NHS
Buckinghamshire
Clinical Commissioning Group

Buckinghamshire Clinical Commissioning Group Annual Report 2021/22

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Foreword from the Clinical Chair

It is my privilege to introduce the fourth, and in all likelihood, the final annual report for NHS Buckinghamshire Clinical Commissioning Group (BCCG), for the year 2021/22.

The headline story for the year has once again been the COVID-19 pandemic and its impact on our communities, our front-line services and the people of Buckinghamshire.
As in each of the last 2 years, I would like to start by acknowledging the resilience and stamina of our keyworkers in health and social care. The pandemic has proved to be much more of a marathon than a sprint and thousands of individuals continue to rise to the challenges it still presents.

The contribution of the vaccination programme, delivered in a variety of settings has been a key element in the country's response to Covid-19.
Our overall vaccination rates in Buckinghamshire have been superb for each wave of the programme receiving national attention. It was especially heartening to see the excellent rates of vaccination in some key communities and clinical population groups who might otherwise have been at significant risk from Covid-19 infection. This was made possible by close working between clinicians, managers and the patient and population groups we seek to serve.

Particular recognition and thanks go to our member GP practices who led our vaccination response, whilst simultaneously meeting the important and significant primary care needs of our population. This was a remarkable achievement supported by an army of volunteers, allied health-care professionals and retired individuals returning to clinical practice. The response of community pharmacists as part of the vaccination programme should also be applauded. On behalf of the CCG, I would like to say thank-you to you all.

Once again, I am grateful to our CCG staff who have worked tirelessly and flexibly to ensure that the services available have met the needs of our residents in Buckinghamshire. I am also grateful to our 48 GP practices and 12 Primary Care Networks (PCNs) that constitute the membership of our organisation for their continued support and forbearance.

We continue our journey towards greater integration as signalled in the Government White Paper (Integration and Innovation: working together to improve health and social care for all) published in February 2021. We are working ever closer with our colleagues in Berkshire West and Oxfordshire CCGs and as part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

I hope that you find the annual report that follows informative, and I wish you all well for the year ahead which I hope will reflect a return to a more normal life for us all.

Dr Raj Bajwa, Clinical Chair, NHS Buckinghamshire CCG

Performance Report

'Everyone working together so that the people of Buckinghamshire have happy and healthier lives'

NHS Buckinghamshire Clinical Commissioning Group (BCCG) is the statutory organisation in Buckinghamshire that plans, buys and oversees health services for more than 578,000 people from a range of NHS, voluntary, community and private sector providers.

BCCG is part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) which covers a population of 1.8 million across the three Clinical Commissioning Groups (CCGs), six NHS Trusts, 14 local authorities and 166 GP practices, working together as 45 Primary Care Networks. Integrated Care Systems aim to bring the NHS together with Local Authorities to further the integration of health and care; improve the health of local populations; transform the quality of care provided and ensure they are sustainable within the allocated funding.

BCCG is a member organisation of 48 GP practices in Buckinghamshire; we work with local people, voluntary sector organisations and partners including Buckinghamshire Council, GPs and Primary Care Networks & GP Federation (FedBucks), Buckinghamshire Healthcare NHS Trust (BHT), Oxford Health NHS Foundation Trust (Oxford Health) and South Central Ambulance NHS Foundation Trust (SCAS).

What we do and who we work with

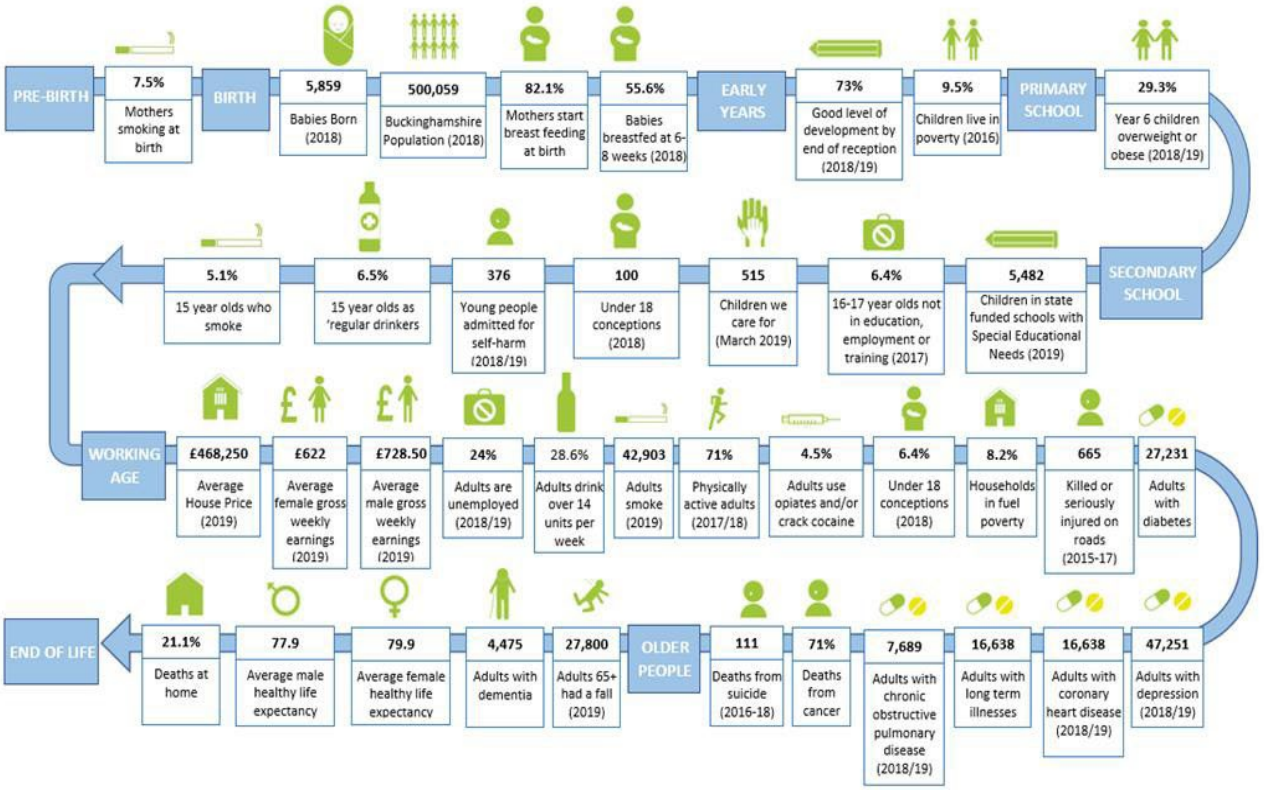
BCCG is responsible for commissioning non-specialist hospital services, both urgent and planned care. As well as commissioning GP services, mental health and learning disability services, ambulance services and community services such as district nursing and physiotherapy. Specialist hospital services, dentistry, pharmacy and optician services are commissioned by NHS England (NHSE). Public Health services are provided by the Local Authority Buckinghamshire Council (BC) and includes drug and alcohol, sexual health, health visiting and health promotion services.

In Buckinghamshire, the Health and Wellbeing Board (H&WB) is responsible for improving the health and wellbeing of the people of the county. The H&WB is a partnership between Local Government, the NHS and the people of Buckinghamshire; Board members include local GPs, Councillors, Healthwatch Buckinghamshire and officers from the NHS and Local Government.

BCCG has a duty to improve the quality of services commissioned; reduce health inequalities; involve the public and patients in commissioning decisions and deliver a Health and Wellbeing Strategy. This Annual Report describes how BCCG carries out its duties.

The joint Health and Wellbeing Strategy (2021 – 2024) – a shared plan for Buckinghamshire was refreshed during 2020/21 and approved by the Health and Wellbeing Board in February 2021. This set out 3 key priorities – Start Well, Live Well and Age Well. It aims to improve the health and wellbeing of local people and reduce health inequalities across the county. This strategy has guided the work of BCCG over the last year alongside our local implementation of the NHS Long Term Plan. The H&WB has also produced its annual report for 2020/21. This report summarises the work of the Buckinghamshire Health and Wellbeing Board over the last year. It provides an overview of some of the work which the Board has been involved in to address its priority areas, meet its statutory requirements, develop its new strategy and direction, and respond to the COVID-19 outbreak. Through all these areas of work, the Health and Wellbeing Board has aimed to use partnership working to improve the health and wellbeing of our residents.

Buckinghamshire's Population



The information above is from the Director of Public Health Annual report for Buckinghamshire Council 2021 which provides information about the county's population and the factors affecting health, wellbeing, and social care needs. It brings together information from different sources to create a shared evidence base. This informs BCCG's strategy and supports its service planning and decision-making. To read more about the health needs of Buckinghamshire's population visit the Buckinghamshire Council website

Overview from Dr James Kent, Accountable Officer

Another extraordinary year in our lives has passed, dominated again by the COVID-19 pandemic.

My condolences to those who have lost loved ones; in the NHS we share in the sadness of those who have suffered a loss, have been seriously ill as a result of the virus or are still suffering from its effects. Many other people have had planned operations and treatments postponed due to the disruption of 'business as usual' services and I share their frustration and disappointment at these delays.

There are also actions through the pandemic we can celebrate. All our partners and colleagues worked far more flexibly to adjust to the demands of COVID and so many came together to successfully deliver the biggest ever vaccination programme in the history of this country. As a result, we are now collectively looking towards the future which will include the resumption of both normal and 'new normal' life and work compared to the challenges of the last two years.

This year, 2021/22, has been remarkable for the success of the vaccination roll-out which has seen 3.7 million jabs delivered across BOB ICS with more people vaccinated than any other vaccination programme. Huge thanks go to the thousands of people across the NHS, local authorities and volunteers who contributed to this success.

We began vaccinating our local population in December 2020 – starting with NHS and care staff, residents of care homes, everyone aged over 70 and people who were clinically extremely vulnerable and by 15 February 2021, everyone in these four top priority groups had been offered

a vaccine. More than a year later, at the end of March 2022, we were offering vaccinations to all 5 -11-year-olds, and a second 'booster' jab to those aged 75.

An outreach and engagement plan - *No one left behind* – was devised across BOB ICS to ensure the vaccine campaign is now targeted at those populations, to increase uptake in areas of deprivation and among groups at increased risk of illness and death from COVID-19 infection. This careful and painstaking work will inform how and where it is best to make approaches and break down the barriers of vaccine hesitancy and address concerns that individuals or communities may have.

As I write we still have over 100 patients in our acute hospitals with COVID, not insignificant but much lower than our peak level of 790 in the second wave. More importantly, the number of patients needing mechanical ventilation across our system has been in single digits for many months, such a different picture to our wave 2 peak of 260 patients needing intensive care. A clear impact of the vaccination programme.

Given the on-going response to the COVID-19 pandemic the past year has seen all NHS organisations and services operating, for the most part, in an emergency preparedness, resilience and response level 4 incident which means that NHS England has coordinated the NHS response nationally in collaboration with local commissioners at the tactical level, as such many decisions and actions were driven nationally.

During the height of the pandemic, health and social care organisations made rapid changes to how services operated, the infection, prevention and control measures that were in place, and other adjustments made to ensure all patients with COVID needing hospital treatment could be treated. Many primary care and hospital outpatient appointments moved to telephone and online consultations.

As the vaccination programme rolled out and the number of patients requiring treatment for COVID reduced, we turned to the task of recovering services and dealing with the inevitable backlogs. This report will show the challenges facing the NHS as we try to reduce waiting times for elective / planned care, develop better ways of working collaboratively to support urgent and emergency care across the three counties of Buckinghamshire, Oxfordshire and Berkshire West; develop services to support the health and wellbeing of our younger population; ensure the timely diagnosis and start of treatment of people with cancer and further develop our primary care services.

Over the past year work has progressed in developing the integrated care system across BOB. Working together in a more integrated way across the NHS, local authorities and with our voluntary sector we want to ensure we deliver joined up health and care services based on the needs of individual and shaped by the circumstances and priorities of local communities. Alongside this we have been planning for the transfer of statutory commissioning functions and staff from the CCGs to the new Integrated Care Board across Buckinghamshire, Oxfordshire and Berkshire West which will happen on 1st July 2022

I also want to extend my gratitude to colleagues within all three CCGs; many have continued to work in different ways, in different roles, and many also volunteered to support front line care or the vaccination programme. None of this was easy when both the pandemic and organisational change has made for an unsettling period. Thank you to everyone.

As we move into 2022/23 and toward a new organisation and Integrated Care System, I am encouraged to see colleagues rise to the challenge; this stands us in good stead for the future as we move forward the work of clinical commissioning groups into the single organisation of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board that will develop and lead system working for the benefits of our population.

Summary of Performance

This section of the report outlines the achievements and performance of BCCG during 2021-22 and how performance is delivered throughout the wide range of services commissioned.

The CCG works collaboratively with the local health economy providers, in particular BHT (Acute and Community), OHFT (Mental Health), and SCAS (999, 111, patient transport) to deliver timely and robust healthcare services.

Regular meetings provide a forum for monitoring and gaining assurance against performance targets. However, where performance is not achieved, remedial actions plans are implemented to recover performance to the extent necessary. The analysis of performance allows the CCG to compare the actual performance achieved against the targets or specification against which it is commissioned from the providers in order to maintain high quality, cost efficient services.

Improving the health and wellbeing of people in Buckinghamshire

The H&WB is a partnership between local government, the NHS and the people of Buckinghamshire. It includes local GPs, councillors, Healthwatch Buckinghamshire and senior local government officers. The Board ensures that organisations across health and care work together to improve everyone's health and wellbeing, especially those who have health problems or are in difficult circumstances.

The Board provides strategic leadership for health and wellbeing across the county and will ensure that plans are in place and action is taken to realise those plans.
While a considerable amount of work has been undertaken to deliver the Health and Wellbeing Strategy much of the NHS resources have been focused on our response to the COVID-19 pandemic.

Buckinghamshire, Oxfordshire and Berkshire West ICS response to the COVID-19 pandemic and delivery of the COVID-19 Vaccination Programme

In response to the pandemic, NHS England & Improvement was given legal directions over all CCG commissioning functions by the Government to direct health services to meet the emergency needs. Each system established an incident structure reporting to NHSE/I SE Region.

During the pandemic, health and social care organisations across the BOB ICS made rapid changes to how services operated, the infection, prevention and control measures that were in place, and other adjustments made to ensure all patients with COVID needing hospital treatment could be treated. Much of primary care and outpatients moved online with face-to-face contacts restricted to clinical necessity to reduce the risk of spreading the infection.

Changes also included telephone triage so patients were provided with advice, care and prescribed treatment without needing to visit their GP practice. For patients with the relevant technology, hospital appointments were available using video conferencing. New services were also brought online quickly to support people throughout the pandemic such as the 24/7 mental health line across Buckinghamshire and Oxfordshire; GPs worked to set up dedicated clinics for patients with suspected COVID-19 to manage the risk of transmission to patients needing non-COVID related care.

In the summer and early autumn of 2020 as the first wave of COVID-19 receded, all services began to look forward to recovery of services which had been paused by the pandemic and preparations started for the delivery of a UK-wide vaccination programme.

The planning and establishment of the COVID vaccination programme and the siting of vaccination centres across the BOB ICS was initially done at pace, in line with national policy, with the first centres across BOB going live in December 2020. The work has been overseen by the BOB Vaccination Programme Operational Executive, whose members include representatives from the NHS and local authorities across BOB.

The NHS across the BOB ICS achieved its target of offering a first dose of the vaccine to all nine priority groups (as directed by the Joint Committee on Vaccination and Immunisation) by 15 April 2021. All first doses for adults aged 18 were offered by July 2021 and second doses by the end of September / early October 2021. It was a huge logistical challenge being delivered at the same time as managing the increased pressures on health and care services caused by the pandemic. Now, around 3.7 million jabs have been delivered across the BOB ICS population of 1.8 million people.

There is now a network of vaccination centres and services across BOB, comprising Primary Care Networks (GP-led services), pharmacies, large vaccination centres, hospital sites, pop-up clinics, a mobile service (Health on the Move), and a schools' programme for children aged 12 and over. As a result of hard work and commitment from GP practices working together with health services partners and an army of volunteers, the BOB ICS has consistently been among the highest performers across England in terms of vaccination uptake and outreach.

The vaccination clinics and services continue to be geographically spread across the BOB ICS area to provide equitable access. Consideration has been given to location, travel, parking and the ability to safely deliver the vaccine and meet and manage the needs of large numbers of people across all the cohorts.

In December 2021, as the Omicron variant began to emerge and spread, health and care systems across the country were required to significantly accelerate the vaccination programme by offering booster jabs to everyone over the age of 18 before 31 December 2021. The Government's target required the BOB ICS to offer 533,000 boosters to all the eligible cohorts of people during a period of three weeks.

Many GP-led vaccinations sites had wound down their vaccination clinics as the 166 GP practices across the BOB ICS focused on 'business as usual' services for their patients, but they answered the call to support the rapid expansion of the booster programme. The need to make boosters available at speed required a lot of staff time and resources, so GP practices were asked to clinically prioritise services. This led to some routine appointments and services being postponed. However, patients were assured that clinically urgent services were open and urgent appointments went ahead as planned.

The BOB Vaccine Equality Group was established to promote the vaccine, ensure equity of access to the vaccination programme and to provide outreach and follow up for those not yet vaccinated or who only had one dose. This has led to local discussions with those communities who have been vaccine hesitant or who have had access difficulties

Three place-based groups were established in Buckinghamshire, Oxfordshire and Berkshire West through which to plan, monitor, review and best manage the programme overall and ensure alignment in the work of the large vaccination centres, GP-led sites and mobile vaccination.

Efforts have been made in each of the places to ensure equality of access and provision of high quality and or bespoke communications to address vaccine hesitancy and enable people to make an informed choice.

Engaging with local communities has been fundamental in reducing inequalities in vaccine uptake.

Work undertaken as part of this workstream has included:

- mapping of engagement events and contacts within each of the three local Place areas
- mapping of key stakeholders to create a distribution network for communications
- a public survey to identify issues and barriers to uptake of the vaccine
- Health and Wellbeing Ambassadors / Vaccine Voices / influencers programmes have been developed to encourage informed decision making through conversations with communities, friends, family and contacts in low take up cohorts.

Additionally, pop up and outreach services, including Health on the Move mobile facilities, have been used to target vaccination hesitant populations and areas where there has been lower take up. This has included homeless people, areas of inequality, Black and Minority Ethnic Communities, and larger employers.

Buckinghamshire's response

The established Buckinghamshire Vaccination Cell oversees the programme and includes colleagues from BCCG, Buckinghamshire Healthcare NHS Trust, Public Health and Buckinghamshire Council. It has overseen the successful establishment of two hospital vaccination hubs; 11 GP-led local vaccination sites; a mass vaccination centre at the Guttman Stadium in Aylesbury and 15 Community Pharmacy sites across the county.

During the year we also set up the Health on the Move Van to reach out to wider communities and tackle health inequalities, ensuring that everyone was given the opportunity to take up the vaccination offer in a way that was sensitive to them. The van visited sites across the county from churches and mosques, train station and supermarket car parks, to homeless shelters to ensure that all had local access to the vaccination offer.

Our Hospital Hub team has also worked hard to encourage uptake in pregnant women offering a range of information webinars, one-to-one sessions and offering vaccination in maternity clinics.

All parts of the Buckinghamshire place system (including our GPs, Community Pharmacists, School Aged Immunisation Team, Buckinghamshire Council colleagues, BCCG colleagues; Buckinghamshire Healthcare NHS Trust colleagues and Oxford Health NHS Foundation Trust colleagues) have worked well together, alongside a huge number of valued volunteers.

As at 31/3/22 we have delivered an amazing 1.18m vaccinations in Buckinghamshire:

- 1st vaccinations - 75.3% of eligible population
- 2nd vaccinations – 71.8% of eligible population
- Booster vaccinations – 79.7% of eligible population

Responding to an emergency

Under the Civil Contingency Act 2004, CCGs are designated Category Two responders and have a duty to co-operate and share information in an emergency. As a Category Two responder, BCCG has roles and responsibilities in emergency preparedness, resilience and response (EPRR) to:

- Co-operate and share relevant information with Category One responders
- Engage in cross-sector planning through Local Health Resilience Partnership
- Support NHS England (South East) in discharging its EPRR functions and duties locally
- Include relevant EPRR elements in contracts with providers
- Ensure that resilience is 'commissioned in' as part of standard provider contracts and to reflect risks identified through wider, multi-agency planning
- Reflect the need for providers to respond to routine operational pressures (e.g. Winter)
- Enable NHS funded providers to participate fully in EPRR exercises and testing programmes as part of the NHS England (South East) assurance process
- Provide commissioned providers with a route of escalation on a 24/7 basis if they fail to maintain their professional levels
- Respond to reasonable requests to assist and co-operate
- Support NHS England (South East) should any emergency require any NHS resources to be mobilised

- Support NHS England (South East) to effectively mobilise all applicable providers that support primary care services should the need arise.

BCCG is responsible for maintaining service delivery across the local health economy to prevent business as usual pressures becoming significant incidents.

All CCGs and NHS-funded providers are required to have an Accountable Emergency Officer who can take executive responsibility for leadership for EPRR. In Buckinghamshire, Oxfordshire and Berkshire West CCGs it is the Director of Governance who holds this executive responsibility. A 24/7 director on call rota is in place to deal with any issues escalated to us by providers and a 24/7 communications on call rota exists for media and communications issues.

BCCG has incident response plans in place which are compliant with the NHS England Emergency Preparedness Framework 2013. BCCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Board in the annual assurance report.

Due to the scale of the pandemic and the subsequent vaccination programme, NHS England determined that its response should be coordinated through Integrated Care Systems (ICS). The Buckingham Oxfordshire Berkshire West ICS (made up of the three CCGs and led by a single Accountable Officer) was able to develop and strengthen the response arrangements to increase resilience and effectiveness.

The first stage took place in October/November 2020 which involved the all three CCGs releasing staff to support the BOB ICS Incident Infrastructure (for example deputy incident director), support for the Incident Coordination Centre rota and BOB-wide cells such as vaccination and supplies. This was strengthened during the second wave of the pandemic (January 2021) and has continued to operate at ICS level ever since.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for 2020/21, Buckinghamshire CCG has been required to assess itself against 24 core standards. The outcome of this self-assessment is that the CCG is fully compliant with the standards. The overall rating is: Full.

