NHS
East Berkshire
Clinical Commissioning Group

EAST BERKSHIRE CCG

Annual report and accounts

2020-21

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PERFORMANCE REPORT

1. FOREWORD

This year we have responded to the biggest issue that health and care organisations have faced in a generation. Across East Berkshire CCG area, your health and care services have made remarkable progress to respond to the Covid-19 pandemic. Unprecedented levels of large scale changes have been made at pace to the way services are prioritised and delivered, to maintain patient and staff safety and to ensure the services available have enough capacity to give our populations the care they need.

During this challenging period, our local population has continued to be able to access GP services and we have maintained essential hospital services, such as cancer and mental health/learning disability care.

This has been achieved thanks to strong partnership working across health and care organisations; the hard work, professionalism and commitment of staff, and the sacrifices and co-operation of our local communities through what has been a difficult time for everyone.

Although we have been repeatedly tested during the pandemic, we are confident that the progress we have made as the Frimley Collaborative - a partnership of Clinical Commissioning Groups, and as Frimley Health and Care Integrated Care System (ICS) over the last year, has put us in a strong position to meet the challenges and respond in an effective, integrated way.

There have been a number of positives that have been achieved in a short period of time. Traditional models of health care which had needed modernising have transformed at pace in response to Covid-19, based on the needs of individuals and including the rapid adoption of technology. It is essential that these benefits continue to be developed, harnessed and enhanced during the coming year.

Throughout this year, we continued to work together as the Frimley Collaborative, representing our communities across North East Hampshire and Farnham, East Berkshire and Surrey Heath. The collaboration strengthened even further as we were successful in becoming a merged organisation, Frimley CCG, from 1st April 2021.

I have become Accountable Officer for the newly formed Frimley CCG at a time of huge opportunity as we look toward the government's plans for Integrated Care Systems over the next 12 months. The government White Paper has set out how Integrated Care Systems will become statutory organisations in 2022 and I look forward to bringing our partners together to work on Frimley's plans for rapid

transformation for the 800,000 people who live in the communities within the system.

As I look back through this report, reflecting on the successes of these organisations over the past year under the leadership of then Clinical Chief Officer Dr Andy Brooks, I can see how much time and energy has been committed to doing the right things for the local people in the communities we serve.

2020-2021 was another year of success with standout projects that will make a real difference to local people's lives, their health and their wellbeing. All three organisations were awarded an 'Outstanding' rating by NHS England, only 22 out of 191 in the whole country achieved the same. Communities in East Berkshire have benefitted from improvements as part of the Enhanced Health in Care Homes work, as well as working towards key new facilities in Britwell in Slough, Heathlands and Blue Mountain in Bracknell Forest and Brook House in Ascot. Connections between partner organisations, particularly in local government have been strengthened even further and have had huge tangible on the ground benefits as part of the impressive Covid-19 vaccination programme. This will stand us in good stead for the year ahead.

As Chief Executive of Frimley Health and Care ICS I have always valued the vital contribution of our commissioning organisations, recognising the connections into places and the commitment to local people and partners. The work achieved this year as part of a system-wide Incident Control approach to managing the resources across all our partner organisations, has really enabled us to integrate further and start working towards our ICS Roadmap to deliver our collective ambitions.

I am very proud to be taking on this dual role as ICS Chief Executive and Frimley CCG Accountable Officer and look forward to what we can achieve together building on the strong foundations of the organisations represented in this report.

Together, we have made some significant developments and changes for the benefit of our local population this year and I would encourage you to find out more within this report. By working collaboratively with individuals, their neighbourhoods, our five places, the system as a whole and across broader boundaries, we have an exciting opportunity to re-shape what we do and collectively make differences to our population that will impact on their lives and the lives of future generations.

Fiona Edwards
Accountable Officer Frimley CCG
Chief Executive Frimley Health and Care ICS
14 June 2021

2. PERFORMANCE OVERVIEW

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

2.1. Our purpose

NHS East Berkshire Clinical Commissioning Group (CCG) covers the geographical areas of Ascot, Bracknell, Maidenhead, Slough and Windsor. The CCG commissions services for the population of 455,676 registered at 46 practices. The CCG is responsible for planning and purchasing (commissioning) healthcare services to meet the needs of our local population.

The CCG has responsibility for both commissioning sustainable primary care services and for all the GP practices within our CCG area, which form part of our membership organisation, responsible for making sure that local people get the health services they need. The CCG has three ‘places’:

Bracknell Forest – population size of 117,986 registered at 10 GP practices and supported by three primary care networks.

Royal Borough of Windsor and Maidenhead - population size of 187,000 registered at 20 GP practices and supported by three primary care networks.

Slough - population size of 166,443 registered at 16 GP practices and supported by four primary care networks.

2.2. Our activities

The CCG is responsible for commissioning safe and effective healthcare services for local people, including:

- primary care services (GPs)
- out of hours primary medical services
- urgent and emergency care including NHS 111, A&E and Ambulance services
- elective (planned) hospital care and day surgery
- community health services such as community nursing, physiotherapy, podiatry, speech and language therapy and rehabilitation services
- audiology services
- mental health services (including psychological therapies)
- services for people with learning disabilities
- maternity and new-born services (excluding neonatal intensive care)
- children and young people's health services such as community child health, therapists, acute care, child and adolescent emotional health and wellbeing
- NHS continuing healthcare for people with ongoing healthcare needs

2.3. Our organisational structure

In July 2019, the CCG's Governing Body took the decision to work more formally with NHS North East Hampshire & Farnham CCG and NHS Surrey Heath CCG to work collaboratively, so as to improve the health and care services provided to its residents in a joined-up way. The three CCGs formed the 'Frimley Collaborative' to learn from each other and spread good practice, make more effective use of our resources and avoid duplication. The Collaborative works together across the same geography as our partner organisations in the Frimley Health and Care Integrated Care System.

The CCG Governing Bodies created a shared decision-making body, the 'Frimley Collaborative Board' and agreed a formal way of working based around five 'Places':

- Bracknell Forest
- North East Hampshire and Farnham
- Royal Borough of Windsor and Maidenhead
- Slough
- Surrey Heath

The vision at place focuses on ensuring everyone has access to preventative services, advice on living well, simple, joined-up services and those who are vulnerable or high risk receive support to keep as well as possible.

Merger

The current three CCGs have a reputation for high quality leadership and effective partnership working within local systems with all CCGs attaining an 'Outstanding' rating by NHS England in 2019-20.

Building on the success of the Collaborative the three CCGs asked NHS England to merge the three organisations into a single CCG. In November 2020, NHS England gave conditional approval and in March 2021 gave the grant of merger and the dissolution agreement for the three CCGs to create a single NHS Frimley CCG from 1 April 2021.

Our Vision as a single Clinical Commissioning Group

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

This enables the clinical commissioning group to focus on the importance of local insight and need, whilst recognising the strength of working as a system with a consistent core approach as we embark on the roadmap towards creating a single ICS organisation by April 2022. We have always seen the merger of our three CCGs as a step in the journey for commissioning, with this evolution intrinsically linked to the emerging thinking about roles and responsibilities of all partners within the Frimley Health and Care System (Frimley ICS). The ICS Roadmap for the development of the Frimley system has been developed with the ICS Partnership Board and over the next 12 months we will collectively determine how the role, functions and activities of CCGs will be carried out as part of the new system landscape that will come from the government's legislative reform.

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

There is no single geography across which all our services are commissioned and although some services will be commissioned on the new CCG (and Frimley ICS) footprint, others will be secured at smaller footprints (for example Slough, Bracknell Forest and Royal of Windsor and Maidenhead). Others may be jointly commissioned within local authority boundary footprints and/or health commissioners in other ICSs, while for rare disorders their services need to be considered and secured nationally or regionally. It is therefore vital that we have a strategic commissioning model that can work optimally across organisational and system boundaries.

The Frimley Health and Care ICS ambitions mean that our collective focus will be on preventing ill health, supporting people to improve their own wellbeing, proactively managing the health and care needs of the population and genuinely integrating care at a local level to collectively deliver on the five-year plan.

The Collaborative and the merged CCG are important steps in the development of the Frimley Health and Care ICS.

Delivering effective place based working

Slough, Bracknell Forest and the Royal Borough are three of the five places in the Collaborative and in the new Frimley CCG. Each of the three places have a leadership team, led by an Executive Managing Director a Clinical Leader and a Lay Member. This structure retains the local focus while working across the broader area of the Frimley Health and Care Integrated Care System. This organisational design will continue to enable us to manage the complexities of our local authority boundaries and continue to enthusiastically search for, and deliver, further opportunities for collaborative working and integrated services.

2.4. Our business model and environment

In 2020-21 the CCG managed itself through a number of business models which included in-house, shared and bought-in services which enabled the CCG to retain ownership of statutory responsibilities while working with partners across the Collaborative and ICS.

In 2020-21 NHS East Berkshire CCG had three components:

- In-house staff
- South, Central and West Commissioning Support Unit
- Shared commissioning expertise.

This balance between in-house, shared and bought-in services enabled us to retain ownership of statutory responsibilities while benefiting from economies of scale of other larger NHS organisations. We also benefit from joint appointments with our local authority partners which facilitates close working across Adult Social Care and CCG teams enabling a more integrated service for residents.

In-house staff

Staff have very successfully adapted to remote working over the last year and have responded to the challenges and opportunities it brings. Working in the Frimley Collaborative has made closer relationships between the CCGs that has enabled better use of our people and our financial resources, avoiding duplication and making us more efficient and cost-effective. Thanks to working in this way prior to the pandemic, we have been able to maintain our close links and relationships whilst having to be based remotely.

The three places in East Berkshire have set up local teams working closely with local authority and provider colleagues planning and making decisions jointly. Each has a Place Based Committee that is a partnership forum which recognises the role of local authorities and provider organisations in the planning and delivery of health and care improvements.

Shared support services

These were provided by NHS South, Central and West Commissioning Support Unit (SCW CSU). They have supported the CCG since 2013 providing expertise in a range of management areas such as contracting, business analytics, information governance, information technology and finance.

We continued to liaise closely with colleagues from public health in the three local authorities in East Berkshire who provide details about the health needs of our local population based on information from the Joint Strategic Needs Assessment (JSNA), which informs our local planning decisions. The CCG has been a key partner in Health and Wellbeing Boards for the three local authorities and has worked closely with them to deliver the local plans.

Shared commissioning expertise

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

- Acute hospitals
  - Frimley Health NHS Foundation Trust (FHFT)
  - Royal Berkshire NHS Foundation Trust (RBFT)
  - Ashford and St Peter's NHS Foundation Trust
- Mental health and community services
  - Berkshire Healthcare NHS Foundation Trust (BHFT)
- Ambulance Trust
  - South Central Ambulance Service NHS Foundation Trust (SCAS)

Local authorities are responsible for commissioning social care services, which are provided by a range of both in-house and external providers, and the following councils commission services for East Berkshire patients depending on where they live - Bracknell Forest Council, Slough Borough Council, Royal Borough of Windsor

and Maidenhead, Surrey County Council and Buckinghamshire County Council. In addition, we have a vibrant voluntary and community sector.

2.5. Frimley Health and Care Integrated Care System

In 2020-21 the Frimley Health and Care ICS ambitions meant that our collective focus has been on preventing ill health, supporting people to improve their own wellbeing, proactively managing the health and care needs of the population, reducing health inequalities and genuinely integrating care at a local level to collectively deliver on the five-year plan.

The partner organisations in the Frimley Health and Care ICS have worked together with a single operating plan and a single financial control total over the past two years. This means that the system has shared priorities and plans of how to deliver them. Working with a single financial control total has allowed us to make partnership based local investment decisions to support the change programme set out in the operating plan as well as delivering our 'business as usual' services.

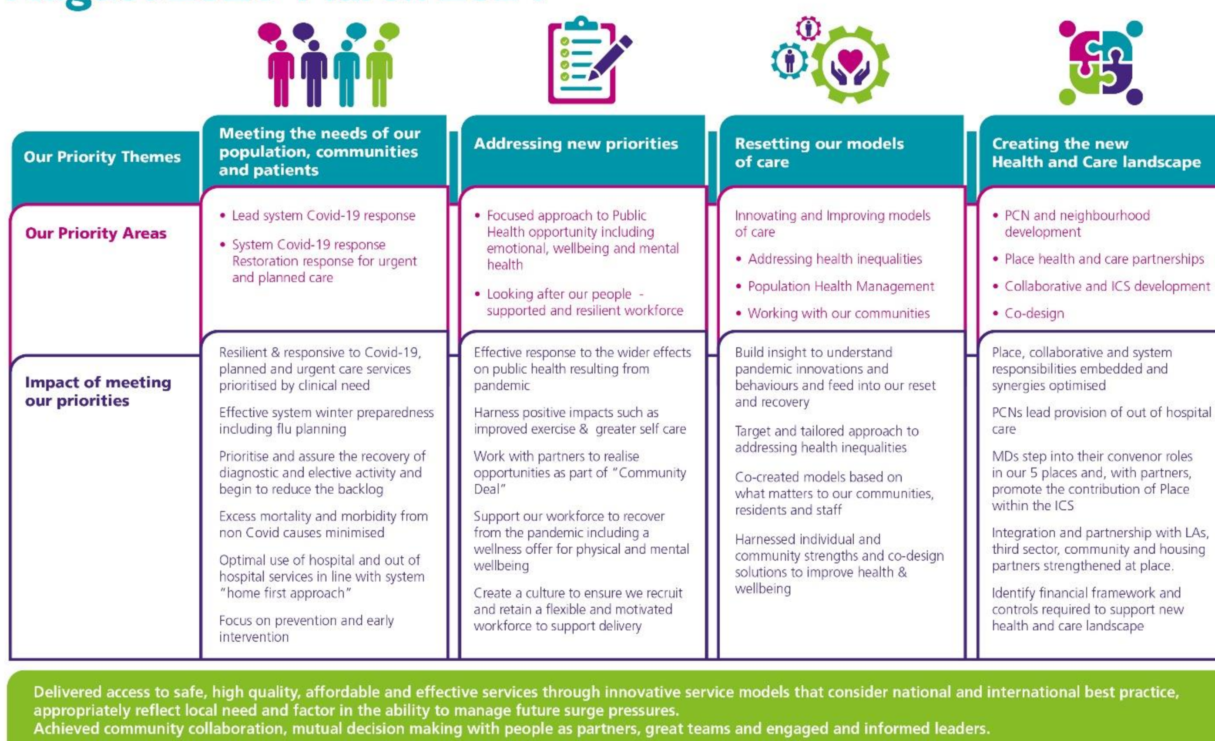
The governance structure of the Frimley Health and Care ICS aligns with that already in place locally with a view to strengthening system level improvement and assurance mechanisms. Over time this will morph into a new organisational form as the new Frimley CCG and ICS become a single organisation in 2022. This year we have been working collectively in response to NHS Long Term Plan and have a single operating plan.

The five-year Frimley Heath and Care ICS ambitions are set out below:

2.6. Our priorities and objectives

The priorities for the CCG reflect the response to Covid-19 and the changing NHS landscape. The key areas of focus for us have been:

- Leading the system Covid-19 response and the restoration for urgent and planned care.
- Looking after our people to create a supported and resilient workforce.
- Addressing health inequalities.
- Working with our communities.
- Primary Care Network development.
- Collaborative and ICS development.



2.7. Key issues and risks

The main risks and issues have been associated with the unprecedented and unplanned demand on health services as a result of the Covid-19 public health emergency. Despite the pressure on capacity, finance and resources the system has been able to work hard and continuously with health and local government partners to manage the impact on the quality of care as the surge for acute services took effect in 2020.

The Covid-19 pandemic has fundamentally changed the way we deliver care and carry out our routine business activities. A need to expand choice and modernise access to services has been a long term ambition which the pandemic has helped

to accelerate, driving a positive impact on people and the environment in which they live and work; both of which are key health and wellbeing priorities for our places over the next 12 to 18 months.

Looking ahead

2021-22 offers us many opportunities as we set plans for recovery and restoration. Each of our places have clear aims to improve access to preventative services, advice on living well, simple joined-up services and those who are vulnerable or high risk receive support to keep as well as possible.

Bracknell Forest

- Recovering from the impact of Covid-19 - re-energise local plans with Bracknell Forest Council to address local health inequalities.
- Focus on partnership integration as we deliver our Health and Wellbeing priorities.
- Restoration and recovery – to help drive improvement in health checks for people with Learning Difficulties and Serious Mental Illness.
- Continue to focus on the development of Blue Mountain Health and Wellbeing Centre and Heathlands Care Home.

Royal Borough of Windsor and Maidenhead

- Recovering from the impact of Covid-19 – recognising the inequalities gap across all ages.
- Co-coordinating integrated services around the residents who need it most.
- Championing mental wellbeing and reducing social isolation.
- Targeting prevention and early intervention to improve wellbeing
- Restoration and recovery – investing in the borough as a place to live in order to reduce inequalities.

Slough

- Recovering from the impact of Covid-19 - Slough is an area of densely populated communities, many families live in multigenerational households and many of our BAME community work in public facing roles such as taxi drivers and bus drivers which leaves them very exposed to the virus.
- Children and Young Persons Integrated therapies – focusing on reducing waiting times and improving access.
- People with mental health needs are presenting with high levels of acuity, and we expect a surge in mental health needs across our communities.
- Restoration and Recovery – ensuring that we are working together.
- Developing a Slough Health and Care Plan with partners.
- Working together with partners to deliver the Slough 2040 vision, which was launched in March 2021.

2.8. Performance Summary

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

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

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

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

3. PERFORMANCE ANALYSIS

3.1. Our performance in 2020-21

The NHS has taken incredible steps to be able to respond to the unprecedented demand of the Covid-19 pandemic. This report goes as far as possible in these circumstances with limited performance data.

This report showcases some of the incredible work that has taken place over the past year, with three specific examples included here:

- Integrated Care Organisational Development Programme;
- Enhanced Health in Care Homes;
- General Practice Resilience.

Integrated Care Organisational Development Programme

The CCG has committed to invest and prioritise the development of integrated care teams alongside the developing clinical leadership in our three Primary Care Networks.

The commitments of the Integrated Care Decision Making model are:

- Anticipatory care: We will try to anticipate future needs and intervene earlier in an integrated way for the most vulnerable in our communities to avoid delay and reduce the need for future care and support.

- Local Access Points: if someone does have needs we will make sure that right from the start of their journey needs are looked at holistically and assessed jointly.

- Multidisciplinary (MDT) working; if needs escalate and are becoming complex to manage we will meet together to agree an integrated action plan and share that plan with the people that need to know.

- Supported Discharge; if someone is admitted to hospital we will work together proactively trying to get them back home as soon as possible in a joined up way and stop them being readmitted, planning any support needed to keep them independent at home as long as possible.

A key part of the programme was the opportunity for relationships to be built between individuals across primary and community care, the acute trust, voluntary services and social care; allowing these relationships to be forged and developed for the delivery of better health and care for our local communities. The establishment of the virtual Local Access Points and MDT arrangements prior to the pandemic was very timely enabling increased levels of support to ensure personalised care to those most vulnerable.

Enhanced Health in Care Homes

Older people living in care homes have some of the most complex health needs and have been shown to be one of the most vulnerable population groups experiencing variable access to health care and consequential high rates of unscheduled admissions to hospital. This vulnerability has been exposed further by the Covid-19 pandemic where residents and care home staff have borne significant challenges and risks associated with the virus.

The aim of the framework for Enhanced Health in Care Homes (EHCH) is to tackle this inequity with an expectation that people living in care homes receive the same level of support as if they were living in their own home. The importance of this is driven by a national NHS approach for contracting and commissioning high quality services in care homes.

The EHCH model moves away from traditional models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach. Working across all the care homes in East Berkshire it was clear that one size would not fit all and it was important to recognise and not undermine the excellent work that local care homes were already delivering. A collaborative decision was made with care home managers to wrap the existing integrated approach around care homes with care home staff having direct access to integrated community health, care and well-being services.

As part of the CCGs Covid response the focus was on 4 key areas of implementation:

- Continuity of contact with a named general practice clinical lead undertaking weekly home rounds. A care home in-reach nurse and medicines optimisation team member supporting the clinical lead and care home staff in the proactive management of medicines and nursing care reducing overprescribing and unnecessary medical intervention.

- An enhanced urgent care pathway with timely escalation to a GP (including Out of Hours services), advice line to a community geriatrician and community admission avoidance pathways. This pathway promotes shared decision-making and patient choice outcomes avoiding unnecessary hospital admission.

- Integrated Care Pathway with direct access to the integrated Locality Access Point. This ensures complex needs are met in a timely way, (including a 2 hour response) supporting care homes with the complex navigation of health and care pathways. Joined up care from an integrated team ensures complex / multiple needs are met reducing risk of ambulance conveyance and admission

to hospital. To reduce delays, care home staff can also make direct referrals to specialist community services.

- Quality improvement initiatives, that included early roll out of NHS Mail, a 24/7 advice line for care homes and a dedicated in box for questions. With infection, prevention & control (IPC) training; anticipatory end of life packs; work on walking with purpose; support with discharge facilitation and outbreak management.

From October 2020, the model was reinforced with dedicated care home MDTs aligned with Primary Care Networks (PCNs) as part of the CCG's integrated winter offer. This will be evaluated early in 2021/2022.

General Practice Resilience

A focus this year has been on the business continuity arrangements during the pandemic and taking the opportunity to flex traditional digital and workforce capacity resulting in retaining high quality care and necessary capacity to address local health needs. The primary care response throughout the pandemic has been exceptional through focusing on:

- Maintaining service offers through securing alternative capacity to ensure safe delivery of care by separating services for people with a Covid-19 infection from other services, to protect staff and patients as far as possible.
- Enhanced models to deliver the additional capacity for the flu campaign and Covid vaccination.
- Design and deliver flexible models for services to respond to demand including impact of Covid-19 in unprecedented times.
- Access to general practice services continued to be available evenings and weekends.
- Deliver enhanced clinical support to care homes through Primary Care Networks.
- Support staff and patients to positively engage with the service model changes required to deliver safe care, Digital First with Total Triage.
- Understand the impact on the population through the waves of the pandemic, ensuring practices remain open to patients specifically for screening and care planning, prevention through vaccination and support for patients with their long term condition management.

4. KEY PERFORMANCE MEASURES

For most of 2020-21, the NHS has been operating under a Level 4 incident response regime, the highest level of critical incident response, which requires NHS England National Command and Control to support the NHS response. In these circumstances, NHS England co-ordinates the NHS response in collaboration with local commissioners.

From the beginning of the year, the Frimley system has therefore been operating an Incident Control Centre to direct and manage its local resource and capacity to focus on the crisis response, in line with NHS England directives. As part of this, we have been adhering to NHSE/I's position on regulatory and reporting requirements which included;

- pausing all non-essential oversight meetings; and
- streamlining assurance and reporting requirements.

The brief respite in the summer of 2020, when Covid case numbers and acuity reduced, allowed the NHS to begin its response to post Covid recovery – including areas elective surgery, cancer care and other long-term conditions where patients had been unable to access their usual outpatient and primary care treatment. Whilst some progress was made during this period on non-Covid priorities, the second and third waves of the pandemic impacted once more and in January of this year, Amanda Pritchard, Chief Operating Officer of NHS England and NHS Improvement reconfirmed the national position on freeing up management capacity and resources to focus on the ongoing challenges faced by healthcare systems.

To this end, much of the performance monitoring and reporting routinely undertaken was suspended this year and is therefore not included in our Annual Report. Where some has continued – referral to treatment times, cancer waits and ambulance response times for example – performance has been significantly below national targets as might be expected and does not reflect the extraordinary work and efforts of services over the last year, where the overriding focus has been to save as many lives as possible.

However, as an organisation, we are aware of our responsibility to maintain an appropriate level of oversight on performance across all our services and for all our population:

- to support our ongoing work in tackling inequalities;
- to ensure that the unintended consequences of the pandemic response for those with non-Covid conditions and needs are minimised; and
- to develop services to respond to the longer term impacts of Covid including mental health support.

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

Collaborative wide assurance of statutory functions;

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

On a monthly basis, a full report on the above metrics was shared with the Collaborative Board and is used to support lay member briefings. The focus has been on system wide performance but with additional information for each of the three CCGs in the Frimley Collaborative.

Operational Performance Management information;

A weekly operational dashboard is produced to support system oversight by the Frimley Incident Control Centre. From the beginning of January 2021, Place level insights have been added to the report to support local partnership conversations.

The place insights focus on the following three priorities; vaccine roll out, reducing burden on acute services (both admissions & discharge), and supporting primary care resilience and local workforce mutual aid.

