NHS
Berkshire West
Clinical Commissioning Group

Berkshire West Clinical Commissioning Group
Annual Report 1 April – 30 June 2022

Contents

Performance Report

The following performance report consists of a performance overview and a performance analysis. It outlines what the NHS Berkshire West Clinical Commissioning Group (BWCCG) was; its purpose, statutory duties and how the CCG executed those duties between 1 April to the end of June 2022 before it was abolished on 30 June 2022. It looks at the work of BWCCG, how the organisation performed over the last few months of its existence and outlines the risks it faced.

Performance Overview

BWCCG was established on 1 April 2018, following the merger of Newbury and District, Wokingham, North and West Reading and South Reading CCGs. BWCCG was the statutory organisation in Berkshire West area that planned, bought and oversaw health services for more than 568,000 people from a range of NHS, voluntary, charitable, community and private sector providers until the end of June 2022 when it was abolished and its functions transferred to Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board.

BWCCG was responsible for commissioning 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 were commissioned by NHS England (NHSE). Public Health is provided by Buckinghamshire County Council (BCC), and includes drug and alcohol, sexual health, health visiting and health promotion services.

BWCCG was a member organisation of 41 GP practices in Berkshire West working with local people, voluntary sector organisations and partners including GPs, Primary Care Networks, West Berkshire Council, Reading Borough Council, Wokingham Borough Council, Berkshire Healthcare NHS Foundation Trust (BHFT), the Royal Berkshire Hospitals NHS Foundation Trust (RBH) and South Central Ambulance Foundation Trust (SCAS). The CCG was also a member of the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System (BOB ICS).

Before being abolished at the end of June 2022 to make way for the establishment of Integrated Care Boards, BWCCG was part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) which covers a population of 1.8 million, previously three Clinical Commissioning Groups (CCGs), six NHS Trusts, 10 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 allocated funding.

The Health and Care Act 2022 put Integrated Care Systems on a statutory footing from 1 July 2022, empowering them to better join up health and care services, improve population health and reduce health inequalities.

Each ICS includes an NHS Integrated Care Board (ICB), for our area this is the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB). This new organisation has responsibility for NHS functions and budgets, also being developed is an Integrated Care Partnership (ICP), a statutory joint committee of the BOB ICB and five local authorities responsible for adult social care bringing together all system partners to produce a health and care strategy.

In Berkshire West, BWCCG was a member of three Health and Wellbeing Boards (H&WBs) which are responsible for improving the health and wellbeing of the people across the Berkshire West areas. The H&WBs are partnerships between the Local Government, the NHS and the people of Berkshire West; Board members include local GPs, Councillors, Healthwatch and officers from the NHS and Local Government.

BWCCG had a duty to improve the quality of services commissioned; reduce health inequalities; involve the public and patients in commissioning decisions and help deliver the three Health and Wellbeing Strategies across the area. This Annual Report describes how BWCCG carried out these duties from 1 April to 30 June 2022 before it was abolished.

Berkshire West's Population

The registered patient population of the BWCCG area is 568,374.

The population is generally affluent and healthy, but there are variations between the Berkshire West localities of Reading, Newbury and District and Wokingham. Life expectancy at birth is higher than the national average for Wokingham and West Berkshire localities. Life expectancy is as follows:

- Wokingham 85.0 years for women and 82.3 years for men
- Reading 81.1 years for women and 77.5 years for men.
- West Berkshire 84.4 years for women and 80.2 years for men.

Our Local Authorities publish Joint Strategic Needs Assessments which describe the health and well-being needs of our population and which use data to identify health differences. Further data on population and health can be found on the Berkshire Observatory website here.

Performance Analysis

Overview Steve McManus, Accountable Officer

Not much time has passed since I last wrote an overview for BWCCG's Annual Report 2021/22; April to the end of June 2022, saw much work continuing from last year alongside preparations to close down the three BOB CCGs and establish a new Integrated Care Board for Buckinghamshire, Oxfordshire and Berkshire West.

I want to take the time to celebrate the success of BWCCG; a major achievement in recent years was the delivery of the COVID-19 vaccination programme. 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. At the end of June 2022, we had delivered 1,169,713 vaccines across Berkshire West including offering vaccinations to all 5 -11-year-olds, and a second 'booster' jab to those aged 75. Huge thanks go to the thousands of people across the NHS, local authorities and volunteers who contributed to this success.

Other successes include the development of an integrated musculoskeletal (MSK) service which implemented a single point of access to triage assessment initially accepting referrals for patients with knee pain. The aim is to deliver improved outcomes for patients and ensure they are supported with the right intervention, in the right place, at the right time. The service standardises care, offers best practice treatment and ensures onward referrals to secondary care are in line with clinical need and patient choice. Despite the pandemic, the programme of work has progressed well, and the service has expanded to include referrals for patients with hip pain with an intention to include referrals for shoulder conditions.

An innovative way to reduce pressure on the RBH was also developed across Berkshire West with the CCG, hospital and local GPs working together to establish ‘overflow’ hubs which allowed the Royal Berkshire NHS Foundation Trust’s Emergency Department to transfer the care of patients to their own GP Practice when appropriate. This programme of work also ensured that more clinical staff were working over winter to meet patients’ care needs.

In primary care, considerable developments have been made with the creation of 15 Primary Care Networks across Berkshire West. The NHS Long Term Plan set an ambitious programme of change for primary care and community services and Berkshire West rose to the challenge. Primary Care Networks are based around a GP-registered list of approximately 30,000 – 50,000 patients, including GP practices and other partners in community and social care. The networks offer services on a scale that is small enough for patients to get the continuous and personalised care they value, but large enough – in their partnership with others in the local health and care system - to be resilient and sustainable.

As well as recognising the achievements of BWCCG, I also want to extend my gratitude to colleagues within the organisation; during the time of the CCG and especially the past couple of years many have worked above and beyond, working in different ways, in different roles and during organisation change which has gone on for quite some time.

As we have now moved into a new organisation, I am encouraged to see colleagues embrace the new BOB ICB and rise to the challenges facing the entire system across BOB. This puts us in a very good place to progress work and develop health and care services to benefit our local population.

Improving the health and wellbeing of people in Berkshire West

Reading, West Berkshire and Wokingham Health and Wellbeing Boards (H&WBs) bring together local leaders from the health and social care system, along with voluntary and community organisations, in shared work to improve the health and wellbeing of their local residents.

Each Health and Wellbeing Board has a statutory duty to produce a Health and Wellbeing Strategy, providing a commitment to improving health and wellbeing by setting out priorities for where members of the Board will work together in planning and delivering local services.

The three HWBs come together with the Berkshire West Integrated Care Partnership (ICP) to promote integrated working and strive to secure improvements in population health. In 2019, the HWBs for Reading, West Berkshire and Wokingham took the decision to develop a shared Health and Wellbeing Strategy to make even more improvements in health.

These H&WB boards across Berkshire West provide strategic leadership for health and wellbeing across the county and ensure that plans are in place and action is taken to realise those plans. The joint Health and Wellbeing Strategy is available here; the strategy has been developed by working closely with local partners from the NHS, social care, local authorities and the voluntary sector along with residents of the three areas. The 2021-2030 strategy is ambitious and identifies five key areas in which the H&WBs aim to make a difference to people's lives.

- Priority 1: Reduce the differences in health between different groups of people
- Priority 2: Support individuals at high risk of bad health outcomes to live healthy lives
- Priority 3: Help families and children in their early years
- Priority 4: Promote good mental health and wellbeing for all children and young people
- Priority 5: Promote good mental health and well being for all adults

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

The planning and establishment of the COVID-19 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 focus of the vaccination programme work during the period 1 April to 30 June 2022 was the spring booster campaign. Working across the BOB ICS, an 85.8 per cent vaccination rate was achieved across the most vulnerable patient groups (over 75s and care home residents) compared with the national average of 82.8 per cent.

In addition, the ICS tried to build on the success of the COVID-19 vaccination inequalities outreach programme by extending this to include an 'all vaccinations' approach and joint working with regional public health teams. The programme focused on the spring boosters and evergreen offer, but more importantly, promoting a *'Making Every Contact Count'(MECC)* [1]approach. This was particularly successful in vulnerable and hard-to-reach groups where there was and continues to be, an opportunity to talk to people about other aspects of health and wellbeing.

[1] MECC is an approach to behaviour change that you can use in day-to-day conversations with patients and the public. Opportunistic interactions that help encourage positive changes to their physical and mental health and wellbeing.

Vaccination of 5–11-year-olds came at the end of the programme and although not seen as essential by many, BOB achieved higher than average vaccination rates by working with Oxford Health as lead provider and vaccinating at family centres in the heart of local communities. This work achieved a vaccination rate of 38.5 per cent which placed the BOB ICS in the top five nationally. For vaccination of 12-15-year-olds, the BOB ICS remains top in the country thanks to the schools' immunisation teams and lead provider follow-up clinics.

More than four million vaccinations have been given across the BOB population of 1.8 million since the start of the programme in December 2020. Vaccination remains open to all and continues to be promoted, providing an evergreen offer that means people can always get first, follow-up, or booster doses.

By the end of June 2022 in Berkshire West:

- 1,169,713 vaccines had been delivered
- 180,653 50-year-olds and over had received two doses
- 171,229 50-year-olds and over had received their booster
- 34,425 of our 75-year-olds and over had received their 2nd booster (fourth vaccine) even though the 2nd booster programme had only commenced 21 March
- 315,857 of those 18-year-olds and over had received their booster (3rd vaccine)
- For 12–15-year-olds 18,820 had received a 1st dose and 13,655 a 2nd
- For 5-11 year-olds,447 had received a 1st dose and 385 a 2nd

Recovery of 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 hampered efforts in elective care recovery. As a result, there are lengthy waiting times for outpatient appointments and treatment across the BOB ICS, this is similar across the country. As such, a key area of focus during April – June 2022 continued to be supporting 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 the 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 testing, 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 hospitals to re-direct patients and reduce waiting times

In June, it was announced nationally that the number of people on the waiting list for diagnostic tests had dropped and there were two-thirds fewer people waiting more than two years for elective care. While hospital Trusts across BOB continue to experience larger waiting lists compared to pre-COVID levels (Royal Berkshire Hospitals NHS Foundation Trust seeing the largest increase of 48%, Oxford University Hospitals NHS Foundation Trust at 22% and BHT at 18%) the number of people waiting over 52-week waits is slowly reducing.

The focus of elective recovery during April to June has been to treat all patients waiting greater than 104 weeks and apart from a small number of complex patients this has been achieved across BOB. Substantial progress has been made on reducing 78-week waiters across BOB and we are currently ahead of trajectory and we are aiming to have no patients waiting longer than 78 weeks by 31 December 2022.

Work also continued to deliver the BOB Elective Recovery Programme including progressing the introduction of a systemwide referral management solution starting in Ear, Nose and Throat (ENT) and Ophthalmology to provide a single point of access, unified primary care pathways, reduce outpatient demand, monitor and identify bottlenecks and enable wider service redesign. Throughout April to June 2022, we continued to work with providers in the Independent Sector to secure capacity and help reduce waiting times.

Cancer services

Like other health service areas, cancer services across the country have continued to 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 the 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. The latest performance[2] places the TVCA compliant at 75% 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 (GI) tract, skin, and breast. However, it does indicate that we are closing the gap on the '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 being referred with a FIT (Faecal Immunochemical Test) test completed in primary care
- delivering 75% population coverage of nonspecific symptom pathways to deliver faster diagnosis and improved performance to the constitutional standards for cancer

[2] Data from December 2021

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

The BOB CCGs along with Trusts across the system set out to achieve the target of returning the number of people waiting 62 days or more for cancer treatment to the February 2020 level (plans reduce waiting list to 360 against a target of 366). This position has proved extremely challenging during April to June 2022 with the latest BOB system position of 869 patients waiting over 62 days. This equates to over 11% of the total waiting list. During this time key workstreams have been set up to support delivery of improvement across all cancer standards which include:

- Extending coverage of non-specific symptom (NSS) pathways
    - Although we are below plan in this area, we are the highest performing system within the South East Region with more than double the NSS referrals of the nearest ICB.
- Timely presentation and effective primary care pathways
- Best practice timed pathways
- Priority pathway improvement – FIT (Faecal Immunochemical Test) testing and skin pathway redesign
- Targeted case finding and surveillance – Targeted lung health checks, Lynch Syndrome, Liver Surveillance
- Population Screening

Tackling urgent care pressures in Berkshire West

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.

Urgent and emergency care continued to be extremely pressured during April to June 2022 and was impacted in this quarter by increased COVID rates and staff sickness.

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 continued to work 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 the hospital, please talk to us. We will always support people to get home with the appropriate care packages

During Q1 work continued, across the BOB ICS, with the development of virtual wards to support patients, who would otherwise be in hospital, to receive the acute care, remote monitoring and treatment they need in their own home or usual place of residence. This is an ambitious programme

to reduce hospital admissions and support the timely discharge of patients from the hospital; the national ambition is to have 40–50 virtual beds per 100,000 population.

