Buckinghamshire
Clinical Commissioning Group

Buckinghamshire Clinical Commissioning Group
Annual Report 1 April – 30 June 2022

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Performance Report

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

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

Performance Overview

BCCG was the statutory organisation in Buckinghamshire that planned, bought and oversaw health services for more than 578,000 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.

BCCG is 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.

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

Before being abolished at the end of June 2022 to make way for the establishment of Integrated Care Boards, BCCG 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.

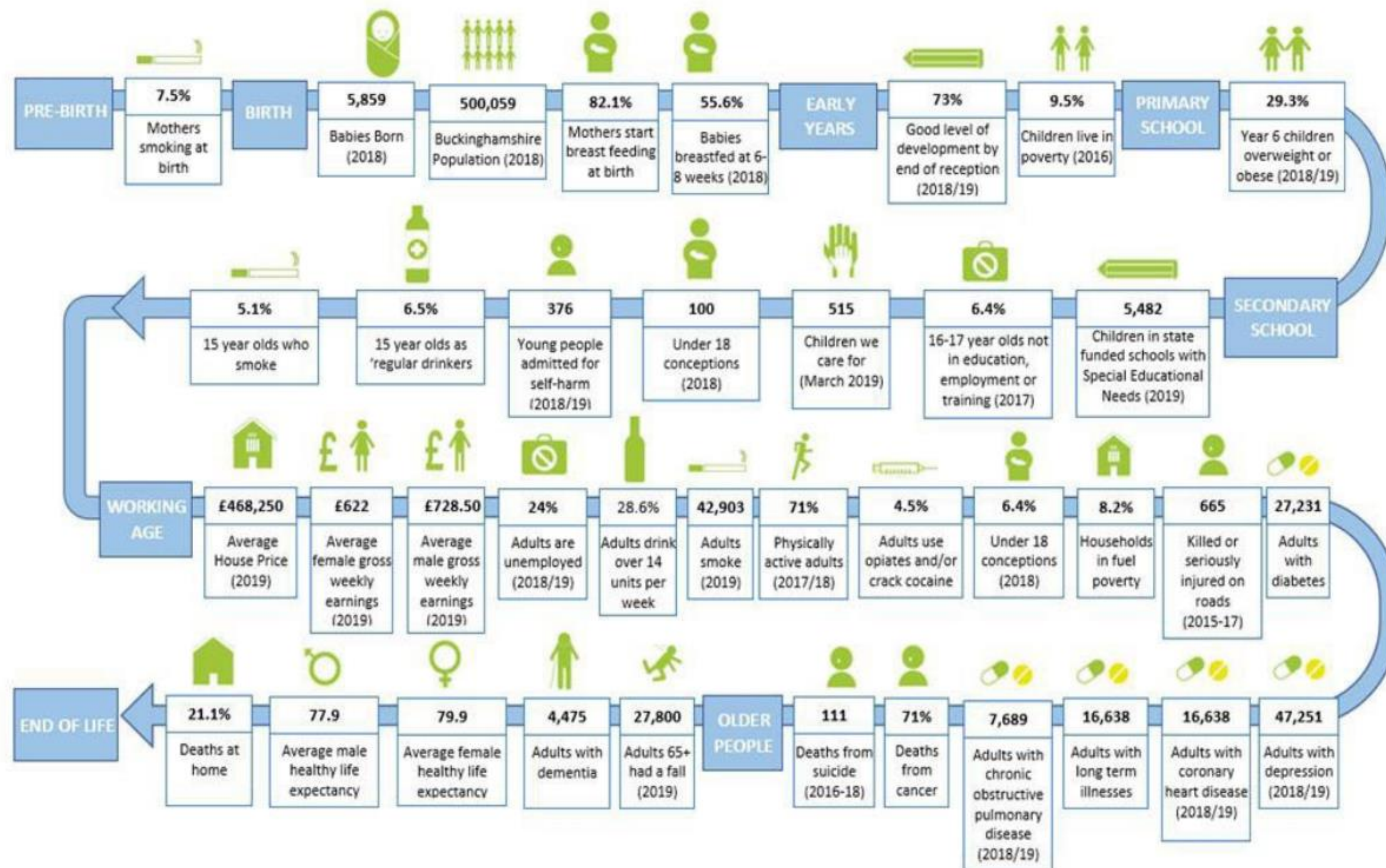
In Buckinghamshire, the Health and Wellbeing Board (H&WB) is responsible for improving the health and wellbeing of the people of the county. The H&WB is a partnership between the Local Government, the NHS and the people of Buckinghamshire; Board members include local GPs, Councillors, Healthwatch Buckinghamshire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

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

The Buckinghamshire joint Health and Wellbeing Strategy (2021 – 2024) – a shared plan for Buckinghamshire was refreshed during 2020/21 and approved by the Health and Wellbeing Board in February 2021. This set out 3 key priorities – Start Well, Live Well and Age Well. It aims to improve the health and well-being of local people and reduce health inequalities across the county. This strategy has guided the work of BCCG over the last year alongside our local implementation of the NHS Long-Term Plan.

Buckinghamshire's Population

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



Performance Analysis

Overview from Steve McManus, Accountable Officer

Not much time has passed since I last wrote an overview for BCCG'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 BCCG; 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 1,235,334 vaccines across Buckinghamshire 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 community assessment and treatment services at Thame and Marlow Community Hospitals. The service is provided by a team of doctors, nurses, therapists and health care assistants who provide a service for frail and/or older patients with complex needs; patients are referred by a health professional and are quickly assessed, treated, and receive rehabilitation support, without having to be admitted to hospital.

The implementation of Immedicare, telemedicine provision, across Buckinghamshire in 130 care homes to ensure 24/7 reactive medical support for care homes as required has been a successful project for BCCG working with its local care homes.

In primary care, considerable developments have been made including improvements to premises for GP practices in Beaconsfield, Aylesbury, Wycombe Hospital (Wye Valle Surgery) and Cressex. In recent years, the development of 13 Primary Care Networks has been a real achievement for Buckinghamshire. The NHS Long Term Plan set an ambitious programme of change for primary care and community services and Buckinghamshire 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 BCCG, I also want to extend my gratitude to colleagues within the organisation; during the time of the CCG and especially in the past couple of years, many have worked above and beyond 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 Buckinghamshire

The Buckinghamshire H&WB board provides strategic leadership for health and wellbeing across the county and will ensure that plans are in place and action is taken to realise those plans. The Health and Wellbeing Strategy 'Happier, Healthier Lives' aims to create the best conditions in Buckinghamshire for people to live healthy, happy and fulfilling lives and achieve their full potential.

The strategy looks at how, across Buckinghamshire, the NHS and local authorities together with the voluntary sector need to deliver the key priorities which include:

- Start Well - we want to make sure that every child has the best possible start in life. The key to getting this right is tackling health and social inequalities and preventing poor outcomes.
- Live Well – we want to improve the health and well-being outcomes of everyone in Buckinghamshire.
- Age Well – we increase the independence of older people and support them to age well.

These align with the COVID-19 recovery plans and have three cross-cutting priorities:

- Tackling health inequalities
- Mental health
- Community engagement

Informing the work of the Board is the Buckinghamshire Joint Strategic Needs Assessment (JSNA) which provides facts and figures about health and wellbeing in Buckinghamshire.

Research, data and intelligence are included from a wide range of sources and provide a common and consistent evidence base for the NHS, local authorities and partners to help pinpoint gaps and target improvements.

While work has continued to deliver the Health and Wellbeing Strategy over the past years, the ongoing COVID-19 pandemic has hampered delivery.

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.

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 a 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 Buckinghamshire:

- 1,235,334 vaccines had been delivered.
- 212,380 50-year-olds and over had received two doses.
- 200,777 50-year-olds and over had received their booster (3rd vaccine)
- 42,313 of our 75-year-olds and over had received their 2nd booster (4th vaccine) even though the 2nd booster programme had only commenced 21 March.
- 333,897 of those 18-year-olds and over had received their booster (3rd vaccine)
- For 12-15 year-olds 18,444 had received a 1st dose and 13,052 a 2nd
- For 5-11 year-olds 6,013 had received a 1st dose and 231 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:

[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.

- the creation of new community diagnostic centres to carry out a range of diagnostic tests, outside 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 from 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 the 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

[2] Data from December 2021

- Delivering 75% population coverage of nonspecific symptom pathways to deliver faster diagnosis and improved performance to the constitutional standards for cancer

TVCA will also focus on earlier diagnosis by identifying the second site for 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 the 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 the 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 the county

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

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.