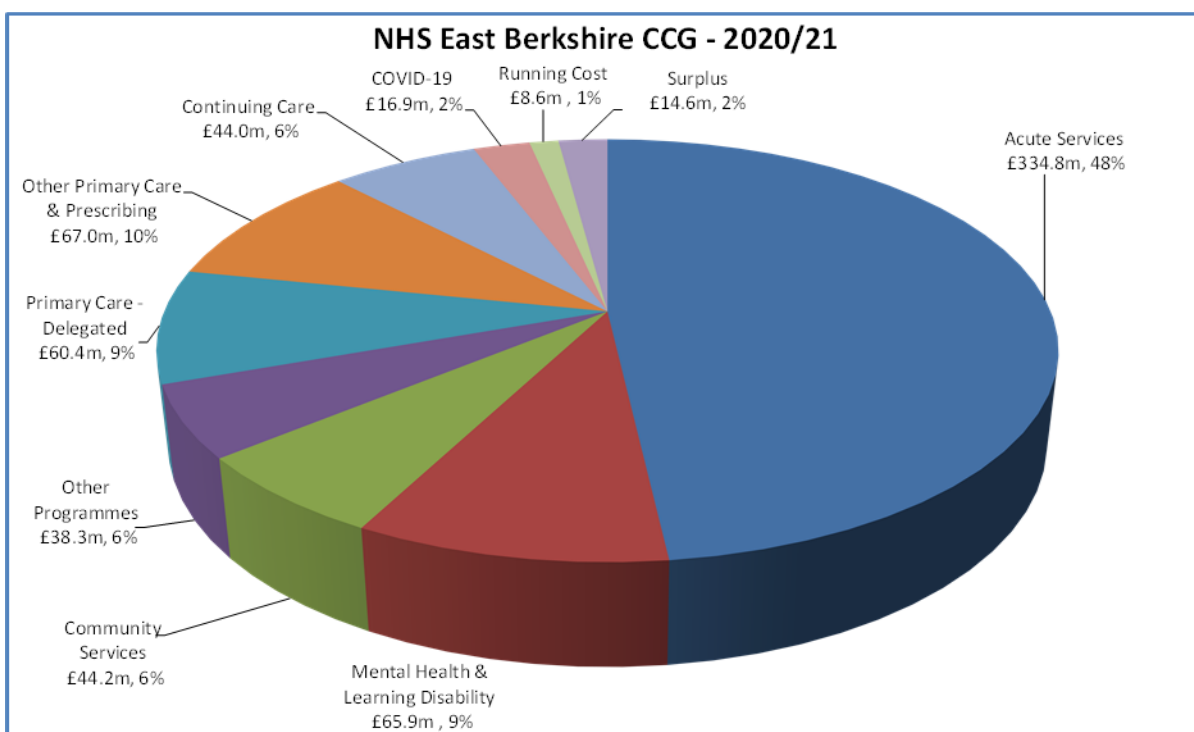
5. SUMMARY OF FINANCIAL PERFORMANCE

5.1. Financial overview

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

The financial regime has been very different this year as a result of Covid-19 with the overriding consideration being that providers had access to sufficient funding to respond to the pandemic. Additional funding was made available to CCGs and Trusts to ensure that all services were adequately resourced for the additional costs of personal protective equipment (PPE), staff and facilities. The CCG has also been reimbursed for costs incurred in ensuring faster discharge from hospital for patients who required ongoing support but could be safely discharged from an acute setting, allowing beds to be made available for more acutely unwell patients.

5.2. Review of the financial year



The CCG spent £680.2m in 2020-21 (net operating costs), which equates to £1,437 for every person registered with our practices. NHS East Berkshire CCG has reported a cumulative surplus of £14.6m for the year.

In 2020-21 we underwent our first enhanced reporting value for money audit which looks at all aspects of how the CCG manages its finances and tests its processes, decision making and financial management to ensure that we are using public money economically, effectively and efficiently for the benefit of our population. This provides further evidence towards the auditor's unqualified opinion. Further information can be found in Section 17 of this report.

Approximately half of our expenditure, £350.9m, is spent on acute services. Our main provider is Frimley Health NHS Foundation Trust (FHFT), with whom we spent £240.6m in 2020-21. Our other main provider is the Royal Berkshire NHS Foundation Trust, £29.5m and then there are range of smaller contracts with other providers such as Ashford and St Peters Hospitals, Royal Surrey County Hospital 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 (£87.9m).

Under full delegated responsibility for Primary Care (GP) commissioning, in 2020-21 the CCG received an allocation of £60.5m from NHS England. The majority of GP costs are funded through contracts held directly by NHS England and administered by East Berkshire CCG. We also meet the cost of drugs prescribed by our local GPs of £54.7m and pay for the GP 'out of hours' service at a cost of £4.8m.

The CCG spent £26.9m in partnership with our local authority partners under the Better Care Funds with Bracknell Forest Council, Slough Borough Council, Surrey County Council and the Royal Borough of Windsor & Maidenhead, supporting greater integration across health and social care services.

The CCG has spent £16.9m of Covid funding, the majority of which, £11.3m, was spent on placements and home-based care under the hospital discharge scheme which was run in conjunction with Bracknell Forest Council, Slough Borough Council, Surrey County Council and the Royal Borough of Windsor & Maidenhead. The scheme enabled patients to be safely discharged from hospital as soon as possible to either a nursing or residential care setting or with additional support at home. This supported the flow of patients through the acute hospitals and freed up bed capacity and nursing resource for Covid patients and those who were more acutely unwell. Covid expenditure within Primary Care amounted to £4.2m.

5.3. Running Costs

The CCG receives a separate allocation for the costs of running the organisation based on the size of our population, which it must not overspend against. In 2020-21, we received and spent £8.6m.

5.4. Financial plan 2021-22

From the 1st April 2021, East Berkshire CCG will form part of the new Frimley CCG following the merger with North East Hampshire & Farnham and Surrey Heath CCGs. The financial planning process for 2021-22 will therefore be undertaken on the new footprint. The expectation that the CCG will continue to manage within its given resources will remain. Our plans will form part of the financial planning for the Frimley ICS, which will also be required to live within its means, requiring ever closer partnership working with our partners to deliver high quality, sustainable services within a challenging environment.

The impact of the Covid pandemic will continue to influence the financial plans for the new CCG, with block payments to most Trusts continuing at least for the first half of 2021-22. The financial plans for the year will support the operational plans which reflect the national priority areas:

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

These priorities are backed by targeted investment as part of a £8.1 billion plan nationally to help the health service manage endemic levels of Covid-19 and begin the process of recovery following the intense winter wave of Covid.

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

Further details about our expenditure in 2020-21 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 2020-21 cost £93,000 plus VAT.

6. SUSTAINABLE DEVELOPMENT

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

In January 2020 the NHS launched the 'For a Greener NHS' programme. This builds on the work being done by trusts and other NHS organisations across the country, sharing ideas on how to reduce the impact on public health and the environment, save money and – eventually – go net carbon zero.

The NHS has already made considerable progress on climate change, with carbon emissions being reduced by 18% in the decade since 2007, at the same time as the NHS has significantly expanded the number of patients treated. In addition, 85% of NHS provider waste is avoiding going directly to landfill and 23% of waste was recycled in 2017. The NHS water footprint was reduced by more than one fifth (21%) between 2010 and 2017.

The NHS Long Term Plan (https://www.longtermplan.nhs.uk/) commitment aligns to this programme. Better use of technology could reduce 30 million outpatient appointments per year, sparing patients thousands of unnecessary trips to and from hospital. It is estimated that 6.7 billion road miles each year are from patients and their visitors travelling to the NHS.

It is our aim to support these ambitions and to help the NHS, as a whole, meet these targets. This section highlights areas where the CCG has demonstrated more efficient and effective ways of working:

- Transforming the way we deliver care;
- Covid vaccination sites;
- Brook House, Ascot;
- Blue Mountain, Bracknell Forest;
- Heathlands, Bracknell Forest;
- Britwell, Slough.

Transforming the way we deliver care

The changes introduced over the past year have helped to set the scene of simplified access to routine health and care services whilst protecting valuable face to face time to meet the needs of the most vulnerable.

Access to improved digital technology has transformed the way we engage with our local communities; conducting virtual clinics, online assessments, booking and attending appointments. Business activities have been conducted virtually through Microsoft Teams software reducing the need to travel, use of office space and releasing more time to engage in front line provision of health and care. The feedback from our local communities has been very positive with a strong desire to retain these changes.

For our local population, digital access has been identified as an area of concern with 1 in 25 households identified as not having access to the internet at home. Addressing asset deprivation and improving digital confidence will be a key enabler in our strategic approach to improving the health and wellbeing of our population going forward into 2021-2022.

Covid Vaccination sites

Bracknell Forest and Ascot health services joined forces with Waitrose to help protect local people from Covid-19. Waitrose donated the use of its Sports and Leisure Centre at its head office in Bracknell providing the much needed capacity for local GPs, nurses and pharmacists to boost the rollout of the Covid-19 vaccine in the community. The support from Waitrose also provided the headroom to reconfigure other venues to support the vaccine programme. The Health Triangle Primary Care Network temporarily refocused its Birch Hill site into a vaccination centre. In Maidenhead, the CCG and GPs worked closely with the Royal Borough of Windsor and Maidenhead to utilise space that was not being used during the pandemic in the Desborough Suite for vaccinations.

Brook House, Ascot

The CCG has worked with practices in the Ascot Primary Care Network and Frimley Health NHS Foundation Trust to deliver modern purpose built facilities to improve the primary care settings at the new Heatherwood Hospital. The scheme has created the opportunity for general practice to team up to deliver sustainable services, these are targeted on local population needs and engage the integrated care model for the population of Ascot. The new premises called Brook House will be available for occupation in March 2021.

The Brook House scheme delivers the first significant milestone for the local Ascot Plan development in partnership with general practices, community, local authority and acute partners. Further modernisation and additional capacity required to sustain local general practices in Ascot, continues with the option to develop fit for purpose facilities for two further local practices in Sunningdale and Sunninghill in 2022.

Blue Mountain, Bracknell Forest

The neighbourhoods of Binfield and Warfield are located within one of Bracknell Forest Council's Major Areas for Growth (MAG) and located adjacent to the planned

Strategic Development locations in the Borough of Wokingham. The closure and residential plan for the former Blue Mountain golf course provided the opportunity to strategically align aspirations to deliver integrated primary care, community health and care services alongside the changing needs of the population.

Over the next 15 years around 15,000 new dwellings are expected to be developed across Bracknell Forest, almost half of which are predicted to be in the Binfield and Warfield areas. Local GP practices are already reporting sizeable increases in the number of registered patients. The impact of this sustained growth is driving the need to change the way Bracknell Forest delivers local health and care services; working closely with local health and care partners to transform local services and provide a high quality, resilient and a sustainable model for the future.

In December 2020, the CCG gained outline approval for the Bracknell Forest business case, which will use funding from NHS England's Estates, Technology and Transformation Fund (ETTF). The CCG and Bracknell Forest Council have worked together on collaborative design plans and will be progressing through the next phase of applying for planning permission.

Heathlands, Bracknell Forest

The population of Bracknell Forest is rapidly increasing with the older population expected to increase at the greatest rate, impacting on the type and scale of services required for a sustainable future. Growth is adding to existing pressures including pressures being faced due to local demographic changes; increased demand on local hospital beds; rising costs of care home placements and increasing demand for nursing care beds. The closure of the former Heathlands residential home in Crosswell provided the opportunity for transformational change across health and social care to respond to these challenges.

The new Heathlands build will see the construction of a 66-bed nursing care facility specifically designed around the core needs of local residents. 46 beds will be dedicated to long term residential care for people with complex nursing and dementia needs. 20 beds will provide shorter term intermediate care for people who require additional rehabilitation and support when they become unwell or following a stay in hospital.

The redevelopment of the site was given the green light after planning permission was approved in early 2020. No objections to the proposals were received. Construction work is underway with completion expected by December 2021.

The development is part of the wider Frimley Integrated Care System (ICS) plans and local health and care strategies to deliver a transformed, resilient, cost effective and sustainable solution for care delivered within the community which includes

enhanced care home capacity, proactive care and support market development and integrated care delivered outside of the hospital sector.

The Heathlands model of nurse and therapy led care, will be underpinned by a strong provider partnership approach across health and care sectors with wrap around support from primary and community integrated care teams ensuring well planned and joined up care including the timely and safe transition of care back home for people using the intermediate care facility.

The CCG is working with Bracknell Forest Council to support the delivery of plans to integrate health and social care services that will help improve the lives of local people, with Heathlands playing a key part in this as it underpins the strategic partnership, provides an opportunity to overcome such challenges and will provide a sustainable community health and care model for the future.

Britwell, Slough

The Britwell Centre, Wentworth Avenue, is to be extended and revamped in a pioneering project to provide improved heath and council services in the heart of the estate.

As part of our vision to create integrated community hubs within our local neighbourhoods in Slough, we are set to realise our first steps through the new community centre being built in Britwell.

Britwell and Northborough are some of the most deprived wards within Slough with significant health inequalities and high prevalence of long-term conditions such as diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD) and respiratory illness. Previously we have had an underutilised community centre and an oversubscribed GP practice.

The new Britwell integrated hub will provide a local one stop service offer where residents can access not just primary care services but also new or enhanced services with person centred care and preventative offers being co-located. It will also include access to the job centre, counselling services and voluntary sector support. This is a truly asset based approach to improving health outcomes at a local level, drawing together partners to share not only the building, but working closely together with community groups and local

residents to improve resilience and wellbeing with a model that's sustainable for the long term.

Councillor Natasa Pantelic, lead member for health and wellbeing, said: "*This facility will be an excellent addition to the Britwell Centre and a fantastic resource for local residents.*

"No longer will people have to drive or attempt to get a bus to Wexham Park for that vital blood test or all important maternity check. Now it will be on the doorstep, easily accessible, convenient and in a modern environment; something local residents can be proud of."

7. IMPROVING QUALITY

The CCG continues to hold the responsibility for ensuring continual quality improvement of all locally commissioned NHS services and our local population have the right to high quality patient care; as stated by the NHS Constitution.

The NHS describes service quality as person-centred care for all that is:

Safe

- Are we protecting our local people from avoidable harm and abuse?
- When things go wrong, are we maximising the opportunity to learn and improve? For example
  - Serious Incidents & Significant Events/incidents
  - Safeguarding
  - Mortality Reviews & LeDeR
  - Infection Prevention and Control

Effective

- Local people receive care and treatment that achieves good outcomes, promotes a good quality of life and is based on the best available evidence for example
  - PROMs – Patient Reported Outcomes Measures
  - Service reviews
  - Quality and Outcomes Framework

Equitable

- Ensure inequalities in health outcomes are a focus for quality improvement
  - Knowing our local people
  - Meaningful community engagement
- Ensure that care quality does not vary due to any protected characteristic
  - Equality Impact Assessments

A Positive Experience

Staff involve and treat people with compassion, dignity and respect, and services respond to people's needs and choices and enable them to be equal partners in their care. Examples are

- Patient survey
- Complaints

Well-led

- Commissioning & service provision is well-led: open and collaborate and committed to learning and improvement
  - Culture of openness and collaboration

  - Acknowledge when things are not right and take action
  - Focus on learning and improvement

Sustainable

- Responsible use of resources, providing fair access to all, according to need, promoting an open and fair culture
  - Access to services

7.1. Covid-19 Quality Response

For the system to understand the quality impact of Covid-19 on services and the potential consequences the Quality Team collated Quality Impact Assessments (QIAs) in March 2020 and throughout the course of the year. They took in to account changing government guidelines and national priorities. The assessments outlined any changes to services due to Covid-19. This included the rationale, timeframe and a risk assessment with any mitigation to ensure services remained safe for patients.

The QIA's and other quality issues were reviewed at a system group comprised of key clinical leaders across the ICS Executive Quality and Clinical Reference Group (EQCRG). The group allowed the key leaders to understand change and impact and give consideration of how any changes that would impact on the whole system and has also given System Leads the opportunity to identify and reduce health inequalities.

QIAs were also undertaken when considering service re-starts to ensure that premises were Covid-19 safe, with infection prevention and control (IPC) measures and access to appropriate personal protective equipment (PPE) in place.

7.2. Care Quality Commission (CQC) Regulation in 2020-21

The pandemic has meant that the CQC cannot return to the fixed timetable or frequency of inspections that they had previously. Where inspections are carried out on-site, the CQC developed the Emergency Support Framework (ESF) as an additional monitoring tool. Combined with other sources of information, the ESF was used to understand where the risks of unsafe care were identified and use this to prioritise support. From October 2020 the CQC implemented their new Transitional Regulatory Approach (TRA).

The CCGs have continued to maintain a close relationship with the local CQC Teams particularly for Primary Care and Care Homes in gathering assurance about the quality of services and providing support to local Providers where there are areas of concern. The CQC approved the local care home designated sites (care facilitates where care home residents are able to be safely transferred to if able to be discharged from hospital before their 14 day isolation period if positive for Covid-19).

7.3. Infection Prevention and Control

The Infection Prevention and Control (IPC) Team has been working across the ICS since March 2020. In response to the Covid-19 pandemic the team resource was increased to ensure additional support was available for primary care, care homes, Local Authorities and the Health Protection teams. This also gave capacity for the CCG to be active partners in the Health Protection Board and support outbreak management processes.

More practically the team provided advice, education and support this included:

- The training was wide ranging, successfully completing the national NHS mutual aid of offering IPC training to all care homes; providing fit testing and training for personal protective equipment;
- Rapid support in service redesign, primary hot and cold pathways, testing units and vaccine centre assurance and training; and
- A source of advice for local services and on the ground eyes and ears for Health Protection Teams.

The increased focus on IPC measures meant that there was an overall reduction in non-Covid community onset infections such as MRSA and Clostridium difficile. However, there was an increase in the initiation of antibiotics in the community, which will be reviewed and addressed in 2021-22.

7.4. End of Life Care (EoL)

The 2020-21 year has been one of significant challenge for the ICS EoL Steering Group and its stakeholders. At the start of the Covid-19 pandemic and national lockdown, a rapid response ICS EoL subgroup was formed, initially meeting on a weekly basis, but continuing to date fortnightly. This has enabled rapid pace of change and implementation of training, support and timely responses to EoL areas of concern in the system.

We have worked on ensuring high quality advance care planning and disseminating resources to all stakeholders across the system. We have undertaken significant training across multiple primary, secondary and voluntary sectors, including care homes to identify end of life, support good end of life care and particular nuances of end of life relevant to patients with Covid-19.

A buddy support scheme was established to support primary care clinicians with complex end of life decision making and peer to peer support. We have worked tirelessly with the medicines management teams to ensure high quality of end of life prescribing in all sectors, commissioning of additional pharmacy capacity and end of life drug availability and training needs around these, as well as creation of standardised electronic end of life prescribing drug charts. The care homes team worked closely with the EoL group to ensure support and training in all aspects of end of life care, including medication reuse schemes. A virtual 'death fair' of 5 sessions from November 2020 to March 2021 was successfully delivered alongside

multiple public information support documents, which were shared locally, regionally and nationally.

We continue to work on our priorities, education and training, improved data, improved EOLC for the homeless, people with learning disabilities and people from different cultures.

Despite all this, the Respect project across the ICS was initiated in September 2020, with a view to launch in April / May 2021. A timeline of resources and activity is available upon request.

The End of Life ICS team worked to support primary care on difficult conversations and advanced care planning which has been very important with supporting care homes.

7.5. Complaints, Concerns, Compliments and Feedback

To ensuring ongoing improvements to commissioned services, the CCG welcomes feedback via complaints, concerns and compliments from members of the public.

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

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

The table below shows the number of complaints and concerns that have been received over the financial year 2020-21:

2020-21	East Berkshire CCG
Complaints	54
Concerns	406

Clinical Feedback

Clinical Feedback is a process which has been running in East Berkshire CCG and North East Hampshire & Farnham CCG for a considerable time and has been shown to be an effective conduit for raising and resolving patient specific issues and also identifying themes for improvement. During the pandemic clinical feedback has continued but was rationalised. There have also been a number of learning events when clinical feedback identifies more than one provider involved; with good learning from these events and actions to improve care.

Serious Incidents

The CCG has responsibility for performance management of Serious Incidents and is clearly defined within the NHS England Serious Incident (SI) Framework.

The CCG has a serious incident management process that allows us to hold providers to account and seek assurance over their arrangement for dealing with, and learning from Serious Incidents and Never Events. Never events are considered to be red flags as they highlight potential weaknesses in how an organisation manages fundamental safety processes.

Serious Incident Panels are held with providers to review the incidents and how they have been investigated. This is also an opportunity to identify any themes and discuss larger pieces of work aimed at minimising systemic risks.

	East Berkshire CCG
Never Events 20/21	2

Harm Reviews

During 2020 and possibly as a consequence of the Covid-19 pandemic, there has been an exceptional increase in the number of patients waiting for treatment, diagnostic testing and surgery for both mental and physical health.

In response to these concerns, members of the Frimley Health and Care System Quality Operational Group set up a harm review task and finish group lead by the CCG Quality Team to develop a proposal for the way forwards to ensure:

- A consistent approach across Frimley Health and Care System.
- A rapid review of potential harm.
- A clear understanding of the level of harm as a result of long waits.
- A concise and effective method of analysing pathways.
- Prompt local and system learning from long waits.

The process to review harm consists of various stages to prevent and minimise harm for those experiencing a long wait, particularly as numbers of patients within this cohort begins to grow as a result of the impact of Covid-19.

Learning Disabilities Mortality Review Programme (LeDeR)

2020-21	East Berkshire CCG
New LeDer cases	24
Completed LeDer	21

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

The LeDeR Steering Group continued to meet on a quarterly basis to review and action lessons learnt to facilitate practice improvements to be shared across organisations. The membership includes providers, Local Authorities and CCGs from across the Frimley ICS area. The new LeDeR Operational Group has been established from March 2021 to link learning and recommendations from the Steering Group into operational practice.

Rapid reviews have taken place during periods of peak Covid-19 outbreaks, which enabled a more rapid overview of the patients' care. This meant that any issues were identified quicker to ensure mitigation of any ongoing risk.

Key learning and initiatives gathered from cases affected by the Covid-19 pandemic are summarised below:

- Developed a specific deterioration tool for use in the care home settings when Covid-19 was suspected (carers /family will often know the person best);
- All providers to have access to an oximeter;
- In the event of another wave of Covid-19 hospitals should make reasonable adjustments for visitors to be with a relative;
- Put in place appropriate explanations of PPE for patients with learning disabilities in acute trust settings;
- The advanced care planning ReSPECT tool is not sufficiently well known and is often being completed when individuals are often too ill to be involved in the decision making for themselves. Greater promotion of the use of this tool to be undertaken by all agencies supporting individuals with a learning disabilities; and
- The availability of Acute Liaison Learning Disability Nurses in Acute Trusts has made a positive impact on the support available to individuals within hospital. We now propose to extend the cover 24 hours, 7 days a week.

7.6. Commissioning of Specialist Palliative Care Services

The vision was to develop a person centred holistic service for our adult residents that enabled more people to die in their preferred place of care, ultimately resulting in a reduction of deaths in hospital. East Berkshire CCG has had an historical grant funding arrangement in place with Thames Hospice for several years. Over the years as the CCG sought to improve its End of Life Care offer to residents, various new services were commissioned, some as contractual and some as grant funding arrangements. This resulted in a significant budgetary commitment to Thames Hospice, with a number of different agreements in place, each with their own reporting and monitoring schedules. For more robust commissioning and monitoring of the outputs, outcomes and impact of the service it was agreed that there should be a move away from a grant funding agreement to a formal contract footing. There was also a need to consolidate the various elements of the service and design a single holistic joined up service. This service was commissioned from October 2020. The expected outcomes of these new contractual arrangements are:-

- More patients achieving their preferred place of care at the end of their lives.
- Increase in the number of patients that are cared for at home
- A reduction of inappropriate hospital admissions and redirection to hospice beds if an inpatient stay is required.
- Decrease in the number of patients that die in hospital

- Reduction in the number of spot purchase of care home beds and domiciliary care as patients in hospital who are rapidly deteriorating will be offered (if available) a hospice bed.
- Patients experience an improvement in their symptom management.
- Improved quality of life and the promotion of dignity and self-worth for patients.
- There is also an increase in the number of inpatient beds
- Increasing the counselling and bereavement offer. Patients and their families and carers are supported through the changes of their disease progression to death and bereavement.

7.7. Safeguarding

The named and designated safeguarding professional meetings extended membership to colleagues across the ICS with North East Hampshire and Surrey Heath CCGs. This has brought about improved communication and collaboration and will positively affect the ICS developing landscape. Increasing meetings during Covid-19 ensured timely sharing of emerging safeguarding themes, good practice and sharing of useful resources. They also provided a space to share concerns which encouraged peer support.

ICS Safeguarding Group

The purpose of this group is to provide an effective and efficient governance process for safeguarding children and adults within the ICS and provider organisations. The group also provides support and challenge to colleagues around issues affecting the welfare of people across lifespans. Agency updates & business continuity plans during Covid-19 including identified risks and mitigation plans were shared with updates from all Safeguarding Boards across East Berkshire, including serious cases and rapid reviews.

Education and safeguarding children and young people

The safeguarding team have supported work in Slough and Royal Borough of Windsor and Maidenhead exploring how, across the partnership, we can ensure children are receiving appropriate education and can be identified where there are safeguarding concerns. This work has evolved from individual case concerns and awareness of unregistered settings, as well as the recognition of how the pandemic has impacted access to schooling and parents choices in how their children are educated. There has been an increase in the number of notifications from parents to the local authority for elective home education, which in itself is not a concern, but could increase the risk of hidden harms for some children. The learning from this will be shared across East Berkshire and include the Safeguarding Lead/Designated Clinical Officer for special educational needs and disability (SEND).