Sustainability

As part of the BOB ICS, Buckinghamshire CCG is committed to delivering against the NHS Green Plan, which provides a focus on reducing the NHS's carbon footprint and delivering services more sustainably. This is an important part of the journey towards delivering the Greener NHS ambition of being the first healthcare system in the world to be net carbon zero. BOB ICS recognises that its sustainability journey will change ways of working which will allow for a positive impact environmentally, socially and financially. In doing so, the ICS will be fit for the future and will support the long-term wellbeing of staff, patients and the wider communities it serves.

The ICS is made up of a number of different organisations to deliver a range of services which harness its ability to innovate and leverage the latest research and technology, to drive sustainability and individual and organisational behaviour change, across Buckinghamshire, Oxfordshire and Berkshire West. The Green Plan is part of the process of anchoring sustainability as key pillar in everything the ICS does.

The BOB ICS has already begun its green journey and is proud to have achieved the following:

- The development of provider estates strategies which has seen rationalisation and consolidation in the use of buildings.
- The uptake in digital tools such as Microsoft Office 365 has enabled the adoption of highly agile ways of working across all teams and services. As well as telephone and video consultations in primary care, secondary care, mental health and community services which avoided thousands of miles of car journeys.
- The removal of single use plastic cutlery and cups across all sites.
- The roll out of carbon literacy training amongst senior level staff.
- The increase in recycling bins amongst many of our sites.

These initiatives not only have reduced the ICS's carbon footprint but have also prompted behaviour changes which is important in moving forward in our delivery of a net zero health service.

Elective care

Early in the pandemic, routine referrals and elective operations and treatments were paused across the BOB ICS in line with national guidance from NHS England & NHS Improvement (NHSE&I). Hospital Trusts across BOB were asked to redirect staff and resources to free up the maximum possible inpatient and critical care capacity for COVID-19 patients and prepare for, and respond to, the anticipated large number of COVID-19 patients who would need respiratory support.

Trusts postponed non-urgent elective operations, rapidly discharged patients who were medically fit to leave and focused on urgent and emergency care, cancer care and implemented virtual online outpatient clinics where clinically appropriate.

While elective operations, treatments and care resumed during 2020/21, further waves of the pandemic have hampered efforts in elective care recovery. As a result, there are lengthy waiting times for outpatient appointments and treatment across the BOB ICS. A key area of focus for in the latter part of 2021/22 and moving forwards, has been to support elective recovery by working collaboratively to address waiting times and offering patients treatment options.

This includes:

- the creation of new community diagnostic centres to carry out a range of diagnostic tests, out of hospital, including
    - imaging (CT, MRI, ultrasound, X-ray, and mammography)
    - physiological measurement (echocardiography, full lung function tests, and ambulatory blood pressure monitoring)
    - pathology (phlebotomy, point of care resting, and simple biopsies)
- 7 days per week working in some specialties
- increasing the use of independent sector outpatient capacity for some specialties
- identifying capacity in neighbouring acute hospitals to re-direct patient and reduce waiting times

To support the resumption of elective care BHT has worked with BCCG and other NHS partners as well as the independent sector partners so patients could be seen as soon as possible. BHT has also:

- Maximised the use of peripheral clinic capacity because updated Infection Prevention and Control guidance has reduced the number of patients who can be seen safely in hospital outpatient clinics, due to the need to maintain safe social distancing in light of

COVID-19

- Worked with a number of new independent providers to offer additional capacity in the hospital. For example, support to nearly 2,000 dermatology patients.
- Reduced the waits for those waiting the longest for treatment e.g. we have seen a reduction in the number of patients waiting 104 weeks or more from 134 in July 2021 to 16 in March 2022.

Recovery work has continued throughout the pandemic with many lessons learnt from the previous year. This enabled services to continue to be fully accessible and operational whilst supporting further pressures, such as Winter 21/22.

2022/23 will continue to see services recover. We will be working with all partners and providers to further reduce the number of people waiting a long time.

Personalised Care:

Personalised care staff have continued to be embedded in PCNs, including social prescribing link workers, care coordinators and health and wellbeing coaches. These roles will ask 'what matters to you' and support patients with their health and wellbeing needs using a personalised care approach.

Virtual Training has been adopted to ensure staff continue to access the skills they require. Training in 'Making Every Contact Count', motivational interviewing and personalised care and support planning has been delivered virtually to enable health care professionals to empower patients to manage their own health.

The 'COPD & Me' training programme continues to be delivered by our specialist respiratory nurse and has been rolled out within a number of PCNs.

A successful bid for additional personalisation funds has led to the recruitment of a small number of training staff who will work across BOB to embed a clear and consistent approach to personalised care.

Physical activity continues to be a priority and work has taken place to increase capacity of exercise specialist to work with those with long term conditions and rehabilitation work has started to consider how best to support those waiting for elective healthcare.

Improving diabetes care and prevention:

BCCG practices continue to refer patients to the National Diabetes Prevention Programme Healthier You programme. The communication and activity plans at place have been refreshed along with BOB wide plans to engage at PCN level to encourage further referral to the programme as patients' numbers return to practices.

Patient education for type 2 diabetes self-management continues to offer a choice of remote group sessions or one to one tailored sessions with on-line digital resources and use of an App for ongoing support.

Cancer waiting times

Like other health service areas, cancer services across the country have been under significant pressure to deliver treatment for all patients due to the COVID-19 pandemic. This is no different for the BOB ICS, which has been working with the Thames Valley Cancer Alliance (TVCA) to ensure delivery of cancer services across the area.

Throughout the pandemic, cancer services across BOB have continued to be delivered based on clinical prioritisation with priority 'P2' surgery, radiotherapy and chemotherapy all continuing uninterrupted. Latest performance places the TVCA slightly below compliance with 70.7% to the new 28 day faster diagnostic standard.

The areas of greatest challenge across the Thames Valley remain in the high-volume cancer pathways of lower gastrointestinal tract, skin, and breast. However, it does indicate that we are closing the gap on 'hidden backlog' as more people come forward with symptoms. TVCA, on behalf of BOB ICS, is leading the plan for cancer in 2022/23 focused on:

- introducing the tele dermatology-led skin pathway
- achieving the national ambition of 80% of all lower GI referrals referred with a FIT test completed in primary care,
- delivering 75% population coverage of NSS (nonspecific symptom) pathways to deliver faster diagnosis and improved performance to the constitutional standards for cancer.

TVCA will also focus on earlier diagnosis by identifying the second site for TLHC (targeted lung health checks) based on areas of highest deprivation, inequality and known poorer outcomes within the BOB ICS geography.

BHT, along with other hospitals across BOB, has been working with the Thames Valley Cancer Alliance (TVCA) in the development of a recovery plan for cancer services with the aims of:

- Reducing unmet need and tackling health inequalities, working with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels
- Managing the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service
- Reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for those waiting longer than 104 days
- Improving access to diagnostics and diagnostic capacity

Description	Standard	Year end position
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	90.4%
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	93%	53.6%
Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	89.6%
Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is Surgery	98%	67.2%
Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is an Anti-Cancer Drug Regimen	94%	94.9%
Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is a Radiotherapy Treatment Course	94%	83.6%
Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer	85%	69.5%
Percentage of patients receiving first definitive treatment within 62 days of referral from NHS Screening Service	90%	83.3%
Percentage of patients receiving first definitive treatment within 62 days of a consultants decision to upgrade their priority status	86%	80.0%

Primary Care and Community Initiatives

Cancer Care Review (CCR) Implementation Support Scheme

The CCR Implementation Support Scheme is part of the Thames Valley Cancer Alliance's five-year delivery plan to improve outcomes for people with cancer by 2020 and it aligns with the national cancer strategy 'Achieving World-Class Cancer Outcomes (A Strategy for England 2015-2020)'.

The scheme looked for all GP practices to adopt the standardised CCR template and undertake a second cancer care review with each patient (the first cancer care review is part of the primary

care Quality Outcomes Framework). After three years of the scheme, it has now been adopted into primary working practices and so will be coming to a close; A new scheme will be taken forward in 2022/23 with renewed focus on specific groups of patients to further improve post treatment care. The scheme has enabled over 4,000 additional reviews to take place for patients across the BOB ICS footprint.

Reducing Inequalities in the access of cancer services

BCCG has been working with community groups to improve access to services for those patients who have traditionally been hard to reach. Through third party charities we have a number of small projects taking place in Buckinghamshire to increase knowledge and awareness of screening and cancer services where activities are taking place in the heart of communities. Projects were worked up during 2021 and implementation started this year, review of progress and impact will be taking place during the summer and autumn. Lessons learned from these initiatives will be used to inform pathway and/or service changes going forward.

Risk Stratified Follow-up

The past year has seen the system working together to implement risk stratified follow-up across prostate, breast and colorectal cancers. The NHS Long Term Plan for Cancer states that after completing treatment, each patient should move to a follow up pathway that will meet their needs. Such pathways should ensure that patients can rapidly access clinical support if they are concerned that their cancer may have returned. Personalised Stratified Follow Up (PSFU) allows patients to have a personalised follow up pathway based on their level of risk, improving the patient experience alongside creating additional capacity in cancer clinics, allowing healthcare professionals to see more patients and those with complex needs. This will allow faster diagnosis and treatment as well as better care. Patients put on to stratified follow up pathways will be given signs and symptoms to look out for so that they can rapidly access their healthcare team in the future if needed. They will still undergo their regular surveillance scans and tests with faster access to results. Patients will avoid unnecessary appointments.

There has been some delay in implementation due to COVID-19 but the system is now on track to have the pathways implemented by June 2022 for Buckinghamshire: Oxfordshire and Berkshire West are also progressing well. Following this, risk stratified pathways will be introduced for other tumour sites.

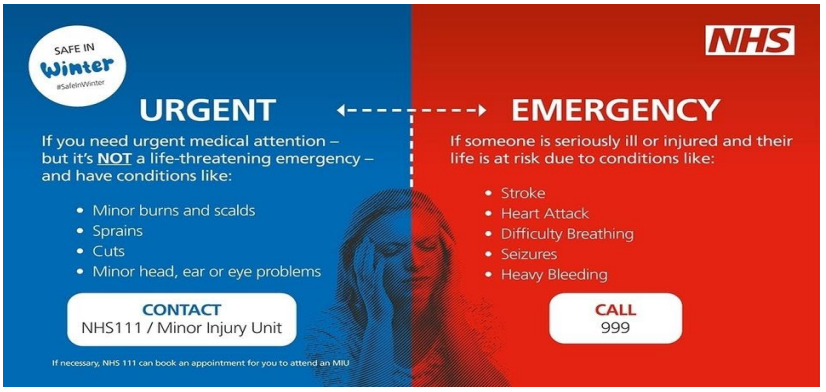
Tackling urgent care pressures in the county

The effects of the pandemic on the health system have made it even more important for health and social care professionals across the BOB system to work together to deliver responsive and joined-up urgent and emergency care services. Over the past few years, pressure on urgent and emergency care has gone beyond the increased need for services during the winter and is now a year-round challenge.

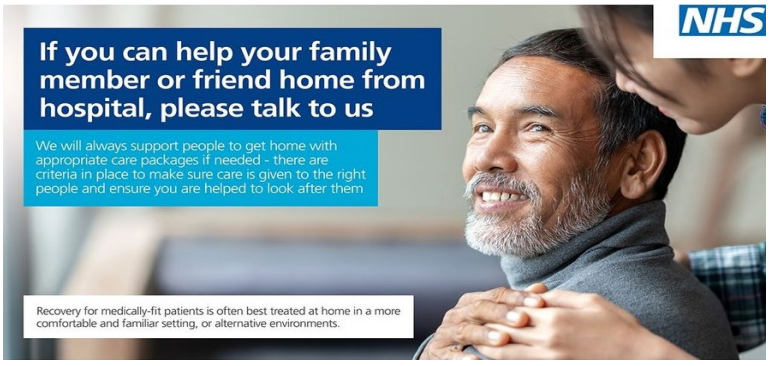
Across the BOB ICS, teams from hospital and community Trusts, the CCGs and local authorities have worked together to ensure people who required urgent and emergency medical treatment were able to access services.

Alongside this, communications teams from the CCGs and system partners have worked together to deliver campaigns to local people encouraging them to look after themselves and stay healthy, and to use healthcare services in the most appropriate way. Key messages over the past year have been:

- Emergency Departments (EDs) are for genuinely life-threatening conditions, for non-life-threatening conditions please use alternative services such as local pharmacies, minor injuries units, your GP and NHS 111 who can advise and direct patients to the best place for care



- Our EDs and hospitals remain very busy. If you can help your family member or friend home from hospital, please talk to us. We will always support people to get home with the appropriate care packages



People were urged to have a winter plan for themselves and their family to keep as well as possible, what they could do if they became unwell, and how to look after more vulnerable neighbours and friends.

2021/2022 has seen unprecedented demand across Urgent and Emergency Care Services and it has been essential that the health and social care partners come together to ensure timely access to services for all people in Buckinghamshire.

NHS 111 continued to be communicated as the key entry point into urgent care services, across Buckinghamshire, with further focus on the NHS 111 First national programme, introduced during the earlier stages of the COVID-19 response. Patients in Buckinghamshire can be directly booked into an appointment, where required, at their GP practice and Urgent Treatment Centres, as well as be directed to other services such as a pharmacy.

NHS 111 First, where people who need clinical advice but are not in a life-threatening emergency are encouraged to contact NHS 111 first, before attending their local Emergency Department, continued to be a key message. Up to 50% of the activity referred by NHS 111 to the Emergency Department at Stoke Mandeville Hospital is booked into timed appointments. The introduction of a new Urgent Treatment Centre pathway at Stoke Mandeville Hospital has enabled patients with minor conditions to be seen in a more appropriate environment while relieving pressure from the Emergency Department. Up to 40% of the daily activity has been allocated to the pathway. Staff will be able to send patients direct to a multitude of services including, Same Day Emergency Care pathways, pharmacists or to the Emergency Department as appropriate. The pathway will now be developed further to include direct bookings away from the hospital.

With pressures on acute settings remaining high, the system has continued to promote and implement alternative urgent care pathways to avoid the need for patients to attend a hospital or be admitted to one. These include phone lines designed to allow healthcare professionals to seek additional expert help to support their decision making, as well as pathways into community services for paramedic staff.

The focus on discharge pathways has remained high during 2021/2022 and Buckinghamshire has significantly increased the number of people being discharged home who require support to do so, via its Home First Service, set up in November 2020. In support of this, personal health budgets for those families able to support the discharge of their family member by caring for them has been successfully launched.

The flu vaccination programme continued to evolve in 2021/2022 with innovative ways of delivery, strong engagement from pharmacies and clear messaging alongside the Covid vaccination programme.

The vaccination levels for the Buckinghamshire population as at 22nd March 2022 are below.

2021/22 Target	Aged 2 years	Age 3 years	Age 65+ years	Under 65 years at clinical risk	Pregnant (all ages)
75%	54.2%	57.4%		54.4%	40.4%
85%			84.2%		

Supporting children and young people with their mental wellbeing

The NHS Long Term plan, building on the 5-year forward view for Mental health, prioritised spend and ambition for meeting a growing mental health need in England. Nationally the plans headline commitments included an additional 345,000 children and young people will access support by NHS funded Mental Health services, including the new Mental Health Support Teams (MHSTs), 95% of children and young people with Eating Disorders (ED) will meet referral to treatment waiting standards and full coverage of 24/7 mental health crisis provision for children and young people.

The pandemic has had a significant impact on the mental health of the population as well as the services that care for and support them. Despite this, service delivery for children and young people has continued throughout the pandemic. However, in addition to the acknowledged rise in general mental health concerns in children and young people there has been an increase in a range and nature of complex presentations, particularly children and young people with Autism and Eating Disorders due to COVID measures. This increase in demand and complexity of cases is putting significant pressure on children and adolescent mental health services across BOB with lengthy waiting times to access services.

As such, NHS Chief Executives and senior leaders from across the BOB ICS have agreed that CAMHS is one of three operational services areas of priority. Work has already commenced with the identification of key areas of development for the BOB ICS to deliver improved access to, and quality of, CAMHS services.

In 2021/22 NHS England re-introduced the mandatory requirement for all CCG areas to develop annual transformation plans. These plans articulate the work that has been completed in the preceding 12 months and outline how as systems we will continue to work together to make improvements in children and young people's mental health and wellbeing over the next 12 months.

The document was published in October 2022, there was a focus around recovery from the pandemic.

Key headlines for the CAMHS service in relation to transformation are outlined below:

- The number of children and young people accessing mental health services has increased year on year (including 21/22) exceeding the national target set for CCGs each year.

Year	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
% Target CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service. (NHSE Mandated Target)	26%	28%	30%	32%	34%	35%
% Actual	No data	No data	47.7%	34.5%	42.7	41.8
Number of patients required to reach access targets		2,543	2,725	2,906	3,088	3,179

- Buckinghamshire's mental health in-reach support teams in schools received additional funding from NHSE and expanded the offer to 47 schools in 2021/22 (increase from 32 schools in 2019/20). Further expansion is planned for 2022/23.
- Buckinghamshire received transformation funding as a trailblazer site to implement a keyworker service. This provides co-ordination support to children and young people with a learning disability and/or autism who are at risk of admission to an acute mental health hospital. The service went live in October 2022.
- BCCG met its mental health investment standard in 2021/22, funding additional posts within the children and young people's eating disorder service. This is in response to national and local increases in the number of young people requiring access to these services.
- A Barnados Buddy has been working in Stoke Mandeville Hospital supporting young people with mental health needs who are receiving acute care. This was started as a pilot but has been successful and it has been agreed that this will continue.

For further information you can view the full plan here: Buckinghamshire Transformation Plan for Children and Young People's Mental Health and Emotional Wellbeing (buckinghamshireccg.nhs.uk)

Ensuring there is parity of esteem for patients

Additional funding has been invested into mental health services in 2021/22 in line with the national mental health investment standard (MHIS), introduced to ensure that there is parity with physical health service. NHSE/I also made additional transformation funding available to support the recovery of mental health services from COVID. In 2021/22 MHIS was targeted towards the following areas:

- Children, young people and adult eating disorder services
- Improving access to psychological therapies (Known locally as healthy minds) and increasing the number of people able to access the service
- Early intervention in psychosis services
- Mental health practitioners working within GP surgeries
- Secondary care mental health services or adult / older adult community mental health
- Joint working arrangements between mental health and substance misuse services
- People with a severe mental illness – accessing annual physical health checks

Delivery of mental health services for adults (over the age of 18)

Mental health services have continued to expand in Buckinghamshire, (with recruitment of additional staff and transformation programmes coming online) in 2021/22 with targeted investment in places where there is the greatest need for development and/or there have been

demonstrable increases in activity.

The all age 24/7 mental health support is now fully embedded at the south-central ambulance (SCAS) control centre in Bicester. People with concerns about their mental health in Buckinghamshire are able to access support via NHS 111, speaking to a dedicated mental health professional.

Improving access to psychological therapies – Healthy Minds

A number of initiatives, as a result of additional investment have been implemented by the service targeted at increasing access and subsequently enabling more people to receive assessment and treatment for their low to moderate mental health needs. National targets have been maintained and, in some areas, exceeded. Buckinghamshire is particularly proud to have a strong theme of recovery within this service achieving a performance of 58.2% (February 2022 data) against a national target of 50%.

People with a severe mental illness (SMI)

In Buckinghamshire, as part of the recovery from COVID, there has been a targeted effort to improve the physical health of people with a SMI, which has been achieved by working in partnership with GPs across the county.

A national quality improvement target is in place, which sets an ambition for each CCG to ensure that 60% of its SMI population receive an annual physical health check. In April 2021 performance against this target was 16.3%, March 2022 performance is 49.4% representing a significant improvement.

Community Mental Health Framework

National transformation funds have been made available recurrently from 2021/22 to embed a new model of community mental health care for people with severe mental health illness. This is in acknowledgement of health inequalities which exist for this cohort of people and a national acceptance that support services require transformational change to ensure improved long-term outcomes. In 21/22 activity in this area has included but is not limited to the following:

- Additional staff have been recruited to mental health posts
- Co-production work has been undertaken with people who have lived experience of using services to help shape the provision
- New relationships have been built with third sector partners and new community services implemented
- Mental health practitioners have been recruited to specifically work within GP practices enabling care to be more joined up and delivered more flexibly

Developing services and support for people with learning disabilities

The BOB ICS has developed a three-year delivery plan for people with learning disabilities and or autism of which the first year has now been completed. Within the first year, concentration has been on Theme 1 - Moving people into the community and reducing reliance on inpatient care, some key areas of work in this area have been:

Positive Partnership Team (HPFT) - Provision of Positive Behaviour Support advice and training to community providers and families to reduce the number of people going into crisis and to support effective transition of individuals back into the community. Supported 24 individuals, training delivered in 19 services, prevented 3 admissions and 2 delayed discharges.

Dynamic Support Register (DSR) - Redeveloping to include MDT format for client support/structure and reviewing system response criteria. Focus on CYP and building in Key Worker Scheme – Dynamic Support facilitators have been allocated.

Safe & Wellbeing Reviews (SWR) – Completing SWR's and then implementing the actions that were identified to improve standards of care in relation to people's physical wellbeing and quality of life in inpatient settings.

We have worked closely with both our primary and secondary care providers to continually improve the quality and uptake of Annual Health Checks for people with Learning Disabilities. We were successful in achieving 76.4%, exceeding the target of 75% which was set by NHS England. Of the Annual Health Checks completed 94% have now got Health Action Plans in place.

Medicines optimisation

The safe and effective use of medicines is an essential element of healthcare. Medicines optimisation teams, which consist of pharmacists, pharmacy technicians and dieticians, work across the BOB ICS supporting clinicians, patients, and carers in making decisions about improvement in health outcomes, service quality and sustainability for our population.

