approach to Staff Health and Wellbeing during 2018 in partnership with the Staff Forum.

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to the CCG on a half yearly basis as part of the workforce reporting process.

Staff policies (not subject to audit)

See equality disclosure section below.

Employee consultation (not subject to audit)

We recognise and value the importance of maintaining positive working relationships with our staff and their representatives. We have established a Staff Forum as our corporate committee for staff engagement and consultation so as to work in partnership on important issues affecting our staff.

The Staff Forum met on four occasions in 2017/18 and considered and made recommendations in relation to HR policy development, organisational change programmes including in-housing of services and organisational development plans. Policies are ratified by the CCG's Executive Committee prior to publication.

The Staff Forum is representative of our workforce and the CCG recognises all of the trade unions outlined in the national NHS Terms and Conditions of Service Handbook who have members employed within the organisation. Each team / directorate has a nominated forum representative responsible for representing the views of their colleagues and feeding back to their team. The purpose of the forum is to:

- Provide a regular and effective means of joint discussion between senior management and staff on issues of mutual interest or concern.
- Foster maximum involvement of all partners in effective communications, engagement and consultation on working practices and employment for example HR policies, procedures, education and training.
- Ensure legal requirements for employee representation are met in respect of all the CCGs staff affected by organisational change (except Executive Team members who are not covered by this agreement).

Towards the end of the year, December 2017 there was a staff consultation on the proposed merger of the three CCGs in East Berkshire to be effective from 1 April 2018. Consultation with staff included a consultation document, staff briefings, team meetings and one-to-one meetings with line managers. Questions, comments and suggestions were gathered and a communication was sent to all staff to reassure that there was no change in the organisational staffing structure.

A selection of the tools and methods to communicate and encourage meaningful, two-way dialogue with staff included:

- Face-to-face staff briefings led by the Executive Team
- Written briefings following Governing Body Meetings and for significant project updates
- Staff surveys to drive improvement in staff experience
- Corporate website and intranet
- Staff Forum

Managers also held regular team and one-to-one meetings with staff. The CCG actively applies its appraisal process and Personal Development Review process, and encourages 360 Feedback to staff. The appraisal system ensures all staff work

towards clearly defined personal objectives which are supported with learning, training and development opportunities detailed in individual personal development plans.

During Q3 the CCG ran a consultation programme for staff within the Retrospective Team within the Continuing HealthCare Team. The consultation process recognised that this part of the service was no longer required, in line with NHS National Framework for Continuing HealthCare provision. Three staff were included within the consultation process. The staff were employed at the NHS Office at Bath Road, Reading. Redeployment was not a viable option due to geographical factors, as all other work relating to the Continuing Healthcare Team is based from the Windsor office. The staff consultation process mirrored the process outlined above. The outcome was that three staff were made redundant.

Equality disclosures (not subject to audit)

The CCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics. Equalities issues are incorporated in policies covering all aspects of the employee lifecycle ranging from recruitment to performance. Our aim is to provide an environment in which all staff are engaged, supported and developed throughout their employment and to operate in ways which do not discriminate our potential or current employees by virtue of any of the protected characteristics specified in the Equality Act 2010. We are also committed to supporting our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

To ensure the duties of the Equality Act 2013 and the requirements of the Public Sector Equality Duty (PSED) are met, we plan to adopt the NHS Equality Delivery System (EDS2) as a tool to enable analysis, review and assessment of performance against 18 evidence based outcomes incorporated within four goals:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and inclusive staff

- Inclusive leadership

We are also committed to implementing the new Workforce Race Equality Standards (WRES) and will work with our providers and partners to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Health and Safety (not subject to audit)

The CCG is a relatively small employer that procures its health and safety services from a range of providers; the CCG's head office is based at King Edward VII Hospital; the site is currently run and operated by NHS Property Services who commission an estates and facilities service from Berkshire Healthcare NHS Foundation Trust including:

- Testing of fire procedures / equipment including risk assessments and audits
- Testing for legionella including risk assessments and audits
- Building maintenance and security and
- Cleaning services including cleaning audits

The CCG commissions' occupational health services from the Royal Berkshire NHS Foundation Trust, including risk assessments of work stations and advice and support for staff on a range of health related issues which may be affecting an individual's ability to remain or return work. Human Resources services are provided by the Commissioning Support Unit. There are policies and procedures in place to safeguard employees' health and well-being including a range of leave policies (flexible working, sickness absence etc.) and working time directive policy amongst many others. All CCG staff is expected to complete mandatory training in Health and Safety and Conflict Resolution.