8. ENGAGEMENT WITH PEOPLE AND COMMUNITIES

We put patients and the public at the heart of our CCG. Local people have a right to be involved in the planning of and decision-making regarding their health and care, the right to information and support to help them make informed decisions, and the opportunity to help shape the services that support them.

We want local people to be at the heart of everything we do. Patients have a right to be involved in the planning and decision making regarding their health and care and the right to information and support which will enable them to make informed decisions. Working in partnership with patients, carers, families and local people within their own communities brings a different perspective to our understanding and can challenge our view of how we think services are received and should be delivered in the future.

We know that service provision can be improved if we can learn more about the views, experiences and concerns of patients, service users, carers and our wider communities.

We believe that better decisions are made when patients and professionals work together. We make sure we get the community involved at the very beginning of a project and build things around local need rather than organisations.

8.1. The impact of the Covid-19 pandemic

The Covid-19 pandemic has posed fundamental challenges to how we go about meeting our usual duties to engage and communicate with our local communities.

The pandemic has affected us all and caused many organisations to change the way they are working with much activity now taking place digitally where appropriate. One challenge for us has been how we continue to carry out the high standards of local engagement activity we would normally be working towards, whilst prioritising the health, safety and welfare of everyone.

Following the introduction of social distancing and in line with government and NHS England advice, we postponed all face-to-face engagement activity in March 2020. However, we have continued to recognise a critical need to engage and have had a continued constructive dialogue with local people and patients throughout this time. We continued to monitor the situation in light of any new guidance and adapted our work accordingly as we wait to resume more traditional forms of engagement work.

8.2. Our legal duties and principles of engagement

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

In this section of the report, we provide an overview of the consultation and engagement activities that have taken place over the past year (April 2020 – March 2021).

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

- Better outcomes and patient experience - involving local people in decisions about their own health and care can improve quality;
- Improved services - gathering and using patient experiences can help the CCG commission (buy) and deliver services more effectively, we can use this feedback to build in elements that we know make people have a more positive experience;
- Reduced demand - informing and engaging people can increase selfcare, improve take-up rates for healthy options, and reduce inappropriate service use;
- Deliver change - involving people in discussions and decisions about service changes can make it easier to manage risks and deliver difficult change successfully.

We are continuing to drive a real culture change across the health and social care system, to put engagement and co-production at the heart of everything that we do, helping residents to actively participate in design and delivery of services – now and in the future. As a Collaborative of CCGs and wider integrated care system we have developed and agreed a set of principles for engagement with people locally, which all staff at the CCG aim to use in everything that they do.

- Be open and honest about what is possible and what is not possible
- Communicate clearly in easy to understand language
- Listen and act on patient and carer feedback at all stages of decision making and identify how that feedback has changed what we do
- Be accessible – the way we engage people should be tailored to the needs of the people we are trying to engage – ask people what is best for them and in places and times that meet their needs
- Involve people as early as possible and make sure our engagement is representative to the piece of work we are engaging on
- Base relations on equality and respect – patients and the public have an equal voice to professionals

- Work hard to seek the views of people and communities who experience the greatest health inequalities and the poorest health outcomes, making it easier for people to take part, identify barriers and remove them
- Allow plenty of time for people to receive information, read it and respond to it
- Review, evaluate and publish the impact of patient, carer and public engagement
- Allocate appropriate resources and support so that engagement can be effective

8.3. Engagement across the Frimley Health and Care System

Working in partnership, our intention is that the Frimley Health and Care system Five Year Strategy is ambitious for our population and system. The strategy was developed through high levels of engagement, reflects local needs, issues and priorities, is rooted in evidence and aims to tackle wider determinants of health and wellbeing for our population - its development has been based on what people have told us, alongside good data and intelligence.

There are six key ambitions for the system. We will continue to support engagement activity across all of these ambitions and our CCG priorities with a focus on the development of 'community deals' with our local residents. We will work with our local residents, families , volunteers and carers to agree how we collectively (as organisations, individuals and families) create healthier communities, supporting healthy choices and designing and delivering new ways of working to improve the health and wellbeing of our local population.

8.4. Engagement response to the Covid-19 pandemic

ICS Community Panel Survey

Frimley Health and Care Community Panel has more than 1,700 members (recruited throughout the Summer of 2019) representing people who live in Ascot, Bracknell, Farnham, Maidenhead, North East Hampshire, Slough, Surrey Heath and Windsor.

The panel helps us to gather views from a representative section of this wide geography to better understand local needs and experiences which can be fed into the planning and improving of local health and care services.

The Frimley Health and Care Integrated Care System wanted to better understand how patients, people with long term health conditions and members of the public were looking after themselves during the Covid-19 global pandemic and what their experiences of health and care services had been.

These views and experiences are now being used to shape the way we work with and support local communities, both during and after this crisis, as well as to identify positive changes to health and care services under the current restrictions and where gaps may have occurred.

This survey took place throughout May therefore we recognise the results of the survey provide only an initial 'snapshot' as the country was in lockdown. As people's perspectives and experiences are changing rapidly throughout the

pandemic this work forms part of a more extensive engagement plan and is being used, alongside a wide range of supporting insights and data from partners across the system, such as local councils, to determine what further work is needed.

8.5. Voluntary sector and integrated care system relationships

As a key partner in Frimley Health and Care Integrated Care System, we actively work and collaborate with our local Healthwatch and voluntary, community and faith sector colleagues. In 2017 we established a Healthwatch Leads Network which brings together our Healthwatch partners from across the ICS area (Hampshire, Surrey, Windsor, Bracknell, Ascot & Maidenhead and Slough). In 2018 we established a Voluntary Sector Leads network bringing together our Council for Voluntary Services (CVS) and volunteer centre partners. These quarterly network meetings continue to allow us to share updates and priorities, actively explore opportunities for collaborative working and to take action on issues raised by participants.

Throughout 2020-21 we have continued to meet regularly via virtual meetings and we have consistently supplied a range of stakeholders with regular updates and briefings in relation to the pandemic.

Our work with Healthwatch throughout 2020-21 has included regular conversations about the feedback they received regarding health and care services which supports our ongoing improvement and development.

The voluntary sector have been integral to the partnership response to the pandemic throughout the year and our relationships with the sector are essential to our day-to-day work. This has been especially true throughout late 2020 and early 2021 where the support of volunteers has been vital to the success of the local vaccination programmes across the Collaborative of CCGs. The voluntary sector, often in partnership with the local authorities, mobilised extremely quickly to enable volunteer support at very short notice at all of our vaccination sites.

8.6. Social media and CCG website

Our website provides information about the work of the CCG, showcasing projects, highlighting the impact of local community involvement, and signposting engagement opportunities. We use the website to inform the public of our plans to engage, raise awareness of any consultation activity and also to provide opportunities to become involved. The website is updated regularly so we can report on the outcomes of all consultations and what we have done as a result of our activity. Although our website is no longer online, members of the public can still access information via the NHS Frimley CCG website https://www.frimleyccg.nhs.uk/

Our Twitter account continues to grow and we are continuing to use the channel as a friendly and informative voice about local health services – with an aim to tweet daily during the week. We also use Twitter as a route for engaging with local people and have increased our following of local partner organisations so we can help

share news. We continue to promote our presence on Facebook and are using Facebook more frequently to engage with other local Facebook users, sharing information about local services, highlighting campaigns and encouraging discussions.

8.7. Engagement summary

Our ambition is to place engagement at the forefront of all we do, creating healthier communities that people recognise and feel a part of. We will harness the strength of individuals to create healthier communities in the places people work or live.

Different relationships will develop between public service providers and the people who use our services, working as equal partners playing an active role in shaping and implementing transformational change.

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

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

9. REDUCING HEALTH INEQUALITY

Equality and diversity are central to our work in ensuring equality of access to, and treatment by, the services that we commission on behalf of the populations that make up the Collaborative of CCGs.

Our commitment to equality and diversity is driven by the principles of the NHS Constitution, the Equality Act 2010 and the Human Rights Act 1998, and also the duties of the Health and Social Care Act 2012 (section 14T) to reduce health inequalities, promote patient involvement and involve and consult with the public.

The specific duties of the Equality Act 2010 require public bodies to publish relevant proportionate information showing how they meet the General Equality Duty by 31 January each year. In addition, they require public bodies to set specific measurable equality objectives by 6 April every four years from 2012. Both general and specific duties are known as the Public Sector Equality Duties (PSED).

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

- CCG's Equality and Diversity Objectives;
- Impact of the Covid-19 pandemic; and
- A renewed focus on inequalities shown through:
    - BAME programme;
    - Dedworth and Clewer projects; and
    - Volunteer Retention Approach.

9.1. Our Equality and Diversity Objectives

The role of equality and diversity is central to the CCG's values, processes and behaviours.

Our ambition

As an NHS organisation we aim to:

- Ensure staff fully understand equality and diversity issues
- Feel empowered to challenge prejudice and make reasonable adjustments in their own work areas
- Include equality and diversity training for all staff

- Ask managers to promote the cultural and behavioural changes to ensure equality and diversity is demonstrated in all aspects of the CCG's work
- Provide an environment for our staff which is free from unlawful discrimination
- Work with staff and use anonymous questionnaires to ascertain staff opinions.

Our objectives

- We will make sure information is accessible
- 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 purpose of setting specific, measurable equality objectives is for the CCG and staff to perform better in the general equality duty.

9.2. The impact of the Covid-19 pandemic

For some time we have been exploring how we can work in partnership with others, particularly our local government and voluntary sector partners, to address health inequalities.

We know that we need to work differently in the future, to work in a more joined-up, cohesive and collaborative way, with the flexibility to tackle issues affecting our local communities, whether they are focussed on health or wider factors that can affect our health.

The impact of Covid-19 has been felt by everyone and it's important that we understand the difficulties people are facing whether they be related to health, housing, finances or family. We know that we are still not hearing from some of the most vulnerable and most in need groups in our communities. To understand them will require a different approach based on relationships and trust . . . we can't do this in isolation.

We must make best use of the rich resources we have to hand. A new data insights tool developed by the Integrated Care System analytics team, alongside stakeholder insights and community feedback helps us build a detailed picture of where and how we need to focus our energy . . . but it will never tell us the whole story. The impact of Covid-19 has also seen many positive changes, both in lifestyle and community spirit - we need to take this opportunity to understand how we can support and maintain some of these new and rediscovered benefits for people and communities.

By supporting projects and approaches that are community-focussed we can begin to build an approach that tackles broader inequalities that affect our health. Our ambition is to work together: communities, voluntary sector, health, care and local government to deliver change together. This is a critical time for health and care services, we are committed to understanding the views and experiences of local

people and those of the organisations we work closely with. We will continue to work closely with our local authority, voluntary sector and Healthwatch partners.

9.3. A renewed focus on inequalities

Currently both at national and local level there is a drive to address inequalities. The pandemic has exacerbated existing inequalities as well as highlighted new ones.

NHS England has directly asked that we work collaboratively with local communities and partners to take action to protect the most vulnerable from Covid-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics and social and economic conditions; and better engage those communities who need most support.

BAME Programme

The CCG recognised early in 2020 the impact Covid-19 was having on the BAME community and subsequently launched a collaborative work programme with the aim to reduce any resulting health inequalities; and reduce impact on our ethnically diverse communities both in loss of life and on livelihoods.

We knew from initial information being published of the additional risk to people from BAME backgrounds due to a number of prevalent risk factors:

- 54% of the population from BAME background, including 11% white non-English;
- Over 8000 (about 6.2%) don't speak English well, or at all;
- In 15.5% households no one speaks English as first language;
- high density population combined with areas of high deprivation;
- Large multigenerational households and many of multiple occupation;
- Significantly higher prevalence of Hypertension, Obesity and Diabetes for 50-59 year olds.

Our programme between the NHS, voluntary sector and local authority focused on the following;

- Engagement and communication with communities;
- Reducing and preventing harm from Covid-19;
- Clinical management of those experiencing symptoms; and
- Gathering intelligence to tailor and target interventions.

Our challenge was to mobilise quickly to contain the spread of infection and minimise risk whilst developing culturally centred interventions that built on existing assets and projects. We needed to reach communities with up-to-date messages and the importance of taking protective measures in different languages, formats and multiple media. The community team and public health worked together with cultural local leaders, faith and community groups and the local radio station.

The partnership has used wider networks and programmes to raise awareness and shared the valuable learning regionally and nationally, with the following results:

- **#OneSlough** - Slough Community Champions with an initial target of 100, now over 600 Community Champions ;
- **#Fit2FightCovid** promoting wider future preparedness and increasing physical activity levels within the community;
- **#OneSlough** Tuk Tuk taking Covid messages around the town;
- Supporting the launch and promotion of the NHS contact tracing app for use across our communities; and
- Working with National Institute for Health Research to engage Indian and Pakistani communities in Slough.

Dedworth and Clewer – partnership with housing, education and young people community organisations identifying the needs of local residents and refining grass roots projects to improve the well-being and outcomes for our most deprived neighbourhoods. A few projects were prioritised from over 20 ideas generated from the community conversations, the projects taken forward have focused on: supporting young people with their resilience, focused employment and skills support, transport through cycling, and open spaces and health & well-being improvements. This provides a blue print and test bed to support other communities.

Covid Volunteer Retention Approach – a massive response to the 'call to action' from local volunteers through all lockdowns has developed a large pool of over 400 people interested in Covid support. To retain this level of support, individuals are invited to join the community champion army of volunteers, encouraging them to push information into their local networks and also to bring information and queries from the community back to help shape and support the local communications plans. These volunteers reached into communities helping patients who were most vulnerable to access health care, and encouraged people to receive the Covid vaccinations.

"Lyon is a secure, online information management platform, tailor-made for Local Governments to support local communities initially during the Covid-19 pandemic. Lyon safely secures thousands of records of individuals in need of help, and volunteers willing to provide it, and allows GDPR compliant matching of individuals to take place. Lyon can also be used to input central government's Clinically Extremely Vulnerable (CEV) data and will display analytics on how this group is being supported. Further development of the Lyon platform will allow an app version

to be launched, providing real-time access to the information required for local residents to continuously support each other in strong communities. All of this achieved on one, safe and secure platform, not reliant on the use of spreadsheets."

Note: Lyon is a council-based system that supports the management of residents' information.

9.4. Reducing health inequality in summary

As demand for health and care becomes more complex, it is essential that our services are people based. We have worked across diverse stakeholder groups and through our clinical leaders to establish a culture of continual learning. We know that our clinicians feel engaged in the conversations and approach we are taking to address health inequalities and inequities.

10. HEALTH AND WELLBEING STRATEGY

The CCG plays an active role on the Health and Wellbeing Boards for Slough, Bracknell Forest and Royal Borough of Windsor and Maidenhead.

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

This year the CCG has been focused on the functionality of joint working, demonstrating what could be achieved through taking a combined approach to meeting the needs and improving health outcomes for the community. This will provide the platform for the development of our local plans which will be the vehicle for delivering our vision of a community collaborative approach to create better outcomes through better partnerships.

Changes to local demographics are driving new challenges including:

- Young people; rising unemployment and gaps in education and development support;
- Vulnerable groups; Increasing multiple deprivations, ethnicity, deprivation and reliance on voluntary services and
- Older adults; those with worse virus outcomes, delayed health seeking behaviours and isolation from shielding and/or digital deprivation.

In addition to these emerging needs, there is a need to tackle ongoing problems such as digital poverty, restoring confidence accessing community services and the long term effects on mental health.

When these trends are combined with the impact of Covid and cross referenced with priorities set out in various other documents by the council and our partners, we identified several reoccurring areas for East Berkshire residents that can be addressed through joint working. These include:

- Mental health services
- A targeted wellbeing offer
- Health inequalities
- Air quality
- Loneliness and isolation
- Obesity
- Helping children to start well

This section shows how the CCG has worked jointly, demonstrating what can be achieved through taking a combined approach to meeting the needs and improving health outcomes for the community.

Bracknell Forest Community Deal

Throughout 2020-2021 Bracknell Forest Council and the CCG have worked on a number of joint ambitions that will underpin this vision and have a significant role in implementing the ICS "Community Deal" ambition through partnership working at Place. These include:

- Aligning social care services with Primary Care Networks to allow improved integration of care and health activities.
- Working together to develop a joint community and health facility at Blue Mountain.
- Joint working to improve access to residential nursing/dementia care and short term intermediate care through the Heathlands development.
- Transforming the way children's centres work, making them into family support hubs.
- Improved access to services for Children and Young People with Autism, Attention Deficit Hyperactivity Disorder and Special Educational Needs.
- Developing aligned health and care plans at place to drive forward integration and address local inequalities.
- Building a different relationship with communities, residents and staff to design and deliver solutions together.
- Working together to realise wider public health opportunities presented by Covid-19 as part of "Community Deal" conversations.

Our joint ambition is to support the community to be as healthy, independent and resilient as possible whilst delivering cost effective and sustainable services. This means that our focus for expanding the range and scale of joint working will be in understanding the priority needs of our community. This shared understanding will guide how the next steps are delivered and embody the principles of joint working that we have agreed to. Our priorities have a life course focus; starting well, living well, ageing well and provide a consistent and agreed approach to guide joint working and align with existing strategies including service plans and coronavirus recovery, restoration and renewal plans.

Working jointly between Bracknell Forest Council and the CCG the deal aims to enhance the impact and reach of positive outcomes. Some of these benefits will be directly experienced by the community; other benefits will be indirect through reinvestment in the community.

Case study:

Bracknell Forest's integrated health and care teams have a direct benefit for the community through early access to coordinated help and support keeping people healthy at home and out of hospital; a positive outcome for Bracknell Forest Council and the CCG. This means that financial savings can be reinvested in services for residents supporting a cycle where joint working maximises outcomes. Delivery of

an integrated Covid response has shown joint working to be more resilient with an improved network of support for patients and our staff.

The foundation to support this community model for joint working will be through effective shared governance, aligning goals and accountability and as joint working across Bracknell Forest matures; this will allow more joint delivery models to be unlocked for a wider range of situations.

It is only by working together that we can make a big difference to outcomes for all our residents.

Royal Borough of Windsor & Maidenhead

Community and voluntary sector

Royal Borough of Windsor and Maidenhead have taken an opportunity from the community response to the pandemic, particularly for those most at risk or shielding, in how to better help communities to help themselves. Residents were encouraged to 'Be a good neighbour' and to 'Get Involved' in playing a key role with a central point where help could be given and received. Volunteers and community champions have been participating in sharing key messages around the pandemic and sharing back to Place teams any questions from their communities to support the winter and Covid-19 communications plans.

Over 750 residents had volunteered in response to all phases of the pandemic, and many staff had volunteered to deliver support over the telephone, undertaking targeted calls to shielded individuals and welfare calls to other vulnerable people. Over half of this number have said that they would like to continue volunteering in RBWM. Fifty different groups have had support from a £20,000 grant fund and groups have been added to an asset map on the website. Staff had been redeployed by local services to help and Community Wardens have been working closely with groups.

Support to engage and develop the role of volunteers has resulted in the creation of an interactive volunteering page, a community asset map and commitment that further projects to connect community groups with each other would be ongoing.

The local authority and CCG place team have committed to working in partnership on a longer term programme to engage our community and voluntary sector through leaders already in place:

- working with our voluntary sector to celebrate all the good work, shining a light on those delivering in our communities by connecting and supporting our voluntary sector to be empowered and independent in targeting the needs of our population.
- The Dedworth and Clewer pilot scheme will feed outcomes and lessons learnt to shape the programme as well as take the opportunity of new entrants through the Community Champion enrolments for those who have come forward in response to Covid.

- Another key area is to support local health services to engage with their community and voluntary leaders through working more closely with general practice and more broadly with Primary Care Networks, to support the focus around health and well being promoting self care.

Wellbeing Service

The Wellbeing Service is a team of support workers who help individuals with practical, situational and social issues. These include housing, money worries, alcohol and drug misuse, gambling, student stress and general wellness (exercise and healthy eating.) The service also provides wellbeing support for sleep, stress, resilience and lack of motivation.

The team provides support using a combination of the follow approaches:

- 1:1 telephone sessions
- Online support
- Supported signposting and advocacy to local authorities and community services, as well as being able to refer into and work with mental health services
- Offer of wellness workshops on resilience, communication, sleep, motivation and anxious thoughts.

Windsor PCN Mental Health Integrated Community Service

The Windsor Mental Health Integrated Community Service is a multi-disciplinary team made up of mental health practitioners, clinical pharmacists, and community connectors overseen by a clinical lead and with access to psychiatrist support aimed at supporting people with serious mental health issues (diagnosed or undiagnosed) within a primary care setting.

The service aims to:

- Support will be delivered closer to people’s communities by wrapping services in and around Primary Care Networks, developing closer links between primary care and Community Mental Health Teams.
- Build on and develop what exists in the community, involving voluntary sector, housing & social care partners, providing improved access to a wider range of services such as services that support admission avoidance, rehabilitation and reablement in the community groups and support networks.
- An easy in, easy out approach will improve access to NICE-recommended interventions where required for people with significant mental illness, removing unhelpful thresholds and barriers.
- Working towards care being stepped up and stepped down flexibly without cumbersome referrals & multiple assessments.

Health and Wellbeing Strategy Summary

The CCG already has a solid foundation of working with partners. The blueprint for the future provides the opportunity to reset the scale of our ambitions for joint

working and deliver the pace of transformational change accelerated by the Covid-19 pandemic, along with the direct and indirect impact this has had on our local communities and the sustainability of health and care community services.

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

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

This section covers examples of where the CCG has taken into consideration social matters and human rights through:

- Multiagency work for asylum seekers to provide accommodation in contingency hotels;
- Response to the new legal duty on serious violence;
- East Berkshire Channel Panels supporting the Prevent agenda;
- Primary care support for the homeless people in Slough.

11.1. Social Matters, Human Rights

Asylum Seeker Accommodation in contingency Hotels

Due to capacity issues of regulated asylum seeking centres, the Home Office has made alternative provision for a proportion of asylum seekers to be temporarily housed in hotels across the UK. In August 2020 a hotel in Slough was commissioned by the Home Office to provide accommodation for between 140 and 260 asylum seekers, including families with children. A multi-agency working group was quickly established to respond to their health and social care needs; however, risks were identified and have been escalated to NHS England. The multiagency working group quickly established action plans to mitigate the risks. The group has continued to meet on a fortnightly basis to review this action plan and respond to issues as they arise. The Designated Nurse and Named Professional for Safeguarding both represent East Berkshire CCG at this group.

Serious Violence

In July 2019, the Government announced a new legal duty on public bodies to prevent and tackle serious violence. The new 'public health duty' covers the police, local councils, local health bodies such as NHS Trusts, education representatives and youth offending services. This is to ensure that these services work together to share data, intelligence and knowledge, and to understand and address the root causes of serious violence, including knife crime. The Slough Safeguarding Partnership has identified Serious Violence as a priority work stream due to the increasing trend in that Local Authority. The Named Professional for Safeguarding

is a member of the Slough Violence Task force group which provides a multi-agency co-ordinated approach to address the issue of serious violence in Slough.

East Berkshire is within the remit of the Thames Valley Violence Reduction Unit (TVRU) and Slough has been successful in a bid to fund a Violence Reduction Hospital Navigators Scheme at Wexham Park Hospital Emergency Department. This scheme is currently being developed and a provider has been commissioned to commence the delivery of this service in Q4.

Prevent

East Berkshire Channel Panels have supported a number of vulnerable people at an early stage who are identified as being vulnerable to being drawn into terrorism. All Places currently have cases that they have adopted to ensure that all safeguarding measures are in place to protect the person and the public. The CCG safeguarding team are represented at each place Steering Board and Channel Panel.

Homeless support in Slough

Slough has been offering primary care support to our rough sleepers since January 2019 after an impact assessment looking at the needs of vulnerable groups and exploring ways through which to improve access. It is a group with which is often difficult to engage and build trust with. Other barriers to building relationships include language; fear and distrust of authorities due to immigration; and with some having no recourse to public funds. However, through the " Everyone In" scheme the all councils supported rough sleepers into accommodation regardless of legal right to support.

Slough had many people housed in temporary hotel accommodation which presented an opportunity to offer access to a weekly clinic, supported by a nurse and GP, on the premises. Many of those staying at the hotel started to engage with the service and together with the regular hot meals being provided by the voluntary sector we saw improvements to the physical health and wellbeing of residents. At the end of the lockdown those in emergency accommodation were offered, and the majority took up, alternative accommodation elsewhere, including that the Lookahead hostel. From July 2020 the clinic has continued to run from Lookahead each week and continued to see homeless population positively engaging and accessing primary care support. We are now looking ahead to ways in which to extend and broaden this outreach service and provide access to other services on site including health promotion advice and support as well as mental health.