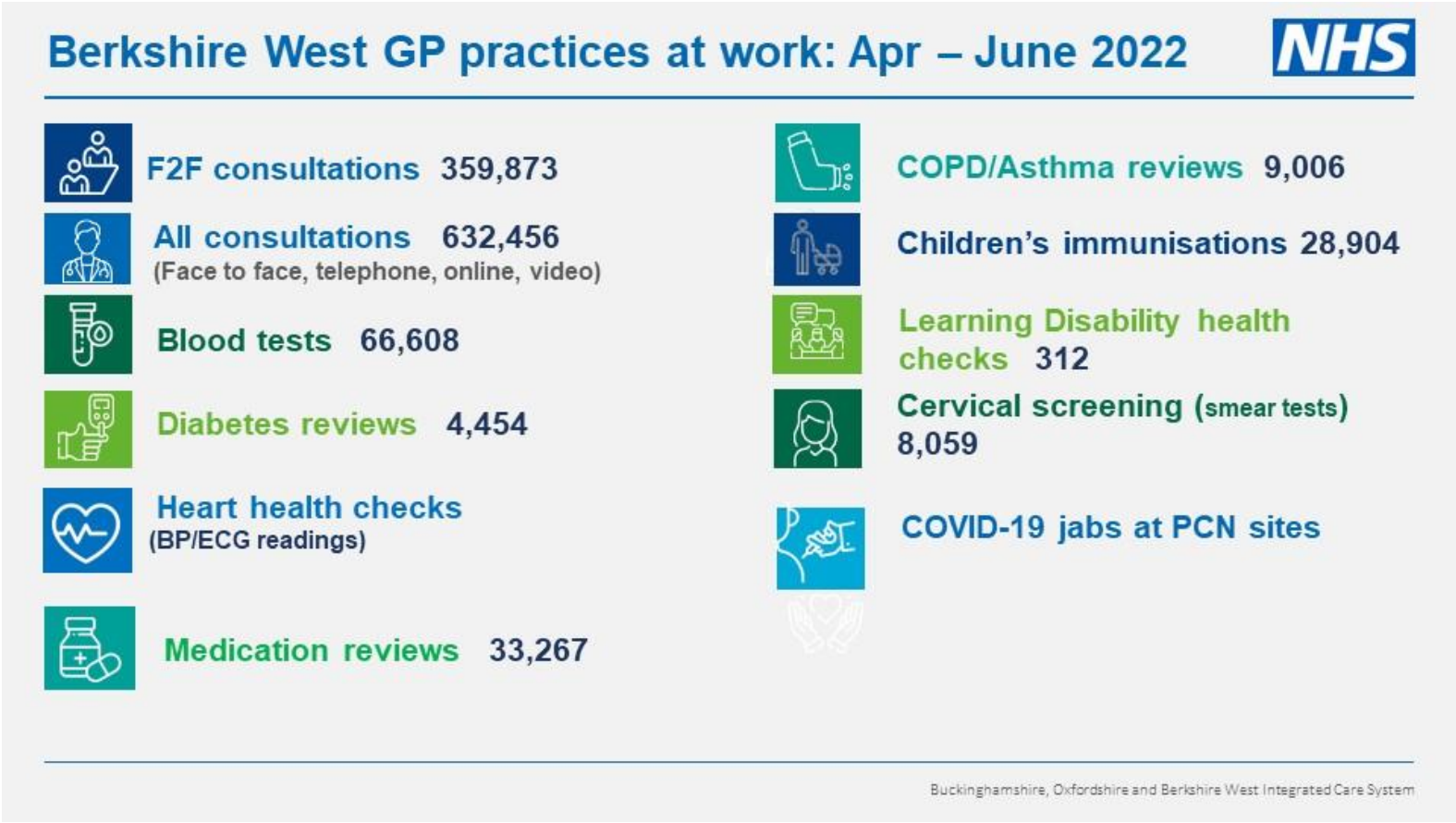
General Practice Services

Since the start of the pandemic many changes were made to the way health services were accessed and delivered; much of this has continued. In Primary Care rapid changes were made 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 were 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 to leave home for a face-to-face appointment. For patients with the relevant technology, appointments have been available using video conferencing with healthcare professionals.

While this way of working has continued; in Berkshire West appointment levels returned to pre-pandemic levels. This was a key deliverable in the restoration and recovery of services. These levels have been sustained at pre pandemic numbers since that time. The appointment patterns follow the seasonal trends seen in previous years and the majority of appointments are delivered face to face.

Below outlines the different areas of work undertaken in general practice from 1 April to 30 June 2022. while also continuing to deliver the COVID-19 Vaccination Programme.



Patient satisfaction was maintained despite the challenges faced by our practices, such as staff sickness and the requirement to redirect resources to the accelerated Covid booster vaccination programme. The latest GP Patient Survey which is an England-wide survey, providing data about patients' experiences of their GP practices, is available here. In BOB 53,363 questionnaires were sent out, and 17,933 were returned completed representing a response rate of 34%. It showed that 75% of respondents felt their experience with the GP practice was good compared to the national average of 72%.

Delivery of mental health services

Throughout the past year and continuing into April to 30 June 2022 work has continued to support mental wellbeing and improve outcomes for people suffering from mental health conditions. This is underpinned by a range of providers across the NHS, councils and voluntary sector that enables flexible ways of working and skills mix to help us meet people's needs promptly. This approach also allows people to remain as independent as possible to prevent the need for longer term specialist services.

To gain greater oversight of progress across Mental Health services, it has been agreed to construct two governance streams separating transformation from performance and assurance reporting for the ICB, which will be developed further from July 2022. TOR (Terms of Reference) and a Governance framework have been established, with clear system responsibilities, accountabilities and reporting arrangements agreed.

During April to 30 June:

- *Children and young people's mental health services (CYP):* Work has begun to ensure consistent and transparent reporting of referral rates, waiting times and activity in delivery, with a focus on clarifying capacity, demand, and service activity across the system.
- *Eating Disorders:* Progress has been made to address recruitment challenges in the workforce teams for eating disorders. Innovative recruitment approaches have led to an increase in workforce capacity.
- *Improving Access Psychological Therapies*: An IAPT (Improving Access to Psychological Therapies) recovery plan has been developed to improve access. A transformation programme is now in place and a marketing campaign has begun to drive referrals for people from Black, Asian, and minority ethnic communities and older people.
- *Dementia Diagnosis Rate (DDR):* A plan has been developed for improving DDR by reaching into care homes.
- *Mental Health Practitioner roles:* Recruitment is taking place across all PCNs to establish Mental Health Practitioner roles, through the Additional Roles Reimbursement Scheme (ARRS) to ensure clinical expertise for Mental Health is developed across our primary care services.

The Berkshire West Local Transformation Plan for Children and Young People's Mental Health and Wellbeing continued to focus on improving access to services through demand and capacity modelling during the April – June 2022 period. A review was planned for Children and Adolescent Mental Health Services (CAMHS) to align more closely with the national Thrive model - a clinically effective app that prevents and screens for mental health conditions and helps manage wellbeing.

In addition, Berkshire West mental health services teams have piloted the Additional Roles Reimbursement Scheme (ARRS) which provides funding for additional roles to create bespoke multi-disciplinary teams in Primary Care Networks, including mental wellbeing coaches. This has been done within the Community Mental Health Framework.

Developing services and support for people with learning disabilities and autism

The BOB ICS Learning Disabilities and Autism 3-year delivery plan was created as a response to the Long-Term Plan, NHS England's strategic guidance for local needs and Integrated Care System (ICS) opportunities.

This plan was developed across system partners to meet the emerging needs of the local and ICS population; it outlines how patient needs would be met with the ICS, local government, health care, social care and third sector working in partnership.

The plan in year 1 (2021/2022) focused on setting the foundations and framework for our population in key areas of reducing health inequalities, improving support for autistic people and autism pathways, reducing reliance on mental health inpatient care and making this care more appropriate for people with a learning disability and/or autistic people. It also included making reasonable adjustments to support access to healthcare services and providing crisis provision for anyone who needs it, when they need it.

Each of the BOB Clinical Commissioning Groups (CCGs) in Buckinghamshire, Oxfordshire and Berkshire West drove this agenda with their local partners and delivered their own initiatives throughout the year.

In April 2022, the BOB ICS moved into the second year of the Learning Disabilities and Autism three-year delivery plan, building on the notable achievement of 73 per cent of annual health checks completed. This demonstrates continued efforts in reducing health inequalities for people with a learning disability.

BOB has further agreed four priorities for 2022/2023 to continue reducing the numbers of people admitted into hospitals and improving the quality of care for inpatients; developing a more robust support model for autistic people; creating a better transition for young people moving into adulthood; and improving health equality by building on the success of annual health checks and health action plans. This work will be driven by the BOB ICB from July in continued collaboration with partners across the system.

Medicines Optimisation

The safe and effective use of medicines is an essential element of healthcare. BWCCG's Medicines Optimisation (MO) team supports clinicians, patients and carers in making decisions about which medications to use to obtain the best possible outcomes.

From April to June 2022, the three MO teams across the BOB moved to a whole team structure ahead of the formation of the ICB on 1 July to maximise individual expertise and minimise duplication. A BOB-wide Area Prescribing Committee was established, and a BOB-wide Prescribing Quality Scheme has been developed ready for roll out in the summer of 2022.

Strong links with colleagues working in PCNs continued, with further joint projects across BOB, including the drafting of an Induction Pack for practice-based pharmacy staff and the review of possible joint roles across PCNs and secondary care. In addition, continued collaborative working with the Local Pharmaceutical Committees (LPCs) ensured that schemes commissioned from community pharmacies could become BOB-wide.

Improving Quality

BWCCG was responsible for ensuring continuous improvement in the quality of services it commissioned in connection with the prevention, diagnosis, or treatment of illness. Quality is defined in the NHS as safe and effective care alongside outstanding patient experience. Improving the quality of healthcare provided to people in Berkshire West was at the heart of what BWCCG does.

BWCCG worked together with partners to improve patient experience, improve the quality of services and learn from incidents to reduce the risk of them happening again.

Part of this quality monitoring included BWCCG collecting feedback from members of the public about their experiences of healthcare through compliments and complaints and patient experience surveys. BWCCG received 5 formal complaints between 1 April to 30 June 2022. No complaint was referred to the Ombudsman.

BWCCG monitored patient satisfaction through the Friends and Family Test (FFT) where patients are asked, on leaving a service, how likely they would be to recommend the ward or service to a friend or a member of their family with the same need. The results are presented as a percentage who responded either 'extremely likely' or 'likely' to recommend. Below outlines the results for Royal Berkshire NHS Foundation Trust:[3]

Indicator[4]	2019/20	2020/21	National Average
Inpatient FFT Recommendation Rate	99.6%	95%	96%
ED FFT Recommendation Rate	98%	87%	88%

Oversight of quality was undertaken at each BWCCG Governing body meeting in public (held in common with Oxfordshire and Berkshire West CCGs) and through the Berkshire West ICP Quality Committee. The Berkshire West ICP Quality Committee was chaired by the Chief Nursing Officer from the BWCCG Governing Body and included Healthwatch representation and brings together local providers to review the agreed quality priorities, scrutinise and challenge each other to develop a shared learning forum and co-production principles for improving quality.

In line with the significant changes to patient safety, via the Patient Safety Strategy and the new Patient Safety Incident Response Framework, a BOB-wide Patient Safety Specialist Forum has been established to support closer working between providers to learn from Patient Safety Incidents.

Addressing health inequalities

Work continues across the BOB ICS to reduce health inequalities; in the past year a BOB- wide equalities group was established to identify inequalities and implement evidence-based interventions to reduce the gaps by working with local communities and ensure learning is shared on best practice which makes 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.

NHS partners continue to work with local authority colleagues and voluntary organisations to return to business as usual and plan work for 2022/23 in

[3] Data from Part 1: Our Quality Priorities 2022-2023 (royalberkshire.nhs.uk)

[4] Data submission and publication for the Friends and Family Test (FFT) were paused for acute and community providers during the response to COVID-19 from March 2020 so there is no further published data for this indicator. Data for the 2019-20 year therefore is incomplete and includes April 19 – Feb 20 data only. National average, NHS best and NHS worst figures are based on Feb 2020 figures.

line with government guidelines and the development of BOB as an Integrated Care System.

Some examples of equalities work are outlined below:

Reading Community Vaccine Champions: Twenty-seven people were trained as Community Vaccine Champions in the period April – the end of June 2022. 93.8% of training attendees reported an improvement in confidence around navigating vaccine hesitancy. Champions were also trained in Making Every Contact Count and have supported the deployment of the Health on the Move vaccine bus to promote vaccination take-up in underrepresented communities in Reading.

PCN Inequalities project: The four Primary Care Networks in West Berkshire joined together on a project to improve take up of Learning Disability and Serious Mental Illness health checks. A successful multi agency event was held at Newbury College on 16 June 2022 which provided an opportunity for people with learning disabilities to discuss health checks, provide feedback about GP access and take part in seated tai-chi. The event was organised by PCNs, ICB representatives and voluntary sector.