Expenditure on consultancy

Slough CCG spent £50,000 on consultancy services during 2017-18

(2016-17 £139,000)

Off-payroll engagements (not subject to audit)

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	2017-18 Number	2016-17 Number
Number of existing engagements as of 31 March 2018	8	9
Of which, the number that have existed:		
for less than one year at the time of reporting	3	0
for between one and two years at the time of reporting	0	1
for between two and three years at the time of reporting	0	0
for between three and four years at the time of reporting	0	8
for 4 or more years at the time of reporting	5	0

Table 2: New off-payroll engagements (not subject to audit)

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than 6 months:

	2017-18 Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	4
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	4

Number engaged directly (via PSC contracted to department) and are on departmental payroll	0
Number of engagements reassessed for consistency/assurance purpose during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements (not subject to audit)

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

	2017-18 Number	2016-17 Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0	6
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 should include both on payroll and off-payroll engagements (2)	10	13

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

Exit packages, including special (non-contractual) payments (subject to audit)

There were three exit packages agreed during the current financial year related to redundancy (2016-17 there were no exit packages). The posts were across the Berkshire CCGs therefore the costs were shared between the 4 West Berkshire CCGs and the 3 East Berkshire CCGs and the 3 East Berkshire CCGs. The cost to Slough CCG was £23,631.

Exit package cost band (inc. any special payment element	2017-18 Compulsory Redundancies		2016-17 Compulsory Redundancies	
	Number	£	Number	£
Less than £10,000	3	23,631	0	0
Total	**3**	**23,631**	**0**	**0**

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 departure**.**

The Remuneration and Staff Report includes the disclosure of exit payments payable to individuals named in that Report**.**

Parliamentary Accountability and Audit Report

Slough CCG is not required to produce a Parliamentary Accountability and Audit Report. The CCG has nothing to report in terms of disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability report. An audit certificate and report is included in the Annual Report in the next section.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SLOUGH CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Slough Clinical Commissioning Group ("the CCG") for the year ended 31 March 2018 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 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health Group Accounting Manual 2017/18.

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.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

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.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 103 the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; 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 to you if the CCG has not made proper arrangements for securing 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 103, 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 CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. 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 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; or

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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 Slough 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 Slough CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Joanne Lees
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
London
E14 5GL

25 May 2018

Abbreviations

A & E	Accident and Emergency.
AMU	Acute Medical Unit.
AIR	Adult Integrated Respiratory Service.
ARP	Ambulance Response Programme.
BCF	Better Care Fund.
BHFT	Berkshire Healthcare NHS Foundation Trust provides specialist mental health and community health services.
CAMHS	Child and Adolescent Mental Health Services.
CCG	Clinical Commissioning Group is responsible for planning and funding local health services and is made up of doctors, nurses and other NHS Staff. Every GP practice is a member of a CCG.
CEPN	Community Education Provider Network
CPA	Care Programme Approach.
CPF	Community Partnership Forum.
CQC	Care Quality Commission. It is the independent regulator of health and adult social care services across England. Their responsibilities include registration, review and inspection of services and their primary aim is to ensure that quality and safety are met on behalf of patients.
CEPN	Community Education Provider Network.
CETV	Cash Equivalent Transfer Value.
CPN	Contract Performance Notice.
CQUIN	Commission for Quality and Innovation The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.
CSCSU	Central Southern Commissioning Support Unit. Provide a wide range of commissioning support services that enable clinical commissioners to focus their clinical expertise and leadership in securing the best outcomes for patients and driving up quality of NHS patient services.
CYPMHS	Children and Young People's Mental Health Services.
DDR	Dementia Diagnosis Rate.
DOH	Department of Health. The Ministerial Department of the United Kingdom Government responsible for government policy on health and adult social care matters in