11.2. Anti-corruption and bribery

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

The CCG has a zero tolerance policy of any fraud, bribery or corruption and aims to eliminate all such activity as far as possible. The Local Area Counter-Fraud Team is active in the prevention and deterrence of fraud, bribery and corruption through its attendance at the Audit and Risk Committee, involvement in policy-setting, awareness training and sharing of information through their website and attendance at CCG meetings. Counter fraud work has been undertaken in each of the four strategic areas. These set out the requirements in relation to:

- Strategic Governance - The organisation's strategic governance arrangements. The aim is to ensure that counter fraud measures are embedded at all levels across the organisation.
- Inform and Involve - Raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of fraud and bribery affecting the NHS.
- Prevent and Deter - Discouraging individuals who may be tempted to commit fraud against the NHS and ensuring that opportunities for fraud to occur are minimised.
- Hold to Account - Detecting and investigating economic crime, obtaining sanctions and seeking redress.

12. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The CCG plans for, and responds to, a wide range of incidents that could impact on health or patient care. These could be anything from a prolonged period of severe pressure on services, extreme weather conditions, an outbreak of an infectious disease, a major transport accident or industrial action.

We work together with partners across the Frimley Health and Care Integrated Care System to deliver the CCGs' responsibilities as 'Category 2' responders under the Civil Contingencies Act 2004. We have 24/7 on call rotas and incident response plans which has been formally agreed by each organisation. We are required to self-assess against the NHS core standards, including Business Continuity Plans, and this report forms part of our formal reporting process.

Our responsibilities are:

- Working with the Local Health Resilience Partnership (LHRP). This is a strategic emergency planning meeting of all the NHS organisations across the Frimley system. The LHRP has produced a strategy and work plan for the year and has carried out an annual review of progress;
- Participating in training and testing exercises which are used to test response plans;
- Assisting with the local co-ordination of emergencies in partnership with NHS England;
- Ensuring a 24 hour, seven days a week on-call system;
- Ensuring compliance with the national core standards for EPRR for both CCG and NHS funded healthcare providers.

Together with our NHS provider organisations, we completed a self-assessment of compliance with the NHS Emergency Preparedness Resilience and Response core standards. The CCGs have incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2015. The CCGs regularly review and make improvements to their plans and there is a programme for testing, the results of which are reported to the Governing Body.

Covid-19 Pandemic

Our response to the Covid-19 pandemic has been in line with our statutory Emergency Preparedness Resilience and Response and builds on the relationships we have with our Local Health Resilience Partnership and Local Resilience Forum.

During the pandemic the Frimley Health and Care Integrated Care System had a single overarching coordination role across all health partners within the

system. To reflect this a single Incident Coordination Centre was set up with 'Gold, Silver and Bronze' functions.

The Incident Coordination Centre was responsible for reporting into the relevant Strategic Coordination Group and Tactical Operations Groups of the Local Resilience Forum.

CCG response

In light of the Covid-19 pandemic, the CCG started to work in new and different ways. CCG staff have had critical roles in leading and supporting the wider health and care system for the challenges we faced together. The priorities during the pandemic were to:

- Lead and resource the Frimley Health and Care Integrated Care System Covid-19 Incident Control Centre;
- Focus on our business critical activities, refocus our leadership and resource to ensure we deliver and support the system to meet demand;
- Plan for business continuity and maintain these during challenging times;
- Work with primary care and community services in their response to Covid-19; and
- Support the health and wellbeing of our people.

Fiona Edwards

Accountable Officer

14 June 2021

ACCOUNTABILITY REPORT

Corporate Governance Report

13. MEMBERS REPORT

This section of the report contains information about our membership, the way we work as a CCG and some of our legal responsibilities.

13.1. Our Membership

East Berkshire CCG is a corporate body (a legal entity) and has 46 member practices which are organised into three Places: Bracknell, Slough and Royal Borough of Windsor and Maidenhead.

Bracknell (10)	Slough (16)	Royal Borough of Windsor and Maidenhead (20)
The Waterfield Practice *The Waterfield Practice - Warfield Medical Centre*	**242 Wexham Road Surgery**	**Runnymede Medical Practice** *Englefield Medical Centre*
The Sandhurst Group Practice *Yorktown Surgery*	**Langley Health Centre**	**Woodlands Park Surgery**
The Ringmead Medical Practice *The Ringmead Med Practice - Great Hollands HC* *The Ringmead Practice - Heath Hill*	**Crosby House Surgery**	**Linden Medical Centre**
The Gainsborough Practice (Warfield)	**The Avenue Medical Centre**	**Ross Road**
Binfield	**Herschel Medical Centre**	**Claremont Surgery** *Holyport Surgery*
The Easthampstead Practice	**Farnham Road Surgery** *Weeks Drive Surgery*	**Datchet Health Centre**
The Great Hollands Practice	**Upton Medical Partnership** *The Village Medical Centre*	**Cedars Surgery**
Forest Health Group *(incl. Boundary House and Balfron)*	**Bharani Medical Centre** *Bath Road Surgery*	**Cookham Medical Centre**
The Crown Wood Medical Centre	**Shreeji Medical Centre**	**Lee House Surgery**
The Evergreen Practice	**Manor Park Medical Centre**	**Symons Medical Centre**
	40 Ragstone Rd	**Green Meadows Partnership**

Bracknell (10)	Slough (16)	Royal Borough of Windsor and Maidenhead (20)
		Sheet Street Surgery
	Cippenham Surgery (Dr. Nabi)	**Clarence Medical Centre**
	Kumar Medical Centre (Grassmere)	**Rosemead Surgery**
	240 Wexham Rd (Dr Sharma)	**Redwood House Surgery**
	Slough Walk in Health Centre (Chapel)	**Cordwallis Road Surgery**
	The Orchard Practice (Willow Parade Surgery)	**South Meadow Surgery** *Dedworth Medical Centre*
		Radnor House Surgery and Ascot Medical Centre
		Magnolia House
		Kings Corner Surgery

13.2. Our Governing Body

The Governing Body is constituted in accordance with the Health and Social Care Act 2012 and is the principle decision-making body in the commissioning and contracting of high-quality healthcare for our local community. It comprises of clinical, lay and executive directors with a variety of backgrounds, with a wide range of skills and experience. These include members overseeing elements of governance and patient and public engagement.

Since January 2020 the Governing Body has met more formally to discharge its responsibilities together as a “Committees in Common” with NHS Surrey Heath and NHS North East Hampshire & Farnham CCGs. This arrangement is known as the Frimley Collaborative Board. East Berkshire CCG shares the statutory board members with the other CCGs in the Collaborative including the Accountable Officer and Executive Team. The table overleaf shows the statutory membership of the Governing Body.

Statutory Membership of the NHS East Berkshire CCG Governing Body as at 31 March 2021

Name and role	
Executive roles	
Dr Andy Brooks – Clinical Chief Officer (Accountable Officer)	
Sarah Bellars – Executive Director of Quality and Nursing	
Dr Lalitha Iyer – Executive Medical Director	
Rob Morgan – Executive Director of Finance (Chief Finance Officer)	
Fiona Slevin-Brown – Executive Managing Director	
Governing Body GP members	
Dr Jim O'Donnell - Interim Place Based Clinical Leader for Slough and interim Clinical Chair for East Berkshire CCG	
Dr Huw Thomas – Interim Place Based Clinical Leader for Royal Borough Windsor and Maidenhead	
Dr Martin Kittel – Interim Place Based Clinical Leader for Bracknell Forest	
Secondary Care Consultant	
Dr Amanda Wellesley	Secondary Care Specialist
Lay members	
Kathy Atkinson	Interim Lay member for Patient and Public Engagement (PPE)
Arthur Ferry	Lay Member for Governance and Audit
Tony Fitzgerald	Interim Lay Member for Primary Care

Other attendees including the Managing Directors are included in the list of Collaborative Board members below.

For details of declared conflicts of interest are published on the following website please click here. http://intranet.frimleyccg.nhs.uk/working-here/governance/conflicts-of-interest

The three CCGs have worked as a Collaborative across five Places of (i) North East Hampshire and Farnham (ii) Surrey Heath (iii) Slough (iv) Windsor and Maidenhead (v) Bracknell Forest. Each of the five Places has an Executive Managing Director, Lay Member and Clinical Leader who form part of the leadership team to manage the place based delivery plans. Stakeholders and local authority colleagues work

alongside the leadership team for each place meeting regularly together at the three local Place Committees.

13.3. Responding to Covid-19 pandemic

The announcement of a Level 4 National Incident on 30 January 2020 in response to Covid-19 and further directives from NHS England and NHS Improvement on 17 March 2020 for the NHS to free up capacity to manage the extraordinary and unprecedented impact of the Covid-19 pandemic - resulted in a significant number of complex changes to how the three Governing Bodies worked together as the Frimley Collaborative in 2020-21 to discharge their respective statutory duties.

NHS East Berkshire CCG together with the other two CCGs in the Frimley Collaborative took the decision at its “Committees in Common” meeting on 24 March 2020 to:

- Suspend all non-essential meetings for a three month period with exception of the Frimley Collaborative Board; Audit and Risk Committees in Common and the Primary Care Commissioning Committees
- Approve the delegation of emergency / extra-ordinary powers to Dr Andy Brooks in his capacity as Accountable Officer and Rob Morgan as Chief Finance Officer and
- Enact Emergency Preparedness Resilience and Response (EPRR) arrangements for each of the three CCGs allowing the establishment of a Command and Control structure for the Frimley Collaborative which aligned statutory roles and responsibilities with the Frimley ICS to form a single Frimley Health and Care Incident Co-Ordination Centre. The Frimley Collaborative led the local place based primary care co-ordination for patients within the community.

The establishment of interim roles to support the response to the pandemic resulted in wide ranging changes to the executive, clinical and lay roles across the three CCGs of the Frimley Collaborative. As a result, members of the three Governing Bodies undertook roles at System level, either as part of the Frimley ICS Board or Frimley Collaborative Board and or locally as members of their respective Place Committees. Details of these roles are set out below and included in the notes section of the Remuneration Report.

- Rob Morgan - System use of resources;
- Fiona Slevin-Brown - Full time system Gold Command lead;
- Nicola Airey - Chief Operating Officer, supporting and co-ordinating places, emphasis on primary care and community services (supported by four Interim Director of Operations, and North East Hampshire CCG’s Interim Managing Director);
- Sarah Bellars – Director of Nursing and Quality - Focus on Infection Prevention and Control, Governance, Safeguarding, & System Quality;

- Emma Boswell - Staff, workforce and communications, capturing improvement practice;
- Lalitha Iyer - Aligning clinical thresholds at System, supporting Chief Operating Officer, and Director of Quality and Nursing. Ensured clinical capacity of CCG GP time in supporting the frontline.

Interim posts were also brought in for Governing Body positions to give greater spread of resources during the year:

Lay and Independent Members took on interim posts:

- Ed Palfrey – acting in an interim role to support Bracknell Forest Place as their Independent Member;
- Kathy Atkinson – acting as Place Based Lay Member for North East Hampshire & Farnham and with an interim Collaborative role as Lay Member for Patient and Public Engagement;
- Arthur Ferry – acting as Place Based Lay Member for Slough and Royal Borough and with an interim Collaborative role as Lay Member for Audit and Governance;
- Tony Fitzgerald – acting as Place Based Lay Member for Surrey Heath and with an interim Collaborative role as Lay Member for Primary Care;
- Amanda Wellesley – acting as the Secondary Care Specialist for each of the three CCGs in the Collaborative;

Place Based Clinical Leaders:

- Martin Kittel – acting as the Place Based Clinical Lead for Bracknell Forest.
- Steven Clarke – acting as the Place Based Clinical Lead for North East Hampshire & Farnham and as interim Clinical Chair for North East Hampshire & Farnham CCG;
- Huw Thomas – acting as the Place Based Clinical Lead for Royal Borough;
- Jim O'Donnell – acting as the Place Based Clinical Lead for Slough and interim Clinical Chair for East Berkshire CCG;
- John Fraser – acting as the Place Based Clinical Lead for Surrey Heath.

13.4. Frimley Collaborative Board in 2020-21

Throughout 2020-21, the Frimley Collaborative Board continued to operate under the terms of the emergency control and command structures that it agreed at its meeting on 24 March 2020 (described in section 1.2).

In July 2020 and again in January 2021 NHS England and NHS Improvement reiterated its earlier March 2020 guidance on regulatory and reporting requirements and the continued need to reduce burden and release capacity to manage the Covid-19 pandemic:

- pausing all non-essential oversight meetings;

- streamlining assurance and reporting requirements;
- providing greater flexibility on various year-end submissions;
- focussing our improvement resources on Covid-19 and recovery priorities; and
- only maintaining those existing development workstreams that support recovery.

The three CCGs in the Frimley Collaborative provided their agreement for two further extensions of their respective EPRR arrangements providing delegated emergency powers to Dr Andy Brooks and Rob Morgan during the ongoing Covid-19 pandemic to support agile decision-making.

At its meetings, the executive members of the Frimley Collaborative Board provided assurances on the decision-making framework for the Frimley ICS Incident Control Centre (ICC) (who continued to co-ordinate the system response to the Covid-19 pandemic) through regular situation reports.

Members of the Frimley Collaborative Board agreed key priorities that aligned with the wider strategic ambitions for the Frimley ICS, they also considered how further integration of System and Place to support patient care and reduce inequalities could be accelerated across the Frimley ICS.

As part of its work to support further system and place integration and in line with the national ambition set out in the Long Term Plan that envisaged there would be one CCG in each ICS - the three CCGs in the Frimley Collaborative agreed to consider the risks and benefits of a potential merger. Following discussion in summer 2020, the Frimley Collaborative Board agreed that it would express an intent to NHS England to merge its three constituent CCGs to one organisation, undertaking merger preparation work during winter 2020-21 and merger from 1 April 2021.

Membership

Throughout the year the Frimley Collaborative Board reviewed its membership arrangements in light of the ongoing Covid-19 pandemic and in response to the decision to progress with a merger application.

Voting Membership of the Frimley Collaborative Board April 2020 to March 2021

Name	Role	East Berkshire	North East Hampshire & Farnham	Surrey Heath
Dr Andy Brooks	Clinical Chief Officer (Accountable Officer)	✓	✓	✓
Sarah Bellars	Executive Director of Quality & Nursing	✓	✓	✓
Rob Morgan	Executive Director of Finance (Chief Finance Officer)	✓	✓	✓
Dr Lalitha Iyer	Medical Director	✓	✓	✓
Dr Steven Clarke	Interim Clinical Chair for NEHF CCG/ Clinical Lead for NEHF Place		✓	
Dr Ed Palfrey	Secondary Care Specialist / Interim independent member for Bracknell Forest Place	Interim	✓	
Kathy Atkinson	Lay Member for Patient and Public Engagement/ Place Based Lay Member for NEHF	Interim	✓	Interim
Dr Huw Thomas	Interim Clinical Leader for the Royal Borough Place	✓		
Dr Jim O'Donnell	Interim Clinical Chair for East Berkshire CCG & Clinical Lead for Slough Place	✓		
Arthur Ferry	Lay Member for Governance and Audit and Place based Lay Member for Royal Borough and Slough Places	✓	Interim	Interim
Dr Amanda Wellesley	Interim Secondary Care Specialist	✓	Interim	✓
Tony Fitzgerald	Interim Lay Member for Primary Care/ Interim Lay Chair for Surrey Heath CCG/ Place Based Lay Member for Surrey Heath Place	Interim	Interim	✓
Dr John Fraser	Interim Clinical Leader for Surrey Heath CCG			✓
Martin Kittel	Interim Clinical Leader Bracknell Forest	✓		

Name	Role	East Berkshire	North East Hampshire & Farnham	Surrey Heath
Dr Peter Bibawy	Clinical Chair for North East Hampshire and Farnham CCG		✓	

Additional executive membership of the Frimley Collaborative Board April 2020 to March 2021

Name	Role	East Berkshire	North East Hampshire & Farnham	Surrey Heath
Emma Boswell	Executive Director of Development and Improvement	✓	✓	✓
Fiona Slevin-Brown	Executive Place Managing Director Bracknell Forest	✓		
Daryl Gasson*	Executive Place Managing Director North East Hampshire & Farnham		✓	
Tracey Faraday-Drake*	Executive Place Managing Director Slough	✓		
Caroline Farrar	Executive Place Managing Director Royal Borough of Windsor & Maidenhead	✓		
Nicola Airey	Executive Place Managing Director Surrey Heath			✓
Ollie White	Interim Place Managing Director North East Hampshire and Farnham from April 2020 to May 2020		✓	
Non-Voting Attendees of the Frimley Collaborative Board April 2020 to March 2021				
Caroline Warner	Lay Person for Surrey Heath CCG and Lay Convenor for the Collaborative Board			✓
Fiona Edwards	Frimley Health and Care Integrated Care System Lead			

Note * joined in May 2020.

In 2020-21 the Frimley Collaborative Board met on thirteen occasions – attendance at these meetings is set out overleaf:

Attendance Table for the Frimley Collaborative Board 1 April 2020 – 31 March 2021.

Name and designation	14 April 2020	12 May 2020	9 June 2020	7 July 2020	8 Sep 2020	29 Sep 2020	13 Oct 2020	27 Oct 2020	10 Nov 2020	8 Dec 2020	12 Jan 2021	9 Feb 2021	9 Mar 2021	No of meetings attended
Dr Andy Brooks	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Sarah Bellars	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Rob Morgan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Dr Lalitha Iyer	✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	11/13
Dr Steven Clarke	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Ed Palfrey	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/13
Kathy Atkinson	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/13
Dr Peter Bibawy	✓	✓	✓	A										3/4
Dr Huw Thomas	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	11/13
Dr Jim O'Donnell	✓	A	A	✓	A	A	✓	✓	✓	✓	✓	✓	✓	9/13
Arthur Ferry	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Dr Amanda Wellesley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Tony Fitzgerald	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Dr John Fraser	✓	✓	A	✓	A	✓	A	✓	✓	✓	A	✓	✓	9/13
Dr Martin Kittel	✓	✓	✓	✓	✓	✓	A	✓	✓	A	✓	✓	✓	11/13
Emma Boswell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13

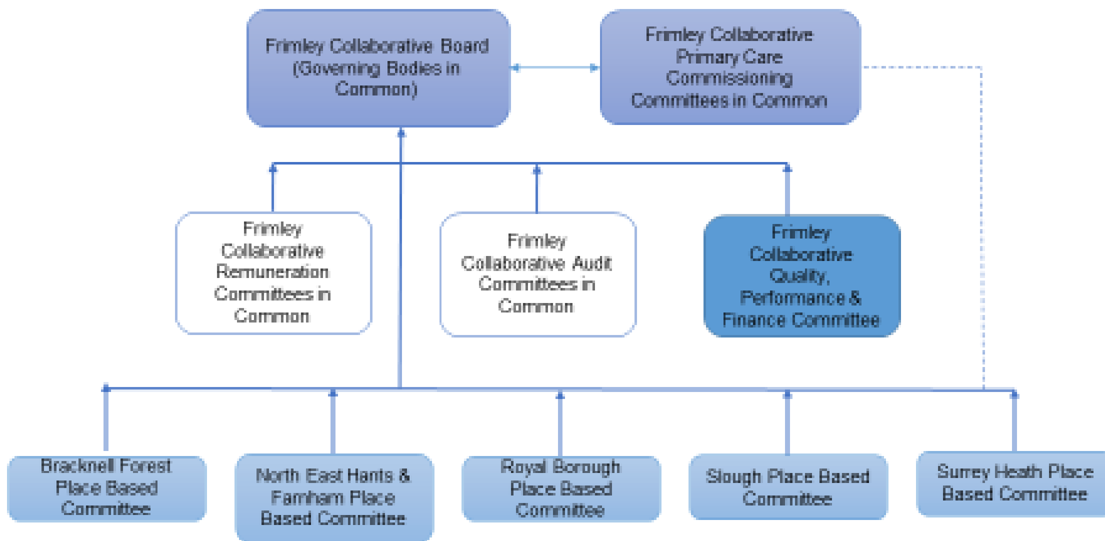
Name and designation	14 April 2020	12 May 2020	9 June 2020	7 July 2020	8 Sep 2020	29 Sep 2020	13 Oct 2020	27 Oct 2020	10 Nov 2020	8 Dec 2020	12 Jan 2021	9 Feb 2021	9 Mar 2021	No of meetings attended
Fiona Slevin-Brown	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	12/13
Daryl Gasson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Tracey Faraday-Drake		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/12
Caroline Farrar		✓	✓	A	A	✓	✓	✓	✓	✓	✓	✓	✓	10/12
Nicola Airey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Ollie White	✓	✓												2/2
NON-VOTING ATTENDEES														
Caroline Warner	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	13/13
Fiona Edwards	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12/13

✓ Attended **A** Absent

Following its formation the Frimley Collaborative Board met in public on 10 March 2021.

13.5. Statutory Committees

The statutory committees of the Governing Body met as committees in common with the other CCG Governing Bodies in the Frimley Collaborative. Diagram below shows the arrangements for 2020-21.



(a) Audit and Risk Committees in Common April 2020 – March 2021

NHS East Berkshire CCG discharged its audit responsibilities through the Frimley Collaborative Committees in Common during 2020-2021. There are three Collaborative voting members on the Committees in Common. The Frimley Collaborative Audit and Risk Committees in Common met on six occasions.

Table showing Audit and Risk Committees in Common membership and attendance between April 2020 – March 2021

Name and designation	21 May 2020	17 June 2020	16 Sept 2020	11 Nov 2020	27 Jan 2021	17 Mar 2021
Arthur Ferry (Convenor) - Lay Member	✓	✓	✓	✓	✓	✓
Tony Fitzgerald - Lay Member	✓	✓	✓	✓	✓	✓
Dr Amanda Wellesley - Secondary Care Specialist	✓	✓	✓	✓	✓	✓

✓ Attended **A** Absent

At each of its meetings, the Audit and Risk Committees in Common received updates and assurances on the impact of Covid-19 on finances, procurements, fraud and control of patient information. The External Auditors gave unqualified opinions on the accounts for NHS East Berkshire, NHS North East Hampshire and Farnham CCG and NHS Surrey Heath CCG for 2019-20.

In 2020-21, the Audit and Risk Committees in Common made good progress on aligning work plans and reports from the various teams across the three CCGs – including the alignment of all internal audit plans for 2021-22.

The Audit and Risk Committees in Common provided oversight and scrutiny on the merger and mobilisation plans to the Frimley Collaborative Board. The Audit and Risk Committees in Common oversaw work to support the merger preparation process – including the alignment of three sets of Standing Financial Instructions to a single set of Standing Financial Instructions; the development of a single Risk Management Framework and a single aligned Conflicts of Interest Policy for the newly merged organisation. The Committees in Common agreed substantive Terms of Reference for the newly merged Frimley CCG Audit and Risk Committee.

(b) Remuneration Committees in Common April 2020 – March 2021

The Remuneration Committee oversees and monitors matters relating to CCG staff and their development. In 2020-2021, NHS East Berkshire CCG discharged its Remuneration responsibilities through the Frimley Collaborative Committees in Common. In line with national NHS guidance issued in response to the Covid-19 pandemic to pause all non-essential oversight meetings – the Remuneration Committees in Common suspended meetings between 6 April 2020 and 4

November 2020. The Frimley Collaborative Remuneration Committees in Common met on six occasions during 2020-21. Specific terms of references were developed for the Committees to meet in common and established a voting membership as described below.

The Remuneration Committees in Common is comprised of both voting members and interim non-voting attendees. In response to the decision to progress with a merger application the capacity of the Remuneration Committees in Common was further strengthened with support from two additional interim attendees – Dr Ed Palfrey and Dr Amanda Wellesley. Membership and attendance are shown below;

Table showing Remuneration Committees in Common interim membership and attendance between April 2020 – March 2021

Name and designation	6 April 2020	4 Nov 2020	2 Dec 2020	13 Jan 2021	3 Feb 2021	3 Mar 2021
Kathy Atkinson – Lay member and Convenor from 27 October 2020 to 31 March 2021	✓	✓	✓	✓	✓	✓
Arthur Ferry – Lay Member	✓	✓	✓	✓	✓	✓
Tony Fitzgerald - Lay Member	✓	✓	✓	✓	✓	✓

Table showing Remuneration Committees in Common interim non-voting attendees between April 2020 – March 2021

Name and designation	6 April 2020	4 Nov 2020	2 Dec 2020	13 Jan 2021	3 Feb 2021	3 Mar 2021
Sally Kemp – Independent Convenor until 6 April 2020	✓					
Caroline Warner – Lay Person for Surrey Heath	A	✓	✓	A	A	A
Dr Amanda Wellesley – Secondary Care Specialist		✓	✓	✓	A	A
Dr Ed Palfrey - Secondary Care Specialist NHS North East Hampshire and Farnham CCG and Interim Independent Collaborative Member for Bracknell Forest		A	✓	A	✓	✓

✓ Attended A Absent

At its meeting in April 2020 the Committees in Common noted the impact of Covid-19 and agreed the suspension of its meetings to allow executive and clinical colleagues to focus on the urgent priorities to support the collaborative response to the pandemic. The Committees in Common considered the impact that this suspension would have on its work to progress the Clinical Chair and Lay Convenor appointment processes and the Accountable Officer remuneration. Members received a paper that set out the proposed interim Clinical Chair and Interim Lay Convenor roles from the three CCGs from 1 April 2020 onwards.

