NHS
Bath and North East Somerset,
Swindon and Wiltshire
Clinical Commissioning Group

BSW CCG Annual Report 2021/22

Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

Contents

PERFORMANCE REPORT

Sue Harriman

Accountable Officer

16 June 2022

Performance overview

NHS organisations produce an annual report and financial accounts at the end of every financial year. In this report, BSW CCG describes how it fulfilled the duties described in the National Health Service Act 2006 for the 2021/22 reporting year. This section provides an overview of how the CCG worked, what it did, the risks it was exposed to and how it performed over the course of the year.

Clinical Chair's report

While the expression has now become something of a cliché, the last year in Bath and North East Somerset, Swindon and Wiltshire has been unlike any other. Not only has the region continued to battle through the ongoing coronavirus pandemic, but hard-working teams have also pulled out all the stops to mobilise the biggest vaccination effort in history, while still ensuring that routine services – even against a backdrop of mounting demand for urgent and emergency care – have been able to continue.

I'd like to offer my most sincere thanks and personal admiration to all the health and care workers in our area. Without your dedication, determination and unrivalled professionalism, the last 12 months would have been even more challenging.

The local rollout of the Covid-19 vaccine truly came into its own this year, with our teams of vaccinators working around the clock – quite literally at some points during the last 12 months – to deliver more than 2.1 million individual vaccinations. It's an incredible achievement, and one that has ensured that the overwhelming majority of adults in our region are fully protected against Covid-19. More than 87 per cent of all local adults over the age of 18 have had both primary doses of the coronavirus vaccine, as well as the all-important booster jab. It's admirable that even at the latter stages in the vaccination programme, our teams were still going all-out to take the vaccine to those yet to come forward, namely by hosting pop-up vaccination clinics in communities where uptake has been low. Our vaccinators held clinics in a range of unique and diverse venues such as pubs, football stadiums, places of worship, army barracks and town centre high streets. The community-based clinics will continue throughout 2022 for those who want to have the vaccine.

The whole programme has been a monumental success, not least because so by many of our vaccinators carried out their role while continuing in their primary place of work, such as a GP practice, care home or hospital, but also due to the fact the vaccination rollout happened at a time when our health and care system had never been busier.

In particular, the first few weeks of 2022 proved to be extraordinarily challenging.

Numerous factors, all of which took a significant toll on day-to-day activity, such as rising Covid-19 admissions, unplanned staff absences, norovirus outbreaks, lengthy ambulance handovers and an ever-increasing demand for primary care services, caused our system to declare a critical incident, also known as Operational Pressures Escalation Level (OPEL) four status, twice in the space of just a few weeks. Being proactive and declaring

an OPEL four status allowed the NHS and its partners to take extraordinary action, such as postponing planned operations and diverting ambulances to hospitals outside of our geographical patch, early on. These measures helped us to mitigate the pressure, support our frontline staff and, most importantly, ensure seriously ill patients continued to receive the care they need.

In addition, several new, short-to-medium-term initiatives were introduced to help us get through the difficult start to the calendar year. These schemes included standing up extra hospital beds at a newly created ward at St Martins Hospital in Bath and transferring some inpatients at the Royal United Hospital in Bath to a temporary care facility based within a hotel in the city centre.

Increasing pressure has also been felt by primary care colleagues across the region, as practices continue to work in a covid-safe way by offering local people a mix of both in-person and virtual appointments. This hybrid model allowed clinicians to not only keep waiting rooms free from overcrowding, but also ensured patients with the most-pressing health needs were prioritised for face-to-face consultations. Although, this way of working first started at the beginning of the pandemic in March 2020, it has since remained a staple of primary care, due in part to its continued popularity with staff and patients alike.

A data snapshot from October 2021 illustrates the increases in demand that GP practices have had to contend with over the last 12 months. During this month, primary care colleagues across the region carried out a total of 535,700 appointments, of which more than two thirds (66.3 per cent) were held in-person. When compared to October 2020, the total number of appointments had increased by almost one fifth (19 per cent) from 449,000. These are big numbers, which have grown throughout this year, and will continue to do so during 2022.

Such was the extent of the pressure felt in primary care, the clinical leads for each of our localities – Dr Bryn Bird for Bath and North East Somerset, Dr Amanda Webb for Swindon and Dr Ed Rendell for Wiltshire – issued an open letter to local people to explain the situation, and why some people were waiting longer for appointments.

The letter, which can still be read in full on the CCG website, also detailed how local people can play their part in supporting their practice through a variety of simple steps, such as visiting a pharmacy for health advice and information instead of automatically calling a GP surgery and using the NHS 111 service when unsure of where to go for the most appropriate care and treatment.

I’d like to thank Bryn, Amanda and Ed for their continued work in each of their respective localities, and for keeping our local population very much in the loop with these important issues.

Although it has been a challenging year for primary care, there have been many positives, such as the construction of the long-awaited Devizes Health Centre getting under way. Contractors moved onto land near Marshall Road May, and I was fortunate enough to be

given a guided tour of the building site not long after. This new facility will be one of the region's first integrated care centres and will offer a home to different health and care providers. When the site opens later this year, local people will benefit from having primary care services, such as those traditionally found in a GP practice, and hospital outpatient services, such as physiotherapy clinics and mental health support, situated under the same roof. What's more, Devizes Health Centre is set to boast a range of green credentials, including heat pumps and solar panels, that will make it one of only a few net-zero health facilities in the country.

Elsewhere, 2021/22 also saw the CCG undertake an extensive public engagement programme in preparation for the development of a new health and care model for the region. The purpose of this exercise, which concluded in mid-December, was to listen to people's feedback and use the information to further influence the new health and care model, which includes plans for improving personalised care, supporting healthier communities, establishing more integrated local teams, prioritising local specialist services and introducing new specialist centres.

More than 750 people shared their views through a short online survey, while a further 1,200 attended dedicated workshops and interviews that were held across the region. I'm extremely pleased at this fantastic turnout and would like to say a big thank you to everyone from the BSW Partnership, which is an integrated care system made up of NHS providers, local authorities and the voluntary and community sectors, along with social enterprises, who helped with this important piece of work.

Involving the people who live across our region in what we do is hugely important, as is taking the time to find out what they think and feel about new and existing services being provided locally, such as Oximetry @Home, which allows Covid-19 patients to have their oxygen levels monitored remotely.

Hundreds of people have already benefited from this new treatment, which works by patients recording their own oxygen levels through a small electronic device on their finger, with the data then sent automatically to a clinical team for review. This state-of-the-art technology allows us to keep our hospital beds reserved for the very sickest Covid-19 patients, while also offering people the opportunity to receive the same routine monitoring that would be provided on a ward, but from the comfort of their own home. So far, the response to Oximetry @Home has been overwhelmingly positive, with 97 per cent of those who used the service in December saying they would rate it as five out of five.

One such person described the service as amazing and said it proved to be a lifeline to the outside world when her husband, who also had Covid-19, was admitted to hospital. In a review, the patient wrote: "I'm not sure what I would have done without you. Your daily phone call was like a ray of sunshine, and I would look forward to it so I could speak to someone and feel reassured."

This sort of feedback illustrates just how much of an impact good health and care services can have on people during uncertain periods of their life and, as our local NHS moves

forward into 2022/23, I hope we can continue to make a positive difference to the lives of many across our region.

Transition to an Integrated Care Board
Clinical Commissioning Groups will be replaced by Integrated Care Boards (ICB) from 1 July 2022.

BSW CCG has, and continues to work through, a comprehensive plan to ensure the safe transition of colleagues and functions to the ICB as required.

This includes recruitment to the ICB's executive leadership team.

