NHS
Berkshire West
Clinical Commissioning Group

NHS Berkshire West CCG

Annual Report 2018/19

Contents

Welcome Message

Berkshire West CCG continues to be recognised as an outstanding system and has been working closely with its partners as a vanguard Integrated Care System (ICS) over the last year. This has meant trailblazing new concepts and driving new learning and transformation. I have been privileged to continue to work with our exceptional staff who are determined to help improve on-going care for our patients.

Our Annual Report is an opportunity to look back at what we have achieved in the past twelve months and I hope you enjoy reading about the detail of the work that has been going on. In any healthcare transformation, strong clinical leadership is paramount and we have, with the support of the King's Fund, invested in a year-long developmental programme for all our clinical programme boards. Close partnership working has been strengthened by a system-wide clinical group that has medical and nursing leads along with patient representatives.

Our vision continues to be that by 2020/21 primary, community and social care services in Berkshire West will have a service model preventing ill-health within our local populations, supporting people with complex needs to receive the care they need closer to home in their community. In addition people will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. We will use advanced IT systems to share records and to co-ordinate person-centred care, and reduce duplication and hand-offs between agencies.

I wanted to share a few highlights of major transformation programmes we have been working on which bring to life our vision. Moving care close to our patients and communities is a priority, and one the biggest transformations programmes has been the start of the redesign of the Royal Berkshire Foundation Trust outpatients service. The current model of outpatients centred around the hospital is outdated and we aim to achieve new seamless pathways where patients are seen and managed by the right person at the right time and in the right place. We are designing and investing in technologies that will mean immediate advice will be available to our GPs and community teams from hospital consultants, potentially negating the need to book an outpatient appointment. Technology will be used so that face to face appointments are not required and can be done via video or email and in some cases initiated by patients themselves. Going forward the hospital will look to offer appointments where patients are seen and have all their investigations and diagnosis made in one visit. These measures will not only make it more convenient for our patients but will release time and allow more patients to be seen.

Preventing ill health has been a huge focus and so, for example, we have secured funding to support improving the management and detection of Atrial Fibrillation in primary care to prevent strokes. We have also worked closely with the Cancer Alliance on a key programme to improve our screening rates for bowel, breast and cervical cancer. Our care and support planning for patients with long term conditions has been expanded to patients with chronic airways disease and heart failure.

Mental Health education and prevention support has been a key priority for our CCG. For example we have invested in mental health teams in the community to prevent crisis. We have also focussed on supporting training and development of school services and the wider children's workforce to help improve the knowledge and skills of staff so that resilience is

promoted in children. By ensuring earlier access for children with emotional support needs our ambition is that fewer specialist interventions are required. This year we have trained over 1400 delegates.

Our local GP colleagues have been working hard to develop Alliances in each locality and further define the neighbourhood model of care with community and social service teams wrapped around clusters of practices. They have successfully planned and delivered the extended GP access scheme and are working as a key partner in a number of other ICS projects to deliver care closer to home. Primary care in Berkshire West is now well-placed to develop Primary Care Networks as described in the *NHS Long Term Plan.*

2019/20 will be very exciting, as well as challenging, but we have the blue print of the NHS Long Term Plan along with significant new investment into primary care. I believe as a system working closely with our patients and communities, we are very well placed to continue to develop and deliver world class integrated services that deliver the best outcomes for our patients. I look forward to working with all our ICS partners over the coming year to achieve our ambitions.

Dr Abid Irfan MB CHB MRCS MRCGP, Clinical Chair

Berkshire West Clinical Commissioning Group

Dr Abid Irfan

PERFORMANCE REPORT

Performance Overview

NHS Berkshire West Clinical Commissioning Group (CCG) was established on 1 April 2018, following the merger of Newbury & District, Wokingham, North and West Reading and South Reading CCGs. The CCG is made up of 47[1] member GP Practices across the whole locality, serving a population of 550,000 people.

Statement of Purpose and Activities

As a Clinical Commissioning Group, we have the statutory responsibility to plan, commission and performance-manage a range of local health services for people in the Berkshire West area, including:

- Urgent and emergency care (including NHS 111, Accident and Emergency, and ambulance services)
- Out-of-hours primary medical services
- Elective (Planned) hospital care
- Community health services (such as rehabilitation services, speech and language therapy, wheelchair services, and home oxygen services)
- Maternity and new-born services (excluding neonatal intensive care)
- Children's healthcare services (mental and physical health)
- Mental health services (including talking therapies)
- NHS continuing healthcare
- General practice (responsibility delegated by NHS England from April 2016)
- Healthcare for veterans, reservists and armed forces families

Who we work with

We commission healthcare from a wide variety of providers, working closely with the main acute services provider in the area, the Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust (for community and mental health services) and a number of private and voluntary sector partners.

The CCG has formed an Integrated Care System (ICS) with Royal Berkshire NHS Foundation Trust, Berkshire Healthcare NHS Foundation Trust and the GP Alliances. We are also part of the Berkshire West, Oxfordshire and Buckinghamshire Sustainability and Transformation Partnership (BOB STP).

We work closely with our partners in the three unitary authorities in the area - West Berkshire Council, Wokingham Borough Council and Reading Borough Council, who commission social care services and are responsible for public health. We are members of the Health and Well Being Boards of the three councils.

Note 1. 2 of the 47 practices hold 2 contracts each

Our population and demography

As at January 2019, the registered patient population of the CCG has grown by 1% to 549,828, an increase of around 6,300 patients

The Berkshire West population is generally affluent and healthy, but there are variations between the Berkshire West localities of Reading, Newbury & District and Wokingham. In Wokingham life expectancy at birth - 85.6 years for women and 81.5 years for men - is significantly better than in Reading were life expectancy is 83.2 for women and 78.6 for men. Reading has less people aged 65+ and a larger percentage of the population from ethnic minority groups, 21% compared to 6.6% in Wokingham and 4.9% in West Berkshire.

There are pockets of deprivation across the CCG's area where health outcomes tend to be poorer, with a deprivation score of 19.3 in Reading, 10.2 in Newbury & District and 5.7 in Wokingham. Smoking rates are higher in Reading and Newbury & District then they are in Wokingham and more people are overweight and are less active in Reading and Newbury & District.

Berkshire West 7

The Berkshire West 7 (BW7)[1] Partnership first came together in 2013, and has continued to progress with the development of a BW7 Integration Programme – focusing on integrating health and social care but also looking at the whole system. It consisted of:

- NHS Berkshire West CCG
- Reading Borough council
- West Berkshire Council
- Wokingham Borough Council
- Royal Berkshire NHS Foundation Trust (RBFT)
- Berkshire Healthcare Foundation Trust (BHFT)
- South Central Ambulance Trust (SCAS)

The Better Care Fund (BCF) is a pooled but to support the implementation of a policy set up to facilitate integration where both social care funding and CCG funding is brought together into one programme. Each LA signs off their BCF plan with their respective CCG and in Berkshire West we also have a fund which includes all partners. Monitoring is done through NHS England via quarterly returns and specifically looks at performance against four metrics:

- Non elective admissions (NEA)
- Delayed transfer of care (DToC)
- Admissions to residential and care homes
- Effectiveness of reablement

Note 1: Previously Berkshire West 10 prior to the merger of the 4 CCGs from 1 April 2018

BCF Metric 1 - NELs

WEST BERKS	
Planned NEL activity 2018/19	13,422
Actual 2018/19	**14,922**
% growth in NEL	**11.2%**

WOKINGHAM	
Planned NEL activity 2018/19	12,848
Actual 2018/19	**14,789**
% growth in NEL	**15.1%**

READING	
Planned NEL activity 2018/19	15,190
Actual 2018/19	**16,643**
% growth in NEL	**9.6%**

BCF Metric 2 - DToCs

WEST BERKS	
Baseline total 2017/18	8,057
Target 2018/19	**5,969**
Actual 2018/19	**5,508**

WOKINGHAM	
Baseline total 2017/18	3,689
Target 2018/19	**3,280**
Actual 2018/19	**3,001**

READING	
Baseline total 2017/18	6,579
Target 2018/19	**3,183**
Actual 2018/19	**5,272**

BCF Metric 3 - Admissions to Residential Homes

WEST BERKS	
Target admissions	**188**
Actual admissions	**183**

WOKINGHAM	
Target admissions	**132**
Actual admissions	**80**

READING	
Target admissions	**116**
Actual admissions	**112**

BCF Metric 4 - Reablement, still at home 91 days after discharge

WEST BERKS	
Target proportion of service users 2018/19	**87%**
Actual proportion of service users 2018/19	**85%**

WOKINGHAM	
Target proportion of service users 2018/19	**85%**
Actual proportion of service users 2018/19	**87%**

READING	
Target proportion of service users 2018/19	**93%**
Actual proportion of service users 2018/19	**82%**
Target service users engaging with reablement 2018/19	**1,315**
Actual service users engaging with reablement 2018/19	**964**

There is more information about Better Care Fund policy at: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Performance analysis

Berkshire West CCG's Diagnostic and A&E performance has been challenging during the winter months in 2018/19. The CCG continues to keep a strong focus on improving performance and achieving national standards in 2019/20. Detailed monthly performance is presented and reviewed at the CCG Governing Body through the integrated performance report.

The CCG works collaboratively with key providers, in particular our main provider of acute hospital services the Royal Berkshire NHS Foundation Trust, our main provider of mental health and community services Berkshire Healthcare NHS Foundation Trust and South Central Ambulance Service NHS Foundation Trust that provides our 999, 111 and patient transport services. These meetings provide the CCG with assurance of action being taken by providers to ensure performance achievement or where performance is not being achieved the remedial actions being implemented to achieve performance.

NHS Constitution Targets

Referral to Treatment Times (RTT)

The CCG has achieved the national RTT standard throughout 2018-19. There were no 52 week wait breaches at RBFT throughout 2018-19. This presents an improvement from previous year where there were two reported breaches in 2017-18.

Time period	NHS Berkshire West CCG - Incomplete RTT pathways (yet to start treatment) waiting 18 weeks or less from referral to hospital treatment											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	>=92%											
2018-19	92.3%	92.1%	93.0%	92.2%	92.2%	92.3%	92.6%	92.3%	92.0%	92.1%	92.2%	92.3%
2017-18	93.0%	92.6%	91.8%	92.4%	92.3%	92.3%	92.2%	92.7%	92.0%	91.9%	91.9%	91.9%

Time period	Royal Berkshire NHS Foundation Trust - RTT wait over 52 weeks for incomplete pathway (yet to start treatment)											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018-19	0	0	0	0	0	0	0	0	0	0	0	0
2017-18	0	0	0	0	1	1	0	0	0	0	0	0

Cancer Wait Times

Royal Berkshire Hospital continued its strong performance against the national standards through 2018-19. Both CCG and RBFT continue to perform well against the two week wait standard. RBFT has achieved the quarterly 62 day standard with the exception of Q2;

this was due to increase in referrals seen in the new urology pathway. Performance recovered in quarter 3 and 4. CCG 62 day performance has been challenging due to delays seen in our out of area providers.

RBFT Cancer Performance

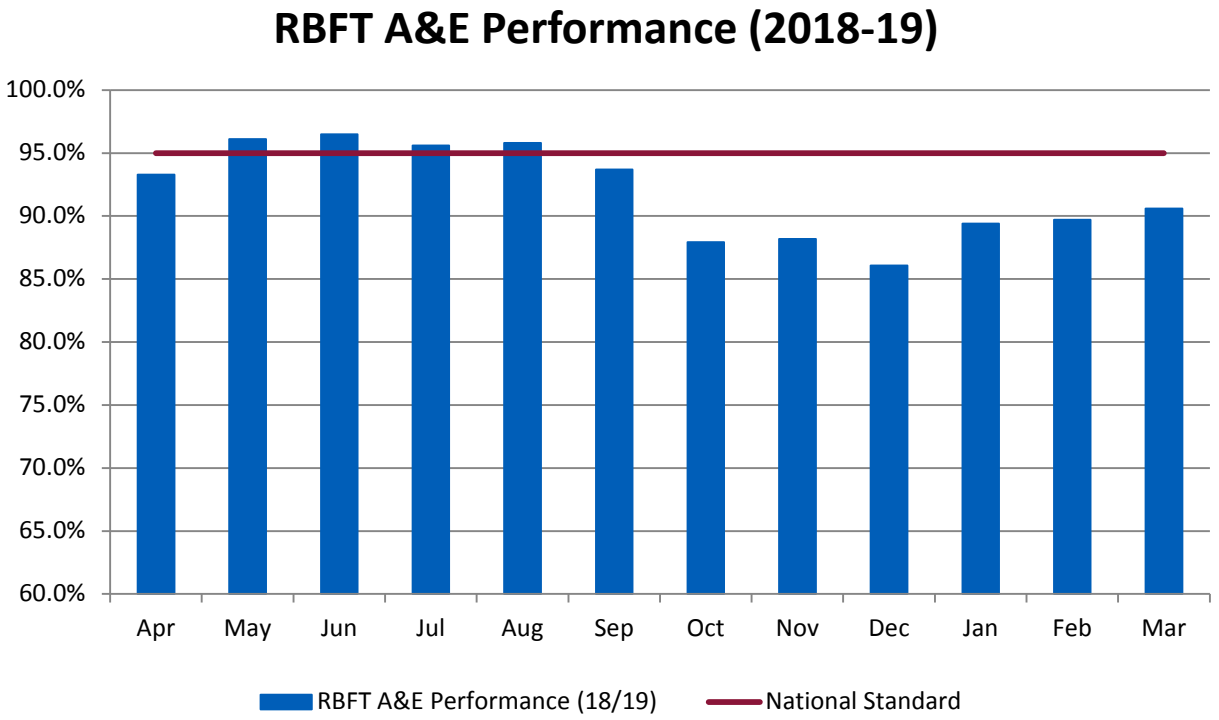
Indicator ->	2 week wait [E.B.6]	2-week waits (breast symptoms) [E.B.7]	31-day wait (first definitive treatment) [E.B.8]	31-day wait (subs - surgery) [E.B.9]	31-day wait (subs - anti-cancer drug regimen) [E.B.10]	31-day wait (subs - radiotherapy) [E.B.11]	62-day wait (GP referral) [E.B.12]	62-day wait NHS screening [E.B.13]	62-day wait (Upgrade) [E.B.14]
Target (>=)	93.0%	93.0%	96.0%	94.0%	98.0%	94.0%	85.0%	90.0%	No Target
Q4	96.3%	96.3%	96.9%	95.2%	98.6%	92.6%	85.1%	92.1%	69.7%
Breaches	*171*	*22*	*20*	*4*	*3*	*25*	*47*	*4*	*5*
Q3	96.8%	98.5%	98.0%	98.4%	99.5%	94.4%	85.1%	86.0%	64.0%
Breaches	*152*	*8*	*14*	*2*	*1*	*21*	*53*	*7*	*4.5*
Q2	94.8%	95.9%	97.1%	95.5%	99.1%	94.6%	77.4%	94.4%	92.9%
Breaches	*252*	*20*	*20*	*4*	*2*	*18*	*89.5*	*2*	*1*
Q1	94.7%	94.4%	97.8%	94.9%	98.9%	96.3%	86.2%	84.7%	66.7%
Breaches	*247*	*30*	*14*	*3*	*2*	*12*	*51*	*4.5*	*4*

Berkshire West CCG Cancer Performance

Indicator ->	2 week wait [E.B.6]	2-week waits (breast symptoms) [E.B.7]	31-day wait (first definitive treatment) [E.B.8]	31-day wait (subs - surgery) [E.B.9]	31-day wait (subs - anti-cancer drug regimen) [E.B.10]	31-day wait (subs - radiotherapy) [E.B.11]	62-day wait (GP referral) [E.B.12]	62-day wait NHS screening [E.B.13]	62-day wait (Upgrade) [E.B.14]
Target (>=)	93.0%	93.0%	96.0%	94.0%	98.0%	94.0%	85.0%	90.0%	No Target
Q4	96.2%	95.5%	97.0%	95.7%	98.4%	93.9%	83.7%	95.9%	66.7%
Breaches	*172*	*25*	*19*	*4*	*3*	*15*	*51*	*2*	*7*
Q3	96.7%	98.2%	98.1%	98.3%	99.5%	92.9%	82.8%	88.0%	76.5%
Breaches	*151*	*9*	*13*	*2*	*1*	*20*	*58*	*6*	*4*
Q2	94.8%	95.8%	97.1%	96.1%	99.1%	95.0%	74.9%	100.0%	87.5%
Breaches	*244*	*19*	*19*	*4*	*2*	*12*	*93*	*0*	*2*
Q1	94.3%	93.8%	98.1%	93.2%	99.4%	94.4%	85.0%	93.1%	66.7%
Breaches	*252*	*32*	*12*	*5*	*1*	*12*	*56*	*2*	*5*

A&E 4 hours

The Berkshire West System A&E performance for 2018-19 was at 94.57% and shows a marked improvement when compared to the previous year. This achievement reflects the close partnership working across the health and social care system and the continual efforts to deliver improvements across the urgent care pathway. Reasons for breaches and themes are continually reviewed to ensure standards are met. RBFT performance for the first half of the year was mostly above the national standard of 95%. Performance dropped during the latter half of the year due to a number of factors including increased demand, higher acuity of patients attending A&E linked to winter pressures. Despite the decline in performance, RBFT has achieved an improvement in performance when compared to previous year. At the end of the year RBFT performance is at 91.87% which is an improvement from last year where performance was at 90.58% and compares favourably with other local A&E departments.



Time period	Thames Valley A&E Performance (2017-18)											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
National Standard	>=95%											
Royal Berkshire NHS FT	93.3%	96.1%	96.5%	95.6%	95.8%	93.7%	87.9%	88.2%	86.1%	89.4%	89.7%	90.6%
Oxford University NHS FT	86.3%	88.6%	91.1%	88.1%	87.0%	88.0%	89.6%	86.5%	87.4%	86.0%	81.4%	85.9%
Great Western Hospital NHS FT	90.0%	93.5%	91.0%	91.7%	93.0%	92.1%	86.8%	89.4%	85.7%	84.4%	83.7%	82.3%
Frimley Hospitals NHS FT	87.6%	88.0%	89.9%	90.8%	90.1%	89.6%	89.1%	85.9%	87.2%	82.7%	81.1%	83.3%
Buckinghamshire Hospitals NHS FT	85.9%	89.1%	91.1%	87.4%	87.0%	89.3%	88.6%	89.0%	90.0%	87.5%	88.1%	87.2%

Diagnostic Waits

The CCG has not achieved the diagnostic standard during 2018-19. Root cause analysis of breaches identified three themes at Royal Berkshire Hospital Foundation Trust; increased demand as a result of embedding the new MPMRI pathway, capacity within echocardiography and endoscopy. Additionally for Newbury patients there are overall capacity issues at Great Western Hospital Foundation Trust which is impacting performance.