The Committees in Common reconvened in November 2020 and discussed the interim Chair posts and interim Clinical leaders at Place and on the Collaborative Board. Members considered the priorities for the merger and the appointments to the Governing Body for the newly merged CCG from 1 April 2021 onwards. In addition, the Committees in Common received regular updates and assurance on the alignment of teams across the three CCGs ahead of the merger in April 2021 and confirmation that a formal TUPE consultation process had been undertaken between January and February 2021.

The Committees in Common agreed substantive Terms of Reference for the newly merged Frimley CCG Remuneration Committee and agreed key pieces of work for 2021-22 including the harmonisation of pay for Place Based Clinical Leads, Lay & Independent Members.

(c) Primary Care Committees in Common April 2020 – March 2021

On April 1 2017, the CCG assumed responsibility for commissioning local primary care services. The delegation of this role from NHS England to NHS East Berkshire CCG was an extremely important development in the planning of healthcare services provided to the local population. As the commissioner for local primary care the CCG works more closely with its member practices on planning the services provided to local people.

The Primary Care Commissioning Committees for the three CCGs in the Frimley Collaborative exercised their respective delegated authority from NHS England for primary care services through membership of an Interim Primary Care Commissioning Committee. This Interim Primary Care Commissioning Committee met in extra-ordinary form in April 2020 to support rapid decision making in response to the Covid-19 pandemic.

The first meeting was held in July 2020 with the Committee receiving and noting a detailed presentation on the general practice response to Covid-19 since January 2020. The Committee also established a reporting process for each of the five places, across the Collaborative, to report on activities and finances. These reports included procurement of and changes to local services and development of the roadmap to support the national Digital First Programme.

Subsequent meetings, held in October and December, focussed on access to general practice during the pandemic. This included adoption of a prioritisation framework for general practice as promoted by the Royal College of General Practitioners. Support has also been provided to assist general practice in responding to the pandemic, including changes to a number of processes e.g. total triage, assistance with communicating with patients and preparing for a second wave of the virus.

Throughout the year, the Collaborative, via the Committee, has continued to provide support to general practice to ensure services were either deprioritised or suspended in a managed way and to support the sector in the recovery and restoration phase.

Table showing membership of the Primary Care Commissioning Committee in Common held between April 2020 and March 2021

Voting members and representation:			
	East Berkshire (EB)	**North East Hampshire and Farnham (NEHF)**	**Surrey Heath (SH)**
Tony Fitzgerald (Lay Member) (Convenor)	✓	✓	✓
Arthur Ferry (Lay Member)	✓	✓	✓
Sarah Bellars (Executive Director of Quality and Nursing)	✓	✓	✓
Caroline Farrar (Executive Managing Director and Executive lead for primary care)	✓	✓	✓
Amanda Wellesley (Secondary Care Specialist)	✓	✓	✓
GP Representatives:			
Dr Steven Clarke		✓	
Dr Huw Thomas	✓		
Dr Jim O'Donnell	✓		
Dr Martin Kittel	✓		
Dr John Fraser			✓
Other representatives from:			
NHS England			
Healthwatch			
Local Medical Committees			

Table showing attendance of voting members at the Primary Care Commissioning Committee in Common held between April 2020 and March 2021

	Voting members			
	21 July 2020	20 Oct 2020	15 Dec 2020	8 Mar 2021
Tony Fitzgerald (convenor)	✓	✓	✓	✓
Arthur Ferry	✓	✓	✓	**A**
Sarah Bellars	✓	✓	A	✓
Caroline Farrar	✓	✓	✓	✓
Amanda Wellesley	✓	✓	✓	**A**
Dr Huw Thomas	✓	✓	**A**	**A**
Dr Martin Kittel	**A**	✓	✓	**A**
Dr Steven Clarke	✓	✓	✓	A
Others in attendance:				
Sue Pilgrim NHS England				
Jo Hanswenzl, NHS England				
Mark Sanders Healthwatch (Bracknell Forest/ Royal Borough of Windsor and Maidenhead)				
Maria Millwood Healthwatch (Surrey Heath)				
Claire Sieber Local Medical Committee (Wessex)				

✓ Attended **A** Absent

(d) Quality Performance and Finance Committees in Common April 2020 – March 2021

In December 2019, Frimley Collaborative Board agreed to establish a Quality Performance and Finance Committee, which would:

- provide a home for specific items displaced by new ways of working across the three CCGs, ensure reporting and assurance functions were fulfilled;
- provide flexibility to adapt to the needs of the Collaborative and Integrated Care System governance and
- allow the Collaborative Board to retain its strategic focus.

The Committee did not meet between April and June as the CCGs responded to the level 4 public health emergency. The Committee started to meet from July 2020 and included representation from each of the five places in addition to executive directors.

Key topics considered during the year included:

- Winter preparedness.
- Future financial framework.
- Issues concerning services for children and young people in East Berkshire.
- Safeguarding annual reports 2019-20.
- Collaborative wide complaints and concerns report.

Throughout the year the Committee has focused its discussions on how best to develop its approach to monitoring performance across the Collaborative, ensuring that it avoided duplication with other assurance bodies. The Committee will continue to review its final Terms of Reference to reflect the ongoing development.

Table showing voting membership and attendance at meetings held between April 2020 and March 2021

Name	28 July 2020	22 Sep 2020	24 Nov 2020	02 March 2021	No of meetings attended
Members					
Amanda Wellesley, Secondary Care Specialist (Chair)	✓	✓	✓	✓	4/4
Dr Lalitha Iyer, Medical Director	✓	✓	✓	✓	4/4
Sarah Bellars, Executive Director of Quality and Nursing	✓	✓	✓	✓	4/4
Rob Morgan, Chief Finance Officer	✓	✓	✓	✓	4/4
Nicola Airey, Executive Managing Director for Surrey Heath	✓	✓	✓	A	3/4
Fiona Slevin-Brown, Executive Managing Director for Bracknell Forest	✓	A	✓	✓	3/4
Daryl Gasson, Executive Director for North East Hampshire & Farnham	✓	✓	✓	✓	4/4
Dr Jim O'Donnell, Clinical Lead for Slough	✓	A	✓	✓	3/4

✓ Attended **A** Absent

Additional notes

13.6. Personal data related incidents

In 2020-21, there were no reported Serious Untoward Incidents relating to data security breaches.

13.7. Statement of Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

13.8. Modern Slavery Act

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

14. STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities),
- The relevant responsibilities of 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 a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of financial position and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

For the year 2020-21 NHS Commissioning Board (NHS England) appointed Dr Andy Brooks as the Accounting Officer of East Berkshire CCG. In April 2021 NHS Commissioning Board (NHS England) appointed Fiona Edwards as the interim Accountable Officer for the merged NHS Frimley CCG and is therefore the signatory for the Annual Report and Accounts for the predecessor organisation of NHS East Berkshire.

The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding East Berkshire CCG's assets, are set out in Managing Public Money published by the HM Treasury.

As the Accounting 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 East Berkshire CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

To the best of my knowledge and belief I have properly discharged the responsibilities set out under the National Health Services Act 2008 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Fiona Edwards

Accountable Officer

14 June 2021

15. GOVERNANCE STATEMENT

15.1. Introduction and context

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

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

As at 31 March 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.'

During 2020-21 the CCG worked in a complex and emerging healthcare environment and it continued its work to develop a single commissioning function for the Frimley ICS. This alignment work for the three CCGs in the Frimley Collaborative is described further in Membership Report.

15.2. Scope of responsibility

'As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's (CCG) policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.'

15.3. Governance arrangements and effectiveness

'The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.'

The Governing Body is constituted in accordance with the Health and Social Care Act 2012 and is the principle decision-making body in the commissioning and contracting of high-quality healthcare for our local community. It comprises of

clinical, lay and executive directors with a variety of backgrounds, with a wide range of skills and experience. These include members overseeing elements of governance and patient and public engagement.

I can confirm that in 2020-21 that the CCG continued to work in a “Committees in Common” form collectively referred to as the Frimley Collaborative. The Frimley Collaborative Board is comprised of executives, clinicians and lay members.

The CCG experienced extraordinary and unprecedented challenges as a result of the Covid-19 health pandemic and the decision in July 2020 to proceed with a merger with NHS North East Hampshire & Farnham CCG and NHS Surrey Heath CCG. Subsequently there have been a significant number of complex changes to how the CCG has worked.

The CCG enacted its individual Emergency Preparedness Resilience and Response (EPRR) arrangements to allow the establishment of a Command and Control structure for the Frimley Collaborative which aligned statutory roles and responsibilities with the Frimley ICS to form a single Frimley ICS Incident Co-Ordination Centre. The Frimley Collaborative led the local Place Based primary care co-ordination for patients within the community.

This establishment of interim roles to (i) support the response to the pandemic and (ii) the decision to proceed with a merger application resulted in wide ranging changes to the executive, clinical and lay roles across the three CCGs of the Frimley Collaborative. As a result, members of the CCG undertook roles at System level, either as part of the Frimley ICS Board or Frimley Collaborative Board and or locally as members of their respective Place Committees. These changes to roles and responsibilities are described in detail in both the Membership and Remuneration Reports.

I confirm that the CCG has been able to maintain the functions of the Governing Body through these arrangements and 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.

I confirm that the CCG has maintained a strong focus on effective governance.

The Constitution requires that the CCG will at all times observe the principles of good governance in the way it conducts its business. These principles include the Good Governance Standard for Public Services, the Nolan Principles, the seven key principles of the NHS Constitution and the Equality Act 2010.

I confirm that the Constitution maintains the embedded Standing Orders. These Standing Orders, combined with the Scheme of Delegation and Prime Financial Policies, form the procedural governance framework. They set out the structure

and arrangements for conducting the business of the CCG, the process to delegate powers and the declaration of interests and standards of conduct.

The membership, attendance records and highlights of the work undertaken by the Frimley Collaborative Board and its sub-committees the (i) Audit and Risk Committees in Common (ii) Remuneration Committees in Common (iii) Primary Care Commissioning Committees in Common and (iv) Quality Finance and Performance Committees in Common for 2020-21 are described separately in the Membership Report.

15.4. UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

15.5. Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

The CCG has restated how it would discharge its responsibilities and functions. As a result, I can confirm that the 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 Executive Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

15.6. Risk management arrangements and effectiveness

As a result of the enactment of EPRR arrangements in 2020-21 in response to the Covid-19 health pandemic, the CCG has realigned its existing Governing Body Assurance Framework priorities with those of the other CCGs in the Frimley Collaborative and taken accounts of the Frimley ICS ambitions. In January 2021 the Assurance Framework was further aligned to the NHS priorities which reflected the continuing response to the Covid-19 Pandemic.

The Assurance Framework supports the system of internal control - these are significant parts of the risk and control framework and are designed to manage risk and to provide reasonable assurance of effectiveness. At each of its meetings, the Frimley Collaborative Board received a Governing Body Assurance Framework report.

I can confirm that the Frimley Collaborative Audit and Risk Committees in Common agreed an overarching Risk Management Framework ahead of its merger with NHS North East Hampshire and Farnham CCG and NHS Surrey Heath CCG and the

formation of a single CCG in the Frimley ICS – that is, NHS Frimley CCG. The Risk Management Framework for the new Frimley CCG aligns all the predecessor risks and a new set of risk management processes have been introduced along with risk management training in 2021-22.

It is important for every employee and clinical lead to understand the Governance Framework, the Risk Management Policy and in particular the benefits of on-going identification and management of risk issues. I am aware that training over the past year has not been given priority over the response to Covid-19 and I am assured that it will be a priority for the merger organisation in 2021.

The CCG reviews any impact that a project or programme of work will have on local people. This includes an assessment of risk that helps the CCG to identify mitigating actions. Engaging with local people and stakeholders is one of the actions taken to reduce potential risks. The CCG listens to patients and makes sure local people are engaged throughout the design process, helping to develop new ideas and improve existing services. These actions are described in the Engaging People and Communities section of this report.

The CCG has continued to receive assurance on risk from Local Counter Fraud Specialist and Security Management Specialists who have provided an evaluation on potential cyber risks during the pandemic. The Audit and Risk Committees in Common receives these assurances on behalf of the Governing Body.

15.7. Capacity to Handle Risk

The past year has seen all CCG teams re-focus their attention to support the wider NHS respond to the pandemic. While teams took a more day to day approach to managing risk, the Incident Control Centre (ICC) and Governance Team kept records of actions and decisions taken.

The Executive Team played an critical role to prioritise the management of risks which could impact upon the achievement of the CCG's objectives; and to evaluated the likelihood of those risks being realised showing the impact should they be realised. Executive Directors provided situation reports (SitReps) in place of previous business as usual risk register reports.

The CCG as part of the Frimley ICS agreed an Ethical Framework that enabled providers and primary care to work closely together offering mutual aid to minimise the impact on the quality of care.

The whole NHS were advised to suspend some non-urgent activities and reduce the number of committee meetings to give greater capacity for staff who were seconded to areas of most need. The CCG took a number of actions:

- All non-essential meetings were suspended in March. Only the Frimley Collaborative Board, the Audit and Risk Committees in Common and the

Primary Care Commissioning Committees in Common continued to meet. All took a pragmatic and risk based approach to the meetings and reduced the amount of time significantly to focus on the priority areas.

- A Frimley ICS Workforce Bureau was established and many members of staff were seconded through the bureau to support NHS colleagues across the Frimley System.
- The Executive Team reported risks that took the form of a monthly situation report based on the previous assurance framework structure.
- The Quality, Finance and Performance Committee started to meet again from July 2020 and included representation from each of the five places in addition to executive directors. The work of the Quality, Finance and Performance Committee between July 2020 and March 2021 is described in the Membership Report. The work of the CCG's Place Committee is set out in the Performance Report.

15.8. Risk Assessment

The Executive Team have described and reported monthly to the Governing Body via the Collaborative Board on five significant risks. The risks are aligned to the Collaborative strategic priorities and also correlate to the five national priorities set out by NHSE/I and system ambitions for the Frimley ICS.

CCG Strategic Priority Theme 1 – meeting the needs of our population, communities and patients.

- RISK: If there is unprecedented and unplanned demand on health services then the providers will not have capacity to respond. This may impact on quality of care; patients may not receive timely and responsive treatment.
- RISK: If there is an un-coordinated response to the influenza pandemic then the whole system will not be able to manage the surge in demand for services.
- RISK: If there is unprecedented and unplanned demand on primary care services then practices will not have capacity, finance and resources to respond. This may result in reduced access, quality and practice resilience.

CCG Strategic Priority Theme 4 – Creating the new Health and Care Landscape. CCG Priority Area Collaborative and ICS Development.

- RISK: If there is unprecedented and unplanned demand on health services then providers will not have the capacity, finance and resources to respond. This will put pressure on the whole system to provide appropriate financial support.

CCG Strategic Priority Theme 5 – Addressing new priorities.

- RISK: If our people experience Covid-19 illness / absence or sustained high volume work, work pressure and significant anxiety then this will have an

impact on performance, increasing staff sickness absence. The Collaborative will not be able to operate effectively and support the wider NHS.

Other significant risks managed through the internal system resilience group include the **Exit from the European Union.**

The UK exited the European Union on 31 Jan 2020 and has now completed the transition period which ended on 31 December 2020.

The Frimley Integrated Care System continued to work with the incident coordination teams that have been set up for Covid-19 to ensure that there was a single, shared operational readiness and response structure across those areas to avoid confliction and to reduce burden on the system. The Frimley Collaborative has an EU Transition Lead and a dedicated Senior Responsible Officer.

Meetings are conducted when required to share intelligence and identify any further potential risks to ensure they are being managed and mitigated. EU Transition information is being managed via the Frimley ICS ICC.

The Frimley Collaborative EU Transition Plan completed in February 2021 reflects the Reasonable Worse Case Scenario planning assumptions cascaded by the Local Resilience Forums from the Ministry of Housing, Communities and Local Government. Although a deal has now been made these will continually monitored going forward.

The respective Integrated Care Systems leads for each risk areas along with the Lead for Winter 2020-21 and Covid-19 will continue to oversee these key risks areas and will link with their counterparts within the other ICS's across the South East and the South East NHS England and NHS Improvement Team via the SE Incident Coordination Centres.

The CCG continues to keep NHS England aware of all strategic risks as part of the regular dialogue and reporting arrangements.

15.9. Other sources of assurance

Internal Control Framework

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

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

The external auditors provide me with their opinion through their Auditor's Annual Report and other reports.

Internal audit has provided reasonable assurance in their head of internal audit opinion (included at the end of this section of the report).

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

During 2020-21 the CCG has worked with the other CCGs in the Frimley Collaborative to share best practice, align the management of conflicts of interest processes to ensure that it is compliant with the statutory guidance. The CCG did not update its Conflicts of Interest policy in 2020 in anticipation of the merger and development of a Conflicts of Interest Policy for the new Frimley CCG. In addition to a new policy the Collaborative have jointly procured a new system to help all staff manage their declarations of interest via an online platform. The system provides the public with easy access to the information and is open and transparent about the CCG's declarations of interest, in line with NHS England guidance.

I am pleased with the progress made and the internal audit of conflicts of interest has given the CCG reasonable assurance on our management of conflicts of interest. I can confirm there have been no conflict of interest breaches reported between 1 April 2020 and 31 March 2021.

Data Quality

High quality data underpins every step of the commissioning cycle. It is only through the analysis of high-quality data that the CCG can move towards safe, effective, and equitable care for all.

The CCG ensures data quality throughout the commissioning process and, although we rely on other NHS organisations and the CSU, we gain direct assurance from these organisations on a monthly basis and gain independent assurance from Internal Audit reports. No significant issues relating to data quality have been reported to the CCG.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. In 2020-21 the CCG received low risk classification from the Internal Auditors on the review of the Data Security and Protection Toolkit.

This provides the assurance that the CCG has established an information governance management framework and developed robust information governance processes and procedures in line with the Data Security and Protection Toolkit. All staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures as part of the merger programme to help develop an information risk culture.

At the time of writing no significant information governance breaches have occurred in 2020-21 and no incidents required reporting to the regulators.

Response to Covid

The CCG responded appropriately to the Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002. In line with the requirements set out by Secretary of State and NHS Digital this allowed action to be taken to share confidential patient information amongst health organisations and other appropriate bodies for the purposes of protecting public health, providing healthcare services to the public and monitoring and managing the outbreak. Further information can be found on NHS Frimley CCG's website https://www.frimleyccg.nhs.uk/policies-and-documents/information-governance-policies/149-covid-privacy-notice/file

Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business-critical models, in line with the recommendations in the Macpherson report. The business critical models of the CCG primarily rely on activity and finance data produced by the Commissioning Support Unit (CSU) which is assured through their own processes.

The work of the CSU and the validity of its data is subject to further independent internal audit scrutiny. As Accountable Officer, I receive assurance through the CSU service auditor reports that relevant controls are in place and have been operating throughout the year. NHS England undertakes a quarterly assurance review which covers the output from these business critical models. All business-critical models have been identified and information about quality assurance processes for those models has been provided to Audit and Risk Committee.

Third party assurances

The CCG business critical-models primarily rely on activity and finance data produced by the CSU which is assured through the CSU own processes. As Accountable Officer, I receive assurance through the CSU service auditor reports that relevant controls are in place for business-critical models and have been operating throughout the year. The output of business-critical models is validated by NHS England through their quarterly assurance process of the CCG.

The CCG receives assurance reports from the following organisations:

- From the CSU for some or all services provided (as agreed between the CCG and CSU annually);
- From NHS Shared Business Services for the provision of Financial and Accounting Services and Primary Care Payments services;
- From IBM on the operation of the Electronic Staff Record (ESR) Payroll infrastructure and service;
- From NHS Business Service Authority on the operation of prescription services and dental services.
- From NHS Digital on the operation of GP payments services.

These are Service Auditor Reports which typically set out the following:

- Respective responsibilities in the Service end to end process;
- A high level description of the governance and assurance arrangements in place at the Service Organisation including arrangements for effective risk management and assurance;
- A high level description of the Service control environment;
- An assertion by the Service Organisation management regarding the design of internal controls over the process; and,
- A low level description of the Service's control objectives and supporting key controls.

Service Auditor Reports are an internationally recognised method for Service Organisations to provide details of controls and their operation in a specified period to their clients, and are prepared to internationally recognised standards (typically ISAE 3000 and 3402).

In drawing a conclusion on the control environment at the end of this Governance Statement, no significant deficiencies in controls have been reported in 2020-21.

Control Issues

During the year, Internal Audit issued a number of advisory audit reports which identified governance, risk management and/or control issues. The Head of Internal Audit Opinion is informed by these reports and is set out within this annual report. I am pleased to have received generally satisfactory assurance rating.

I can confirm that the CCG did not receive any limited assurance opinions.

No significant control issues have been identified by the auditors that might prejudice or undermine the integrity or reputation of the CCG and/or wider NHS.

15.10. Review of economy, efficiency & effectiveness of the use of resources

I am confident the CCG actively promotes the three E's in all aspects of the CCG's business. The Executive Team and the Quality, Performance and Finance Committee provide critical oversight on investments from both a clinical and financial perspective. All of the achievements of the CCG have been performed within resource limits set by NHS England.

Recruiting the right people to the right posts has been a fundamental approach the CCG has taken forward as part of managing its resources throughout 2020-21. It has maintained its strong leadership with clinical leadership central to the areas that the CCG is responsible for commissioning. The CCG has been fully involved in the first appointment process for the new NHS Frimley CCG Governing Body ensuring the retention of existing knowledge, expertise and skills.

CCGs are statutory organisations responsible to their Governing Body for the delivery of both their statutory and constitutional duties and improvements in the health outcomes of their population. NHS England approaches assurance from the assumption that CCGs will deliver against these requirements.

The process uses information derived from a variety of sources including, where necessary, face-to-face visits. The nature of the oversight, including the expected frequency of assurance meetings, is agreed between NHS England and individual CCGs.

The assurance process introduces a more risk-based approach which differentiates high performing CCGs, those whose performance gives cause for concern, and those in between. It consists of the following components:

- well-led organisation;
- performance: delivery of commitments and improved outcomes;
- financial management;
- planning; and
- delegated functions.

For 2020-21 NHS East Berkshire CCG has received an **'outstanding assurance'** rating on all domains assessed.

15.11. Delegation of functions

On April 1 2017, the CCG assumed responsibility for commissioning local primary care services. The delegation of this role from NHS England to the CCG is an extremely important development in the planning of healthcare services provided to the local population.

As the commissioner for local primary care the CCG works more closely with its member practices on planning the services provided to local people.

No control issues have been raised by the auditors and the annual NHS England Mandated Delegated Primary Care Commissioning Review provided full assurance on effectiveness of the arrangements put in place by the CCG to exercise the primary medical care commissioning functions of NHS England as set out in the Delegation Agreement.

15.12. Counter fraud arrangements

TIAA Ltd provide Counter Fraud services and play an active role in the prevention and deterrence of fraud, bribery and corruption through its attendance at the Audit and Risk Committees in Common. The Counter Fraud team are engaged in policy-setting, sharing of information through attendance at CCG meetings, as well as alerts, bulletins and articles which are shared with relevant departments within the CCG as well as appropriate notices being added to the CCG intranet.

The emergence of the Covid-19 global pandemic has created unprecedented challenges, and, across the NHS, fraud referrals have increased compared to the same period in 2019-20. A bespoke Covid-19 Fraud and Security Risk Assessment was designed and undertaken across the CCG which provided support for all key functions to mitigate fraud risk.

In 2020-21, four allegations were received, of which two were investigated. Both matters remain under investigation at year end. Losses identified for each investigation have yet to be quantified so it cannot be stated at this stage whether these are material.

The NHS Counter Fraud Authority Standards for Countering Fraud, Bribery and Corruption in the NHS have been replaced with the Cabinet Office Government Functional Standard GovS13 with effect from January 2021. The self-assessment tool has not been published and is due for release and submission in May 2021. However, a provisional rating has been undertaken which assesses the CCG as an overall ‘Amber’ rating.

The CCG has established a positive training and awareness culture to ensure all staff receive regular training in person, virtually and through the dedicated online e-learning package. Awareness articles produced by the Counter Fraud Team have been disseminated to all staff and published online for all staff to access.

The Anti-Crime Specialist attends the Audit and Risk Committees in meetings and reports on progress against the Annual Plan. The plan, which is targeted to meet the 13 NHS Counter Fraud Authority Requirements in line with the 12 Components of the Government Functional Standard (GovS13).

No significant control issues have been raised by the Counter Fraud Team.

15.13. Review of the Effectiveness of Governance, Risk Management and Internal Control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their Auditor's Annual Report and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised and given assurance on the effectiveness of internal controls throughout the year through the work carried out by the following:

- Collaborative Board;
- Incident Control Centre;
- Audit and Risk Committees in Common;
- Quality Performance and Finance Committee; and
- Internal audit.

Our board assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed. During Covid-19 Public Health pandemic I have taken assurance from situation reports provided to the Collaborative Board on a monthly basis. I also attended weekly ICS Chief Officer briefings to ensure a whole system approach to our response to the pandemic.

Conclusion : No significant internal control issues have been identified.

Fiona Edwards

Accountable Officer

14 June 2021

15.14. Head of Internal Audit Opinion (HoIA)

Introduction

This report outlines the internal audit work we have carried out for the year ended 31st March 2021.