	England.
DXS	Referral pathway management tool.
ED	Emergency Department.
EDS	Equality Delivery System.
EIP	Early Intervention Psychosis.
EoLC	End of Life Care.
ENHT	East & North Herts Trust.
ERS	Electronic Referral System.
ETTF	Estates and Technology Transformation Fund
FFT	Friends and Family Test. A national programme which asks patients whether they would recommend for example hospital wards maternity and A&E to their friends and family if they needed similar care or treatment.
FOI	Freedom of Information. The Freedom of Information Act 2000 provides a right of access to a wide range of information held by public authorities, including the NHS. The purpose is to promote greater openness and accountability.
FHFT	Frimley Park Hospital NHS Foundation Trust is a major trust providing NHS hospital services for around 900,000 people across Berkshire, Hampshire, Surrey and South Buckinghamshire.
FTE	Full Time Equivalent. The hours worked by one employee on a full- time basis. Sometimes called whole time equivalent. (WTE).
GCC	Good Corporate Citizenship.
GMC	General Medical Council. An independent organisation that helps to protect patients and improve medical education and practice across the UK by setting standards for students and doctors.
GP	General Practitioner. The general practitioner is a specialist trained to work in the front line of a healthcare system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the healthcare system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care, and palliation, using and medical sociology.
GPFV	General Practice Forward View.

HCAIs	Healthcare Associated Infections
HCPF	Health Care Professional feedback (HCPF).
HSCIC	Health & Social Care Information Centre. The trusted national provider of high-quality information, data and IT systems for health and social care.
HWBB	Health and Wellbeing Board
HWBS	Health and Wellbeing Strategy developed by the Health and Wellbeing Board, includes locally determined priorities to improve services and support local people to live healthy lives.
IAF	Improvement Assessment Framework
IAPT	Improved Access to Psychological Therapies
ICS	Integrated Care System.
IG	Information Governance. The legal framework governing the use of personal confidential data in health care.
IM&T	Information, Management and Technology.
IPCN	Infection Prevention Control Nurse.
IP&C	Infection Prevention and Control. Aim to ensure the protection of those who might be vulnerable to acquiring an infection both in the general community and while receiving care due to health problems, in a range of settings. The basic principle of infection prevention and control is hygiene.
IRIS	Integrated Referral Information System
LeDer	Learning Disabilities Mortality Review Steering Group.
LCFS	Local Counter Fraud Service.
MOU	Memorandum of Understanding.
MRI	Magnetic Resonance Imagery.
NHSE	National Health Service England.
NICE	National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care. It also advises on ways to promote healthy living and prevent ill health OLT Operational Leadership Team.
NVOC	New Vision of Care.
PGP	Productive General Practice.
PPI	Patient and Public Involvement. Involvement, by the people who use and care about NHS services, enables us to understand and respond to their needs; including those people who have the poorest health. This helps us to improve access to services and reduce

	differences in health in different communities. It helps us to see things through other people's eyes and to be innovative, leading to better use of taxpayers' money.
PTS	Patient Transport Service.
PYLL	Potential Years of Life Lost.
QIPP	Quality, Innovation, Productivity and Prevention. A large-scale programme to drive forward quality improvements in NHS care, at the same time resulting in efficiency savings.
QOF	Quality and Outcomes Framework Is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004.
RBH	Royal Berkshire Hospital (Royal Berkshire NHS Foundation Trust) is a major trust providing a full range of services and is the regions specialist centre for cancer, eye and renal (kidney) care serving over one million people across Berkshire and south Oxfordshire. While the main site is the Royal Berkshire Hospital in Reading, in 2011 The Trust opened a major new cancer and renal centre at the Royal Berkshire Bracknell Clinic in Bracknell.
RBWM	Royal Borough of Windsor and Maidenhead.
RTT	Referral to Treatment.
SAR	Subject Access Requests.
SCAS	South Central Ambulance Trust is part of the NHS, and serves the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire. This area covers approximately 3,554 sq. miles with a residential population of over four million.
SCW CSU	South, Central and West Commissioning Support Unit.
SDMP	Sustainable Development Management Plan
SI	Serious Incident. Very serious incidents that are investigated either internally externally and reported nationally.
SMI	Serious Mental Illness.
STP	Sustainability and Transformation Plan.
TCP	Berkshire Transforming Care Programme.
UEC	The Urgent and Emergency Care.
VSM	Very Senior Managers.