Sue Harriman was appointed Chief Executive Officer – designate, for the ICB in February 2022, and took on Accountable Officer responsibility for BSW CCG from 1 April 2022.

Who we are and what we do
As a clinically-led statutory NHS body, Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group is responsible for planning and commissioning healthcare services for the local area in order to achieve the best possible health outcomes for the local population. This has been done by assessing local needs, agreeing priorities and strategies, and then buying services on behalf from a range of providers, while constantly responding and adapting to changing local circumstances. Being led by local doctors and elected members, lay members and a nurse – all of whom are close to patients and their needs – enabled the CCG to provide quality care to people living in BSW.

Our vision and values
Our vision guides the organisation and inspires the action needed to make change happen.

'Working together to empower people to lead their best life'

Our vision is underpinned by three core principles:

1. **Collective voice** – working together as a collaboration and one whole system.
2. **Healthy communities** – empowering people to lead on their health with their families, their communities and health professionals.
3. **Stories and strengths** – holding people's strengths, stories and experiences, and what matters to them at the heart of our system.

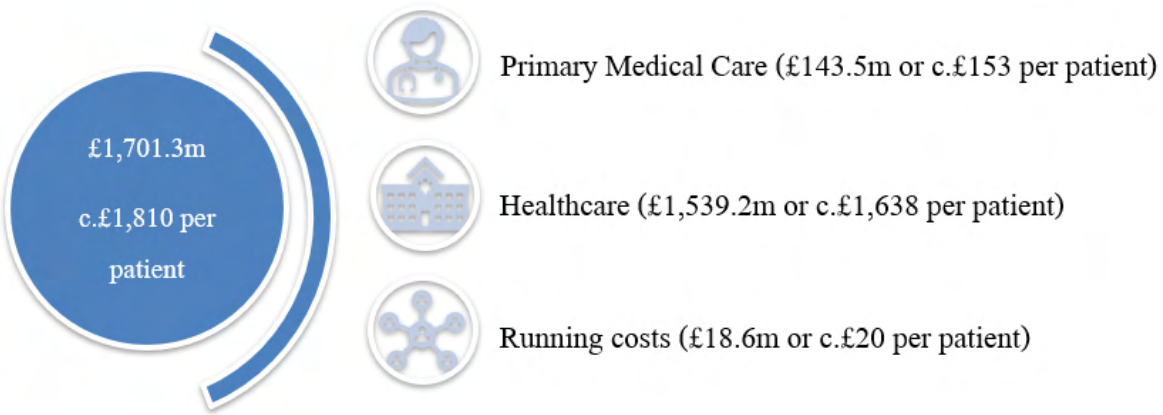
Developed by colleagues across the organisation, our five core values describe the way we work and help to guide our actions and the decisions we make for local people and communities.

How we spend our money

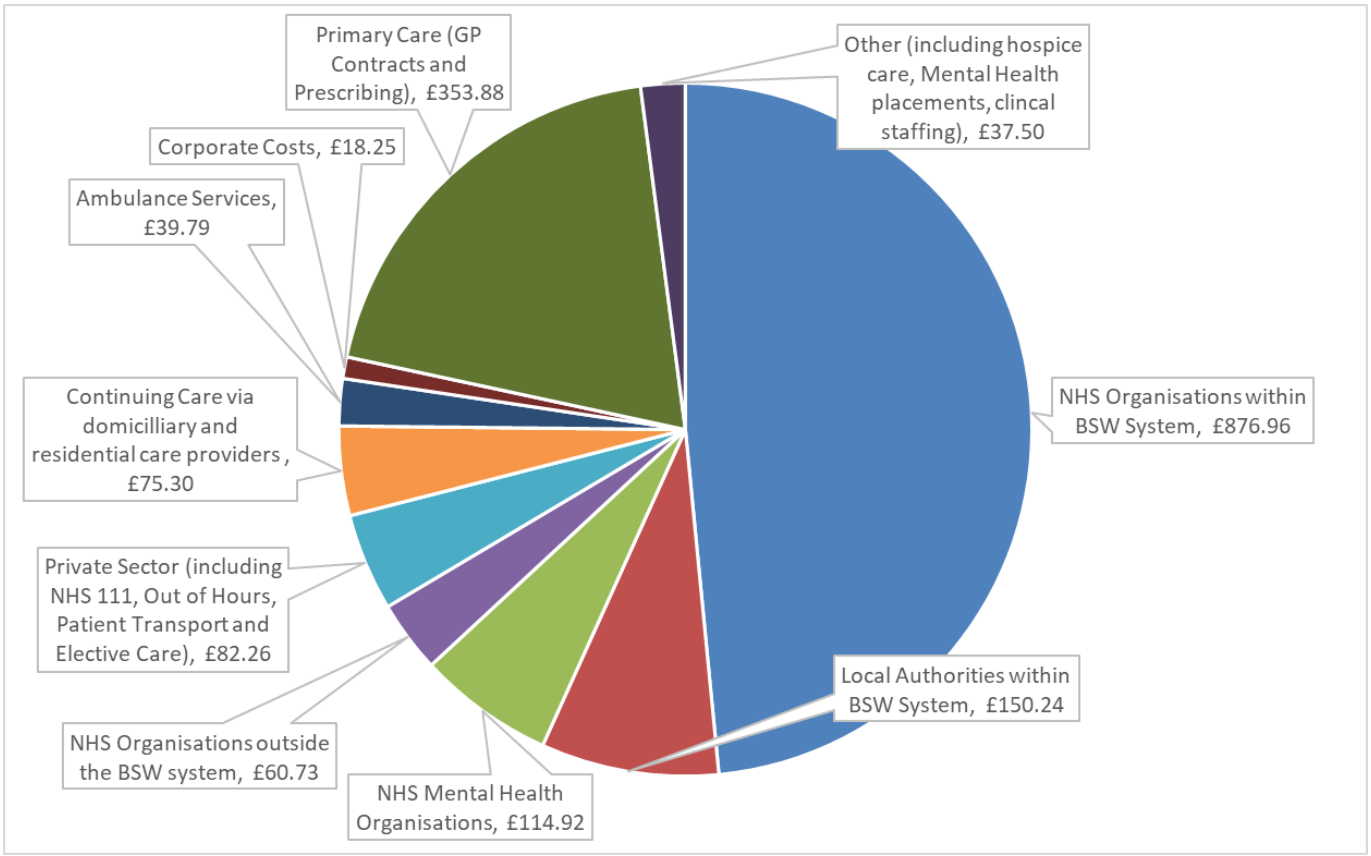
NHS England allocates funding for CCGs across the country by considering local healthcare needs and health inequalities. The CCG uses its funding for local plans and pays for the health services that the population uses.

In 2020-21, temporary changes were made to how national funding was distributed to enable CCGs to respond to the Covid-19 pandemic. These changes have continued into 2021-22. We have received extra funding to support additional local services in the community to help protect acute bed capacity.