The Public Sector Internal Audit Standards require the Head of Internal Audit to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit and Risk Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below and set out in Appendix 1. The opinion does not imply that Internal Audit has reviewed all risks relating to the organisation.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is in conformance with the Public Sector Internal Audit Standards.

Head of internal audit opinion

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

Opinion: Generally satisfactory with some improvements required

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk.

Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.

Basis of opinion

Our opinion is based on:

- All audits undertaken during the year.
- Follow up action taken in respect of audits from previous periods.
- NHSE requires that the assurance rating for each review of delegated commissioning needs to be included in EBCCG's annual report and governance statement and discussed at a Governing Body meeting in public.

We reviewed Primary Care Finance with an overall assurance rating of Full in line with NHSE classifications.

- The coronavirus outbreak (Covid-19), which emerged and spread to the UK in early 2020, has become a global pandemic, resulting in the 2020-21 internal audit plan being completed remotely and the scheduled time frames for reviews being impacted as a result of the pandemic, as well as the pressures that this has placed on the CCG. Our work has not specifically been designed to address the risks associated with Covid-19 unless explicitly stated in the agreed Terms of Reference for the individual reviews.

Commentary

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

- Of our 7 reviews completed in the year, one has been rated as medium risk overall and six have been rated as low risk overall. We have not raised any high risk rated reports in 2020-21. The seven reports included 1 high, 4 medium, 7 low and 1 advisory findings, with no critical rated issues identified within those reports.
- In addition to the findings raised in the 2020-21 reviews, our follow up procedures performed in November 2020 and February 2021 identified that of the 26 findings from prior years, 12 of these were completed during 2020-21.
- The number of medium and low risk rated reports, the nature of the issues raised within them, has led us to conclude that the internal controls in place at the CCG are satisfactory with some improvements required. We have highlighted in section 2 specific findings which have contributed to this overall assessment, and the CCG should consider whether these findings are reflected within the Annual Governance Statement.

Acknowledgement

We would like to take this opportunity to thank East Berkshire CCG staff, for their cooperation and assistance provided during the year.

16. REMUNERATION REPORT AND STAFF REPORT

16.1. REMUNERATION REPORT

16.1.1. Definition of senior manager

The definition of 'senior managers' as per NHS England Annual Reporting guidance is:

"Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the clinical commissioning group."

This means those who influence the decisions of the clinical commissioning group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory or lay members.

For the purpose of this remuneration report, 'senior managers' constitute both voting and non-voting members of the CCG Governing Body.

16.1.2. Remuneration Committee

It is a statutory requirement that a CCG's governing body has a remuneration committee to determine and approve remuneration packages for the Accountable Officer, Chief Finance Officer, Executive Directors and Board members. It will also approve policies relating to remuneration and the terms and conditions of employment for all CCG staff.

Their role is to provide advice, guidance and workforce related data as required by the Committee. No committee member is present for discussions about their own remuneration or terms of service.

For further details about the Remuneration Committee, please see Member report.

16.1.3. Remuneration of Very Senior Managers

For any senior manager who is paid in excess of £150,000 on a full time annualised basis, the remuneration is agreed and discussed with the CCG Non-Executives at the Remuneration Committee. Some individuals, including the Clinical Chief Officer of the Frimley Collaborative, have expanding and more complex portfolios covering multiple systems and geographies, and this has been strongly taken into consideration when agreeing the remuneration values. The Salary and Allowances table that follow contain further disclosures on the remuneration of the CCG's senior managers.

16.1.4. Statement of Policy

The Remuneration Committee has the responsibility to maintain awareness of statutory requirements, national guidance and directions in relation to remuneration and workforce matters and to ensure appropriate weight is given in its deliberations to the need to conserve public resources and deliver value for money.

16.1.5. Senior Managers Service Contracts

There have been no payments made for loss of office to any senior manager who was a member of the Governing Body during 2020-21.

16.1.6. Salaries and allowances

The tables below show the salaries and allowances paid to senior managers during 2020-21.

Table one reflects the senior managers across both the CCG and the Frimley Collaborative.

The second table show senior managers that have been appointment or have taken up new roles a result of the CCG working in the new Frimley Collaborative.

All senior managers from the Frimley Collaborative have been disclosed irrespective of whether or not they are specific to the CCG and the CCG's share of their remuneration is nil, as they have senior management responsibility across the entire collaborative arrangements of which the CCG is a part of.

The figures shown under "All Pension Related Benefits" in the table are a calculation of the increase in the senior manager's accrued pension benefit at the beginning and the end of the financial year.

The required formula for this item includes a factor of 20 to allow for the predicted value of the annual pension over an average period of 20 years.

16.1.7. Salaries and allowances of Senior Managers 2020-21 (subject to audit)

Name	Title		2020-21							
							NHS East Berkshire CCG			
			Full Salary & Fees (Bands of £5000) £000	Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000	Salary & Fees (Bands of £5000) £000	Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000
Dr Andy Brooks	Clinical Chief Officer	1	170-175	0	0	170-175	100-105	0	0	100-105
Rob Morgan	Executive Director of Finance	2	130-135	0	37.5-40	170-175	75-80	0	22.5-25	100-105
Nicola Airey	Executive Place Managing Director for Surrey Heath	3	110-115	0	67.5-70	175-180	0	0	0	0
Oliver White	Interim Executive Place Managing Director for North East Hampshire and Farnham	4	10-15	0	2.5-5	15-20	0	0	0	0
Daryl Gasson	Executive Place Managing Director for North East Hampshire and Farnham	5	95-100	0	35-37.5	130-135	0	0	0	0
Fiona Slevin-Brown *	Executive Place Managing Director for Bracknell Forest	6	115-120	0	27.5-30	145-150	115-120	0	27.5-30	145-150
Caroline Farrar	Executive Place Managing Director for Royal Borough of Windsor and Maidenhead	7	110-115	0	30-32.5	140-145	110-115	0	30-32.5	140-145
Tracey Faraday-Drake *	Executive Place Managing Director for Slough	8	95-100	0	22.5-25	120-125	95-100	0	22.5-25	120-125
Sarah Bellars *	Executive Director of Quality and Nursing	9	115-120	0	35-37.5	150-155	65-70	0	20-22.5	90-95
Emma Boswell	Executive Director of Development and Improvement	10	95-100	0	35-37.5	130-135	55-60	0	22.5-25	80-85
Lalitha Iyer *	Executive Medical Director (Shared)	11	95-100	5-10	0-2.5	105-110	65-70	5-10	0-2.5	75-80
Kathy Atkinson	Non-Executive/Lay Member (North East Hampshire & Farnham CCG)	12	10-15	0	0	10-15	0	0	0	0
Arthur Ferry	Non-Executive/Lay Member (East Berkshire CCG)	13	20-25	0	0	20-25	5-10	0	0	5-10
Tony Fitzgerald	Non-Executive/Lay Member (Surrey Heath CCG)	14	15-20	0	0	15-20	5-10	0	0	5-10
Amanda Wellesley	Secondary Care Consultant	15	20-25	0	0	20-25	5-10	0	0	5-10
Dr Peter Bibawy	Clinical Chair - NHS North East Hampshire & Farnham CCG	16	40-45	0	10-12.5	50-55	0	0	0	0
Dr Steven Clarke	Interim Clinical Chair for NEHF CCG/ Clinical Lead for North East Hampshire and Farnham Place	17	15-20	0	2.5-5	20-25	0	0	0	0
Dr Edward Palfrey	Secondary Care Specialist/Interim Independent member for Bracknell Forest Place	18	10-15	0	0	10-15	10-15	0	0	10-15
Dr Huw Thomas	Interim Clinical Leader for the Royal Borough Place	19	40-45	0	2.5-5	45-50	40-45	0	2.5-5	45-50
Dr Jim O'Donnell	Interim Clinical Chair for East Berkshire CCGs & Clinical Lead of Slough Place	20	70-75	0	0	70-75	70-75	0	0	70-75
Dr Martin Kittel	Interim Clinical Leader Bracknell Forest Place	21	40-45	0	0	40-45	40-45	0	0	40-45
Dr John Fraser	Interim Clinical Leader for Surrey Heath CCG	22	40-45	0	0	40-45	0	0	0	0

On 1 January 2020 NHS East Berkshire CCG, NHS Surrey Heath CCG and NHS North East Hampshire and Farnham CCG formed a collaborative governing body in common. The governing bodies of the 3 CCGs meet collectively and while each CCG still has appointed members, all those members of the collaborative governing body meetings are able to vote on decisions affecting the CCG. As a result all members of the collaborative governing body are disclosed in the remuneration report for 2020-21. Some of these roles have not been recharged to East Berkshire CCG.

The titles in the table are for the roles held by those individuals at 31 March 2021 unless where stated their role as a senior manager has ceased during the year. Please see the notes for details of roles undertaken during the year for those who held more than one position.

1. Dr Andy Brooks was Clinical Chief Officer for Surrey Heath CCG Surrey Heath CCG, East Berkshire CCG and North East Hants & Farnham CCG and 60% of his remuneration was charged to East Berkshire CCG for this role. His full salary and fees includes a £15k performance related element which was paid in advance and which could be recovered depending on achievement of objectives.
   Dr Brooks opted out of the pension scheme in 2017. No further disclosure information has been received from the Pensions Agency since 2017-18.
2. Rob Morgan was Executive Director of Finance for Surrey Heath CCG, East Berkshire CCG and North East Hants & Farnham CCG and 60% of his remuneration was charged to East Berkshire CCG for this role.
3. Nicola Airey was Executive Place Managing Director for Surrey Heath. No recharges were made to the other CCGs for her remuneration.
4. Ollie White was Interim Executive Place Managing Director for North East Hampshire and Farnham until 17th May 2020. No costs were recharged to East Berkshire CCG for this role.
5. Daryl Gasson was the Executive Place Managing Director for North East Hants and Farnham CCG from 18th May 2020. No costs were recharged to East Berkshire CCG for this role.
6. Fiona Slevin-Brown was Executive Place Managing Director for Bracknell Forest. No recharges were made to the other CCGs for her remuneration.
7. Caroline Farrar was Executive Place Managing Director for Royal Borough of Windsor and Maidenhead from 1st April 2020. No recharges were made to the other CCGs for her remuneration.
8. Tracey Faraday-Drake was Executive Place Managing Director for Slough from 18th May 2020. No recharges were made to the other CCGs for her remuneration.

9. Sarah Bellars was Executive Director of Quality and Nursing for Surrey Heath CCG, East Berkshire CCG and North East Hants & Farnham CCG and 60% of her remuneration was charged to East Berkshire CCG for this role.
10. Emma Boswell was the Executive Director of Development and Improvement for Surrey Heath CCG, East Berkshire CCG and North East Hants & Farnham CCG and 60% of her remuneration was charged to East Berkshire for this role.
11. Lalitha Iyer was Executive Medical Director for Surrey Heath CCG, East Berkshire CCG and North East Hants & Farnham CCG and 60% of her remuneration was charged to East Berkshire CCG for this role.
12. Kathy Atkinson was the Lay Member for Patient and Public Engagement (PPE) for the Collaborative and the Place Based Lay Member for North East Hants and Farnham. One third of her costs are attributed to East Berkshire CCG for her Collaborative role in 2020-21.
13. Arthur Ferry was the Lay Member for Governance and Audit and the Place Based Lay Member for Royal Borough and Slough Places. One third of his costs are attributed to East Berkshire CCG for his Collaborative role in 2020-21.
14. Tony Fitzgerald was the Lay Member for Primary Care for the Collaborative and Interim Chair and Place Based Lay Member for Surrey Heath. One third of his costs are attributed to East Berkshire CCG for his Collaborative role in 2020-21.
15. Dr Amanda Wellesley was the Interim Secondary Care Specialist for Surrey Heath and East Berkshire CCGs and 30% of her remuneration was charged to East Berkshire for this role.
16. Dr Peter Bibaway was Clinical Chair for North East Hants and Farnham CCG until 31st August 2020.
17. Dr Steven Clarke was Interim Clinical Chair for NEH&F CCG and Clinical Lead for NEH&F Place. No costs were recharged to East Berkshire for this role.
18. Dr Ed Palfrey was Secondary Care Specialist for North East Hampshire and Farnham CCG and Interim Independent Member for Bracknell Forest Place. No costs were recharged to East Berkshire CCG for this role.
19. Dr Huw Thomas was Interim Clinical Leader for Royal Borough of Windsor and Maidenhead Place. No recharges were made to the other CCGs for his remuneration.
20. Dr Jim O'Donnell was Interim Clinical Chair for East Berkshire CCG and Clinical Leader for Slough Place. No recharges were made to the other CCGs for his remuneration.
21. Dr Martin Kittel was Interim Clinical Leader for Bracknell Forest Place. No recharges were made to the other CCGs for his remuneration.
22. Dr John Fraser was Interim Clinical Leader for Surrey Heath Place. No recharges were made to the other CCGs for his remuneration.

* In February 21, Remuneration Committee recommended a backdated uplift back to 1 April 20 in line with the national recommendation for Very Senior Managers. As the deadline had passed for provision of the pensionable pay data to the Pensions Agency for the Greenbury disclosures, the Pensions Agency have been unable to provide uplifted pensions figures to reflect the uplift in pay for these individuals. Therefore the pension related benefit figures disclosed above for these individuals will be based on the estimated pensionable pay at 31 March 2021 prior to the uplift.
Notes: The Amount disclosed in the All Pensions Related Benefits column is the Clinical Commissioning Groups proportion not the full amount.

16.1.8. Salaries and allowances of Senior Managers 2020-21 (subject to audit)

Name	Title		2019-20							
							NHS East Berkshire CCG			
			Full Salary & Fees (Bands of £5000) £000	Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000	Salary & Fees (Bands of £5000) £000	Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL (Bands of £5000) £000
Dr Andy Brooks	Clinical Chief Officer	1	170-175	0	0	170-175	90-95	0	0	90-95
Rob Morgan	Executive Director of Finance	2	125-130	0-5	30-32.5	160-165	25-30	0	5-7.5	30-35
Nicola Airey	Executive Place Managing Director for Surrey Heath	3	100-105	0-5	42.5-45	150-155	0	0	0	0
Ruth Colburn-Jackson	Managing Director for North East Hampshire and Farnham	4	85-90	0	12.5-15	100-105	0	0	0	0
Oliver White	Interim Executive Place Managing Director for North East Hampshire and Farnham	5	20-25	0	2.5-5	20-25	0	0	0	0
Fiona Slevin-Brown	Executive Place Managing Director for Bracknell Forest	6	115-120	0	25-27.5	140-145	115-120	0	25-27.5	140-145
Sarah Bellars	Executive Director of Quality and Nursing	7	110-115	0	30-32.5	140-145	95-100	0	25-27.5	120-125
Emma Boswell	Executive Director of Development and Improvement	8	90-95	0	17.5-20	110-115	10-15	0	2.5-5	15-20
Lalitha Iyer	Executive Medical Director	9	85-90	10-15	52.5-55	150-155	75-80	10-15	47.5-50	135-140
John Fraser	Medical Director	10	40-45	0	0	40-45	0	0	0	0
Kathy Atkinson	Non-Executive/Lay Member (North East Hampshire & Farnham CCG)	11	10-15	0	0	10-15	0	0	0	0
Arthur Ferry	Non-Executive/Lay Member (East Berkshire CCG/North East Hampshire & Farnham CCG)	12	20-25	0	0	20-25	15-20	0	0	15-20
Sally Kemp	Non-Executive/Lay Member (East Berkshire CCG)	13	10-15	0	0	10-15	10-15	0	0	10-15
Clive Bowman	Non-Executive/Lay Member (East Berkshire CCG)	14	10-15	0	0	10-15	10-15	0	0	10-15
Tony Fitzgerald	Non-Executive/Lay Member (Surrey Heath CCG)	15	10-15	0	0	10-15	0	0	0	0
Amanda Wellesley	Secondary Care Consultant	16	20-25	0	0	20-25	5-10	0	0	5-10
Dr Edward Palfrey	Secondary Care Consultant	17	10-15	0	0	10-15	0	0	0	0
Dr Peter Bibawy	Clinical Chair (NHS North East Hampshire & Farnham CCG)	18	100-105	0	22.5-25	125-130	0	0	0	0
Dr Steven Clarke	GP Elected Member - NHS North East Hampshire & Farnham CCG	19	45-50	0	0	45-50	0	0	0	0
Dr William Tong	Clinical Chair	20	30-35	0	0	30-35	30-35	0	0	30-35
Dr Jim O'Donnell	GP Locality Lead	21	90-95	0	0	90-95	90-95	0	0	90-95
Dr Jackie McGlynn	GP Locality Lead	22	70-75	0	12.5-15	85-90	70-75	0	12.5-15	85-90
Dr Huw Thomas	GP Locality Lead	23	45-50	0	10-12.5	55-60	45-50	0	10-12.5	55-60
Dr Martin Kittel	GP Board Member	24	40-45	0	0	40-45	40-45	0	0	40-45
Dr Nithya Nanda	GP Board Member	25	5-10	0	0	5-10	5-10	0	0	5-10
Dr Michael Hoskin	GP Board Member	26	15-20	0	5-7.5	25-30	15-20	0	5-7.5	25-30
Dr Nuzhet A-Ali	GP Board Member	27	20-25	0	7.5-10	30-35	20-25	0	7.5-10	30-35
Dr Claire Nieland	GP Board Member	28	10-15	0	167.5-170	180-185	10-15	0	167.5-170	180-185
Nigel Foster	Director of Finance	29	145-150	0	22.5-25	170-175	0	0	0	0
Debbie Fraser	Deputy Director of Finance	30	65-70	0	22.5-25	90-95	65-70	0	22.5-25	90-95

On 1 January 2020 NHS East Berkshire CCG, NHS Surrey Heath CCG and NHS North East Hampshire and Farnham CCG formed a collaborative governing body in common. The governing bodies of the 3 CCGs meet collectively and while each CCG still has appointed members, all those members of the collaborative governing body meetings are able to vote on decisions affecting the CCG. As a result all members of the collaborative governing body are disclosed in the remuneration report for 2019-20. Some of these roles have not been recharged to East Berkshire CCG.
The titles in the table are for the roles held by those individuals at 31 March 2020 unless where stated their role as a senior manager has ceased during the year. Please see the notes for details of roles undertaken during the year for those who held more than one position.

1. Dr Andy Brooks was Clinical Chief Officer for Surrey Heath CCG and East Berkshire CCG until 30 November 2019 and from 1 December 2019 became Clinical Chief Officer for Surrey Heath CCG, East Berkshire CCG and North East Hampshire and Farnham CCG. Dr Brooks opted out of the pension scheme in 2017. No further disclosure information has been received from the Pensions Agency since 2017-18.
2. Rob Morgan was Interim Managing Director and Chief Finance Officer for Surrey Heath CCG until 30th November 2019 and from 1 December 2019 became Executive Director of Finance for Surrey Heath CCG, East Berkshire CCG and North East Hampshire and Farnham CCG.
3. Nicola Airey was Director of Planning and Delivery for Surrey Heath CCG until 1st December 2019 and from 2nd December 2019 became Executive Place Managing Director for Surrey Heath.
4. Ruth Colburn-Jackson was the Managing Director for NHS North East Hampshire and Farnham CCG. She left the CCG on 19 January 2020. No funding was recharged for this role.
5. Oliver White was appointed Interim Executive Place Managing Director for North East Hampshire and Farnham on 20 January 2020. No funding was recharged for this role.
6. Fiona Slevin-Brown was Director of Strategy and Operations for East Berkshire CCG until 1 December 2019 and from 2nd December 2019 became Executive Place Managing Director for Bracknell Forest, the Executive Place Managing Director posts for Slough and RBWM were vacant during the period. No funding was recharged for this role.
7. Sarah Bellars was Director of Nursing and Quality for East Berkshire CCG until 1 December 2019 and from 2n December 2019 became Executive Director of Nursing and Quality for Surrey Heath CCG, East Berkshire CCG and North East Hampshire and Farnham CCG.
8. Emma Boswell was the Executive Director of Nursing and Quality with a Frimley system focus for the Hampshire and Isle of Wight Partnership of CCGs until 30th November 2019, with her remuneration split equally across all 5 CCGs. From 1st December

2019 Emma Boswell stood down as the Executive Director of Quality and Nursing for the Hampshire and Isle of Wight Partnership of CCGs, but remained the Executive Director of Quality and Nursing for NHS North East Hampshire and Farnham CCG until 31 December 2019. On 1 January 2020 she was appointed to the role of Executive Director of Development and Improvement for the Frimley Collaborative, with her remuneration split between NHS East Berkshire CCG (60%), NHS North East Hampshire and Farnham CCG (20%) and NHS Surrey Heath CCG (20%).
9. Lalitha Iyer was Medical Director for East Berkshire CCG until 1 December 2019 and from 2 December 2019 became Executive Medical Director for Surrey Heath CCG, East Berkshire CCG and North East Hampshire and Farnham CCG. The performance related pay in the table relates to both 2018/19 and 2019/20
10. Dr John Fraser was the Medical Director of Surrey Heath CCG until 31 December 2019.
11. No disclosure required.
12. Arthur Ferry was a Non-Executive/Lay Member (East Berkshire CCG). As of 1 August 2019, he additionally provided lay member support to North East Hampshire and Farnham CCG.
13. Sally Kemp was a Non-Executive/Lay Member (East Berkshire CCG) and resigned as of 6 January 2020. After which she continued to provide support as Independent Chair for the Interim Remuneration Committees in Common and for the Frimley Collaborative Board for the remainder of the year.
14. Clive Bowman was a Non-Executive/Lay Member (East Berkshire CCG) and resigned as of 31 March 2020.
15. Tony Fitzgerald is the Lay Member for Governance for Surrey Heath CCG and was also Interim Chair for Surrey Heath CCG from 30 September 2019.
16. Dr Amanda Wellesley is the Secondary Care Consultant for Surrey Heath CCG and East Berkshire CCG.
17. Dr Edward Palfrey is a Secondary Care Specialist Consultant for both NHS North East Hampshire & Farnham CCG and the four other Hampshire and Isle of Wight Partnership of CCGs. His remuneration as a Secondary Care Specialist Consultant for NHS North East Hampshire and Farnham CCG is fully attributable to the CCG, with the remuneration relating to his role as a Secondary Care Specialist Consultant for the four other Hampshire and Isle of Wight Partnership of CCGs split equally across all four CCGs.
18 - 19. No disclosure required.
20. Dr William Tong stepped down from the role of Clinical Chair for East Berkshire CCG as of the 31 March 2020
21 – 27. No disclosure required.
28. Dr Claire Nieland was appointed GP governing body member on 1 May 2019.
29. Nigel Foster continued his role as Director of Finance for East Berkshire CCG under an honorary contract to the 30 November 2019. The CCG did not pay a salary, and no contribution was made in year to FHFT. During the period to the 30t November

2019, the Deputy Director of Finance undertook day to day operations and all the relevant statutory responsibilities where the Director of Finance is conflicted. Nigel Foster remains the Director of Finance and IM&T at Frimley Health NHS Foundation Trust (FHFT).
30. During the period to the 30 November 2019, the Deputy Director of Finance (East Berkshire CCG) undertook day to day operations and all the relevant statutory responsibilities where the Director of Finance is conflicted.

Notes: The Amount disclosed in the All Pensions Related Benefits column is the Clinical Commissioning Groups proportion not the full amount.

16.1.9. Pension Benefits as at 31 March 2021 (subject to audit)

Name	Title	2020/21							
		Real increase in pension at pension age (bands of £2,500) £'000	Real increase in pension lump sum at pension age (bands of £2,500) £'000	Total accrued pension at pension age at 31 March 2021 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2021 £'000	Cash Equivalent Transfer Value at 1 April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension £'000
Rob Morgan	Executive Director of Finance	2.5-5	0	15-20	0	240	197	21	0
Nicola Airey	Executive Place Managing Director for Surrey Heath	2.5-5	2.5-5	30-35	65-70	636	547	63	0
Oliver White	Interim Executive Place Managing Director for North East Hampshire and Farnham	0-2.5	2.5-5	15-20	25-30	215	178	5	0
Daryl Gasson	Executive Place Managing Director for North East Hampshire and Farnham	0-2.5	0-2.5	45-50	95-100	862	797	45	0
Fiona Slevin-Brown *	Executive Place Managing Director for Bracknell Forest	0-2.5	0-2.5	45-50	95-100	841	781	30	0
Caroline Farrar	Executive Place Managing Director for Royal Borough Windsor and Maidenhead	0-2.5	0	10-15	0	166	131	17	0
Tracey Faraday-Drake *	Executive Place Managing Director for Slough	0-2.5	0	0-5	0	48	22	10	0
Sarah Bellars *	Executive Director of Quality and Nursing	2.5-5	0-2.5	35-40	70-75	635	578	30	0
Emma Boswell	Executive Director of Development and Improvement	2.5-5	0-2.5	25-30	55-60	461	410	31	0
Lalitha Iyer *	Executive Medical Director	0-2.5	0-2.5	15-20	55-60	459	429	12	0
Dr Peter Bibawy	Clinical Chair - NHS North East Hampshire & Farnham CCG	0-2.5	0	5-10	0-5	93	65	5	0
Dr Steven Clarke	Interim Clinical Chair for NEHF CCG/ Clinical Lead for North East Hampshire and Farnham Place	0-2.5	0-2.5	5-10	25-30	207	6	192	0
Dr Huw Thomas	Interim Clinical Leader for the Royal Borough Place	0-2.5	0-2.5	20-25	60-65	426	405	9	0

* In February 21, Remuneration Committee recommended a backdated uplift back to 1 April 20 in line with the national recommendation for Very Senior Managers. As the deadline had passed for provision of the pensionable pay data to the Pensions Agency for the Greenbury disclosures, the Pensions Agency have been unable to provide uplifted pensions figures to reflect the uplift in pay for these individuals. Therefore the pension figures disclosed above for these individuals will be based on the estimated pensionable pay at 31 March 2021 prior to the uplift.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

- 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.
- 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.