Engaging the public and local communities

The CCGs across BOB were committed to continuously strengthening public participation in all areas of work. However, progressing this throughout the pandemic has been challenging. Understandably, the COVID-19 pandemic has been a major focus in the NHS 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.

April to the end of June 2022 was spent developing a new strategy for how the developing BOB ICB would work with people and communities in line with the published guidance available here. An initial draft was developed following some early discussion with the five Healthwatches across Buckinghamshire, Oxfordshire and Berkshire West, lead governors from hospital Trusts and the VCSE alliance. A period of engagement was also undertaken with the public; the draft strategy was shared and comments / feedback received. The feedback received on the approach to engagement shared in the draft strategy, including input from the BOB Health and Wellbeing Boards and Overview and Scrutiny Committees has informed the updated strategy being presented to the ICB Board in September 2022.

Developing a sustainable environment

As part of the BOB ICS, BWCCG was 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 carbon net 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.

Between April to the end of June 2022, BWCCG as part of the BOB ICS continued its efforts and commitment to delivering against the NHS Green Plan, the BOB ICS has now developed the Sustainability Forum alongside the Net Zero Programme Board which oversees the implementation of Sustainable and Net Zero initiatives. The forum aims to bring together people from across the ICS to share the work already happening towards sustainability, allowing expansion and development of further initiatives, sharing funding opportunities, and collaborating on new and existing projects. Additionally, it is

hoped to identify Green Champions within this Forum, who have a passion for Sustainability and who will work to create new ideas and get others involved. The goal is to embed sustainability into all aspects of NHS work.

Funding applications have recently been submitted to the 'Healthier Futures Action Fund' for three new projects. One Menu is an effort towards creating a universal menu to be served across all BOB hospitals from locally sourced ingredients. The initial pilot will take place in Buckinghamshire Healthshare Trust hospitals and, if successful, will be implemented across BOB.

The second project aims to investigate the carbon footprint of paper prescriptions. The investigation will focus on the waste produced by the prescription process, specifically with repeat prescriptions, with a view to improving these numbers by educating the public.

The Electric Bikes project aims to provide Electric Bikes to the Community Nurses based in Oxford City to help remove cars from roads, improving air quality and carbon emissions, and will benefit the nurses who will no longer require their own vehicles.

In Berkshire West reductions in carbon emissions are being achieved through medication management. Anaesthetists at the Royal Berkshire Hospital in Reading have responded by swapping one of their regularly used anaesthetic gases Desflurane, with the less carbon intensive Sevoflurane, which will save 413 tonnes of CO2 per year.

Responding to an emergency

Under the Civil Contingency Act 2004, CCGs were designated Category Two responders and had a duty to co-operate and share information in an emergency. As a Category Two responder, BWCCG had 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.

BWCCG was responsible for supporting service delivery across the local health economy to prevent business as usual pressures becoming significant incidents.

All CCGs and NHS-funded providers were required to have an Accountable Emergency Officer who can take executive responsibility for leadership for EPRR. The BWCCG Director of Governance held this executive responsibility for all three BOB CCGs. A 24/7 director on-call rota was 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.

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

Given the on-going response to the COVID-19 pandemic the past couple of year has seen all NHS organisations and services operating, for the most part, in an EPRR level 4 incident which is means that NHS England coordinates the NHS response nationally in collaboration with local commissioners at the tactical level.

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 developed to strengthen the response arrangements to increase resilience and effectiveness across the three counties.

The first stage took place in October/November 2020 which involved 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. From May 2022 the three CCGs implemented a single two-tier director on call rota in preparation for the establishment of the ICB.

NHS England has published NHS core standards for EPRR 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.

How does BWCCG manage its money?

The BOB ICB is responsible for ensuring that accounts are produced for BWCCG to close off the final three months of their existence in 2022. The ICB submitted a draft unaudited accounts template by the national deadline of 22 July 2022 and took part in a national Agreement of balances exercise. No other submissions are required until summer 2023.

Performance Targets

As you will see from this report, the CCG works collaboratively with providers in the local health economy, in particular RBH (acute and elective Services), BHFT (mental health and community services), and South Central Ambulance Services NHS Foundation Trust (999, 111, and patient transport services) to deliver timely and robust healthcare provision. Meetings are held to provide assurance on actions being taken by providers to ensure performance achievement. Where performance is not achieved, we work together in partnership to resolve the issues and to develop remedial action plans to recover performance.

NHS services in the system have faced unprecedented pressures over the course of the pandemic waves and have responded to a significant increase in demand for Primary, Community and Acute services as well as delivering the biggest vaccination programme in history. During Q1 2022/23 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 COVID-19 numbers associated with Delta and more recently Omicron during the latter half of this year. This has been compounded by a high level of demand during the winter months. System providers have generally maintained planned treatment during Omicron and are working to reduce the significant wait 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 performance in Berkshire West for April to the end of June 2022:

Group	Standard Description	Standard	April to 30 June 2022
Cancer	Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	87.2%
	Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	93%	90.1%
	Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	95.5%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is Surgery	98%	89.2%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is an Anti-Cancer Drug Regimen	94%	98.9%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is a Radiotherapy Treatment Course	94%	79.7%
	Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer	85%	63.5%
	Percentage of patients receiving first definitive treatment within 62 days of referral from NHS Screening Service	90%	91.7%
	Percentage of patients receiving first definitive treatment within 62 days of a consultants decision to upgrade their priority status	86%	81.0%
RTT – Incomplete	Incomplete Pathways over 52 weeks at month end	Plans at ICB level. RAG	1704
	Incomplete Pathways over 78 weeks at month end		82
	Incomplete Pathways over 104 weeks at month end		2

		rating as ICB total	
Mental Health	IAPT - Access Rate	6.25%	5.8%
	IAPT - Moving to Recovery	50%	46.3%
	Dementia Diagnosis Rate	67%	58.4%
C&YP Eating Disorders	CYP Eating Disorders - Urgent (1 week)	95%	33.3%
	CYP Eating Disorders - Routine (4 weeks)	95%	21.5%
Ambulance Response Times (SCAS across Thames Valley)	Category 1 Incidents 90th Percentile	15:00	15:12
	Category 2 Incidents 90th Percentile	40:00	66:47
	Category 3 Incidents 90th Percentile	120:00	352:03
	Category 4 Incidents 90th Percentile	180:00	412:25

How does BWCCG monitor performance?

The BWCCG 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 BWCCG and health providers are delivering contracted services; these are the Finance Committee, Audit Committee, Berkshire West ICP Quality Committee, and the Commissioning Committee (for more information about the committees and their purpose please see page 30). 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 Berkshire West and local authorities across Berkshire West. 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 BWCCG Governing Body and Committees met in common with those of Oxfordshire and Buckinghamshire CCGs. This has enabled us to develop joint reporting and receive a different perspective on the topics discussed.

How is BWCCG 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.

Managing risk

Reducing risk across the health system is a priority for BWCCG to ensure patients receive high standards of care. Risks are events or scenarios which can hamper BWCCG'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 BWCCG Governing Body meeting in public. They are continually reviewed at Governing Body committee meetings including the Audit Committee, the Finance Committee, the Berkshire West Primary Care Commissioning Committee, the Berkshire West ICP Quality Committee and the Commissioning Committee. The report on BWCCG's principal, strategic and operational risks and mitigations as of end of June 2022 can be found here.

Steve McManus
Accountable Officer
28 June 2023

Accountability Report

Corporate Governance Report

Members Report

Details of the Berkshire West member practices can be found below, and on the CCG's website: here

CCG Locality	PCN	Surgery
Newbury	A34	DOWNLAND PRACTICE
	A34	EASTFIELD HOUSE SURGERY
	Kennet	FALKLAND SURGERY
	A34	STRAWBERRY HILL (Northcroft and St Mary's)
	Kennet	BURDWOOD SURGERY
	Kennet	THATCHAM HEALTH CENTRE
	West Berkshire Rural	KINTBURY AND WOOLTON HILL SURGERY
	West Berkshire Rural	HUNGERFORD SURGERY
	West Berkshire Rural	LAMBOURN SURGERY
	West Reading Villages	CHAPEL ROW SURGERY
CCG Locality	PCN	Surgery
North & West Reading	Caversham	BALMORE PARK
	Caversham	EMMER GREEN
	Reading West	CIRCUIT LANE (Split main site with Western Elms)
	Reading West	TILEHURST SURGERY PARTNERSHIP
	Reading West	WESTERN ELMS SURGERY
	West Reading Villages	MORTIMER SURGERY
	West Reading Villages	THE BOAT HOUSE SURGERY
	West Reading Villages	THEALE MEDICAL CENTRE

CCG Locality	PCN	Surgery

South Reading	**Whitley**	ABBEY MEDICAL CENTRE
	Reading Central	CHATHAM STREET SURGERY
	Reading Central	ELDON ROAD SURGERY (now merged with Melrose 01 Oct 19)
	Reading Central	MELROSE SURGERY (now merged with Eldon Road 01 Oct 19)
	Reading Central	PEMBROKE SURGERY
	Reading Central	RUSSELL STREET SURGERY
	Whitley	WALK IN CENTRE
	Tilehurst	GROVELANDS MEDICAL CENTRE
	Tilehurst	TILEHURST VILLAGE SURGERY (Chancellor House)
	Tilehurst	WESTWOOD SURGERY
	University	UNIVERSITY (OF READING) MEDICAL GROUP
	Whitley	KENNET SURGERY (now merged with Milman Road on 01 Oct 20)
	Whitley	MILMAN ROAD SURGERY (now merged with Kennet surgery on 01 Oct 20)
	Reading Central	LONDON STREET SURGERY/New PM started 06 Oct 21
CCG Locality	**PCN**	**Surgery**
Wokingham	**Earley**	BROOKSIDE GROUP PRACTICE
	Earley	WILDERNESS ROAD SURGERY
	Wokingham East	BURMA HILL SURGERY
	Wokingham East (Crowthorne)	NEW WOKINGHAM ROAD SURGERY
	Wokingham East	WOOSEHILL MEDICAL CENTRE
	Wokingham East	WOKINGHAM MEDICAL CENTRE
	Wokingham North (Woodley)	LODDON VALE PRACTICE
	Wokingham North	PARKSIDE FAMILY PRACTICE (GREEN RD SURGERY)
CCG Locality	**PCN**	**Surgery**

Wokingham	**Wokingham North**	TWYFORD SURGERY
	Wokingham North	WOODLEY CENTRE SURGERY
	Wokingham North	WARGRAVE SURGERY
	Wokingham South	SWALLOWFIELD MEDICAL PRACTICE
	Wokingham South	FINCHAMPSTEAD SURGERY

Members of the Governing Body

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

- Dr Abid Irfan, Clinical Chair
- Dr James Kent, Accountable Officer, BWCCG and Executive Lead for the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System

Decisions are made by a governing body that meets in public on a quarterly basis. For April - June 2022 it consisted of three GP members, a Chief Officer, Nurse Director, Joint Commissioning Director, Chief Finance Officer, two lay members, and a Secondary Care consultant. The CCG also had two operational Directors who take a lead on locality matters and on programmes of work who attended Governing Body meetings. The members of the Governing Body are responsible for directing the major activities of the CCG while the year.

Individual profiles are available on the CCG's website here.

The members of the CCG Governing Body as at the 30 June 2022 were:

- Wendy Bower, Lay Member (PPE)
- Geoffrey Braham, Lay Member (Governance)
- Niki Cartwright, Director of Joint Commissioning
- Shairoz Claridge, Director of Operations (Newbury & District)
- Edward Haxton, (Acting) Chief Finance Officer
- Dr Abid Irfan, Clinical Chair and GP Locality Lead (Newbury and District)
- Dr James Kent, Accountable Officer
- Maureen McCartney, Director of Operations (Reading)
- Dr Debbie Milligan (OBE), GP Locality Lead (Wokingham)
- Dr Kajal Patel, GP Locality Lead (Reading)
- Dr Raju Reddy, Secondary Care Consultant
- Debbie Simmons, Nurse Director

Statement of Disclosure to Auditors

Everyone who was a member of the CCG during April to 30 June 2022 confirmed:

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

Please see the Annual Governance Statement on page 29 for information about the committees of the Governing Body including membership and attendance.

BWCCG's Register of Interests for 2021/22 is available here.

Personal Data Related Incidents

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

Modern Slavery Act

BWCCG 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.

Steve McManus
Accountable Officer
28 June 2023

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 the Accountable Officer of Berkshire West CCG.

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent
- 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 Berkshire West CCG auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Steve McManus
Accountable Officer
28 June 2023

Annual Governance Statement

Introduction and context

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

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

As at 30 June 2022, the clinical commissioning group was 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 was responsible for ensuring that the clinical commissioning group was administered prudently and economically and that resources were applied efficiently and effectively, safeguarding financial propriety and regularity. I also had 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 was to ensure that the group had made appropriate arrangements for ensuring that it exercised its functions effectively, efficiently and economically and complied with such generally accepted principles of good governance as are relevant to it.