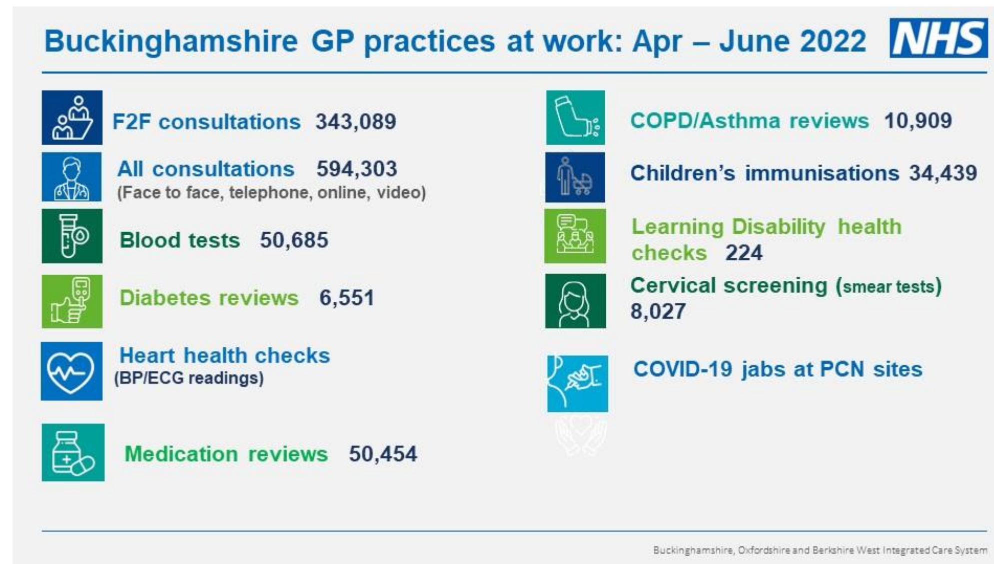
General Practice Services

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 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 the 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 Buckinghamshire appointment levels returned to pre-pandemic levels in September 2020. 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 many 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 to 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 in 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 NHS Long Term Plan outlines an ambition for all CCG areas to provide a comprehensive physical health check to at least 60 per cent of their patient population who have a diagnosis of severe mental illness (SMI). These checks help reduce health inequalities among this group.

Performance against this target was significantly impacted by the pandemic. Subsequently, the performance in Buckinghamshire dropped as low as 12.6 percent (February 2021). In response, from March 2021 BCCG worked with GP surgeries providing investment to enable them to outreach to their individual SMI population. There were three main areas of focus were:

- to ensure that patients had a physical health check
- to ensure that their vaccinations were up to date and

- to encourage and emphasise the importance of the flu jab during the winter.

The impact of the drive to improve outcomes for this group of people can be seen the April – June 2022 when Buckinghamshire's performance reached a high of 49.4 per cent.

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.

Similar to the national picture and across the rest of BOB, Buckinghamshire has longer than ideal waits for diagnostic assessments for children and young people's autism and ADHD. As part of the work to improve the pathway, parents were asked about their key concerns in supporting a child with a neurodiverse presentation. A clear gap emerged in the information advice and guidance support that was absent for people while waiting for an assessment. As a result of the feedback received, a pre-assessment service was commissioned via a third-sector partner (Autism Early Support) and started in March 2022.

Autism Early Support has implemented a tiered model of support, (workshops, targeted workshops and 1:1), that run over five weeks. Among the issues covered are self–harm, anger management, sleep, language, and emotional and social needs. In the period April to June 2022 positive outcomes were achieved with 86 per cent of parents and carers who attended reporting the programme helped them to address the concerns they had when they first started the course. All respondents said that they would recommend the course to others.

Medicines Optimisation

The safe and effective use of medicines is an essential element of healthcare. BCCG'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 rollout 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 work with the Local Pharmaceutical Committees (LPCs) ensured that schemes commissioned from community pharmacies could become BOB-wide.

In addition to the usual work programme, the MO team continued to be actively involved in the COVID-19 vaccine rollout, supporting the PCN sites with preparation and vaccination as well as transporting the vaccine between sites under mutual aid arrangements.

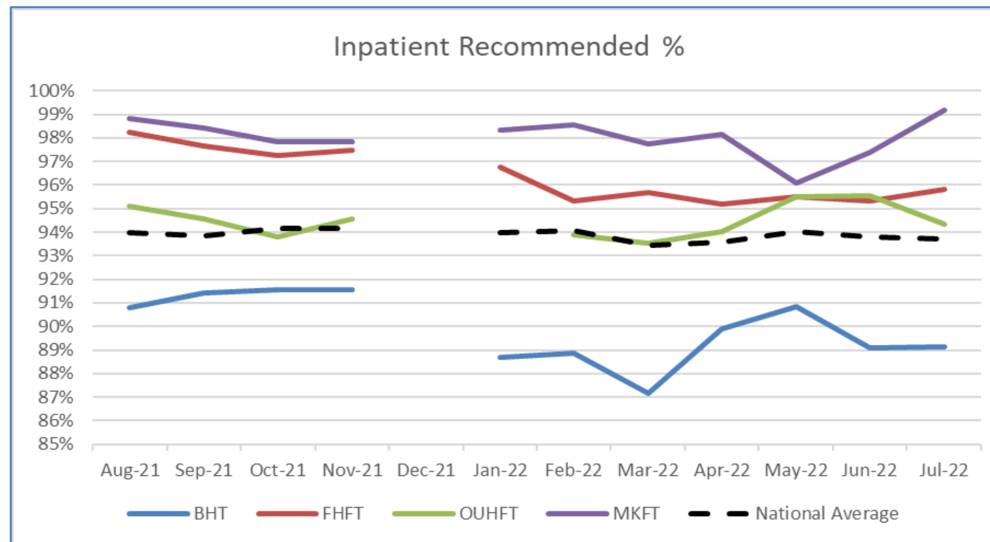
Improving Quality

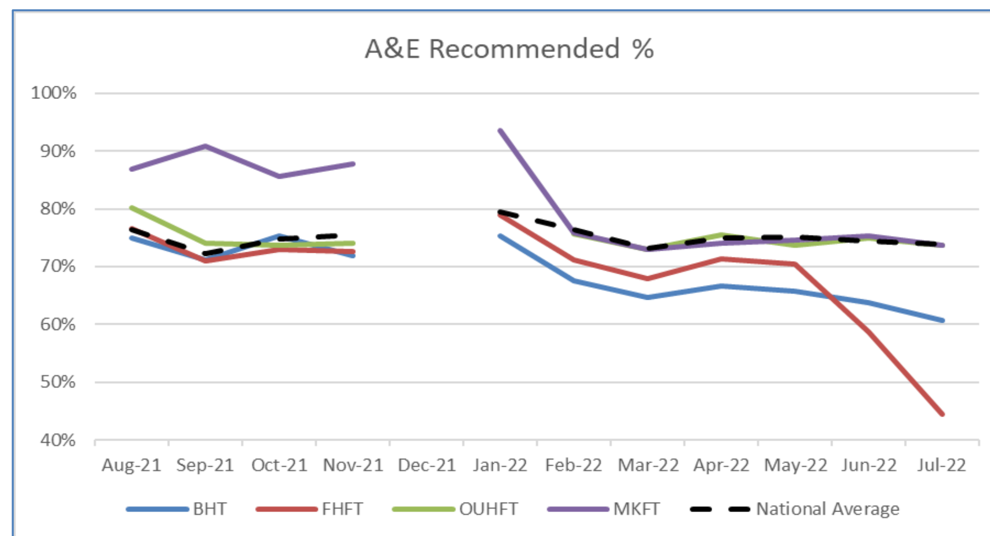
BCCG was responsible for ensuring continuous improvement in the quality of services it commissioned in connection with the prevention, diagnosis, or treatment of illness. Quality is defined in the NHS as safe and effective care alongside outstanding patient experience. Improving the quality of healthcare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

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

BCCG 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 gives a couple of inpatient services and A&E at BHT.





Oversight of quality was undertaken at each BCCG Governing body meeting in public (held in common with Oxfordshire and Berkshire West CCGs) and through the Buckinghamshire Quality Committee. The Buckinghamshire Quality Committee was chaired by the Medical Specialist Advisor from the BCCG Governing Body and included Healthwatch Buckinghamshire and local NHS 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 line with government guidelines and the development of BOB as an Integrated Care System.