The teams have and continue to be closely involved in COVID-19 related work supporting changes in clinical pathways, responding to clinical enquiries, the extension of services provided by community pharmacies, support to care homes, accreditation of GP led primary care network COVID-19 vaccine sites and supporting vaccine clinics. The role of the primary care lead pharmacist for Covid-19 vaccines ensured vaccination delivery was to a high quality, safe and consistent service across the CCG.

In addition, the teams regularly published lists of 'frequently asked questions' on CCG websites to keep prescribers up to date on changes and recommendations during the pandemic. Staff were also redeployed to support moving patients out of a hospital to a community setting and supporting vaccination sites.

Alongside this, in 2021/22, BCCG's medicines optimisation team continued to support appropriate prescribing across Buckinghamshire, including the review and implementation of clinical guidelines, collaborative work with providers including PCNs, the introduction of new pathways and the review of governance arrangements. The team continued to focus on national key initiatives on safety and quality. An example of this was to align with the project already underway to reduce stroke rates in line with the NHS Long Term Plan and the "Detect, Protect and Perfect pathway" initiatives by NHSE relating to the cardiovascular work streams. The team worked across Buckinghamshire to reduce the potential safety risk to patients on certain high-risk medications.

There has been significant growth in the Primary Care Network pharmacy teams and the BCCG Medicines Management Team alongside the Medicines Resource Centre colleagues at BHT have supported the development and training across the network.

The team have continued to work with community pharmacies to enhance services like Discharge Medicines Services and Community Pharmacist Consultation Scheme to reduce winter pressures by supporting transfer of care on discharge and increase access to services outside general practice.

Improving Quality

Improving the quality of healthcare provided to people in Buckinghamshire is at the heart of BCCG's work. We work together with our partners to improve patient experience, improve the quality of services and learn from incidents to reduce the risk of them happening again.

During 2021/2022 the Quality and Safeguarding Team continued to ensure high quality care for the population of Buckinghamshire a well as adapting to support the needs of the pandemic. Members of the CCG's Quality team were redeployed to support the incident response, including support to community facing services, this has included support for responsive visits to various care settings to support the improvement in quality of care and improved outcomes from safeguarding alerts raised within our local system. The team also supported a variety of activities

during the mobilization of the pandemic response to include care homes and other settings Infection Prevention & Control (IPC) training, roll out of information technology in primary care and support for complex case reviews and COVID-19 safe quality support visits related to safeguarding and quality concerns.

The team routinely monitored and reviewed feedback from primary care. All feedback was then passed on to secondary care services, which considered and acted on the information provided. Services were asked to respond to concerns within 30 days unless an identified immediate response was required and responses were reviewed by BCCG. This information is valuable to the services to identify concerns specific to a patient, or wider concerns and safety risks. BCCG also uses this information to identify developing issues and to ensure that work is undertaken to prevent any patient safety incidents. This has led to reviews of pathways for patients and remains a focus for sharing information and learning in the local place based system.

The GP Feedback continued throughout the pandemic with a focus on addressing immediate safety concerns during particularly busy periods. This included liaison with system partners to address issues for patient pathways and ensure collaboration to minimise clinical harms.

Our Complaints and Patient Advice and Liaison Service continued to help members of the public navigate services. and

Another core duty of the Quality Team at BCCG is to review Serious Incidents (as defined in the Serious Incident Framework, 2015) from all our providers – the focus is to act as a critical friend to providers and services to ensure that the issues are addressed with robust measures to prevent future incidents. There has been a decrease in Serious Incidents reported in 2021/22 (91) compared to the 2020/21 financial year (96) – the decrease is in line with what was expected following the changes to Outpatient appointments made during the peak of the COVID19 pandemic

Addressing health inequalities

Work continues across the BOB ICS to reduce health inequalities; in the past year a BOB- wide equalities group has been established to identify inequalities and implement evidence-based interventions to reduce the gaps by working with local communities and ensure we share learning and best practice on local initiatives, which make a difference. The BOB Reducing Inequalities Board has agreed that coronary heart disease will be the priority, with a focus on hypertension case finding and management and stopping smoking as its main interventions.

The BOB Vaccine Equality Board was established in 2021/22, as part of the BOB Vaccination Programme to provide a focus on ways to increase vaccine confidence and ensure equitable access for people living in deprived and/or rural areas, diverse ethnic or vulnerable groups by working with big employers and community and voluntary groups.

While uptake of the COVID vaccine is high across BOB, in January 2022 a BOB-wide Outreach and Engagement Plan was developed and is being implemented to target specific groups such as Gypsy, Traveller, Romany, pregnant women and the Chinese and Black African communities where there has been relatively poor vaccination uptake.

We continue to work in partnership with local authority colleagues and voluntary organisations on our equality agenda as we return to business as usual and plan our work for 2022/23 in line with government guidelines and the development of BOB as in Integrated Care System.

In Buckinghamshire, we have a have a multi-agency approach to reducing inequalities. During COVID-19 considerable work has been undertaken to reach black, ethnic and minority groups and areas of inequality to ensure information on the pandemic, outbreak management and vaccine programme are accessible

Examples of activity include:

- “Pop up” clinics in community venues. Successful “pop up” clinics have been delivered at

mosque and community centres aimed at people in communities that have not previously taken up the offer for vaccination. Feedback suggests that there has been a subsequent positive impact as some people from the target communities have gone on to attend other sites for vaccination.

- Outreach clinics for people in emergency accommodation have been offered via a community-based clinic at a homeless hub. Ongoing engagement with Homeless services continues encouraging and supporting further take up and access. Work is ongoing to deliver vaccines in local hostels and supported housing facilities.
- Outreach to support homeless, drug and alcohol services and sex workers have taken place.
- Data mapping and targeting of known areas of lower take up has taken place through use of the Health on the Move Vaccination Bus. Multiple sites across Buckinghamshire have been repeatedly visited with communications and promotions being distributed via community and voluntary organisations.
- In an attempt to address people's questions and concerns re Covid and the vaccine Webinars, Q& A sessions and virtual community conversations have taken place in different communities supported by Public Health, GPs and Acute Specialist doctors.
- Vaccine Voices Training has been developed and delivered to support people to have open and informed conversation with those who may have reservations about the vaccine. This has been offered to community groups and leaders and health professionals including midwives.
- A Ramadan Communications Plan is delivering targeted messages about the access to the vaccine during the period. Messages were also promoted via a direct letter to mosque leaders about a Safer Ramadan from the Director of Public Health.

Engaging the public and local communities

The CCGs across BOB are committed to continuously strengthening public participation in all areas of work. However, progressing this during 2021/22 has been challenging. Understandably, the COVID-19 pandemic has been a major focus in the NHS across the county and resources, including communications and engagement staff, were diverted to supporting frontline services in caring for patients. Information and guidance to support patients, the public and clinicians working across the local NHS needed to be refreshed, updated and communicated speedily. Despite this re-routing, some engagement work has been undertaken across BOB and at a local level.

In the early response to COVID-19, and as part of the level 4 incident declared by NHS England nationally, healthcare organisations made rapid changes to how services were accessed and delivered. Many of the changes were intended to reduce the face-to-face contact which in turn reduced the risk of spreading the infection.

A key feature and point of difference during the pandemic was accelerated delivery of remote and virtual services. As a clear step to reduce the spread of COVID-19, GP practices were required to introduce total triage. Patients were assessed by a GP over the phone or online first, allowing many people to be offered advice, prescriptions or referral without the need for a face-to-face appointment. For patients with the relevant technology, appointments have been available using video conferencing with healthcare professionals.

Part of this new way of working included the introduction of an online advice and appointment system. The form-based online consultation platform collects a patient's medical or administrative request and sends it through to their GP practice to triage and decide on the right care.

Across BOB, GP practices use various tools so patients can contact their GP. To get a better understanding of the patient experience and to inform a BOB-wide procurement process for an online consultation platform across the ICS, a survey was undertaken to seek feedback on what patients thought of these tools and how they help to manage their health. The survey was promoted through the three CCGs and focused on three tools:

- **Online Consultations**: Online consultation enables patients to contact their GP or other health professional by completing an online form or speaking to someone online about health concerns.
- **Video Consultations**: Some practices also now offer video consultation tools which allow patients to have a video appointment with a GP or healthcare professional.
- **Text messaging**: GP practices have the ability to send text messages to patients to communicate with them regarding care and inform them of things that are happening at the practice.

More than 1,000 survey responses were received across BOB and the feedback informed the procurement process for a BOB-wide system for primary care**.** BCCG looks carefully at each project and considers the scale, who should be involved and what methods to use.

The need to protect patients and staff from infection meant face-to-face methods of engaging patients and the public were not used (or at least much less, and with safety measures adopted). This meant meetings in public continued to be held online, requiring members of the public to have access to the internet to be able to participate. More information about the guidance BCCG follows, including the principles for engagement is available here.

While the ongoing pandemic has meant fewer engagement projects, below are several examples of pieces of communications and engagement work from the last year.

COVID-19 vaccination roll-out

The ongoing COVID-19 vaccination rollout has been a key piece of work for the CCG throughout 2021/22, as we made different patient cohorts aware of the vaccination options available across Buckinghamshire. This alone has been the most extensive piece of communications work undertaken during this period, and BCCG worked in close collaboration with partners across BOB to ensure we could pool resources where possible and share messaging, reaching as many people as possible and providing them with the accurate information they needed to make informed choices about the vaccine.

The communications and engagement approach to the vaccination roll-out has been adaptive and intelligence-led, as BCCG has worked with health and care colleagues across the Buckinghamshire system to ensure we kept our population informed. In particular, this data-led approach helped us focus some of our efforts on those people who may have been reluctant to take up the vaccine, ensuring they were given every opportunity to do so.

To this end we have worked to promote the Health on the Move vaccination van and community ‘pop-up’ vaccination clinics. We have targeted communications to particular geographical areas of low vaccination uptake, working with Buckinghamshire Council’s Community Engagement teams (who have established strong contacts with many trusted voices within our communities) and the host venues themselves. We have also supported online Q&A events with healthcare professionals to tackle myths and misapprehensions around the various vaccines available. This is an evolving piece of work that is informing, and informed by, ongoing efforts to tackle health inequalities across the Buckinghamshire system.

Our social media channels and website have been essential for sharing up-to-date information about vaccination clinics and the changing nature of the roll-out, as well as more traditional media engagement, and we have seen increases in online traffic to our ‘vaccination update’ page in particular. We have been working collaboratively to share and amplify the messages of our partner organisations (such as BHT, OH and the council), with great success, further

strengthening our increasingly collaborative approach across the Buckinghamshire system.

The COVID-19 vaccination campaign came to run alongside the 2021/22 Winter Campaign, with focus on encouraging uptake of key vaccines (COVID and flu), alongside the usual promotion of different service options available to patients in Buckinghamshire. This work was undertaken in close collaboration with our partner CCGs across BOB (Oxfordshire and Berkshire West), as we shared resources, approaches, and the skills of our respective teams.

Patient awareness around restrictions across health and care settings

While restrictions have been relaxed several times over the past year (and in some cases reimposed), this has meant some confusion for the patient population and a difficult time for health and care settings. Communications teams across the local system (including BHT and the council) have worked together to continue to support settings where restrictions remained in place.

This has taken the form of posters, information updates, targeted social media and toolkits, which aim to inform patients and support healthcare professionals, many of whom are now working differently. To do this we consulted with professionals (such as the Buckinghamshire Local Medical Committee) and patient representatives (such as Healthwatch), using their feedback to hone messages. This is an ongoing, adaptive piece of work as we continue to emerge from the pandemic.

Lace Hill Health and Care Centre consultation:

The Swan Practice, which currently serves the Buckingham area from four buildings, has been developing proposals to move from three of these sites (which are no longer fit for purpose) into a new purpose-built health centre.

Working with BCCG, a full consultation took place with an online survey being made available on Your Voice Bucks, BCCGs digital engagement tool. Patients were also invited to feed back by paper survey, to write/ email directly to the practice and to attend one of two drop-in sessions arranged by the practice.

To ensure all patients were reached, BCCG also supported The Swan Practice with press releases, social media, texts to patients, general statements and FAQs, building on engagement the practice had already undertaken with patient groups and local stakeholders. Just over 2,200 responses were received to the consultation (the vast majority via the Your Voice Bucks online platform) and this feedback is informing the Swan Practice's business case and approach to the potential move.

How does BCCG manage its money?

The financial regime established in 2020/21 in response to the COVID-19 pandemic has continued into 2021/22 with the full planning process being suspended by NHSE. The CCG developed two six monthly plans based on the actual outturn of 2021/21 adjusted for growth and acute Independent Sector providers for services being devolved back to CCGs to procure. The block payment approach for NHS providers was extended in order to simplify payment arrangements and to ensure sufficient cash flow to providers to enable their response to the pandemic

This plan provided an in-year breakeven position in line with the expectation set by NHS England. The CCG carried forward a cumulative historic deficit of £3.2m into 2021/22. At the end of the year the CCG achieved an in-year surplus of £3,228k, which means that the CCG exceeded its financial plan of breakeven. This will be added to the historic deficit of £3.167k resulting in a small net surplus of £61k to be carried forward to future years.

The CCG received a capital allocation of £740.0k to cover the development and implementation of an IT one network system for Buckinghamshire. The CCG has spent £739.5k against this allocation.

For the financial year 2021/22, BCCG's total in year funding was £932.3m. Of this, £921.8m was allocated for healthcare programmes and £10.5m for the CCG's running costs. The table below which summarises our budget (plan) and actual expenditure for 2021/22:

Summary of position Month 12 March 2022	Annual Plan £'000	Plan to Date £'000	Year to Date Actual £'000	YTD Variance £'000
Allocation	**929,103**	**929,103**	**929,041**	**61**
Commissioning				
Planned and Unscheduled Care	501,573	501,573	502,481	(908)
Prescribing	76,988	76,988	75,068	1,920
Mental Health & Joint Care	85,715	85,715	84,976	739
Community	64,498	64,498	63,657	842
Continuing Healthcare	61,837	61,837	61,837	0
Delegated Co-Commissioning	82,155	82,155	82,155	0
Primary Care IT	2,301	2,301	2,214	86
Other / Reserves	46,697	46,697	46,822	(125)
Commissioning sub-total	**921,764**	**921,764**	**919,209**	**2,554**
Running Costs	10,506	10,506	9,832	674
Total CCG Expenditure	**932,270**	**932,270**	**929,041**	**3,228**
Expected M12 allocations	0	0	**0**	0
Surplus/Deficit In Year	**932,270**	**932,270**	**929,041**	**3,228**
Planned deficit	0	0	0	0
Historical b/f Deficit	(3,167)	(3,167)	0	(3,167)

**The above table includes Covid-19 Charges in YTD & FOT*

BCCG has formal delegated responsibility from NHS England for GP Primary Care Commissioning and the CCG received an allocation of £82.2m to deliver this.

During 2021/22 the COVID-19 pandemic continued including a second peak during December 2021, as a result of the Omicron variant, and through the year NHS England maintained COVID-19 level four incident - the highest level of emergency preparedness planning. As such the NHS continued to respond to the pandemic which it began in 2020/21 with a significant mobilisation to reduce the number of Medically Optimise Fit for Discharge patients (MOFD) in the acute setting. Through the year BCCG were allocated a further £3.2m to cover the additional revenue expenditure directly related mainly to Primary care to enable remote management of patients and management of COVID-19 positive patients in the community. The funding for the additional expenditure in relation to hospices and to the hospital discharge programme which was aimed at freeing up hospital capacity continued against which the CCG received allocation of £15.3m.

During the year, BCCG continued joint commissioning and pooled budget arrangements with Buckinghamshire Council. These pooled budgets covered - the Better Care Fund (BCF), Children and Adolescence Mental Health Services (CAMHS), Speech and Language Therapy, Residential Respite Short Breaks, Integrated Community Equipment Service Contract Management, Integrated Community Equipment Service, Section 117 and Integrated Commissioning Team. BCCG's contribution to the pooled budgets in 2021-22 was £62.4m while BC contributed £27.6m.

For 2021/22 BCCG had a Mental Health Investment Standard (MHIS) target of growing the mental health services by 4.42% resulting in a target spend of £80.7m. The CCG achieved a total spend of £80.7m and therefore achieved the target.

For the next financial year 2022/23, national arrangements have been put in place to ensure that NHS providers receive cash as required by means of a national block contracting arrangement through CCGs and CCG's developing plans with a view to returning to more usual commissioning and contracting arrangements.

In line with national policy direction for the NHS, Buckinghamshire CCG continues to work more closely within the BOB ICS and is anticipated to become part of BOB ICB a statutory organisation

from 1 July 2022. As such the 2022/23 plan is under development at that level. Organisations now work more closely together to make choices and decisions about how the Buckinghamshire pound (£) is spent. Improved system working across Buckinghamshire and across the wider BOB ICS area will contribute to getting the best possible value from the Buckinghamshire pound (£).

Constitutional Targets

NHS services have faced unprecedented pressures over the course of the pandemic waves and have responded to a significant increase in demand on Primary, Community and Acute services as well as delivering the biggest vaccination programme in history. During 2021/22 we have made use of the available technology to enable our meetings to continue and our actions have been weighted towards the system response to the pandemic.

The system has been under significant pressure during the increase in the number of COVID positive patients associated with the Delta and, more recently, Omicron waves during the latter half of this year. Pressures have been compounded by the high level of demand during the winter months. System providers maintained the level of planned treatment during Omicron and focusing on reducing the significant waiting times and backlogs generated during previous waves. To support NHS Trusts' capacity for urgent care, Independent Sector Provider (ISPs) sites were directed by NHSE under a national contractual and financial arrangement to assist all regions and protect capacity for elective services (including cancer).

The table below outlines the NHS constitutional targets BCCG has a duty to meet. Due to COVID-19 illness and the need to release capacity across the NHS to support the response, the collection and publication of data and official statistics was paused delayed transfers of care, mixed sex accommodation and cancelled operations.

Group	Description	Standard	Year end position
Cancer	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	90.4%
	Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	93%	53.6%
	Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	89.6%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is Surgery	98%	67.2%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is an Anti-Cancer Drug Regimen	94%	94.9%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is a Radiotherapy Treatment Course	94%	83.6%
	Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer	85%	69.5%
	Percentage of patients receiving first definitive treatment within 62 days of referral from NHS Screening Service	90%	83.3%
	Percentage of patients receiving first definitive treatment within 62 days of a consultants decision to upgrade their priority status	86%	80.0%
RTT - Incomplete	Incomplete pathways at month end	92%	50.6%
	Incomplete Pathways over 52 weeks at month end	0	4,136
Mental Health	IAPT - Access Rate	6.25%	7.220%
	IAPT - Moving to Recovery	50%	53.8%
	IAPT - Treated within 6 Week	75%	97.4%
	IAPT - Treated within 18 Week	95%	100.0%
	Dementia Diagnosis Rate	67%	56.9%
C&YP Eating Disorders	CYP Eating Disorders - Urgent (1 week)	95%	64.3%
	CYP Eating Disorders - Routine (4 weeks)	95%	33.3%
Ambulance Response Times	Category 1 Incidents Mean	7:00	11:02
	Category 1 Incidents 90th Percentile	15:00	20:10
	Category 2 Incidents Mean	18:00	45:17
	Category 2 Incidents 90th Percentile	40:00	87:15
	Category 3 Incidents 90th Percentile	120:00	447:39
	Category 4 Incidents 90th Percentile	180:00	597:44

How does BCCG monitor performance?

The BCCG Governing Body is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of service providers. The Governing Body receives an integrated performance report at the bi-monthly meetings in public.

Formal committees of the Governing body scrutinise in more detail how BCCG and health providers are delivering contracted services; these are the Finance Committee, Audit Committee, Quality & Performance Committee, Integrated Care Executive Committee and the BCCG Executive Committee (for more information about the committees and their purpose please see page 38. In addition to the monitoring requirements outlined above, the Urgent & Emergency Care Board also has a role to play in monitoring performance, to the extent necessary. The members include the Chief Operating Officers and Governing Body level representatives from NHS organisations in Buckinghamshire and Buckinghamshire Council. The group aims to develop and maintain resilience across the urgent care services and improve the flow of patients through A&E, admission, treatment and discharge. Over 2021/22 the BCCG Governing Body and Committees met in in common with those of Oxfordshire and Berkshire West CCGs. This has enabled us to develop joint reporting and receive a different perspective on the topics discussed.

How is BCCG monitored?

NHS England has a statutory duty to undertake annual assessment of CCGs. This is undertaken using the NHS System Oversight Framework 2021/22. The framework is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and integrated care systems. The NHS providers and CCGs in the BOB ICS are currently in segment 3 (1-4 segments). This means the BOB ICS is working with NHSE/I regional teams work to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved and then improvement actions are agreed.

Managing risk

Reducing risk across the health system is a priority for BCCG to ensure patients receive high standards of care. Risks are events or scenarios which can hamper BCCG's ability to achieve its objectives. These risks, divided into strategic and operational, are identified, assessed and managed by the organisation and reviewed at every BCCG Governing Body meeting in public. They are continually reviewed at Governing Body meetings including the Audit Committee, Finance Committee, Primary Care Commissioning Committee, Quality & Performance Committee, Integrated Care Executive Committee and the BCCG Executive Committee. Governing Body and CCG directors review all risks on a bi-monthly basis. The reports on BCCG's principal, strategic and operational risks, and mitigations as of 31 March 2021 can be found on BCCG website here

The year ahead

Through the first three months of 2022/23 BCCG will remain the statutory organisation for commissioning health services in Oxfordshire. We will use these months to continue to prepare for organisational change with the close of BCCG and the safe transfer of CCG functions and staff into the new BOB ICB.

As we move to become an ICB we will at the same time develop our integrated care system (ICS) which will aim to deliver health and social care to people in a more joined up way across local councils, the NHS, voluntary organisations and other partners. The ICS will be a new partnership of health and care organisations across BOB that will come together to plan and deliver joined up services and improve the health and wellbeing of people who live and work in the area. The four main goals of the ICS are to

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

While these were all set out as goals in the Long Term Plan and are not new, how we organise ourselves across health and care is changing. We hope with the development of an BOB ICS, where traditional barriers may have existed between different parts of the NHS, between physical and mental health and between the NHS and local authorities, these will be removed, and care will be delivered in a more seamless way with better outcomes for our patients.