Note on the previous table: Dr Brooks opted out of the pension scheme in 2017. No further disclosure information has been received from the Pensions Agency since 2017-18.

16.1.10. Pension Benefits as at 31 March 2020 (subject to audit)

Name	Title	2019/20							
		Real increase in pension at pension age (bands of £'000	Real increase in pension lump sum at pension age (bands of £'000	Total accrued pension at pension age at 31 March £'000	Lump sum at pension age related to accrued pension at 31 £'000	Cash Equivalent Transfer Value at 31 March 2020 £'000	Cash Equivalent Transfer Value at 1 April 2019 £'000	Real increase in Cash Equivalent Transfer £'000	Employer's contribution to stakeholder pension £'000
Rob Morgan	Executive Director of Finance	0.0-2.5	0	15-20	0	197	159	15	0
Nicola Airey	Executive Place Managing Director for Surrey Heath	2.5-5.0	0.0-2.5	25-30	55-60	547	481	41	0
Ruth Colburn-Jackson	Managing Director for North East Hampshire and Farnham	0-2.5	0	25-30	50-55	361	334	4	0
Oliver White	Interim Executive Place Managing Director for North East Hampshire and Farnham	0-2.5	0	15-20	20-25	178	157	1	0
Fiona Slevin-Brown	Executive Place Managing Director for Bracknell Forest	0-2.5	0	40-45	95-100	781	721	26	0
Sarah Bellars	Executive Director of Quality and Nursing (Shared)	0-2.5	0-2.5	30-35	65-70	578	525	25	0
Emma Boswell	Executive Director of Development and Improvement	0-2.5	0	25-30	50-55	410	376	12	0
Lalitha Iyer	Executive Medical Director	2.5-5.0	7.5-10	15-20	50-55	429	346	63	0
Dr Peter Bibawy	Clinical Chair - NHS North East Hampshire & Farnham CCG	0-2.5	0-2.5	5-10	0-5	65	39	10	0
Dr Jackie McGlynn	GP Locality Lead	0-2.5	0-2.5	35-40	90-95	689	644	22	0
Dr Nithya Nanda	GP Body Member	0-2.5	0	10-15	30-35	207	197	1	0
Dr Michael Hoskin	GP Body Member	0-2.5	0-2.5	5-10	15-20	156	135	15	0
Dr Huw Thomas	GP Body Member	0-2.5	0-2.5	20-25	60-65	405	377	12	0
Dr Nuzhet A-Ali	GP Body Member	0-2.5	0-2.5	10-15	30-35	230	211	12	0
Dr Claire Nieland	GP Body Member	5-7.5	20-22.5	5-10	25-30	172	28	130	0
Nigel Foster	Director of Finance & Performance	0-2.5	0	35-40	65-70	679	623	20	0
Debbie Fraser	Deputy Director of Finance	0-2.5	0-2.5	20-25	55-60	492	432	24	0

- NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.
- During the year, the Government announced that public sector pension schemes will be required to provide the same indexation in payment on part of a public service scheme pensions known as the Guaranteed Minimum Pension (GMP) as applied to the remainder of the pension i.e. the non GMP. Previously the GMP did not receive full indexation. This means that with effect from August 2019 the method used by NHS Pensions to calculate CETV values was updated. So the method in force at 31 March 2020 is different to the method used to calculate the value at 31 March 2019. The real increase in CETV will therefore be impacted (and will in effect include any increase in CETV due to the change in GMP methodology).
- 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.
- 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.
- Nigel Foster held the position of Director of Finance for East Berkshire CCG until 30th November 2019 under an honorary contract. He also held the role of Director of Finance and IM&T for Frimley Health NHS Foundation Trust (FHFT) and the pension disclosed in the above table relates to his NHS role with FHFT.

16.1.11. Cash Equivalent Transfer Values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.
The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). 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.

16.1.12. Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

16.1.13. Compensation on Early Retirement or for Loss of Office (subject to audit)

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

16.1.14. Payments to Past Members (subject to audit)

There were no payments made to past directors in 2020-21 (nil 2019-20)

16.1.15. Pay Multiples

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

The banded remuneration of the highest paid director or member in the CCG in the financial year 2020-21 was £115k - £120k (2019-20, £115k – £120k).

This was 2.5 times (2019-20 – 2.8 times) the median remuneration of the workforce which was £46,294 (2019-20, £41,854). Figures are based on full time salaries and no adjustment is made for staff shared across the Frimley Commissioning Collaborative.

In 2020-21, two employees received remuneration in excess of the highest paid director or member. Remuneration ranged from £2,000 to £131,000 (compared with two employees in 2019-20 with a range of £7,000 to £131,000).

The highest paid director remains the same as the previous year; there has been a slight increase in the median remuneration.

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

16.2. Staff Report

Under the Equality Act 2010, it is essential that the CCG collects and reports on its current relevant workforce information. To do this, it is updated on a regular basis to ensure that current policies, practices and support mechanisms remain relevant to the needs and requirements of the workforce.

The CCG employs permanent staff and also uses a limited amount of agency staff, classified as 'other'. It also buys in services from Commissioning Support Units and other CCGs. The following table sets out the staff costs for the permanent and agency staff for 2020-21:

Note: This only reflects the headcount of staff on the CCG's Payroll.

16.2.1. Number of Senior Managers

Senior Manager Banding	Number of employees
Band 8a	15
Band 8b	12
Band 8c	6
Band 8d	9
Band 9	3
Director	5
Total	50

Please note – In addition to these senior managers there are a further 69 employees, total headcount including figure above for East Berkshire CCG as at 31 March 2021 – 119 employees.

16.2.2. Staff numbers and costs (subject to audit)

	Admin			Programme			Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	3,150	9	**3,159**	2,293	1,284	**3,577**	5,443	1,293	**6,736**
Social security costs	360	-	**360**	261	-	**261**	621	-	**621**
Employer contributions to the NHS Pension Scheme	727	-	**727**	324	-	**324**	1,051	-	**1,051**
Apprenticeship Levy	12	-	**12**	-	-	**-**	12	-	**12**
Gross employee benefits expenditure	**4,249**	**9**	**4,258**	**2,878**	**1,284**	**4,162**	**7,127**	**1,293**	**8,420**

	Admin			Programme			Total		2019-20
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	2,817	181	**2,998**	2,007	1,678	**3,685**	4,824	1,859	**6,683**
Social security costs	312	-	**312**	209	-	**209**	520	-	**520**
Employer contributions to the NHS Pension Scheme	667	-	**667**	262	-	**262**	929	-	**929**
Apprenticeship Levy	11	-	**11**	-	-	**-**	11	-	**11**
Gross employee benefits expenditure	**3,807**	**181**	**3,988**	**2,478**	**1,678**	**4,156**	**6,285**	**1,859**	**8,144**

16.2.3. Average number of Staff Employed (subject to audit)

	2020-21			2019-20
	Total Number	Permanently Employed Number	Other Number	Total Number
Total	130	116	14	116
Of the above:				
Number of whole time equivalent people engaged on capital projects	0	0	0	0

16.2.4. Staff composition (not subject to audit) numbers are as at 31 March 2021

The table below outlines the gender breakdown of staff.

	Female Headcount	Male Headcount	Total
Governing Body	5	3	8
Very Senior Managers	3	0	3
All other Employees	87	21	108
Total Employees	95	24	119

Please note (‘All other Employees are those with Agenda for change banding)

16.2.5. Sickness Absences data (not subject to audit)

Sickness absences data is not reported as the CCG has opted for the permitted reduction in disclosure this year in line with national guidance under the sickness header.

There were no ill retirements 2020-21. (nil 2019-20)

16.2.6. Cost Allocation and Setting of Charges for Information

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

There were no ill health retirements in 2020-21 (nil 2019-20)

16.2.7. Principles for Remedy

The Parliamentary and Health Service Ombudsman’s six Principles for Remedy (below for information) are embedded into the Complaints Policy and Procedure in use by the CCG to ensure that the approach taken to complaints handling is reasonable, fair and proportionate and meets the needs of individuals. As commissioners, the CCG is committed to ensuring high-quality, clinically-effective services, treatments and interventions that meet the needs of patients and that through the highlighting of complaints and concerns the CCG can make improvements to these services.

The six Principles for Remedy are:

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

The Lay Member for Patient and Public Engagement has the role of the Freedom to Speak Up Guardian to give independent support and advice to staff who want to raise concerns.

The Director of Quality and Nursing has the role of the Freedom to Speak up Guardian to give independent support and advice to anyone from primary care who want to raise concerns.

16.2.8. Employee Consultation

The CCG believes that by working in partnership with staff we can learn about peoples' experiences and views, to help prioritise the best ways to support and work together, ultimately acting as a good employer, with strong, supported teams who share organisational learning to shape the delivery of high-quality care for all.

As in previous years, the CCG continues to regularly communicate and engage with staff through monthly team briefs – a meeting where staff are informed of organisational change and are invited to be engaged and involved. Staff are also involved and invited to stakeholder events, where CCG priorities are debated and shaped, and regular communications are sent to staff via emails and one-to-one meetings are held with line managers on a frequent basis. Objective settings and personal development plans are written for staff to follow as part of their performance management plans each year too.

16.2.9. Staff Partnership Forum

The Staff Partnership Forum was established to improve communication between managers and staff, as well as to improve the working environment within the CCG and thereby staff morale. The forum is made up of representatives nominated by each team within the CCG. It is chaired by the CCG's Governing Body Lay Member for Patient and Public Engagement and is also attended by the CCG's HR Manager.

The forum is the CCG's primary means of consulting staff on a range of work-related issues, such as:

- Merger programme
- Health and Wellbeing Activities
- Organisational Development
- Health and Safety
- Equality Act
- Organisational Policies

Forum members also consider suggestions made by colleagues on any aspect of working conditions or environment and take decisions or make recommendations to senior management accordingly.

Forum meeting notes are shared with CCG colleagues by the nominated team representatives. The representatives also consult their team members on issues raised at the forum and feed their views back to the forum, as well as supporting and encouraging colleagues to put forward suggestions or ideas.

16.2.10. Staff policies

We have a range of policies and procedures that we apply to govern our approach to staff recruitment and development. These include:

- Concerns and Whistleblowing Policy
- Leave and Flexible Working Policy
- Maternity, Paternity, Adoption Leave & Shared Parental Leave and Pay Guidance
- Organisational Change Policy
- Policy for the Management of Policies and Corporate Documents
- Recruitment and Exit Procedure
- Travel and Expenses Policy

The Staff Partnership Forum has taken an active role in reviewing the HR policies as part of the merger programme to align all policies and create new policies for the NHS Frimley CCG.

16.2.11. Staff training

All staff are required to undertake statutory and mandatory training on a variety of topics to keep standards high, ensure compliance with regulations, and to keep you safe at work.

The training staff are required to do will be specific to their role. Some training is required to be completed annually and others every three years. Training includes but is not limited to:

- Display Screen Equipment
- Fire Safety
- Information Governance
- Equality and Diversity
- Health Safety and Wellbeing
- Safeguarding Adults
- Safeguarding Children
- Fraud awareness
- Moving and Handling

16.2.12. Equality (not subject to audit)

An equalities and diversity impact assessment has been completed as part of the merger process. A copy can be found here http://intranet.frimleyccg.nhs.uk/working-here/equality-and-diversity .

The CCG did not expect the merger itself to impact on people's roles as has been a direct transfer of contracts under TUPE. The direct impact on tackling discrimination and opportunity was therefore assessed as being neutral: i.e. that no adverse impact will be experienced by those affected by the proposal in relation to any of the protected characteristics (as defined by the Equality Act 2010).

Staff were given briefings and the opportunity to comment on and discuss the merger proposals prior to submission of the proposal to NHS England. A 30-day period was implemented in line the statutory consultation period. This ensured that affected employees were fully consulted on the proposal. Staff were also given an opportunity to comment on the equality impact assessment through the Staff Partnership Forum and via the Network for Black, Asian, Minority Ethnic Group staff.

The CCG considers equality and diversity an important part of the alignment of the three CCGs' workforce and HR policies.

Each policy is subject to an equality impact assessment to identify positive and negative impacts for staff from protected characteristic groups. This includes the impact for prospective and existing staff with disabilities. Where necessary, policies are amended to minimise potential negative equality impacts and better advance equal opportunities for disabled employees, via reasonable adjustments.

16.2.13. Freedom to speak up

In accordance with the duty of candour the CCG is committed to conducting its business with openness, honesty and integrity and staff are encouraged to raise concerns about any suspected wrongdoing either via the Counter Fraud Team or with one of the two Freedom to Speak Up Guardians. In 2020-21 the CCG agreed with the other two CCGs in the Frimley Collaborative to streamline its arrangements for raising concerns and Lay Member Kathy Atkinson was appointed as the independent Freedom to Speak Up Guardian for staff and Sarah Bellars as the Freedom to Speak Up Guardian for Primary Care colleagues. I can confirm that staff are provided with information about how to access the website of the National Freedom to Speak Up Guardian's Office.

The CCG has a Whistleblowing Policy which provides further guidance on the arrangements for raising concerns and the CCG is working with the other two

CCGs in the Frimley Collaborative to develop a single aligned Whistleblowing Policy in 2021-22.

16.2.14. Disabled Employees

Recruitment by the CCG is carried out in accordance with its recruitment policy. All candidates' application forms are shortlisted anonymously and all applicants considered according to the same criteria. The organisation adheres to the Two Tick scheme in that the CCG guarantees to interview all applicants with a disability who meet the essential criteria for a job vacancy and to consider them on their abilities. Where an individual identifies a disability the CCG will make reasonable adjustments throughout the recruitment process.

Employees who become disabled in the course of their employment will have a regular review with their manager to consider how to best utilise and develop their abilities. Any adjustments which are deemed reasonable, to their employment or working conditions that would assist them in the performance of their duties should be considered.

16.2.15. Trade Union

Public sector organisations are required to report on trade union facility time, which is the paid time off for union representatives to carry out trade union activities. During 2020-21 no staff from the CCG have acted as Trade Union officials.

16.2.16. Expenditure on Consultancy

NHS East Berkshire CCG spent £435,000 on consultancy services during 2020-21 (2019-20: £372,000).

Off Payroll Engagements (not subject to audit)

Table 1: Off-payroll engagements longer than 6 months

	2020-21 Number	2019-20 Number
Number of existing engagements as of 31 March 2021	34	28
Of which, the number that have existed:		
for less than one year at the time of reporting	2	4
for between one and two years at the time of reporting	6	2
for between two and three years at the time of reporting	6	3
for between three and four years at the time of reporting	2	1
for 4 or more years at the time of reporting	18	18

For all off-payroll engagements as at 31 March 2021 for more than £245 per day and that last longer than six months.

Table 2: New Off-payroll engagements

	2020-21 Number	2019-20 Number
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	2	13
Of which:		
Number assessed as caught by IR35	2	10
Number assessed as not caught by IR35	0	3
Number engaged directly (via PSC contracted to department) and are on departmental payroll	0	0
Number of engagements reassessed for consistency/assurance purpose during the year	0	0
Number of engagements that saw a change to IR35 status following the consistency review	0	0

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 2020 and 31 March 2021, for more than £245 per day and that last for longer than 6 months:

Table 3: Off-payroll engagements / Senior official engagements

	2020-21 Number	2019-20 Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements (2)	22	29

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021.

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

Exit package cost band (inc. any special payment element	2020-21 Compulsory Redundancies		2019-20 Compulsory Redundancies	
	Number	£	Number	£
£10,001 to £25,000	1	20,305	0	0
Total	**1**	**20,305**	**0**	**0**

Redundancy and other departure cost have been paid in accordance with the provisions of NHS Agenda for Change Terms & Conditions. Exit costs in this note are accounted for in full in the year of departure. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Parliamentary Accountability and Audit Report

East Berkshire 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.

Fiona Edwards

Accountable Officer

14 June 2021

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS FRIMLEY CCG IN RESPECT OF NHS EAST BERKSHIRE CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS East Berkshire Clinical Commissioning Group ("the CCG") for the year ended 31 March 2021 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 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – Going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 April 2021, NHS East Berkshire CCG was dissolved and its services were transferred to the newly formed NHS Frimley CCG. Under the continuation of service principle NHS East Berkshire CCG is a going concern and the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor CCG. Our opinion is not modified in respect of this matter.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of the CCG-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included seldom used accounts review, material post close journals, last five non-material year-end journal entries and those posted to unusual accounts combinations.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Agreeing a sample of year end accruals to relevant supporting documents, including actual invoices after year end, where applicable.
- Performing cut-off testing of income and expenditure in the period before and after 31 March 2021 to determine whether amounts have been recorded in the correct period.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under the NHS Act 2006, as amended by paragraph 223I1 (3) of Section 27 of the Health and Social Care Act 2012, the CCG must ensure that its revenue resource allocation in any financial year does not exceed the amount specified by NHS England. Expenditure in excess of the amount specified is unlawful.

We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- 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 has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 74, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

Report on the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 85, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General (‘the Code of Audit Practice’) to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Frimley CCG in respect of NHS East Berkshire 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 East Berkshire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Dean Gibbs

for and on behalf of KPMG LLP,

Chartered Accountants

London

14 June 2021

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(1,375)	(3,940)
Other operating income	2	(29)	(19)
Total operating income		**(1,404)**	**(3,959)**
Staff costs	3	8,420	8,143
Purchase of goods and services	4	669,924	626,918
Depreciation and impairment charges	4	60	38
Provision expense	4	2,805	541
Other operating expenditure	4	368	539
Total operating expenditure		**681,577**	**636,179**
Comprehensive expenditure for the year		**680,173**	**632,220**

The notes on pages 126 to 142 form part of this statement

Statement of Financial Position as at 31 March 2021

	Note	**2020-21** £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	7	106	166
Total non-current assets		106	166
Current assets:			
Trade and other receivables	8	3,665	10,037
Cash and cash equivalents	9	3	180
Total current assets		**3,668**	10,217
Total assets		**3,774**	10,383
Current liabilities			
Trade and other payables	10	(65,711)	(77,352)
Borrowings	11	(1,325)	-
Provisions	12	(2,379)	(748)
Total current liabilities		**(69,415)**	(78,100)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(65,641)**	(67,717)
Non-current liabilities			
Provisions	12	(625)	(387)
Total non-current liabilities		**(625)**	(387)
Assets less Liabilities		**(66,266)**	(68,104)
Financed by Taxpayers' Equity			
General fund		(66,266)	(68,104)
Total taxpayers' equity:		**(66,266)**	(68,104)

The notes on pages 126 to 142 form part of this statement

The financial statements on pages 122 to 142 were approved by the Audit Committee on 9th of June 2021 and signed on its behalf by:

Accountable Officer

Date: 14th June 2021

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000
Changes in taxpayers' equity for 2020-21	
Balance at 01 April 2020	(68,104)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21	
Net operating expenditure for the financial year	(680,173)
Net funding	682,011
Balance at 31 March 2021	**(66,266)**

	General fund £'000
Changes in taxpayers' equity for 2019-20	
Balance at 01 April 2019	(65,318)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20	
Net operating costs for the financial year	(632,220)
Net funding	629,434
Balance at 31 March 2020	**(68,104)**

The notes on pages 126 to 142 form part of this statement

Statement of Cash Flows for the year ended 31 March 2021

	Note	**2020-21 £'000**	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(680,173)	(632,220)
Depreciation and amortisation	7	60	38
Decrease in trade & other receivables	8	6,372	962
(Decrease)/increase in trade & other payables	10	(11,518)	1,528
Provisions utilised	12	(936)	(109)
Increase in provisions	12	2,805	541
Net Cash Outflow from Operating Activities		**(683,390)**	(629,260)
Cash Flows from Investing Activities			
Payments for property, plant and equipment		(123)	(19)
Net Cash Outflow from Investing Activities		**(123)**	(19)
Net Cash Outflow before Financing		**(683,513)**	(629,279)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		682,011	629,434
Net Cash Outflow from Financing Activities		**682,011**	629,434
Net (Decrease)/Increase in Cash & Cash Equivalents	9	**(1,502)**	155
Cash & Cash Equivalents at the Beginning of the Financial Year		**180**	25
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(1,322)**	180

The notes on pages 126 to 142 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 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 East Berkshire Clinical Commissioning Group (the CCG) was dissolved on 31 March 2021 having joined with NHS Surrey Heath Clinical Commissioning Group and NHS North East Hampshire and Farnham Clinical Commissioning Group to establish NHS Frimley CCG with effect from 1 April 2021. This followed approval at the NHSE Regional Support Group (RSG) meeting of 2 November 2020.
The activities undertaken by the CCG have continued within the formation of NHS Frimley CCG. In accordance with the Department of Health and Social Care Group Accounting Manual, the continuation of the provision of services within the public sector means that the accounts of the CCG should be prepared on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

The CCG has entered into pooled budget arrangements with Local Authorities including Royal Borough of Windsor and Maidenhead, Slough Borough Council, Bracknell Forest Borough Council and Surrey County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Community Equipment Store and Better Care Fund and note 15 to the accounts provides details of the income and expenditure.

The pool is hosted by Local Authorities. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.4 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Notes to the financial statements

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.

1.8 **Leases**

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

1.8.1 **The Clinical Commissioning Group as Lessee**

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.
Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

1.11 **Clinical Negligence Costs**

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

1.12 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.
All CCGs Financial assets are classified as loans and receivables.

1.12.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.12.2 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate.
Any adjustment is recognised in profit or loss as an impairment gain or loss.

Notes to the financial statements

1.13 **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 **Other Financial Liabilities**

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

1.15 **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 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.17.1 **Critical accounting judgements in applying accounting policies**

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

NHS East Berkshire CCG hosts the London Focus Group, a collaboration of 12 CCGs which commissions activity at 16 London Trusts.

1.17.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Prescribing accrual.

There is a time lag between when the Clinical Commissioning Group's patients receive drugs and certain other medical consumables prescribed by our GPs and when the Group pays the NHS Prescription Services for their issue. At the balance sheet date the Clinical Commissioning Group has estimated the value of this lag in relation to drugs and goods issued but not paid for to be £8,441k (19-20: £8,198k).

Partially Completed Spells.

The Clinical Commissioning Group recognises expenditure relating to spells of care that are started, but not yet completed at the balance sheet date. This recognition is limited to cost and volume contracts where the activity will incur extra costs for the Clinical Commissioning Group. At the 31st March 2020, the Clinical Commissioning Group was recognising a Partially Completed Spells liability of £2,811k.

Maternity Pathway adjustment.

The Clinical Commissioning Group recognises reductions to expenditure relating to pathways of care where payment is recognised at the start of the ante-natal or post-natal period but where at the balance sheet date the pathway phase is incomplete. This recognition is limited to cost and volume contracts where the activity will incur extra costs for the Clinical Commissioning Group. At the 31st March 2020, the Clinical Commissioning Group was recognising a Maternity Pathway adjustments asset of £2,002k.

The financial regime in 2020/21 which is being rolled into next year involved fixed payments for activity in the year with no additional variability for the number of patients treated. Therefore, there are no grounds to calculate accruals at 31st March 2021 or carry forward opening accruals for partially completed spells of care or the maternity pathway adjustment.

The CCG has reached agreement with its main providers and intends to pay down the positions based on the values as at 31st March 2020.

Continuing Care Accrual

The Clinical Commissioning Group holds its approved care packages, Personal Health budgets (PHB), funded nursing care and additional associated charges to care in a Continuing Healthcare database which provides a forecast of annual costs. An accrual is made between the current year invoices received in year and the forecast of the annual costs

Accruals

For goods and/or services that have been delivered but for which no invoice has been received/sent, the CCG has made an accrual based upon known commitments, contractual arrangements that are in place and legal obligations.