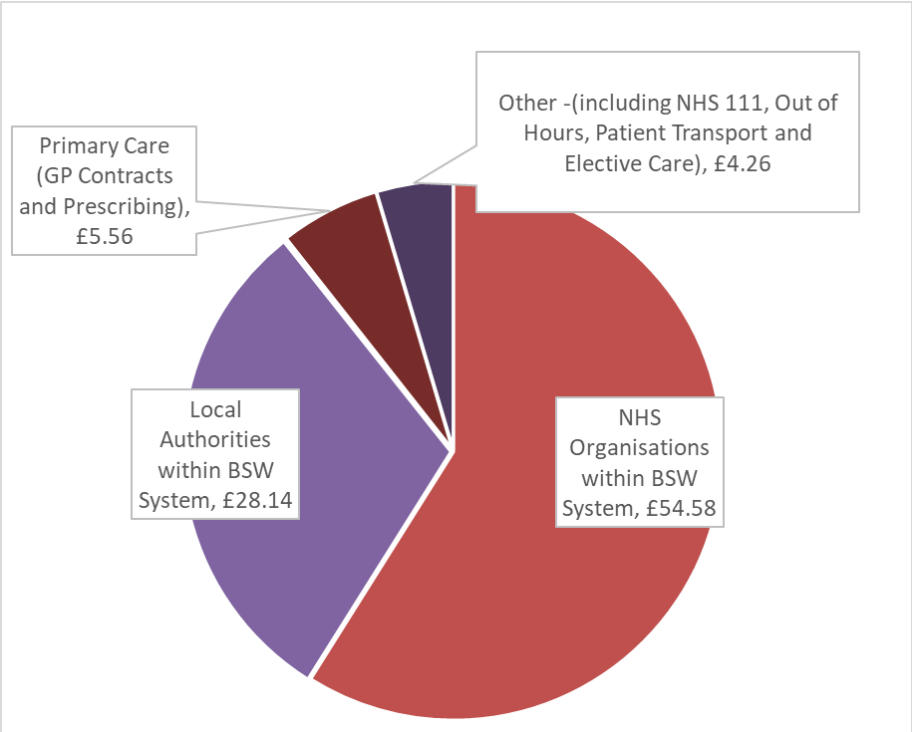
Funding received



Where we spent the £1,810 per patient



As outlined in the chart below, the CCG spent £87.1 million on its response to Covid-19, which equates to around £93 per patient.



Further details on the CCG's financial performance for the year are included within the financial statements (pages 98 to 128).

The CCG publishes details of all payments over £25,000 online: www.bswccg.nhs.uk/about-us/how-we-spend-your-money/expenditure-over-25-000

Our population and their health

We serve a population of approximately 940,000, across a large and varied geographical area that includes the densely populated town of Swindon to the north, Salisbury plains to the south, and Bath and the rolling Mendip Hills to the west. While the collective area of Bath and North East Somerset, Swindon and Wiltshire is relatively less deprived than other parts of England, there are areas with high levels of deprivation.

People living in these more deprived areas do not live as long as those in other areas, and they are more likely to experience both physical and mental health issues. The three main causes of mortality are cancer, cardiovascular disease and respiratory disease, and people living in areas classified as more deprived face poorer health outcomes across these three disease areas, as well as almost all other health outcomes.

We know the main contributing factors for these diseases are smoking, being overweight, not getting enough physical activity and having a high alcohol consumption. As an integrated care system, our attention is focused on supporting those people in high-risk groups to make healthy lifestyle choices, and altering the policy and physical environment around them to make it easier to do so.

Corporate objectives
Eight corporate objectives were identified for BSW CCG and agreed for 2021/22:

1. Workforce recovery, health and wellbeing.
2. Recovering from Covid-19.
3. Developing the Integrated Care System to meet expectations set out in the integrating care guidance.
4. Improving patient safety and embedding our system approach.
5. Ensuring financial sustainability.
6. Transforming services and developing local priorities.
7. Running things well.
8. Enablers.

A Board Assurance Framework (BAF) for 2021/22 was developed and highlighted the risks to BSW CCG in achieving its strategic objectives. In light of CCGs ceasing to exist as a legal entity from 1 July 2022, the Governing Body agreed to base the BAF on the corporate objectives agreed for the CCG in 2021/22.

Each objective has an executive risk owner, overall risk rating and risk appetite. The risks to delivering the objective, as well as the actions to mitigate the risk and to fill any identified gaps, are set out in the controls and assurances.

Key risks and issues
During 2021/22, the profile of our most significant risks changed. However, by March 2022, our corporate risk register and risk map still reflected the ongoing impact of Covid-19 and other themes. The risk categories that had the highest number of red risks were that of ‘capacity and capability’ and ‘public, patient and staff safety, including clinical harm’. The highest scoring risks were:

- Further waves of Covid-19.
- Delivery of the Covid-19 vaccine to BSW population.
- System-wide workforce and resilience.
- Seasonal planning.
- Demands on primary care and GP practices.
- Hospital handover delays and ambulance call stack delays.
- Delays in hospital discharges for patients.
- Elective recovery.

Further information can be found on page 56.

Statement of going concern
The corporate risk register, risk map and Board Assurance Framework are subject to regular reviews by several committees of the CCG, including the:

- Governing Body
- Audit Committee
- Risk Management Panel

At the time of preparing the financial statements, the Governing Body is required to assess whether the CCG is a going concern, which relates to whether the organisation can continue to operate for the foreseeable future. It would require a parliamentary intervention for the CCG to cease to operate and, in the event of such an intervention, there is existing legislation whereby the functions undertaken by the CCG would be transferred, either to an existing public sector entity or one that is newly created.

The Secretary of State for Health and Social Care has directed that where parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

During 2020/21, NHS England launched a consultation on Integrated Care Systems (ICSs). Under the changes, CCGs will cease to exist as organisations and their assets, liabilities and duties will transfer to Integrated Care Boards (ICBs). Subject to legislation, the CCG's assets, liabilities and duties will transfer to Bath and North East Somerset Swindon and Wiltshire Integrated Care Board on 1 July 2022.

Performance analysis

Year-end performance summary

In 2021/22, BSW CCG focused on delivering key NHS priorities specific to the year:

- Managing the Covid-19 pandemic, including the vaccination programme.
- Supporting patients and services that have been impacted by high pressures in urgent and emergency care across the system.
- Working to reopen all services.
- Recovering the elective care services to support reduction of waiting lists and the number of people who have waited a long time for their required treatment.

This has changed how NHS England has asked us to deliver the national access standards, including the NHS constitutional measures. For example, for elective care, the NHS is focused on reducing waiting lists and the number of people waiting two years for treatment, rather than 18-week access times. For access to mental health services, we are being asked to support an absolute number calculated for us, rather than a percentage.

BSW has taken a system level approach to developing initiatives and solutions to recover the delivery of services, both now and in the future, which will enable the system to deliver timely access with the right outcomes for our population.

We also work with providers to ensure that patient safety is not compromised during times of increased pressure and demand for emergency care, and that the longer waiting patients are managed in a way that maintains safety and clinical effectiveness. We have consistently aimed to improve the quality of health and care services, so patients have a good experience and services are delivered safely and effectively. We have done this in the context of working within our financial allocation and managing the ever-increasing demand for services.

NHS Oversight Framework

The NHS System Oversight Framework used in 2021/22 is the updated regulatory regime being implemented for Integrated Care Systems (ICSs) and NHS provider trusts, which reinforces system-led delivery of integrated care. There are four ratings or segments that each ICS and trust will be assessed and categorised with, all of which identify the level of support needed by each trust or system:

Segment	Scale and nature of support needs
1 – Consistently high performing across the oversight themes and on track to deliver the ICS priorities.	No specific support needs identified. Trusts encouraged to offer peer support.
2 - On a development journey, with plans that have the support of system partners in place to address areas of challenge.	Flexible support delivered through peer support, clinical networks, NHS England and NHS Improvement universal support offer or a bespoke support package via one of the regional improvement hubs.
3 - Significant support needs against one or more of the six oversight themes.	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required.
4 - Very serious, complex issues manifesting as critical quality and/or financial concerns that require intensive support.	Mandated intensive support delivered through the Recovery Support Programme.