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 was 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, BCCG 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 well-being of staff, patients and the wider communities it serves.

Between April to the end of June 2022, BCCG 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 Buckinghamshire, High Wycombe Hospital has been undergoing major renovations to repair and modernise the buildings. The NHS Wycombe Energy Centre has been designed to allow stable, predictable, accurate forecasting for future energy expenditure and will provide a 40 per cent reduction in energy costs for the site. The Energy Centre will enable significant de-steaming of the site and once available, can be converted into Hydrogen Power.

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, BCCG 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.

BCCG was responsible for supporting service delivery across the local health economy to prevent business-as-usual pressures from 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 BCCG 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.

BCCG had incident response plans in place which are compliant with the NHS England Emergency Preparedness Framework 2013. BCCG 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 the 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 that 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 BCCG manage its money?

For the financial year 2022/23, Buckinghamshire CCG was in existence from 1st April 2022 to 30th June 2022 after which it ceased to be a legal body and its assets and liabilities transferred to newly created Integrated Commissioning Board covering Buckinghamshire Oxfordshire and Berkshire West.

For Buckinghamshire CCG the total funding for the period 1st April 2022 to 30th June 2022 was £230.3m. Of this, £227.7m was allocated for healthcare programmes and £2.6m for the CCG’s running costs. The table below which summarises our budget (plan) and actual expenditure for the period covering April to June 2022/23:

Summary of position Month 3 June 2022	Plan Q1 £'000	Year to Date Actual £'000	YTD Variance £'000
Allocation	**230,280**	**230,280**	**0**
Commissioning			
Planned and Unscheduled Care	123,716	125,172	(1,457)
Prescribing	19,111	19,189	(78)
Mental Health & Joint Care	22,136	22,126	9
Community	16,324	16,423	(99)
Continuing Healthcare	15,980	15,423	557
Delegated Co-Commissioning	21,408	20,712	696
Primary Care IT	655	655	0
Other / Reserves	5,314	7,937	(2,623)
Commissioning sub-total	**224,644**	**227,638**	**(2,995)**
Running Costs	2,641	2,641	0
Total CCG Expenditure	**227,285**	**230,280**	**(2,995)**
Surplus/Deficit In Q1	**227,285**	**230,280**	**(2,995)**
Planned Surplus	2,995	0	2,995
Reported Position	**0**	**0**	**0**

BCCG has formal delegated responsibility from NHS England for GP Primary Care Commissioning and the CCG received an allocation of £21.4m to deliver this.

During 2022/23 the COVID-19 pandemic has subsided from that seen in previous years although the reduction in the number of Medically Optimise Fit for Discharge patients (MOFD) in the acute setting to free beds to enable recovery and reduce waiting lists remains challenging.

During the year, BCCG continued joint commissioning and pooled budget arrangements with Buckinghamshire Council. These pooled budgets covered - the Better Care Fund (BCF), Children and Adolescence Mental Health Services (CAMHS), Speech and Language Therapy, Residential Respite Short Breaks, Integrated Community Equipment Service Contract Management, Integrated Community Equipment Service, Section 117 and Integrated Commissioning Team. BCCG's contribution to the pooled budgets for this reporting period in 2022-23 was £24.0m while Buckinghamshire Council contributed £8.3m.

For the remainder of the financial year 2022/23, national arrangements have been put in place to ensure that NHS providers receive cash as required by means of a national block contracting arrangement through CCGs and CCG's developing plans with a view to returning to more usual commissioning and contracting arrangements in 2023/24.

In line with national policy direction for the NHS, Buckinghamshire CCG continued to work more closely within the BOB ICS and became part of BOB ICB a statutory organisation from 1 July 2022.

As such the 2023/24 plan is under development at that level. Organisations now work more closely together to make choices and decisions about how the Buckinghamshire pound (£) is spent. Improved system working across Buckinghamshire and across the wider BOB ICS area will contribute to getting the best possible value from the Buckinghamshire pound (£).

Performance Targets

As you will see from this report, the CCG works collaboratively with providers in the local health economy, in particular, BHT (acute, elective and community services), Oxford Health (mental health 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 Buckinghamshire 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%	89.1%
	Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected	93%	40%
	Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat')	96%	89.2%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is Surgery	98%	76.4%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is an Anti-Cancer Drug Regimen	94%	95.8%
	Percentage of patients receiving first subsequent treatment within 31-day, where that treatment is a Radiotherapy Treatment Course	94%	89.3%
	Percentage of patients receiving first definitive treatment within two months (62 days) of an urgent GP referral for suspected cancer	85%	57.6%
	Percentage of patients receiving first definitive treatment within 62 days of referral from NHS Screening Service	90%	73.5%
	Percentage of patients receiving first definitive treatment within 62 days of a consultants decision to upgrade their priority status	86%	80%
RTT – Incomplete	Incomplete Pathways over 52 weeks at month end	Plans at ICB level. RAG rating as ICB total	4008
	Incomplete Pathways over 78 weeks at month end		463
	Incomplete Pathways over 104 weeks at month end		4
Mental Health	IAPT - Access Rate	6.25%	6.63%
	IAPT - Moving to Recovery	50%	53.4%
	Dementia Diagnosis Rate	67%	56.8%
C&YP Eating Disorders	CYP Eating Disorders - Urgent (1 week)	95%	73.3%
	CYP Eating Disorders - Routine (4 weeks)	95%	30.4%
	Category 1 Incidents 90th Percentile	15:00	17:41
	Category 2 Incidents 90th Percentile	40:00	61:09

Ambulance Response Times	Category 3 Incidents 90th Percentile	120:00	275:54
	Category 4 Incidents 90th Percentile	180:00	335:06

How does BCCG monitor performance?

The BCCG Governing Body is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising the performance of service providers. The Governing Body receives an integrated performance report at the quarterly meetings in public. Formal committees of the Governing body scrutinise in more detail how BCCG and health providers are delivering contracted services; these are the Finance Committee, Audit Committee, Quality & Performance Committee, Integrated Care Executive Committee and the BCCG Executive Committee (for more information about the committees and their purpose please see page 29). In addition to the monitoring requirements outlined above, the Urgent & Emergency Care Board also has a role to play in monitoring performance, to the extent necessary. The members include the Chief Operating Officers and Governing Body level representatives from NHS organisations in Buckinghamshire and Buckinghamshire Council. The group aims to develop and maintain resilience across the urgent care services and improve the flow of patients through A&E, admission, treatment and discharge. Over 2021/22 the BCCG Governing Body and Committees met in in common with those of Oxfordshire and Berkshire West CCGs. This has enabled us to develop joint reporting and receive a different perspective on the topics discussed.

How is BCCG monitored?

NHS England has a statutory duty to undertake annual assessments 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 BCCG to ensure patients receive high standards of care. Risks are events or scenarios which can hamper BCCG's ability to achieve its objectives. These risks, divided into strategic and operational, are identified, assessed and managed by the organisation and reviewed at every BCCG Governing Body meeting in public. They are continually reviewed at Governing Body committee meetings including the Audit Committee, the Finance Committee, the Buckinghamshire Primary Care Commissioning Committee, the Buckinghamshire Quality Committee and the BCCG Executive Committee. The report on BCCG's principal, strategic and operational risks and mitigations during 1 April to 30 June 2022 can be found on BCCG's website here.

Steve McManus,

Accountable Officer,

28 June 2023

Accountability Report

Corporate Governance Report

Members Report

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

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

Members of the Governing Body

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

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

Along with the Accountable Officer and Clinical Chair, the Governing Body of BCCG comprised GP representatives, lay members, executive directors, and a representative from Public Health, Adult Social Care and an external Medical Specialist. The composition of the Governing Body as of 30 June 2022 included:

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

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 30 for information about the committees of the Governing Body including membership and attendance.

The Governing Body member Register of Interests 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

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

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 has appointed Dr James Kent to be the Accountable Officer of Buckinghamshire CCG.

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

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

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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 Buckinghamshire 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

Buckinghamshire 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 Clinical Directors.

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
- Quality & Performance 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, Director of Finance 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.

Executive Committee

The focus of the Committee in this period was on managing safe transition of commissioning functions and alignment where possible. While the Executive Committee did not meet in public, its minutes are available to the public within the Governing Body papers.

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

The Executive Committee did not meet during the period of this report.

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.