ANNUAL ACCOUNTS

John Lisle

Accountable Officer

Slough CCG

25 May 2018

Data entered below will be used throughout the workbook:

Entity name:	NHS Slough CCG
This year	2017-18
Last year	2016-17
This year ended	31-March-2018
Last year ended	31-March-2017
This year commencing:	01-April-2017
Last year commencing:	01-April-2016

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(506)	(713)
Other operating income	2	(24)	(1,026)
Total operating income		**(530)**	**(1,739)**
Staff costs	3	2,235	1,963
Purchase of goods and services	4	202,042	172,949
Depreciation and impairment charges	4	53	55
Provision expense	4	(304)	415
Other operating expenditure	4	110	274
Total operating expenditure		**204,136**	**175,656**
Total comprehensive net expenditure for the year		**203,606**	**173,917**

The notes on pages 5 to 18 form part of this statement

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment		2	55
Total non-current assets		2	55
Current assets:			
Trade and other receivables	7	5,536	8,374
Cash and cash equivalents	8	210	107
Total current assets		**5,746**	8,481
Total assets		**5,748**	8,536
Current liabilities			
Trade and other payables	9	(31,537)	(26,255)
Provisions	10	(541)	(843)
Total current liabilities		**(32,078)**	(27,098)
Non-current liabilities			
Provisions	10	(592)	(796)
Total non-current liabilities		**(592)**	(796)
Assets less Liabilities		**(26,922)**	(19,358)
Financed by Taxpayers' Equity			
General fund		(26,922)	(19,358)
Total taxpayers' equity:		**(26,922)**	(19,358)

The notes on pages 5 to 18 form part of this statement

The financial statements on pages 1 to 18 were approved by the Joint Federated Audit Committee on the 22nd of May 2018 and signed on its behalf by:

Accountable Officer Date:

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

	General fund £'000
Changes in taxpayers' equity for 2017-18	
Balance at 01 April 2017	(19,358)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18	
Net operating expenditure for the financial year	(203,606)
Net funding	196,042
Balance at 31 March 2018	**(26,922)**

	General fund £'000
Changes in taxpayers' equity for 2016-17	
Balance at 01 April 2016	**(15,554)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17	
Net operating costs for the financial year	(173,917)
Net funding	170,113
Balance at 31 March 2017	**(19,358)**

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(203,606)	(173,917)
Depreciation and amortisation	4	53	55
Decrease/(increase) in trade & other receivables	7	2,838	(610)
Increase in trade & other payables	9	5,282	4,224
Provisions utilised	10	(202)	(275)
(Decrease)/increase in provisions	10	(304)	415
Net Cash (Outflow) / Inflow from Operating Activities		**(195,939)**	(170,108)
Cash Flows from Investing Activities			
Payments for property, plant and equipment		0	(3)
Net Cash Outflow from Investing Activities		**0**	(3)
Net Cash Outflow before Financing		**(195,939)**	(170,111)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		196,042	170,113
Net Cash Inflow from Financing Activities		**196,042**	170,113
Net Increase in Cash & Cash Equivalents	8	**103**	2
Cash & Cash Equivalents at the Beginning of the Financial Year	8	**107**	105
Cash & Cash Equivalents at the End of the Financial Year	8	**210**	107

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis. NHS Slough Clinical Commissioning Group was dissolved on 31 March 2018 having joined with NHS Bracknell and Ascot Clinical Commissioning Group and NHS Windsor, Ascot and Maidenhead Clinical Commissioning Group to establish NHS East Berkshire CCG with effect from 1 April 2018. This followed approval at the NHS England Assurance and Development Committee meeting and the NHS England Grant of Merger effective 1 April 2018, was issued dated 7 March 2018.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention.

1.3 **Pooled Budgets**

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

1.4 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 **Critical Judgements in Applying Accounting Policies**

There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.4.2 **Key Sources of Estimation Uncertainty**

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

The three Berkshire East Clinical Commissioning Groups (CCG) share the majority of joint management expenditure which is apportioned in proportion to the Clinical Commissioning Group running cost allowance.

As at the date of the Statement of Financial Position final information on secondary healthcare activity and prescribing data was not available. Accruals were made for these on the basis of year to date information that was available and the trends in the data.

An amount of £1,132k has been included in the provisions relating to the following items:

Continuing Health Care (CHC) Waiting List clients awaiting assessment at 31 March 2018	£687k
Appeals against earlier CCG decisions of non-eligibility for CHC funding	£445k

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 has been calculated using the average local current nursing home and homecare package weekly costs for NHS CHC Adult Fully Funded clients.

Provision has been made at 72% as per the current 2017/18 approval rate for first-time applications for CHC funding.

The CHC Appeals provision has been calculated on an individual basis for each client appealing against a CHC decision of non-eligibility. The calculation of provision is based on the time period from the start-date of the claim up to 31 March 2018 (or RIP date) using the average local current nursing home and homecare package weekly costs for NHS CHC Adult Fully Funded clients.