Further details on the NHS System Oversight Framework can be found by following the below link:
https://www.england.nhs.uk/wp-content/uploads/2021/06/B0693-nhs-system-oversight-framework-2021-22.pdf

The new national Recovery Support Programme (RSP) provided to all trusts and systems in segment four of the NHS System Oversight Framework was launched in July 2021. The trusts and systems named in the programme were made publicly available, and there were no trusts from BSW in segment four.

In October 2021, the segment one to three ratings were issued to systems and NHS trusts. The full set of framework metrics are still in development and these initial assessments have been made using a reduced set of criteria – elective and cancer performance, CQC assessments, financial plans and spend and workforce staff survey – and triangulated with soft intelligence.

System / Trust	Rating Segment
BSW system	Two

Avon and Wiltshire Mental Health Partnership NHS Trust	Three
Great Western Hospitals NHS Foundation Trust	Two
Royal United Hospitals Bath NHS Foundation Trust	Two
Salisbury NHS Foundation Trust	Three

BSW performance is aligned to national results with 45 per cent of systems in segment two, 48 per cent of trusts in segment two and 31 per cent of trusts in segment three.

There will be a set of identified exit criteria developed by NHS England. These are the key actions that the provider or system would need to shift the dial on to move up a segment.

Performance reporting and management

During 2021/22, Bath and North East Somerset, Swindon and Wiltshire CCG continued to develop the system performance, quality and finance report for both CCG and ICS use.

The focus on workforce development has led to the establishment of a new set of system metrics which have enabled understanding of the current challenges and progress required.

In 2021/22 the report focused on key metrics from the NHS System Oversight Framework, with additional system metrics and a more detailed quality appendix section including:

- Urgent care: NHS 111, A&E, ambulance handovers and hospital discharge
- Local authority: social care needs and safeguarding concerns
- Safe, high-quality care: patient safety, patient experience, infection prevention and control
- Finance: system performance against financial plan
- Primary care: access
- Mental health and learning disabilities: access and treatment in psychological therapies, inpatients with learning disabilities, annual health checks
- Planned care: waiting lists, cancer treatment, diagnostic, elective care and outpatient appointments
- Workforce: vacancies, staff experience and retention
- Covid-19: system status, prevalence and vaccinations

Key system boards and place-based meetings use this reporting in multiple forums as a key tool to provide knowledge, enable review and scrutiny and provide assurance:

- Governing Body: providing assurance with an integrated view on the quality, performance and finance of the CCG.

- ICS Executives and wider ICS Partnership: including the CCG, local providers (acute and community), local authorities and NHS England and NHS Improvement.
- Joint Quality and Performance Assurance Committee (QPAC): providing clinical and operational review and scrutiny of the report and feeding into Governing Body where required.

Delivery of National Standards
One of the key pledges in the NHS Constitution is the right of everyone to access the care they need. There are a number of national standards that enable us to measure access performance. In recent years, additional national measures have been made available for wider and improved understanding of access and waiting that are not in the constitution and some of these are reported here. In 2021/22, these measures have been reported with a focus on current NHS priorities.

Figures quoted below are the most recent available with benchmarking data.

Performance delivery of the national standards is managed by the quality team who work with providers to ensure patient safety is not compromised during times of increased pressure in A&E, and that waiting lists are managed in a way that maximises patient safety and clinical effectiveness. This work has taken on significant importance during the Covid-19 pandemic, with longer waits for all types of planned care, as well as delays in receiving emergency care.

Clinically led review of NHS access standards
NHS access standards have been reviewed with the aim of recommending updates and improvements to the current measures in line with the long-term plan and the latest clinical and operational evidence.

The recommendations from the clinically led review of NHS access standards for urgent and emergency care, mental health and cancer went to consultation in 2021/22. The review is now considering how best to advise and communicate the proposed new measures to patients and visitors, as well as the opportunities or challenges of implementation.

Delivery of national standards during the pandemic
The NHS response to the pandemic changed the way many services operated, with some having to close in 2020, which reduced access to planned services, including hospital, community and mental health. During 2021/22, there has been significant focus on managing the subsequent waiting.

Demand for urgent and emergency care reduced during 2020 as there were fewer opportunities to catch illnesses or to be involved in an accident. However, demand steadily grew as Covid-19 restrictions were eased, with many services experiencing significant pressuring during the summer of 2021.

The increased prevalence of Covid-19 across 2021/22 meant there have been more patients with the virus at the same time as there have been high workforce absences, both of which have limited access to care.

In 2021/22, primary care played a significant role in delivering the Covid-19 vaccination, while also returning face-to-face activity back towards pre-pandemic levels, as well as starting to recover non-urgent patient support, such as clinical reviews.

For urgent care, in particular, the workforce absence impacted many services' ability to step-up support to the wider-system during times of high pressure.

For elective care, the increase in availability of remote appointments could be taken as a positive outcome of the pandemic. However, it still does not offset the need for face-to-face attendances for many diagnostic tests and procedures. Waiting lists have increased across the board, with a return to more usual referral levels and a continued reduction in available support due to Covid-19 infection prevention and control measures, workforce absences, patient availability and the knock-on impact of system flow pressures.

Access to urgent and emergency care

The A&E four-hour target measures the time a patient spends in A&E from arrival to transfer, admission or discharge. These waiting times are often used as a barometer for overall performance of the NHS and social care system. This is because A&E waiting times can be affected by changing activity and pressures in other areas, such as the ambulance service, primary care, community-based care and social services.

For example, patients cannot be admitted quickly from A&E if wards are full as a result of delays in transferring patients to other NHS services or in arranging required social care. The target A&E performance is for 95 per cent of patients to wait no more than four hours. Provider performance based on the latest available data is shown in the table below.

The clinically led review of urgent and emergency care standards has recommended moving to a bundle of measures, which track activity across the urgent and emergency care pathway, rather than focusing on a single element of care. It is hoped this approach will help patients and the public understand what to expect at each stage of care, as well as implement overall improvements.

National standard	Period reported	Target	Performance		BSW Total		
			England	South West	BSW Total	vs Eng.	vs SW
Percentage of patients admitted, transferred or discharged from A&E within four hours* (All)	Q4 22	95%	73.0%	82.9%	71.4%		
Ambulance response times (minutes) Cat 1 Mean	Mar-22	7	9.5	13.1	12.3		
Ambulance response times (minutes) Cat 1 90th percentile	Mar-22	15	16.8	23.4	21.7		
Ambulance response times (minutes) Cat 2 Mean	Mar-22	18	n/a	113.7	100.3		
Ambulance response times (minutes) Cat 2 90th percentile	Mar-22	40	n/a	271.8	240.1		
Ambulance response times (minutes) Cat 3 90th percentile	Mar-22	120	n/a	957.2	780		
Ambulance response times (minutes) Cat 4 90th percentile	Mar-22	180	n/a	1134	579.6		
NHS 111 answered in 60 seconds	Mar-22	95%	44.60%	48.90%	66.5%		
NHS 111 % calls clinically triaged	Mar-22	75%	92.30%	90.20%	82.9%		

* Provider data: BANES - RUH, Swindon - GWH, Wiltshire – SFT

Key for benchmarking ratings				
vs Eng. (England**) or SW** (South West): Compares BSW and CCG to England or South West result and target	Better than Eng. or SW and/or target		Similar or within acceptable variance to Eng. or SW and/or target	Worse than Eng. or SW and target; outside amber tolerance

Throughout 2021/22, local systems were not able to meet the national A&E four-hour target. However, the national average rate for quarter four demonstrated that the target had not been achieved across the country.

People needing urgent and emergency care had reduced during the pandemic but, since August 2021, A&E attendances have increased in both volume and complexity, with hospitals becoming full and ambulance services being stretched. This reached a peak between January and March 2022.