Quality and Performance 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 Committee 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 Buckinghamshire 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 undertook 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 delegated responsibilities to the Audit Committee, Quality and Performance 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 are 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 were 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 Quality and Performance 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 had 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 Chief Finance Officer 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

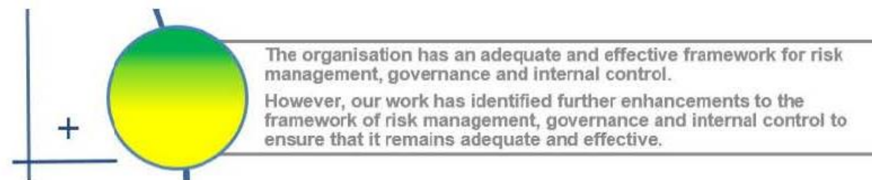
THE ANNUAL INTERNAL AUDIT OPINION

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 Buckinghamshire 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 Buckinghamshire 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.

Steven McManus

Accountable Officer

28 June 2023

Renumeration Report

Remuneration Committee

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 31.

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 BCCG 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 BCCG'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
James Kent (*)	Accountable Officer	10-15	1	0-5	0-5	90-92.5	105-100
Kate Holmes	Interim Chief Finance Officer	25-30	0	0-5	0-5	92.5-95	120-125
Robert Majilton	Deputy Accountable Officer	25-30	0	0-5	0-5	0-2.5	25-30
Dr Raj Bajwa	GP Clinical Chair	15-20	0	0-5	0-5	0-2.5	15-20
Dr Karen West	Clinical Director for Integrated Care & Quality Lead	10-15	0	0-5	0-5	0-2.5	10-15
Louise Smith	Associate Director Commissioning & Locality Delivery	25-30	0	0-5	0-5	5-7.5	30-35
Dr Robin Woolfson	Secondary Care - Specialist Doctor	0-5	0	0-5	0-5	0-2.5	0-5
Dr Dal Sahota	Clinical Director - Unplanned Acute Care	10-15	0	0-5	0-5	0-2.5	10-15
Dr Raj Thakkar	Clinical Director - Planned Care	10-15	0	0-5	0-5	0-2.5	10-15
Dr Rashmi Sawhney	Clinical Director -Health Inequalities and The Primary Care Networks DES	10-15	0	0-5	0-5	0-2.5	10-15
Dr Sian Roberts (****)	Clinical Director - Mental Health & Learning Disabilities	10-15	0	0-5	0-5	5-7.5	15-20
Sonya Wallbank	Director of People and Organisational Development	30-35	0	0-5	0-5	95-97.5	125-130
Robert Parkes	Lay Member	0-5	0	0-5	0-5	0-2.5	0-5
Anthony Dixon	Lay Member	0-5	0	0-5	0-5	0-2.5	0-5
Dr Crystal Oldman (***)	Registered Nurse - Governing Body	0-5	0	0-5	0-5	0-2.5	0-5
Wendy Bower (**)	Lay Member Patient Public Engagement	0-5	0	0-5	0-5	0-2.5	0-5

Note:

- Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension notices and replicated in the HM Treasury financial reporting manual.
- 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 30.40% for Buckingham CCG.
- ** W Bower is Lay member for Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG. Single remuneration is disclosed on Berkshire West CCG.
- *** Dr Crystal Oldman payments paid to Queen's Institute
- **** Dr Sian Roberts holds an additional role in the CCG as Clinical Champion - Learning Disability and Autism

Senior Manager Remuneration (including salary and pension entitlements) 2021/2022

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

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

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

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

(3) Graham Smith left in August 2021

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

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

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

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

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

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 30 June 2022 (bands of £5,000) £'000	Lump sum at age 60 related to accrued pension at 30 June 2022 (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 30 June 2022 £'000	Employer's contribution to stakeholder pension £'000
James Kent (*)	Accountable Officer	2.5-5	0-2.5	10-15	0-5	125	67	203	0
Kate Holmes	Interim Chief Finance Officer	2.5-5	5-7.5	40-45	95-100	674	85	784	0
Robert Majilton	Deputy Accountable Officer	0-2.5	0-2.5	50-55	55-60	672	10	707	0
Dr Karen West	Clinical Director for Integrated Care & Quality Lead	0-2.5	0-2.5	15-20	25-30	237	2	248	0
Louise Smith	Associate Director Commissioning & Locality Delivery	0-2.5	0-2.5	30-35	65-70	525	12	559	0
Dr Dal Sahota	Clinical Director - Unplanned Acute Care	0-2.5	0-2.5	15-20	20-25	212	3	224	0
Dr Raj Thakkar	Clinical Director - Planned Care	0-2.5	0-2.5	5-10	20-25	150	1	157	0
Dr Rashmi Sawhney	Clinical Director -Health Inequalities and The Primary Care Networks DES	0-2.5	0-2.5	10-15	35-40	0	58	60	0
Dr Sian Roberts	Clinical Director - Mental Health & Learning Disabilities	0-2.5	0-2.5	5-10	0-5	98	5	108	0
Sonya Wallbank	Director of People and Organisational Development	5-7.5	0-2.5	15-20	0-5	143	65	217	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 Accountable Officer for Buckinghamshire CCG, Oxfordshire CCG and Berkshire West CCG. Salary disclosure is for Buckinghamshire CCG share of costs (30.4%).
- 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.
- 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.

Pension Benefits 2021/22

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

Notes:

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

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

(3) Graham Smith left in August 2021

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

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

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

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

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Real Increase in CETV

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

Pay Ratio Disclosures

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 £135k-£140k (2021/22 was £130k to £135k) 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 (£)	39,426	53,245	76,274
Salary component of total remuneration (£)	39,426	53,245	76,274
Pay ratio information	3.49	2.58	1.80
2021-22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	39,056	53,841	75,874
Salary component of total remuneration (£)	39,056	53,841	75,874
Pay ratio information	3.39	2.46	1.75

Year on Year Pay ratio variance %	**3%**	**5%**	**3%**

The pay ratio shows the number of times the average staff renumeration in relation to the highest paid director and the 25th percentile is higher due to a higher average renumeration (3%) compared to highest paid director.

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

In 2022/23, 0 employee (2021/22 no employee) received remuneration in excess of the highest paid director/member of the CCG Governing Body. Remuneration ranged from £11,000 to £184,000 (2021/22 £11,500 to £132,500).

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.

Fair pay disclosures

The banded remuneration of the highest paid director / member in BCCG in the financial year 2022-23 was £135k to £140k (2021-22, £130k - £135k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

Percentage Changes	**22/23**	**21/22**	**Change**	**% Change**	**201/22% Change**
Highest paid director					
Salary and Allowances	135,000	132,500	2,500	1.89%	0.00%
Performances and bonuses	0	0	0	0.00%	0.00%
Employees of the entity taken as a whole (Average)					
Salary and Allowances	60,577	61,863	-1,286	-2.08%	6.20%
Performances and bonuses	0	18,200	0	0.00%	0.00%

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

Staff Report

Staff sickness absence

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

	1 April 2022 – 30 June 2022
Sum of full time equivalent (FTE)	225
Sum of FTE days available	8,773
Average annual sick days per FTE	5.8%

Sickness absence was managed in a supportive and effective manner by BCCG 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. BCCG'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 BCCG on a quarterly basis as part of the workforce reporting process.

BCCG 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

BCCG had a workforce comprised of employees from a wide variety of professional groups. At the end of June 2022 BCCG employed 102 staff (headcount), of which 70 were women and 32 men. At the end of June 2022, the Board of BCCG was made up of 6 women and 6 men. Below is a breakdown of gender analysis. The membership body of BCCG is made up of all 48 (as of 30 June 2022) GP practices within Buckinghamshire; 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	6	6	12
Very Senior Managers	0	1	1
All other Employees	64	25	89
Total Employees	70	32	102

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

	Permanently employed Number	Other Numbers	20/21 Total Number
Total (headcount)	102	11	113

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

	Permanently employed Number	Other Numbers	Total Number
Average number of whole time equivalent people	71.87	4.91	76.78
Of which: (WTE) people engaged on capital projects	0	0	0

Staff turnover from 1 April to 30 June 2022 for BCCG was 4.53%.