Much work has already been undertaken to transfer from three CCGs to the new ICB; an interim executive team is in place and recruitment for permanent leaders for the new organisation to develop the ICS is well underway. Work is continuing to develop better relationships across health and care and develop a BOB ICS System Development Plan to further our work. NHS Chief Executives and senior leaders from across the system have agreed three operational services areas of priority for the next six to 12 months. There will be a focus on

- Planned / elective care (which includes elective recovery as we make our way out of the pandemic)
- Children and adolescent mental health services
- Urgent and emergency care

These areas are considerably challenged across all three places, indeed nationally, and would benefit from working better together across the ICS. Capacity has been increased and there is dedicated resource working with place leads across the ICS reviewing and working to improve the most challenged pathways. For example, in elective care the BOB work is focused on ENT and ophthalmology.

As we progress into 2022/23 the ICS will develop a comprehensive strategy to identify the medium- and long-term priorities for the system with clearly defined outcomes and resourced programmes to deliver our ambitions. This will be done in partnership with our stakeholders and local communities within each place across BOB.

For most people, their day-to day care and support needs will be met locally in the place where they live; the way patients access services will not change.

Dr James Kent, Accountable Officer.

21 June 2022

Accountability Report

Corporate Governance Report

Members Report

Buckinghamshire CCG's 48 member practices are grouped in 13 Primary Care Network (PCN) areas covering the registered population, each with their own Clinical Directors:

North Bucks PCN	Dashwood PCN	Mid Chiltern PCN
3W Health Ashcroft Surgery Waddesdon Surgery Edlesborough Surgery	Chiltern House Medical Centre Cressex Health Centre Carrington House Surgery Riverside Surgery Stokenchurch Medical Centre Wye Valley Surgery	Hughenden Valley Surgery John Hampden Surgery Prospect House Surgery Rectory Meadow Surgery Amersham Health Centre
Central BMW PCN	**Central MAPLE PCN**	**Westongrove Partnership**
Berryfields Medical Centre Meadowcroft Surgery Whitehill Surgery	The Mandeville Practice Oakfield Surgery Poplar Grove Practice	Westongrove Partnership (Aston Clinton, Bedgrove)
Phoenix Health/Aylesbury Vale South PCN	**Chesham & Little Chalfont PCN**	**Cygnet PCN**
Cross Keys Surgery Haddenham Medical Centre Unity Health	Water Meadow Surgery The New Surgery / Dr Firth Gladstone Surgery Little Chalfont Surgery	Desborough Surgery Kingswood Surgery Priory Surgery Tower House Surgery
The Chalfonts PCN	**South Bucks PCN**	**The Arc Network**
The Misbourne Practice The Allan Practice The Hall Practice	Denham Medical Centre Burnham Health Centre Southmead Surgery Threeways Surgery Iver Medical Centre	Cherrymead Surgery Highfield Surgery Marlow Medical Group Millbarn Medical Centre The Simpson Centre The Bourne End & Wooburn Green Medical Centre
	North Bucks PCN	
	The Swan Practice	

Members of the Governing Body

The names of the Clinical Chair and the Accountable Officer for Buckinghamshire CCG are:

- Dr Raj Bajwa, Clinical Chair, Buckinghamshire CCG
- Dr James Kent, Accountable Officer, BCCG and Executive Lead for the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System

Decisions are made by a governing body that meets every month apart from August. In 2021/22 it consisted of: GP members, a Chief Officer, Registered Director, Clinical Directors, (Interim) Chief Finance Officer, three lay members, and a Secondary Care Doctor. The CCG also has operational Directors who take a lead on locality matters and on programmes of work, to the extent necessary. The members of the Governing Body are responsible for directing the major activities of the CCG during the course of the year. The composition of the Board as of 31 March 2022 includes:

- Dr Raj Bajwa, GP Clinical Chair
- Wendy Bower, Lay member, (PPI) – (Appointed 10 June 2021)
- Anthony Dixon, Lay Member (Governance)
- Kate Holmes, Interim Chief Finance Officer
- Dr James Kent, Accountable Officer
- Robert Majilton, (Deputy) Chief Officer
- Crystal Oldman, Registered Nurse
- Robert Parkes, Lay Vice Chair
- Dr Daljit Sahota, Clinical Director
- Dr Rashmi Sawhney, Clinical Director
- Dr Karen West, Clinical Director, Quality, and integration
- Dr Robin Woolfson, Secondary Care Doctor

The following people were members of the Governing Body during 2021/22, but were not in post as of March 2022:

- Graham Smith, Lay member – (Left June 2021)

The following Governing Body members formed the CCG's Audit Committee throughout the year:

- Wendy Bower, Lay Member
- Anthony Dixon, Lay Member
- Robert Parkes, Lay Member (Chair)

The Remuneration Report includes details of the membership of the Remuneration Committee and the Governance Statement includes details of all other Governing Body and Membership Body Committees.

From the CCG Clinical Directors

Dr Raj Thakkar

Clinical Director for Planned Care

The scope of planned care includes cancer care, radiology, surgical specialties and some medical specialties, including dermatology and gastroenterology. In addition to being the clinical director for planned care, I am also the subject matter expert for cardiovascular disease at Buckinghamshire CCG.

I have always promoted the ethos that if we deliver high quality care to our population, efficiencies will follow. That ethos, together with promoting a focus on patients who need healthcare the most, has led to several awards and publications over the years, including an all-party parliamentary award, 2 AFA pioneer awards and HSJ finalist awards.

The pandemic has accelerated significant change in the way care needs to be delivered. Planned care recognised this in the first wave and highlighted the need to focus on several key areas including how we manage care despite COVID.

In addition, I started the Buckinghamshire frailty group which recognised the need for education, identification of clinically frail patients and provision of individual care plans with community support. This work has had significant positive impact on patients and system resilience, including a reduction in 30-day re-admissions from 17.8% in the year to January 2020 to 15.9% in January 2021. Readmissions within seven days had also reduced, as did mean length of stay in hospital. This work has now evolved into an ICS frailty programme.

Significant work is going on around detecting cancer and cardiovascular risk in areas of deprivation. Like frailty, this is a cross organisational piece of work that is outcome focused. There are 17,000 more cases of hypertension to identify, and I am part of a group to support this work.

There is also work across Buckinghamshire to transform the way outpatient services are delivered to enable people to connect with consultants virtually, at the right time and in some cases initiated by patients themselves.

I am leading on a collaborative project to detect and treat patients at high risk of cardiovascular disease, including those with inherited lipid disorders called familial hypercholesterolaemia. This will have profound benefits for patients across the population.

I'm leading on atrial fibrillation work in a COVID-safe way, which offers remote digital checks for irregular pulses and can lead to further significant reduction in stroke risk. Equally, the excellence in heart failure programme has increased prevalence by over 15% in practices which took part and has just been restarted across the county.

The planned care team is dedicated to the patients of Buckinghamshire and committed to transform and deliver the best care possible.

CCG Boards, Committees & Groups member

- Executive Body
- Planned care Board
- Elective Care Board
- Transforming Outpatients' Group
- Cancer Strategy Group
- Clinical Harms Group
- Cardiovascular /Hypertension Groups
- Frailty Delivery Group
- Frailty ICS group

Networks member

- Primary care cardiology lead, Oxford Academic Health Science Network
- Thames Valley Cancer Alliance
- National expert advisory group for heart failure and heart valve disease
- GP co-lead: national cardiac pathways improvement programme

Dr Dal Sahota

Clinical Director for Urgent and Emergency Care

I have served the county as a working clinician and Clinicial Director for several years. Collectively we strive to provide the highest quality care, listening to our patients their families and carers with a focus to continually improve the quality of care that patients receive.

The area of urgent and Emergency care has undoubtedly been one of the most challenging during the pandemic and may of the pressure are ongoing post pandemic. We have worked to support access to appropriate urgent care Via 111, as well as adopting an urgent treatment centre model at the front door of Stoke Mandeville hospital

I provided system leadership support to our trust in setting up of Virtual wards, working closely with our hospital trust and NHS England.

Children's urgent care - We continued our Children's Urgent Care Group meetings and worked proactively with our clinical director for children's services to send out comms to schools and via other media to relay to the public to please consult with general practice for sick children. We have a trusted network of consultants, managers, and comms team who can meet and proactively make changes to improve and safeguard our children and young people.

Discharge to Assess - For inpatients who have recovered from an acute illness in hospital, we continue to enact the home first principle. There has been additional domiciliary capacity commissioned to care for residents at home. Where this has not been possible, patients have been placed in care homes settings once medically fit awaiting their assessments for onward care needs.

There has been significant learning from this work, and we have adapted the care these patients receive to ensure they can access local high-quality primary care services.

Important co production and close working with colleague in the council, linking with Immediate care – (a service that provides immediate access to nursing staff online) as well as working with care homes.

As part of our commitment to care closer to home, I have supported work with a multidisciplinary group to create options for Urgent community responses being a viable alternative to a hospital admission.

Working as a local GP, this has included dealing with easy access to colleagues in general practice availability for one-2-one calls. Working in tandem with our quality team picking up individual complaints and any themes arising from issues. The most important part of my role is and continues to be challenge, to keep questioning to seek assurance that we are doing the best we can with our resource for our population.

CCG Boards, Committees & Groups member

- Governing Body
- Executive committee
- Urgent and Emergency Care Board – Deputy Chair
- 24/7 and Out of Hours Contract Review Meetings - Chair

ICP Boards, Committees, Groups & Forums member

- BOB UEC systemwide Board
- Acute respiratory assessment hubs- NHSE- SE region

Dr Sian Roberts
Clinical Director for Mental Health, Learning Disabilities and Dementia

As a GP and an Executive Clinical Director of Buckinghamshire CCG my role is to drive the clinical work of the CCG with the aim of improving outcomes for people with poor mental health, learning disabilities and dementia.

Mental Health

The Covid Pandemic has had a significant impact on our mental health. In Buckinghamshire, we strive to improve timely access to mental health support across all the age groups, as determined in the NHS Long Term Plan, and reduce the mortality gap of 20 years of those living with serious mental health illness. This year, we have seen uptake of a complete physical health check for those with serious mental health issues increase from 16.4% to 49.6%. This has been achieved

by Primary Care, Secondary Care and PCN colleagues working innovatively and collaboratively to encourage this patient group to have a health check. Throughout the past year I have contributed to the development of our mental health services through working with our local provider Oxford Health and primary care, An example of this includes the development of a Community Mental Health Framework to support seamless and readily accessed mental health care in the community.

Learning Disabilities

Over a third of people with a learning disability die prematurely from avoidable causes, compared with 8.8% of the general population. The key to reduce this health inequality is an annual health check, to enable early detection and treatment of any preventable conditions. The risk of covid further increased the mortality risk in this vulnerable group and as such, conducting health checks has remained a priority during the pandemic. In 2021, primary care colleagues completed health checks in 83% of our population with a Learning Disability in Buckinghamshire. It was going to be a challenge to reach this again, with the addition pressures of the covid and the covid vaccination programme. However, we again have exceeded the national target of 75% by reaching 76.2%. We have also achieved a higher covid vaccination rate in this vulnerable group than the general population.

Dementia

My work in dementia focuses on the need to provide timely diagnosis to ensure people and their carers have access to good post diagnostic support to live well with dementia. Throughout the past year I have helped deliver webinars to clinical, non-clinical and care home staff; promoted the use of a dementia care toolkit for primary care with a personalised approach to dementia care and a toolkit to support care homes to manage patients living with dementia. Due to the covid pandemic and less footfall through primary care, our dementia diagnosis rate has fallen, which means more people are living with dementia, but without a diagnosis. This could be a disadvantage to accessing timely support. Our challenge for 2022/23 is to consider how we identify people living with dementia and ensure they have seamless access to the support they need.

CCG Boards, Committees & Groups member

- Executive Committee
- Mental Health and Learning Disability and Autism Board ICP Board
- Learning Disability and Autism Transformation Board
- Integrated Commissioning Executive Team Board
- Health and Wellbeing Board
- Staying healthy and well with LD
- Community Mental Health Framework
- Dementia Strategy Group

Rashmi Sawhney

Clinical Director for Health Inequalities & PCN Direct Enhanced Services (DES)

As the Clinical Director for Health Inequalities and the Primary Care Network Direct Enhanced Services, my focus over the last year has continued to be on services to support and address both COVID-19 and non-COVID-19 related health inequalities. This has been achieved through playing an active role in clinical aspects of the Buckinghamshire COVID-19 vaccination programme.

The population of Buckinghamshire is multi-cultural. Therefore, it was important to work with our communities to understand their concerns regarding covid immunisation, dispel myths and

thereby increase uptake of covid vaccination. A multi-disciplinary team was set up as a COVID vaccination inequalities group. The membership included CCG personnel, public health consultants, council colleagues and those from Oxford health. Data regarding immunisation has been reviewed regularly. This includes data regarding age groups, ethnicity and deprivation. Based on data, community engagement events and vaccine outreach clinics have been set up. Over the past year, pop up clinics have been set up at community centres, local Mosques, the three Bucks colleges, The Hive, Buckingham library and Women's Aid centre. Work has also involved homeless charities. Going forward, pop up clinics are planned in shopping centres, supermarkets with the aim of targeted interventions in low take-up and high footfall areas that are easily accessible. The health on the move bus has also supported the outreach work.

Vaccine voices educational sessions were rolled out initially for communities and care home staff and later for community midwives and pregnant women to help improve engagement with covid vaccination programme and uptake of immunisation.

Results of all the above efforts have been positive.

Clinical lead for Bucks Integrated Care Partnership Working Group: This workstream was established to support the delivery of the Integrated Care Partnership's objective to reduce health inequalities and increase prevention related to cardiovascular disease.

This programme will use a person-centred approach to empower and support individuals to take management of their own health conditions and increase their healthy behaviours, thereby improving health and wellbeing. Behavioural science and insight will guide the planning and delivery of projects in the programme to ensure the desired outcomes are achieved.

This is a 3-year programme made up of 4 themes, these being key to reducing health inequalities linked to cardiovascular disease. The themes are as follows:

- Blood Pressure
- Wider prevention and community engagement
- Smoking cessation
- Obesity / Physical Activity / Diabetes Prevention

As part of the blood pressure stream there are 2 community-based hypertension projects are underway. The Wycombe BP project involves 2 pilots with faith communities. Learning from these pilots will be shared and applied appropriately across the county.

A blood pressure at home project has also been rolled out across the PCNs.

I support the CCG Primary Care Team and the delivery of the PCN Direct Enhanced Services (DES) care delivery in the local care homes and delivery of the supplementary network service. We have set specific, measurable, achievable, relevant and time bound outcome measures for the supplementary network service.

My role also requires me to provide clinical advice and support to a variety of development projects within the CCG. For example, I have worked with colleagues from various teams to support the development of a frailty strategy for Buckinghamshire.

Statement of Disclosure to Auditors

Each individual who, on 31 March 2022, is a member of the Governing Body confirms:

- so far as the Governing Body member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware and;
- that the Governing Body member has taken all the steps that they ought to have taken as a member to make themselves aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Please see the Annual Governance Statement on page 36 for information about the committees of the Governing Body including membership and attendance.

The Governing Body Membership Register of Interests is available on the CGGs website here

Personal Data Related Incidents

There have been no personal data related incidents formally reported to the Information Commissioner's office.

Modern Slavery Act

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

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 appointed Dr James Kent to be Accountable Officer of NHS Oxfordshire Clinical Commissioning Group.

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 Section 14R 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.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Ernst & Young LLP auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Dr James Kent, Accountable Officer.

21 June 2022

Annual Governance Statement

Introduction and context

Buckinghamshire 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 of 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 CCGs 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. The CCG has the following statutory committees:

- The Audit Committee
- The Remuneration Committee
- The Primary Care Commissioning Committee

It has also established:

- Finance Committee
- Executive Committee
- Quality & Performance Committee

The terms of reference for each of these committees have been ratified by the Governing Body, and the minutes are publicly available along with those of the Governing Body meeting papers (except for Remuneration Committees). Each Committee submits an annual report to the Governing Body giving assurance they are carrying out their 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 CCGs scheme of delegation and the CCGs prime financial policies, provide the procedural framework within which the CCG discharges its business.

Covid-19 Pandemic

During the whole of 2021/22 the NHS has been responding to the Covid-19 pandemic. This has included operating at level 4 (national control) or Level 3 (regional control) for most of the year. This required some amendment to the way the CCG operated including the following:

- Implementation of Covid-19 specific and temporary framework of meetings, an extension of those agreed in 2020/21.
- Governing Body and Primary Care Commissioning Committees were held virtually as meetings in public with attendees able to submit questions.

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICS)

The Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (ICS) operates as a partnership to support each place and organisation within the system for the delivery of services, constitutional standards and requirements of the NHS Long Term Plan. This also includes groups for system leaders to regularly meet, along with financial and delivery oversight. The role of the ICS is to:

- Improve population health and healthcare
- Tackle unequal outcomes and access
- Enhance productivity and value for money
- Help the NHS to support broader social and economic development

Governing Body

To align its process and across the three CCGs' and in accordance with the Buckinghamshire, Oxfordshire, and Berkshire West (BOB) CCGs' Constitution, the BOB CCGs' Governing Bodies held their meetings 'in common' during 2021/22, holding five meetings in public during this period. The meetings that were due to be held in December 2021 were postponed due to the need to concentrate on the NHS response to COVID-19); this meeting subsequently took place in January 2022.

All meetings were quorate in terms of executive and lay member representation. Where meetings were not quorate, in terms of GP clinical representation, matters that required approval were obtained virtually. A table of members attendance is included in Appendix 1.

Matters Reserved to the Membership Body (Practice Members) are clearly defined in the CCGs Constitution. The responsibilities of the Membership Body include among others:

- Assurance including audit and remuneration
- Assuring the decision-making arrangements
- Oversight of arrangements for dealing with conflict of interest
- Leading the setting of vision and strategy
- Quality
- Financial stewardship of public funds
- Promoting patient and public engagement
- Approving commissioning plans on behalf of the CCG
- Monitoring performance against plan
- Providing assurance of strategic risks

The Practice Members are represented on the Governing Body through the Locality Clinical Directors/Locality Leads, and meetings are convened by a GP/Clinical Lead.

The Governing Bodies in 2021/22 focused on organisational objectives, national priorities, and the local health economy's priorities in the Operational Plan. The Board has also held workshops on 'Constitutional alignment across the BOB CCGs'.

Standing agenda items include the Accountable Officers' report, items in relation to finance, strategic risk, corporate governance, performance, patient and public involvement, and clinical concerns. Other items discussed this year include:

- Budget setting and arrangements for annual report and accounts
- Standing items on Quality, Finance, Contracting and Performance
- Review of Quality, Innovation, Productivity and Prevention (QIPP) plans
- Review of strategic risk through the Governing Body Risk Report
- Ratification of policies and procedures as required
- NHS Priorities and Operational Planning
- Governance Alignment
- Developing the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (ICS)
- Future provision for GP IT
- Operational Priority Service – Urgent and Emergency Care
- Communications, Patient and Public Community Engagement
- Emergency Preparedness Response and Resilience (EPRR) winter preparedness and Annual Report
- Response to and recovery from Covid-19, including governance accountability and compliance with statutory duties.

The Governing Bodies also reviewed its own governance arrangements and effectiveness. Members' attendance, apologies for absence, and declarations of interests and/or conflicts of interests (including gifts, hospitality) were formally recorded and published in the minutes of the meetings.

Governing Body Committees

All committees outlined provide assurance to its Governing Body through presentation of their minutes and annual reports. The Committees may also undertake self-assessments of their effectiveness.

Audit Committee

As for the Governing Bodies, the BOB CCG Audit Committees held their meetings 'in common'. The Committee reviews critically the CCGs' financial reporting and internal control principles; ensures that all the CCGs 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 Audit Committees met four times in 2021/22.

The Audit Committees 'in common' receive regular reports to provide it with assurance from:

- The Directors of Finance and deputies on finances and performance, losses and special payments and single tender waivers
- Internal Audit and External Audit – including reports on the outcome of reviews together with recommendations on any necessary actions

- The Local Counter Fraud Specialists (LCFS)
- The Director of Finance and Head of Governance in respect of the Strategic and Operational risk registers
- The Director of Governance in respect of corporate governance including conflicts of interest exceptions, gifts, hospitality, sponsorship, joint working agreements.
- The Senior Information Risk Owner (SIRO) in respect of data security and protection arrangements.

The Accountable (Chief) Officer and other executive directors attend meetings as requested. Representatives of internal audit, external audit and local counter fraud service attend each meeting. A meeting in private session with the Lay Members is also held at least once per annum. The agenda of the Audit Committee is governed by its annual business cycle. A table of members attendance is included in Appendix 1.

Remuneration Committee

As for the Governing Bodies and Audit Committees, the Remuneration Committees held their meetings 'in common'. This Committee reviews the framework for the remuneration, allowances and terms of service for employees of the CCG's and for people who provide services to the CCGs'. It makes recommendations to ensure effective oversight of the performance of the CCGs' Convenor, Accountable (Chief) Officer, Directors of Finance, and other senior posts, and for scrutiny of any redundancy payments. The Remuneration committees met four times in 2021/22.

The overall purpose of the Remuneration Committee is to assure the Governing Bodies that the duty to act effectively, efficiently, and economically has been met, and that use of resources for remuneration does not exceed any amount specified. A table of members attendance is included in Appendix 1.

Primary Care Commissioning Committees (PCCC)

The BU CCG Primary Care Commissioning Committee held its individual (at Place) meeting in April 2021 (Q1 April - June) before moving to a combined BOB PCCC meeting (Q2 - 4 July to March). The PCCC Committee has been established in accordance with the statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in Buckinghamshire, Oxfordshire, and Berkshire West under delegated authority from NHS England.

Meetings are held four times a year and in public. Health and Wellbeing Board representatives and NHS England are also invited to attend in accordance with the Delegation Agreement. The CCGs' clinical leads are voting members.

The Committee met three times in 2021/2022 as one meeting was stood down due to the requirement to support the national response to the Covid-19 pandemic.