The CCG's 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 Constitution details the functions, general duties and the powers and authority of the practice members. The matters reserved to the Membership Body (Practice Members) were clearly defined in the Constitution.

The Practice members were represented on the Governing Body through the Locality Leads.

To align process across the three CCGs, the BOB CCGs' Governing Bodies have held their meetings 'in common'. One meeting was held in public during the period of this report. The meeting was quorate in terms of executive and lay member representation. A table of members attendance is included in Appendix 1. The meeting concentrated on the close-down of the CCG and establishment of the Integrated Care Board.

The CCG had the following statutory committees:

- Audit Committee
- Remuneration Committee
- Primary Care Commissioning Committee

It has also established:

- Finance Committee
- Executive Committee
- ICP Quality Committee

The terms of reference for each of these committees set out the role and purpose and had been ratified by the Governing Body. The minutes are publicly available as part of the Governing Body meeting papers (except for Remuneration Committee). In a full year each of the committees submitted an annual report to the Governing Body giving assurance they were carrying out their duties and would also undertake self-assessments of their effectiveness; the reports for 2021/22 were presented to the Governing Body on 9 June 2022. The Governing Body agreed the mechanism of handover from the CCG committees to the ICB.

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 Scheme of Reservation and Delegation (SoRD) and the Prime Financial Policies, provide the procedural framework within which the CCG discharges its business.

Governing Body Committees

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

Audit Committee

As for Governing Bodies, the BOB CCGs Audit Committees held their meetings in common. The Committee reviewed critically the CCG's financial reporting and internal control principles; ensured that all the CCG's activities were managed in accordance with legislation and regulations governing the NHS; ensured adequate assurance was in place over the management of significant risks; and ensured that appropriate relationships with both internal and external auditors were maintained.

The Accountable (Chief) Officer and other executive directors attend meetings as requested. Representative of internal audit, external audit and local counter fraud service attended each meeting. The Agenda of the Audit Committee was governed by its annual business cycle.

The Audit Committees met three times during the period of this report. Two of the three meetings were to consider the Annual Report and Accounts 2021/2022. 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 reviewed the framework for the Remuneration, Allowances and Terms of Service for employees of the CCG and the people who provide services to the CCG. It made recommendations to ensure effective oversight of the performance of the CCG's Accountable Officer, Chief Finance Officer and other senior posts, and for scrutiny of any redundancy payments. The overall purpose of the Remuneration Committee was to assure the Governing Bodies that the duty to act effectively, efficiently, and economically was met, and that resources for remuneration did not exceed any amount specified. The Remuneration Committees did not meet in the period covered by this report.

Primary Care Commissioning Committee (PCCC)

As for the Governing Bodies, Audit Committees and Remuneration Committees, the PCCCs held their meetings in common. The PCCC was 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 BOB under delegated authority from NHS England.

The Committees met once during the period covered by this report. A table of members attendance is included in Appendix 1.

Clinical Commissioning Committee

The Clinical Commissioning Committee was responsible for the overall management and delivery of the operational plan and its associated work programme and had the responsibility for day-to-day management of the CCG and certain functions as delegated by the Governing Body. While the Clinical Commissioning Committee did not meet in public, its minutes are available to the public within the Governing Body papers.

The Clinical Commissioning Committee met once during the period of this report (in common with Oxfordshire CCG's Executive committee). A table of members attendance is included in Appendix 1.

Finance Committee

As with the Governing Bodies delegated Committees, and to align services across BOB, the Finance Committees held their meetings in common during Q1 2022/23 (April – June). The Finance Committee scrutinised 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 took relevant decisions as required under delegated authority, such as business cases.

The Committee reviewed reports, identified key issues and risks and gave opinion and assurance to Governing Body on the stewardship of CCG financial resources and their going concern status. Additionally, the Governing Body would require that the Finance Committee reviews specific aspects of financial performance where they require additional scrutiny and assurance.

The Finance Committees met once during the period of this report. A table of members attendance is included in Appendix 1.

ICP Quality Committee

Reviewed and assured provider performance, had oversight of the quality and safety of commissioned services considering safety, effectiveness and patient experience; ensured that the patient voice was heard; reviewed reports on Serious Incidents and Never Events; ensured that there were processes in place to safeguard adults and children; considered national quality inspection reports; monitored arrangements relating to equality and diversity; review the corporate risk register; and received chairs reports from various subcommittees for oversight and assurance.

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

The Committee met once during the period of this report. A table of members attendance is included in Appendix 1.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code considered relevant to clinical commissioning groups. For the period covered by this report we complied with the provisions set out in the Code and applied the principles of the Code.

Discharge of Statutory Functions

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

As a result, I, the Accountable Officer, can confirm that the clinical commissioning group was clear about the legislative requirements associated with each of the statutory functions for which it was responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power was clearly allocated to a lead Director. Directorates had confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness

The Audit Committees, at their meetings in common, reviewed the approach to developing a single Risk Management Framework and Corporate Risk Register with an update on risk within the CCG; the Quality Committees reviewed and discussed risks relating to quality and performance; the Finance Committees, at their meetings in common, reviewed and discussed financial risks; the Primary Care Commissioning Committees reviewed and discussed primary care risks and the Governing Body reviewed and discussed the strategic risks.

Capacity to Handle Risk

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

Risk Assessment

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

CCG staff were responsible for their risks and for maintaining risk awareness and identifying and reporting risks as appropriate to their line manager. Staff were to ensure that they familiarised themselves with the Risk Management Policy and Framework and undertook risk management training appropriate to their role.

The BOB CCGs had no appetite for fraud/financial risk and zero tolerance for regulatory breaches. The CCG supported well managed risk taking and ensured that the skill, ability, and knowledge was in place to support innovation and maximise opportunities to improve its service.

Other sources of assurance

Internal Control Framework

A system of internal control was the set of processes and procedures in place in the clinical commissioning group to ensure it delivered its policies, aims and objectives. It was 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 allowed 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) required CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England published a template audit framework.

The CCG's internal auditors carried out their annual audit for 2021/22 and this was reported in the Berkshire West CCG Annual Report & Accounts 2021/22 available here.

Data Quality

The sourcing of data and management of provider data quality is achieved via contracts. The data contract management processes were well established in the three CCGs, and we continued 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 submitted its Data Security and Protection Toolkit for 2021/22 before the deadline of 30 June 2022 and achieved Standard Exceeded.

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

There were processes in place for incident reporting and investigation of serious incidents. In the period covered by this report there were no incidents which required reporting to the Information Commissioner's Office.

Information governance was reported to the Audit Committees in common as a standing agenda item and was reviewed regularly through the individual CCG management meetings.

Business Critical Models

The CCG was aware of the Macpherson Report on government business critical models and quality assurance mechanisms, and of its findings. The BOB CCGs did not operate any business-critical models as defined in the report.

Third party assurances

Where the CCG relied on third party providers, it gained assurance through service level agreements 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 were reported to the Audit Committees in common and informed this governance statement and external audit conclusion.

Control Issues

Performance against constitutional targets has been impacted by the COVID-19 pandemic and further details can be found in the Performance Report. Recovery of performance through the course of 2022/23 will be managed by the new Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

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

The CCG had well-established systems and processes for managing its resources effectively, efficiently, and economically. The Governing Body had an overarching responsibility for ensuring the CCG had appropriate arrangements in place, and delegates responsibilities to the Audit Committee, ICP Quality Committee, and the Finance Committee. The Chief Finance Officer had delegated responsibility to determine arrangements to ensure a sound system of financial control. An audit programme was followed to ensure that resources were used economically, efficiently, and effectively.

The Audit Committee reviewed and monitored the CCG's financial reporting and internal control principles; to ensure the CCG's activities were managed in accordance with legislation and regulations governing the NHS; and to ensure that appropriate relationships are maintained with internal and external auditors.

The Finance Committee monitored contract and financial performance, savings plans and overall use of resources; approved business cases and released finance from allocated reserves; and monitored and provided a scrutiny function to ensure the delivery of projects within the CCG's care programme boards.

The CCG had processes in place to secure economy, efficiency and effectiveness through its procurement, contract negotiation and contract management processes. Effectiveness was monitored specifically through the quality processes and ICP Quality Committee.

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

The CCG informed its control framework by the work of Internal and External Audit. The CCG's external auditors were 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 was made available to and reviewed by the Audit Committee and Governing Body.

Delegation of functions

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

The Governing Body received reports from each of its committees detailing the delivery of work, and associated risks, within their specific remit. Additionally, the Governing Body maintained a high-level overview of the organisation's business and identified and assessed risks and issues straddling committees. These risks were owned and overseen at Governing Body level and scrutinised at each meeting to ensure appropriate management and reporting is in place.

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

Counter fraud arrangements

The CCG was committed to reducing the risk from fraud and corruption and discharged its counter fraud responsibilities locally through its appointed Local Counter Fraud Specialist (LCFS) who acted as the "first line of defence" against fraud, bribery, and corruption, working closely with the CCG and the NHS Counter Fraud Authority (CFA). The Chief Finance Officer was the Executive Lead for counter fraud. The CCG had a Counter Fraud and Corruption Policy and Response plan in place. This was last reviewed in January 2022.

Fraud awareness material, including fraud alerts and information on bribery, was regularly circulated to CCG staff. Fraud referrals were investigated by the LCFS, and the progress and results of investigations were reported to the Director of Finance and the Audit Committees in common. Audit Committees received a report at each meeting on an aspect of counter fraud work. There was a proactive risk-based work plan aligned to the NHS CFA Standards for Commissioners to maintain and improve compliance and performance against each of the standards which was assessed on an annual basis.

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

Head of Internal Audit Opinion

For the three months ended 30 June 2022, the head of internal audit opinion for Berkshire West CCG is as follows:

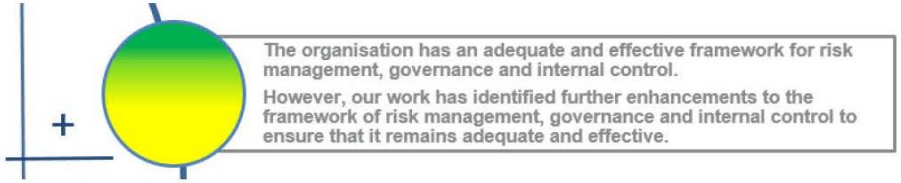
THE ANNUAL INTERNAL AUDIT OPINION

This report provides a three-month internal audit 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 should contribute to the organisation's annual governance reporting.

The opinion

The opinion takes into consideration the framework in place in the period up to and including 30 June 2022; and our cumulative knowledge of Berkshire West CCG. The opinion does not consider the arrangements of the Integrated Care Board (ICB) or the Integrated Care Partnership (ICP).

For the three months ended 30 June 2022, the head of internal audit opinion for Berkshire West CCG is as follows:



Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be a substitute for management responsibility around the design and effective operation of these systems.

Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management / lead individual;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention; and

  our opinion is limited to the internal audit work for the three-month period of 1 April 2022 to 30 June 2022; it also takes into consideration our cumulative knowledge of the client.

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

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

The BOB CCGs have been developing a single Risk Management Framework and Corporate Risk Register with an update on risk being undertaken within each CCG. The main focus of the CCG's work in Q1 2022/23 was to ensure there was a safe transition of functions to the Integrated Care Board. A Programme approach was adopted by the three CCGs with senior SROs overseeing each work programme. The due diligence checklist was used to support CCG closedown and a comprehensive report was provided to the last Governing Body meeting as well as being assured by NHS England. I have been informed by the effectiveness of this work in my review and am assured that all functions have been safely transferred to the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.

Conclusion

No significant internal control issues have been identified.

Steve McManus
Accountable Officer
28 June 2023

Renumeration

Each clinical commissioning group has a Remuneration Committee; the role of the committee is to advise on appropriate remuneration levels and terms of service for the Executive Team and Clinical Leads. Details of membership and terms of reference of the Remuneration Committee are available on page 29.

Policy on the remuneration of senior managers

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

Executive senior managers are ordinarily 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. All GPs on the BWCCG Board have employment contracts and are paid via payroll.