Ambulance response times for people with the most serious conditions (Category 1) are measured as a mean response time and at the 90th percentile, which measures delivery on the every-call-counts principle of the current standards. Performance was close to the national targets at the beginning of the year but off-target for the reminder of the year as incidents increased to 14.3 per cent above contracted plan. The pressure in hospitals resulted in a 60 per cent increase in delays for ambulance handovers, which ultimately reduced the availability of ambulances for new calls.

The number of calls to NHS 111 increased in 2021/22, prompted by a rise in Covid-19 related concerns and the launch of Think 111 in December 2021. The number of calls answered within 60 seconds was below target throughout the year, but higher than England and South West levels. The level of clinical triage was above target, though below England and South West levels.

Access to Planned Care

The 18-week referral to treatment target has been the key measure of the NHS Constitution for planned care. In recognition of the continuing growth in waiting lists and long waiters, CCGs were asked to focus on these measures in 2021/22.

National Standard	Period reported	Target	Performance		BSW Total		
			England	South West		vs Eng.	vs SW
Referral To Treatment Overall Waiting List % growth in year	Mar 2022		28.4%	25.9%	19.5%		
Patients waiting 18 weeks or less from referral to hospital treatment	snapshot Mar 2022	92%	62.4%	61.1%	64.5%		
Patients waiting over 52 weeks for treatment^	snapshot Mar 2022	0%	306,286	31,503	2,508		
Patients waiting over 104 weeks for treatment^	snapshot Mar 2022	0	16,796	2,374	27		
Patients waiting six weeks or more for Diagnostics	snapshot Mar 2022	1%	24.8%	31.7%	34.1%		

Patients seen within two weeks of a referral for suspected Cancer	Q4 2021/22	93%	78.9%	74.2%	83.8%		
People with urgent GP referral being told of cancer diagnosis outcome within 28 days of referral (FDS)	Q4 2021/22	75%	70.5%	73.4%	73.7%		
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q4 2021/22	85%	63.9%	68.2%	69.3%		

^ Comparison weighted by overall RTT waiting list

Key for benchmarking ratings			
vs Eng. (England**) or SW** (South West): Compares BSW and CCG to England or South West result and target	Better than Eng. or SW and/or target	Similar or within acceptable variance to Eng. or SW and/or target	Worse than Eng. or SW and target; outside amber tolerance

The BSW-wide waiting list has grown from 45,245 patients in March 2021 to 78,163 patients (19.5 per cent) as of March 2022.

In March 2022, 2,508 patients had been waiting over 52 weeks, which is a reduction of 35 per cent against the 3,902 patients who were waiting longer than a year in March 2021. Twenty-seven patients were waiting longer than two years, as of March 2022.

BSW has been running a system-wide elective recovery programme in order to reduce waiting times for patients, especially those who are classed as a long waiter.

Tools were put in place to identify and to track the patients at risk of breaching 104 weeks. Key actions included looking for opportunities for transfers and mutual aid, as well as setting up five system groups that focused on each of the high-risk specialties. In March 2022, there were 27 patients waiting more than 104 weeks. The number of patients waiting more than two years has remained low. NHS England is working with systems to reduce this to zero by July 2022.

Diagnostic waiting times have continued to be challenging in the BSW system over the last year, with around 28 per cent of patients waiting longer than six weeks. This figure was higher in March 2022, when more than 34 per cent of patients were waiting longer than 42 days. Most test services have seen increased breaches across 2021/22, and MRI has seen the number of people waiting more than six weeks increase from 283 in March

2021 to 3,380 in March 2022.

Cancer access waiting times have performed worse during 2021/22 and recovery plans are in place for the areas of most challenge. When compared to pre-pandemic data, BSW saw higher suspected cancer referrals, as well as initiated more cancer treatments, than most other systems in the South West. Access to cancer services in two weeks improved in quarter four to 83.8 per cent, which is just above the England average. There is a new national standard to support diagnosis within 28 days, and 73.7 per cent of diagnoses in quarter four met this standard, which is just shy of the 75 per cent standard. Of those requiring treatment, 69.3 per cent were treated within 62 days of referral, which is just above the England average, but below the average South West performance.

BSW CCG belongs to the South West Cancer Alliance Group (SWAG) and also the Thames Valley Cancer Alliance Group, which covers Swindon. These groups include commissioners and providers, as well representatives from NHS England, and focus on implementing best practice.

Access to mental health

In recent years, national standards have been developed to enable us to measure waiting times for many mental health services. This allows us to understand our progress in delivering timely access to mental health services. BSW CCG has been working with local partners on the BSW THRIVE workstream to develop services, while also keeping a focus on local outcomes.

National Standard	Period reported	Target	Performance		BSW Total		
			England	South West		vs Eng.	vs SW
Improving Access to Psychological Therapies – access (Qtr)	Feb-22	5,936	300,148	26,420	2,930		
Improving Access to Psychological Therapies – recovery rate (Qtr)	Feb-22	50%	50.7%	48.0%	18.9%		
Improving Access to Psychological Therapies – treated within six weeks of referral (Monthly)	Feb-22	75.0%	89.5%	91.0%	91.4%	G	G
Improving Access to Psychological Therapies –	Feb-22	95.0%	98.4%	100.0%	99.1%	G	G

treated within 18 weeks of referral (Monthly)							
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within two weeks of referral (Qtr)	Feb-22	60%	68.6%	65.3%	66.7%	G	G
Access to Children and Young People's Mental Health Services (one contact) rolling 12 mth	Feb-22	12,642	661,280	48,900	7,915		
Children and Young People Eating Disorders: seen within four weeks for non-urgent cases.	Q4 2021/22	95%	64.1%	59.4%	69.1%	G	G
Estimated diagnosis rate for people with dementia (diagnoses as % of prevalence)	Mar-22	66.7%	62.0%	57.5%	57.3%	A	A

Key for benchmarking ratings			
vs Eng. (England**) or SW** (South West): Compares BSW and CCG to England or South West result and target	Better than Eng. or SW and/or target	Similar or within acceptable variance to Eng. or SW and/or target	Worse than Eng. or SW and target; outside amber tolerance

Psychological therapies are our community talking services, which includes group and one-to-one sessions. The national target for growth in service access is set on an estimated expected prevalence. This has been difficult to achieve during the pandemic due to a reduction in service capacity, particularly for group sessions. A review is under way to support the service to meet the new expected demand. The recovery performance of 18.5 per cent has been driven by a post-lockdown data review of the patient list. Patients who choose not to engage with the service are being discharged.

The National Institute for Health and Care Excellence (NICE) recommended that care for people with a first episode of psychosis should be given in a mental health ward setting. Although the CCG had good performance in this area, it is expected that future performance will fluctuate due to the low numbers of people needing the service.

Access to children and young people's mental health services, similar to adults' psychological therapies, measures access against an expected prevalence of need. We developed a range of services sitting alongside our traditional Child and Adolescent Mental Health Service (CAMHS), such as an online support service, as well as smaller local providers offering groups and one-to-one sessions. These smaller local providers have not previously reported activity nationally, and we are supporting those providers to meet the technology and data standards that are needed to submit.

The access standard for eating disorder services for children and young people went live from the end of 2019/20. Unfortunately, performance has been impacted by the pandemic and a recovery plan is being put in place to support the waiting list.

BSW CCG are not meeting the national standard for dementia diagnosis rates. Diagnoses fell during 2020/21 but have been improving slowly during this year, at a rate similar to the expected prevalence.

Covid-19

A main priority this year has been ensuring residents have been vaccinated against Covid-19. In total, 1,652,935* vaccinations were given during 2021/22 across Bath and North East Somerset, Swindon and Wiltshire.