Time period	NHS Berkshire West CCG - Diagnostic tests - the percentage of users waiting 6 weeks or more from referral for a diagnostic test											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	>=92%											
2018-19	1.4%	3.2%	3.4%	2.5%	2.2%	1.4%	1.2%	1.4%	2.7%	4.4%	1.8%	2.3%
2017-18	0.6%	0.1%	0.6%	0.5%	1.0%	0.7%	0.7%	3.5%	1.0%	2.2%	0.9%	1.2%

Healthcare Associated Infections (HCAI)

Berkshire West CCG is performing within the nationally set target for clostridium difficile. There was no MRSA cases attributed to the CCG in 2018/19.

Time Period	NHS Berkshire West CCG - Clostridium difficile (C. difficile) counts in patients aged 2 years and over											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	7	12	10	11	13	11	8	11	2	2	3	2
2018/19	2	9	6	7	4	7	2	5	3	10	2	6

Time Period	NHS Berkshire West CCG - MRSA											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	0	0	0	0	0	0	0	0	0	0	0	0
2018/19	0	0	0	0	0	0	0	0	0	0	0	0

Ambulance response times

At the end of October 2017, there was a national requirement to implement the new national standards to replace existing performance standards as a result of the Ambulance Response Programme which was commissioned by Professor Sir Bruce Keogh (National Medical Director, NHS England).

South Central Ambulance Service has performed well against the new Ambulance Indicators throughout the year. Detailed performance against each indicator is listed below:

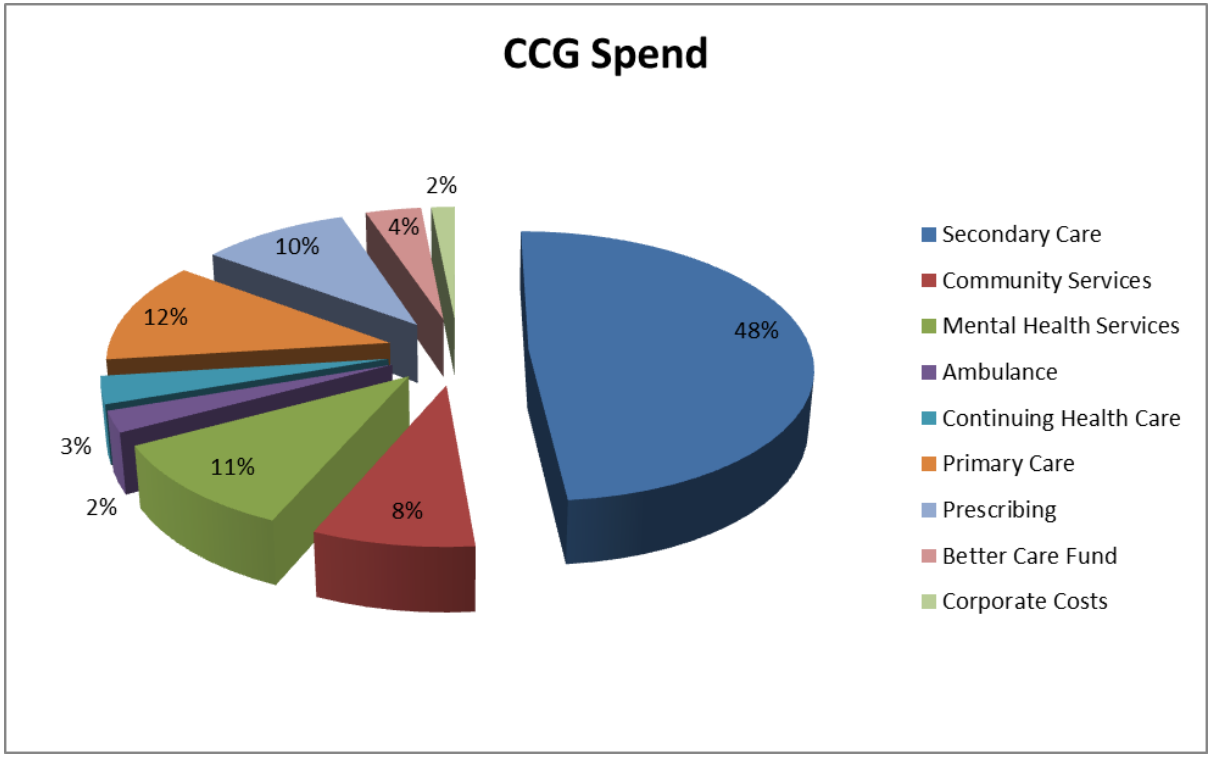
Indicator	Target	Org	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cat 1 (Mean) - Category 1 calls mean time taken for a response to arrive	<= 00:07:00	BW CCG	0:06:38	0:07:06	0:06:23	0:06:44
		Thames Valley	0:06:44	0:07:10	0:06:55	0:07:06
Cat 1 (90th Percentile) - Category 1 calls - 90th percentile taken for a response to arrive	<=00:15:00	BW CCG	0:11:50	0:12:52	0:11:19	0:11:55
		Thames Valley	0:12:29	0:13:13	0:12:53	0:12:57
Cat 2 (Mean) - Category 2 calls mean time taken for a response to arrive	<=00:18:00	BW CCG	0:14:04	0:15:12	0:15:58	0:17:06
		Thames Valley	0:14:14	0:15:35	0:16:39	0:17:38
Cat 2 (90th Percentile) - Category 2 calls - 90th percentile taken for a response to arrive	<=00:40:00	BW CCG	0:28:36	0:30:45	0:32:44	0:34:25
		Thames Valley	0:27:39	0:30:32	0:33:12	0:35:11
Cat 3 (Mean) - Category 3 calls mean time taken for a response to arrive	No target	BW CCG	0:50:11	0:54:23	0:56:25	0:58:56
		Thames Valley	0:46:29	0:52:23	0:54:47	0:57:40
Cat 3 (90th Percentile) - Category 3 calls - 90th percentile taken for a response to arrive	<=02:00:00	BW CCG	1:54:49	2:08:39	2:08:48	2:18:26
		Thames Valley	1:46:43	2:00:06	2:06:12	2:12:37
Cat 4 (Mean) - Category 4 calls mean time taken for a response to arrive	No target	BW CCG	1:12:06	1:18:36	1:20:19	1:13:18
		Thames Valley	1:09:03	1:15:18	1:19:30	1:21:14
Cat 4 (90th Percentile) - Category 4 calls - 90th percentile taken for a response to arrive	<=03:00:00	BW CCG	2:41:48	3:01:39	2:59:44	2:40:30
		Thames Valley	2:37:08	2:48:39	2:55:46	2:58:58

Financial Review

NHS Berkshire West CCG received revenue resource allocations of £678.5m (including the cumulative surplus brought forward of £12.5m) and delivered an in year deficit of £3m against a plan to breakeven. This has resulted in a section 30 referral to the Secretary of State by the CCG's auditors. The CCG has a cumulative surplus of £9.5m to carry into 2019/20. NHS Berkshire West CCG met all of its other statutory financial duties for 2018-2019.The CCG also operated with the running cost allocation of £10.9m. The CCG played a strong role in supporting ICS partners to achieve their control totals and the £3m deficit is a reflection of the overall deficit for the system.

The accounts have been prepared under a direction issued by NHS Commissioning Board under the NHS Act 2006 (as amended) and specifically the Health and Social Care Act 2012 c. 7 Schedule 2 s.17. The full financial results are set out in our 2018-2019 accounts which form an integral part of this report.

The chart below gives a high level analysis of the use of funding by the CCG:



Sustainable Development

The CCG is required to report its progress in delivering against sustainable development indicators.

The CCG continues to develop plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction, waste management and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. The CCG has a sustainability strategy.

The CCG has increased its use of teleconferences and has promoted the use of public transport, cycling and/or walking to work to reduce the negative impact of transport on the environment and promote a healthy lifestyle. 52,281 business miles were claimed during the year.

The CCG operates an effective recycling system as part of its approach to waste management and has increased the use of mobile technology to reduce its use of paper, ink and electricity.

The CCG has introduced electronic pay slips in year.

We will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

Quality

Overview

Quality is at the heart of all we do. The CCG has a comprehensive Quality strategy in place, which was updated in 2017 and is further supported by a Quality Policy. The NHS defines quality as effectiveness, safety and the provision of an excellent patient experience. Delivering compassionate, high quality care focused on outcomes is at the very heart of our clinical values, and by establishing a shared understanding of quality and a commitment to place it at the centre of everything we do, the CCG has an opportunity to continually improve and safeguard the quality of local NHS services for everyone, now and for the future. The full Quality Strategy can be found on our website. www.berkshirewestccg.nhs.uk

The CCG exercises this responsibility through the quality committee, where information and data is scrutinised and triangulated, with any issues with provider performance challenged. The CCG has a good working relationship with all associate commissioners to ensure and assure Berkshire West patient safety when requiring care from other provider organisations. The Integrated Quality and Performance (IQPR) report is presented for assurance and discussion on a monthly basis to the Governing Body, under the structure of the three domains of quality:

- Patient experience (including complaints, patient surveys and information from the NHS Choices website and provider data)
- Patient safety (including serious incidents, falls, pressure damage, suicides and unexpected deaths)
- Clinical effectiveness (including provider compliance with national guidance NICE and National clinical audit)

During 2018/19 National Commissioning for Quality and Innovation (CQUINs) schemes were released to incentivise joint working across the health economy to achieve the goal of improving quality through integrated working for the main providers, acute, community, mental health and ambulance. The team worked with the small contract holders and independent providers to establish the local CQUINs that would drive improvement for the patient population.

The IQPR for all the main providers has been utilised for combined reporting throughout 18/19, where required, additional indicators have been added and removed to provide up to date reporting and triangulation. The CCG has sought further assurance regarding organisation quality improvement initiatives whereby an upward trend in patient safety was noticed. The report continues to be inclusive of the independent sector and those providers where we are associate commissioners, in order to provide assurance narrative regarding actions taken.

Development of Quality Assurance systems and processes as an Integrated Care System

During 2018/19, we have embedded an overarching Quality Framework to support continuous quality improvement as an Integrated Care System, with shared responsibility and accountability for patient outcomes. This work has included the development of an ICS Integrated Quality and Performance Dashboard which has been established and forms part of the joint ICS Quality Committee alongside ensuring that the patient voice and experience is captured within this forum.

Local implementation of National Guidance

The Quality team has a robust process for reviewing any national publications and guidance and ensuring that there is local implementation as required. An example is the publication of National Guidance on Learning from Death – A Framework for NHS Trusts and NHS Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care, National Quality Board, (March 2017) which resulted in the setting up of the STP mortality review group. The LeDeR steering group continues to meet on a bimonthly basis to ensure themes are identified and local action is taken in response to recommendations to drive improvements in care and pathways.

Monitoring and Governance

During 2018/19 the CCG has embedded the joint ICS Quality Committee, as previously outlined, to fulfil our quality assurance and governance role. It is hoped

that in 2019/20 this will include representation from our smaller commissioned providers to further strengthen our position as a system. The CCG uses the ICS Quality Forum to provide further opportunity to scrutinise and monitor full implementation of action plans from national guidance reviews; discussion includes any risk to implementation which is detailed within the defined risk register. This forum reports into the ICS governance structure.

Quality Assurance Visits

The Quality team continue to carry out their programme of quality assurance visits to a variety of clinical and non-clinical areas across all services and providers during this past year. These visits are led by the Nurse Director and where possible, involve CCG lay members and members of the Board. These visits have allowed us to see first-hand the quality of care being delivered to our patients, allowed us to speak to patients, families and directly to staff. We feedback immediately to management on any findings, both positive and negative, and provide a short report highlighting any recommendations to providers within 10 days of the visit. These reports are scrutinised through the Quality Committee and examples taken to Governing Body meetings. Through this work we will ensure that the patient remains at the centre and that a culture of openness, transparency and candour is promoted throughout the system.

Partnership working

The CCG is committed to working with all healthcare providers irrespective of contractual financial scope to ensure that our patients receive the best possible care within our local area, have a positive experience of healthcare and are treated safely. This has been evident with the inclusion of the quality team supporting the transformation project pathways with relevant Quality Impact Assessments and formulation of mitigating actions. We will strive to continually improve the quality of the services and pathways we commission by both listening and responding to the views of our patients, carers and the extended community partners. This is furthermore illustrated by the current Care Homes project board and strategy group involving all stakeholders from the within CCG and Unitary Authority, provider organisations. These fora aid the triangulation of various information sources to ensure robust assurance is gained for our patients who reside in the care home setting or are in receipt of domiciliary care support services.

Safeguarding

As a public sector organisation the CCG has a statutory duty to make arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse. We are committed to fulfilling this function to a high quality standard. Commissioning organisations also have a responsibility to ensure that all providers from which we commission services (both public and independent sector) have comprehensive single and multi-agency policies

and procedures to meet these requirements. We have ensured that systems and processes are in place to fulfil specific duties of cooperation and that best practice is embedded. All contracts and service level agreements (SLAs) have required providers to adhere to Berkshire-wide safeguarding policies and procedures which promote the welfare of adults and children and quality schedules within contracts have included key safeguarding metrics.

Contracts have also required all providers to complete an annual audit based on section 11 of the Children Act (2004) (adapted to include safeguarding adults) and to provide assurance of compliance with required staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regards to safeguarding children, adults at risk, children looked after, the Mental Capacity Act and Deprivation of Liberty Safeguards. The CCG has used contract levers to take action when provider performance is not meeting the standards required i.e. non-compliance with safeguarding training, which has led to improvement with all of our provider organisations in 2017/18. Where training compliance has not been met, full scrutiny of a Trust remedial action plan and contractual mechanisms have been used in order to drive improvements regarding the statutory responsibility. Providers must inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

In order to fulfil its responsibilities effectively, the CCG operates within the legislative framework of the Children Act 1989/2004 and the Care Act 2014 in upholding the safeguarding of both children and adults. The CCG promotes the following general principles as set out in 'Working Together to Safeguard Children' HM Government 2015 which are:

- ensure that all affected children receive appropriate and timely therapeutic and preventative interventions
- professionals who work directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of care they offer
- professionals who come into contact with children, parents and carers in the course of their work also need to be aware of their safeguarding responsibilities
- ensure that all health professionals can recognise risk factors and contribute to reviews, enquiries and child protection plans, as well as planning support for children and providing on going promotional and preventative support through proactive work
- Safeguarding children standards should be included in all clinical contracts.

The CCG's Nurse Director has provided senior clinical leadership and oversight of safeguarding arrangements at Board level for both Adults and Children and is supported by the Head of Safeguarding Children and Head of Safeguarding Adults, who represent the CCG on the three Safeguarding Children Boards in Berkshire West and the Berkshire West Safeguarding Adults Board respectively.

The CCG is fully committed to the Safeguarding Boards' priorities and ensure that all our providers are fully engaged in working in partnership to deliver health elements of these priorities.

The Head of Safeguarding Children incorporates the statutory function of the Designated Nurse Safeguarding Children role. The Head of Safeguarding Adults leads on the PREVENT agenda for the CCG and provides consultation for both Mental Capacity Act and Deprivation of liberty safeguards. The Safeguarding Team is supported by dedicated administration, thus ensuring that communication, resource and expertise is available to lead this important agenda.

The Designated Nurse for Looked After Children, fulfils the statutory function for the very vulnerable cohort of Looked After Children across the West of Berkshire and sits alongside the Safeguarding Team, supporting the role.

We are also committed to using this enhanced resource to support the improvement in safeguarding practice across primary care providers in Berkshire West supported by the Named GP function.

Engaging people and communities

Patient and Public Involvement

Under Section 14Z2 of the Health and Social Care Act 2006, CCGs are asked to make arrangements for how they will involve patients and the public in commissioning planning, decision making and changes to proposals and plans that will impact upon individuals or groups and how health services are provided to them.

The CCG follows the Patient and Public Participation Policy, and accompanying statement of arrangements and guidance, both published by NHS England. A Berkshire West Communications and Engagement Strategy is in place for 2014-19 (refreshed 2017) which sets out the local approach to patient and public involvement. From this, and the other objectives set out in the annual operational plan, annual communication and engagement activity plans are established for the CCG.

Activities are reported and reviewed in a number of fora. These include: quarterly Clinical Commissioning Committee, lay member reports to CCG governing body meetings in public and patient and public reference groups. The latter group membership includes representation from local patient participation groups, Healthwatch and health and social sector partners.

Our priorities for patient and public involvement are to:

- Put patients at the heart of everything we do
- Listen to and involve people when planning, evaluating and seeking to improve services

- Put in place coherent structures and accountability for patient and public involvement
- Encourage the development of local patient reference groups
- Ensure involvement includes those from seldom heard groups
- Share and build on best practice

This is done through activity including:

- Holding meetings in public to seek views on our strategy and commissioning plans, and attending community group meetings to inform and involve local people
- Sharing proposed information to patient groups to ensure it is appropriate and understandable
- Asking people for their views about local services through surveys, both online and otherwise
- Involving patient experts in commissioning projects to provide assurance that our plans are robust
- Developing our database of patients to ensure our online consultations and engagement is representative of communities we represent
- Demonstrating how patient feedback has made a difference
- Targeting hard to reach communities and groups and ensuring information they receive is easy to understand and public engagement events are easily accessible and tailored to their needs

Key activity this year has included:

- ICS – Berkshire West is one of the exemplar ICS across England recognised by NHS England. Over the last year there have been two major public engagement events aimed at healthcare professionals and patient group representatives with a further series of events planned for 2019. Work is progressing on Designing our Neighbourhoods – a key part of the ICS objective of improving and modelling patient care at a neighbourhood level, and patient and public involvement is central to this work. An ICS website has been developed www.berkshirewestics.org and Berkshire West ICS has a strong and active social media presence.

- A raft of engagement work with children, families, schools and communities has been carried out and new partnerships forged which is further driving transformation. Our ambitious partnership is committed to continuous improvement and has been recognised by CQC, OFSTED, NHS England Regional Team and the Children's Commissioner for England. We supported a major event for World Mental Health Day at the Reading FC stadium attended by hundreds of schoolchildren and university students which aimed to break taboos and raise awareness.