Employee benefits and cost

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

		Total	2022-23
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	1,113	174	1,287
Social security costs	122	-	122
Employer Contributions to NHS Pension scheme	177	-	177
Apprenticeship Levy	3	-	3
Gross employee benefits expenditure	1,415	174	1,589
Total - Net admin employee benefits including capitalised costs	1,415	174	1,589
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	1,415	174	1,589

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

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

Trade union official facility time

BCCG 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 £52k between 1 April to 30 June 2022 (£185k in 2021/22) as per Note 5 to the Accounts page 78.

Below outlines consultancy spend:

- Consultancy – Continuing Healthcare Management (Crisante Consulting) - £51k
- Consultancy – Continuing Healthcare Management (Kokot Consultng) - £1k

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 at 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 2022 and 30 June 2022

There were no 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)	12

Exit Packages 2021/22

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 BCCG's Compulsory Redundancy Scheme in line with Agenda for Change standard entitlements where applicable.

Any exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

BCCG had not agreed any early retirements. If it had, the additional costs would be met by BCCG and not by the NHS Pension Scheme and would be included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

No non-contractual payments (£0) were made to individuals where the payment value was more than 12 months of their annual salary. The Remuneration Report would include the disclosure of exit payments payable to individuals named in that Report. There were none during 2021/22.

Health & wellbeing of staff

BCCG working closely with Oxfordshire and Berkshire West 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 BCCG 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 BCCG 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

BCCG 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 BCCG have actively and successfully worked with colleagues across BOB to align policies with those of Oxfordshire and Berkshire West CCGs to support the development of the BOB ICB. Policies are ratified in line with the scheme of delegation prior to publication.

The BOB CCGs SPF is representative of the workforce and BCCG recognises all the trade unions outlined in the national NHS Terms and Conditions of Service Handbook that 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.

BCCG 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

BCCG 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. BCCG's aim is to provide an environment in which all staff are engaged, supported and developed throughout their employment and to operate in ways which do not discriminate our potential or current employees by virtue of any of the protected characteristics specified in the Equality Act 2010. BCCG is also committed to supporting employees to maximise their performance including making any reasonable adjustments that may be required on a case-by-case basis.

BCCG 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 BCCG website.

Health and safety

BCCG recognises that the maintenance of a safe workplace and safe working environment is critical to our continued success and accordingly, we view our responsibilities for health, safety and welfare with the upmost importance. However, the past year the majority of staff have been working from home. During this time, considerable effort 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

Buckinghamshire 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 38 and 39, pension benefits of senior managers and related narrative on pages 40 and 41, the fair pay disclosures and related narrative notes on page 44 to 45 and exit packages and any other agreed departures on page 49 and 50.

Steve McManus
Accountable Officer
28 June 2023

Parliamentary Accountability and Audit Report

Buckinghamshire 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, losses and special payments, gifts, fees or charges.

Steve McManus
Accountable Officer
28 June 2023

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

Buckinghamshire CCG – Governing Body Meetings 1 April – 30 June 2022

Attendees	09 June 2022
All Voting Members	
Dr Raj Bajwa	Y
Wendy Bower	Y
Tony Dixon	Y
Kate Holmes	A
Dr James Kent	Y
Robert Majilton	Y
Crystal Oldman	A
Robert Parkes	Y
Dr Dalijit Sahota	Y
Dr Rashmi Sawhney	Y
Dr Karen West	Y
Dr Robin Woolfson	A

Buckinghamshire CCG – Audit Committee Meetings 1 April – 30 June 2022

Attendees	22 April 2022	27 April 2022	15 June 2022
Wendy Bower	A	Y	Y

Alan Cadman	Y	Y	Y
Tony Dixon	Y	Y	Y
Kate Holmes	Y	Y	Y
Robert Majilton	Y	Y	Y
Robert Parkes	Y	Y	Y

Buckinghamshire CCG – Executive Committee Meetings 1 April – 30 June 2022

No Executive Committee meetings were held in this period

Buckinghamshire CCG – Finance Committee Meetings 1 April – 30 June 2022

Attendees	09 June 2022
Alan Cadman	Y
Tony Dixon	Y
Kate Holmes	A
Robert Majilton	Y
Robert Parkes	Y

Buckinghamshire 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

Buckinghamshire CCG – Remuneration Committee Meetings 1 April – 30 June 2022

No Remuneration Committee meetings were held in this period

Buckinghamshire CCG – Quality and Performance Committee Meetings 1 April – 30 June 2022

Attendees	June 2022
Voting Members	
Frances Burdock	Y
Dr Karen West	Y
David Williams	Y
Dr Robin Woolfson	Y
Non-voting members	
Gilly Attree	A
Neil Flint	Y
Robert Majilton	A
Zoe McIntosh	Y
Catherine Richards	A
Julie Simpkins	Y

FINANCIAL ACCOUNTS

FOR THE PERIOD ENDED 30 JUNE 2022

NHS BUCKINGHAMSHIRE Clinical Commissioning Group

Financial Information - Accounts Year Ended 30 June 2022

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

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

Opinion

We have audited the financial statements of NHS Buckinghamshire 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 Buckinghamshire 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 19 E vents 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 26 to 27, 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 Buckinghamshire CCG is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.*
- *We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. In response to the risk of fraud in 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.*
- *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 Buckinghamshire 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 risks 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 Buckinghamshire 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 Buckinghamshire CCG in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

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	(225)	(1,605)
Other operating income	2	(18)	(126)
Total operating income		**(243)**	**(1,732)**
Staff costs	4	1,589	5,420
Purchase of goods and services	5	228,604	923,326
Depreciation and impairment charges	5	104	202
Provision expense	5	125	501
Other Operating Expenditure	5	99	1,324
Total operating expenditure		**230,521**	**930,773**
Net Operating Expenditure		**230,278**	**929,041**
Finance expense		1	-
Net Operating Expenditure for the Year		**230,279**	**929,041**
Total Net Expenditure for the Financial Year		**230,279**	**929,041**
Comprehensive Expenditure for the year		**230,279**	**929,041**

The net expenditure of £230,279k represents Q1 (April - June) 2022-23 financial year being the end of CCG account is more or less comparable to previous year (£929,041k/4= £232,260k)

The notes on pages 68 to 90 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	157	196
Right-of-use assets	9	694	-
Intangible assets	10	703	740
Total non-current assets		1,554	936
Current assets:			
Trade and other receivables	11	2,014	5,444
Cash and cash equivalents	12	215	96
Total current assets		**2,229**	**5,540**
Total current assets		**2,229**	**5,540**
Total assets		**3,783**	**6,476**
Current liabilities			
Trade and other payables	13	(61,778)	(65,597)
Lease liabilities	9	(112)	-
Provisions	14	(1,022)	(1,073)
Total current liabilities		**(62,913)**	**(66,670)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(59,129)**	**(60,194)**
Non-current liabilities			
Lease liabilities	9	(582)	-
Provisions	14	(340)	(287)
Total non-current liabilities		**(922)**	**(287)**
Assets less Liabilities		**(60,052)**	**(60,481)**
Financed by Taxpayers' Equity			
General fund		(60,052)	(60,481)
Total taxpayers' equity:		**(60,052)**	**(60,481)**

The notes on pages 68 to 90 form part of this statement

The financial statements on pages 68 to 90 were approved by 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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2022-23		
Balance at 01 April 2022	(60,481)	**(60,481)**
Net operating expenditure for the financial year	(230,279)	**(230,279)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(230,279)**	**(230,279)**
Net funding	230,709	**230,709**
Balance at 30 June 2022	**(60,052)**	**(60,052)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(68,146)	**(68,146)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs for the financial year	(929,041)	(929,041)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(929,041)**	**(929,041)**
Net funding	936,706	936,706
Balance at 31 March 2022	**(60,481)**	**(60,481)**

The notes on pages 68 to 90 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		(230,279)	(929,041)
Depreciation and amortisation	5	104	202
Interest paid		1	0
(Increase)/decrease in inventories		-	1,028
(Increase)/decrease in trade & other receivables	11	3,430	(1,616)
Increase/(decrease) in trade & other payables	13	(3,464)	(6,880)
Provisions utilised	14	(122)	(617)
Increase/(decrease) in provisions	14	125	501
Net Cash Inflow (Outflow) from Operating Activities		**(230,205)**	**(936,424)**
Cash Flows from Investing Activities			
Interest received		0	-
(Payments) for property, plant and equipment		(354)	(20)
(Payments) for intangible assets		(0)	(280)
Net Cash Inflow (Outflow) from Investing Activities		**(354)**	**(300)**
Net Cash Inflow (Outflow) before Financing		**(230,559)**	**(936,724)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		230,709	936,706
Repayment of lease liabilities		(30)	-
Net Cash Inflow (Outflow) from Financing Activities		**230,679**	**936,706**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**120**	**(18)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**96**	**114**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**215**	**96**

The notes on pages 68 to 90 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 Movement of Assets within the Department of Health and Social Care Group

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

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

1.4 Pooled Budgets

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

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

This is a Pool Budget with Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of Children and Adolescence Mental Health Service, Speech & Language Therapies, Residential Respite Short Breaks, Integrated Community Equipment Service Contract Management and Section 117 aftercare. This covers the period 1st April 2022 to 30th June 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council covers the provision of Integrated Community Equipment Service (including Adult Social Care, Telecare and Children and Young People's Service) for the period of 1st April 2022 to 30th June 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement. The Joint Pooled Fund supports procurement, storage, delivery, installation and technical demonstration as well as subsequent collection, cleaning, recycling, maintenance and repair of equipment, for use by eligible clients.