Provision has been made at 72% as per the current 2017/18 approval rate. The three Berkshire East Clinical Commissioning Groups were not risk-shared at any point during 2017/18.

Notes to the financial statements

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**

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

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.8 **Operating Leases**

1.8.1 **The Clinical Commissioning Group as Lessee**

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.

1.9 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.10 **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.

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

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

1.11 **Clinical Negligence Costs**

Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.12 **Continuing healthcare risk pooling**

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

Notes to the financial statements

1.13 **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.

1.13.1 **Loans & Receivables**

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

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

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

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

1.14 **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.

1.14.1 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost.

1.15 **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.

1.16 **Losses & Special Payments**

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

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2017-18, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2. Other Operating Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	**£'000**	**£'000**	£'000
Education, training and research	22	22	0	18
Charitable and other contributions to revenue expenditure: non-NHS	24	0	24	87
Non-patient care services to other bodies	484	0	484	695
Other revenue	0	0	0	939
Total other operating revenue	**530**	**22**	**508**	**1,739**

3. Employee benefits and staff numbers

3.1 Employee benefits

	2017-18			2016-17		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits						
Salaries and wages	1,855	1,506	349	1,672	1,178	494
Social security costs	166	166	0	133	133	0
Employer Contributions to NHS Pension scheme	211	211	0	158	158	0
Apprenticeship Levy	3	3	0	0	0	0
Gross employee benefits expenditure	**2,235**	**1,886**	**349**	**1,963**	**1,469**	**494**

NHS Windsor, Ascot and Maidenhead CCG hosts all the shared management teams for the Berkshire East CCGs (NHS Bracknell and Ascot CCG, NHS Slough CCG, NHS Windsor, Ascot and Maidenhead CCG). The figures in the table include the staff directly employed by the Clinical Commissioning Group and an apportionment for the shared teams hosted by NHS Windsor, Ascot and Maidenhead CCG.

The full staff cost note is in the staff report in the annual report.

3.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**37**	**35**	**2**	**33**

There were no ill health retirements in 2017-18 (2016-17: nil).

3.3 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2016-17 Compulsory redundancies	
	Number	£	Number	£
Less than £10,000	3	23,631	0	0
Total	**3**	**23,631**	**0**	**0**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

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 departure.

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 in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £20,121 were payable to the NHS Pensions Scheme (2016-17: £18,543) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1

4. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	2,033	1,075	958	1,740
Executive governing body members	202	193	9	223
Total gross employee benefits	**2,235**	**1,268**	**967**	**1,963**
Other costs				
Services from other CCGs and NHS England	2,324	1,129	1,195	2,132
Services from foundation trusts	133,165	8	133,157	125,689
Services from other NHS trusts	3,307	0	3,307	3,336
Purchase of healthcare from non-NHS bodies	22,651	0	22,651	21,810
Chair and Non Executive Members	54	54	0	220
Supplies and services – clinical	443	0	443	357
Supplies and services – general	113	102	11	281
Consultancy services	50	12	38	139
Establishment	478	86	392	354
Premises	794	116	678	1,083
Depreciation	53	53	0	55
Audit fees	38	38	0	56
Prescribing costs	16,804	0	16,804	16,320
GPMS/APMS and PCTMS	21,100	0	21,100	472
Other professional fees excl. audit	593	34	559	289
Legal fees	59	48	11	70
Clinical negligence	1	1	0	1
Education and training	123	50	73	149
Provisions	(304)	0	(304)	415
CHC Risk Pool contributions	0	0	0	412
Other expenditure	55	0	55	53
Total other costs	**201,901**	**1,731**	**200,170**	**173,693**
Total operating expenses	**204,136**	**2,999**	**201,137**	**175,656**

Audit fees - statutory audit services excluding VAT is £32k, amount shown £38k is inclusive of VAT (2016-17: £56K).

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 £2m limitation of their liability.

As of 1st April 2017 the CCG assumed full delegated responsibility for Primary Care Commissioning.