Policy on the remuneration of very senior managers

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

Senior Manager Remuneration (including salary and pension entitlements) 1 April to 30 June 2022

Name	Title	Berkshire West CCG Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £	Performance Pay and bonuses (Bands of £5,000) £000	Long Term performance pay and bonuses (Bands of £5,000) £000	All Pension related benefits (bands of £2,500) £000	Total (Bands of £5,000) £000
Debbie Simmons	Director of Nursing	30-35	0	0-5	0-5	40-42.5	70-75
Dr James Kent *	ICS Lead & Accountable Officer for BOB CCGs	10-15	0	0-5	0-5	97.5-100	110-115
Edward Haxton	Acting Chief Finance Officer	25-30	0	0-5	0-5	0-2.5	25-30
Raju Reddy	Secondary Care Consultant	5-10	0	0-5	0-5	0-2.5	5-10
Dr Abid Irfan **	BWCCG Chair/GP Clinical Lead - Newbury & District Locality	30-35	0	0-5	0-5	0-2.5	30-35
Niki Cartwright ***	Director of Joint Commissioning	25-30	0	0-5	0-5	0-2.5	25-30
Katie Summers	Director of Operations - Wokingham Locality & Digital Lead	20-25	0	0-5	0-5	5-7.5	30-35
Shairoz Claridge	Director of Operations - Newbury & District Locality & Long Term Conditions Lead	20-25	0	0-5	0-5	0-2.5	25-30
Maureen McCartney ****	Director of Operations - Reading Locality & CCG Director Lead for Urgent Care	20-25	0	0-5	0-5	0-2.5	20-25
Dr D Milligan	GP Clinical Lead - Wokingham Locality	5-10	0	0-5	0-5	12.5-15	20-25
Dr Kajal Patel	GP Clinical Lead - Reading Locality	20-25	0	0-5	0-5	20-22.5	45-50
G E Braham	Lay member - Governance & Probity	0-5	0	0-5	0-5	0-2.5	0-5
W Bower *****	Lay member - Patient & Public Engagement	0-5	0	0-5	0-5	0-2.5	0-5

Notes:

- * Dr James Kent is Accountable Officer for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and is recharged from Buckinghamshire CCG.
- The remuneration for 2022/23 shown above is a proportion of his total salary and is based on 'fair shares' (average registered population relative to the two other CCGs in the ICS) which equates to 29.45% for BWCCG.
- ** Dr Abid Irfan is salaried chair and clinical lead with 2 employment contracts since 2018 but no longer contribute to the pension scheme.
- ***** W Bower is Lay member for Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG. Single remuneration is disclosed on Berkshire West CCG.
- **** Maureen McCartney is salaried director but no longer contribute to the pension scheme.
- *** Niki Cartwright is salaried director but no longer contribute to the pension scheme.

Senior Manager Remuneration (including salary and pension entitlements) 2021/22

Name	Title	Berkshire West CCG Salary (Bands of £5,000) £000	Expense payments (taxable) (Rounded to the nearest £100) £	Performance Pay and bonuses (Bands of £5,000) £000	Long Term performance pay and bonuses (Bands of £5,000) £000	All Pension related benefits (bands of £2,500) £000	Total (Bands of £5,000) £000
Rebecca Clegg *	Chief Finance Officer	40-45	0	0-5	0-5	5-7.5	45-50
Debbie Simmons	Director of Nursing	115-120	0	0-5	0-5	72.5-75	190-195
Dr James Kent *	ICS Lead & Accountable Officer for BOB CCGs	50-55	0	5-10	0-5	47.5-50	105-110
Edward Haxton *	Acting Chief Finance Officer	75-80	0	0-5	0-5	140-142.5	215-220
Raju Reddy	Secondary Care Consultant	35-40	0	0-5	0-5	0-2.5	35-40
Dr Abid Irfan *	BWCCG Chair/GP Clinical Lead - Newbury & District Locality	125-130	0	0-5	0-5	42.5-45	165-170
Helen Clark *	Director of Primary Care	20-25	0	0-5	0-5	25-27.5	45-50
Niki Cartwright	Director of Joint Commissioning	105-110	0	0-5	0-5	0-2.5	105-110
Katie Summers	Director of Operations - Wokingham Locality & Digital Lead	90-95	0	0-5	0-5	25-27.5	115-120
Shairoz Claridge	Director of Operations - Newbury & District Locality & Long Term Conditions Lead	90-95	0	0-5	0-5	30-32.5	120-125
Maureen McCartney *	Director of Operations - Reading Locality & CCG Director Lead for Urgent Care	75-80	0	0-5	0-5	0-2.5	75-80
Dr D Milligan	GP Clinical Lead - Wokingham Locality	75-80	0	0-5	0-5	0-2.5	75-80
Dr Kajal Patel	GP Clinical Lead - Reading Locality	90-95	0	0-5	0-5	25-27.5	115-120
G E Braham	Lay member - Governance & Probity	5-10	0	0-5	0-5	0-2.5	5-10
S Chetcuti	Lay member - Governance	5-10	0	0-5	0-5	0-2.5	5-10
W Bower *	Lay member - Patient & Public Engagement	5-10	0	0-5	0-5	0-2.5	5-10

Notes:

* Dr James Kent is Accountable Officer for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and is recharged from Buckinghamshire CCG.
  The remuneration for 2021/22 shown above is a proportion of his total salary and is based on 'fair shares' (average registered population relative to the two other CCGs in the ICS) which equates to 29.45% for BWCCG.
  James Kent was contractually entitled to a performance bonus for 2021/22, the Berkshire West CCG share of which is shown above.
* Rebecca Clegg in substantive post from 1 April 2021 to 1 August 2021 - on secondment to Berkshire Healthcare NHS Foundation Trust.
* Helen Clark in substantive post from 1 April 2021 to 25 July 2021 - on secondment to PCN
* Dr Abid Irfan is salaried chair and clinical lead with 2 employment contracts since 2018 but no longer contribute to the pension scheme.
* Maureen McCartney is salaried director but no longer contribute to the pension scheme since last year.
* W Bower is Lay member for Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG. Single remuneration is disclosed on Berkshire West CCG.

Pension Benefits as at 30 June 2022

Name	Title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2023 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 31 March 2023 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1st April 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2023 £'000	Employer's contribution to stakeholder pension £'000
Debbie Simmons	Director of Nursing	0-2.5	0-2.5	35-40	85-90	775	50	853	0
Dr James Kent *	ICS Lead & Accountable Officer for BOB CCGs	2.5-5	0-2.5	10-15	0-5	125	74	203	0
Edward Haxton	Acting Chief Finance Officer	0-2.5	0-2.5	35-40	105-110	900	0	58	0
Dr Abid Irfan	BWCCG Chair/GP Clinical Lead - Newbury & District Locality	0-2.5	0-2.5	0-5	0-5	436	0	0	0
Katie Summers	Director of Operations - Wokingham Locality & Digital Lead	0-2.5	0-2.5	20-25	20-25	314	10	337	0
Shairoz Claridge	Director of Operations - Newbury & District Locality & Long Term (	0-2.5	0-2.5	20-25	35-40	399	8	422	0
Dr D Milligan	GP Clinical Lead - Wokingham Locality	0-2.5	0-2.5	20-25	25-30	329	17	358	0
Dr Kajal Patel	GP Clinical Lead - Reading Locality	0-2.5	0-2.5	20-25	35-40	270	18	301	0

Notes: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

- Full year pension values are shown although the reporting period is April to June 2022.
- * Dr James Kent is joint Chief Officer for Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG. Salary disclosure is for Berkshire West CCG share of costs (29.45%).

McCloud - The calculations above do not take account of the recent McCloud ruling (This is a legal case concerning age discrimination over the way 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.

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.

Factors determining the variation in the values recorded between individuals include but is not limited to: -

- A change in role with a resulting change in pay and impact on pension benefits.
- A change in the pension scheme itself.
- Changes in the contribution rates.

Pension Benefits as at 31 March 2022

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2022 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1st April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Rebecca Clegg *	Chief Finance Officer	0-2.5	0-2.5	45-50	90-95	823	0	861	0
Debbie Simmons	Director of Nursing	2.5-5	5-7.5	35-40	80-85	675	79	775	0
Dr James Kent *	ICS Lead & Accountable Officer for BOB CCGs	2.5-5	0-2.5	5-10	0-5	67	27	125	0
Edward Haxton *	Acting Chief Finance Officer	2.5-5	7.5-10	35-40	100-105	726	98	900	0
Dr Abid Irfan *	BWCCG Chair/GP Clinical Lead - Newbury & District Locality	2.5-5	0-2.5	25-30	45-50	392	32	436	0
Helen Clark *	Director of Primary Care	0-2.5	0-2.5	20-25	40-45	300	0	329	0
Katie Summers	Director of Operations - Wokingham Locality & Digital Lead	0-2.5	0-2.5	20-25	15-20	284	17	314	0
Shairoz Claridge	Director of Operations - Newbury & District Locality & Long Term Conditions Lead	0-2.5	0-2.5	20-25	35-40	359	25	399	0
Dr D Milligan	GP Clinical Lead - Wokingham Locality	0-2.5	0-2.5	15-20	25-30	315	2	329	0
Dr Kajal Patel	GP Clinical Lead - Reading Locality	0-2.5	0-2.5	20-25	30-35	243	9	270	0

(*) Dr James Kent recharge of salary 29.45% BWCCG

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.

Factors determining the variation in the values recorded between individuals include but is not limited to: -

- A change in role with a resulting change in pay and impact on pension benefits.
- A change in the pension scheme itself.
- Changes in the contribution rates.

Cash Equivalent Transfer Value

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

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

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

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

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

Real Increase in CETV

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

Fair Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director 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 of the CCG Governing Body in the financial year 2022/23 was £210k-£215k (2021/22 was £210k to £215k) on an annualised basis. The relationship to the remuneration of the organisation's workforce is disclosed in the table below: -

2022-23	25th percentile	Median	75th percentile
Total remuneration (£)	35,172	47,526	67,275
Salary component of total remuneration (£)	35,172	47,526	67,275
Pay ratio information	6.04	4.47	3.16
2021-22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	35,866	48,338	65,664
Salary component of total remuneration (£)	35,866	48,338	65,664
Pay ratio information	5.92	4.40	3.24

Year on Year Pay ratio variance %	**2%**	**2%**	**-2%**

In 2022/23, no employee (2021-22 no employee) received remuneration in excess of the highest paid director/member of the CCG Governing Body. Remuneration ranged from £8,000 to £211,000 (2021/22 £8,000 to £211,000).

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

Percentage change in renumeration of highest paid director

The financial year 2022/23 figures from the Workforce Remuneration section has been updated in accordance with NHS GAM. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Percentage changes	22/23	21/22	Change	% Change	% Change 21/22
Highest paid director					
Salary and Allowances	211,178.56	211,178.56	-	0.00%	0.00%
Performances and bonuses	-	-	-	0.00%	0.00%
Employees of the entity taken as a whole (Average)					
Salary and Allowances	58,175.31	57,886.64	288.67	0.50%	8.40%
Performances and bonuses	0.00	18,200.00	- 18,200.00	0.00%	0.00%

There has been no change in the salary of the highest paid director year on year (2021/22 was 0.00%) and overall employees' salaries have increased by 0.50% on average (pay award for 2022/23 was 4-5.5%).

Bonuses paid have been included in the calculation. Only one employee received a bonus in 2020/21 and 2021/22 and no other bonuses were received by the remaining workforce.

Staff Report

Staff sickness absence

Below outlines BWCCG's sickness absence data from 1 April 2022 – 30 June 2022

	1 April 2022 – 30 June 2022
Sum of full time equivalent (FTE)	95
Sum of FTE days available	11,544
Average annual sick days per FTE	0.6%

Sickness absence was managed in a supportive and effective manner by BWCCG managers, with professional advice and targeted support from human resources (HR), occupational health, employee assistance programme and staff support services which are appropriate and responsive to the needs of our workforce. BWCCG's approach to managing sickness absence is governed by a clear HR policy and this is further supported by the provision of HR advice and training sessions for all line managers on the effective management of sickness absence.

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

BWCCG proactively promotes the health and wellbeing of staff in line with its Health and Wellbeing Policy. Implementation is supported by an active staff led Health and Wellbeing Group who organise events throughout the year with a large number of staff participating.

Staff numbers and gender analysis

BWCCG had a workforce comprised of employees from a wide variety of professional groups. At the end of June 2022 BWCCG employed 120 staff (headcount), of which 92 were women and 28 men. At the end of June 2022, the Board of BWCCG was made up of 4 women and 5 men. Below is a breakdown of gender analysis. The membership body of BWCCG is made up of all 41 (as of 30 June 2022) GP practices within Berkshire West; a breakdown of membership by gender is not available.

Below outlines the gender breakdown of staff:

	Female Headcount	Male Headcount	Total Headcount
CEO and Board	4	5	9
Very Senior Managers	0	0	0
All other Employees	88	23	111
Total Employees	92	28	120

Staff turnover from 1 April to 30 June 2022 for BWCCG was 6.55%.

The below table shows the number of people (headcount) employed by BWCCG and other numbers, either employed by other organisations or temporary staff who are working for BWCCG as at 30 June 2022.

	Permanently employed Number	Other Numbers	20/21 Total Number
Total (headcount)	120	17	137

The below table shows the average number of people employed (whole time equivalent) by BWCCG and other numbers either employed by other organisations or temporary staff working for BWCCG between 1 April 2022 to June 2023.