The Committee undertakes the following activities:

- Review and monitor GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, taking contractual action such as issuing breach/remedial notices, and removing a contract) and enhanced services ("Local Commissioned Services" and "Directed Enhanced Services")
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area and to approve practice mergers and making decisions on 'discretionary' payments
- To plan, including needs assessment, primary care services across BOB and undertakes and delivers a primary care estates strategy across the BOB geography

- To undertake reviews and manage the budget for commissioning of primary care services at Place and to co-ordinate a common approach to the commissioning of primary care services generally
- To assist and support NHS England in discharging its duty under section13E of the NHS Act 2006 (as amended by the Health and Social Care Act2012) so far as relating to securing continuous improvement in the quality of primary medical services.

A table of members attendance is included in Appendix 1

Executive Committee

Certain matters are considered at most meetings as part of a standing agenda including the Finance~~,~~ Performance and Quality Reports alongside corporate risks.

In addition to the standing items, the Executive Committee also considered the following items which include discussion, reporting and decision making under delegated authority:

- Commenting on proposed changes to the commissioning of some primary care services (extended access, early visiting service, and City Social prescribing)
- Mental Health services
- Ongoing developing of Primary Care Networks
- Continuing development of the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board
- MSK, community gynaecology, musculoskeletal, audiology and termination of pregnancy procurements
- Review of terms of reference and corporate objectives
- Response to and recovery from COVID-19 – including hospital discharge, command and control arrangements and local outbreak control plan
- Emergency Preparedness Resilience and Response (EPRR), winter preparedness, flu outbreak planning and CCG business continuity plans
- Joint Strategic Needs Assessment and the Director of Public Health Annual Report.

While the Executive Committee does not meet in public, its minutes are available to the public within the Governing Body papers.

The CCG also works across the Health and Social Care system on Urgent Care through the A&E Delivery Board. This includes representatives of key providers and commissioners of Urgent Care Services. The Board escalates to the Executive as and when required.

Finance Committee

As with the Governing Bodies delegated Committees, and to align services across BOB, the Finance Committees held their meetings 'in common' during 2021/22. The Finance Committee scrutinises the financial plans and performance in relation to key national targets and in support of the delivery of the outcomes included in the NHS Long Term Plan. It also takes relevant decisions as required under delegated authority, such as business cases.

The Committee reviews reports, identifying key issues and risks and gives opinion and assurance to Governing Body on the stewardship of CCG financial resources and their going concern status. Additionally, the Governing Body may request that the Finance Committee reviews specific aspects of financial performance where they require additional scrutiny and assurance. The Committee met nine times in 2021/22.

A table of members attendance is included in Appendix 1.

The work of the Committee also includes the following activities:

- Monitor use of financial resources and to ensure that value for money can be demonstrated and that the best possible value is secured for the BOB pound
- Scrutiny of Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Programmes (CIPs)
- Evaluate, scrutinise and quality assure the financial validity of the investment, disinvestment, and business case framework.
- Maintain an overview of the value for money provided by the CCGs' expenditure, contracts, and support arrangements (for example, the contract provided by NHS South, Central and West Commissioning Support Unit)
- Approves the release of finance from allocated reserves to support investments and to make recommendations to the Governing Bodies as appropriate.
- Advise the Governing Bodies on relevant reports by NHS England, regulators and other national bodies, and, where appropriate, management's response to these.

Quality and Performance Committee

Reviews and assures provider performance; has oversight of the quality and safety of commissioned services considering safety, effectiveness and patient experience; 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.

It promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness, outcomes, and patient experience. This includes a responsibility to promote research and the use of research and monitor reports made to the National Reporting and Learning System.

The Committee met 6 times in 2021/22. A table of members attendance is included in Appendix 1.

The work of the Committee also includes the following activities:

- Assure the Governing Body in respect of constitutional standards e.g., Stroke services, cancer waiting times and A&E performance etc., alongside safeguarding, infection control, incident management, complaints, workforce data, staff surveys, reporting of quality accounts, or any other area of quality
- Receive assurance on performance and quality and clinical risks, and compliance with National Institute for Health and Care Excellence (NICE) Quality Standards
- Receive assurance on Quality Impact Assessments (QIAs), to assess any impact on quality and performance, in order to provide challenge where necessary
- Ensure that there is a continuing structured process for leadership, accountability and working arrangements for quality and performance within the CCG
- Approval and ratification of policies relating to quality and patient safety

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on its governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered relevant to the clinical commissioning groups and best practice. The Corporate Governance

Report is intended to demonstrate the clinical commissioning groups' compliance with the principles as set out in the Code.

For the financial year ending 31 March 2022 and up to the signing of the statements, we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

In light of the 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 legislation and regulations.

As a result, I, the Accountable Officer, 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 the clinical commissioning groups' statutory duties.

Dr James Kent, Accountable Officer.

21 June 2022

Risk management arrangements and effectiveness

The Audit Committees, at their meetings in common, review the full Strategic Risk Register at every meeting; the Quality Committees review and discusses risks relating to quality and performance; the Finance Committees, at their meetings in common, review and discuss financial risks; the single Primary Care Commissioning Committee reviews and discusses Primary Care risks and the CCG Executive/Clinical Commissioning Committee reviews and discusses the strategic risks.

Capacity to Handle Risk

The Governance Team co-ordinate production of risk registers, offer advice and training (when required) and work with designated risk owners and Executive Directors via individual 1:1s or designated Executive/Director meetings. The purpose of the meeting is to identify any new risk areas; ensuring the appropriate management, quality of recording and scoring of that risk; the review of all current risks obtaining assurance that appropriate actions and mitigations are in place and that all risks are reviewed and managed appropriately. The Governance Leads also maintain the risks cycle ensuring that timely reminders are sent to risks managers for each risk cycle as per Board and Sub-Committee meetings.

Risk Assessment

All risks are reviewed and managed at programme board level before being taken to the appropriate executive/director for review/sign-off at place, with review and escalating to the appropriate Committee; and subsequently Governing Body, providing the necessary assurances that risks are being managed effectively and appropriately.

CCG staff are responsible for own risk and for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager. Staff are to ensure that they familiarise themselves with the Risk Management Policy and undertaking risk management training as appropriate to their role.

The BOB CCGs have no appetite for fraud/financial risk and zero tolerance for regulatory breaches. The CCG support well managed risk taking and will ensure that the skill, ability,

and knowledge are in place to support innovation and maximise opportunities to improve its service. The Audit committees and the Directors Risk Review meetings will review the appetite statement on an annual basis and propose any changes to its Governing Bodies.

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.

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 revised statutory guidance (further updated in June 2017) provides for a practical toolkit, which includes templates and case studies to support CCGs with conflicts of interest management. The CCG also takes guidance and assurance from the managing conflicts of interest in the NHS – guidance for staff and organisations (published June 2017) applicable to CCGs, NHS Trusts and NHS Foundation Trusts and NHS England. Other bodies involved in the provision of NHS services are invited to consider implementing this guidance.

The CCGs recognise the potential for interests of members to conflict with the business of the CCG; consequently, the CCGs' have embedded within its governance a number of policies, protocols and processes to ensure that potential conflicts are recognised and managed, and that informed decisions are made only by those who do not have a vested interest.

The CCGs' internal auditors carried out their annual audit for 2021/22 and made the following assessments/recommendations:

Buckinghamshire CCG: Rated: 'substantial assurance'. Two low priority and one medium actions recommendation (a clear and consistent set of staff groups to be identified for each of the three conflicts of interest training modules; the standards of Business Conduct Policy should be updated to include Local Counter Fraud Service recommendations; and management of an undisclosed interest for one individual should be investigated.

- The first two actions will be picked up as part of the work for the new Integrated Care Board.
- The undisclosed interest was investigated and found to be immaterial

Data Quality

The sourcing of data and management of provider data quality is achieved via contracts. The data contract management processes are well established in the three CCGs, and we continue to capitalise on strong relationships between NHS South Central and West Commissioning Support Unit and information governance teams within provider organisations to drive continuous improvement.

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 is due to submit its Data Security and Protection Toolkit for 2021/22 by the 30 June 2022. The date for submission was extended by NHS England due to the pressure on organisations caused by the COVID-19 pandemic.

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 established processes in place for incident reporting and investigation of serious incidents. In 2021/22, there were no incidents which required reporting to the information Commissioner's Office.

Information Governance is reported to the Audit Committees in common as a standing agenda item at each meeting and is reviewed regularly through the individual 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 BOB CCGs do 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. Third party assurances are reported to the Audit Committees in Common and informs this governance statement and external audit conclusion.

Control Issues

The CCGs performance against constitutional targets has been impacted by the Covid-19 pandemic and further details can be found in the Performance Report along with information about how the CCGs performance will be recovered through the course of 2021/22.

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

The Financial regime

The financial regime put in place by NHSE for 21/22 followed that which was in place for 20/21 and fell into two halves – H1 and H2, the Finance and contracting arrangements for the six-month period from 1 April 2021 to 30 September 2021 ('H1 2021/22' or 'H1') and October 2021 to March 2022 (H2 2021/22 or H2).

The H1 arrangements

The funding was based on a System funding envelope, comprising of adjusted CCG allocations based on the H2 2020/21 envelopes adjusted for known pressures and policy

priorities. The payment arrangements for NHS providers remained on a block payment arrangement but amended to reflect the changes to system funding envelopes, e.g., application of inflation and distribution of additional funding e.g., top up, Covid funding. Signed contracts with NHS providers were not required. The commissioning of services from acute independent sector (IS) services devolved back to the CCG's which were covered by the national IS contract during 2020/21.

The H1 being based on the 20/21 budgets with proposed uplifts from NHSE and extra ordinary expenditure covering COVID, and Hospital Discharge Programmes up to six weeks funded by a retrospective allocation to bring the CCG's back to a balanced position.

Through the H1 financial regime, systems will have access to the following additional growth funding:

i. acute services – access to additional funding through the Elective Recovery Fund
ii. mental health services – additional CCG programme funding and service development funding (SDF) to enable delivery of the Mental Health Investment Standard (MHIS) and Long-Term Plan (LTP) priorities
iii. primary medical care services – additional primary care growth has been issued in line with the 2021/22 published CCG primary medical care
iv. community services – funding for demographic growth has been included within system funding envelopes. Access to additional non-demographic growth will be available through SDF for transforming community services, including for accelerating the rollout of the two-hour crisis community health response at home.

The H2 arrangements

For the H2 period the budget was based on the H1 funding envelope with additional uplifts applied as notified by NHSE to tariff and pay inflation. Payment arrangements continues, the funding for Hospital Discharge period moved from 6 weeks to 4 weeks, COVID and other system funding to Providers maintained with the view that organisations will achieve a breakeven position.

For 22/23 the System has been issued a Financial Envelope which includes growth funding but reductions in system support and COVID funding with a view that the financial performance returns to a sustainable position.

The CCG has well-established systems and processes for managing its resources effectively, efficiently, and economically. The Governing Body has an overarching responsibility for ensuring that the CCG has appropriate arrangements in place, and delegates responsibilities to the Audit Committee, the ICP 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 Committees met regularly throughout the 2021/22 financial year to review and monitor the CCGs' financial reporting and internal control principles; to ensure that the CCGs 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 Committees 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 CCGs' 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 ICP Quality Committee/Quality Committee.

The Chief Finance Officer meets regularly with the CCG's finance teams and holds monthly meetings with the CSUs 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 CCGs 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 not yet received the annual rating from NHSE&I.

Delegation of functions

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

The Governing Body receive 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 organisations' 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 is in place.

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 CCGs and NHSCFA. The Director of Finance is the Executive Lead for Counter Fraud. The CCGs have a Counter Fraud and Corruption Policy and Response Plan in place, and this was last reviewed in January 2022.
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 Director of Finance and the Audit Committees in Common. Audit Committees 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:

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control, and governance processes. The opinion contributes to the organisation's annual governance statement. For the 12 months ended 30 March 2022,
The Head of Internal Audit Opinion is included in the Annual Report that follows.

During the year, Internal Audit issued the following audit reports:

Audit Area	Buckinghamshire CCG Assurance Level
Key Financial Controls	Final - Substantial Assurance
Financial Planning and Forecasting	Final - Substantial Assurance
Covid-19 Recovery/Lessons Learnt	Final - Substantial Assurance
Section 117	Final - Reasonable Assurance
Continuing Healthcare	Final – Reasonable Assurance
Conflicts of Interest	Final – Reasonable Assurance

There are no issues from the work to date that we believe the CCG need to consider as significant control issues.

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 groups 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.

The strategic risk register itself provides me with evidence of the effectiveness of controls that manage risks to the clinical commissioning groups achieving its principle objectives have been reviewed.

I have been guided on the effectiveness of controls through the oversight of the Board and its committees and this has also informed my review. If necessary, a plan to addresses weaknesses, for example responses to audit recommendations and ensure continuous improvement of the system, will be put in place

Conclusion

No significant internal control issues have been identified.

Dr James Kent
Accountable Officer
21 June 2022

Remuneration and Staff Report

Remuneration policy

The CCGs use Agenda for Change terms and conditions for all employees except those classified as Very Senior Managers (VSMs). The Remuneration Committee has a standing agreement that VSM pay and expenses are up lifted in accordance with Agenda for Change awards as made by the national Pay Review Body. This agreement is reviewed at each Agenda for Change award to ensure that it remains an appropriate strategy.

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 content of the roles and individuals' performance in them. This ensures a fair, independent and transparent process for setting the pay of the senior managers. 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 Committee

The overall purpose of this committee is to assure the Governing Bodies that the duty to act effectively, efficiently and economically has been met, and that use of resources for remuneration does not exceed any amount specified.

Membership of the Remuneration Committee is drawn from the Governing Bodies. The Chief Finance Officer and Chief Officer would normally attend in addition a representative from Human Resources. No member is present for matters involving their personal remuneration. Additional lay members can be co-opted to ensure relevant experience is available. The committee met 7 times in 2021/22.

The following is the remuneration of the Governing Bodies, Executive and Non-Executive members for 2021/22

Name and Title	Buckinghamshire CCG Salary (Bands of £5000) £000	Expense Payments Taxable (rounded to nearest £100) £00	Performance pay & bonuses (Bands of £5000) £000	Long Term Performance pay & bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Buckinghamshire CCG (Bands of £5000) £000
Board members						
James Kent (5) Accountable Officer	55-60	0	5-10	0-5	47.5-50	105-110
Kate Holmes Interim Chief Finance Officer	105-110	0	0-5	0-5	95-97.5	200-205
Robert Majilton Deputy Accountable Officer	110-115	0	0-5	0-5	32.5-35	145-150
Dr Raj Bajwa GP Clinical Chair	70-75	0	0-5	0-5	50-52.5	120-125
Dr Karen West Clinical Director for Integrated Care & Quality Lead	45-50	0	0-5	0-5	10.0-12.5	60-65
Dr Stuart Logan (1) Clinical Director - Long Term Conditions, Prevention and supported Self-Care	20-25	0	0-5	0-5	0-2.5	20-25
Dr Juliet Sutton Clinical Director - Children's	20-25	0	0-5	0-5	5-7.5	25-30
Louise Smith Interim Director of Primary Care and Transformation	100-105	0	0-5	0-5	50-52.5	150-155
Dr Robin Woolfson Secondary Care (8) - Specialist Doctor	10-15	0	0-5	0-5	0-2.5	10-15
Dr Dal Sahota Clinical Director - Unplanned Acute Care	45-50	0	0-5	0-5	10-12.5	60-65
Dr Raj Thakkar Clinical Director - Planned Care	45-50	0	0-5	0-5	7.5-10	55-60
Dr Rashmi Sawhney Clinical Director -Health Inequalities and The Primary Care Networks DES	50-55	0	0-5	0-5	0-2.5	45-50
Dr Sian Roberts Clinical Director (7)- Mental Health & Learning Disabilities	40-45	0	0-5	0-5	7.5-10	45-50
Dr Shona Lockie (2) Clinical Director - Medicines Management	15-20	0	0-5	0-5	2.5-5	20-25
Non Executive Board						
Robert Parkes Lay Member	10-15	0	0-5	0-5	0-2.5	10-15
Anthony Dixon Lay Member	10-15	0	0-5	0-5	0-2.5	10-15
Graham Smith (3) Lay Member	0-5	0	0-5	0-5	0-2.5	0-5
Wendy Bower (6) Lay Member Patient and Public Involvement	0	0	0-5	0	0	0
Dr Crystal Oldman (4) Registered Nurse - Governing Body	0-5	0	0-5	0-5	0-2.5	0-5

*Note: Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual

(1) Dr Stuart Logan left in December 2021. He has never been a member of the NHS Pension Scheme
(2) Dr Shona Lockie left the CCG in September 2021
(3) Graham Smith left in August 2021
(4) Dr Crystal Oldman Payments paid to Queen's Institute

(5) James Kent was appointed as Accountable Officer for Buckinghamshire Clinical Commissioning Group, Oxfordshire Clinical Commissioning Group and West Berkshire Clinical Commissioning Group on a shared basis in May 2020.
As James Kent works across the 3 CCG's, Buckinghamshire CCG accounts for 30.4% of salary and bonus. The Bonus paid in 21/22 of £27,300 covers £18,200 for 20/21 and £9,100 for 21/22. There is a further £9,100 due for 21/22 which will be payable in 22/23

(6) Wendy Bower became a Lay Member in December 2021 and remuneration is being paid by BW CCG and no recharges are being made.

(7) Dr Sian Roberts from 1/1/22 has held an additional role in the CCG as Clinical Champion – Learning, Disability and Autism
(8) Dr Robin Woolfson is not a member of NHS Pension Scheme

The following is the remuneration of the Governing Bodies, Executive and Non-Executive members for 2020/21.

Salaries & Allowances of the Buckinghamshire CCG Board members including Senior Managers 20/21

		2020-21						
Name	Title	TOTAL Salary & Fees (Bands of £5000) £000	Buckinghamshire CCG Salary & Fees (Bands of £5000) £000	Taxable benefit (rounded to nearest £100) £00	Annual Performance Related Bonuses (Bands of £5000) £000	Long Term Performance Related Bonuses (Bands of £5000) £000	All Pension Related Benefits (Bands of £2500) £000	TOTAL Buckinghamshire CCG (Bands of £5000) £000
Board members								
James Kent (1)	Accountable Officer	160-165	45-50	0	5-10	0-5	35-37.5	90-95
Gary Heneage (2)	Chief Finance Officer	55-60	55-60	0	0-5	0-5	45-47.5	100-105
Kate Holmes (3)	Interim Chief Finance Officer	80-85	80-85	0	0-5	0-5	80-82.5	160-165
Robert Majilton	Deputy Accountable Officer	110-115	110-115	0	0-5	0-5	25-27.5	140-145
Fiona Wise (4)	Acting Accountable Officer and ICS Lead	35-40	15-20	1	0-5	0-5	0-2.5	15-20
Dr Raj Bajwa	GP Clinical Chair	70-75	70-75	0	0-5	0-5	15-17.5	85-90
Dr Karen West	Clinical Director for Integrated Care & Quality Lead	45-50	45-50	0	0-5	0-5	7.5-10	55-60
Dr Malcolm Jones	Clinical Lead for End of Life Care	10-15	10-15	0	0-5	0-5	0-2.5	10-15
Dr Stuart Logan	Clinical Director - Long Term Conditions, Prevention and supported Self-Care	25-30	25-30	0	0-5	0-5	0-2.5	25-30
Dr Juliet Sutton	Clinical Director - Children's	20-25	20-25	0	0-5	0-5	0-2.5	25-30
Louise Smith	Interim Director of Primary Care and Transformation	95-100	95-100	1	0-5	0-5	37.5-40	135-140
Dr Robin Woolfson	Secondary Care - Specialist Doctor	10-15	10-15	0	0-5	0-5	0-2.5	10-15
Dr Dal Sahota	Clinical Director - Unplanned Acute Care	45-50	45-50	0	0-5	0-5	7.5-10	55-60
Dr Raj Thakkar	Clinical Director - Planned Care	75-80	75-80	0	0-5	0-5	0-2.5	75-80
Dr Rashmi Sawhney	Clinical Director -Health Inequalities and The Primary Care Networks DES	45-50	45-50	0	0-5	0-5	0-2.5	45-50
Dr Sian Roberts	Clinical Director - Mental Health & Learning Disabilities	35-40	35-40	0	0-5	0-5	7.5-10	45-50
Dr Shona Lockie	Clinical Director - Medicines Management	35-40	35-40	0	0-5	0-5	2.5-5	40-45
Non Executive Board								
Robert Parkes	Lay Member	10-15	10-15	0	0-5	0-5	0-2.5	10-15
Anthony Dixon	Lay Member	10-15	10-15	0	0-5	0-5	0-2.5	10-15
Colin Seaton (5)	Non Exec Director	0-5	0-5	0	0-5	0-5	0-2.5	0-5
Graham Smith	Lay Member	5-10	5-10	0	0-5	0-5	0-2.5	5-10
Dr Crystal Oldman (6)	Registered Nurse - Governing Body	0-5	0-5	0	0-5	0-5	0-2.5	0-5

(1) James Kent was appointed as Accountable Officer for Oxfordshire Clinical Commissioning Group and West Berkshire Clinical Commissioning Group on a shared basis in May 2020. James Kent is contractually eligible for performance bonus for 2020-21 which have not been included as a result of not yet settled in the year.
(2) Gary Heneage left the CCG in October 2020
(3) Kate Holmes replaced Gary Heneage in October 2020
(4) Fiona Wise was Acting Accountable Officer and ICS Lead for three months then was replaced by James Kent
(5) Colin Seaton left in October 2020
(6) Dr Crystal Oldman Payments paid to Queen's Institute

The above table has been restated due to restating the performance bonus of James Kent to align with the reporting guidance to disclose all bonuses paid and accrued for the financial year. James Kent is contractually eligible to performance bonus in 2020-2021 but only settled this current year and was omitted in the prior year disclosure.

With the exception of Accountable Officer who was paid a bonus of £27,300 of which £18,200 related to 20/21 and £9,100 to 21/22 with a further payment due in 22/23 of £9,100 (Buckinghamshire CCG accounts for its share at 30.4%), the Remuneration package does not include any performance related bonuses and no remuneration has been paid in relation to this.