- Homelessness – Following West Berkshire Healthwatch Homeless and Rough Sleepers Report 2018, Berkshire West CCG has been involved in commissioning new health outreach services for homeless people in the area.

- Berkshire West CCG sits on the steering group of the West Berkshire Make Every Adult Matter (MEAM) Partnership – a multi-agency initiative which works to support people facing multiple disadvantages and, by offering a co-ordinated intervention, saves money and promotes more efficient use of services. There were 25 MEAM Operational Meetings in 2018 which generated specific actions and positive interactions between partnerships. The West Berkshire MEAM has received strong praise from MEAM nationally and its Information Sharing Agreement is being shared with other areas. In 2018 there were 60 referrals to MEAM in West Berkshire.

- Berkshire West CCG is part of the First Stop Reading Partnership along with Thames Valley Police, South Central Ambulance Service, Reading Borough Council and Reading's Minister Church. It's a night time urgent care service aimed at vulnerable people using the town centre night time economy and keeps them safe, away from A&E and cutting ambulance call-outs.

- Events have been organised throughout the year highlighting key priorities including: **TB** (Awareness Day in South Reading, social media, posters in taxis, local TV media coverage); **Cervical Cancer Screening** (A Pop Up Smear Testing Clinic and on-going engagement work by the 25 specially trained Cancer Champions). They have held a number of awareness events aimed at hard to reach communities including Nepalese, Zambian, Polish, LGBT communities and more than 1,300 people have directly benefitted from their work.

- Recognising the impact of loneliness and isolation on a person's health and wellbeing, Berkshire West CCG works in partnership with Reading Borough Council and Reading Voluntary Action to promote the Social Prescribing Service.

- MSK – patients were closely involved in major re-design of the service which has seen a one-third cut in duplicate appointments, a big reduction in waiting times and savings so far of £200k. Patients played a lead role on the governing structure and there is a patient lead on the services board.

Patient Voice Group

The North and West Reading locality has a Patient Participation Group championing patient and public involvement. It meets monthly and makes sure the CCG is including patients' views on their plans and that local factors like demographics and accessibility to healthcare services are taken into account. The Forum is one of a raft

of groups in place giving patients opportunities to have their say in planning and delivery of health care services

Reducing health inequality

Our role as a CCG is to reduce inequalities between patients in accessing the services we commission. To reduce health inequality and improve outcomes for all, we work with colleagues in the local public health team as they provide us with a source of expertise in using health related data sets to inform commissioning, reduce inappropriate variation in the local area, identify vulnerable populations and marginalised groups, and support commissioning to meet their needs.

To help us respond to health inequalities in the population, we carried out equality impact assessments on changes we make to services. We also review the uptake of services to ensure they are accessible to all and link in with public health colleagues for advice on steps to take when health inequalities are identified.

Our work to reduce health inequalities is reviewed by local Health and Wellbeing Boards.

The work of MEAM in West Berkshire and Reading is committed to working with people facing multiple disadvantage and experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives. There have been across the board increases in outcomes and engagement with the individuals the scheme has worked with over the last 12 months. The fluid client engagement process is a person centred approach and looks to create ‘system flex’ for those most in need.

The new health clinics for the Homeless have adopted a flexible approach to engagement and proactively visit day centres, night shelters and substance misuse partner agencies to target those most at risk. The nurses have engaged with 28 clients over the winter months and link directly with housing teams and local groups to draw in those with health needs that are not being addressed in routine Primary Care settings.

The CCG took part in the Voice of Disability event organised by Healthwatch designed to seek the views across a range of disabled people, including carers and various agencies. It was an opportunity for all agencies to review areas where the needs of those with disabilities could be better served.

People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. The CCG has taken steps to commission a high quality NICE recommended physical health checks for the Berkshire West residents who have SMI, with a view to reducing the current health inequalities experienced by

people with SMI nationally. There are currently approx. 3869 patients with SMI on GP Mental Health registers in Berkshire West. The CCG is tasked to ensure that at least 60% (2321) of patents on GP Mental Health register to have an annual health check by 31st March 2020 and this service aims to contribute 50% (1935) of this total.

Equality and Diversity

CCGs have a statutory duty to ensure that commissioning decisions reduce inequalities, improve quality of services for all patients, and involve and engage with a broad spectrum of individuals and communities (Health and Social Care Act 2012). At the same time, the Equality Act 2010, which incorporates the public sector equality duty (PSED), requires that CCGs, when commissioning services, do not unlawfully discriminate and must promote equality for the needs of people from the nine protected groups.

The CCG is committed to embedding equality and diversity values into its policies, procedures, employment and commissioning processes, to ensure that there is equality of access and treatment for all, and that health inequalities are reduced. The CCG is an active member of the three Health and Wellbeing Boards in the area, which are made up of the key partners from the health and care system who work together to improve the health and wellbeing of our local population and to reduce health inequalities.

The CCG has established an ICS Equality and Diversity committee which includes health and local authority partners to ensure consistent approach across Berkshire West.

The CCG is committed to the principles of the Workforce Race Equality Standard (WRES), and action to encourage progress including supporting provider organisations, through inclusion in contract of requirement to implement WRES and provide an annual report, and monitoring through regular quality assurance visits and contract review. Leadership within the CCG is demonstrated by:

- ensuring robust systems for collecting, challenging and analysing workforce data
- reviewing workforce data at relevant committees
- running an annual staff survey to address underreporting of ethnicity, allow comparison of staff experiences between white and BME staff, and identify areas of concern

The CCG is part of the Thames Valley Inclusion Network, which supports those with a role and responsibility for inclusion and diversity across the system to work together, exchange information and good practice, and support each other in the implementation of the Equality Delivery System, the Workforce Race Equality Standard and the Accessible Information Standard across the area.

Primary Care

During 2018-19 the CCG continued to discharge its delegated responsibilities for the commissioning of primary care services through the Primary Care Commissioning Committee which is constituted in line with NHS England guidance and meets quarterly in public, reporting into the Governing Body and to the Finance Committee in respect of investment decisions. The Primary Care Commissioning Committee has also overseen the delivery of our transformation programme for primary care which in 2018-19 was based around the *General Practice Forward View.* Key areas progressed in 2018-19 were as follows:

- **Care Models** – The new GP contract was announced in February, which will support individual practices to work together as a Primary Care Networks as described in the *NHS Long Term Plan*. The networks aim to coordinate Primary, Community and Social Care for a local population, and improve the stability and sustainability of General Practice. During the latter part of the year, the CCG has been supporting practices to plan for the transition into the PCN model which will build upon existing workstreams such as integrated care planning and collaborative delivery of enhanced access to primary care (see below).
- **Workforce** – The CCG is developing a workforce strategy for Primary Care that will identify how current staffing gaps can be filled by using new types of health care professionals. We are also working with partners across the region to invest in a programme to retain existing staff, especially GPs. The CCG has successfully found a work placement for an international GP recruit, the first one across our regional area.
- **Workload** – The CCG has continued to deliver the 'Time for Care' programme, which aims to help Practices find ways to free up time in their surgeries by refining existing and developing new administration systems, freeing up clinical staff to see patients. By the end of the year, all practices will offer patients the option of online consultations.
- **Infrastructure** – Development of our estates strategy has continued through building partnerships with our local authorities, and several smaller scale local schemes are progressing to improve practice facilities. The CCG is also providing all practices with Wi-Fi access for staff and patients, which allow them to make full use of the NHS app when it is release next year.
- **Access** – In October 2018 the CCG commissioned an Enhanced Access service which means that all patients are able to access GP appointments 8am – 8pm Monday to Friday and during a 4 hour period on Saturdays, Sundays and Bank Holidays.
- **Quality and Contracting** –the CCG continues to fulfil its statutory duty to commission primary care services for its population and has a framework for improving the quality of primary care services which is monitored via the Primary Care Commissioning Committee and the Quality Committee. The CCG is developing the framework further to ensure that the quality of services commissioned is always being appropriately reviewed.

Urgent and Emergency Care

The Berkshire West System A&E performance for 2018-19 was at 94.57% and shows a marked improvement when compared to the previous year. This achievement reflects the close partnership working across the health and social care system in Berkshire West and the continual efforts to deliver improvements across the urgent care pathway.

Reasons for breaches and themes are continually reviewed to ensure standards are met. RBFT performance for the first half of the year was mostly above the national standard of 95%. Performance dropped during the latter half of the year due to a number of factors such as increased demand, higher acuity of patients attending A&E and winter pressures.

Despite the decline in performance, RBFT has achieved an improvement in performance when compared to previous year. At the end of the year RBFT performance is at 91.87% which is an improvement from last year's where performance was at 90.58%.

NHS 111 is increasingly being positioned as the entry point to urgent care. In Berkshire West the Integrated Urgent Care service is commissioned from an alliance of providers led by South Central Ambulance Service (SCAS) and comprises both a call answer and clinical assessment service. This service ensures that callers can access a wide range of clinical advice through a single call, including dental, pharmacy and mental health.

In 2018-19 the service met the national requirement for more than half of calls to receive a clinical assessment and is building the capability to directly book appointments for callers who need to be seen face to face.

In 2018 NHS 111 online was also launched successfully across the Thames Valley supporting access to the Integrated Urgent Care service online as well as by telephone.

Within the Royal Berkshire Hospital the focus has been on ensuring patients arriving are assessed and streamed to the most appropriate service for their needs. The hospital now has a protected ambulatory care unit supporting patients to be treated same day wherever possible, a frailty service identifying frail patients on arrival and a primary care service for those patients more suited to being seen in a primary care setting. This frees up the hospital's specialist services for those really in need.

For patients who need admission to hospital, significant efforts are being made to target processes and delays in patient pathways to ensure patients can stay for the shortest time possible.

The NHS has worked really closely with our Local Authority partners to ensure that patients who need care following hospital discharge are supported to get the right care without delay. Our level of delays at the Royal Berkshire Hospital in June 2018 was the lowest since records began in April 2013. We have introduced a new coding system to ensure that we fully understand what causes delays and senior leaders

from across health and social care now meet on a weekly basis to discuss and address any issues. The system has also been working to deliver the High Impact Change model for delayed transfers of care which includes introduction of trusted assessors preventing patients being assessed multiple times by different organisations; discharge to assess arrangements supporting people in returning home rather than being assessed in hospital; and arrangements to ensure the market for care provision meets local needs.

The South Central Ambulance Service, a key part of the urgent care system, has continued to meet the vast majority of the national performance standards in 2018-19 which is a huge achievement. We are working closely together to ensure that the ambulance service can treat as many people at the scene of the incident as possible and if they need to be seen by another healthcare professional they can be taken directly to the appropriate service. Targets have been set for the percentage of patients that can be treated without being taken to hospital and these are being achieved.

We believe that the voluntary sector has an important role to play in supporting the urgent care system. To this end, a number of voluntary sector run pilots were funded for winter 2018-19. These included a take home and settle service supporting people with low level needs after discharge from hospital, a signposting service putting patients in touch with voluntary sector support to help them maintain their health and wellbeing and a befriending service on the wards.

Improvement initiatives launched in previous years went from strength to strength in 2018-19. The SCAS and RBFT collaborative Falls and Frailty service which treats people and keeps them safely in their own homes was the subject of very high praise from patients and has received local NHS and media interest. The ‘First Stop Service’, the night time urgent care, health and wellbeing service operating at week-ends in St Mary’s Church, Reading was shortlisted for an award by the Health Service Journal.

During the latter part of 2018-19 we began work on a longer term strategy for urgent and emergency care. A number of design principles were agreed and further work will now be undertaken to see how these can be applied locally.

Emergency Preparedness, Resilience and Response

We certify that the Clinical Commissioning Group has a Major Incident Plan and incident response plan in place. These are fully compliant with the NHS England Emergency Preparedness Framework 2015 and NHS England Core Standards for Emergency Preparedness, Resilience and Response 2014. The Clinical Commissioning Group annually reviews and updates the plans and as a result of lessons learnt from exercises and live incidents amends plans accordingly. Reports are provided to the Governing Body as required.

Rebecca Clegg, Executive Lead for Emergency Preparedness, Resilience and Response

Elective/Planned Care

Our strategy for Planned Care aspires to implement a step change in the productivity of elective care by redesigning planned care services to improve health outcomes for patients, reducing lengths of stay in hospital and the number of outpatient appointments required. During 2018/2019 we continue working with ICS partners to redesign musculoskeletal pathways to provide a more integrated, patient centred, goal focused, and locally based, de-medicalised model. It is proposed for patients to have access to first contact physiotherapists in primary care, access shared decision making and to be managed closer to home through a community service.

In 2018/2019 the Dermatology department at Royal Berkshire Hospital continued to meet its cancer standards however, due to the on-going national shortage of Dermatologists this led to an increase in waiting times for routine appointments. This led to making a difficult decision to restrict referrals to routine appointments from 1st December 2018 in order to reduce demand to ensure access to and deliver high quality dermatology services. We are working towards a network model of care working with our GP Alliances and other acute trusts to commission a sustainable service.

The CCG continues to work with all partners to deliver our Cancer framework which includes a series of initiatives across the patient pathway emphasising the importance of earlier diagnosis and of living with and beyond cancer in delivering outcomes that matter to patients. In South Reading we have cancer champions that support community engagement and education with hard to reach demographics and we started to deliver aspects of the recovery package through our acute trust and GP practices for patients living with and beyond cancer. The Rosemary Centre was opened in Newbury through funding provided by local charities to provide high-quality chemotherapy services closer to patients' homes.

Long Term Conditions

The Long Term Conditions Programme Board (LTCPB) continues to build on the strategic vision of increased integrated and joined up care for people living with more than one long term condition. Working with partners across the ICS, the Board identified specific priorities to address current variation and improve outcomes for patients across Berkshire West.

Work-streams are in place to identify people earlier at risk from Atrial Fibrillation (AF) and high blood pressure, and ensure closer working between GP practices and specialist clinicians supporting optimal treatment and management, and reducing the risk of stroke. A review of the pathways which support people to achieve the best possible outcomes following a stroke is underway, with an ambition to focus on the impact of both physical and mental health for individuals and families.

Care and Support Planning has been embedded across Berkshire West for people with Diabetes. So far an estimated 19,000 out of 21,000 patients with Diabetes have

been recorded as having a self-management care plan. Where patients have been actively involved in a care and support planning review, evidence indicates that over the 12 month period following a care and support planning discussion, there has been significant reduction in GP consultation; circa 5 per patient versus the preceding year before care and support planning was in place.

The LTCPB recognise that many people live with one or more long term conditions, therefore the intention is to further develop a more co-ordinated, person centred approach that will improve an individual's ability to self-care, and ensure patients are able to utilise resources effectively.

Triage of renal referrals continues demonstrating a sustained reduction in first out-patient appointments, ensuring appropriate referral. Multi-disciplinary Team meetings (MDT) between cardiology and renal teams have been occurring on a monthly basis, improving the care for patients with complex needs.

Work continues to progress, supported through additional national transformation funding to increase access to education for patients with both Type 1 and Type 2 diabetes, which will also include digital options where this is the most appropriate approach. Working with partners across the system, further work continues to develop a more integrated approach for people with the most complex needs as a result of their diabetes ensuring access to the right specialist skills via a range of approaches, including technology enabled.

We are focusing on improving our COPD pathway to support earlier diagnosis, closer MDT working, telephone access for specialist advice, increasing access to pulmonary rehabilitation, all of which will support people to better understand their disease and proactively manage it.

The LTCPB is working with partners across the system to adopt ReSPECT, which is a process that "creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices e.g. about care and treatment that could help to achieve the outcome that they would want or things they would not want".

Following the roll out by RBFT in September 2018, we have provided a series of training events for primary care, care home and community staff as part of a phased roll out.

Transforming Care

The Transforming Care Programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition. The CCG is part of a Transforming Care Partnership that includes all health and social care bodies across Berkshire.

Key achievements:

- Reduction in the number of commissioned Assessment & Treatment Unit beds from 16 to 9 (decommissioning of Little House site in Bracknell)
- Implementation of a community based Intensive Support team (IST) provided by Berkshire Healthcare. This team provides intensive support to those individuals who are escalating into crisis in order to maintain individuals in their home setting. This team has also supported discharges back in to the community. Across Berkshire, in 2018, 80 people were supported by the IST. Of these, 4 were in inpatient services and 76 lived in the community.
- Care & Treatment Reviews (CTRs) carried out for all individuals in an inpatient setting mainly post admission but in some cases pre-admission to ensure hospital is the right place for the individual. Post admission CTRs are completed within 4 weeks of admission and 6 monthly thereafter until discharged.
- Work continues to improve and increase access to annual health checks
- £1.1million capital funding successfully bid for to purchase a property in Wokingham to support discharges from inpatient into the community
- £1.17million successfully bid for to deliver Home Ownership for People with Long Term Disabilities (HOLD) scheme across Berkshire which has enabled 7 people to own their own home; supporting discharge and preventing admission.
- Reduction of number of individuals in inpatient setting (CCG & NHSE funded) from 44 to 31 – many of whom who have been in an inpatient setting for a number of years.

Children and Young People

Emotional health and wellbeing - Key achievements

- **School based services** have expanded with a focus on training and developing the knowledge and skills of school staff so that resilience is promoted, children who are identified as having emotional needs access help earlier, the quality and accuracy of referrals to CAMHs improve and fewer children require specialist interventions..
- Berkshire West has been selected by NHS England as a pilot area for the initial three year project which will see more than £800,000 per year provided to run two dedicated mental health support teams. The project, which aims to initially support more than 500 children and young people, is a partnership between Berkshire West Clinical Commissioning Group, Reading Borough Council, West Berkshire Council and Berkshire Healthcare NHS Foundation Trust. Each local authority area will have its own mental health support team.
- **Mental health training for the wider children's workforce** (GPs, social care, nurses, schools, voluntary sector). Over 1400 delegates were trained

last year. 69% indicated that they had previously received no training around mental health difficulties in children and/or young people. 98.5% of delegates would recommend the training to a colleague. Delegates consistently report increased knowledge and confidence post training as measured on 10 point scales.