5.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	5,002	22,857	4,176	18,386
Total Non-NHS Trade Invoices paid within target	4,747	19,979	3,755	16,577
Percentage of Non-NHS Trade invoices paid within target	**94.90%**	**87.41%**	**3,755**	**16,577**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	5,148	194,389	5,179	191,055
Total NHS Trade Invoices Paid within target	4,936	193,240	4,859	187,438
Percentage of NHS Trade Invoices paid within target	**95.88%**	**99.41%**	**93.82%**	**98.11%**

6. Operating Leases

6.1 As lessee

6.1.1 Payments recognised as an Expense			**2017-18**			2016-17
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	764	5	**769**	1,033	0	**1,033**
Total	**764**	**5**	**769**	**1,033**	**0**	**1,033**

Slough CCG occupies property owned and managed by NHS Property Services (NHSPS). For 2015-16, the CCG was charged the costs of the space for property previously owned by Berkshire East PCT, however from 2016-17 NHSPS has moved to a market rent basis. The costs have been shared on a weighted resident population basis across the three Berkshire East CCGS. Whilst our arrangement with the NHSPS falls within the definition of an operating lease, including void spaces, the rental charge for future years has not yet been agreed, consequently, this not does not include the future minimum lease payments for the arrangement.

7. Trade and other receivables	**Current 31/03/2018 £'000**	Current 31/03/2017 £'000
NHS receivables: Revenue	1,694	874
NHS prepayments	939	913
NHS accrued income	2,239	6,324
Non-NHS and Other WGA receivables: Revenue	172	169
Non-NHS and Other WGA prepayments	306	71
Non-NHS and Other WGA accrued income	168	22
VAT	18	1
Total Trade & other receivables	**5,536**	**8,374**

The great majority of trade is with other NHS Bodies, including other Clinical Commissioning Groups as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is necessary.

7.1 Receivables past their due date but not impaired	**2017-18 £'000**	**2017-18 £'000**	2016-17 £'000
	DH Group Bodies	**Non DH Group Bodies**	All receivables prior years
By up to three months	994	12	353
By three to six months	0	9	14
By more than six months	181	1	341
Total	**1,175**	**22**	**708**

8. Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	107	105
Net change in year	103	2
Balance at 31 March 2018	**210**	**107**
Made up of:		
Cash with the Government Banking Service	210	107

9. Trade and other payables	**Current 31/03/2018 £'000**	Current 31/03/2017 £'000
NHS payables: revenue	9,191	10,624
NHS accruals	9,477	6,114
Non-NHS and Other WGA payables: Revenue	5,779	4,473
Non-NHS and Other WGA accruals	5,863	4,609
Social security costs	3	1
Tax	2	1
Other payables and accruals	1,222	433
Total Trade & Other Payables	**31,537**	**26,255**

10. Provisions

	Current 31/03/2018 £'000	**Non-current 31/03/2018 £'000**	Current 31/03/2017 £'000	Non-current 31/03/2017 £'000
Restructuring	0	0	47	0
Continuing care	541	592	796	796
Total	**541**	**592**	**843**	**796**

	Restructuring £'000	**Continuing Care £'000**	**Total £'000**
Balance at 01 April 2017	**47**	**1,592**	**1,639**
Arising during the year	0	433	433
Utilised during the year	(36)	(166)	(202)
Reversed unused	(11)	(726)	(737)
Balance at 31 March 2018	**0**	**1,133**	**1,133**
Expected timing of cash flows:			
Within one year	0	541	541
Between one and five years	0	592	592
Balance at 31 March 2018	**0**	**1,133**	**1,133**

Continuing Care provision relates to amounts set aside for Continuing Care Waiting List clients awaiting assessment at 31st March 2018 and 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 2018 is £3k (31 March 2017 £9k).

	Restructuring £'000	**Continuing Care £'000**	**Total £'000**
Balance at 01 April 2016	**47**	**1,452**	**1,499**
Arising during the year	0	796	796
Utilised during the year	0	(275)	(275)
Reversed unused	0	(381)	(381)
Balance at 31 March 2017	**47**	**1,592**	**1,639**
Expected timing of cash flows:			
Within one year	47	796	843
Between one and five years	0	796	796
Balance at 31 March 2017	**47**	**1,592**	**1,639**

11. Financial instruments

11.1 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 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 Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

11.1.1 Currency risk

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

11.1.2 Interest rate risk

The Clinical Commissioning Group has no borrowings in 2017/18 (2016/17 nil) and therefore has low exposure to interest rate fluctuations.

11.1.3 Credit risk

Because the majority of the Clinical Commissioning Group's revenue comes from parliamentary funding the 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.

11.1.4 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.