Through weekly operational meetings with all vaccination centres, the CCG has continuously driven the programme for the benefit of residents to ensure everyone has had access to a Covid-19 vaccination at a time and location convenient to them.

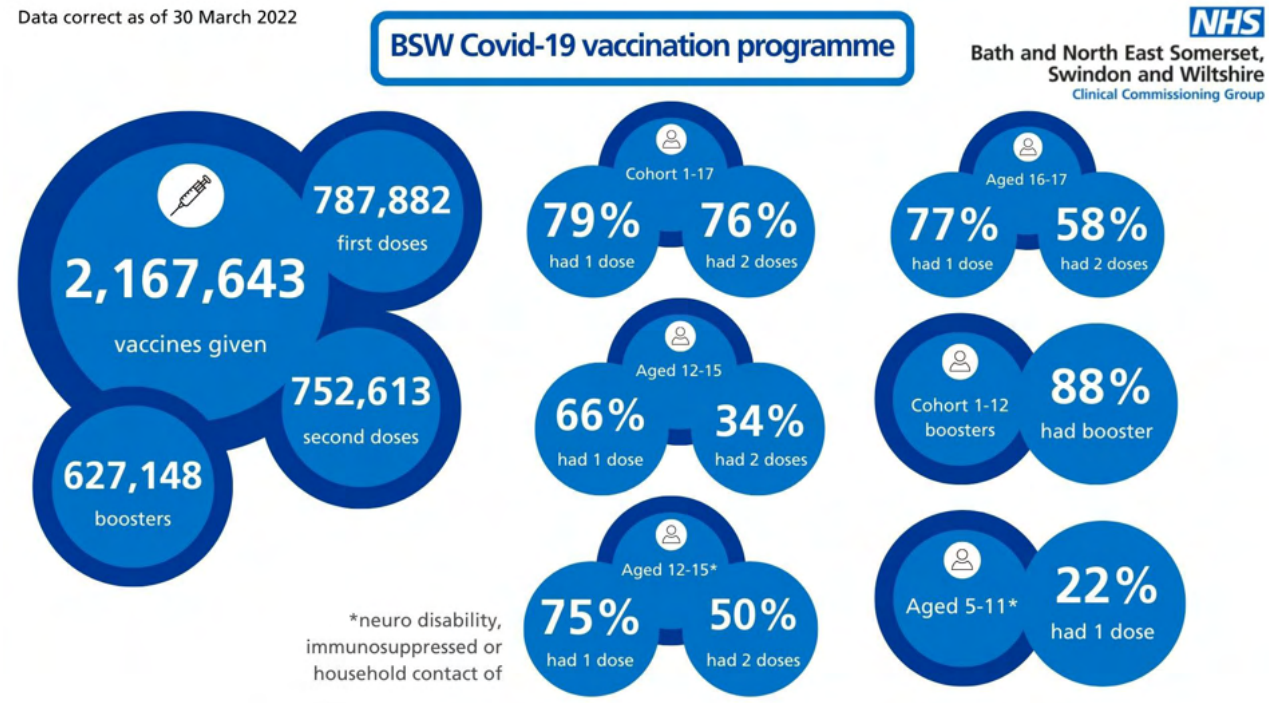
During the last 12 months, vaccinations have been available from 55 sites, including 25 run by primary care networks, as well as 22 community pharmacy-led sites.

In addition, between April 2021 and March 2022, the CCG hosted 241 pop-up vaccination clinics at 110 sites. More than 7,000 people, many of whom would otherwise not have been vaccinated, visited these pop-up clinics.

Throughout the vaccination programme, NHS England had set targets for every cohort in line with the Joint Committee on Vaccination and Immunisation (JCVI) recommendations, and the CCG has delivered every time.

In December 2021, following the national announcement to accelerate the vaccination programme due to the Omicron variant, more than 210,000 vaccines were given during a three-week period. More than 20 per cent of the eligible population received a vaccine during this time, with teams carrying out up to 20,000 vaccinations every day in the week before Christmas. The CCG met the government's target of vaccinating 80 per cent of the eligible population on 2 January 2022.

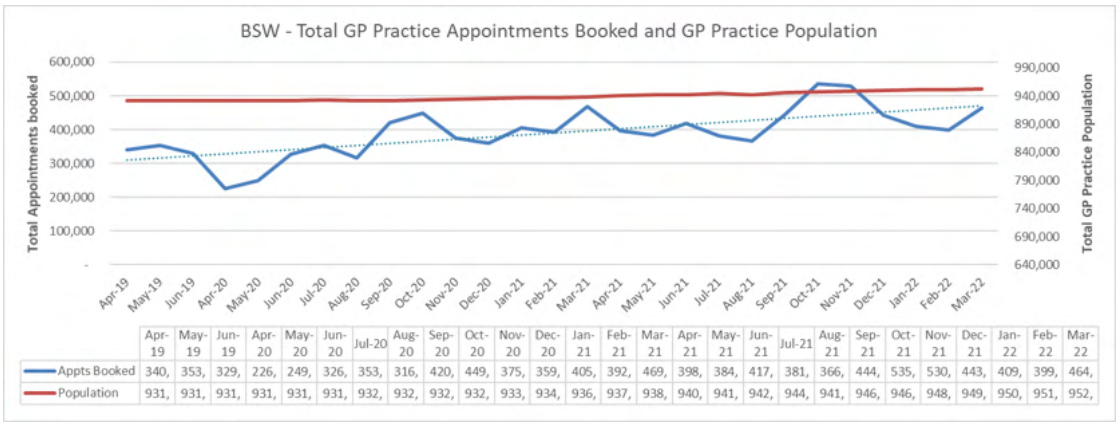
An overview of the CCG's Covid-19 vaccination performance during 2021/22 can be seen in the infographic below.



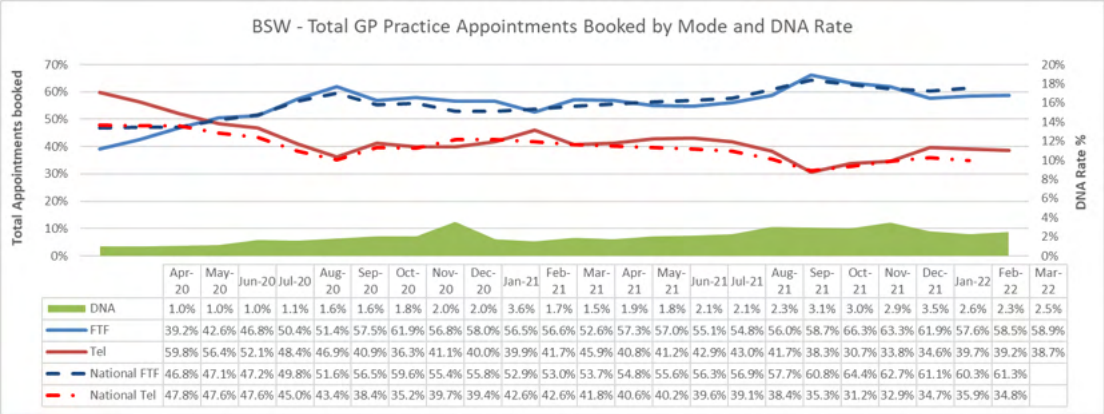
Primary care

GP practices across Bath and North East Somerset, Swindon and Wiltshire have maintained a high level of service to patients throughout the pandemic and, through the utilisation of digital technologies and risk-based approaches, have provided as comprehensive a range of services as possible.

More than five million primary care appointments were offered between April 2021 and March 2022, with 59 per cent of these carried out face-to-face.