- **Emotional health and wellbeing in Looked After Children project -** Berkshire West is one of just nine areas from across England selected to take part in this pilot that will help to ensure the approach used for mental health assessment is more suitable for looked after children's needs. The aim is to help children to access the right support at the right time, and respond to each child's individual needs. Funded by the Department for Education (DfE), the pilot will be led by the Anna Freud National Centre for Children and Families, along with a consortium of partners including Action for Children, Research in Practice, and the Child Outcomes Research Consortium (CORC). Berkshire West CCG and West Berkshire Council will work closely with partners during the two year-long pilot to design a new approach to mental health assessments and will benefit from additional funding and dedicated support including training.
- **Help for children with anxiety and depression.** We have commissioned the University of Reading to provide lower intensity services for children with anxiety and depression before problems become entrenched.
- The CCG Designated Clinical Officer for SEND has worked closely with family forums, the Local Authorities and healthcare providers to quality assure Education Health and Care Plans for children and young people with SEND. Learning from Berkshire multiagency quality assurance audits was presented at a regional good practice event attended by 150 delegates from a range of partner organisations as well as speakers from national organisations and experts by experience with a view to improving practice.
- We have worked with Local Authorities, schools and parent forums to make the provision of specialist equipment for children with disabilities simpler and more cost effective through greater use of the joint equipment store. This initiative will also increase the amount of equipment that can be recycled and reissued.
- SEND arrangements in West Berkshire were inspected by CQC and OFSTED this year. Health, education and social care services were praised. We have been working to further improve services in the area.

Mental Health

Key achievements

- In 2018/19 the CCG has continued to make steady progress in delivering the Mental Health Five Year Forward View delivery targets.

- We continued to meet the national delivery standards targets for IAPT and EIP.
- We continued to work with the Berkshire Healthcare NHS Foundation Trust to ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals. A review of The Psychiatric Liaison service was carried out in 18/19 and was able to evidence good practice and outcomes. Data is currently being captured to demonstrate that the mental health liaison team routinely responds to referrals within 1 hour in emergency departments and within 24 hours following referral from wards. The 1 hour response time for liaison teams in emergency departments is usually necessary to meet the wider 4-hour Emergency Department waiting time target. Currently we are performing at 70% with the aim of moving to 100% by the end of quarter 3.
- Maintained investment into our street triage service in collaboration with Thames Valley Police.
- Ensured provision of an at risk mental state for psychosis (ARMS) service for people aged 14 to 65.
- We have continued to invest in our Common Point of Entry as we work towards the development of a Primary Care facing MH service.
- We have seen substantial improvement in the dementia diagnosis rate in 18/19 and are currently on target to achieve the national target of 66.7% by March 2019.
- We continued to make progress towards developing a specialist community perinatal mental health service provided by Berkshire Healthcare Trust. We are currently in wave one after a successful bid to NHS England to develop these services. Over the next 3 years this funding will be used to ensure all elements of the perinatal 5YFV targets are met.

Reading Localities

Health and wellbeing strategy – locality working

In 2018 the Reading Locality Team reviewed specific local targets to improve health outcomes for local people that were initially set in 2017 as part of the CCG two year Operating Plan.

Both localities have made significant progress towards achieving their targets and better outcomes for their local populations. Key achievements include:

- Supporting the promotion of healthy lifestyles by increasing GP referrals to SmokeFreeBerkshire. Between Q1 and Q3, North & West Reading have made 128 referrals (target >139); South Reading have exceeded their target and have made 194 referrals (target 151).

- Improving care of patients with diabetes by supporting patients to reduce their HbA1c (blood sugar levels), as the higher the HbA1c, the greater the risk of developing diabetes-related complications. At Q4, both localities have managed to significantly reduce the % of patients with an HbA1c over 75mmol and achieve their individual targets for the year: North & West Reading 11.7% and South Reading 12.9%.
- Both North & West Reading and South Reading have exceeded the national dementia diagnosis target (66.7%) for this year.
- With a higher prevalence of TB in South Reading, a target was set to increase screening of new entrants[1] for latent TB to >250 patients. At end of Q4, 281 patients had been screened.
- North & West Reading Locality had a specific target set to increase the number of known veterans registered in GP practices by 10% on last year (>217). At the end of Q4, 352 veterans had been identified. Veterans who are known to their GP practice are able to receive priority treatment if they have a health condition related to their military service, and specialist trauma and mental health support.

Better Care Fund

As in previous years, the BCF has a particular focus on initiatives aimed at reducing the level of avoidable hospital stays and delayed transfers of care (DTOCs) as well a number of national conditions that partners must adhere to (including reducing the number of non-elective admissions to hospital; reducing admissions to residential accommodation; and increasing the volume of individuals remaining at home 91 days after receiving reablement services).

Key successes from Reading's BCF programme include:

- Meeting the national BCF target in respect of limiting the number of new residential care home admissions across the financial year (with 82 new admissions against the target of no more than 116 new admissions)
- Driving further reductions in the number of delayed transfers of care (DToC) compared to performance in the previous financial year (with the exception of December and February). While the target of having no more than 419.75 bed days lost per month has not been met in every month of the year, the system has delivered against the target in May-July, September and January (2018-19).
- Streamlining the Discharge to Assess (D2A) service to offer fewer beds in line with an identified reduction in need. D2A offers a bed-based reablement service to people who are clinically optimised and do not require an acute hospital bed, but may still require care services with short term funded support

[1] Recent arrivals (within 5 years) aged 16-35 inclusive to the UK from countries with a TB incidence >150:100,000 population.

in order to be subsequently discharged to their own home (where appropriate) or another community setting. The service has been relocated from its former base in The Willows (a residential home run by Reading Borough Council) to the Extra Care service Charles Clore Court, with a reduction in beds from 14 to 4 in line with a reduced demand from the service across the previous financial year. The move has not only released funds resulting from also reducing staffing levels in line with the reduced need; but has also supported better practice by moving the service from a residential setting (where the support emphasis was on delivering long-term care) to an Extra Care setting (where there is more of a culture of enabling service users to live more independent lives), which supports the overall goals of a reablement service. Funds released from the service will be redeployed to support other integration initiatives.

- Reviewing our Community Reablement Team (CRT) service and making recommendations for driving further performance improvements against the national BCF target of having 93% of service users remaining at home 91 days after discharge from hospitals into reablement services. These will be discussed as part of the wider review of the reablement offer across Berkshire West in 19/20.
- Launching the 6-month pilot of the Neighbourhood Care Planning Group (NCPG), which brings key professionals together to provide a forum for multi-disciplinary discussion, risk assessment and comprehensive care planning. Monthly multi-disciplinary team (MDT) meetings will jointly review clients/patients who are referred to the team – with a focus on clients who are or have experienced:
    - A decline in functional Activities of Daily Living (ADL's)
    - Falls or who are at risk of falls
    - Social isolation or recent dependence on crisis social support/re-ablement or any long term social support in the last 6 months
    - Dementia or severe and enduring Mental Health illness where it is not their primary issue
    - Severe and enduring Long term conditions
    - Patients on multiple medications
    - Two or more unplanned admissions to acute hospital or intermediate care facility in previous 6 month
    - Patients who make frequent appointments with GP that could be resolved through other professionals
    - Frequent call outs to SCAS which do not need action or conveyance.

Joint working with Reading Borough Council:

The CCG is a member of the Reading Health and Wellbeing Board. Dr Andy Ciecierski, who is the North & West Reading locality clinical lead, is also the vice

chair of the Health & Wellbeing Board). The CCG has worked closely with local authority, health and voluntary sector partners to support the delivery of the Reading Health and Wellbeing Strategy which sets out the areas of focus in 2017 to 2020 to improve and protect Reading's health and wellbeing. The strategy sets out eight key priorities:

- Supporting people to make healthy lifestyle choices (reducing obesity, increasing physical activity, reducing smoking);
- Reducing loneliness and social isolation;
- Promoting positive mental health and wellbeing in children and young people;
- Reducing deaths by suicide;
- Reducing the amount of alcohol people drink to safe levels;
- Making Reading a place where people can live well with dementia;
- Increasing uptake of breast and bowel screening and prevention services;
- Reducing the number of people with tuberculosis.

The CCG was a key contributor to the development of the strategy and contributes to priorities where they align with the need to improve health outcomes, such as;

- In partnership with the council, the CCG established a Social Prescribing service supporting residents from across both Reading localities to improve their emotional and physical wellbeing as well as supporting them to take greater control of their own health and social care needs. The service, which started June 2018, has supported approximately 60 new referrals per quarter and seen a positive increase in Wellbeing Star scores for clients exiting their service.
- Supporting GP practices to become dementia friendly and identifying dementia patients to ensure that appropriate support is available to them.
- In partnership with Macmillan and Rushmore Health Living, the CCG set up a 'Cancer Champions' network across all GP practices to raise awareness of cancer and promote patient education among our seldom heard communities.
- Running a new entrant Latent TB Infection (LTBI) screening programmes which offers screening for recent arrivals to the UK aged 16-35 inclusive (within 5 years), from countries with a TB incidence of >150:100,000 population.

Wokingham Locality

Better Care Fund

Key successes for Wokingham's BCF programme include:

- It is one of only seven systems shortlisted for Graduation status
- It is been recognised as an example of good integrated care in action and invited to shape national policy on health and social care integration.
- Integrating our short term health and social care teams Wokingham Integrated Social and Health (WISH – short term care) and Berkshire Integrated Hub,

with plans in place to do the same for the long term health and social care teams Community Health and Social Care (CHASC – longer term care) by the end of 2018/19

Wokingham Local Plan 2017-19

- We have been working with Wokingham Borough Council to promote healthy lifestyles/services. Local authority referral schemes are promoted at practice visits. Promotion of local services is also part of the Community Navigator role.
- We have been implementing a new Community Health and Social Care (CHASC) integrated model of care. Multi-Disciplinary Team meetings continue to be well attended.
- The Wokingham GP Alliance was established as a limited company, with shares held by participating practices. The Alliance has been taking forward projects grouped under two themes. “Sustainability” projects are looking at the use of paramedics, pharmacists, and work flow optimisation. “Innovation and transformation” projects include access and pre-operative assessments.
- We increased from 5.86% to 21%, the number of patients with diabetes (diagnosed for less than a year) who attended a structured education course.
- We are supporting people to stay well by linking them to sources of support in the community. We are seeing increasing referrals to the Community Navigator scheme, which has become embedded and recognised locally, and is now operational in 10 out of 13 surgeries.
- To ensure there is sufficient built capacity of primary care for the borough’s growing population, we have seen building works completed at Chalfont, Finchamsptead, Swallowfield and Brookside practices.

Joint Working with Wokingham Borough Council

The CCG has worked closely with Wokingham Borough Council, health and voluntary sector partners to support the delivery of the Wokingham Well Being Strategy which prioritises the following themes of health and wellbeing:

- Narrowing the health inequalities gap
- Creating physically active communities
- Reducing isolation

The Strategy continues to be developed with the CCG as a key contributor to that work with the aim of ensuring that the actions that support the strategy are aligned to improve outcomes for all residents.

The CCG is a member of the Wokingham Well Being Board, a partnership of the local commissioning authorities, patient representatives and elected officials that come together and take an overview of the health and social care system in the local area, with accountability to ensure the alignment of all health and social care commissioning activity. The Health and Wellbeing Board is being consulted on the

Sustainability and Transformation Plan footprint with the Accountable Officer framing the discussions. Dr Debbie Milligan, GP Locality Lead for Wokingham, is Vice Chair of the Wellbeing Board.

The CCG and Borough Council, together with the Wokingham GP Alliance, Berkshire Health Care Trust, Optalis, Royal Berkshire Foundation Trust, Heathwatch and Involve, sit together as the Wokingham Leader Partnership Board. This well established governance partnership is responsible for the business and overall performance of BCF projects within Wokingham's Health and Social Care Integration programme as well as informing and leading Wokingham's contribution to plan West of Berkshire integration work.

Both the CCG and the Borough Council are members of the Berkshire West 7 health and care organisations. This has a programme of work to deliver better integration of services by developing initiatives such as enhanced support to care homes.

The CCG has also attended meetings of the Council's Health Overview and Scrutiny Committee.

Newbury and District Locality

Our main 2018/19 objective was to improve delayed transfers of care (DToC). This was achieved by including weekend social worker presence at Royal Berkshire Foundation Trust (RBFT) and a link worker at Prospect Park mental health hospital. Purchasing additional capacity in the community and utilising step down beds in the community have all contributed to lowering DToC as much as possible.

There has also been work to develop a joined up way of working for health and social care across West Berkshire to reduce non elective hospital admissions. It is based on the concept of providing joint management of complex patients and preventative care to patients deemed to be at high risk of future admissions. The model of multi-disciplinary working has been established with GPs locally including the ability for practitioners to use Skype to co-ordinate meetings.

The Better Care Fund also includes funding for West of Berkshire projects. These include the programmes Connected Care and Care Homes which focus on reducing the disproportionately high number of non-elective admissions from care homes. The West of Berkshire projects have been expanded to incorporate the Mental Health Street Triage. This reflects the intention of expanding the Better Care Fund to incorporate a broader range of priorities.

We have also agreed with the local authority to include investment related to the contract held with Berkshire Health Foundation Trust. This covers a range of services including intermediate care, speech and language therapy and the community geriatrician.

Joint working with West Berkshire Council

The CCG is a member of the West Berkshire Health and Well Being Board, a partnership of the Local Commissioning Authorities, patient representatives and elected officials. The Board takes an overview of the health and social care system in West Berkshire, with accountability to ensure the alignment of all health and social care commissioning activity. Dr Bal Bahia, Clinical Lead for the CCG was

vice-chair of the Health and Wellbeing Board.

The CCG works alongside the Local Authority in delivering a number of priorities identified through the Heath & Wellbeing strategy. Previous priorities for 2017/18 included reducing alcohol related harm and increasing the number of community conversations. These were following by improving mental health and supporting vulnerable people into work in 2018/19

The Mental Health Action Group (MHAG) was established to deliver on the first priority and has focussed on four areas specifically:

(1) Celebrate, promote and connect existing resources especially those who provide Community Navigation and Peer Support.

(2) Explore the introduction of a digital community resource directory for prevention, recovery and self-care

(3) Investigate preventable deaths from physical health conditions of people with serious mental illness

(4) Work with users and BHFT to co-produce improvements to patients experience when in crisis

Supporting vulnerable people into work was chosen as the second priority because employment is a primary determinant of health, impacting both directly and indirectly on the individual, their families and communities. Unemployment is associated with an increased risk of mortality and morbidity, including limiting illness, cardiovascular disease, poor mental health, suicide and health-damaging behaviours. Whilst West Berkshire experiences high employment, the gap in employment rates between those with a learning disability or a long term condition and the general population is significantly higher that regional and national averages.

Other areas of focus have included reducing alcohol related harm, falls prevention, tackling homelessness and the progressing the Making Every Adult Matter (MEAM) approach project for individuals with multiple needs and supporting Community Conversations.

Forward View

We have now reached the end of the first full year of operation for the newly created Berkshire West CCG. Following the merger of the four CCGs at the end of the previous year, Berkshire West CCG is now in a good position to create a strong, place-based identity for the delivery of high quality service transformation in the year ahead.

A key priority in 2018/19 was the maturing of the Berkshire West Integrated Care System (ICS) to ensure the delivery of identified change programmes. The ICS, which is comprised of the CCG and two provider Foundation Trusts in Berkshire West, identified five core strategic priorities and a number of key delivery projects. The five priorities were as follows and will continue to be our priorities in 2019/20:

- Develop a resilient urgent care system that meets the on-the-day need of patients and is consistent with our constitutional requirements
- To redesign care pathways to improve patient experience, clinical outcomes and make the best use of clinical and digital resources
- Progress a whole system approach to transforming primary care to deliver resilience, better patient outcomes and experience and efficiency
- Develop the ICS supporting infrastructure to deliver better value for money and reduce duplication
- Deliver the ICS financial control total agreed by the Boards of the constituent statutory organisations

The ICS has signed a Memorandum of Understanding with NHS England, which confirms these priorities and the support available to do so. In 2018/19, following this prioritisation, the ICS achieved the implementation of some significant change programmes, such as:

Design and implementation of new clinical pathways

- GP Extended Access
- Outpatients – Advanced Advice & Guidance
- Primary care streaming model – evaluated and revised

Launch of next phase of Thames Valley Integrated Urgent Care Service (111 Online)

- New online service for patents to receive safe clinical diagnoses from 111 through their smartphone or tablet

Implementation of the Connected Care IT platform

- Shared care record for all patients across Berkshire West

New ways of doing business between ICS partner organisations

- New financial risk share arrangements between partner organisations
- New payment mechanisms for the allocation of money between partners
- Alignment of incentives for changes to services

Changed organisational landscape

- Merged single CCG
- Development of primary care alliances (also known as Primary Care Networks / PCNs)
- Working more closely with Local Authorities on shared programmes

For 2019/20, ICS partners will continue to work together to improve care pathways for patients and make efficiencies through projects to share back office functions, reduce running costs and make the best use of public sector estate. Despite the efficiencies identified, the financial challenge for the Berkshire West system remains significant, with a system shortfall of approximately £16.4m

Cathy Winfield

Accountable Officer 23 May 2019

ACCOUNTABILITY REPORT

Cathy Winfield

Accountable Officer 23 May 2019

Corporate Governance Report

Members Report

Composition of Governing Body

The CCG's decisions are made by a governing body that meets every month. In 2018-2019 it consisted of 4 GP members, a Chief Officer, Nurse Director, Joint Commissioning Director, Strategy Director, Chief Finance Officer, three lay members, and a Secondary Care Consultant. The CCG also has 3 Operational Directors who take a lead on locality matters and on programmes of work. The current Governing Body Members are:

Chair (Newbury and District Locality)	Abid Irfan
GP Member South Reading Locality	Kajal Patel
GP Member North and West Reading Locality	Andy Ciecierski
GP Member Wokingham Locality	Debbie Milligan
Chief Officer	Cathy Winfield
Chief Finance Officer	Rebecca Clegg
Nurse Director	Debbie Simmons
Secondary Care Consultant	Raju Reddy
Director of Strategy	Sam Burrows
Director of Joint Commissioning	Katrina Anderson
Operations Director Newbury and District Locality	Shairoz Claridge
Operations Director Reading Localities	Maureen McCartney
Operations Director Wokingham	Katie Summers
Lay member	Geoff Braham
Lay member	Wendy Bower
Lay member	Sabrina Chetcuti

Member profiles can be found at https://www.berkshirewestccg.nhs.uk/about-us/who-we-are/whos-who/

Audit Committee

The Audit Committee members are the CCG's 3 lay members. In accordance with its terms of reference the Committee held four meetings in 2018-2019 and attendance at meetings was as follows:

Member	May-18	Sept-18	Jan-19	Mar-19
Geoff Braham(Chair)	✓	✓	✓	✓
Sabrina Chetcuti	✓	✓	✓	✓
Wendy Bower	✓	A	✓	✓