	Permanently employed Number	Other Numbers	Total Number
Average number of whole time equivalent people	93.3	11.1	104.3
Of which: (WTE) people engaged on capital projects	0	0	0

Employee benefits and cost

Below are the employee benefits and costs as at 30 June 2022:

	2022-23		
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	**1,230**	**295**	**1,525**
Social security costs	**138**	**-**	**138**
Employer Contributions to NHS Pension scheme	**223**	**-**	**223**
Apprenticeship Levy	**4**	**-**	**4**
Gross employee benefits expenditure	**1,595**	**295**	**1,890**

Below are the employee benefits and costs for 2021/22:

	2021-22		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	4,551	1,234	5,785
Social security costs	550	-	550
Employer Contributions to NHS Pension scheme	931	-	931
Apprenticeship Levy	13	-	13
Termination benefits	233	-	233
Gross employee benefits expenditure	**6,278**	**1,234**	**7,512**

Trade union official facility time

BWCCG had one trade union but no trade union facilities time has been recorded for the period 1 April to 30 June 2022.

Expenditure on consultancy

Expenditure on consultancy was £163k between 1 April to 30 June 2022 (£185k in 2021/22) as per Note 5 to the Accounts page 73.

Off Payroll Engagements

Under Treasury guidance PES (2013) 09, all public sector organisations are required to disclose information about high paid off payroll appointments. As of 31 March 2022, there were no off payroll engagements for more than £245 per day that lasted longer than six months. The CCG did not make any new off payroll engagements, or any that reached six months in duration, which cost more than £245 per day, between 1 April 2020 and 31 March 2021.

For any off-payroll engagements of Board members and senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022 – see below:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll who have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	8

There were no non-contractual severance payments made following judicial mediation, and no payments relating to non-contractual payments in lieu of notice.

Exit Packages 2022/23

There were no exit packages in the period of 1 April to 30 June 2022 and consequently no associated payments.

Analysis of Other Agreed Departures

There were no departures made in the period 1 April to 30 June 2022 year or previous year 2021/22 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 BWCCG'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.

BWCCG had not agreed any early retirements. If it had, the additional costs would be met by BWCCG 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. There were none during 2021/22.

Health & wellbeing of staff

BWCCG working closely with Oxfordshire and Buckinghamshire proactively promotes the health and wellbeing of staff in line with its Health and Wellbeing Policy. The policy is implemented by an active staff led Health and Wellbeing Group. The group had been working hard to support colleagues with various initiatives since the start of the pandemic:

- The BWCCG Health and Wellbeing Team channel was set up in MS Teams for staff to share lockdown-friendly entertainment and cooking recipe suggestions, as well as tips and ideas for maintaining fitness routines. This had continued until the end of the CCG.
- Weekly Friday Wellbeing were open to all BWCCG staff and those acrossthe BOB ICS; these sessions provide mindfulness activities and stretching exercises for staff to follow and have continued throughout the past year.

The activities have been based on MS Teams and 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 anonymously to 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.

Staff Policies

BWCCG recognise and value the importance of maintaining positive working relationships with its staff and their representatives. Since December 2020 we had a Staff Partnership Forum (SPF) for all three CCGs to meeting together 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 BWCCG have actively and successfully worked with colleagues across BOB to align policies with those of Oxfordshire and Buckinghamshire CCGs to support the development of the BOB ICB. Policies are ratified in line with the scheme of delegation prior to publication.

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

The CCG had a Health and Wellbeing Policy and an active, staff led, Health and Wellbeing Group which supports implementation of this policy which had 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.

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

- Weekly BOB CCGs 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 CCGs

The results of the staff surveys have been assessed by the BOB SPF, themes identified and an action plan developed by staff to address different aspects of the feedback.

Disability information

BWCCG had 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. BWCCG'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. BWCCG 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.

BWCCG was committed to implementing the Workforce Race Equality Standards (WRES) and worked 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.

Equality and Diversity

The Workforce Race Equality Standard and how we gave 'due regard' to eliminating discrimination was on the BWCCG website.

Health and safety

BWCCG 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 had 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

Berkshire West CCG had a whistleblowing policy that was communicated to all staff and was 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 37 and 38, pension benefits of senior managers and related narrative on pages 39 and 40, the fair pay disclosures and related narrative notes on page 41 to 43 and exit packages and any other agreed departures on page 48 and 49.

Steve McManus
Accountable Officer
28 June 2023

Parliamentary Accountability and Audit Report

NHS Berkshire West CCG is not required to produce an Accountability and Audit but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report. For 1 April to 30 June 2022 there were no remote contingent liabilities, gifts, fees or charges. Below outlines the total number of Berkshire West CCG's losses and special payments cases, and their total value:

	Total Number of Cases 2022-23 Number	**Total Value of Cases 2022-23 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Cash losses	**1**	**0**	-	-
Special Severance Payments	**-**	**-**	1	37

Steve McManus
Accountable Officer
28 June 2023

Appendix 1: Table of Attendance for Governing Body and Committee Meetings

Berkshire West CCG – Governing Body Meetings 1 April – 30 June 2022

Attendees	09 June 2022
All Voting Members	
Dr Abid Irfan	Y
Wendy Bower	Y
Geoffrey Braham	Y
Edward Haxton	Y
Dr James Kent	Y
Dr Debbie Milligan	A
Dr Kajal Patel	A
Dr Raju Reddy	Y
Debbie Simmons	Y
Non-voting Members	
Nicki Cartwright	Y
Shairoz Claridge	A
Maureen McCartney	A

Berkshire West CCG – Audit Committee Meetings 1 April – 30 June 2022

Attendees	22 April 2022	27 April 2022	15 June 2022
Wendy Bower	A	Y	A
Geoffrey Braham	Y	A	A
Ed Haxton	Y	Y	Y
Noreen Kanyangarara	Y	Y	Y

Berkshire West CCG – Clinical Commissioning Committee Meetings 1 April – 30 June 2022

No Clinical Commissioning Committee meetings were held during this period.

Berkshire West CCG – Finance Committee Meetings 1 April – 30 June 2022

Attendees	09 June 2022
Geoffrey Braham	A
Edward Haxton	Y
Dr Abid Irfan	A
Dr Raju Reddy	Y

Berkshire West CCG – Primary Care Commissioning Committee Meetings 1 April – 30 June 2022

Attendees	16 June 2022
Voting Members	
Dr Raj Bajwa	Y
Wendy Bower	A
Adrian Chamberlain	Y
David Chapman	Y
Jo Cogswell	Y
Tony Dixon	Y
Kate Holmes	Y
Dr Abid Irfan	Y
Dr James Kent	A
Rebecca Mallard-Smith	Y
Dr Kajal Patel	Y
Dr Meenu Paul	Y
Rashmi Sawhney	Y
Debbie Simmons	Y
Duncan Smith	Y
Catherine Williams	A
Non-voting members	
Sushma Acquilla	A
Neil Bolton-Heaton	A
Julia Booth	A
Adrian Chamberlain	Y
Julie Dandridge	Y
Professor Tracy Daszkiewicz	A
Sanjay Desai	Y
Colin Hobbs	Y
Stuart Ireland	Y
Mandeep Kaur Bains	A
Dr Jim Kennedy	A
Rebecca Mallard-Smith	Y
Zoe McIntosh	Y
James McNally	Y
Rosalind Pearce	Y
Andrew Sharp	Y
Catherine Williams	A

Berkshire West CCG – Remuneration Committee 1 April – 30 June 2022

No Remuneration Committee meetings were held during this period.

Berkshire West CCG – ICP Quality Committee Meetings 1 April – 30 June 2022

Attendees	12 April 2022	28 June 2022
Voting Members		
Daniel Badman	Y	Y
John Black	A	A
Wendy Bower	Y	Y
Simon Brown	A	A
Pat Brunch	Y	A
Claire Burnett	A	Y
Jane Campbell	Y	A
June Carmichael	A	Y
Niki Cartwright	A	Y
Jane Chandler	A	A
Ashmita Chandra	Y	A
Paul Corcoran	A	A
Neil Cox	A	A
Rachael De Caux	A	A
Seona Douglas	A	A
Heather Duignan	Y	Y
Katherine Edwards	A	A
Susan Finch	A	A
Debbie Fulton	A	A
Sharon Herring	Y	A
Vicky Holliday	A	Y
Saima Hussain-Sheik	Y	Y
Debbie Marrs	Y	A
Debbie Milligan	Y	Y
David Munday	A	A
Louise Noble	Y	A
Patricia Pease	A	Y
Raju Reddy	Y	Y
Belinda Seston	A	A
Andy Sharp	A	Y
Jennifer Shoemark	Y	Y
Debbie Simmons	Y	Y
Helen Spokes	A	A
Eamonn Sullivan	A	A
Jane Thomson-Smith	Y	Y
Helen Ward	A	A
Melanie Wise	A	A
Sarah Wise	Y	Y

FINANCIAL ACCOUNTS

FOR THE PERIOD ENDED 30 JUNE 2022

NHS BERKSHIRE WEST Clinical Commissioning Group

Financial Information - Accounts Year Ended 30 June 2022

These accounts for the year ended 30th June 2022 have been prepared by Berkshire West Clinical Commissioning Group under a Direction issued by the NHS Commissioning Board, now known as NHS England under the National Health Service Act 2006.

NHS Berkshire West CCG - Annual Accounts 2022-23 as at 30 June 2022

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERSKHIRE WEST INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Berkshire West Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 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 20, 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 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the Accounts Direction issued by NHS England with the approval of the Secretary of State.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Berkshire West CCG as at 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

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 18 Events After the Reporting Period, which describes the Clinical Commissioning Group's transition into the NHS 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 other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023.

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 2022 to 2023; 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 three-month period ended 30 June 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 page 25 to 26, 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.

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 National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022 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 Berkshire West 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. In response to the risk of fraud in 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 year-end accounts were free form material mis-statement and performed substantive procedures on Department of Health balances data, investigating significant differences outside of Department of Health tolerances.

- 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.

- 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. NHS Berkshire West CCG has robust policies and procedures to mitigate the 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 January 2023 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 three-month period ended 30 June 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. The Code of Audit Practice does not require us to refer to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resource 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

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

Use of our report

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

Maria Grindley (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Reading

30 June 2023

Statement of Comprehensive Net Expenditure for the year ended 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Income from sale of goods and services	2	(365)	(2,301)
Total operating income		**(365)**	**(2,301)**
Staff costs	4	1,890	7,512
Purchase of goods and services	5	214,008	876,054
Depreciation and impairment charges	5	41	15
Provision expense	5	647	885
Other Operating Expenditure	5	74	2,822
Total operating expenditure		**216,660**	**887,288**
Net Operating Expenditure		**216,295**	**884,987**
Finance expense	6	2	-
Net expenditure for the Year		**216,297**	**884,987**
Comprehensive Expenditure for the year		**216,297**	**884,987**

The CCG achieved a breakeven position for Q1 2022/23 (2021/22: £585k) against revenue resource allocation (RRL) of £216,297k (2021/22: £885,572k).

The notes on pages 65 to 81 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	2022-23 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	8	45	51
Right-of-use assets	9	800	-
Total non-current assets		845	51
Current assets:			
Trade and other receivables	11	1,407	2,438
Cash and cash equivalents	12	189	63
Total current assets		**1,596**	2,501
Total assets		**2,441**	2,552
Current liabilities			
Trade and other payables	13	(43,998)	(52,633)
Lease liabilities	9	(102)	-
Provisions	14	(2,302)	(1,682)
Total current liabilities		**(46,402)**	(54,315)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(43,961)**	(51,763)
Non-current liabilities			
Lease liabilities	9	(699)	-
Provisions	14	(1,500)	(1,500)
Total non-current liabilities		(2,199)	(1,500)
Assets less Liabilities		**(46,160)**	(53,263)
Financed by Taxpayers' Equity			
General fund		(46,160)	(53,263)
Total taxpayers' equity:		**(46,160)**	(53,263)

The notes on pages 65 to 81 form part of this statement

The financial statements on pages 65 to 81 were approved by the Audit Committee on behalf of the Governing Body on 28 June 2023 and signed on its behalf by:

Steve McManus
Chief Accountable Officer

Matthew Metcalf
Chief Finance Officer

Statement of Changes In Taxpayers Equity for the year ended 30 June 2022

	2022-23	2021-22
	General fund £'000	**General fund £'000**
Changes in taxpayers' equity for 2022-23		
Balance at 01 April 2022	(53,263)	(42,850)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(53,263)**	**(42,850)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23		
Total transition adjustment for initial application of IFRS 16	0	0
Net operating expenditure for the financial year	(216,297)	(884,987)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(216,297)**	**(884,987)**
Net funding	223,400	874,575
Balance at 30 June 2022	**(46,160)**	**(53,263)**

The notes on pages 65 to 81 form part of this statement

Statement of Cash Flows for the year ended 30 June 2022

	Note	2022-23 **£'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(216,297)	(884,987)
Depreciation and amortisation	5	41	15
Interest paid	9	2	0
(Increase)/decrease in inventories	10	0	2,459
(Increase)/decrease in trade & other receivables	11	1,032	2,562
Increase/(decrease) in trade & other payables	13	(8,616)	4,580
Provisions utilised	14	(28)	(208)
Increase/(decrease) in provisions	14	647	885
Net Cash Inflow (Outflow) from Operating Activities		**(223,219)**	(874,694)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	13	(19)	0
Net Cash Inflow (Outflow) from Investing Activities		**(19)**	0
Net Cash Inflow (Outflow) before Financing		**(223,238)**	(874,694)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		223,400	874,574
Repayment of lease liabilities	9	(36)	0
Net Cash Inflow (Outflow) from Financing Activities		**223,364**	874,574
Net Increase (Decrease) in Cash & Cash Equivalents	12	**126**	(120)
Cash & Cash Equivalents at the Beginning of the Financial Year		**63**	183
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**189**	63

The notes on pages 65 to 81 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 2022-23 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.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish Clinical Commissioning Groups (CCG). ICBs will take on the commissioning functions of CCGs. Should the Bill be passed the CCG functions, assets and liabilities will therefore transfer to an ICB.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

1.2 **Accounting Convention**

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

1.3 **Pooled Budgets**

The Clinical Commissioning Group has entered into a number pooled budget arrangements with Local Authorities including Wokingham Borough Council, Reading Borough Council and West Berkshire Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Community Equipment Stores and the Better Care Fund and note 15 to the accounts provides details of the income and expenditure.