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of the Better Care Fund, for health and social care, to cover the period of 1st April 2022 to 30th June 2022. The Joint Pooled Fund supports the provision of community health teams and social care activities for the population of Buckinghamshire. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

1.5 Operating Segments

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

Notes to the financial statements

1.6 **Revenue**

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

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

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

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

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

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

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

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

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

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.9.2 **Measurement**

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

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

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

1.9.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.10 Intangible Assets

1.10.1 Recognition

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

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

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

1.10.2 Measurement

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

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

1.10.3 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

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

1.11 Leases

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.

Notes to the financial statements

1.11.1 **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.

1.12 **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

1.13 **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 3.00% (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.

1.14 **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.

1.15 **Non-clinical Risk Pooling**

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

1.16 **Contingent liabilities and contingent assets**

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

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

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

1.17 **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.

1.18 **Financial Assets at Amortised cost**

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

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

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

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

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

Notes to the financial statements

1.18.3 Impairment

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

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

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

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

1.19 Financial Liabilities

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

1.20 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.

1.21 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.

1.21.1 Critical accounting judgements in applying accounting policies

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

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

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

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

Notes to the financial statements

1.22 **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 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 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.

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 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 group recognised £0.9m or right-of-use assets and lease liabilities of £0.9m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0m impact to tax payers' equity.

The 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 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	130
Operating lease commitments discounted used weighted average IBR	130
Add: Finance lease liabilities at 31 March 2022	565
Less: Variable payments not included in the valuation of the lease liabilities	694
Lease liability at 1 April 2022	**0**

1.23 **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 Total	2021-22 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	163	1,051
Prescription fees and charges	62	554
Total Income from sale of goods and services	225	1,605
Other operating income		
Other non contract revenue	18	126
Total Other operating income	18	126
Total Operating Income	243	1,732

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

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

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

This can be amended locally to a presentation that's more appropriate to the entity circumstances.

	Patient transport services	Prescription fees and charges
	£'000	£'000
Source of Revenue		
Non NHS	163	62
Total	163	62

	Patient transport services	Prescription fees and charges
	£'000	£'000
Timing of Revenue		
Point in time	163	62
Total	163	62

3.2 Transaction price to remaining contract performance obligations

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

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Permanent Employees £'000	Total Other £'000	2022-23 Total £'000
Employee Benefits			
Salaries and wages	1,113	174	1,287
Social security costs	122	-	122
Employer Contributions to NHS Pension scheme	177	-	177
Apprenticeship Levy	3	-	3
Gross employee benefits expenditure	1,415	174	1,589
Total - Net admin employee benefits including capitalised costs	1,415	174	1,589
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	1,415	174	1,589

4.1.1 Employee benefits

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

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	71.87	4.91	76.78	74.08	4.30	78.38

The Clinical Commissioning Group has no whole time equivalent people engaged on capital projects in 2022-23 (nil for 2021-22).

The Clinical Commissioning Group has not had any Exit packages in 2022-23 nor in 2021-22.

The Clinical Commissioning Group has had one ill health retirement in 2022-23 £0, (£22,641 in 2021-22).

4.3 Pension costs

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

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

4.3.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 30 June 2022, is based on valuation data as 31 March 2022, updated to 30 June 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.3.2 Full actuarial (funding) valuation

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

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

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

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

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

5. Operating expenses

	2022-23 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	258	5,192
Services from foundation trusts	55,460	209,523
Services from other NHS trusts	96,383	399,156
Purchase of healthcare from non-NHS bodies	33,017	139,181
Prescribing costs	18,542	72,742
General Ophthalmic services	8	39
GPMS/APMS and PCTMS	22,408	90,865
Supplies and services – clinical	298	1,194
Supplies and services – general	1,434	1,837
Consultancy services	52	185
Establishment	540	2,672
Transport	0	1
Premises	-	131
Audit fees	115	102
Other non statutory audit expenditure		
· Internal audit services	11	45
· Other services	29	61
Other professional fees	3	269
Legal fees	43	128
Education, training and conferences	3	2
Total Purchase of goods and services	**228,604**	**923,326**
Depreciation and impairment charges		
Depreciation	67	201
Amortisation	37	1
Total Depreciation and impairment charges	**104**	**202**
Provision expense		
Provisions	125	501
Total Provision expense	**125**	**501**
Other Operating Expenditure		
Chair and Non Executive Members	32	140
Inventories consumed	-	1,028
Other expenditure	66	156
Total Other Operating Expenditure	**98**	**1,324**
Total operating expenditure	**228,930**	**925,353**

5.1 COVID Expenditure

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

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

All of the expenditure incurred during 2021-22 has been fully funded by NHS England. For 2022-23 there is no further funding available although the Hospital Discharge Scheme continues under the guise of Discharge to Access

The elements of expenditure:	**2021-22**
	£'000
Supply of PPE	**0**
Support to GP practises, infection control, backfill, additional hrs, digital services, texts etc	**1,916**
COVIDLine Triage, Swabbing Services, Hot Hubs, Visiting Service On -call etc	**1,442**
COVID additional Primary Care capacity	**1,099**
Long COVID Primary Care	**283**
Continuing Healthcare Assessments	**406**
Hospital Discharge Programme Scheme 1	**7,436**
Hospital Discharge Programme Scheme 2	**7,925**
Discharge to Access (2022-23)	0
Total Expenditure	**20,507**

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

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

	2021-22
	£'000
Employee Costs	**93**
Establishment	**0**
Premises	**142**
GPMS/APMS	**1,383**
Services from other NHS Foundation Trusts	**116**
Services from other NHS trusts	**246**
Purchase of healthcare from non-NHS bodies	**18,527**
Total	**20,507**

6. 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	5,253	53,894	17,677	216,627
Total Non-NHS Trade Invoices paid within target	5,142	53,007	17,147	211,342
Percentage of Non-NHS Trade invoices paid within target	**97.9%**	**98.4%**	**97%**	**97.6%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	123	149,558	566	614,002
Total NHS Trade Invoices Paid within target	123	149,558	555	613,984
Percentage of NHS Trade Invoices paid within target	**100%**	**100%**	**98.1%**	**100%**

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

7. Finance costs

	2022-23 £'000
Interest	
Interest on lease liabilities	1
Total finance costs	**1**

8. Property, plant and equipment

2022-23	**Information technology £'000**	**Furniture & fittings £'000**	**Total £'000**
Cost or valuation at 01 April 2022	1,645	46	1,690
Reclassifications	19	-	19
Disposals other than by sale	(899)	(46)	(944)
Cost/Valuation at 30 June 2022	**765**	**-**	**765**
Depreciation 01 April 2022	1,448	46	1,494
Reclassifications	19	-	19
Disposals other than by sale	(899)	(46)	(944)
Charged during the year	39	-	39
Depreciation at 30 June 2022	**607**	**(0)**	**607**
Net Book Value at 30 June 2022	**157**	**0**	**157**
Purchased	157	0	157
Total at 30 June 2022	**157**	**0**	**157**
Asset financing:			
Owned	157	0	157
Total at 30 June 2022	**157**	**0**	**157**

8.1 Economic lives

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

9 Leases

The Clinical Commissioning Group occupies and pays rent on offices located at Amersham Hospital and at New County Hall in Aylesbury. The rent is paid to Buckinghamshire Healthcare Trust and Buckinghamshire Council respectively.