Member practices

Details of member practices can be found on the CCG's website:
https://www.berkshirewestccg.nhs.uk/about-us/primary-care/gp-practices/

Register of Interests

Name	Position	Declaration	Nature of Interest
Katrina Anderson (Started Sept 2018)	(Interim) Director of Joint Commissioning	None	
Wendy Bower	Lay Member for Patient and Public Engagement	1. Director of Moneymaximiser Ltd 2. Governor for CCG Federation at RBFT 3. Brother is Clinical Trials Specialist with Quintiles 4. Daughter works at Royal Berkshire NHS Foundation Trust	Personal Personal Family Family
Sam Burrows	Director of Strategy	None.	
Geoffrey Braham	Lay Member Governance	1. Governor of Langtree School, Woodcote 2. Oxford Health NHS Foundation Trust Governor 3. Goring & Woodcote Surgery PPG Committee Member	Personal Personal Personal
Sabrina Chetcuti	Lay Member Governance	1. Appointed Governor of South Central Ambulance Service	Personal
Dr Andy Ciecierski	GP Locality Lead (North & West Reading)	1. GP Partner, Emmer Green Surgery 2. GP with Special Interest in ENT (running a Tier 2 ENT Clinic) at Emmer Green Surgery. 3. Vice-Chair, Health and Wellbeing Board (Reading) 4. Wife, Chief Medical Officer, BPL (Pharmaceutical Company – commenced employment September 2016)	Personal Personal Personal Family
Rebecca Clegg	Chief Finance Officer	1. Secretary of Bluequelle Ltd 2. Partner works for OLM Systems Limited, which delivers services for Health & Social Care organisations. 3. Partner has a consultancy for additional work called Bluequelle Ltd	Personal Family Family

Name	Position	Declaration	Nature of Interest
Shairoz Claridge	Operations Director (ND)	None.	
Sarah Garner (Left Aug 2018)	(Interim) Director of Joint Commissioning	None.	
Dr Abid Irfan	CCG Chair and GP Locality Lead (Newbury & District)	1. GP Partner-Strawberry Hill Medical Centre (SHMC) , Newbury 2. Director of Northnova Ltd-miscellaneous medical activities 3. SHMC is shareholder of Newbury GP Alliance Ltd. 4. Member NHS England GP Contracting Team	Personal Personal Personal Personal
Maureen McCartney	Operations Director (NWR)	1. Governor of Blessed Hugh Farringdon Catholic School, Reading	Personal
Dr Debbie Milligan	Chair, Council of Members GP Locality Lead (Wokingham)	1. Salaried doctor Swallowfield Medical Practice 2. Westcall Out of Hours	Personal Personal
Kajal Patel	GP Locality Lead (SR)	1. GP Milman Road Surgery (Salaried)	Personal
Dr Raju Reddy	Secondary Care Consultant	1. Consultant Anaesthetist, Birmingham Children's Hospital 2. Wife is a salaried GP in Birmingham, Modality Group	Personal Family
Debbie Simmons	Nurse Director	1. None.	
Katie Summers	Operations Director	1. Shareholder for Capital and tribal 2. Husband, Director of Physio Service – Kennel & Paddock	Personal Family
Cathy Winfield	Chief Officer	1. Director of Linden House Management Committee, Alton, Hampshire 2. Mentor for external individuals 3. Director, Fresh Solutions for Health for work as NHS England GP Contracting Team member.	Personal Personal Personal

Personal data related incidents

The CCG did not have any personal data related serious incidents in 2018-2019. This is as reported in the Governance Statement.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31March 2018 will be published on our website http://www.berkshirewestccg.nhs.uk/

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Berkshire West 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 Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

Make judgements and estimates on a reasonable basis;

State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,

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.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosures:

S30 letter issued by external auditors in relation to the CCG's reported deficit of £3m

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.

Cathy Winfield

Accountable Officer, 23 May 2019

Governance Statement

Introduction and context

Berkshire West CCG is a body corporate established by NHS England on 1 April 2018 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG Constitution sets out how the organisation will work with and on behalf of the local clinical community to enhance the health and wellbeing of its local population, and how it will fulfil its statutory duties.

Standing Orders regulate the proceedings of the CCG, as set out in the Health and Social Care Act 2012 ("HSCA"). The Standing Orders, together with the CCG's scheme of delegation and the CCG's prime financial policies, provide the procedural framework within which the CCG discharges its business.

The Membership Body

Matters Reserved to the Membership Body (the Council of Members) are clearly defined in the CCG Constitution. The responsibilities of the Membership Body include among others: actively participating in and contributing to the productive, effective and efficient operation of the CCG; and assisting in the analysis, development and implementation of patient pathways within the local health economy with a view to improving services in a cost-effective manner.

The Membership Body met throughout the year in four locality groupings as follows:

Newbury	12
North & West Reading	9
South Reading	11
Wokingham	11

Formal meetings were chaired by a GP. GP attendance at meetings has been high; other participants have included Practice Managers, CCG senior management, local authority/public health representatives, and NHS service providers.

Standing agenda items are commissioning updates, finance, performance, practice issues, and clinical concerns. Other items discussed this year include cancer care, enhanced access, district nursing, Berkshire West Integrated Care System, the NHS Long Term Plan and progress towards locally agreed targets.

Members' attendance, apologies for absence, and declarations of interests and/or conflicts of interests are formally recorded in the minutes of the meetings. Following each meeting, the chair provides a summary report on membership body activities, agenda item discussions and decisions taken, to the next meeting of the Governing Body.

The Governing Body

The CCG has established a governing body for strategic clinical leadership of the commissioning of healthcare and related services for the people in the local area. The governing body comprises GPs from across the local area, a secondary care consultant, three lay members, and the CCG's senior management team.

In accordance with its responsibilities, the CCG governing body has met at least four times in public in 2018/19, with additional sessions (not held in public) in other months. The meetings held in public are publicised on the CCG website, and via social media, and through posters or screens in GP practices. Members of the public and of local patient interest groups are invited to attend. Questions on specific agenda items can be put to the CCG in advance of the meeting to enable the relevant governing body member to provide an informed response; and time is allocated for such questions on the agenda of the meetings held in public. Members' attendance, apologies for absence, and declarations of interests and/or conflicts of interests are formally recorded in the minutes of the meetings.

Throughout the year the governing body received regular reports from the CCG Chief Officer and other members of the executive team, including reports on finance, quality and performance, risk and governance, patient and public engagement, and the work of the delegated committees and programme boards.

Delegated Committees and coverage of their work (terms of reference)

The CCG Governing Body has delegated certain of its responsibilities to the following committees:

- Audit Committee
- Remuneration Committee
- Commissioning Committee
- Finance Committee
- Quality Committee
- Primary Care Commissioning Committee
- (Individual Funding) Case Review Committee and Joint Appeals Panel

The terms of reference of each of these committees are reviewed and approved annually by the governing body and are made available through the publication of the CCG Constitution and of governing body meeting papers on the CCG website. Following each meeting (except the Case Review Committee) the committee chair provides a summary written report to the next governing body meeting in order to provide assurance that the committee is effectively discharging its responsibilities.

The Audit, Finance and Quality Committees undertake a self-assessment exercise on their effectiveness as part of their annual report. Attendances, apologies for absence and declarations and/or conflicts of interest are formally recorded in the minutes of meetings.

Audit Committee: reviews critically the CCG's financial reporting and internal control principles; ensures that all the CCG activities are managed in accordance with legislation and regulations governing the NHS; ensures adequate assurance is in place over the management of significant risks; and ensures that appropriate relationships with both internal and external auditors are maintained.

The Committee met four times in 2018-19, in accordance with its terms of reference. Membership comprises the 3 lay members of the CCG. The CCG's Clinical Chair will be invited to review the annual accounts at an additional meeting prior to the submission to NHSE. The Chief Officer and other members of the CCG executive team and of South, Central and West Commissioning Support Unit (SCWCSU) attend meetings as requested. Representatives of internal audit, external audit and local counter fraud service attend each meeting, and also meet in private session with the Lay Members at least once per annum. The agenda of the Audit Committee is governed by its annual business cycle which is reviewed and agreed at each committee meeting.

Remuneration Committee: reviews the framework for the Remuneration, Allowances and Terms of Service for employees of the CCG and for people who provide services to the CCG. It makes recommendations to ensure effective oversight of the performance of the CCG's Chair, Chief Officer, Chief Finance Officer and other senior posts, and for scrutiny of redundancy payments.

The Committee comprises the three lay members of the CCG Governing Body. The Chief Finance Officer attends each meeting of the committee. The committee met three times in 2018/19.

Commissioning Committee: provides clinical leadership and direction for the CCG, develops commissioning policy and oversees its delivery, supports the development of the ICS, supports joint commissioning with the three unitary authorities in Berkshire West, and oversees the work of the CCG programme boards.

The Committee comprises four GPs from across the CCG, the secondary care consultant, and the CCG's executive team. The committee meets monthly; and in accordance with the CCG Constitution is chaired by Governing Body chair. The Committee met 11 times in 2018/19

Finance Committee: monitors the CCG's internal Cost Improvement Programmes (CIPs) and the Berkshire West Integrated Care System (ICS) Efficiency Plan; monitors overall use of resources and to ensure that value for money can be demonstrated and that the best possible value is secured for the Berkshire West pound; monitors the financial performance in relation to key national targets and in support of the delivery of the outcomes included in the Long Term Plan; approves business cases and make recommendations to the Governing Body as appropriate; approves the release of finance from allocated reserves to support investments and to make recommendations to the Governing Body as appropriate; monitors and provides a scrutiny function to ensure the delivery of projects to the CCG programme boards. One CCG Lay Member (or their appropriate proxy) (Deputy Chair); Secondary Care Consultant; GP member of the Governing Body; Chief Officer (CO); Chief Finance Officer (CFO) (Chair) supported by other officers as appropriate. The Committee has met 11 times in 2018/19.

Quality Committee*:* reviews and assures provider performance; has oversight of the quality and safety of commissioned services; ensures that the patient voice is heard; reviews reports on Serious Incidents and Never Events; ensures that there are processes in place to safeguard adults and children; considers national quality inspection reports; monitors arrangements relating to equality and diversity; reviews the corporate risk register; and receive chairs reports from various subcommittees for oversight and assurance.

In accordance with its term of reference, the Committee met four times in 2018/19. Membership includes: the lay member with responsibility for patient engagement; a clinical member; the Secondary Care Consultant; the Nurse Director; a patient/public representative; and is supported by CCG managers with responsibility for governance and safeguarding, and the CCG Quality Team with responsibility for quality improvement.

Primary Care Commissioning Committee*:* Meetings are held quarterly and in public, with an Operational Group meeting in the intervening months. The voting membership of the Committee comprises two lay members (one of which is the chair), two Governing Body GP Leads, the Chief Officer, the Nurse Director (deputy chair) and the Chief Finance Officer. Non-voting membership comprises: The Operations Directors of the four CCGs, the Director of Primary Care, CCG Practice Manager Representatives, the Primary Care Commissioning Managers, a Local Medical Committee representative, Healthwatch representatives, GP Alliance representatives and a Local Pharmaceutical Committee representative. Health and Wellbeing Board representatives and NHS England are also invited to attend in accordance with the Delegation Agreement.

The Primary Care Commissioning Committee is directly accountable to the Governing Body, and additionally to the Finance Committee for financial investment matters.

(Individual Funding) Case Review Committee (CRC)*:* considers individual funding requests (IFRs) put to it; considers whether the CCG's full requirements for statement of clinical exceptionality, as defined in the relevant CCG policy, have been

demonstrated within the case submitted for consideration of funding; carries out its decision making about the IFR in line with the CCG Ethical Framework; and ensures it is consistent in its decision making.

Meetings are held monthly or more frequently when caseload demands and/or at the discretion of the CCG. Membership of the CRC comprises a Lay Member from the CCG, who chairs the meetings, two GPs, CCG Operations Director, CCG Associate Director for Quality and Nursing, and a member of the CCG Medicines Optimisation Team. Because of the sensitive and potentially identifiable nature of the cases reviewed by the CRC, the outcome of the committee's decisions is only communicated to referring clinicians. If patients/family representatives are not satisfied with the outcome, they have the opportunity to request a review by the IFR Appeals Panel which meets when such requests are made.

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

However, the Code is recognised as good practice, and this Governance Statement demonstrates the clinical commissioning group's compliance with the principles set out in it. For the financial year ended 31 March 2019, and up to the date of signing this statement, the CCG complied with the provisions set out in the Code, and applied its principles. In 2018/19 the CCG has identified no instances of non-compliance with the principles of the Code.

Discharge of Statutory Functions
In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director.

Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness
Robust risk management and internal control measures enable the CCG to achieve an effective corporate governance environment. Two organisation-level forms of risk register were in use in 2018-19 – the Corporate Risk Register and the Governing Body Assurance Framework. The Governing Body Assurance Framework is used by the Governing Body to identify, monitor and evaluate risks to its strategic objectives.

It is used alongside other key management tools, such as financial reporting, to give the Governing Body a comprehensive picture of the organisational risk profile. The Corporate Risk Register outlines operational risks to the objectives of teams and services. Both documents address risk appetite at an individual risk level, by indicating whether current ratings are acceptable, and why. In addition, business cases presented to the Finance Committee include quality and equality impact assessment, a privacy impact assessment, and information on potential risks associated with a proposed project or investment.

Capacity to Handle Risk
The Risk Management Framework and Strategy provide guidance to all staff on the management of strategic and operational risks within the organisation and help them to identify, evaluate and reduce the risks that threaten delivery of our key objectives. These documents:

- Describe the organisation's accountability framework and reporting structure;
- Describe the principal processes for managing risk, and the tools to be used;
- Provide guidance on the escalation and acceptability (tolerance) of risk at different levels of the organisation;
- Outline risk management responsibilities at all levels of the CCG, and the support/training available within the organisation.

Identified risks are documented and managed through the use of project and programme board risk registers, in line with the risk management strategy. The registers are updated monthly for review by the relevant programme board or delegated committee, before escalation to the governing body.

Prevention is embedded in the operation of the CCG through the impact assessment of all policies, practices, procedures and decisions.

Staff are supported to manage risk in a way appropriate to their level of authority and duties. This occurs through the provision of guidance, the regular review processes of the strategic and operational risk registers, and through the transformation project management processes.

Risk Assessment
Risk assessment is conducted in a systematic manner across all aspects of the CCG's strategic and operational goals. Risk and the CCG's risk profile is managed by every member of the CCG as part of their work. It is also managed through regular receipt and review of risk registers and risk-related reports by the governing body, and its delegated committees, and by the CCG's care programme boards which in turn report to the Commissioning Committee.

Significant risks faced by the CCG this year have included financial performance, provider performance and workforce challenges. The Governing Body, responsible programme boards and delegated committees have challenged and advised on the controls and actions being taken to manage these risks throughout the year.

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 CCG maintains a comprehensive system of internal control through the application of its standing orders, prime financial policies and scheme of delegation.

The Audit Committee routinely considers financial and non-financial reports, including from internal audit, external audit and the local counter fraud specialist (LCFS), which enable it to assess the effectiveness of the CCG's internal control mechanisms. It then provides an opinion to the Governing Body as to the adequacy of the assurances available.

All risks are managed through a risk register, and all groups reporting to the CCG Governing Body are responsible for highlighting new risks. Throughout 2018/19, the corporate risk register, in full or in part, and other relevant risk-related reports were reviewed variously by Audit Committee, Finance Committee, Quality Committee, and the Programme Boards.

Risks to the achievement of the CCG's strategic objectives are captured in the governing body assurance framework. A summary risk profile based on this is reviewed at each meeting of the Governing Body, together with the high-level risks from the Corporate Risk Register.

Annual audit of conflicts of interest management

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

The CCG's internal auditors carried out this audit for 2018-19 and made two low risk findings, in relation to the design of single tender waiver forms, and additional detail in the Primary Care Commissioning Committee terms of reference.

Data Quality

The Council of Members and the Governing Body both receive a variety of financial, performance and quality data to support them in discharging their respective responsibilities.

Data quality is reviewed and challenged by CCG staff before presentation to the Governing Body and to the Council of Members, and interrogated by those bodies during their meetings. The CCG has no significant concern about data quality overall, but any individual data issues identified are reviewed with the source provider.

Information Governance

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

The CCG submitted a Data Security and Protection Toolkit that met all of the required standards in March 2018/19.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. An information governance management framework and processes and procedures are in place and aligned to the information governance toolkit. All staff

undertake annual information governance training and a staff information governance handbook is promoted 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. In 2018/19, there were no incidents which required reporting to the Information Commissioner's Office.

Information Governance is reported to the Audit Committee as a standing agenda item in each meeting and is reviewed regularly through the CCG management meetings.

Business Critical Models
The CCG is aware of the Macpherson Report on government business critical models and quality assurance mechanisms, and of its findings. The CCG does not operate any business critical models as defined in the report.

Third party assurances
Where the CCG relies on third party providers, it gains assurance through service level agreement and contract specifications; regular review meetings with providers on multiple levels; the use of performance data and external regulatory inspection reports; and monitoring and review by appropriate programme boards and committees, with onwards reporting in to the Governing Body.

Control Issues

As a result of the CCG delivering an in year deficit of £3m against a plan to breakeven, external audit have issued a modified value for money conclusion as well as issuing a Section 30 referral to the Secretary of State. The CCG has a cumulative surplus of £9.5m to carry into 2019/20. NHS Berkshire West CCG met all of its other statutory financial duties for 2018-2019.The CCG also operated with the running cost allocation of £10.9m.

Review of economy, efficiency & effectiveness of the use of resources
The CCG has well-established systems and processes for managing its resources effectively, efficiently and economically.

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place, and delegates responsibilities to the Audit Committee, the Quality Committee and the Finance Committee. The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control. An audit programme is followed to ensure that resources are used economically, efficiently and effectively.

The Audit Committee met regularly throughout the 2018/19 financial year to review and monitor the CCG's financial reporting and internal control principles; to ensure that the CCG activities were managed in accordance with legislation and regulations governing the NHS; and to ensure that appropriate relationships were maintained with internal and external auditors.

The Finance Committee met throughout the year to monitor contract and financial performance, savings plans and overall use of resources; to approve business cases

and release of finance from allocated reserves; and to monitor and provide a scrutiny function to ensure the delivery of projects within the CCG's care programme boards.