	Apr-19	May-19	Jun-19	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Appts Booked	340,	353,	329,	226,	249,	326,	353,	316,	420,	449,	375,	359,	405,	392,	469,	398,	384,	417,	381,	366,	444,	535,	530,	443,	409,	399,	464,
Population	931,	931,	931,	931,	931,	931,	932,	932,	932,	932,	933,	934,	936,	937,	938,	940,	941,	942,	944,	941,	946,	946,	948,	949,	950,	951,	952,



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
DNA	1.0%	1.0%	1.0%	1.1%	1.6%	1.6%	1.8%	2.0%	2.0%	3.6%	1.7%	1.5%	1.9%	1.8%	2.1%	2.1%	2.3%	3.1%	3.0%	2.9%	3.5%	2.6%	2.3%	2.5%
FTF	39.2%	42.6%	46.8%	50.4%	51.4%	57.5%	61.9%	56.8%	58.0%	56.5%	56.6%	52.6%	57.3%	57.0%	55.1%	54.8%	56.0%	58.7%	66.3%	63.3%	61.9%	57.6%	58.5%	58.9%
Tel	59.8%	56.4%	52.1%	48.4%	46.9%	40.9%	36.3%	41.1%	40.0%	39.9%	41.7%	45.9%	40.8%	41.2%	42.9%	43.0%	41.7%	38.3%	30.7%	33.8%	34.6%	39.7%	39.2%	38.7%
National FTF	46.8%	47.1%	47.2%	49.8%	51.6%	56.5%	59.6%	55.4%	55.8%	52.9%	53.0%	53.7%	54.8%	55.6%	56.3%	56.9%	57.7%	60.8%	64.4%	62.7%	61.1%	60.3%	61.3%	
National Tel	47.8%	47.6%	47.6%	45.0%	43.4%	38.4%	35.2%	39.7%	39.4%	42.6%	42.6%	41.8%	40.6%	40.2%	39.6%	39.1%	38.4%	35.3%	31.2%	32.9%	34.7%	35.9%	34.8%	

During the winter period, BSW submitted a plan to NHS England with the focus on working across the GP practices, primary care networks and local systems to use some of the additional national funding to support primary care in the difficult months ahead in response to the unprecedented levels of demand.

Locality plans included expanding the community pharmacy consultation service, with independent prescribing for minor illness, and support for clinical assessment service.

Throughout the year, the primary care networks of GP practices across BSW were delivering the Covid-19 vaccination programme, and the accelerated booster programme during December 2021.

Temporary national GP contract changes were brought in to support the Covid-19 vaccination programme to create capacity and offer financial support to allow, wherever possible, practices and PCNs to continue pursuing the clinical ambitions underlying the Quality Outcomes Framework (QOF) and Investment Impact Fund (IIF), while still releasing capacity to support the increased vaccine effort.

Between the end of December 2021 and the end of March 2022, the national ask for practices and primary care networks was to focus on three key priority areas, while also using professional judgement to clinically prioritise care.

These three areas were:

- Continued delivery of general practice services.
- Management of symptomatic Covid-19 patients in the community.
- The ongoing delivery of the Covid-19 vaccination programme, with the focus on reaching the most vulnerable people and minimising any inequalities in uptake.

During times of system pressure, such as in January 2022, there was a strong clinically led focus on surge planning with primary care networks and practices across BSW to support daily reporting and the development of local plans to support mutual aid between practices which have enabled essential services to be maintained.

Service changes over the last year to improve patient services, include:

- Increased blood and sample collection and delivery service and link to the reform of diagnostic services

A second blood and sample collection and delivery service was implemented across all BSW GP practices to support the increased urgent need for safe, patient-centred diagnostic activity. The new service also allowed samples to be taken closer to the home of the patient without them needing to travel to a nearby acute hospital.

Primary care network (PCN) directed enhanced service (DES) delivery support

- Enhanced health in care homes

The enhanced health in care homes (EHCH) aims to support people who live and work in and around care homes though proactive care, centred on the needs of individual residents, families and staff by a whole-system collaborative approach.

Over the last year, primary care networks have strengthened core standards of delivery to ensure every care home is aligned to a named primary care network and every care home has a named clinical lead, and that weekly ward rounds take place with residents who have been prioritised for review based on a multi-disciplinary team clinical judgement.

Further development is planned to expand this programme of work wider than just primary care.

Impact and investment fund

- Providing high quality care – GP access

Improving access to primary care services is a core aim of the NHS Long Term Plan and Investment and Evolution. The response of primary care to Covid-19 has seen rapid and widespread changes in how patients access GP services. As part of the Investment and Impact Fund (IIF), work was completed across BSW to support improvements in access to general practice by recognising primary care networks for helping more patients to access the right care in the right place and at the right time.

In July 2021, practices in primary care networks mapped all active appointment slot types to the new set of national appointment categories, commencing the development of a comprehensive and structured dataset describing access to general practice based on better and more consistent recording of appointment data, via consistent established standards.

Primary Care Networks have been supported over the last 12 months with the development of multi-disciplinary teams. Appointments are being made with the support provided through the PCN direct enhanced services (DES) and the Additional Roles Recruitment Scheme (ARRS). There are 15 different roles now available under the scheme with recent progress on the rotational paramedic roles with South Western Ambulance Service and the mental health practitioner roles that are jointly appointed with Avon and Wiltshire Mental Health Partnership NHS Trust. At the end of March 2022, there have been 258 appointments across under ARRS (WTE 213.11). The additional staff have proved to be invaluable during the past year and have supported both practices and Covid-19 vaccination clinics.

Learning disability health checks
It is well recognised that people with learning disabilities can experience poorer physical and mental health than other people.

The provision of an annual health check provides a holistic view of patients and can identify undetected health conditions early, ensuring appropriate on-going treatment while establishing trust and continuity of care.

During the last year, 2,979 health checks have been fully completed for patients aged 14 and over who have a learning disability. This is an increase of 322 when compared to the previous year.

Diabetes
Following disruption to regular diabetes and cardiovascular care during the pandemic, primary care is now being supported to ensure that patients with the most urgent needs are identified and receive the care they require, while those with less complex needs also receive appropriate care.

We have used funding from the National Diabetes Transformation Programme to develop a diabetes and cardiovascular disease (CVD) primary care support team, which are supporting process improvements, clinical guidance and training for staff in primary care to ensure that patients continue to receive the best possible care. This programme is already starting to deliver improvements in service with the number of patients with urgent diabetes issues in early adopter practices beginning to decrease.

Having been identified as one of the leading areas nationally for attendance at the National Diabetes Prevention Programme, we are now seeking to ensure that every eligible patient is encouraged to attend. Working with primary care across BSW and with Xyla Health and Wellbeing, which provides the programme, we are offering every eligible patient the opportunity to have a conversation with a member of the programme team. This will ensure potential participants are aware of the benefits of participating. We expect this to substantially increase the numbers of patients completing the course.

Sustainable development
The Delivering a 'Net Zero' National Health Service report provides a national-level framework for action on climate change and sustainability.

Every NHS organisation has an essential role to play in meeting this ambition.

In BSW, the CCG and its partner organisations have been working together to consider and plan how this ambition can be met. Each NHS trust in BSW has a Green Plan and, together, we have produced an NHS BSW Green Plan.

This CCG annual report reflects our shared mission and the work we have started with our NHS partners in BSW.

NHS BSW Green Plan
NHS organisations in BSW have the following shared priorities:

- Shift to 100 per cent renewable energy for all electricity supplies.
- Align with Greener NHS Estates Delivery Plan.
- Apply a minimum 10 per cent social value weighting to all contracts.
- Switch to 100 per cent recycled paper.
- Address single use plastics.
- Share learning on driving sustainable procurement.
- To reduce the use of desflurane.
- To prescribe lower carbon inhalers.
- To increase virtual outpatients and primary care appointments.
- Develop plans to support active travel.
- To embed carbon reduction principles in the way all care is delivered.