9.1 Right-of-use assets

2022-23	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	723	723
Cost/Valuation at 30 June 2022	**723**	**723**
Depreciation 01 April 2022	-	-
Charged during the year	29	29
Depreciation at 30 June 2022	**29**	**29**
Net Book Value at 30 June 2022	**694**	**694**

This is a new application standard for 2022-23 as a result of adoption of IFRS 16.

9.2 Lease liabilities

	2022-23 £'000
Lease liabilities at 01 April 2022	-
IFRS 16 Transition Adjustment	723
Interest expense relating to lease liabilities	1
Other	(30)
Lease liabilities at 30 June 2022	**694**

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £'000
Within one year	(112)
Between one and five years	(547)
After five years	(35)
Balance at 30 June 2022	**(694)**
Effect of discounting	0
Included in:	
Current lease liabilities	(112)
Non-current lease liabilities	(582)
Balance at 30 June 2022	**(694)**

The Clinical Commissioning Group occupies and pays rent on offices located at Amersham Hospital and at New County Hall in Aylesbury. The rent is paid to Buckinghamshire Healthcare Trust and Buckinghamshire Council respectively.

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	2022-23 £'000
Depreciation expense on right-of-use assets	29
Interest expense on lease liabilities	1

10. Intangible non-current assets

2022-23	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	1,339	**1,339**
Additions purchased	0	**0**
Reclassifications	(19)	**(19)**
Disposals other than by sale	(580)	**(580)**
Cost / Valuation At 30 June 2022	**740**	**740**
Amortisation 01 April 2022	599	**599**
Reclassifications	(19)	**(19)**
Disposals other than by sale	(580)	**(580)**
Charged during the year	37	**37**
Amortisation At 30 June 2022	**37**	**37**
Net Book Value at 30 June 2022	**703**	**703**
Purchased	703	**703**
Total at 30 June 2022	**703**	**703**

10.4 Economic lives

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

11.1 Trade and other receivables	**Current 2022-23 £'000**	Current 2021-22 £'000
NHS receivables: Revenue	98	0
NHS accrued income	153	2
NHS Non Contract trade receivable (i.e pass through funding)	372	2,296
Non-NHS and Other WGA receivables: Revenue	310	49
Non-NHS and Other WGA prepayments	922	2,901
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	9	154
Expected credit loss allowance-receivables	(17)	(17)
VAT	164	55
Other receivables and accruals	3	5
Total Trade & other receivables	**2,014**	**5,445**
Total current and non current	**2,014**	**5,445**

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

11.2 Receivables past their due date but not impaired

	2022-23	**2022-23**	2021-22	2021-22
	DHSC Group Bodies	**Non DHSC Group Bodies**	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	(31)	49	20	5
By three to six months	16	33	-	1
Total	**(16)**	**82**	**20**	**6**

11.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies**	**Total**
	£'000	**£'000**
Balance at 30 June 2022	(17)	(17)
Total	**(17)**	**(17)**

12. Cash and cash equivalents

	2022-23	2021-22
	£'000	£'000
Balance at 01 April 2022	96	114
Net change in year	120	(18)
Balance at 30 June 2022	**215**	**96**
Made up of:		
Cash with the Government Banking Service	215	96
Cash and cash equivalents as in statement of financial position	**215**	**96**
Balance at 30 June 2022	**215**	**96**

13. Trade and other payables	**Current 2022-23 £'000**	Current 2021-22 £'000
NHS payables: Revenue	434	595
NHS accruals	5,499	779
Non-NHS and Other WGA payables: Revenue	3,702	3,232
Non-NHS and Other WGA payables: Capital	104	460
Non-NHS and Other WGA accruals	48,778	58,191
Social security costs	69	58
Tax	80	60
Other payables and accruals	3,111	2,221
Total Trade & Other Payables	**61,778**	**65,597**
Total current and non-current	**61,778**	**65,597**

Other payables include £849 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	1,022	340	1,073	287
Total	**1,022**	**340**	**1,073**	**287**
Total current and non-current	**1,362**		**1,360**	

	Continuing Care £'000	**Total £'000**	**Balance at 31 March 2022 £'000**
Balance at 01 April 2022	**1,360**	**1,360**	**1,475**
Arising during the year	125	125	501
Utilised during the year	(122)	(122)	(616)
Balance at 30 June 2022	**1,362**	**1,362**	**1,360**
Expected timing of cash flows:			
Within one year	1,022	1,022	1,073
Between one and five years	340	340	287
Balance at 30 June 2022	**1,362**	**1,362**	**1,360**

£0 is included in the Provisions of the NHS Litigation Authority as at 30 June 2022 in respect of clinical negligence liabilities of the Clinical Commissioning Group (31 March 2022 £0)

Provision for Continuing Healthcare of £1,362k. The Clinical Commissioning Group is responsible for providing Continuing Healthcare to its population once potential patients have been assessed and deemed to meet criteria to qualify for funding. The provision covers those who have not been assessed where there could be a high probability of a financial liability.

15. Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

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

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.1.5 Financial Instruments

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

15. Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other receivables with NHSE bodies	250	250
Trade and other receivables with other DHSC group bodies	374	374
Trade and other receivables with external bodies	321	321
Cash and cash equivalents	215	215
Total at 30 June 2022	**1,160**	**1,160**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Total 2022-23 £'000
Trade and other payables with NHSE bodies	1,269	1,269
Trade and other payables with other DHSC group bodies	4,664	4,664
Trade and other payables with external bodies	56,391	56,391
Total at 30 June 2022	**62,324**	**62,324**

16. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of healthcare services.	230,522	(243)	**230,279**	3,783	(63,835)	**(60,052)**
Total	**230,522**	**(243)**	**230,279**	**3,783**	**(63,835)**	**(60,052)**

16.1 Reconciliation between Operating Segments and SoCNE

	2022-23 £'000
Total net expenditure reported for operating segments	230,279
Total net expenditure per the Statement of Comprehensive Net Expenditure	230,279

16.2 Reconciliation between Operating Segments and SoFP

	2022-23 £'000
Total assets reported for operating segments	3,783
Total assets per Statement of Financial Position	**3,783**

	2022-23 £'000
Total liabilities reported for operating segments	(63,835)
Total liabilities per Statement of Financial Position	**(63,835)**

17. Joint arrangements - interests in joint operations

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

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

	2022-23 Part Year £'000	2021-22 £'000
Income	**15,732**	62,508
Expenditure	**(15,732)**	(62,508)

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

The memorandum accounts for pooled budgets are :

Children and Adolescence Mental Health Services (CAMHS)

This is a Pool Budget with Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of Children and Adolescence Mental Health Service. This covers the period 1st April 2022 to 30th June 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

	2022-23 Part Year £'000	2021-22 £'000
Expenditure		
Pooled fund CAMHS	**2,501**	10,665
Income		
Contribution from Buckinghamshire Council	**(416)**	(1,662)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(2,085)**	(9,003)
Total	**(2,501)**	(10,665)
Balance	**0**	0

Speech and Language Therapy Pooled Budget

The Pooled budget is between Buckinghamshire Commissioning Group and Buckinghamshire Council for the provision of Speech & Language Therapies. This covers the period 1st April 2022 to 30th June 2022. Buckinghamshire County

	2022-23 Part Year £'000	**2021-22** £'000
Expenditure		
Pooled Fund SALT	**948**	3,793
Income		
Contribution from Buckinghamshire Council	**(436)**	(1,745)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(512)**	(2,048)
Total	**(948)**	(3,793)
Balance	**0**	0

Residential Respite Short Breaks Pooled Fund

The Pooled budget is between Buckinghamshire Commissioning Group and Buckinghamshire Council for the provision of Residential Respite Short Breaks This covers the period 1st April 2022 to 30th June 2022. Buckinghamshire County Council is the host and lead authority.

	2022-23 Part Year £'000	2021-22 £'000
Expenditure		
Pooled fund Residential Respite Short Breaks	**495**	1,933
Income		
Contribution from Buckinghamshire Council	**(360)**	(1,406)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(135)**	(527)
Total	**(495)**	(1,933)
Balance	**0**	0

17.2 Joint arrangements - interests in joint operations cont'd

Integrated Community Equipment Service Contract Management Pooled Fund

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of Integrated Community Equipment Service Contract Management. The agreement covers the period 1st April 2022 to 30th June 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement.