The CCG has processes in place to secure economy, efficiency and effectiveness through its procurement, contract negotiation and contract management processes. There are regular performance review meetings on the following contracts: Royal Berkshire NHS Foundation Trust (hospital services), Berkshire Healthcare NHS Foundation Trust (community and mental health services), and South Central Ambulance Services. Effectiveness is monitored specifically through the quality processes and Quality Committee.

The Chief Finance Officer has met regularly with the CCG's finance team and held monthly meetings with the CSU's finance leads to review month-end reporting. Regular meetings are also held with the local authorities' finance leads.

The CCG informs its control framework by the work over the year of the Internal and External Audit functions. As part of their annual audit, the CCG's external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. Their audit work is made available to and reviewed by the Audit Committee and Governing Body.

The CCG has been rated as green by NHS England for the Quality of Leadership indicator of the CCG Improvement and Assessment Framework 2018/19, but this is subject to national moderation.

Delegation of functions

The CCG's Scheme of Reservation and Delegation outlines the control mechanisms in place for delegation of functions and is found in the Constitution.

The Governing Body receives reports from each of its Committees detailing the delivery of work, and associated risks, within their specific remit. Additionally, the Governing Body maintains a high level overview of the organisation's business and identifies and assesses risks and issues straddling Committees. These risks are owned and overseen at Governing Body level and scrutinised at each meeting to ensure appropriate management and reporting.

Internal Audit is used to provide an in-depth examination of any areas of concern.

Counter fraud arrangements

The CCG is committed to reducing the risk from fraud and corruption and discharges its counter fraud responsibilities locally through its appointed Local Counter Fraud Specialist (LCFS) who acts as the "first line of defence" against fraud, bribery and corruption, working closely with the CCG and NHSCFA. The Chief Finance Officer is the Executive Lead for Counter Fraud. The CCG has a Counter Fraud and Corruption Policy and Response Plan in place and this was reviewed in January

2018. Fraud awareness material, including fraud alerts and information on bribery, is regularly circulated to CCG staff. Fraud referrals are investigated by the LCFS and the progress and results of investigations are reported to the Chief Finance Officer and the Audit Committee. Audit Committee receives a report each meeting on an aspect of counter-fraud work. There is a proactive risk based work plan aligned to the NHSCFA Standards for Commissioners to maintain and improve compliance and performance against each of the standards is assessed on an annual basis.

The CCG also participates in the National Fraud Initiative Exercise now run by the Cabinet Office which is a mandatory exercise that matched electronic data within and between public and private sector bodies to prevent and detect fraud. It has been run every two years since 1996.

Head of Internal Audit Opinion

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

Head of Internal Audit Opinion

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

Opinion

Our opinion is as follows:

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

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

Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control. Please see our Summary of Findings in Section 2.

Commentary

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

- Of the six reviews completed in the year, three have been rated as low risk overall and a further three were not risk rated as these were advisory reviews. We have not raised any high risk rated reports in 2018/19.
- In addition to the findings raised in the 2018/19 reviews, our follow up procedures performed in Quarter 4 2018/19 identified that of the 12 findings followed up 11 had been completed and one superseded. This demonstrates progress by management in completing actions to mitigate identified risks.
- Whilst there have been no high or medium risk reports issued this year we have concluded that the internal controls in place at the CCG are generally satisfactory with some improvements required. This was due to: 1) The number of medium rated findings raised in year; 2) The findings from the GDPR review though not risk rated identified improvements required to reduce the risk of a personal data breach and the associated financial and reputational damage; and 3) the wider challenges associated with the move to working as an Integrated Care System, especially around good governance and ensuring both statutory responsibilities are discharged whilst working effectively as a system.

We have highlighted below specific findings which have contributed to this overall assessment, and the CCG should consider whether these findings are reflected within the Annual Governance Statement.

Primary care commissioning

In August 2018, NHS England published the Primary Medical Care Commissioning and Contracting: Internal Audit Framework for delegated Clinical Commissioning Groups ("the Guidance"). There is a formal requirement for an annual audit of primary care provision that must cover the following four areas over the course of a three-year cycle:

- Commissioning and Procurement of Services;
- Contract Oversight and Management Functions;
- Primary Care Finance; and
- Governance (common to each of the above areas).

It was agreed with members of the Audit Committee and management that the 2018/19 audit would focus on Contract Oversight and Management Functions and the Governance arrangements in this area.

Our report was rated low risk overall, and we raised a one medium and two low risk findings; the medium rated issue was in relation to:

Improvements required over the development of a targeted programme of GP practice list maintenance – With funding for primary care provided on a capitated basis ensuring that a GPs patient list is accurate is important to ensure the correct allocation of resources. As a commissioner the CCG is required to ensure practice list maintenance is appropriately managed so that patient lists reflect changes in the population. While we were able to evidence a three year rolling programme of list maintenance and a review of student registrations we were unable to evidence a

targeted programme focussing on practices whose geography include attributes that suggest a higher risk of over- or under-stating the number of patients. For example, the construction of a large housing development or a highly mobile population.

However, we recognise that Primary Medical Care Policy Guidance Manual states that list management is excluded from delegation within the responsibilities of NHS England i.e. Primary Care Support England (PCSE). The CCG has previously contacted PCSE for support in undertaking a programme of targeted list maintenance, they have not received a response and there is now a planned national review of patient lists. Therefore, the actions the CCG can undertake to address this risk are limited.

Corporate Governance – Conflicts of Interest – Information Governance

This review covered three areas:

Corporate Governance: Having previously considered the repatriation of HR services from the CSU to the CCG the decision was ultimately made to continue with an outsourced service. As part of this review we considered the level and adequacy of performance reporting received from the CSU and how any deficiencies are addressed. The CCG did, however, elect to repatriate the Complaints / PALS and FoI services from the CSU and this review looked at how the services have been integrated into the CCG.

Conflicts of Interest: NHS England has not released any additional guidance since the last review undertaken in 2017/18. However, NHS England have shared with the CCG a draft internal audit report that identified a number of deficiencies, though these varied by CCG in terms of number and severity. Therefore, we looked at two areas highlighted by the report: 1) Management of CoI at the Remuneration Committee as this was where the most significant deficiencies were identified; and 2) Procurement decisions and the contract monitoring process as issues were identified at all CCGs.

Information Governance: The Data Security and Planning Toolkit (DSP Toolkit), was launched in line with GDPR requirements in May 2018, to take effect for the year ending 31 March 2019. We reviewed whether the CCG's DSP toolkit submission is line with the guidance from the Department of Health and NHS Digital.

Each of the three areas was assessed as low risk with seven low risk findings identified as part of this review. Three in relation to corporate governance, three in relation to conflicts of interest, and one in relation to information governance.

Core Financial Systems

The CCG is in receipt of a number of small pots of transformation funding from NHS England for designated purposes, such as supporting improvement in the treatment and care of people with diabetes. This review looked at the existing funding streams to confirm that they are individually appropriately monitored and managed, including that expenditure is in line with their restrictions placed on them (generally the formally approved plan) and, where applicable, that reporting requirements to NHS England are being adhered to.

Our report was rated low risk overall and we raised one medium risk rated findings. The medium rated risk finding was in relation to the fact that adequate

documentation around the terms of transformation funds and their associated expenditure had not been retained for six out of 20 transformation fund payments tested.

General Data Protection Regulations Programme Review

This was an advisory piece review a high-level consideration of the CCG's programme to manage compliance following the introduction of GDPR. In light of the high-level nature of this review and the fact detailed testing on risks and controls has not been performed, the report and all findings have been categorised as unclassified, the CCG should risk assess them against its ongoing programme actions.

The key observations were:

- Data Breach Response Testing – A data breach policy is in place with a supporting structure for incident reporting which includes the SIRO, Caldicott Guardian, and DPO. The CCG has operationalised the breach procedure in response to past incidents, though a data breach simulation to assess the effectiveness and potential improvement areas of the current procedure is not planned for 2019. In addition, staff understanding of data breach operational procedures has not been tested. Simulation exercises will test the ability of the CCG to capture the necessary information across a variety of data breach scenarios before making an informed decision on the impact of the breach.

  Polling of user's operational understanding can be used to assess whether additional training and awareness activities are required. User awareness is crucial to identifying an incident early. The 2018 Cyber Security Breaches Survey by the UK Department for Digital, Culture, Media & Sport notes that data breaches are more likely to be detected by a member of staff than IT network tools.

- Asset Inventory Management – As part of the GDPR programme, the CCG has undertaken a data inventory exercise performed by CCG departments. The inventory intends to document information used throughout the organisation. The inventory structure includes details such as the processing purpose, the lawful bases relied upon, confidentiality requirement and an assessment of risk posed by each activity against the CCG's standard methodology. Discussions with key stakeholders indicated that the inventory of information assets is not yet fully complete and formally agreed by the CCG. Additionally, inventories have not yet been reviewed to evaluate areas such as retention, and ensure that all personal data assets are being handled in-line with requirements. A detailed review of data inventories often results in identification of previously unexplored risks or outstanding areas of work which can be incorporated into a programme of continuous improvement or spot-checks, noted below.

- Compliance Schedule - Yearly review cycles are in place for existing data protection policies, documents, and controls as part of the CCG's DSP Toolkit requirements. Interviews with stakeholders noted a desire to incorporate GDPR-related spot-checks into this yearly programme, however such activities have not yet been collated into a single data protection compliance

lifecycle. This will provide visibility and comfort to management that content is accurate and up to date in response to evolving data protection risks. Such schedules also support accurate resource planning and structured testing of controls.

ICS – Stakeholder Engagement:

- This audit focused on the engagement with two key groups: 1) The clinical workforce at both providers and commissioners; and 2) local authorities. The scope has been agreed with management and the review is ongoing. This review will not result in any risk rated findings, or contribute to the Head of Internal Audit Opinion, as it considers the operation of the ICS as a whole.

ICS – Efficiency and Transformation:

- This audit focused on the processes around the ICS's large transformation programme, including a deep dive into a sample of programmes, to understand if these support the effective delivery of cost savings and broader efficiencies to the system. The scope has been agreed with management and the review is ongoing. This review will not result in any risk rated findings, or contribute to the Head of Internal Audit Opinion, as it considers the operation of the ICS as a whole.

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

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

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

My review is also informed by:

- the reports provided throughout the year to the Governing Body from the relevant delegated committees and programme boards in relation to their management of key risks.
- the reviews, progress reports and opinions provided by our Internal and External Auditors.
- the work of the Audit Committee.
- the regular review of the Governing Body Assurance Framework, Summary Risk Profile and Corporate Risk Register.

- assurance of our delivery, capability and organisational health gained through assurance meetings with NHSE.

Action plans are implemented and monitored for any area where a need for improvement is identified.

Conclusion

No significant internal control issues have been identified.

Cathy Winfield

Accountable Officer 23 May 2019

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The CCG has a Remuneration Committee and the membership for 2018-2019 was as follows:

Saby Chetcuti, Lay Member (Chair)
Geoffrey Braham, Lay Member
Wendy Bower, Lay Member

Policy on the remuneration of senior managers

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

Senior managers' remuneration is set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them. This ensures a fair and transparent process via bodies that are independent of the senior managers whose pay is being set. No individual is involved in deciding his or her own remuneration

Executive senior managers are on permanent NHS contracts. The length of contract, notice period and compensation for early termination are set out in the Agenda for Change, NHS terms and conditions of service handbook.

Remuneration of Very Senior Managers

There are 3 Very Senior Managers (VSMs) who have individual notice periods. During the period 1 April 2018 to 15 July 2018, the post of Chief Finance Officer was covered by a senior management on secondment on the Agenda for Change pay scale. This appointment was made permanent from 16 July 2018 and the employee moved to the VSM pay scale.

All VSM remuneration is determined by the Remuneration Committee based on available national guidance, benchmarking data against other CCGs and with due regard for national pay negotiations/awards for NHS staff on national terms and conditions. The Remuneration Committee is also cognisant of public sector pay restraint and its responsibility to ensure that Executive pay remains publicly justifiable. The Remuneration Committee acknowledges and commits to the requirement to seek pre-approval for salaries in excess of £142,500.

Senior Managers have not received any remuneration linked to performance.

The CCG does not hold a provision for compensation for early retirement. Any non-contractual payments made outside of the Agenda for Change framework would be subject to treasury approval.

Senior manager remuneration 2018/19 Subject to audit

Name	Title	Berkshire West CCG Salary (Bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100	Performance Pay and bonuses (Bands of £5,000)	Long Term performance pay and bonuses (Bands of £5,000)	All Pension related benefits (bands of £2,500)	Total (Bands of £5,000)
		£000	£00	£000	£000	£000	£000
Cathy Winfield	Chief Officer	135-140	0	0-5	0-5	2.5-5	135-140
Rebecca Clegg	Chief Finance Officer	115-120	0	0-5	0-5	45-47.5	160-165
Debbie Simmons	Director of Nursing	95-90	0	0-5	0-5	15-17.5	110-115
Gabrielle Alford	Director of Joint Commissioning*	25-30	0	0-5	0-5	0-2.5	25-30
Sarah Garner	Interim Director of Joint Commissioning*	70-75	0	0-5	0-5	0	70-75
Katrina Anderson	Interim Director of Joint Commissioning	105-110	0	0-5	0-5	0	105-110
Raju Reddy	Secondary Care Consultant	35-40	0	0-5	0-5	0	35-40
Dr Abid Irfan	Chair	125-130	0	0-5	0-5	527.5-530	655-660
Helen Clark	Director of Primary Care	60-65	0	0-5	0-5	22.5-25	85-90
Sam Burrows	Deputy Chief Officer and Director of Strategy	100-105	0	0-5	0-5	25-27.5	125-130
Katie Summers	Director of Operations	80-85	0	0-5	0-5	20-22.5	100-105
Shairoz Claridge	Director of Operations	70-75	0	0-5	0-5	25-27.5	100-105
Maureen McCartney	Director of Operations	85-90	0	0-5	0-5	7.5-10	90-95
Eleanor Mitchell	Director of Operations*	20-25	0	0-5	0-5	2.5-5	25-30
Raghuv Bhasin	Deputy Director of ICS Delivery**	0	0	0-5	0-5	0	0
Dr D Milligan	GP Clinical Lead	85-90	0	0-5	0-5	22.5-25	105-110
Dr Andy Ciecierski	GP Clinical Lead	65-70	0	0-5	0-5	0	65-70
Kajal Patel	GP Clinical Lead	75-80	0	0-5	0-5	12.5-15	90-95
D George	Lay member*	0-5	0	0-5	0-5	0	0-5
G E Braham	Lay member	5-10	0	0-5	0-5	0	5-10
L Jones	Lay member*	0-5	0	0-5	0-5	0	0-5
S Chetcuti	Lay member	5-10	0	0-5	0-5	0	5-10
W Bower	Lay member	5-10	0	0-5	0-5	0	5-10

*Gabrielle Alford, Director of Joint Commissioning employed from 1 April 2018 to 17 May 2018, Sarah Garner, Interim Director of Joint Commissioning employed from 1 April 2018 to 17 May 2018, Katrina Anderson, Interim Director of Joint Commissioning employed from 27 August 2018 – ongoing. Eleanor Mitchell, Director of Operations employed from 1 April 2018 to 30 June 2018. D George and L Jones, Lay members from 1st April 2018 to 31 May 2018. **Raghuv Bhasin, Deputy Director of ICS Delivery is employed by Royal Berkshire NHS Foundation Trust so there is not disclosure.

Senior manager remuneration 2017/18 Subject to audit

Name	Title	Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £00	Performance Pay and bonuses (Bands of £5,000) £000	Long Term performance pay and bonuses (Bands of £5,000) £000	All Pension related benefits (bands of £2,500) £000	Total(Bands of £5,000) £000
Cathy Winfield	Chief Officer	135-140	0	0-5	0-5	17.5-20	150-155
Rebecca Clegg	Acting Chief Finance Officer	110-115	0	0-5	0-5	150-152.5	260-265
Debbie Simmons	Nurse Director	90-95	0	0-5	0-5	12.5-15	105-110
Gabrielle Alford	Director of Joint Commissioning	95-100	0	0-5	0-5	45-47.5	140-145
Raju Reddy	Secondary Care Consultant	35-40	0	0-5	0-5	0-2.5	35-40
Dr Abid Irfan	Chair	20-25	0	0-5	0-5	0-2.5	20-25
Helen Clark	Director of Primary Care	55-60	0	0-5	0-5	22.5-25	80-85
Sam Burrows	Director of Strategy	90-95	0	0-5	0-5	20-22.5	110-115
Katie Summers	Director of Operations	80-85	0	0-5	0-5	82.5-85	165-170
Maureen McCartney	Director of Operations	80-85	0	0-5	0-5	50-52.5	135-140
Shairoz Claridge	Director of Operations	70-75	0	0-5	0-5	25-27.5	95-100
Eleanor Mitchell	Director of Operations	80-85	0	0-5	0-5	12.5-15	95-100
Dr Debbie Milligan	GP Clinical Lead	90-95	0	0-5	0-5	95-97.5	185-190
Dr Johan Zylstra	GP Clinical Lead	100-105	0	0-5	0-5	0-2.5	100-105
Dr Will Beacham	GP Clinical Lead	35-40	0	0-5	0-5	0-2.5	35-40
Dr Andy Ciecierski	GP Clinical Lead	100-105	0	0-5	0-5	0-2.5	100-105
Kajal Patel	GP Clinical Lead	55-60	0	0-5	0-5	10-12.5	65-70
GE Braham	Lay member	5-10	0	0-5	0-5	0-2.5	5-10
L Jones	Lay member	5-10	0	0-5	0-5	0-2.5	5-10
S Chetcuti	Lay member	5-10	0	0-5	0-5	0-2.5	5-10
W Bower	Lay member	5-10	0	0-5	0-5	0-2.5	5-10
David George	Lay member	5-10	0	0-5	0-5	0-2.5	5-10

The comparatives relate to individuals who previously worked for the 4 legacy CCGs and have continued to be employed by NHS Berkshire West CCG.