11.2 Financial assets

	Loans and Receivables 31/03/2018 £'000	Loans and Receivables 31/03/2017 £'000
Receivables:		
· NHS	3,933	7,198
· Non-NHS	340	191
Cash at bank and in hand	210	107
Total at 31 March 2018	**4,483**	**7,496**

11.3 Financial liabilities

	Other 31/03/2018 £'000	Other 31/03/2017 £'000
Payables:		
· NHS	18,668	16,738
· Non-NHS	12,864	9,515
Total at 31 March 2018	**31,532**	**26,253**

12. 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.

13. Pooled budgets

The CCG has a pooled budget arrangement with Slough Borough Council for the Better Care Fund (BCF). The Pool is hosted by the Council. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for joint commissioning arrangements.

The CCG's contribution and share of the expenditure is shown below:

	BCF - Slough Borough Council 2017-18 £'000	**BCF - Slough Borough Council** 2016-17 £'000
Income	8,407	7,407
Expenditure	(8,407)	(7,407)

14 Losses and special payments

14.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Store losses	1	0	0	0
Total	1	0	0	0

There were no losses over £300,000

15. Related party transactions

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

The amounts shown below in the table are payments/receipts to the related party and not the member.

	2017-18				2016-17			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Jim O'Donnell - Chair (GP Partner - Farnham Road Practice)	3,077	0	8	0	513	0	21	0
Dr Ajaz Nabi - GP Governing Board Member (GP Partner - Bath Road Surgery Slough)	0	0	0	0	33	0	3	0
Dr Asif Ali - GP Governing Board Member (GP Partner - Langley Health Centre)	0	0	0	0	423	0	12	0
Dr Siva Sithirapathy - Co-opted GP Board Member (GP Partner - Wexham Road Surgery)	494	0	18	0	135	0	12	0
Dr Mike Hoskin - GP Governing Board Member (GP Partner - Crosby House Surgery)	1,156	0	19	0	0	0	0	0
Dr Nithya Nanda - GP Governing Board Member (GP Partner - Farnham Road Practice)	3,077	0	8	0	0	0	0	0
Dr Lalitha Iyer - Medical Director (GP Partner - Farnham Road Surgery)	3,077	0	0	0	513	0	21	0
Remuneration paid to management entity for services provided by Paul Sly	0	0	0	0	12	0	0	0
Nigel Foster - Director of Finance (Director of Finance and IM&T - Frimley Health NHS Foundation Trust)	87,627	0	4,299	963	82,795	0	4,104	932

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 Director of Finance of the CCG is also the Director of Finance and IM&T for Frimley Health NHS Foundation Trust. All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. Material transactions are disclosed appropriately in the accounts.

* In 2017-18, Slough CCG received £898k (2016-17 £921k) funding from the GP Access Fund to support extended Primary Care and GP access service in 2017-18. The extended access is delivered by the Slough GP Practices organised into 4 Cluster groups, each with a lead GP Practice who sub contracted with the other GP Practices within their cluster. Farnham Road Surgery, Crosby House, Bharani Health Centre and Langley Health Centre are the lead GP Practices for the Clusters. Payments are paid via these lead GP practices to the practices within the Cluster to deliver the services.

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:
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 Bracknell and Ascot CCG
NHS Windsor, Ascot & Maidenhead CCG
NHS Central Southern Commissioning Support Unit
Oxford University Hospital NHS Trust
Royal Berkshire NHS Foundation Trust
South Central Ambulance Service NHS Foundation 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 Slough Borough Council in respect of joint commissioning arrangements.

16. Financial performance targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).
The Clinical Commissioning Group's performance against those duties was as follows:

	2017-18 Target	2017-18 Performance	2017-18 Surplus/ (Deficit)	2017-18 Target Met	2016-17 Target	2016-17 Performance	2016-17 Surplus/ (Deficit)	2016-17 Target Met
Expenditure not to exceed income	208,843	204,136	4,707	Y	179,329	175,656	3,673	Y
Capital resource use does not exceed the amount specified in Directions	0	0	0	Y	6	3		Y
Revenue resource use does not exceed the amount specified in Directions	208,313	203,606	4,707	Y	177,590	173,917	3,673	Y
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Y	0	0		Y
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	Y	0	0		Y
Revenue administration resource use does not exceed the amount specified in Directions	3,196	2,977	219	Y	3,180	3,180		Y

17. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group (£nil in 2016/17)
Bracknell and Ascot, Slough and Windsor, Ascot and Maidenhead CCGs merged to form a single statutory body, NHS East Berkshire CCG, on the 1st April 2018.