The estimates and associated assumptions are based on historical experience, trends and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Notes to the financial statements

Continuing Care Provision

The estimates and associated assumptions are based on historical experience, trends and other factors, that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.
As at the date of the Statement of Financial Position final information on 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.
During 2020/21 the CCG paid for it's NHS secondary healthcare activity on a block basis and therefore no accruals as at 31 March 2021.
An amount of £3,005k has been included in the NHS Continuing Healthcare (CHC) provisions relating to the following items:
• Continuing Health Care (CHC) Waiting List clients awaiting assessment at 31 March 2021 £10k
• Appeals against earlier CCG decisions of non-eligibility for CHC funding £1,778k
• Previously Unassessed Periods of Care (PUPoC) claims awaiting assessment £1,167k
(these relate to claims in respect of clients who have died and other clients requesting an assessment for a past period of time)
• Provision for Redundancy Costs for carers employed by Personal Health Budget holders £50k
The final outcome has yet to be determined therefore the resultant financial effects remain uncertain at the year end.
The total cost of all outstanding CHC Waiting List clients' claims has been calculated using the average local current nursing home and homecare package weekly costs for NHS CHC Adult Fully Funded clients.
The CHC Appeals provision has been calculated on an individual basis for each client appealing against the CCG's decision of non-eligibility. The provision is based on the time period from the start-date of the claim up to 31 March 2021 (or date client died) using the current average local nursing home and homecare package weekly costs. Provision has been made at 62% for Local appeals, 55% for Independent Review Panels (IRPs), 60% for PUPoC & those appeals that are successful are provided for 100%.
The Redundancy Costs in respect of PHB clients has been estimated on a notional basis. The numbers of Personal Health Budget (PHB) clients have increased during 2020/21 and the target is for all CHC homecare clients to be offered PHB status during 2021/22. As per national guidance, the CCG is financially responsible for bearing the redundancy costs of carers of Third Party and Direct Payment PHB clients and hence it is probable that the CCG will have to incur some expenditure of this type during 2020/21. However, at present the timings and amounts are unclear and therefore a provision has been set up to act as a reserve.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

The introduction of IFRS16 will lead to assets subject to leases that are currently recorded in the Statement of Comprehensive Net Expenditure having the value of the future payments to be made under the lease recorded as a liability on the Statement of Financial Position and a corresponding asset recognised. Charges to the Statement of Comprehensive Net Expenditure will reflect depreciation and interest on the lease as opposed to the rental payments.
The CCG has commenced the assessment of the application of IFRS 16 to its financial statements. This commenced with work to identify leases which are currently operating leases and should be reclassified as finance leases as well as a broader review of recurring expenditure streams where right to use assets may be embedded in contracting arrangements. The work progressed to March 2020, when the CCG revised it's operational priorities and working patterns to deal with the COVID19 pandemic and combined with the decision to defer the implementation of IFRS16 in the NHS to 1 April 2021 means that it has not been practical to complete this work or present it for audit. The work to identify the impact of this standard is expected to recommence in Autumn 2021.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
The application of this Standard would not have a material impact on the accounts for 2020-21, were it applied in that year.

2 Other Operating Revenue

	2020-21 Total	2019-20 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**205**	356
Non-patient care services to other bodies	**1,170**	2,939
Other Contract income	**-**	645
Total Income from sale of goods and services	**1,375**	**3,940**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**29**	19
Total Other operating income	**29**	**19**
Total Operating Income	**1,404**	**3,959**

3. Employee benefits and staff numbers

3.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2020-21 Total £'000
Employee Benefits			
Salaries and wages	**5,443**	**1,293**	**6,736**
Social security costs	**621**	**-**	**621**
Employer Contributions to NHS Pension scheme	**1,051**	**-**	**1,051**
Apprenticeship Levy	**12**	**-**	**12**
Gross employee benefits expenditure	**7,127**	**1,293**	**8,420**

The full staff cost note is in the staff report in the annual report.

3.1.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2019-20 Total £'000
Employee Benefits			
Salaries and wages	4,824	1,859	6,683
Social security costs	520	-	520
Employer Contributions to NHS Pension scheme	929	-	929
Apprenticeship Levy	11	-	11
Gross employee benefits expenditure	6,284	1,859	8,143

3.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**115.50**	**14.28**	**129.78**	**99.00**	**17.02**	**116.02**

There were no ill health retirements in 2020-21 (2019-20: nil).

3.3 Exit packages agreed in the financial year

The CCG has 1 exit package agreed in 2020-21 (2019-20: nil).

	2020-21 Compulsory redundancies	
	Number	£
£10,001 to £25,000	1	20,305
Total	**1**	**20,305**

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.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

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

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. From 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

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

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

For 2020-21, total employers’ contributions of £1,049,315 (CCG: £730,220 and NHSE: £319,095) were payable to the NHS Pensions Scheme (19-20 CCG: £699,028 and NHSE: £313,318) at the rate of 20.6% (2019-20: 20.6%) of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2016 and was published on the Government website. These costs are included in the NHS pension line of note 3.1. The value included in note 3.1. £1,051,087 (19-20: £929,466) varies from the total employers' contribution of £1,049,315 (19-20: £1,002,323) as a result of recharges from other organisation £1,772 (19-20: £72,857) as opposed to recharged to other organisations last year.

4. Operating expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	4,657	4,822
Services from foundation trusts	420,192	405,155
Services from other NHS trusts	9,987	9,226
Purchase of healthcare from non-NHS bodies	113,027	91,205
Prescribing costs	51,657	48,265
GPMS/APMS and PCTMS	63,444	59,467
Supplies and services – clinical	1,066	1,483
Supplies and services – general	509	187
Consultancy services	435	372
Establishment	958	1,550
Transport	-	1
Premises	2,940	3,178
Audit fees	112	102
Other non statutory audit expenditure		
· Other services	12	14
Internal Audit Fees	73	97
Other professional fees	690	1,148
Legal fees	66	86
Education, training and conferences	99	560
Total Purchase of goods and services	**669,924**	**626,918**
Depreciation and impairment charges		
Depreciation	60	38
Total Depreciation and impairment charges	**60**	**38**
Provision expense		
Provisions	2,805	541
Total Provision expense	**2,805**	**541**
Other Operating Expenditure		
Chair and Non Executive Members	214	275
Grants to Other bodies	-	157
Clinical negligence	1	1
Expected credit loss on receivables	3	3
Other expenditure	150	103
Total Other Operating Expenditure	**368**	**539**
Total operating expenditure	**673,157**	**628,036**

During 2020-21, a national financial regime was put in place to manage flows of funding to NHS Trusts and other healthcare providers ensuring resource was available to respond to the COVID pandemic in the most effective way and with additional funding being provided for COVID related activities. Therefore comparison between the two years is less straightforward than in prior years with overall increases/decreases being more complex in their composition, particularly in the healthcare services lines.

Audit fees - statutory audit services excluding VAT is £93k (2019-20: £85k), amount shown £112k (2019-20: £102k) is inclusive of VAT.

The CCG has provided £10k excluding VAT (2019-20: £12k) for the fee for the external auditors assurance report on compliance of the Mental Health Investment Standard.

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.

5.1 Better Payment Practice Code

Measure of compliance	**2020-21 Number**	**2020-21 £'000**	2019-20 **Number**	2019-20 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	21,640	117,454	21,140	90,722
Total Non-NHS Trade Invoices paid within target	20,920	102,533	20,515	87,218
Percentage of Non-NHS Trade invoices paid within target	**96.67%**	**87.30%**	**97.04%**	**96.14%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,966	473,727	5,689	445,784
Total NHS Trade Invoices Paid within target	1,839	473,378	5,393	424,538
Percentage of NHS Trade Invoices paid within target	**93.54%**	**99.93%**	**94.80%**	**95.23%**

The Better payment practice code requires the CCG to pay all valid invoices within 30 days of receipt of invoice.

6. Operating Leases

6.1 As lessee

6.1.1 Payments recognised as an Expense			**2020-21**			2019-20
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	2,885	0	**2,885**	3,015	5	**3,020**
Total	**2,885**	**0**	**2,885**	**3,015**	**5**	**3,020**

East Berkshire CCG occupies property owned and managed by NHS Property Services (NHSPS). 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 does not include the future minimum lease payments for the arrangement.

7. Property, plant and equipment

2020-21	Information technology £'000	Total £'000
Cost or valuation at 01 April 2020	762	762
Cost/Valuation at 31 March 2021	**762**	**762**
Depreciation 01 April 2020	596	596
Charged during the year	60	60
Depreciation at 31 March 2021	**656**	**656**
Net Book Value at 31 March 2021	**106**	**106**
Purchased	106	106
Total at 31 March 2021	**106**	**106**
Asset financing:		
Owned	106	106
Total at 31 March 2021	**106**	**106**

2019-20	Information technology £'000	Total £'000
Cost or valuation at 01 April 2019	641	641
Additions purchased	121	121
Cost/Valuation at 31 March 2020	**762**	**762**
Depreciation 01 April 2019	558	558
Charged during the year	38	38
Depreciation at 31 March 2020	**596**	**596**
Net Book Value at 31 March 2020	**166**	**166**
Purchased	166	166
Total at 31 March 2020	**166**	**166**
Asset financing:		
Owned	166	166
Total at 31 March 2020	**166**	**166**

7.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	3	5

8. Trade and other receivables

	Current 2020-21 £'000	Current 2019-20 £'000
NHS receivables: Revenue	1,252	4,246
NHS prepayments	-	2,002
NHS accrued income	470	584
NHS Contract Receivable not yet invoiced/non-invoice	62	1,778
Non-NHS and Other WGA receivables: Revenue	547	248
Non-NHS and Other WGA prepayments	498	490
Non-NHS and Other WGA accrued income	336	140
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	103	255
Non-NHS Contract Assets	226	219
Expected credit loss allowance-receivables	(3)	(3)
VAT	174	78
Total Trade & other receivables	**3,665**	**10,037**
Total current and non current	**3,665**	**10,037**

8.1 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	329	61	530	252
By three to six months	17	95	246	1
By more than six months	149	137	380	31
Total	**495**	**293**	**1,156**	**284**

8.2 Loss allowance on asset classes

	2020-21 Trade and other receivables - Non DHSC Group Bodies £'000	2020-21 Total £'000	2019-20 Trade and other receivables - Non DHSC Group Bodies £'000	2019-20 Total £'000
Balance at 01 April 2020	(3)	**(3)**	(2)	(2)
Lifetime expected credit losses on trade and other receivables-Stage 2	-	**-**	(1)	(1)
Total	**(3)**	**(3)**	**(3)**	**(3)**

9. Cash and cash equivalents

	2020-21 £'000	2019-20 £'000
Balance at 01 April 2020	180	25
Net change in year	(1,502)	155
Balance at 31 March 2021	**(1,322)**	**180**
Made up of:		
Cash with the Government Banking Service	3	180
Cash and cash equivalents as in statement of financial position	**3**	**180**
Bank overdraft: Government Banking Service	(1,325)	-
Total bank overdrafts	**(1,325)**	**-**
Balance at 31 March 2021	**(1,322)**	**180**

A BACS payment run was processed on 31st March 2021 as part of preparations for the CCG merger on 1st April 2021. This was posted to the 2020-21 ledger, however, the cash did not clear the bank account until April 2021. This has resulted in a 'technical' bank overdraft.

10. Trade and other payables	**Current 2020-21 £'000**	Current 2019-20 £'000
NHS payables: Revenue	1,947	13,760
NHS accruals	1,790	8,403
Non-NHS and Other WGA payables: Revenue	19,983	20,057
Non-NHS and Other WGA payables: Capital	-	123
Non-NHS and Other WGA accruals	26,265	19,260
Non-NHS and Other WGA deferred income	158	19
Social security costs	88	86
Tax	77	67
Other payables and accruals	15,403	15,577
Total Trade & Other Payables	**65,711**	**77,352**
Total current and non-current	**65,711**	**77,352**

Other payables include £431k outstanding pension contributions at 31 March 2021 (31 March 2020 £421k).

11. Borrowings	**Current 2020-21 £'000**	**Current 2019-20 £'000**
Bank overdrafts:		
· Government banking service	1,325	-
Total overdrafts	**1,325**	**-**
Total Borrowings	**1,325**	**-**
Total current and non-current	**1,325**	**-**

A BACS payment run was processed on 31st March 2021 as part of preparations for the CCG merger on 1st April 2021. This was posted to the 2020-21 ledger, however, the cash did not clear the bank account until April 2021. This has resulted in a 'technical' bank overdraft.

12. Provisions

	Current 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
Continuing care	2,379	625	748	387
Total	**2,379**	**625**	**748**	**387**

	Continuing Care £'000	Total £'000
Balance at 01 April 2020	**1,135**	**1,135**
Arising during the year	3,532	**3,532**
Utilised during the year	(936)	**(936)**
Reversed unused	(727)	**(727)**
Balance at 31 March 2021	**3,004**	**3,004**
Expected timing of cash flows:		
Within one year	2,379	**2,379**
Between one and five years	625	**625**
Balance at 31 March 2021	**3,004**	**3,004**

Continuing Care provision relates to amounts set aside for Continuing Care Waiting List clients awaiting assessment at 31st March 2021 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 2021 is £5k (31 March 2020: £56k).

	Continuing Care £'000	Total £'000
Balance at 01 April 2019	**704**	**704**
Arising during the year	1,377	**1,377**
Utilised during the year	(110)	**(110)**
Reversed unused	(836)	**(836)**
Balance at 31 March 2020	**1,135**	**1,135**
Expected timing of cash flows:		
Within one year	748	**748**
Between one and five years	387	**387**
Balance at 31 March 2020	**1,135**	**1,135**

13. Financial instruments

13.1 Financial risk management

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

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

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

13.1.1 Currency risk

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

13.1.2 Interest rate risk

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

13.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.4 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.

13.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

13.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	**Total 2020-21 £'000**	Financial Assets measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Trade and other receivables with NHSE bodies	1,230	**1,230**	2,515	2,515
Trade and other receivables with other DHSC group bodies	922	**922**	3,978	3,978
Trade and other receivables with external bodies	845	**845**	976	976
Cash and cash equivalents	3	**3**	180	180
Total at 31 March 2021	**3,000**	**3,000**	**7,649**	**7,649**

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	**Total 2020-21 £'000**	Financial Liabilities measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Loans with external bodies	1,325	**1,325**	-	-
Trade and other payables with NHSE bodies	2,065	**2,065**	5,025	5,025
Trade and other payables with other DHSC group bodies	6,627	**6,627**	22,758	22,758
Trade and other payables with external bodies	56,696	**56,696**	49,398	49,398
Total at 31 March 2021	**66,713**	**66,713**	**77,181**	**77,181**

14. 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.

15. Joint arrangements - interests in joint operations

The CCG has a pooled budget arrangement with Local Authorities (LA) including Royal Borough of Windsor and Maidenhead (RBWM), Slough Borough Council (SBC), Bracknell Forest Borough Council (BFBC) and Surrey County Council (SCC) for the Better Care Fund (BCF). The Pool is hosted by the Councils. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for joint commissioning arrangements.

15.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2020-21 Expenditure £'000	Amounts recognised in Entities books ONLY 2019-20 Expenditure £'000
BCF Pooled budget arrangement with the Royal Borough of Windsor and Maidenhead	NHS East Berkshire CCG and the Royal Borough of Windsor and Maidenhead	Commissioning of Health and Social care	9,428	9,547
BCF Pooled budget arrangement with Bracknell Forest Borough Council	NHS East Berkshire CCG and Bracknell Forest Borough Council	Commissioning of Health and Social care	7,202	6,923
BCF Pooled budget arrangement with Slough Borough Council	NHS East Berkshire CCG and Slough Borough Council	Commissioning of Health and Social care	9,541	9,070
BCF Pooled budget arrangement with Surrey County Council	NHS East Berkshire CCG and Surrey County Council	Commissioning of Health and Social care	774	726

16. Related party transactions

Details of related party transactions with individuals are as follows:

	2020-21				2019-20			
	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	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
Dr Huw Thomas - Interim Clinical Leader for the Royal Borough Place (GP Partner - Claremont & Holyport Practice)	2,032	0	4	0	2,039	0	3	0
Dr Huw Thomas - Interim Clinical Leader for the Royal Borough Place (GP - East Berkshire Out of Hours)	14,186	0	254	0	9,306	0	194	0
Dr Huw Thomas - Interim Clinical Leader for the Royal Borough Place (Patient at Rosemead Surgery)	820	0	21	0	0	0	0	0
Dr Lalitha Iyer - Medical Director - (GP Partner - Farnham Road Surgery)	3,123	0	6	0	3,090	0	9	0
Dr Lalitha Iyer - Medical Director (Surrey Heath CCG)	229	0	0	0	322	0	10	0
Dr Lalitha Iyer - Medical Director (North East Hampshire and Farnham CCG)	305	0	2	0	231	0	0	0
Dr Lalitha Iyer - Medical Director - (Patient at Dr V Sharma Surgery)	778	0	0	0	0	0	0	0
Arthur Ferry - Non-Executive/Lay Member East Berkshire CCG (Surrey Heath CCG)	229	0	0	0	0	0	0	0
Arthur Ferry - Non-Executive/Lay Member East Berkshire CCG (North East Hampshire and Farnham CCG)	305	0	2	0	0	0	0	0
Dr Jim O'Donnell - Interim Clinical Chair for East Berkshire CCG & Clinical Lead for Slough Place (GP Partner - Farnham Road Practice)	3,123	0	6	0	3,090	0	9	0
Dr Jim O'Donnell - Interim Clinical Chair for East Berkshire CCG & Clinical Lead for Slough Place - (Patient at Newton Court medical centre)	1,529	0	0	0	0	0	0	0
Dr Mike Hoskin - GP Board member (Crosby House Surgery)	0	0	0	0	1,261	0	0	0
Dr Nithya Nanda GP Board member (Farnham Road Practice)	0	0	0	0	3,090	0	9	0
Dr Nithya Nanda GP Board member (Smart Medic Limited)	0	0	0	0	12	0	0	0
Dr Martin Kittel - Interim Clinical Leader Bracknell Forest - (Director & Shareholder - Thames Valley Vasectomy Services)	62	0	0	0	68	0	0	0
Dr Martin Kittel - Interim Clinical Leader Bracknell Forest - (GP Parter - Forest End Medical Centre & Forest Health Group)	2,244	0	0	0	2,040	0	1	0
Nigel Foster - Director of Finance (Director of Finance and IM&T - Frimley Health NHS Foundation Trust)	0	0	0	0	249,005	0	26,749	0
Andy Brooks - Clinical Chief Officer (Surrey Heath CCG)	229	0	0	0	231	0	0	0
Andy Brooks - Clinical Chief Officer (North east Hampshire and Farnham CCG)	305	0	0	0	322	0	10	0
Sarah Bellars - Executive Director of Quality & Nursing (Surrey Heath CCG)	229	0	0	0	231	0	0	0
Sarah Bellars - Executive Director of Quality & Nursing (North East Hampshire and Farnham CCG)	305	0	2	0	322	0	10	0
Fiona Slevin-Brown - Executive Place Managing Director Bracknell Forest (Surrey Heath CCG)	229	0	0	0	231	0	0	0
Fiona Slevin-Brown - Executive Place Managing Director Bracknell Forest (North East Hampshire and Farnham CCG)	305	0	2	0	322	0	0	0
Fiona Slevin-Brown - Executive Place Managing Director Bracknell Forest (Patient at Forest Health Group)	187	0	0	0				
Nicola Airey - Executive Place Managing Director Surrey Heath CCG (Surrey Heath CCG)	229	0	0	0	231	0	0	0
Peter Bibawy - Clinical Chair for North East Hampshire and Farnham CCG (North East Hampshire and Farnham CCG)	305	0	2	0	322	0	10	0
Tony Fitzgerald - Non-Executive/Lay Member Surrey Heath CCG (Surrey Heath CCG)	229	0	0	0	231	0	0	0
John Fraser - Interim Clinical Leader for Surrey Heath CCG (Surrey Heath CCG)	229	0	0	0	231	0	0	0
John Fraser - Interim Clinical Leader for Surrey Heath CCG (Patient at Magnolia House Surgery)	1,022	0	18	0				
Robert Morgan - Executive Director of Finance (Surrey Heath CCG)	229	0	0	0	231	0	0	0
Robert Morgan - Executive Director of Finance (North East Hampshire and Farnham CCG)	305	0	2	0	322	0	10	0
Ed Palfrey - Secondary Care Specialist / Interim independent member for Bracknell Forest Place (North East Hampshire and Farnham CCG)	305	0	2	0	322	0	10	0
Amanda Wellesley - Interim Secondary Care Specialist - (Chief of Medicine and A&E consultant in Western Sussex NHS FT)	9	0	0	0	58	0	5	0
Amanda Wellesley - Interim Secondary Care Specialist (Surrey Heath CCG)	229	0	0	0	231	0	0	0
Amanda Wellesley - Interim Secondary Care Specialist (North East Hampshire and Farnham CCG)	305	0	2	0	0	0	0	0
Tracey Faraday-Drake - Executive Place Managing Director Slough (Surrey Heath CCG)	229	0	0	0	0	0	0	0
Tracey Faraday-Drake - Executive Place Managing Director Slough (North East Hampshire and Farnham CCG)	305	0	0	0	0	0	0	0
Caroline Farrar - Executive Place Managing Director Royal Borough of Windsor & Maidenhead (Surrey Heath CCG)	229	0	0	0	0	0	0	0
Caroline Farrar - Executive Place Managing Director Royal Borough of Windsor & Maidenhead (North East Hampshire and Farnham CCG)	305	0	2	0	0	0	0	0
Daryl Gasson - Executive Place Managing Director North East Hampshire & Farnham (Surrey Heath CCG)	229	0	0	0	0	0	0	0
Daryl Gasson - Executive Place Managing Director North East Hampshire & Farnham (North East Hampshire and Farnham CCG)	305	0	2	0	0	0	0	0
Sally Kemp - Non Executive/Lay Member (Alemus Limited)	0	0	0	0	4	0	0	0
Kathy Atkinson - Non-Executive/lay Member North East Hampshire and Farnham CCG (North east Hampshire and Farnham CCG)	305	0	2	0	322	0	10	0
Oliver White - Interim Place Managing Director North East Hampshire and Farnham (North East Hampshire and Farnham CCG)	305	0	2	0	322	0	10	0
Emma Boswell - Executive Director of Development and Improvement (Surrey Heath CCG)	229	0	0	0	0	0	0	0
Emma Boswell - Executive Director of Development and Improvement (North East Hampshire and Farnham CCG)	305	0	2	0	0	0	0	0
Steven Clarke - Interim Clinical Chair for North East hampshire and Farnham CCG/ Clinical Lead for North east Hampshire and Farnahm Place (North East Hampshire and Farnham CCG)	305	0	2	0	0	0	0	0

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 East Berkshire CCG (also the Director of Finance and IM&T for Frimley Health NHS Foundation Trust) ceased to be the Director of Finance of the CCG as of the 30th November 2019. The Clinical Chair for North East Hampshire and Farnham CCG stepped down in August 20, and Interim Place Managing Director North East Hampshire and Farnham was in post from April 2020 to May 2020. All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. Material transactions are disclosed appropriately in the accounts.

The Department of Health is 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 South, Central And West 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 Royal Borough of Windsor and Maidenhead, Bracknell Forest Council, Slough Borough Council and Surrey County Council in respect of joint commissioning arrangements.

17. Losses and special payments

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 2020-21 Number	**Total Value of Cases 2020-21 £'000**	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Administrative write-offs	10	3	4	1
Store losses	9	5	9	2
Total	**19**	**8**	**13**	**3**

Special payments

	Total Number of Cases 2020-21 Number	**Total Value of Cases 2020-21 £'000**	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Compensation payments	1	0	-	-
Total	**1**	**0**	**-**	**-**

There were no losses over £300,000

18. Events after the end of the reporting period

NHS East Berkshire CCG was dissolved on 31 March 2021 having merged with NHS Surrey Heath Clinical Commissioning Group and NHS North East Hampshire and Farnham Clinical Commissioning Group to establish NHS Frimley CCG with effect from 1 April 2021. This followed approval by the NHSE Regional Support Group (RSG) on 2 November 2020.

The merger of CCGs within the NHS England 'group' is regarded as a 'transfer of function'. The DHSC Group Accounting Manual directs that such changes should be accounted for as a 'transfer by absorption'. The new Frimley CCG will recognise the assets and liabilities received as at the date of transfer (1 April 2021) after taking into account inter company transactions.

	Surrey Heath CCG	North East Hampshire and Farnham CCG	East Berkshire CCG
	£'000s	**£'000s**	**£'000s**
Property, Plant and Equipment as at 31 March 2021	-	-	106
Cash and cash equivalent as at 31 March 2021	41	2	3
Receivables as at 31 March 2021	362	5,264	3,665
Payables as at 31 March 2021	(9,204)	(29,577)	(68,090)
Borrowings as at 31 March 2021	-	(667)	(1,325)
Provisions as at 31 March 2021	(193)	(2,398)	(625)
General Funded balance at 31 March 2021	**(8,994)**	**(27,376)**	**(66,266)**

19. Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2020-21 Target	**2020-21 Performance**	**2020-21 Surplus/ (Deficit)**	**2020-21 Target Met**	2019-20 Target	2019-20 Performance	2019-20 Surplus/ (Deficit)	2019-20 Target Met
Expenditure not to exceed income	681,593	681,577	16	Y	636,182	636,180	3	Y
Capital resource use does not exceed the amount specified in Directions	-	-	-	Y	121	121	-	Y
Revenue resource use does not exceed the amount specified in Directions	680,189	680,173	16	Y	632,223	632,220	3	Y
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	Y	-	-	-	Y
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	Y	-	-	-	Y
Revenue administration resource use does not exceed the amount specified in Directions	8,663	8,627	36	Y	9,774	9,064	710	Y