Pension Benefits 2018-2019 subject to audit

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cathy Winfield	Chief Officer	0-2.5	2.5-5	50-55	155-160	1034	129	1194	0
Rebecca Clegg	Chief Finance Officer	2.5-5	0-2.5	35-40	85-90	558	120	695	0
Debbie Simmons	Director of Nursing	0-2.5	0-2.5	25-30	70-75	496	72	583	0
Gabrielle Alford	Director of Joint Commissioning*	0-2.5	0-2.5	30-35	85-90	681	0	0	0
Dr Abid Irfan	Chair	5-7.5	420-422.5	15-20	450-455	175	125	306	0
Helen Clark	Director of Primary Care	0-2.5	0-2.5	15-20	30-35	176	50	231	0
Sam Burrows	Deputy Chief Officer	0-2.5	0-2.5	5-10	0-5	20	23	44	0
Katie Summers	Director of Operations	0-2.5	0-2.5	15-20	15-20	172	47	224	0
Shairoz Claridge	Director of Operations	0-2.5	0-2.5	15-20	30-35	206	53	265	0
Maureen McCartney	Director of Operations	0-2.5	2.5-5	40-45	120-125	884	0	0	0
Eleanor Mitchell	Director of Operations*	0-2.5	0-2.5	25-30	80-85	546	17	631	0
Dr D Milligan	GP Clinical Lead	0-2.5	0-2.5	10-15	20-25	177	45	227	0
Kajal Patel	GP Clinical Lead	0-2.5	0-2.5	10-15	30-35	146	39	189	0

Gabrielle Alford, Director of Joint Commissioning employed form 1 April 2018 to 17 May 2018. Eleanor Mitchell, Director of Operations employed from 1 April 2018 to 30 June 2018. There are no entries in respect of pensions for Lay Members as they do not receive pensionable remuneration. Where individuals are not members of the NHS Pension Scheme in respect of their role with the CCG, there will be no entries in respect of pensions for those individuals.

McCloud Ruling

The calculations above do not take account of the recent McCloud ruling (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 eldest members who retained a Final Salary design). We believe this to be appropriate given the considerable uncertainty on the implications of any future ruling in this matter'

Pension Benefits 2017-2018 subject to audit

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cathy Winfield	Chief Officer	0-2.5	5-7.5	45-50	145-150	938	86	1,034	0
Rebecca Clegg	Acting Chief Finance Officer	7.5-10	15-17.5	30-35	80-85	411	143	558	0
Debbie Simmons	Nurse Director	0-2.5	2.5-5	20-25	70-75	442	50	496	0
Gabrielle Alford	Director of Joint Commissioning	2.5-5	7.5-10	30-35	95-100	590	86	681	0
Helen Clark	Director of Primary Care	0-2.5	0-2.5	10-15	30-35	156	19	176	0
Sam Burrows	Director of Strategy	0-2.5	0-2.5	0-5	0-5	9	11	20	0
Katie Summers	Director of Operations	2.5-5	0-2.5	10-15	15-20	152	18	172	0
Maureen McCartney	Director of Operations	2.5-5	7.5-10	35-40	115-120	775	101	884	0
Shairoz Claridge	Director of Operation	0-2.5	0-2.5	10-15	25-30	174	30	206	0
Eleanor Mitchell	Director of Operation	0-2.5	2.5-5	25-30	75-80	493	49	546	0
Dr Debbie Milligan	GP Clinical Lead	2.5-5	12.5-15	10-15	30-35	133	90	224	0

There are no entries in respect of pensions for Lay Members as they do not receive pensionable remuneration. Where individuals are not members of the NHS Pension Scheme in respect of their role with the CCG, there will be no entries in respect of pensions for those individuals. The comparatives relate to individuals who previously worked for the 4 legacy CCG's and have continued to be employed by NHS Berkshire West CCG

Cash equivalent transfer values subject to audit

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Change in CETV

The opening balances on some of the Cash Equivalent Transfer Values (CETV) have changed from the prior year audited accounts. The reason for the change is that some of the factors used in the calculation of the closing 2017/18 position have been updated and this has resulted in a change specifically for members in the 2015 Scheme

Pay multiples subject to audit

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

The banded remuneration of the highest paid director/Member in NHS Berkshire West CCG in the financial year 2018/19 was £210k-215k (2017/18: £210k-£215k). This was 5.2 times (2017/18: 4.7) the median remuneration of the workforce, which was £41,034 (2017/18: £45,159).

In 2018/19, 0 employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £8k to £211k (2017/18: £8k to £211k)

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

Staff Report

Number of senior managers

The CCG has 3 VSMs.

Staff composition

As at 31 March 2019, the composition of the CCG's employees was as follows:

Governing Body Members	10 females	5 males
Other Employees	80 females	16 males
Total	**90 females**	**21 males**

Sickness absence data

Sickness absence data is supplied by NHS Digital based on data from the Eletronic Staff Record Data Warehouse. The period covered is usually a calendar year so for this report, it is for January 2018 to December 2018. There is only 11 months of data available for Berkshire West, split over 2 lines:

		a=d/365*12/e Average FTE 2018 a	b= c/d*225 Average Annual Sick Days per FTE b	Sum of FTE Days Sick c	Sum of FTE Days Available d	Months e
11D	NHS Wokingham CCG*	95	10	123	2,878	1
15A	NHS Berkshire West CCG	90	6	710	27,296	10
	Combined	**184**	**6**	**833**	**30,174**	11

Staff policies

The CCG regularly reviews how well the CCG's recruitment and selection processes work to reduce conscious or unconscious bias against characteristics protected by diversity legislation.

The CCG has established a staff forum to provide a regular and effective means of joint discussion between senior management and staff on issues of mutual interest or concern, and to foster maximum involvement of all partners in effective communications, engagement and consultation on working practices and employment.

The CCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics but it has incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance discipline. Our aim is to operate in ways which do not discriminate our potential or current employees with any of protected characteristics specified in the Equality Act 2010 and to support our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

The CCG has a range of HR policies in place that are approved by the Governing Body, in relation to employees and cover social community and human rights issues.

Employee Consultation

HR Services and Policy Development are outsourced to South Central and West Commissioning Support Unit under a Service Level Agreement. Policies are available to staff via the ConSultHR portal. The CCG has consulted with staff with regard to a number of HR policies.

Health and Safety

The Clinical Commissioning Group is fully committed to protecting the health, safety and welfare of its staff and anyone else whose health, safety and welfare could be affected by its work and activities.

The CCG recognises its statutory responsibilities as described within the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999 and aims to do all that it can to ensure staff and others are not exposed to unacceptable risk. The CCG's Statement of Commitment describes the commitment and safety culture within the CCG and all staff must have read the statement.

We also recognise that a healthy workforce working within a safe working environment has a positive impact on our abilities to deliver services and achieve excellence in our work. As such the CCG will provide the leadership and resources to ensure that individuals and managers have the guidance, understanding and opportunity to maintain welfare, a safe working environment and to work safely.

The CCG has an approved Health and Safety Policy in place and the Accountable Officer is the Executive lead for Health and Safety within the CCG. The

implementation of our Health and Safety Policy is an individual and management responsibility and accountability is clear at every level. Health and Safety Management is part of our everyday approach to our work and its effectiveness is overseen by Remuneration Committee.

Expenditure on consultancy

Expenditure on consultancy is reported in the Annual Accounts note 5: Operating Expenses.

Off-payroll engagements

The CCG did not have any off-payroll engagements during the reporting period.

Staff numbers and costs subject to audit

Employee benefits 2018/19	Admin			Programme			Total		2018-19
	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	3,363	340	**3,704**	946	914	**1,860**	4,310	1,254	**5,564**
Social security costs	380	-	**380**	100	-	**100**	480	-	**480**
Employer contributions to the NHS Pension Scheme	462	-	**462**	130	-	**130**	592	-	**592**
Apprenticeship Levy	9	-	**9**	-	-	**-**	9	-	**9**
Gross employee benefits expenditure	**4,215**	**340**	**4,555**	**1,176**	**914**	**2,090**	**5,391**	**1,254**	**6,645**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**4,215**	**340**	**4,555**	**1,176**	**914**	**2,090**	**5,391**	**1,254**	**6,645**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**4,215**	**340**	**4,555**	**1,176**	**914**	**2,090**	**5,391**	**1,254**	**6,645**

Employee benefits 2017/18	Admin			Programme			Total		2017-18
	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	3,328	90	**3,418**	961	631	**1,592**	4,289	722	**5,010**
Social security costs	387	-	**387**	98	-	**98**	484	-	**484**
Employer contributions to the NHS Pension Scheme	465	-	**465**	106	-	**106**	571	-	**571**
Apprenticeship Levy	5	-	**5**	-	-	**-**	5	-	**5**
Gross employee benefits expenditure	**4,185**	**90**	**4,275**	**1,165**	**631**	**1,796**	**5,350**	**722**	**6,071**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**4,185**	**90**	**4,275**	**1,165**	**631**	**1,796**	**5,350**	**722**	**6,071**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**4,185**	**90**	**4,275**	**1,165**	**631**	**1,796**	**5,350**	**722**	**6,071**

Parliamentary Accountability and Audit Report

NHS Berkshire West CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at note 20. An audit certificate and report is also included in this Annual Report at Page 1 of the Annual Accounts.

ANNUAL ACCOUNTS

NHS Berkshire West CCG - Annual Accounts 2018-19
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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BERKSHIRE WEST CCG

Opinion

We have audited the financial statements of NHS Berkshire West CCG for the year ended 31 March 2019 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 20. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2018/19 HM Treasury's Financial Reporting Manual (the 2018/19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

In our opinion, the financial statements:

- give a true and fair view of the financial position of NHS Berkshire West CCG as at 31 March 2019 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the clinical commissioning group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

– the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Clinical Commissioning Group's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report set out on pages 1 to 71, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health and Social Care Act 2012

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

In respect of the following, we have matters to report by exception:

Referral to Secretary of State

We refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 15 May 2019 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to the CCG reporting a deficit position in its financial statements for 2018/19.

Proper arrangements to secure economy, efficiency and effectiveness

We report to you, if we are not satisfied that the CCG has put in place proper arrangements to secure economy efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

The CCG reported a deficit of £3 million in its financial statements for the year ending 31 March 2019, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget.

This issue is evidence of weaknesses in proper arrangements for planning finance effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion (Except for)

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, NHS Berkshire West CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 44 to 45, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the Clinical Commissioning Group'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 the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. 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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

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

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. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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 its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements
Qualified Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give reasonable assurance that 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.

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them, except for the £3 million expenditure in excess of statutory limits. We referred this matter to the Secretary of State on 15 May 2019 under section 30b of the Local Audit and Accountability Act 2014.

Certificate

We certify that we have completed the audit of the accounts of NHS Berkshire West CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Berkshire West CCG in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG 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 as a body, for our audit work, for this report, or for the opinions we have formed.

Maria Grindley (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Reading
23-May-19

The maintenance and integrity of the NHS Berkshire West CCG web site is the responsibility of the members; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(3,026)	(9,389)
Total operating income		**(3,026)**	**(9,389)**
Staff costs	4	6,645	6,071
Purchase of goods and services	5	664,827	647,654
Depreciation and impairment charges	5	36	408
Provision expense	5	(107)	121
Other Operating Expenditure	5	639	1,498
Total operating expenditure		**672,040**	**655,752**
Net Operating Expenditure		**669,014**	**646,363**
Net expenditure for the year		**669,014**	**646,363**
Total Net Expenditure for the Financial Year		**669,014**	**646,363**
Comprehensive Expenditure for the year		**669,014**	**646,363**

The CCG achieved a cumulative surplus of £9,480k against the revenue resource allocation (RRL) of £678,494k (including the cumulative surplus brought forward of £12.5m)
for 2018/19 and in 2017/18 achieved a surplus of £12,478k against an RRL of £658,841k
The CCG achieved an in year deficit of £2,997k (2017/18 surplus of £222k)
The notes on pages 7 to 29 form part of these accounts

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	8	91	67
Total non-current assets		**91**	**67**
Current assets:			
Inventories	9	2,540	987
Trade and other receivables	10	4,942	5,128
Cash and cash equivalents	11	28	49
Total current assets		**7,510**	**6,164**
Total current assets		**7,510**	**6,164**
Total assets		**7,601**	**6,231**
Current liabilities			
Trade and other payables	12	(39,231)	(35,192)
Provisions	13	(932)	(953)
Total current liabilities		**(40,163)**	**(36,145)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(32,562)**	**(29,914)**
Non-current liabilities			
Provisions	13	(394)	(630)
Total non-current liabilities		**(394)**	(630)
Assets less Liabilities		**(32,956)**	**(30,544)**
Financed by Taxpayers' Equity			
General fund		(32,956)	(30,544)
Total taxpayers' equity:		**(32,956)**	**(30,544)**

The notes on pages 7 to 26 form part of this statement

The financial statements on pages 5 to 6 were approved by the Audit Committee on behalf of the Governing Body on 23 May 2019 and signed on its behalf by:

Cathy Winfield
Chief Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	2018-19 £'000	2017-18 £'000
Changes in taxpayers' equity for 2018-19		
Balance at 01 April	(30,544)	(35,418)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(30,544)**	**(35,418)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19		
Net operating expenditure for the financial year	**(669,014)**	(646,363)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(669,014)**	**(646,363)**
Net funding	666,602	651,237
Balance at 31 March	**(32,956)**	**(30,544)**

The notes on pages 7 to 28 form part of this statement

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(669,014)	(646,363)
Depreciation and amortisation	5	36	408
Impairments and reversals	5		
(Increase)/decrease in inventories	9	(1,553)	(987)
(Increase)/decrease in trade & other receivables	10	186	4,116
(Increase)/decrease in other current assets			
Increase/(decrease) in trade & other payables	12	4,011	(6,919)
Increase/(decrease) in other current liabilities			
Provisions utilised	13	(151)	(285)
Increase/(decrease) in provisions	13	(106)	121
Net Cash Inflow (Outflow) from Operating Activities		**(666,592)**	(649,909)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(31)	(38)
Net Cash Inflow (Outflow) from Investing Activities		**(31)**	(38)
Net Cash Inflow (Outflow) before Financing		**(666,623)**	(649,947)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		666,602	651,237
Net Cash Inflow (Outflow) from Financing Activities		**666,602**	651,237
Net Increase (Decrease) in Cash & Cash Equivalents	11	**(21)**	1,290
Cash & Cash Equivalents at the Beginning of the Financial Year		**49**	(1,241)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**28**	**49**

The notes on pages 7 to 26 form part of this statement

Notes to the financial statements

1.0 Accounting Policies

NHS England has directed that the financial statements of CCGs 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 2018-19 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 CCGs, 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis
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.

1.2 Accounting Convention

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

1.3 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the Clinical Commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget arrangement.
If the Clinical Commissioning Group is in a "jointly controlled operation", the Clinical Commissioning Group recognises:
- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,
- The Clinical Commissioning Group's share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a "jointly controlled assets" arrangement, in addition to the above, the Clinical Commissioning Group recognises;

- The Clinical Commissioning Group's share of any liabilities incurred jointly; and,
- The Clinical Commissioning Group's share of the expenses jointly incurred.

The CCG has entered into a number of pooled budget arrangements with Local Authorities including Wokingham Borough Council, Reading Borough Council and West Berkshire District Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Community Equipment Store and the Better Care Fund and note 16 to the accounts provides details of the income and expenditure.

The community equipment pool is hosted by the Local Authority. The CCG 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 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 adoption 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 CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The CCG 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 CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

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. Payment terms are standard reflecting cross government principles.

1.5 Employee Benefits

1.5.1 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.

1.5.2 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 though they were defined contribution schemes: the cost to the CCG of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Notes to the financial statements

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

Some employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. The interest earned during the year from scheme assets is recognised within finance income. Re-measurements of the defined benefit plan are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive [income / net expenditure].

1.6 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, Plant & Equipment

1.7.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,

Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

1.7.2 Measurement

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

1.7.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.7.4 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the CCG checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

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. The CCG does not hold finance leases and disclosures in the financial statements pertain to operating leases.

1.8.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value, using the *first-in first-out* cost formula.

1.10 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Notes to the financial statements

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.11 Provisions

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG 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:

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. 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 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) 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% (2017-18: negative 1.56% in real terms) 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% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.12 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the CCG 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.

1.13 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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.

1.14 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG 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.

1.15 Value Added Tax

Most of the activities of the CCG 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 Foreign Currencies

The CCG's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the CCG's surplus/deficit in the period in which they arise.

1.17 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 CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.18 Critical accounting judgements

In the application of the CCG'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.

1.19 Key sources of estimation uncertainty

Notes to the financial statements

The following are the key estimations that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the Financial Statements:

Partially completed spells

Expenditure relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. The CCG use figures as agreed with local Providers.

Maternity pathways

Expenditure relating to all antenatal maternity care is made at the start of the pathway. As a result, at the year-end part completed pathways are treated as a prepayment. The CCG use figures as agreed with local Providers.

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.

Prescribing liabilities

NHS England actions monthly cash charges to the CCG for prescribing contracts. These are issued approximately 8 weeks in arrears. The CCG use information provided by the NHS Business Authority as part of the estimate for full year expenditure.

Continuing Care Provisions

NHS Continuing Health Care (CHC) provision relates to amounts set aside for CHC Waiting List clients awaiting assessment at 31 March 2019, CHC appeals and a Responsible Commissioner dispute with another CCG. 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 Waiting List clients' claims has been calculated using average local current nursing home and homecare package weekly costs for NHS CHC Adult Fully Funded clients multiplied by the number of days on the waiting list since the date of application until 31st March 2019. Provision has been made at 54% as per recent average approvals rate for first-time applications for CHC funding.

The 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 31st March 2019 (or RIP date) and either the actual weekly cost where known or the current average local nursing home and homecare package weekly costs. Provision has been made at 20% as per the current financial year's appeal success rate.

The Responsible Commissioner dispute provision has been estimated as a worst case based on an invoice received for retrospective costs. The CCG and its legal advisers are currently negotiating an appropriate settlement amount.

1.20 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

● 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.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Other Operating Income

	2018-19 Total	2018-19 Admin	2018-19 Programme	2017-18 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	**1**	**1**	**-**	-
Non-patient care services to other bodies	**277**	**5**	**272**	1,741
Prescription fees and charges	**392**	**-**	**392**	385
Other Contract income	**2,356**	**640**	**1,716**	7,263
Total Income from sale of goods and services	**3,026**	**646**	**2,380**	**9,389**
Total Operating Income	**3,026**	**646**	**2,380**	**9,389**

Admin other operating income is income received that is not directly attributable to the provision of healthcare or healthcare services.

The CCG received £4,865k income from NHSE in 17/18 for Estates and Technology Transformation Funding (ETTF) £955k and Identification Rules £3,910k, these amounts are included in 17/18 Other Contract income on gross accounting basis.

In 18/19 the CCG received £790k ETTF income which has been net accounted and is included on note 5 Services from other CCGs and NHS England. The reduction in income received from NHSE and the difference in accounting treatment are the main reasons for the material reduction in income compared to 17/18.