All appointments to the Governing Bodies, other than those described as "officers" are substantive employees of the CCGs.

Those who are officers have fixed term contracts with their specific arrangements described in the table below:

All appointments to the Governing Body, other than those described as 'officers', are substantive employees of the CCG. Those who are officers have fixed term contracts with their specific arrangements described in the table below:

Governing Body Officers	Role on Governing Body	Date of Contract	Unexpired Term	Notice Period	Provision for compensation for early termination
Dr Raj Bajwa	Clinical Chair	01/11/2018	32 weeks	12 weeks	Nil
Robert Parkes (1)	Lay Member & Audit Committee Chair - Vice Chair	04/01/2019	13 weeks	12 weeks	Nil
Graham Smith (2)	Lay Member - Primary Care Joint Committee Chair	01/08/2018	0 weeks	12 weeks	Nil
Crystal Oldman (1)	Registered Nurse Specialist	17/01/2013	13 weeks	12 weeks	Nil
Anthony Dixon (1)	Lay Member & Finance Committee Chair	01/04/2018	13 weeks	12 weeks	Nil
Robin Woolfson (1)	Secondary Specialist Doctor	01/03/2016	140 weeks	12 weeks	Nil
Wendy Bower (3)	Lay Member - Patients and Public Engagement				

1) Term extended until 30th June 2022
2) Left in December 2021
3) Member of Berkshire West now working across all BOB CCG's

NHS Buckinghamshire CCG - Pension Benefits – Greenbury Disclosure 2021/22

Name and Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Board members								
James Kent (5) Accountable Officer	2.5-5	0-2.5	5-10	0-5	67	27	125	0
Kate Holmes Interim Chief Finance Officer	5-7.5	7.5-10	30-35	75-80	519	81	618	0
Robert Majilton Deputy Accountable Officer	0-2.5	0-2.5	45-50	55-60	626	27	672	0
Dr Raj Bajwa GP Clinical Chair	0-2.5	2.5-5	25-30	60-65	459	50	510	0
Dr Karen West Clinical Director for Integrated Care & Quality Lead	0-2.5	0-2.5	15-20	25-30	220	9	237	0
Dr Stuart Logan (1) Clinical Director - Long Term Conditions, Prevention and supported Self-Care	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Juliet Sutton Clinical Director - Children's	0-2.5	0-2.5	10-15	25-30	227	8	239	0
Louise Smith Interim Director of Primary Care and Transformation	2.5-5	2.5-5	30-35	60-65	466	39	525	0
Dr Robin Woolfson Secondary Care (8) - Specialist Doctor	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Dal Sahota Clinical Director - Unplanned Acute Care	0-2.5	0-2.5	10-15	20-25	196	8	212	0
Dr Raj Thakkar Clinical Director - Planned Care	0-2.5	0-2.5	5-10	20-25	137	5	150	0
Dr Rashmi Sawhney (6) Clinical Director -Health Inequalities and The Primary Care Networks DES	0-2.5	0-2.5	10-15	35-40	0	0	0	0
Dr Sian Roberts Clinical Director (7) - Mental Health & Learning Disabilities	0-2.5	0-2.5	5-10	0-5	86	6	98	0
Dr Shona Lockie (2) Clinical Director - Medicines Management	0-2.5	0-2.5	15-20	35-40	303	2	315	0
Non Executive Board								
Robert Parkes Lay Member	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Anthony Dixon Lay Member	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Graham Smith (3) Lay Member	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Crystal Oldman (4) Registered Nurse - Governing Body	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Wendy Bower (6) Lay Member Patient and Public Involvement	0-2.5	0-2.5	0-5	0-5	0	0	0	0

(1) Dr Stuart Logan left in December 2021. He has never been a member of the NHS Pension Scheme

(2) Dr Shona Lockie left the CCG in September 2021

(3) Graham Smith left in August 2021

(4) Dr Crystal Oldman Payments paid to Queen's Institute

(5) James Kent was appointed as Accountable Officer for Buckinghamshire Clinical Commissioning Group, Oxfordshire Clinical Commissioning Group and West Berkshire Clinical Commissioning Group on a shared basis in May 2020.
As James Kents works across the 3 CCG's, Buckinghamshire CCG accounts for 30.4% of salary and bonus. The Bonus paid in 21/22 of £27,300 covers £18,200 for 20/21 and £9,100 for 21/22. There is a further £9,100 due for 21/22 which will be payable in 22/23

(6) Wendy Bower became a Lay Member in December 2021 and remuneration is being paid by BW CCG and no recharges are being made.

(7) Dr Sian Roberts from 1/1/22 has held an additional role in the CCG as Clinical Champion – Learning, Disability and Autism

(8) Dr Robin Woolfson is not a member of NHS Pension Scheme

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

NHS Buckinghamshire CCG - Pension Benefits – Greenbury Disclosure 2020/21

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Board members									
James Kent (1)	Accountable Officer	2.5-5	0-2.5	0-5	0-5	25	13	67	0
Gary Heneage (2)	Chief Finance Officer	0-2.5	0-2.5	15-20	0-5	152	12	189	0
Kate Holmes (3)	Interim Chief Finance Officer	2.5-5	2.5-5	25-30	65-70	433	28	519	0
Robert Majilton	Deputy Accountable Officer	0-2.5	0-2.5	45-50	55-60	578	22	626	0
Fiona Wise (4)	Acting Accountable Officer and ICS Lead	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Raj Bajwa	GP Clinical Chair	0-2.5	0-2.5	20-25	55-60	422	15	459	0
Dr Karen West	Clinical Director for Integrated Care & Quality Lead	0-2.5	0-2.5	10-15	25-30	203	7	220	0
Dr Malcolm Jones	Clinical Lead for End of Life Care	0-2.5	0-2.5	10-15	30-35	237	4	247	0
Dr Stuart Logan	Clinical Director - Long Term Conditions, Prevention and supported Self-Care	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Juliet Sutton	Clinical Director - Children's	0-2.5	0-2.5	10-15	25-30	215	5	227	0
Louise Smith	Associate Director Commissioning & Locality Delivery	2.5-5	0-2.5	25-30	60-65	416	25	466	0
Dr Robin Woolfson	Secondary Care - Specialist Doctor	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Dal Sahota	Clinical Director - Unplanned Acute Care	0-2.5	0-2.5	10-15	20-25	180	5	196	0
Dr Raj Thakkar	Clinical Director - Planned Care	0-2.5	0-2.5	5-10	20-25	131	0	137	0
Dr Rashmi Sawhney	Clinical Director -Health Inequalities and The Primary Care Networks DES	0-2.5	0-2.5	10-15	30-35	286	0	0	0
Dr Sian Roberts	Clinical Director - Mental Health & Learning Disabilities	0-2.5	0-2.5	5-10	0-5	74	5	86	0
Dr Shona Lockie	Clinical Director - Medicines Management	0-2.5	0-2.5	15-20	35-40	286	4	303	0
Non Executive Board									
Robert Parkes	Lay Member	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Anthony Dixon	Lay Member	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Colin Seaton	Non Exec Director	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Graham Smith	Lay Member	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Dr Crystal Oldman (5)	Registered Nurse - Governing Body	0-2.5	0-2.5	0-5	0-5	0	0	0	0

(1) James Kent joined in May 2020

(2) Gary Henage left the CCG in October 2020

(3) Kate Holmes replaced Gary Henage in October 2020

(4) Fiona Wise was Acting Accountable Officer and ICS Lead for three months then was replaced by James Kent

(5) Dr Crystal Oldman Payments paid to Queen's Institute

The above table has been restated to amend the Real increase in Cash Equivalent Transfer Value to reflect employee contributions which was incorrectly excluded.

* 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 McCloud - 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 pensions schemes introduced a CARE benefit design in 2015 for all but the eldest members who retained a Final Salary design). We confirm that Buckingham CCG is unaffected by the McCloud Judgment. As such we do not anticipate any adjustments to the pension positions of its employees to occur due to this ruling.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their 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.

The benefits and corresponding CETV do not allow for any potential adjustment in relation to the McCloud judgement

Real Increase in CETV

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

Consultation outcome McCloud remedy part 1: proposed changes to NHS Pension Schemes Regulations 2022 Public Service Pensions and Judicial Offices Bill

The government has laid proposed primary legislation, the Public Service Pensions and Judicial Offices Bill (the 'bill') before Parliament to implement changes in public service pension schemes to remedy the discrimination identified by the McCloud judgment. When new public service schemes were introduced in 2015, a transitional protection allowed older workers to continue building pension in the legacy schemes whilst younger workers were moved into the new schemes.

Subject to parliamentary approval, the bill puts in place a legal framework which requires departments to make amendments to pension scheme regulations to facilitate implementation of the remedy.

The remedy has 2 parts:

- to ensure equal treatment for all members within each of the main public service pension schemes by moving all members into the new schemes on 1 April 2022 irrespective of age
- to remove the effect of transitional protection by offering eligible members a choice

over the set of benefits (legacy scheme or new scheme) they wish to receive for any pensionable service during the period 1 April 2015 to 31 March 2022

NHS Pension Scheme regulations to allow for the implementation are being drafted following the enabling legislation known as the Public Service Pensions and Judicial Offices Act 2022 (which came into force in March 2022).

Exit Packages 2021/22

There were no exit packages in the year 2021/22 and consequently no associated payments.

Analysis of Other Agreed Departures

There were no departures made in the year 2021/22 or the previous year 2020/21 in respect of voluntary redundancy, ill health retirements, mutually agreed resignations, early retirements in the efficiency of the service, payments in lieu of notice, exit payments following employment tribunals or court orders or non-contractual payments requiring HMT approval.

Redundancy and other departure costs would be paid in accordance with the provisions of BCCG's Compulsory Redundancy Scheme in line with Agenda for Change standard entitlements where applicable. Any exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure. BCCG has not agreed any early retirements. If it had, the additional costs would be met by BCCG and not by the NHS Pension Scheme and would be included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

No non-contractual payments (£0) were made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. However, none were made during 2021/22.

Fair pay disclosures

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in [the organisation] in the financial year 2021-22 was £130k to £135k (2020-21, £130k - £135k). The relationship to the remuneration of the organisation's workforce is disclosed in the below tables:

Percentage Changes	21/22	20/21	Change	% Change
Highest paid director				
Salary and Allowances	132,500	132,500	-	0.00%
Performances and bonuses	-	-	-	0.00%
Employees of the entity taken as a whole (Average)				
Salary and Allowances	61,863	58,252	3,611	6.20%
Performances and bonuses	18,200	18,200	-	0.00%

The bonus relates to one employee for both years and no other bonuses are received by the remaining workforce.

2021-22	25th Percentile	Median	75th Percentile

Total remuneration (£)	39,056	53,841	75,874
Salary component of total remuneration (£)	39,056	53,841	75,874
Pay ratio information	3.39	2.46	1.75
2020-21	25th Percentile	Median	75th Percentile
Total remuneration (£)	36,396	50,326	73,684
Salary component of total remuneration (£)	36,396	50,326	73,684
Pay ratio information	3.64	2.63	1.80
Comparative	25th Percentile	Median	75th Percentile
Total remuneration (£)	2,660	3,516	2,190
Salary component of total remuneration (£)	2,660	3,516	2,190
Pay ratio information	-0.25	-0.17	-0.05

The pay ratio shows the number of times the average staff renumeration in relation to the highest paid director and the 25th percentile is higher due to a lower average renumeration (25%) compared to highest paid director.

The total annualized remuneration of the Accountable Officer James Kent was used in the calculation of average salary and pay ratios, but the highest paid director was determined using the cost specific to BCCG.

In 2021-22, 0 (2020-21, 0) employees received remuneration in excess of the highest-paid director / member. Remuneration ranged from £11,500 to £132,500 (2020-21 £11,500-£132,500. The 2020-21 renumeration has been rebased to reflect annualised values

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.

The change in median pay relates to the

- timing of employees leaving and new starters coming in,
- the skill mix and levels of job positions being vacated, and positions filled
- the impact of in year pay awards
- Use of Agency staff backfilling vacant position where a premium is paid above normal pay rates

Expenditure on consultancy

Expenditure on consultancy was £185k in 2021/22 (£263k in 2020/21) as per Note 5 to the accounts' page 87.

Off-payroll Engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Departments and their arm's length bodies (this is taken to include all those bodies included within the DH reporting boundary) must publish information on their highly paid and/or senior off-payroll engagements.

For all off-payroll engagements as of 31 March 2022, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0

Confirmation that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	0
Number of new engagements which include contractual clauses giving the Buckinghamshire CCG the right to request assurance in relation to income tax and National Insurance obligations (IR35)	0
Number for whom assurance has been requested	0
Of which:	
Assurance has been received	0
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0
Number of off-payroll engagements of Governing Body members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed “Governing Body members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements	0

Staff Report

Staff sickness absence

Staff sickness absence Below outlines BCCG's sickness absence data from 1 April 2021 to 31 March 2022

	2021/22
Total days lost	1021
Average full time equivalent	2.44
Average working days lost	11.73

Health & wellbeing of staff

BCCG proactively promotes the health and wellbeing of staff in line with its Health and Wellbeing Strategy. The CCG has a Wellbeing Champion who has been working hard to support colleagues with various initiatives since before the start of the pandemic:

- The CCG have several Mental Health First Aiders who are available for staff to talk to and are supportive, and able to sign post the member of staff accordingly
- Wellbeing Champion promotes various nationwide initiatives and sessions amongst others: Recognising Stress & Anxiety, Eating for Health, The Importance of Physical Actively, Looking after Ourselves to support staff keep well both mentally and physically
- BCCG are part of the Mindful Employer network and have signed up to their Charter to support mental health in the workplace

The activities have been based on MS Teams since the pandemic began and have been well received and attended by staff across a range of teams and directorates.

The Employee Assistant Programme (EAP) is a free service for staff to anonymously access impartial advice and counselling services. The service supports staff with a range of things including managing stress, coping with bereavement, relationship breakdown, debt advice or a challenge or issue which could benefit from being talked through.

A weekly staff email update is sent by the Wellbeing Champion and commenced before the beginning of the pandemic, this has continued throughout the year; it includes lots of work-related information and also signposts to resources for mental and physical wellbeing. The weekly update has been well received by staff across the organisation.

Staff numbers and gender analysis

BCCG has a workforce comprised of employees from a wide variety of professional groups. At the end of 2021/22 BCCG employed 87 staff (headcount) of which 60 were women and 27 men.

As of 31 March 2022, the Board of BCCG was made up of 4 women and 1 man.

Below is a breakdown of gender analysis. The membership body of BCCG is made up of all 87 (as of 31 March 2022) GP practices within Buckinghamshire; a breakdown of membership by gender is not available.

This table shows the breakdown of the staff gender:

	Female Headcount	Male Headcount	Total Headcount
CEO and Board	4	1	5
Very Senior Managers including GPs	9	8	17
All other Employees	47	18	65
Total Employees	**60**	**27**	**87**

This table shows the number of people (headcount) employed by BCCG and others employed by other organisations or temporary staff who are working for BCCG:

	2021/22 Permanently employed Number	Other Numbers	21/22 Total Number
Total	**76**	**11**	**87**
Of the above: Number of whole time equivalent	64.38	7.2	71.40
(WTE) people engaged on capital projects	0	0	0

Staff turnover in 2021-22 for BCCG, by headcount, was 24.60%.

Trade union official facility time

No matters occurred during the year requiring this time

Staff Policies

BCCG recognise and value the importance of maintaining positive working relationships with its staff and their representatives. Since December 2020 we have a Staff Partnership Forum (SPF) for all three CCGs to form a single BOB wide forum. The SPF is a joint management and staff forum for staff engagement and consultation; a key focus of the BOB SPF is wellbeing and inclusion of staff.

Staff and managers from BCCG have actively and successfully worked with colleagues across BOB to align policies with those of Oxfordshire and Berkshire West CCGs to support the development of the BOB ICB. Policies are ratified by BCCG's Executive prior to publication.

The BOB SPF is representative of the workforce and BCCG recognises all of the trade unions outlined in the national NHS Terms and Conditions of Service Handbook who have members employed within the organisation.

The CCG has a Health and Wellbeing Policy and an active, staff led, Health and Wellbeing Group which is responsible for the implementation of this policy which has been vital during the past year of the pandemic and different ways of working. Events are held throughout the year with a large number of staff participating. Events have included quizzes and events aimed to support employee's wellbeing. The Wellbeing Wednesday sessions commenced in 2020 are available to staff across the three CCGs.

BCCG with the BOB SPF have developed a range of methods to communicate and encourage meaningful, two-way dialogue with staff include:

- Weekly BOB ICS Accountable Officer Staff Briefings
- CCG and BOB ICS Staff surveys to drive improvement in staff experience
- Staff development / training sessions with opportunities across the BOB ICS

The results of the staff surveys have been assessed by the BOB SPF, themes identified and action plans developed by staff to address different aspects of the feedback. This has resulted in the development of a more agile working approach and focus on BCCG values. Managers hold regular one-to-one meetings with staff and use the values-based appraisal system ensuring all staff work towards clearly defined personal objectives and standards of behaviour. These are supported with learning, training and development opportunities detailed in individual Personal Development Plans.

Disability information

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

BCCG is committed to implementing the Workforce Race Equality Standards (WRES) and will work with those organisations it commissions services from and partners to ensure employees from black and ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The 2021 WRES return is available on the CCGs website.

Equality and Diversity

For information of the Workforce Race Equality Standard and how we give 'due regard' to eliminating discrimination please see the annual submission which is available on our website.

In 2021/22 all three BOB CCGs took part in the national staff survey; results have recently been received and will be used to support the development of the Integrated Care Board.

Health and safety

BCCG recognises that the maintenance of a safe workplace and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the upmost importance. However the past year the majority of staff have been working from home. During this time, considerable effort has gone into supporting staff as they continue to work from home. This included all staff undertaking risk assessments of their 'at home' working environment and purchasing equipment (for example office chairs and monitor) to accommodate individual staff need.

Health and Safety training forms part of the suite of statutory and mandatory training which is undertaken by all employees.

Whistleblowing

BCCG has a whistleblowing policy that is communicated to all staff and available on the CCG staff intranet.

Auditable elements

Please note that the elements of this remuneration and staff report that have been subject to audit are the tables of salaries and allowances of senior managers and related narrative notes on page 50 and 51, pension benefits of senior managers and related narrative on pages 52 to 53, the Fair Pay disclosure and related narrative notes on page 54 - 55 and exit packages and any other agreed departures on page 54 - 55.

Dr James Kent, Accountable Officer

21 June 2022

Parliamentary Accountability and Audit Report

Buckinghamshire Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report, however, has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 2021/22 there is nothing to disclose.

Dr James Kent, Accountable Officer

21 June 2022

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

Opinion

We have audited the financial statements of NHS Buckinghamshire Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which 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 21, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2021/22 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).

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Buckinghamshire Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been properly prepared in accordance with the National Health Service Act 2006 (as amended).

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. We are independent of the CCG 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.

Emphasis of Matter – Transition to an Integrated Care Board

We draw attention to Note 20 - Events After the End of the Reporting Period, which describes the Clinical Commissioning Group's transition into the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board from the 1 July 2022. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's, or the

successor body's, ability to continue as a going concern for a period of at least 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

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.

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 course of 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 themselves. 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 the Remuneration and Staff Report

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

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 in the Department of Health and Social Care Group Accounting Manual 2021/22; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 34-35, 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 for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.
In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has 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.

Auditor's responsibility 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the Health and Social Care Act 2012 and other legislation governing NHS CCGs, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

- We understood how NHS Buckinghamshire CCG is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.

- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. In response to the risk of fraud in revenue and expenditure recognition for year-end accruals, we reviewed and tested revenue and expenditure accounting policies, year-end accruals, and expenditure cut-off at the period end date. We specifically focused on key aspects of unrecorded liabilities to provide assurance that the year-end accounts were free from material misstatement; we reviewed Covid19 income and expenditure and how it had been accounted for, and performed substantive procedures on Department of Health agreement of balances data, investigating significant differences outside of Department of Health tolerances.

- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations. Buckinghamshire CCG has robust policies and procedures to mitigate potential for override of controls, there is a culture of ethical behaviour, supported by a number of policies in respect of human resources and counter fraud, bribery and corruption.

- We addressed our fraud risk related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions.

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 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria 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 2022.

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 (as amended) 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 (as amended) 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

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 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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.

Certificate

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the year ended 31 March 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the members of the Governing Body of NHS Buckinghamshire CCG in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) 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.

Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
21 June 2022

Appendix 1:

Table of Attendance for Board and Committee Meetings
(Membership in line with Constitution dated 14 January 2016)

Key:

Present	**Y**
Apologies/Absent	**A**
N/A	

Buckinghamshire CCG - Governing Body Meetings 2021-22

Buckinghamshire CCG Attendees	8/4/21	11/5/21	10/6/21	13/7/21	August	9/9/21	12/10/21	11/11/21	December	13/1/22	8/2/22	10/3/22
Dr James Kent	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Matthew Tait	Y	Y	Y	Y	No Meetings take place in August	Y	A	Y	No meeting took place in December	Y	Y	Y
All Voting Members												
Dr Raj Bajwa	Y	A	Y	A		Y	A	Y		Y	A	Y
*Wendy Bower						Y	Y	Y		Y	Y	Y
Anthony Dixon	Y	Y	Y	A		Y	Y	Y		Y	Y	Y
Kate Holmes	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y
Robert Majilton	Y	Y	Y	Y		Y	Y	Y		Y	A	Y
Crystal Oldman	Y	Y	Y	A		Y	A	A		A	A	Y
Robert Parkes	Y	Y	Y	Y		A	Y	Y		Y	Y	Y
Dr Dalijit Sahota	A	A	Y	A		Y	A	Y		Y	A	Y
Dr Rashmi Sawhney	Y	A	Y	A		Y	Y	Y		Y	Y	A
Graham Smith	Y	A	A	A								
Dr Karen West	A	A	Y	A		Y	Y	A		A	A	Y
Dr Robin Woolfson	Y	Y	A	A		Y	Y	A		A	Y	Y

Buckinghamshire CCG – Remuneration Committee Meetings 2021-22

Attendees	02/06/2021	21/09/2021	18/01/2022	09/08/2021	13/08/2021	15/12/2021	16/02/2022
Raj Bajwa	Y	A	A	Virtual meetings were held on these dates. Attendance was not recorded.			
Anthony Dixon	Y	Y	Y				
Robert Parkes	Y	Y	Y				
Graham Smith	Y						

Buckinghamshire CCG – Audit Committee Meetings 2021-22

Attendees	28/07/2021	27/10/2021	26/01/2022
Robert Parkes	Y	Y	U
Anthony Dixon	Y	Y	Y
Kate Holmes	Y	Y	Y
Alan Cadman	Y	A	Y
Robert Majilton	Y	A	Y

Buckinghamshire CCG – Finance Committee Meetings 2021-22

Attendees	29/4/21	01/06/21	24/06/21	02/09/21	07/10/21	04/11/21	02/12/21	03/02/22	03/03/22
James Kent	Y	Y	A	A	A	Y	A	A	A
Anthony Dixon	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kate Holmes	Y	Y	Y	Y	Y	Y	Y	Y	Y
Robert Majilton	Y	A	Y	A	Y	Y	Y	A	Y
Robert Parkes	Y	Y	Y	A	Y	Y	Y	Y	A
Graham Smith	Y	Y	Y						
Alan Cadman	Y	Y	Y	Y	Y	Y	Y	Y	Y

Buckinghamshire CCG – Executive Committee Meetings 2021-22

Attendees	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
								*Replaced by BOB CCGs Combined Executive meetings				Extra-ordinary
Voting Members												
James Kent												Y
Robert Majilton	Y	Y	Y	A	Y	Y	A					Y
Louise Smith	A	A	A	A	A	A	A					A
Kate Holmes	Y	Y	Y	Y	Y	Y	Y					Y
David Williams	A	Y	Y	A	Y	Y	A					Y
Dr Raj Bajwa	A	Y	Y	A	Y	y	A					Y
Dr Karen West	A	Y	A	A	A	A	A					A
Dr Juliet Sutton	Y	Y	Y	A	Y	Y	Y					Y
Dr Dal Sahota	Y	Y	Y	Y	A	Y	Y					Y
Dr Sian Roberts	Y	Y	Y	Y	Y	A	Y					Y
Dr Shona Lockie	Y	A	Y	Y	A	A	Y					
Dr Raj Thakkar	Y	Y	Y	Y	Y	Y	A					Y
Dr Stuart Logan	Y	Y	Y	Y	Y	Y	Y					
Dr Rashmi Sawhney	Y	Y	A	Y	Y	A	Y					Y
Alan Cadman (depute)			Y									
Non-voting Members												
Russell Carpenter	Y	Y										
Neil Flint	Y	A	Y	Y	A	Y	Y					Y

*Due to the re-scheduling/aligning of the Buckinghamshire and Oxfordshire CCGs Executive Committee meetings, GP Clinical Leads were unable to attend due to GP Practices commitments. Therefore, Buckinghamshire CCG attendance was stood down during: November 2021 – February 2022.

Buckinghamshire CCG – Quality and Performance Committee Meetings 2021-22

Attendees	Apr 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Voting Members												
David Williams	Meeting cancelled	A	Meeting cancelled	Y	Y	Y	Meeting cancelled			Y	Meeting cancelled	Y
Dr Robin Woolfson		Y		Y	Y	Y				Y		Y
Dr Karen West		Y		A	A	Y				A		A
Frances Burdock		A		A	A	Y				Y		A
Non-voting Members / Standing Invitees												
Robert Majilton		A		A	Y	Y				A		A
Gilly Attree		A		Y	Y	y				Y		A
Zoe McIntosh		A		A	Y	A				Y		A
Neil Flint		Y		Y	A	Y				A		A
Catherine Richards		Y		Y	Y	A				Y		Y
Julie Simpkins		Y		Y	Y	Y				Y		Y

Cancellations/absences: These are due to pressures regarding Covid-19 and subsequent staff redeployments

Buckinghamshire CCG – Primary Care Commissioning Committee Meetings 2021-22

Attendees	13/07/2021	16/09/2021	16/12/2021	17/03/2022
Dr James Kent	A	A	Meeting cancelled	A
Anthony Dixon	Y	Y		Y
Dr Raju Bajwa	A	Y		Y
Kate Holmes	Y	Y		A
Rashmi Sawhney	A	Y		A
Jessica Newman	Y	Y		
Adrian Chamberlain				Y
Catherine Williams		A		A
Zoe Mcintosh	Y	Y		Y
Rebecca Mallard-Smith	Y	Y		Y

Glossary of Terms

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS): The NHS and local authorities across Buckinghamshire, Oxfordshire and Berkshire West are working together to support delivery of NHS England's Five Year Forward View to deliver better health, better patient care and improved NHS efficiency.

Buckinghamshire Healthcare NHS Trust – an integrated acute and community healthcare organisation delivering care in a range of ways; from community health services provided in people's homes or from one of local bases, to hospitals at Stoke Mandeville, Wycombe and Amersham

Buckinghamshire Joint Health and Wellbeing Strategy: The story of how the NHS, councils and Healthwatch work together to improve the health and wellbeing of people in Buckinghamshire. The strategy has been developed with input from the people of Buckinghamshire.

Buckinghamshire Joint Health Overview Scrutiny Committee: looks at the work of the NHS clinical commissioning groups, healthcare trusts, and the NHS England Local Area Team. The committee acts as a 'critical friend' by suggesting ways that health related services might be improved.

Care Quality Commission: monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety

Clinical Chair: medical doctor at the head of Buckinghamshire Clinical Commissioning Group.

Delayed Transfer of Care (DTOC): when a patient is medically fit to leave a hospital or similar care provider but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

Frimley Health NHS Foundation Trust - provides NHS hospital services for people across Berkshire, Hampshire, Surrey and south Buckinghamshire

GP Federation: a group of GP practices which come together to provide a greater range of services to patients in their local area e.g. FedBucks,

Health and Wellbeing Board (HWB Board): key leaders from the health and social care services and Healthwatch work together to improve the health and wellbeing of their local population and reduce health inequalities

Healthwatch: UK consumer watchdog for patients which aims to improve health and social care

Joint Strategic Needs Assessment for Buckinghamshire: provides information about the county's population and the factors affecting health, wellbeing, and social care needs.

Local Authorities: the elected bodies responsible for the most strategic local government services in the county.

Local Health Resilience Partnership: a group for local health organisations (including private and voluntary sector where appropriate) which looks at readiness and planning for major health emergencies

Local Medical Committee: a statutory body for local GPs which looks after the interests of family doctors

Locality Plans: intended to build resilient, sustainable primary care for the future based

on local need. The plans are intended to support the vision for health services where patients will receive more care closer to home and be supported out of hospital as much as possible.

Medicines Optimisation Team: helps health professionals and patients make the right treatment and medicines choices by promoting cost effective and evidence based clinical practice and effective risk management

National Institute for Clinical Excellence: provides national guidance and advice to improve health and social care. It aims to help medical practitioners deliver the best possible care, give people the most effective treatments based on the latest evidence, to provide value for money, to reduce inequalities and variation

NHS Long Term Plan: The NHS Long Term Plan, published in January 2019, is a 10 year plan for the NHS to improve the quality of patient care and health outcomes. Its ambitions include measures to prevent 150,000 heart attacks, strokes and dementia cases, and better access to mental health services for adults and children.

Oxford Health Foundation Trust (OHFT): provides physical, mental health and social care for people of all ages across Buckinghamshire. Its services are delivered at community bases, hospitals, clinics and people's homes.

Oxford University Hospitals NHS Foundation Trust (OUHFT): is one of the largest teaching hospitals in England. It is made up of four hospitals - the John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre, all in Oxford, and the Horton General Hospital in Banbury. It provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation), medical education, training and research.

Patient Participation Groups (PPG): Patient representatives from a GP practice who advise and inform the practice on what matters most to patients and to help identify solutions to problems as a 'critical friend'

PINCER risk stratification tool: This is a tool that has been developed to identify at-risk patients so that corrective action can be taken to reduce clinically important medication errors in primary care.

Primary Care: most people's first point of contact with health services, for example, GPs, dentists, pharmacists or optometrists

Primary Care Networks: Primary care networks bring general practices together to work at scale. This helps to recruit and retain staff; manage financial and estates pressures; provide a wider range of services to patients and to more easily integrate with the wider health and care system.

Referral to Treatment Times: The period of time from referral by a GP or other medical practitioner to hospital for treatment in the NHS South Central Ambulance NHS Foundation Trust (SCAS): SCAS provides and accident and emergency service to respond to 999 calls; the NHS 111 service for when medical help is needed fast but not a 999 emergency and a non-urgent patient transport service. It covers the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire

Social prescribing: This process enables GPs, nurses and other primary care professionals to refer people to a range of local, non- clinical services.

FINANCIAL ACCOUNTS

FOR THE PERIOD ENDED 31 MARCH 2022

NHS BUCKINGHAMSHIRE COMMISSIONING GROUP

Financial Information - Accounts Year Ended 31 March 2022

These accounts for the year ended 31st March 2022 have been prepared by Buckinghamshire Clinical Commissioning Group under a Direction issued by the NHS Commissioning Board, now known as NHS England under the National Health Service Act 2006.

Buckinghamshire Clinical Commissioning Group management have assessed the entity's ability to continue as a going concern. The management are not aware of any material uncertainties related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern.

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The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(1,605)	(1,506)
Other operating income	2	(126)	(84)
Total operating income		**(1,732)**	**(1,591)**
Staff costs	4	5,420	5,371
Purchase of goods and services	5	923,326	839,833
Depreciation and impairment charges	5	202	445
Provision expense	5	501	730
Other Operating Expenditure	5	1,324	1,417
Total operating expenditure		**930,773**	**847,796**
Net Operating Expenditure		**929,041**	**846,205**
Total Net Expenditure for the Financial Year		**929,041**	**846,205**
Comprehensive Expenditure for the year		**929,041**	**846,205**

The notes on pages 74 to 101 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	8	196	377
Intangible assets	9	740	1
Total non-current assets		936	378
Current assets:			
Inventories	10	-	1,028
Trade and other receivables	11	5,444	3,828
Cash and cash equivalents	12	96	114
Total current assets		**5,540**	4,970
Total current assets		**5,540**	4,970
Total assets		**6,476**	5,348
Current liabilities			
Trade and other payables	13	(65,597)	(72,018)
Provisions	14	(1,073)	(764)
Total current liabilities		**(66,670)**	(72,782)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(60,194)**	(67,434)
Non-current liabilities			
Provisions	14	(287)	(711)
Total non-current liabilities		**(287)**	(711)
Assets less Liabilities		**(60,481)**	(68,146)
Financed by Taxpayers' Equity			
General fund		(60,481)	(68,146)
Total taxpayers' equity:		**(60,481)**	(68,146)

The notes on pages 74 to 101 form part of this statement

The financial statements on pages 74 to 77 were approved by the Governing Body on 21 June 2022 and signed on its behalf by:

James Kent
Chief Accountable Officer

Kate Holmes
Interim Chief Finance Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(68,146)	0	0	**(68,146)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(68,146)**	**0**	**0**	**(68,146)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating expenditure for the financial year	(929,041)			**(929,041)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(929,041)**	**0**	**0**	**(929,041)**
Net funding	936,706	0	0	**936,706**
Balance at 31 March 2022	**(60,481)**	**0**	**0**	**(60,481)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(45,467)	0	0	**(45,467)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2021	**(45,467)**	**0**	**0**	**(45,467)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating costs for the financial year	(846,205)			(846,205)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(846,205)**	**0**	**0**	**(846,205)**
Net funding	823,526	0	0	823,526
Balance at 31 March 2021	**(68,146)**	**0**	**0**	**(68,146)**

The notes on pages 74 to 101 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	**2021-22 £'000**	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(929,041)	(846,205)
Depreciation and amortisation	5	202	445
(Increase)/decrease in inventories		1,028	1,113
(Increase)/decrease in trade & other receivables	11	(1,616)	4,829
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	(6,880)	15,805
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	14	(617)	(35)
Increase/(decrease) in provisions	14	501	730
Net Cash Inflow (Outflow) from Operating Activities		**(936,424)**	(823,318)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(20)	0
(Payments) for intangible assets		(280)	0
Net Cash Inflow (Outflow) from Investing Activities		**(300)**	0
Net Cash Inflow (Outflow) before Financing		**(936,724)**	(823,318)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		936,706	823,526
Net Cash Inflow (Outflow) from Financing Activities		**936,706**	823,526
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(18)**	208
Cash & Cash Equivalents at the Beginning of the Financial Year		**114**	(94)
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**96**	114

The notes on pages 74 to 101 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on 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.

As set out in Note 20 – Events after the Reporting Period, on 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of Buckinghamshire CCG will transfer to Buckinghamshire Oxfordshire Berkshire West Integrated Care Board from the 1 July 2022.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. It remains the case that the Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2022/23 and CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the Buckinghamshire Oxfordshire Berkshire West Integrated Care Board, rather than Buckinghamshire CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, is not considered to impact on going concern. Our considerations cover the period through to 30 June 2023, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, the Governing Body have a reasonable expectation that the CCG (and the successor commissioning organisation) will have adequate resources to continue in operational existence for the foreseeable future.

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 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Pooled Budgets**

The Clinical Commissioning Group has entered into a pooled budget arrangement with Buckinghamshire Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of health and social care services and Note 17 provides details of the income and expenditure.

The pools are hosted by Buckinghamshire Council. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Clinical Commissioning Group.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Payment terms are standard reflecting cross government principles. There are no significant terms agreed.

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

1.70 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

Notes to the financial statements

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

1.9.1 **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 Clinical Commissioning Group;
- 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; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **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.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.9.3 **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.

1.10 **Intangible Assets**

1.10.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Clinical Commissioning Group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the Clinical Commissioning Group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

Notes to the financial statements

1.10.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.10.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, 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 Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group 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 the shorter of the lease term and the estimated useful life.
At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its property, plant and equipment assets 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.

1.11 **Leases**

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

1.12 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.13 **Cash & Cash Equivalents**

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

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

1.14 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

A restructuring provision is recognised when the Clinical Commissioning Group 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.

Notes to the financial statements

1.15 **Clinical Negligence Costs**

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

1.16 **Non-clinical Risk Pooling**

The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **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.

1.19 **Financial Assets at Amortised cost**

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

1.19.1 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.19.2 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.19.3 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

Notes to the financial statements

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.20 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.20.1 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Clinical Commissioning Group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.20.2 **Other Financial Liabilities**

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

1.21 **Value Added Tax**

Most of the activities of the Clinical Commissioning Group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 **Foreign Currencies**

The Clinical Commissioning Group'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 Clinical Commissioning Group's surplus/deficit in the period in which they arise.

1.23 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

1.24 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

1.25.1 **Critical accounting judgements in applying accounting policies**

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

· The Clinical Commissioning Group generates provisions to cover future liabilities of more than one year. These provisions are estimated by management based on knowledge of the business, assumptions of probability and are reviewed on an annual basis.

· The Provision relates to Continuing Healthcare claims that have to be assessed. There is a potential uncertainty in respect of the number of successful claims resulting in financial cost. Actual claims settled may differ from those calculated.

Notes to the financial statements

1.25.2 **Sources of estimation uncertainty**

The following are the key estimations that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

· Accruals are calculated utilising management knowledge, market intelligence and contractual arrangements. These accruals cover areas such as prescribing and contracts for healthcare and non healthcare services. Actual results may differ from those calculated.

1.26 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022, but CCGs will still need to provide adequate disclosure on the impact of the new standard. HM Treasury have issued application guidance which will assist entities in assessing the impact and this can be found at IFRS_16_Application_Guidance_December_2020.pdf (publishing.service.gov.uk).

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Clinical Commissioning Group will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Clinical Commissioning Group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Clinical Commissioning Group's incremental borrowing rate. The Clinical Commissioning Group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Clinical Commissioning Group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.
in accordance with IFRS
16 and using HM Treasury Discount rate of 1.99%, the CCG would have recognised a right of use asset of £0.9m and a lease liability of £0.9m in the SOFP. The impact on the SOCNE would have been an additional cost of approximately £4k.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**1,051**	1,222
Prescription fees and charges	**554**	284
Total Income from sale of goods and services	**1,605**	**1,506**
Other operating income		
Other non contract revenue	**126**	84
Total Other operating income	**126**	**84**
Total Operating Income	**1,732**	**1,591**

Revenue in this note does not include cash received from NHS England which is drawn down directly into the bank account of the Clinical Commissioning Group and credited to the General Fund.

The Clinical Commissioning Group has no other revenue from that of the supply of services.

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

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000
Source of Revenue		
NHS	-	-
Non NHS	1,051	554
Total	**1,051**	**554**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000
Timing of Revenue		
Point in time	1,051	554
Over time	-	-
Total	**1,051**	**554**

3.2 Transaction price to remaining contract performance obligations

The Clinical Commissioning Group has no Contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,681**	**468**	**4,149**
Social security costs	**485**	**0**	**485**
Employer Contributions to NHS Pension scheme	**781**	**0**	**781**
Apprenticeship Levy	**6**	**0**	**6**
Gross employee benefits expenditure	**4,953**	**468**	**5,420**
Total - Net admin employee benefits including capitalised costs	**4,953**	**468**	**5,420**
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	**4,953**	**468**	**5,420**

4.1.1 Employee benefits	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,766**	**220**	**3,986**
Social security costs	**545**	**0**	**545**
Employer Contributions to NHS Pension scheme	**836**	**0**	**836**
Apprenticeship Levy	**4**	**0**	**4**
Gross employee benefits expenditure	**5,151**	**220**	**5,371**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	**5,151**	**220**	**5,371**
Less: Employee costs capitalised	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	**5,151**	**220**	**5,371**

Employee Benefits is shown net of recharges covering:

1) Recharge of a proportion of the Chief Officers employee benefits to NHS Oxfordshire Clinical Commissioning Group and Berkshire West Clinical Commissioning Group

2) Recharge of staff members to NHS Oxfordshire Clinical Group who host the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership (STP)

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**74.08**	**4.30**	**78.38**	**75.68**	**2.00**	**77.68**

The Clinical Commissioning Group has no whole time equivalent people engaged on capital projects in 2021-22 (nil for 2020-21).

The Clinical Commissioning Group has not had any Exit packages in 2021-22 nor in 2020-21.

The Clinical Commissioning Group has had one ill health retirement in 2021-22 £22,641, (nil in 2020-21).

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. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports

5. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	5,192	5,715
Services from foundation trusts	209,523	197,549
Services from other NHS trusts	399,156	329,765
Purchase of healthcare from non-NHS bodies	139,181	142,089
Prescribing costs	72,742	72,031
General Ophthalmic services	39	25
GPMS/APMS and PCTMS	90,865	84,278
Supplies and services – clinical	1,194	1,164
Supplies and services – general	1,837	1,693
Consultancy services	185	263
Establishment	2,672	4,566
Transport	1	0
Premises	131	151
Audit fees	102	102
Other non statutory audit expenditure		
· Internal audit services	45	45
· Other services	61	27
Other professional fees	269	115
Legal fees	128	250
Education, training and conferences	2	4
Total Purchase of goods and services	**923,326**	**839,833**
Depreciation and impairment charges		
Depreciation	201	328
Amortisation	1	117
Total Depreciation and impairment charges	**202**	**445**
Provision expense		
Provisions	501	730
Total Provision expense	**501**	**730**
Other Operating Expenditure		
Chair and Non Executive Members	140	146
Inventories consumed	1,028	1,113
Other expenditure	156	157
Total Other Operating Expenditure	**1,324**	**1,417**
Total operating expenditure	**925,353**	**842,425**

5.1 COVID Expenditure

In response to the COVID pandemic that was identified in late 2019/20 the CCG was required to support the impact to the population of Buckinghamshire by providing additional services that enabled the safe and secure delivery of healthcare. The pandemic has continued through 21/22 with another variant being identified as Omicron which created further pressures from November 2021.

This support covered the need for more people to be discharged from hospital and to avoid admissions so our acute hospitals had the space and resources to care for patients affected by COVID-19, to enable GP practices to introduce telephone triaging to reduce footfall at surgeries and reduce the risk of spreading infection. Face-to-face patient appointments were available when clinically appropriate and under careful infection control measures and through additional additional IT equipment and software that allowed more staff to work from home, thus protecting themselves and patients

All of the expenditure incurred has been fully funded by NHS England.

The elements of expenditure:	2021-22 £'000	2020-21 £'000
Supply of PPE	**0**	**155**
Support to GP practises, infection control, backfill, additional hrs, digital services, texts etc	**1,916**	**3,067**
COVIDLine Triage, Swabbing Services, Hot Hubs, Visiting Service On -call etc	**1,442**	**3,552**
COVID additional Primary Care capacity	**1,099**	**1,366**
Long COVID Primary Care	**283**	**0**
Continuing Healthcare Assessments	**406**	**416**
Hospital Discharge Programme Scheme 1	**7,436**	**13,604**
Hospital Discharge Programme Scheme 2	**7,925**	**9,364**
Total Expenditure	**20,507**	**31,526**

Hospital Discharge Programme scheme 1 was put in place for the 1st six months of 21/22 and continued from 20/21 which enabled Medically Fit For Discharge patients to be moved from the Acute Hospitals promptly to free capacity to treat COVID patients into a community care setting either in a care home or at home with appropriate support. During in this time assessments were processed to determine future care pathways and the CCG was funded for 6 weeks of the cost. Hospital Discharge Programme scheme 2 put in place for the remaining 6 months of 21/22 was an extension of scheme 1 with the change being that the CCG is funded for a maximum of 4 six weeks whilst the assessments are processed.