The Community Equipment pool is hosted by West Berkshire 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.

1.4 **Revenue**

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

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

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

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

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

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. Significant terms include paying all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice unless other payment terms have been 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.

Notes to the financial statements

1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**

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

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

1.5.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as 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.

1.6 **Other Expenses**

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

1.7 **Property, Plant & Equipment**

1.7.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the 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.

1.7.2 **Measurement**

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

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.

1.7.3 **Depreciation, Amortisation & Impairments**

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the 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.

Notes to the financial statements

1.8 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The Clinical Commissioning Group assesses whether a contract is or contains a lease, at inception of the contract.

1.8.1 **The Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.9 **Inventories**

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

Given the impending merger of NHS Berkshire West CCG into the BOB ICS it was agreed that the value of the inventory stock £2,459k should be written off in full at the end of 2021/22. This would enable NHS Berkshire West CCG's accounting policy reference to the Community Equipment budget to be in line with that of NHS Buckinghamshire CCG and NHS Oxfordshire CCG.

1.10 **Cash & Cash Equivalents**

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

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.

Notes to the financial statements

1.11 **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 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% (2021-22: 0.70%) 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 3.51% (2021-22: 0.95%) 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 3% (2021-22: 0.66%) 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.

1.12 **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.

1.13 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.14 **Financial Liabilities**

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

1.15 **Value Added Tax**

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

1.16 **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 30 June. 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.

1.17 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Notes to the financial statements

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).

1.18 **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 various judgements, estimates and assumptions. These are regularly reviewed.

1.18.1 **Critical accounting judgements in applying accounting policies**

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.

1.18.2 **Sources of estimation uncertainty**

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

Accruals

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

Prescribing liabilities

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

Continuing Care Provisions

NHS Continuing Health Care (CHC) provision at 30th June 2022 relates to amounts set aside for adult CHC clients awaiting their first assessment at 30 June 2022, Children's Continuing Care clients awaiting their first assessment at 30 June 2022, PUPoC claims (Previously Unassessed Periods of Care) awaiting assessment at 30 June 2022 and amounts set aside to cover outstanding CHC appeals, Local Authority disputes and CCG Responsible Commissioner disputes.

The total cost of all adult CHC clients awaiting their first assessment has been calculated using the average local current nursing home and homecare package weekly costs for NHS CHC Adult Fully Funded clients multiplied by the number of days on the waiting list since the date of application (less 28 days) until 30th June 2022. Provision has been made at 18% of the total as per the average approval rate over the last three complete financial years for first-time applications for CHC funding.

The total cost of all Children's Continuing Care clients awaiting their first assessment has been calculated using the average local current placement and homecare package weekly costs for Children's Continuing Care clients multiplied by the number of days on the waiting list since the date of application until 30th June 2022. Provision has been made at 24.5% of the total as per the average approval rate over the last two complete financial years for first-time applications for CHC funding.

The PUPoC claims (Previously Unassessed Periods of Care) provision has been calculated on an individual basis for each client. The provision is based on the time period from the start-date of the claim up to 30th June 2022 (or RIP date) and either the actual weekly cost where known or the current average local nursing home and homecare package weekly costs. Provision has been made at 67% of the total as per the average approval rate over the last two financial years for PUPoC claims.

The CHC appeals, Local Authority disputes and CCG Responsible Commissioner disputes provision has been calculated on an individual basis for each client. The provision is based on the time period from the start-date of the claim up to 30th June 2022 (or RIP date) and either the actual weekly cost where known or the current average local nursing home and homecare package weekly costs. Provision for the CHC appeals and local authority disputes has been made at 14.51% of the total as per the average approval rate over the last four years (a longer time-period has been used due to the variation in the number of cases assessed per annum during the pandemic). The CCG Responsible Commissioner dispute provision has been estimated at a 50% risk-rating.

1.19 **Adoption of new standards**

On 1 April 2022, The Clinical Commissioning Group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.

Under IFRS 16 the Clinical Commissioning Group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the Clinical Commissioning Group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Notes to the financial statements

Impact assessment

The Clinical Commissioning Group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The Clinical Commissioning Group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the Clinical Commissioning Group recognised £835k of right-of-use assets and lease liabilities of £835k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £4k impact to tax payers' equity.

The Clinical Commissioning Group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.

The following table reconciles the Clinical Commissioning Group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	(850)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	8
Operating lease commitments discounted used weighted average IBR	(842)
Add: Finance lease liabilities at 31 March 2022	-
Add: Peppercorn leases revalued to existing value in use	
Add: Residual value guarantees	-
Add: Rentals associated with extension options reasonably certain to be exercised	-
Less: Short term leases (including those with <12 months at application date)	-
Less: Low value leases	7
Less: Variable payments not included in the valuation of the lease liabilities	-
Lease liability at 1 April 2022	(835)

1.20 **New and revised IFRS Standards in issue but not yet effective**

● 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

	2022-23 Admin £'000	2022-23 Programme £'000	2022-23 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)				
Non-patient care services to other bodies	-	14	**14**	141
Other Contract income	0	351	**351**	2,160
Total Income from sale of goods and services	**0**	**365**	**365**	**2,301**
Total Operating Income	**0**	**365**	**365**	**2,301**

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

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

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

	2022-23 Education, training and research £'000	2022-23 Non-patient care services to other bodies £'000	2022-23 Other Contract income £'000
Source of Revenue			
NHS	-	14	7
Non NHS	-	-	344
Total	**-**	**14**	**351**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue			
Point in time	-	14	351
Total	**-**	**14**	**351**

	2021-22 Education, training and research £'000	2021-22 Non-patient care services to other bodies £'000	2021-22 Other Contract income £'000
Source of Revenue			
Non NHS	-	141	2,160
Total	**-**	**141**	**2,160**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue			
Point in time	-	141	2,160
Total	**-**	**141**	**2,160**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

			2022-23
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**1,230**	**295**	**1,525**
Social security costs	**138**	**-**	**138**
Employer Contributions to NHS Pension scheme	**223**	**-**	**223**
Apprenticeship Levy	**4**	**-**	**4**
Gross employee benefits expenditure	**1,595**	**295**	**1,890**

4.1.1 Employee benefits

			2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,551	1,234	5,785
Social security costs	550	-	550
Employer Contributions to NHS Pension scheme	931	-	931
Apprenticeship Levy	13	-	13
Termination benefits	233	-	233
Gross employee benefits expenditure	**6,278**	**1,234**	**7,512**

4. Employee benefits and staff numbers continued

4.2 Average number of people employed

	2022-23			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**93.3**	**11.1**	**104.3**	**96.1**	**16.9**	**113.0**

4.3 Exit packages agreed in the financial year

The CCG had no agreed exit packages in 2022-23

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
£100,001 to £150,000	-	-	1	109,960	1	109,960
£150,001 to £200,000	1	160,000	-	-	1	160,000
Total	**1**	**160,000**	**1**	**109,960**	**2**	**269,960**

	2022-23 Departures where special payments have been made		2021-22 Departures where special payments have been made	
	Number	£	Number	£
£25,001 to £50,000	-	-	1	36,809
Total	**-**	**-**	**1**	**36,809**

Analysis of Other Agreed Departures

	2022-23 Other agreed departures		2021-22 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	-	-	1	73,151
Non-contractual payments requiring HMT approval*	-	-	1	36,809
Total	**-**	**-**	**2**	**109,960**

Exit package costs of £269,960 were paid in 2021-22, of which £36,809 were non contractual. The non-contractual payment was approved and authorised by NHSE regional office after consideration of the circumstances.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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:

4.5.1 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 30 June 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.

4.5.2 Full actuarial (funding) valuation

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

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

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

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

5. Operating expenses

	Admin £'000	Programme £'000	2022-23 Total £'000	2021-22 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	**1,267**	**623**	**1,890**	**7,512**

	Admin £'000	Programme £'000	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	3	185	188	4,463
Services from foundation trusts	-	145,908	145,908	600,098
Services from other NHS trusts	-	670	670	729
Purchase of healthcare from non-NHS bodies	-	24,321	24,321	101,158
Purchase of social care	-	1,189	1,189	4,328
Prescribing costs	-	17,494	17,494	69,311
GPMS/APMS and PCTMS	-	21,626	21,626	83,963
Supplies and services – clinical	-	38	38	97
Supplies and services – general	782	134	916	2,377
Consultancy services	1	162	163	332
Establishment	(48)	580	532	4,540
Transport	-	0	0	1
Premises	99	508	607	3,376
Audit fees	115	-	115	106
Other non statutory audit expenditure				
· Internal audit services	16	-	16	59
· Other services	4	-	4	18
Other professional fees	6	72	78	693
Legal fees	-	29	29	357
Education, training and conferences	114	-	114	48
Total Purchase of goods and services	**1,092**	**212,916**	**214,008**	**876,054**
Depreciation and impairment charges				
Depreciation	35	6	41	15
Total Depreciation and impairment charges	**35**	**6**	**41**	**15**
Provision expense				
Provisions	-	647	647	885
Total Provision expense	**-**	**647**	**647**	**885**
Other Operating Expenditure				
Chair and Non Executive Members	-	-	-	325
Grants to Other bodies	74	-	74	-
Inventories consumed	-	-	-	2,459
Other expenditure	-	-	-	38
Total Other Operating Expenditure	**74**	**-**	**74**	**2,822**
Total Other Costs	**1,201**	**213,569**	**214,770**	**879,776**
Total Operating Expenditure	**2,468**	**214,192**	**216,660**	**887,288**

*Inventories Consumed - relates to in year write off of nil (2021/22: £2,459k) community equipment and note 10 Inventories, provides further details of this write off.

6. Finance costs

	2022-23 £'000	2021-22 £'000
Interest		
Interest on lease liabilities	2	-
Total finance costs	**2**	**-**

7. Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,979	30,598	15,273	163,987
Total Non-NHS Trade Invoices paid within target	2,853	29,908	14,706	161,866
Percentage of Non-NHS Trade invoices paid within target	**95.8%**	**97.7%**	**96.3%**	**98.7%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	62	2,932	356	18,619
Total NHS Trade Invoices Paid within target	62	2,932	330	17,749
Percentage of NHS Trade Invoices paid within target	**100.0%**	**100.0%**	**92.7%**	**95.3%**

Reduction in NHS Payables is due to NHS Providers being paid on block which requires a different payment method.

8. Property, plant and equipment

2022-23	Information technology £'000
Cost or valuation at 01 April 2022	172
Disposals other than by sale	(96)
Cost/Valuation at 30 June 2022	**76**
Depreciation 01 April 2022	121
Disposals other than by sale	(96)
Charged during the year	6
Depreciation at 30 June 2022	**31**
Net Book Value at 30 June 2022	**45**
Purchased	45
Total at 30 June 2022	**45**
Asset financing:	
Owned	45
Total at 30 June 2022	**45**

2021-22	Information technology £'000
Cost or valuation at 01 April 2021	127
Additions purchased	45
Cost/Valuation at 31 March 2022	**172**
Depreciation 01 April 2021	106
Charged during the year	15
Depreciation at 31 March 2022	**121**
Net Book Value at 31 March 2022	**51**
Purchased	51
Total at 31 March 2022	**51**
Asset financing:	
Owned	51
Total at 31 March 2022	**51**

8.1 Economic lives

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

9. Leases

9.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000
Cost or valuation at 01 April 2022	-
IFRS 16 Transition Adjustment	835
Cost/Valuation at 30 June 2022	**835**
Depreciation 01 April 2022	-
Charged during the year	35
Depreciation at 30 June 2022	**35**
Net Book Value at 30 June 2022	**800**

9.2 Lease liabilities

	2022-23 £'000
Lease liabilities at 01 April 2022	-
IFRS 16 Transition Adjustment	835
Repayment of lease liabilities (including interest)	2
Lease remeasurement	(36)
Lease liabilities at 30 June 2022	**801**

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(102)
Between one and five years	(699)
Balance at 30 June 2022	**(801)**
Effect of discounting	0
Included in:	
Current lease liabilities	(102)
Non-current lease liabilities	(699)
Balance at 30 June 2022	**(801)**

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2022-23 £'000
Depreciation expense on right-of-use assets	35
Interest expense on lease liabilities	2

9.5 Amounts recognised in Statement of Cash Flows

	2022-23 £'000
Total cash outflow on leases under IFRS 16	(36)

10. Inventories

Given the merger of NHS Berkshire West CCG into the BOB ICS it was agreed that the value of the inventory stock £2,459k was written off in full at the end of 2021/22. This would enable NHS Berkshire West CCG's accounting policy re the Community Equipment budget to be in line with that of NHS Buckinghamshire CCG and NHS Oxfordshire CCG.