	2022-23 Part Year £'000	2021-22 £'000
Expenditure		
Pooled fund expenditure	**21**	85
Income		
Contribution from Buckinghamshire Council	**(7)**	(28)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(14)**	(57)
Total Income	**(21)**	(85)
Balance	**0**	0

Integrated Community Equipment Service Pooled Budget

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council covers the provision of Integrated Community Equipment Service (including Adult Social Care, Telecare and Children and Young People's Service) for the period of 1st April 2022 to 30th June 2022. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement. The Joint Pooled Fund supports procurement, storage, delivery, installation and technical demonstration as well as subsequent collection, cleaning, recycling, maintenance and repair of equipment, for use by eligible clients.

	2022-23 Part Year £'000	2021-22 £'000
Expenditure		
Pooled fund expenditure	**2,670**	9,704
Income		
Contribution from Buckinghamshire Council	**(725)**	(2,642)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(1,945)**	(7,062)
Total Income	**(2,670)**	(9,704)
Balance	**0**	0

Better Care Fund

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council for the provision of the Better Care Fund, for health and social care, to cover the period of 1st April 2022 to 30th June 2022. The Joint Pooled Fund supports the provision of community health teams and social care activities for the population of Buckinghamshire. Buckinghamshire Council is the host and lead authority for this pooled fund arrangement. The previous part year figures have been up-dated to include additional applicable investment not identified at the time of publication.

	2022-23 Part Year £'000	2021-22 £'000
Pooled Fund Expenditure	**11,043**	42,495
Contribution from Buckinghamshire Council	**(2,505)**	(8,959)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(8,439)**	(33,163)
Contribution from NHS Milton Keynes Clinical Commissioning Group	**(99)**	(373)
Total Income	**(11,043)**	(42,495)
	0	0

S117

The Pool Budget between Buckinghamshire Clinical Commissioning Group and Buckinghamshire Council covers the provision of Section 117 aftercare, to cover the period 1st April 2022 to 30th June 2022, providing care packages that are suitable for the clients requirements. Buckinghamshire County Council is the host and lead authority for this pooled fund arrangement.

	2022-23 Part Year £'000	2021-22 £'000
Pooled Fund S117 Expenditure	**5,504**	21,296
Income		
Contribution from Buckinghamshire Council	**(2,752)**	(10,648)
Contribution from NHS Buckinghamshire Clinical Commissioning Group	**(2,752)**	(10,648)
Total	**(5,504)**	(21,296)
Balance	**0**	0

18 Related Party Transactions

As a prerequisite of the ICS, during 22-23 Buckinghamshire, Oxfordshire and Berkshire West CCG's have been meeting in common as decision making forums covering Finance, Audit and Governing Body. All Executive members of each CCG attend and are members of these In Common meetings. Additional responsibilities are given to Robert Parkes, Non-Executive Director of Buckinghamshire to act as Convener of the Audit in Common meetings and Duncan Smith, Non-Executive Director of Oxfordshire CCG to act as Convener of the Finance in Common meetings.

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

Name	Title	Relationship	Related Party	Payments to Related Party £ (expenditure) Q1 22-23	Amounts owed to Related Party at 30th Jun 2022 (CR)	Receipts from Related party £ (income) 30th Jun 22	Amounts due from Related Party at 30th Jun 2022 (DR)
Dr Raj Bajwa (63501)	Clinical GP Chair	GP Partner & 50% owner	Little Chalfont Surgery	353,345	-	-	-
		Member	FedBucks	3,704,920	-	-	232,092
		Partner in a GP practice in the Chesham and Little Chalfont Primary care Network	Chesham and Little Chalfont Primary Care Network (PCN)	-	-	-	-
		Spouse is a community pharmacist	Lloyds Pharmacy Group	-	-	-	-
Dr James Kent	Chief/Accountable Officer (BOB CCG's) & ICS Executive Lead	Wife is a senior Pharmacist employed by the Chalfont's PCN and the Hall Practice	Hall Practice and Chalfont PCN	242,470	-	-	-
		John Storey, Chief Executive of Porthaven, is a friend.	Porthaven	778,392	45,003	-	-
		I am a Director of Curzon Partners Limited.	Curzon Partners Limited	-	-	-	-
		Member of The Royal Foundation Covid-19 Grant Response Fund Committee	The Royal Foundation Covid-19 Grant Response Fund Committee	-	-	-	-
Robert Parkes	Lay Member	NHS Oxfordshire CCG	Governing Body Lay Member	40,384	-	-	8,170
		SFO (Senior Financial Officer)	Chearsley Parish Council	-	-	-	-
Anthony (Tony) Dixon	Lay Member	Patient	Frimley Health NHS Foundation Trust	16,699,000	-	-	-
		Director	Directorship, Windsor Theatre Ltd	-	-	-	-
		Patient	Patient- Oxford United Hospitals Trust	-	-	-	-
Dr Karen West	Member GP / Clinical Commissioning Director for Integrated Care	GP Partner	Haddenham Medical Centre	342,743	-	-	-
		Member	FedBucks	3,704,920	-	-	232,092
		Husband	Brain Lab - Medical Software and Hardware Innovators	-	-	-	-
Dr Robin Woolfson	Hospital Doctor	Consultant Nephrologist Royal Free Hospital NHS FT	Royal Free London NHS FT	-	-	-	-
		Medical Director Royal Free Hospital NHS FT	Royal Free London NHS FT	-	-	-	-
Robert Majilton	Deputy Chief Officer	Wife works as a customer delivery manager	Vodafone Group as Customer Delivery Manager	-	-	-	-
Wendy Bower	Lay Member Patient and Public Involvement (PPI) (Voting)	Director	Moneymaximer Ltd	-	-	-	-
		Governor	CCG Federation at Royal Berskhire NHS FT (RBFT)	893,000	-	-	-
		Brother	Clinical Trails Specialist at Quintiles	-	-	-	-
		Daughter	Nurse / staff support for the duration of the COVID-19 pandemic at Royal Berskhire NHS FT (RBFT)	893,000	-	-	-
		Engagement	NHS Berkshire West CCG	7,100	-	-	-

18 Related Party Transactions

18.2 Related party transactions Cont'd

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

Related Party	Payments to Related Party £ (expenditure) Q1	Amounts owed to Related Party at 30th Jun 2022 (CR)	Receipts from Related party £ (income) Q1	Amounts due from Related Party at 30th Jun 2022 (DR)
Oxford Health NHS Foundation Trust	13,642,498	-	-	-
Buckinghamshire Healthcare NHS Trust	94,523,495	-	-	226,253
Oxford University Hospitals NHS Foundation Trust	5,539,500	-	-	-
Milton Keynes NHS FT	3,208,000	-	-	-
South Central Ambulance Service NHS Foundation Trust	7,095,786	-	-	-
Royal Berkshire NHS Foundation Trust	893,000	-	-	-
NHS South Central and West CSU	222,049	-	-	-
NHS England	1,596	-	51,909	-
Fedbucks	3,704,920	-	-	232,092
Frimley Health NHS Foundation Trust	16,699,000	-	-	-
NHS Berkshire West CCG	7,100	-	-	-
NHS Oxfordshire CCG	40,384	-	-	8,170
Total	145,577,328	-	51,909	466,515

18.3 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
The Rt Hon Steve Barclay MP
The Rt Hon Dr Thérèse Coffey MP
The Rt Hon Sajid Javid MP
Edward Argar MP
Gillian Keegan MP
Dr Caroline Johnson MP
Robert Jenrick MP
William Quince MP
Helen Whately MP
Maggie Throup MP
Maria Caulfield MP
James Morris MP
Neil O'Brien MP
Lord Markham
Lord Kamall

Senior Officials
Sir Chris Wormald KCB
Professor Sir Christopher Whitty KCB
Shona Dunn
Clara Swinson CB
Jonathan Marron
Matthew Style
Michelle Dyson
Andrew Brittain
Stephen Oldfield
Matthew Gould
Professor Lucy Chappell
Jenny Richardson
Hugh Harris
Lorraine Jackson

Non-executive Directors
Kate Lampard
Doug Gurr
Gerry Murphy
Julian Hartley

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

19. Events after the end of the reporting period

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

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	**2022-23**		2021-22	2021-22	
	Target	**Performance**	**Duty Achieved**	Target	Performance	**Duty Achieved**
Expenditure not to exceed income	230,523	230,521	Yes	934,762	931,533	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	N/A	760	760	Yes
Revenue resource use does not exceed the amount specified in Directions	230,280	230,278	Yes	932,270	929,041	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-	
Revenue administration resource use does not exceed the amount specified in Directions	2,641	2,641	Yes	10,506	9,832	Yes