This expenditure is included in the following categories of Note 5:

	2021-22 £'000	2020-21 £'000
Employee Costs	**93**	**144**
Establishment	**0**	**5**
Premises	**142**	**0**
GPMS/APMS	**1,383**	**1,384**
Services from other NHS Foundation Trusts	**116**	**129**
Services from other NHS trusts	**246**	**365**
Purchase of healthcare from non-NHS bodies	**18,527**	**29,500**
Total	**20,507**	**31,526**

6 Better Payment Practice Code

Measure of compliance	**2021-22 Number**	**2021-22 £'000**	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	17,677	216,627	11,972	137,438
Total Non-NHS Trade Invoices paid within target	17,147	211,342	11,522	136,268
Percentage of Non-NHS Trade invoices paid within target	**97.00%**	**97.56%**	**96.24%**	**99.15%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	566	614,002	1,522	531,252
Total NHS Trade Invoices Paid within target	555	613,984	1,498	530,687
Percentage of NHS Trade Invoices paid within target	**98.06%**	**100.00%**	**98.42%**	**99.89%**

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of an invoice, whichever is later.

7. Operating Leases		**2021-22**			2020-21	
	Buildings	**Other**	**Total**	Buildings	Other	Total
7.1.1 Payments recognised as an expense	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000
Minimum lease payments	130	2	**132**	150	2	**152**
Total	**130**	**2**	**132**	150	2	152

The Clinical Commissioning Group occupies and pays rent on offices located at Amersham Hospital and at New County Hall in Aylesbury. The rent is paid to Buckinghamshire Healthcare Trust and Buckinghamshire Council respectively. Under paragraph 9 of IFRIC4 these arrangements are a lease and as such accounted for in accordance with IAS17. Payments in respect of these arrangements for 2021-22 are disclosed above.

7.1.2 Future minimum lease payments		**2021-22**			2020-21	
	Buildings	**Other**	**Total**	Buildings	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Payable:						
No later than one year	130	2	**132**	150	-	**150**
Total	**130**	**2**	**132**	150	-	150

8. Property, plant and equipment

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	2,073	46	2,118
Additions purchased	20	-	20
Reclassifications	2	-	2
Disposals other than by sale	(451)	-	(451)
Cost/Valuation at 31 March 2022	**1,645**	**46**	**1,690**
Depreciation 01 April 2021	1,698	43	1,741
Reclassifications	2	-	2
Disposals other than by sale	(451)	-	(451)
Charged during the year	199	2	201
Depreciation at 31 March 2022	**1,448**	**46**	**1,494**
Net Book Value at 31 March 2022	**196**	**0**	**196**
Purchased	196	0	196
Total at 31 March 2022	**196**	**0**	**196**
Asset financing:			
Owned	196	0	196
Total at 31 March 2022	**196**	**0**	**196**

The Clinical Commissioning Group has purchased Tangible IT assets required by the Interoperability and Integration project including Softcat (Interoperability) and Airedale projects which is a Buckinghamshire wide project to enable IT to work across various platforms and environments - e.g visibility of patient records.

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	2	5
Furniture & fittings	5	10

9. Intangible non-current assets

2021-22	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2021	646	**646**
Additions purchased	740	**740**
Reclassifications	(2)	**(2)**
Disposals other than by sale	(44)	**(44)**
Cost / Valuation At 31 March 2022	**1,339**	**1,339**
Amortisation 01 April 2021	645	**645**
Reclassifications	(2)	**(2)**
Disposals other than by sale	(44)	**(44)**
Charged during the year	1	**1**
Amortisation At 31 March 2022	**599**	**599**
Net Book Value at 31 March 2022	**740**	**740**
Purchased	740	**740**
Total at 31 March 2022	**740**	**740**

The Clinical Commissioning Group has purchased Intangible IT assets required by the Interoperability and Integration project. This relates to software to cover projects including Softcat (Interoperability) and Airdale projects which is a Buckinghamshire wide project to enable IT to work across various platforms and environments - e.g visibility of patient records.

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	**2**	**5**

10 Inventories

	Consumables £'000	Total £'000
Balance at 01 April 2021	1,028	**1,028**
Additions	-	**-**
Inventories recognised as an expense in the period	-	**-**
Write-down of inventories (including losses)	(1,028)	**(1,028)**
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	**-**
Transfer (to) from -Goods for resale	-	**-**
Balance at 31 March 2022	**-**	**-**

Inventories relate to equipment that is out in the Community being used by the patients to aid recovery from illness or to improve their lives. Following a review of net realisable value the Clinical Commissioning Group has concluded that there is no value in the inventory covered and has written this value down to nil.

11.1 Trade and other receivables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS accrued income	2	-	18	-
NHS Non Contract trade receivable (i.e pass through funding)	2,296	-	1,279	-
Non-NHS and Other WGA receivables: Revenue	49	-	818	-
Non-NHS and Other WGA prepayments	2,901	-	1,556	-
Non-NHS and Other WGA accrued income	-	-	49	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	154	-	108	-
Expected credit loss allowance-receivables	(17)	-	(17)	-
VAT	55	-	17	-
Other receivables and accruals	5	-	-	-
Total Trade & other receivables	**5,444**	**-**	**3,828**	**-**
Total current and non current	**5,444**		**3,828**	
Included above:				
Prepaid pensions contributions	-		-	

The great majority of trade is with NHS Organisations and Local Government Organisations. As NHS organisations and Local Government organisations are funded by Government to provide funding to Clinical Commissioning Groups to commission services no credit scoring of them is considered necessary.

11.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	20	5	22	270
By three to six months	-	1	-	638
By more than six months	-	-	-	-
Total	**20**	**6**	**22**	**907**

11.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2020	(17)	-	**(17)**
Total	**(17)**	**-**	**(17)**

12. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	114	(94)
Net change in year	(18)	208
Balance at 31 March 2022	**96**	**114**
Made up of:		
Cash with the Government Banking Service	96	114
Cash and cash equivalents as in statement of financial position	**96**	**114**
Bank overdraft: Government Banking Service	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2022	**96**	**114**

13 Trade and other payables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	595	-	1,388	-
NHS accruals	779	-	1,227	-
Non-NHS and Other WGA payables: Revenue	3,232	-	3,285	-
Non-NHS and Other WGA payables: Capital	460	-	-	-
Non-NHS and Other WGA accruals	58,191	-	63,682	-
Social security costs	58	-	66	-
Tax	60	-	62	-
Other payables and accruals	2,221	-	2,308	-
Total Trade & Other Payables	**65,597**	**-**	**72,018**	**-**
Total current and non-current	**65,597**		**72,018**	

Included above are liabilities of £0, for 0 people, due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2021: £0 for 0 people).

Other payables include £630k outstanding pension contributions at 31 March 2022

14 Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Continuing care	1,073	287	764	711
Total	**1,073**	**287**	**764**	**711**
Total current and non-current	**1,360**		**1,475**	

	Continuing Care £'000	Total £'000	Balance at 01 April 2020 £'000
Balance at 01 April 2021	**1,475**	**1,475**	781
Arising during the year	501	**501**	729
Utilised during the year	(617)	**(617)**	(35)
Balance at 31 March 2022	**1,360**	**1,360**	**1,475**
Expected timing of cash flows:			
Within one year	1,073	**1,073**	764
Between one and five years	287	**287**	711
After five years	-	**-**	-
Balance at 31 March 2022	**1,360**	**1,360**	**1,475**

£0 is included in the Provisions of the NHS Litigation Authority as at 31 March 2022 in respect of clinical negligence liabilities of the Clinical Commissioning Group (31 March 2021 £0)

Provision for Continuing Healthcare of £1,360k. The Clinical Commissioning Group is responsible for providing Continuing Healthcare to its population once potential patients have been assessed and deemed to meet criteria to qualify for funding. The provision covers those who have not been assessed where there could be a high probability of a financial liability.

15 Financial instruments

15.1 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.

15.1.1 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.

15.1.2 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.

15.1.3 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.

15.1.4 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial Instruments

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

15 Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with other DHSC group bodies	2,298		2,298
Trade and other receivables with external bodies	208		208
Other financial assets	-		-
Cash and cash equivalents	96		96
Total at 31 March 2022	**2,601**	**-**	**2,601**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	179		**179**
Trade and other payables with other DHSC group bodies	1,196		**1,196**
Trade and other payables with external bodies	64,104		**64,104**
Total at 31 March 2022	**65,479**	**-**	**65,479**

16 Operating segments

The Clinical Commissioning Group consider there is only one segment: Commissioning of healthcare services.

17 Joint arrangements - Interests in joint operations

The NHS Clinical Commissioning Group has entered into a pooled budget agreements with Buckinghamshire Council and these agreements are hosted by Buckinghamshire Council.

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2021-22 £'000	2020-21 £'000
Income	**62,508**	58,541
Expenditure	**(62,508)**	(58,541)

Under the arrangement funds are pooled under section 75 of the NHS Act 2006 for provision of Mental Health and Continuing Care Services within the Buckinghamshire community.

The memorandum accounts for pooled budgets are :

Children and Adolescence Mental Health Services (CAMHS)

This is a Pool Budget with Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of Children and Adolescence Mental Health Service. This covers the period 1 April 2021 to 31 March 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

	2021-22 £'000	2020-21 £'000
Expenditure		
Pooled fund CAMHS	**10,665**	10,231
Income		
Contribution from Buckinghamshire Council	**(1,662)**	(2,517)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(9,003)**	(7,714)
Total	**(10,665)**	(10,231)
Balance	**0**	0

Speech and Language Therapy Pooled Budget

The Pooled budget is between Buckinghamshire Commissioning Group and Buckinghamshire Council for the provision of Speech & Language Therapies. This covers the period 1st April 2021 to 31st March 2022. Buckinghamshire County Council is the host and lead authority.

	2021-22 £'000	2020-21 £'000
Expenditure		
Pooled Fund SALT	**3,793**	3,792
Income		
Contribution from Buckinghamshire Council	**(1,745)**	(1,744)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(2,048)**	(2,048)
Total	**(3,793)**	(3,792)
Balance	**0**	0

Residential Respite Short Breaks Pooled Fund

The Pooled budget is between Buckinghamshire Commissioning Group and Buckinghamshire Council for the provision of Speech & Language Therapies. This covers the period 1st April 2021 to 31st March 2022. Buckinghamshire County Council is the host and lead authority.

	2021-22 £'000	2020-21 £'000
Expenditure		
Pooled fund Residential Respite Short Breaks	**1,933**	1,950
Income		
Contribution from Buckinghamshire Council	**(1,406)**	(1,418)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(527)**	(532)
Total	**(1,933)**	(1,950)
Balance	**0**	0

17 Joint arrangements - interests in joint operations cont'd

Integrated Community Equipment Service Contract Management Pooled Fund

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of Integrated Community Equipment Service Contract Management. The agreement covers the period 1st April 2021 to 31st March 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

	2021-22	2020-21
	£'000	£'000
Expenditure		
Pooled fund expenditure	**85**	85
Income		
Contribution from Buckinghamshire Council	**(28)**	(28)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(57)**	(57)
Total Income	**(85)**	(85)
Balance	**0**	0

Integrated Community Equipment Service Pooled Budget

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council covers the provision of Integrated Community Equipment Service (including Adult Social Care, Telecare and Children and Young People's Service) for the period of 1st April 2021 to 31st March 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement. The Joint Pooled Fund supports procurement, storage, delivery, installation and technical demonstration as well as subsequent collection, cleaning, recycling, maintenance and repair of equipment, for use by eligible clients.

	2021-22	2020-21
	£'000	£'000
Expenditure		
Pooled fund expenditure	**9,704**	11,133
Income		
Contribution from Buckinghamshire Council	**(2,642)**	(3,510)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(7,062)**	(7,623)
Total Income	**(9,704)**	(11,133)
Balance	**0**	0

Better Care Fund

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of the Better Care Fund, for health and social care, to cover the period of 1st April 2021 to 31st March 2022. The Joint Pooled Fund supports the provision of community health teams and social care activities for the population of Buckinghamshire. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

	2021-22	2020-21
	£'000	£'000
Pooled Fund Expenditure	**42,495**	40,255
Contribution from Buckinghamshire Council	**(8,959)**	(8,476)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(33,163)**	(31,425)
Contribution from NHS Milton Keynes Clinical Commissioning Group	**(373)**	(354)
Total Income	**(42,495)**	(40,255)
	0	0

S117

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council covers the provision of Section 117 aftercare, to cover the period 1st April 2021 to 31st March 2022, providing care packages that are suitable for the clients requirements. Buckinghamshire County Council is the host and lead authority for this pooled fund arrangement.

	2021-22	2020-21
	£'000	£'000
Pooled Fund S117 Expenditure	**21,296**	18,284
Income		
Contribution from Buckinghamshire Council	**(10,648)**	(9,142)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(10,648)**	(9,142)
Total	**(21,296)**	(18,284)
Balance	**0**	0

18 Related party transactions

As a prerequisite of the ICS, during 21-22 Buckinghamshire, Oxfordshire and Berkshire West CCG's have been meeting in common as decision making forums covering Finance, Audit and Governing Body. All Executive members of each CCG attend and are members of these In Common meetings. Additional responsibilities are given to Robert Parkes, Non-Executive Director of Buckinghamshire to act as Convener of the Audit in Common meetings and Duncan Smith, Non-Executive Director of Oxfordshire CCG to act as Convener of the Finance in Common meetings.

18.1 Details of related party transactions with individuals are as follows:

Name	Title	Relationship	Related Party	Payments to Related Party £ (expenditure) 21-22	Amounts owed to Related Party at 31st Mar 2022 (CR)	Receipts from Related party £ (income) Mar 22	Amounts due from Related Party at 31st Mar 2022 (DR)
Dr Raj Bajwa (63501)	Clinical GP Chair	GP Partner & 50% owner	Little Chalfont Surgery	1,068,256	-	-	-
		Member	FedBucks	6,009,116	130,810	162,239	32,748
		Partner in a GP practice in the Chesham and Little Chalfont Primary care Network	Chesham and Little Chalfont Primary Care Network (PCN)	-	-	-	-
		Spouse is a community pharmacist	Lloyds Pharmacy Group	-	-	-	-
				-	-	-	-
Dr James Kent	Chief/Accountable Officer (BOB CCG's) & ICS Executive Lead	Wife is a senior Pharmacist employed by the Chalfont's PCN and the Hall Practice	Hall Practice and Chalfont PCN	1,079,046	-	-	-
		John Storey, Chief Executive of Porthaven, is a friend.	Porthaven	3,289,274	-	-	-
		I am a Director of Curzon Partners Limited.	Curzon Partners Limited	-	-	-	-
		Member of The Royal Foundation Covid-19 Grant Response Fund Committee	The Royal Foundation Covid-19 Grant Response Fund Committee	-	-	-	-
Robert Parkes	Lay Member, Lay Vice Chair and Chair of Audit Committee, OCCG Governing body Lay member governance	Responsible Financial Officer (RFO)	Chearsley Parish Council	-	-	-	-
		Lay member Governance	Oxforfshire CCG	838,692	23,006	1,318,596	247,007
Anthony Dixon	Lay Member & Chair of Finance Committee	Director	Windsor Theatre Ltd	-	-	-	-
		Patient	Patient- Oxford United Hospitals Trust				
			Patient- Wexham Park Hospital	-	-	-	-
Dr Karen West	Member GP / Clinical Commissioning Director for	GP Partner	Haddenham Medical Centre	1,197,208	-	-	-
		Member	FedBucks	6,009,116	130,810	162,239	32,748
		Husband	Brain Lab - Medical Software and Hardware Innovators	-	-	-	-
Dr Robin Woolfson	Hospital Doctor	Consultant Nephrologist Royal Free Hospital NHS FT	Royal Free London NHS FT	-	-	-	-
		Medical Director Royal Free Hospital NHS FT	Royal Free London NHS FT	-	-	-	-
				-	-	-	-
				-	-	-	-
Robert Majilton	Deputy Chief Officer	Vodaphone - Wife works as a customer delivery manager	Vodafone Group as Customer Delivery Manager	-	-	-	-
Wendy Bower	Lay Member Patient and Public Involvement (PPI) (Voting)	Director	Moneymaximer Ltd	0	-	-	-
		Governor	CCG Federation at Royal Berskhire NHS FT (RBFT)	0	-	-	-
		Brother	Clinical Trails Specialist at Quintiles	0	-	-	-
		Daughter	Nurse / staff support for the duration of the COVID-19 pandemic at Royal Berskhire NHS FT (RBFT)	3,576,311	-	-	-
		Engagement	NHS Berkshire West CCG	71,202	-	-	-

18 Related party transactions

18.2 Related party transactions Cont'd

Where the Clinical Commissioning Group has a transactional (financial) relationship , then these values are included in the following tables. If the related party is not shown then the Clinical Commissioning Group does not have a transactional (financial) relationship.

Details of related party transactions with individuals for 21/22 are as follows:

Related Party	Payments to Related Party £ (expenditure) at 31st Mar 2022	Amounts owed to Related Party at 31st Mar 2022	Receipts from Related party £ (income) 31st Mar 22	Amounts due from Related Party at 31st Mar 22 (DR)
(CV Health) Chiltern Health	0	0	0	0
Fed Bucks	6,009,116	130,810	162,239	32,748
Oxford Health NHS Foundation Trust	57,881,766	0	0	0
Queen's Nursing Institute	4,800	0	0	0
NHS Confederation	0	0	0	0
Buckinghamshire Healthcare NHS Trust	394,988,352	0	896,758	268,915
Frimley Health NHS Foundation Trust	66,069,232	0	0	0
Oxford University Hospitals NHS Foundation Trust	22,407,949	0	0	0
Milton Keynes NHS FT	12,333,562	0	0	0
South Central Ambulance Service NHS Foundation Trust	26,023,839	140,918	0	0
NHS South Central and West CSU	5,104,480	78,067	0	0
NHS England	241,213	0	4,219,332	1,632,578
NHS Oxfordshire CCG	838,692	23,006	1,318,596	247,007
NHS Berkshire West CCG	71,202	0	108,726	5,754
Totals	**591,974,203**	**372,802**	**6,705,651**	**2,187,003**

18.3 Related party transactions Cont'd

Buckinghamshire CCG Practices	2021-22 Payments to Related Party £ (expenditure)	2020-21 Payments to Related Party £ (expenditure)
3W HEALTH K82070	4,118,846	3,734,008
AMERSHAM HEALTH CENTRE	1,425,608	1,380,844
ASHCROFT SURGERY	845,767	888,292
BERRYFIELDS MEDICAL CENTRE	1,321,081	1,078,648
BOURNE END & WOOBURN GREEN MEDICAL CE	1,828,495	0
BURNHAM HEALTH CENTRE	2,517,747	2,510,544
CALCOT MEDICAL CENTRE	992,970	0
CARRINGTON HOUSE SURGERY	1,146,889	1,150,997
CHERRYMEAD SURGERY	1,326,711	1,353,498
CHILTERN HOUSE MEDICAL CENTRE	936,872	677,902
CRESSEX HOUSE PRACTICE	1,296,075	1,397,376
CROSS KEYS SURGERY	1,944,235	1,761,364
DENHAM MEDICAL CENTRE	1,422,903	1,588,138
DESBOROUGH AVENUE SURGERY	1,452,935	1,456,536
EDLESBOROUGH SURGERY	1,547,922	1,452,832
GLADSTONE SURGERY	569,196	538,789
HADDENHAM MEDICAL CENTRE	1,197,208	1,182,934
HALL PRACTICE	1,079,046	1,106,960
HIGHFIELD SURGERY HIGH WYCOMBE	834,764	803,733
IVER MEDICAL CENTRE	1,051,963	998,564
JOHN HAMPDEN SURGERY	400,769	380,876
KINGSWOOD SURGERY HIGH WYCOMBE	1,117,891	1,197,836
LITTLE CHALFONT SURGERY	1,068,256	849,972
MANDEVILLE PRACTICE	1,580,520	1,593,399
MARLOW MEDICAL GROUP	3,599,609	3,284,142
MEADOWCROFT SURGERY	1,713,544	1,726,497
MILLBARN MEDICAL CENTRE	933,057	867,889
MISBOURNE SURGERY	1,501,687	1,528,821
NEW SURGERY	925,281	1,005,411
OAKFIELD SURGERY AYLESBURY	680,507	601,996
POPLAR GROVE SURGERY	2,542,594	2,478,301
PRACTICE PROSPECT HOUSE	406,018	415,062
PRIORY AVENUE SURGERY HIGH WYCOMBE	1,376,456	1,429,061
RECTORY MEADOW SURGERY	1,313,744	1,154,825
RIVERSIDE SURGERY	1,113,800	1,156,238
SIMPSON CENTRE	2,068,017	1,993,869
SOUTHMEAD SURGERY	781,772	743,069
STOKENCHURCH MEDICAL CENTRE	1,071,401	1,068,175
SWAN PRACTICE	5,154,240	4,620,485
THREEWAYS SURGERY	792,409	775,487
TOWER HOUSE SURGERY HIGH WYCOMBE	1,058,915	1,029,657
UNITY HEALTH SURGERY	3,490,910	3,564,614
WATER MEADOW SURGERY	1,453,192	1,429,759
WADDESDON SURGERY	1,313,507	1,376,997
WESTONGROVE PARTNERSHIP	4,929,366	4,343,399
WHITEHILL SURGERY	1,443,018	1,503,905
DR ALLAN AND PARTNERS	0	3,345
HUGHENDEN VALLEY SURGERY HIGH WYCOMB	2,136,345	16,000
WYE VALLEY SURGERY	1,433,750	1,051,109
TOTAL	**76,257,806**	**68,252,155**

Norden House, Wing, and Whitchurch surgeries have merged and is now known as 3W HEALTH K82070

19 Losses and special payments

The Clinical Commissioning Group has had no cost relating to losses or special payment in the year (nil in 2020-21).

20 Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of Buckinghamshire CCG will transfer to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements

21 Financial performance targets

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

	2021-22	**2021-22**		2020-21	2020-21	
	Target	**Performance**	**Duty Achieved**	Target	Performance	Duty Achieved
Expenditure not to exceed income	934,762	931,533	Yes	847,935	847,796	Yes
Capital resource use does not exceed the amount specified in Directions	760	760	Yes	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	932,270	929,041	Yes	846,344	846,205	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	10,506	9,832	Yes	10,509	9,984	Yes