11. Trade and other receivables

	Current 2022-23 £'000	Current 2021-22 £'000
NHS receivables: Revenue	117	896
NHS prepayments	699	699
NHS Non Contract trade receivable (i.e pass through funding)	-	105
Non-NHS and Other WGA receivables: Revenue	423	653
Non-NHS and Other WGA prepayments	169	39
Expected credit loss allowance-receivables	(2)	(2)
VAT	1	48
Total Trade & other receivables	**1,407**	**2,438**
Total current and non current	**1,407**	**2,438**

11.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £'000	**2022-23 Non DHSC Group Bodies £'000**	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	63	194	618	2
By three to six months	72	-	96	-
By more than six months	7	-	7	-
Total	**142**	**194**	**721**	**2**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2022	(2)
Total	**(2)**

12. Cash and cash equivalents

	2022-23 £'000	2021-22 £'000
Balance at 01 April 2022	63	183
Net change in year	126	(120)
Balance at 30 June 2022	**189**	**63**
Made up of:		
Cash with the Government Banking Service	189	63
Cash and cash equivalents as in statement of financial position	**189**	**62**
Balance at 30 June 2022	**189**	**62**

13. Trade and other payables

	Current 2022-23 £'000	Current 2021-22 £'000
NHS payables: Revenue	1,696	808
NHS accruals	2,917	3,065
Non-NHS and Other WGA payables: Revenue	3,227	7,982
Non-NHS and Other WGA payables: Capital	26	45
Non-NHS and Other WGA accruals	15,651	18,284
Social security costs	89	84
Tax	72	72
Other payables and accruals	20,320	22,293
Total Trade & Other Payables	**43,998**	**52,634**

Other payables include £790k outstanding pension contributions at 30 June 2022

14. Provisions

	Current 2022-23 £'000	Non-current 2022-23 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Continuing care	2,302	1,500	1,682	1,500
Total	**2,302**	**1,500**	**1,682**	**1,500**
Total current and non-current	**3,802**		**3,182**	

	Restructuring £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2022	**-**	**3,182**	**3,182**
Arising during the year	-	647	**647**
Utilised during the year	-	(27)	**(27)**
Balance at 30 June 2022	**-**	**3,802**	**3,803**
Expected timing of cash flows:			
Within one year	-	2,302	**2,302**
Between one and five years	-	1,500	**1,500**
Balance at 30 June 2022	**-**	**3,802**	**3,802**

NHS Continuing Health Care (CHC) provision totalling £3,182k at 30 June 2022, 3,802k (2021/22: £3,182k) relates to amounts set aside for the following items:

	2022-23 £'000	2021-22 £'000
Clients waiting over 28 days to be assessed for the first time for NHS Continuing Healthcare Funding	61	59
Children's Waiting List (new provision)	229	91
PUPoC's Claims arising 2013/14 onwards	393	412
CCG Appeals, Local Authority Disputes and CCG Responsible Commissioner Disputes	3,119	2,620
	3,802	**3,182**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group (PUPoC claims). However, the legal liability and the responsibility for processing and assessing the claims remains with the CCG. All of the remaining PCT Legacy PUPoC claims have now been assessed as eligible or not eligible and no claims remain outstanding at 30 June 2022. The total value of provisions and accruals accounted for by NHS England on behalf of this CCG at 30 June 2022 therefore stands at nil (2021/22: nil).

£Nil is included in the provisions of the NHS Resolution as at 30 June 2022 in respect of clinical negligence liabilities of the Clinical Commissioning Group (2021/22: £nil).

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.

15.2 Financial assets

	Financial Assets measured at amortised cost	
	2022-23	2021-22
	£'000	£'000
Trade and other receivables with NHSE bodies	50	514
Trade and other receivables with other DHSC group bodies	67	938
Trade and other receivables with external bodies	423	203
Cash and cash equivalents	189	63
Total at 30 June 2022	**729**	**1,718**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost	
	2022-23	2021-22
	£'000	£'000
Trade and other payables with NHSE bodies	1,636	739
Trade and other payables with other DHSC group bodies	3,311	4,698
Trade and other payables with external bodies	39,690	47,040
Total at 30 June 2022	**44,637**	**52,477**

16. Interests in joint operations

			Amounts recognised in Entities books ONLY 2022-23		Amounts recognised in Entities books ONLY 2021-22	
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Income**	**Expenditure**	Income	Expenditure
Community Equipment Stores	Pooled Budget with West Berkshire Council (consortium lead), Reading Borough Council, Wokingham Borough Council, Bracknell Forest Borough Council, Slough Borough Council, Royal Borough of Windsor and Maidenhead, NHS Frimley CCG (formerly NHS East Berkshire CCG), Royal Berkshire Fire and Rescue Service and Berkshire West CCG.	West Berkshire Council acts as the consortium lead hosting the contract with NRS Healthcare Ltd to provide community equipment (also known as home loans) for Berkshire residents and patients. The equipment items are prescribed by social services, health and fire professionals from the partner organisations. The provision of this community equipment is intended to facilitate timely discharges of patients from hospital to home, prevent unnecessary hospital admissions, and promote health and independence in enabling people to continue living safely in their own homes.	1,148	1,148	4,328	4,328
Better Care Fund	Pooled Budget with Wokingham Borough Council and Berkshire West CCG	Short term integrated health and social care, Step up beds at Wokingham Hospital, Community health and social care, Preventative services and Protection of adult social care	1,399	1,399	5,295	5,295
Better Care Fund	Pooled Budget with Berkshire West CCG and Wokingham Borough Council	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	988	988	3,862	3,862
Better Care Fund	Pooled Budget with West Berkshire Council and Berkshire West CCG	Step down beds in West Berkshire Care Home, adult social care, 7 day week service, protecting social care services and delayed transfer of care projects	1,622	1,622	6,139	6,139
Better Care Fund	Pooled Budget with Berkshire West CCG & West Berkshire Council	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	1,158	1,158	4,421	4,421
Better Care Fund	Pooled Budget with Reading Borough Council and Berkshire West CCG	Protection of social care, time to decide beds, Care Act costs, carers funding and delayed transfer of care projects	1,637	1,637	6,198	6,198
Better Care Fund	Pooled Budget with Berkshire West CCG & Reading Borough Council	Reablement, Out of hospital services include speech & language therapy, care homes in reach, community geriatrician, intermediate care and health hub, connected care and street triage	1,288	1,288	4,953	4,953

17. Related party transactions

Details of related party transactions with individuals are as follows:

Member	Related Party	2022-23			
		Payments to Related (Apr-Jun22)	Receipts from Related (Apr-Jun22)	Amounts owed to Related Party as at 30 Jun 22	Amounts due from Related Party as at 30 Jun 22
		£'000	£'000	£'000	£'000
Dr Abid Irfan CCG Chair and GP Locality Lead (ND)	GP Partner - Strawberry Hill Medical Centre (SHMC), Newbury	875	-	-	-
	Member GP Contracting Team (NHSE)	92	23	55	-
Dr Debbie Milligan Chair, Council of Members GP Locality Lead (Wokingham)	Salaried Doctor - Swallowfield Medical Practice	934	-	-	-
	Governance Lead - Urgent Care/NHS111 (SCAS)	6,840	-	-	-
	GP - Westcall Out of Hours (BHFT)	39,242	-	20	36
Geoffrey Braham - Lay Member, Governance	Governor - Oxford Health NHS Foundation Trust	144	-	7	2
Edward Haxton - Interim Chief Finance Officer from 02-08-2021*	Spouse works as Midwife at Royal Berkshire NHS Foundation Trust	88,133	-	145	29
Saby Chetcuti - Lay Member Governance	Governor - South Central Ambulance Service (CCGs North)	6,840	-	-	-
Wendy Bower - Lay Member for Patients and Public Engagement	Governor for CCG Federation - Royal Berkshire NHS Foundation Trust	88,133	-	145	29
	Nurse/Staff support RBFT (during Covid19 pandemic)	88,133	-	145	29
	Daughter works for - Royal Berkshire NHS Foundation Trust	88,133	-	145	29
James Kent Accountable Officer (Across BOB - Buckinghamshire, Oxfordshire, Berkshire West CCGs)	Friend John Storey, CEO Porthaven Care Homes	-	-	-	-
Kajal Patel GP Locality Lead Reading	Salaried GP - Milman and Kennet Surgery	997	-	-	-

* Edward Haxton was in a substantive role from August 2021, amounts shown relate to period in post in 2021-22.

GP practices within the area have joined other professionals in the Clinical Commissioning Group in order to plan, design and pay for services. Under these arrangements some services are designed to be delivered in a primary care setting. This involves paying GP practices for the delivery of these services. A GP is also paid by the CCG for taking a lead role on clinical services. All such arrangements are in the ordinary course of business and follow the CCGs strict governance and accountability arrangements. From 1 April 2016, the CCG had delegated commissioning responsibility for primary care GP services. This means that the CCG now makes all payments due to practices based on the Statement of Financial Entitlement and the Premises Direction and this has resulted In a significant increase in the amounts recorded against practice based Governing Body members. Material transactions are disclosed appropriately in the accounts.

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.

The amounts in the table above represent the amounts paid to organisations named rather than the individual. Where an organisation appears several times, it is a duplicate of the previous entry but related to a different Governing Body member.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which
- Clinical Commissioning Groups
- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Resolution; and,
- NHS Business Services Authority.

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Local Authority in respect of joint commissioning arrangements.

17. Related party transactions - continued

Department of Health and Social Care (DHSC) related party information for group bodies 2022-23

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group.

This note therefore sets out the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2023 to assist group bodies in preparing disclosures compliant with IAS 24.

Ministers	**Senior Officials**	**Non-executive Directors**
The Rt Hon Steve Barclay MP	Sir Chris Wormald KCB	Kate Lampard
The Rt Hon Dr Thérèse Coffey MP	Professor Sir Christopher Whitty KCB	Doug Gurr
The Rt Hon Sajid Javid MP	Shona Dunn	Gerry Murphy
Edward Argar MP	Clara Swinson CB	Julian Hartley
Gillian Keegan MP	Jonathan Marron	
Dr Caroline Johnson MP	Matthew Style	
Robert Jenrick MP	Michelle Dyson	
William Quince MP	Andrew Brittain	
Helen Whately MP	Stephen Oldfield	
Maggie Throup MP	Matthew Gould	
Maria Caulfield MP	Professor Lucy Chappell	
James Morris MP	Jenny Richardson	
Neil O'Brien MP	Hugh Harris	
Lord Markham	Lorraine Jackson	
Lord Kamall		

The CCG has no related party transactions with entities related to above individuals.

18. Events after the end of the reporting period

The functions, assets and liabilities of Berkshire West CCG transferred to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board on 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.

19. Losses & Special Payments

	Total Number of Cases 2022-23 Number	**Total Value of Cases 2022-23 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Cash losses	**1**	**0**	-	-
Special Severance Payments	**-**	**-**	1	37

In 2021-22 the CCG, with the agreement and authorisation of the NHSE regional office, made a non-contractual payment of £36,808. This payment did not fully follow the national NHSE process for approval of such payments, and has therefore been classified by NHSE as an irregular payment.

The National Audit Office (NAO) identified an irregularity with regard to elements of the exit package made to the former Accountable Officer (AO) of the Berkshire West CCG. This package was agreed in good faith between NHSE SE Region, the CCG and the former AO during the first wave of COVID, but paid out this year following a secondment with NHSE. However as a special severance payment it should have been approved at the time by NHSE and HM Treasury. We have reviewed and clarified the CCG processes for setting and approving exit packages. The NAO did not make any specific recommendations for Berkshire West CCG, but has made a number of recommendations to NHS England to strengthen compliance and scrutiny.

The payment noted above is also included in the exit packages disclosure on note 4.3.

20. 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:

	2022-23 Target	**2022-23 Performance**	**Target Achieved?**	2021-22 Target	2021-22 Performance	Target Achieved?
Expenditure not to exceed income	216,661	216,660	Yes	887,439	887,333	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	N/A	45	45	Yes
Revenue resource use does not exceed the amount specified in Directions	216,296	216,294	Yes	885,093	884,987	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	N/A	-	-	N/A
Revenue administration resource use does not exceed the amount specified in Directions	2,471	2,470	Yes	9,837	9,829	Yes