Income in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3.1 Disaggregation of Income - Income from sale of services (contracts)

Income is generated wholly from the supply of services. The CCG receives no income from the sale of goods.

Source of Revenue	Education, training and research	2018-19 Non-patient care services to other bodies	Prescription fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
NHS	1	215	-	1,604
Non NHS	-	62	392	752
Total	**1**	**277**	**392**	**2,356**
Timing of Revenue				
Point in time	-	-	-	-
Over time	1	277	392	2,356
Total	**1**	**277**	**392**	**2,356**

Source of Revenue	Education, training and research	2017-18 Non-patient care services to other bodies	Prescription fees and charges	Other Contract income
	£'000	£'000	£'000	£'000
NHS	-	1,175	-	6,098
Non NHS	-	566	385	1,165
Total	**-**	**1,741**	**385**	**7,263**
Timing of Revenue				
Point in time	-	-	-	-
Over time	-	1,741	385	7,263
Total	**-**	**1,741**	**385**	**7,263**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2018-19

	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**4,310**	**1,254**	**5,564**
Social security costs	**480**	**-**	**480**
Employer Contributions to NHS Pension scheme	**592**	**-**	**592**
Apprenticeship Levy	**9**	**-**	**9**
Gross employee benefits expenditure	**5,391**	**1,254**	**6,645**

The increase in other staff costs is due to full year costs of senior staff paid through agency, increase in agency staff and recharge of CFO costs seconded to NHSE in 17/18.

4.1.1 Employee benefits

2017-18

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,289	722	**5,011**
Social security costs	484	-	**484**
Employer Contributions to NHS Pension scheme	571	-	**571**
Apprenticeship Levy	5	-	**5**
Gross employee benefits expenditure	**5,349**	**722**	**6,071**

	2018-19			2017-18		
4.2 Average number of people employed	**Permanently employed Number**	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**89**	**13**	**102**	87	10	97

4. Employee benefits and Staff numbers (continued)

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

4.3.1 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, 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.

4.3.2 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. The Department of health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2018-19, employers' contributions of £636,097 were payable to the NHS Pensions Scheme (2017-18: £628,283) at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2016 and was published on the Government website on 9 June 2016. These costs are included in the NHS pension line of note 4.1.

5. Operating expenses

	2018-19 Total £'000	2018-19 Admin £'000	2018-19 Programme £'000	2017-18 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	**6,645**	**4,555**	**2,090**	**6,071**
Purchase of goods and services				
Services from other CCGs and NHS England	7,861	3,734	4,127	7,128
Services from foundation trusts	432,792	-	432,792	423,098
Services from other NHS trusts	3,534	-	3,534	3,490
Services from Other WGA bodies	6	-	6	9
Purchase of healthcare from non-NHS bodies	78,447	-	78,447	74,559
Purchase of social care	1,828	-	1,828	1,728
Prescribing costs	65,049	-	65,049	63,992
GPMS/APMS and PMS	69,154	-	69,154	66,361
Supplies and services – clinical	455	-	455	464
Supplies and services – general	1,223	627	596	1,592
Consultancy services	138	76	62	250
Establishment	1,297	195	1,102	2,147
Transport	2	0	2	6
Premises	1,811	404	1,407	1,800
Audit fees	106	106	-	116
Other non statutory audit expenditure				
· Internal audit services	63	63	-	65
· Other services	18	18	-	51
Other professional fees	797	687	110	517
Legal fees	146	35	111	182
Education, training and conferences	100	53	47	100
Total Purchase of goods and services	**664,827**	**5,998**	**658,829**	**647,655**
Depreciation and impairment charges				
Depreciation	35	-	35	408
Total Depreciation and impairment charges	**35**	**-**	**35**	**408**
Provision expense				
Change in discount rate	-	-	-	-
Provisions	(107)	20	(127)	121
Total Provision expense	**(107)**	**20**	**(127)**	**121**
Other Operating Expenditure				
Chair and Non Executive Members	451	428	23	1,090
Grants to Other bodies	187	-	187	472
Expected credit loss on receivables	-	-	-	28
Other expenditure	2	0	2	(92)
Total Other Operating Expenditure	**640**	**428**	**212**	**1,498**
Total other costs	**665,395**	**6,446**	**658,949**	**649,682**
Total Operating Expenses	**672,040**	**11,001**	**661,039**	**655,753**

The CCG has a contract for the supply of external audit services with Ernst and Young LLP (the Supplier), which covers the period 1 April 2017 to 31 March 2020. The contract includes limitation of liability of £2m in respect of the following:
- The work undertaken by the Supplier is for the sole use of the CCGs in Berkshire West
- If the Supplier becomes liable to the CCG or any other customer to which services are provided, for loss or damage to which other persons have contributed, liability shall be several and not joint with others and shall be limited to its fair share of that total loss or damage based on its contribution to the loss or damage relative to the others' contributions.
- The CCG shall make any claim or bring any proceedings only against the Supplier

6.1 Better Payment Practice Code

Measure of compliance	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	16,720	84,692	17,345	78,815
Total Non-NHS Trade Invoices paid within target	16,185	82,320	15,913	74,704
Percentage of Non-NHS Trade invoices paid within target	**96.8%**	**97.2%**	91.7%	94.8%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,083	439,883	7,702	445,659
Total NHS Trade Invoices Paid within target	3,970	438,071	7,382	443,668
Percentage of NHS Trade Invoices paid within target	**97.2%**	**99.6%**	95.8%	99.6%

7. Operating Leases

Payments recognised as an Expense	Buildings £'000	Other £'000	2018-19 Total £'000	Buildings £'000	Other £'000	2017-18 Total £'000
Payments recognised as an expense						
Minimum lease payments	1,733	6	**6**	1,741	6	1,747
Total	**1,733**	**6**	**6**	1,741	6	1,747

Whilst our arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only. The amounts included are the CCG charges made by NHS Property services for administrative property, void space in clinical estate and any historic subsidisation of provider organisation occupancy of NHSPS owned clinical estate.

8 Property, plant and equipment

2018-19	Information technology £'000
Cost or valuation at 01 April 2018	1,270
Additions purchased	60
Cost/Valuation at 31 March 2019	**1,330**
Depreciation 01 April 2018	1,204
Charged during the year	35
Depreciation at 31 March 2019	**1,239**
Net Book Value at 31 March 2019	**91**
Purchased	91
Total at 31 March 2019	**91**
Asset financing:	
Owned	91
Total at 31 March 2019	**91**

2017-18	Information technology £'000
Cost or valuation at 01 April 2017	1,225
Additions purchased	46
Cost/Valuation at 31 March 2018	**1,271**
Depreciation 01 April 2017	796
Charged during the year	408
Depreciation at 31 March 2018	**1,204**
Net Book Value at 31 March 2018	**67**
Purchased	67
Total at 31 March 2018	**67**
Asset financing:	
Owned	67
Total at 31 March 2019	**67**

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	2	3

9 Inventories

Loan Equipment - (Community Equipment)	2018-19 £'000	Total £'000
Balance at 01 April 2018	987	**987**
Additions	1,959	**1,959**
Write-down of inventories (including losses)	(406)	**(406)**
Balance at 31 March 2019	**2,540**	**2,540**

The CCG purchases home equipment for patients in the community under pooled budget arrangements with West Berkshire District Council and the CCG share joint Control of this equipment as specified in the s75 pooled budget arrangements.

The additions and write-down of community equipment at 31st March 2019 has resulted in a net increase of £1,553k as illustrated on the following table:

Total Value of Equipment in the Community

	31-Mar-18 £'000	Increase £'000	31-Mar-19 £'000
Bedroom	247	275	**522**
Tissue Viability	740	793	**1,533**
Specials (Bedroom)	Not valued	485	**485**
Total	987	**1,553**	**2,540**

10 Trade and other receivables

10.1 Trade and other receivables

	Current 2018-19 £'000	Current 2017-18 £'000
NHS receivables: Revenue	1,198	1,073
NHS prepayments	1,788	2,412
NHS accrued income	260	402
NHS Contract Receivable not yet invoiced/non-invoice	50	-
NHS Non Contract trade receivable (i.e pass through funding)	849	-
Non-NHS and Other WGA receivables: Revenue	262	503
Non-NHS and Other WGA prepayments	335	172
Non-NHS and Other WGA accrued income	66	437
Expected credit loss allowance-receivables	(10)	(10)
VAT	144	139
Total Trade & other receivables	**4,942**	**5,128**

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

The reduction in receivables is mainy due to £606k write off of historic cumulative 50% share of the CCG overseas visitors with RBH which has previously been recognised against the NHS prepayments.

NHS Non Contract trade receivables (i.e pass through funding) is a new classification for 18/19 and £849k outstanding at 31 March 2019 is due from NHSE.

10.2 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	904	179	956	453
By three to six months	-	15	-	37
By more than six months	94	-	-	-
Total	**998**	**194**	**956**	**490**

10.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018

The application of IFRS 9 had no impact on the CCG financial assets opening balances.

10.4 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - external £000s	Total £000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018		
Financial Assets held at Amortised cost (ie the 1718 Closing Provision)	(10)	**(10)**
Financial assets held at FVOCI	-	**-**
Total at 31st March 2018	**(10)**	**(10)**
Loss allowance under IFRS 9 as at 1st April 2018		
Financial Assets measured at amortised cost	(10)	**(10)**
Financial Assets measured at FVOCI	-	**-**
Total at 1st April 2019	**(10)**	**(10)**
Change in loss allowance arising from application of IFRS 9	**-**	**-**

11 Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	49	(1,241)
Net change in year	(21)	1,290
Balance at 31 March 2019	**28**	49
Made up of:		
Cash with the Government Banking Service	28	49
Cash and cash equivalents as in statement of financial positi	**28**	**49**
Balance at 31 March 2019	**28**	**49**

12 Trade and other payables

	Current 2018-19 £'000	Current 2017-18 £'000
NHS payables: Revenue	3,594	3,244
NHS accruals	4,633	4,370
Non-NHS and Other WGA payables: Revenue	14,724	12,988
Non-NHS and Other WGA payables: Capital	37	8
Non-NHS and Other WGA accruals	5,719	3,630
Social security costs	73	76
Tax	70	74
Other payables and accruals	10,381	10,802
Total Trade & Other Payables	**39,231**	**35,192**

Other payables include £96,844 outstanding pension contributions at 31 March 2019

12.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018
The application of IFRS 9 had no impact on the CCG financial liabilities opening balances.

13 Provisions

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
Continuing care	906	394	947	630
Other	26	-	6	-
Total	**932**	**394**	**953**	**630**
Total current and non-current	**1,326**		**1,583**	

	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2018	**1,577**	**6**	**1,583**
Arising during the year	1,056	20	**1,076**
Utilised during the year	(151)	-	**(151)**
Reversed unused	(1,182)	-	**(1,182)**
Balance at 31 March 2019	**1,300**	**26**	**1,326**
Expected timing of cash flows:			
Within one year	906	26	**932**
Between one and five years	394	-	**394**
After five years	-	-	**-**
Balance at 31 March 2019	**1,300**	**26**	**1,326**

Continuing Care Provision relates to amounts set aside for Continuing Care Waiting List clients awaiting assessment at 31 March 2019 and CHC appeals arising within the last four financial years.

NHS Continuing Health Care (CHC) provision totalling £1.300m at 31st March 2019 relates to amounts set aside for the following items:

	2018-19 £'000	2017-18 £'000
· NHS Continuing Health Care (CHC) Waiting List clients awaiting assessment at 31 March 2019	318	108
· CHC appeals	576	650
· Responsible Commissioner dispute with another CCG (negotiation of final settlement amount and legal fees following adjudication by NHS England)	406	819
	1,300	**1,577**

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 establishment of the Clinical Commissioning Group (PUPoC claims). However, the legal liability and the responsibility for processing and assessing the claims remains with the CCG. The total value of contingent liabilities accounted for by NHS England on behalf of this CCG at 31 March 2019 is £180k.

However, the legal liability and the responsibility for processing and assessing the claims remains with the CCG.

£Nil is included in the provisions of the NHS Litigaton Authority as at 31 March 2019 in respect of clinical negligence liabilities of the Clinical Commissioning Group (£Nil 2017/18).

14 Financial instruments

14.1 Financial risk management

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

Because NHS 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.

14.1.1 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.

14.1.2 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.

14.1.3 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.

14.1.4 Liquidity risk

The 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.

14.2 Financial assets

	Financial Assets measured at amortised cost	
	2018-19 £'000	2017-18 £'000
Trade and other receivables with NHSE bodies	600	282
Trade and other receivables with other DHSC group bodies	1,796	1,192
Trade and other receivables with external bodies	287	941
Cash and cash equivalents	28	49
Total at 31 March 2019	**2,712**	**2,463**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2018-19 £'000	2017-18 £'000
Trade and other payables with NHSE bodies	1,537	1,479
Trade and other payables with other DHSC group bodies	11,324	6,134
Trade and other payables with external bodies	15,846	16,628
Other financial liabilities	10,382	10,803
Total at 31 March 2019	**39,088**	**35,043**

15 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in CCG's books ONLY		Amounts recognised in CCG's books ONLY	
			2018-19		2017-18	
			Income	Expenditure	Income	Expenditure
			£'000	£'000	£'000	£'000
Community Equipment Stores	Pooled Budget with West Berkshire Council (consortium lead), Reading Borough Council, Wokingham Borough Council, Bracknell Forest Borough Council, Slough Borough Council, Royal Borough of Windsor and Maidenhead, NHS East Berkshire CCG, Royal Berkshire Fire and Rescue Service and Berkshire West CCG.	West Berkshire Council acts as the consortium lead hosting the contract with NRS Healthcare Ltd to provide community equipment (also known as home loans) for Berkshire residents and patients. The equipment items are prescribed by social services, health and fire professionals from the partner organisations. The provision of this community equipment is intended to facilitate timely discharges of patients from hospital to home, prevent unnecessary hospital admissions, and promote health and independence in enabling people to continue living safely in their own homes.	**3380**	**3380**	2708	2708
Better Care Fund	Pooled Budget with Wokingham Borough Council and Berkshire West CCG	Short term integrated health and social care, Step up beds at Wokingham Hospital, Community health and social care, Preventative services and Protection of adult social care	**4187**	**4128**	4121	4121
Better Care Fund	Pooled Budget with Bershire West CCG and Wokingham Borough Council	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	**3738**	**3768**	3656	3638
Better Care Fund	Pooled Budget with West Berkshire Council and Berkshire West CCG	Step down beds in West Berkshire Care Home, adult social care, 7 day week service, protecting social care services and delayed transfer of care projects	**5262**	**5262**	5080	5080
Better Care Fund	Pooled Budget with Berkshire West CCG & West Berkshire Council	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	**3878**	**3898**	3885	3930
Better Care Fund	Pooled Budget with Reading Borough Council and Berkshire West CCG	Protection of social care, time to decide beds, Care Act costs, carers funding and delayed transfer of care projects	**5345**	**5144**	5254	5254
Better Care Fund	Pooled Budget with Berkshire West CCG & Reading Borough Council	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	**4298**	**4344**	4210	4295

16 Events after the end of the reporting period.

The CCG has not identified any reportable events after the end of the reporting period.

17 Related party transactions

Details of related party transactions with individuals are as follows:

Member	Related Party	2018-19				2017-18
		Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party	Net Payments to Related Party
		£'000	£'000	£'000	£'000	£'000
Dr Abid Irfan -CCG Chair and GP Locality Lead (ND)	GP Partner - Strawberry Hill Medical Centre (SHMC), Newbury	2,929	0	0	0	2,813
	SHMC Shareholder - Newbury GP Alliance	369	0	0	0	0
Dr Debbie Milligan -Chair. Council of Members , Governing Body GP Member	Salaried Doctor - Loddon Vale Practice (Woodley Centre Surgery) - left part year	1,925	0	0	0	1,785
	Salaried Doctor - Swallowfield Medical Practice - started part year	2,164	0	0	0	0
	GP - Westcall Out of Hours (BHFT)	113,632	0	9,874	0	0
Geoffrey Braham -Lay Member, Governance	Governor - Oxford Health NHS Foundation Trust	113	0	129	0	0
Saby Chetcuti-Lay Member Governance	Governor - South Central Ambulance Service (CCGs North)	21,648	1	50	0	20,950
Wendy Bower-Lay Member for Patients and Public Engagement	Governor for CCG - Royal Berkshire NHS Foundation Trust	251,719	0	756	0	250,243
	Daughter works for - Royal Berkshire NHS Foundation Trust	251,719	0	756	0	250,243
Dr Andy Ciecierski-GP Locality Lead (NWR)	GP Partner - Emmer Green Surgery	1,266	0	0	0	1,126
	GP with special interest in ENT - Emmer Green Surgery	1,266	0	0	0	1126
Kajal Patel-GP Locality Lead (SR)	GP - Dr Mittal & Partners (Milman Road Surgery)	1,935	0	1	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. All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. From 1 April 2016, the CCG had delegated commissioning responsibility for primary care GP services. This means that the CCG now makes all payments due to practices based on the Statement of Financial Entitlement and the Premises Direction and this has resulted In a significant increase in the amounts recorded against practice based Governing Body members. Material transactions are disclosed appropriately in the accounts.

The amounts in the table above represent the amounts paid to organisations named rather than the individual. Where an organisation

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:

- Clinical Commissioning Groups
- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

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 Local Authority in respect of joint commissioning arrangements.

18 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:

	2018-19			2017-18		
	Target	**Performance**	**Target Achieved?**	Target	Performance	Target Achieved?
Expenditure not to exceed income	669,043	672,040	No	662,038	661,758	Yes
Capital resource use does not exceed the amount specified in Directions	60	60	Yes	60	46	Yes
Revenue resource use does not exceed the amount specified in Directions	655,162	658,660	No	646,643	646,364	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-	
Revenue administration resource use does not exceed the amount specified in Directions	10,855	10,354	Yes	10,794	10,554	Yes

19 Effect of application of IFRS 15 on current year closing balances

The application of IFRS 15 had no impact on the CCG current year closing balances.

20. 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 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	-	-	5	28
Total	**-**	**-**	**5**	**28**

The CCG 18/19, 50% share of uncollectable risk sharing arrangement with Royal Berkshire NHS Foundation Trust for Overseas Vistors outside European Economic Area has been charged against services from Foundation Trust line on note 5.

20.1 Special payments

	Total Number of Cases 2018-19 Number	**Total Value of Cases 2018-19 £'000**	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Compensation payments	2	1	-	-
Total	**2**	**1**	**-**	**-**