Our shared challenges with these priorities are:

- Achieving the NHS Carbon footprint PLUS on plan.
- Collaboration as one Integrated Care System.
- Championing and driving culture changes across the system.
- Ensuring local ownership to deliver on agreed actions.
- Reducing the emissions caused by staff and patients.

The NHS BSW Green Plan sets out in more detail what we have all achieved to date, within trusts and across partners.

In 2022, some important launches to note are as follows:

- Board-level sustainability training will be delivered by Centre for Sustainable Healthcare for the new ICB Board.
- A dedicated webpage and communications plan is being developed to support the rollout of the Green Plan.
- A dedicated estates sub-group will focus on planning the decarbonisation of estates.
- A review of current fleet, lease car schemes and travel policies will be undertaken across partners.
- The BSW Health and Care model will be embedded into strategy and operational planning, which will support the development of more sustainable care models.
- Targeted projects and interventions to reduce the impact of inhalers and anaesthetic gases will be delivered.
- Our digital strategy will continue to support the rollout of digital transformation projects that help to reduce the need for travel and support the delivery of care, such as the Integrated Care Record, video and online consultations, patient-held records and remote working for staff.

BSW CCG's progress in 2021/22
We have identified Board-level leadership and a sustainability lead at BSW CCG. As we move to become the BSW Integrated Care Board, the Board-level leader and sustainability lead will be reviewed, along with governance.

In 2021/22, staff continued to work predominantly from home, with a small number of staff accessing offices. We have used this time to formalise and embed agile working, review and reduce our office accommodation and share our space with our partners, as well as reduce the waste we produce.

Moving forward we will be looking at ways we can keep travel to a minimum. Where staff do need to travel, we will be promoting and encouraging sustainable ways of travel.

The CCG's lease car salary sacrifice scheme now only offers zero emission vehicles. This scheme will continue as we move to become the ICB.

Quality, engagement, health inequality and strategy
We have worked to ensure that we comply with the statutory duties outlined in the National Health Service Act 2006 (as amended).

In this section, we have reflected on our duties under:

- Quality improvement of services
- Patient and public feedback and engagement
- Reducing inequalities
- Contribution to the delivery of joint health and wellbeing strategies

Improvement in quality of services
The NHS Constitution places a requirement on all providers of healthcare to strive to

achieve high quality and safe care delivery to patients. Commissioners of healthcare have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations they commission. In the last year, the CCG has been further developing a collaborative approach to quality assurance and quality improvement, to ensure delivery of compassionate, high-quality care for our population, both at place and system level.

Quality assurance

The CCG's role in quality surveillance and assurance has continued to progress towards an integrated care system approach, with attendance of the quality team at internal provider quality assurance meetings and support to joint quality improvement workstreams.

We have continued to align key metrics for quality assurance across the BSW system.

Key metrics for quality assurance across the system

Clinical incidents, including serious incidents and never events	The CCG reviews trends in clinical incidents, and those that meet the threshold of a serious incident or never event in line with the national frameworks. It is important to the CCG and wider health and care system that any learning then informs improvement to reduce the risk of harm.
Falls with moderate or severe harm	The CCG monitors the trend of falls in inpatient care and the number of patients whose falls result in moderate or severe harm, such as fracture.
Mortality	The CCG monitors hospital mortality data for trends. Monitoring patient outcome data, in conjunction with other metrics, can provide information regarding the quality of patient care.
Patient experience	What patients say about a service is a key element of quality assurance. We monitor Friends and Family Tests, complaints and concerns for themes, trends and potential actions for patient experience improvement. Understanding and sharing of learning from people's experience of care is also promoted via use of patient stories.

Workforce, staff health and wellbeing	The CCG monitors staff turnover, vacancy and sickness rates, mandatory training and appraisal compliance. In addition, agency and bank staffing usage is monitored. This has been of particular importance this year, due to high levels of community transmission of Covid-19 leading to high levels of staff absence. The CCG has been working on staff wellbeing strategies with its system partners.

Commissioning for Quality and Innovation (CQUIN) continued to be stood down nationally for 2021/22 due to the Covid-19 pandemic.

The use of CQUIN to support quality improvement will be part of contracts in 2022/23.

Patient safety

We have a responsibility to ensure the services we commission are safe. We strive to ensure that individuals are not harmed when receiving healthcare. However, it is acknowledged that, occasionally, a serious incident or patient safety incident may occur.

All serious incidents are reported in line with the National Serious Incident Framework and are jointly reviewed by serious incident panels to ensure that a robust investigation has been undertaken to inform learning and improvement, and to prevent such incidents happening again.

This includes reviewing:

- Lessons that could be learnt by another organisation.
- Learning regarding strengths and weaknesses of the wider system.
- Quality improvement projects that could be undertaken, or any issues that require further research and development.

During 2021/22, preparation for transition to Patient Safety Incident Response Framework (PSIRF) commenced. A system-wide Patient Safety Community of Practice has been established to support and take forward PSIRF as a shared learning space. The Patient Safety Incident Response Framework is a key part of the NHS Patient Safety Strategy and was published in July 2019.

The strategy aims to support the NHS in improving its understanding of safety by drawing insight from patient safety incidents. The PSIRF is being developed to replace the current Serious Incident Framework, with updated guidance on how NHS organisations should respond to patient safety incidents, and how and when a patient safety investigation should be conducted.

BSW system risks are shared and monitored within the quality performance and assurance committee (QPAC) and multi-agency System Quality Group (SQG).

Infection prevention and control
BSW CCG has a responsibility to ensure that systems and processes are in place to support the management, prevention and control of healthcare-associated infections (HCAI).

It is the CCG's role to determine and ensure compliance with infection prevention and control requirements and to assess providers' contribution towards sustained improvement. Additionally, CCG and provider organisations work together to support quality improvement initiatives aimed at delivering safer services. The CCG sets, agrees and systematically monitors and reviews surveillance data against nationally set objectives for specific organisms and other locally agreed indicators. Learning identified and shared from post-infection reviews or root cause analysis of incidents is used to inform key improvement areas and address potential risks.

During 2021/22, the BSW system infection prevention and control specialists continued to work collaboratively to support the health and care system throughout the Covid-19 pandemic, by ensuring that updates to national guidance were implemented and understood as a system, undertaking risk assessments to ensure patient safety remained a priority and ensuring that all changes were monitored.

Throughout 2021/22, the BSW infection prevention and control peer network began working collaboratively to reduce healthcare associated infections, such as Clostridium difficile and E-coli bacteraemia. Coming together as a system to drive forward reduction plans means there are opportunities for collective learning, which will allow the BSW system to begin implementing change at scale to reduce healthcare associated infections and take a preventative approach to ensuring that the community and population of BSW are not harmed by an avoidable health care associate infection.

A more detailed Annual Infection Prevention and Control Report for 2021/22 will be available on the CCG website in 2022.

Patient experience

The CCG welcomes all comments and feedback about its role in commissioning services, and aims to provide a clear and simple way for people to understand the process for managing feedback that is fair and impartial, widely publicised, and accessible to all. Since February 2021, the CCG Patient Advice and Liaison Service and Complaints service (PALS) has been managed by South, Central and West Patient Advice and Complaints Teams (SCW PACT). All feedback received is valued and acted on, with all concerns and complaints viewed as a rich source of information.

When complaints or concerns are raised, we work proactively with providers to ensure that service improvements are implemented. The CCG report the trends and themes across the healthcare system within the Quality Assurance and Performance Committee. As the integrated care system develops and matures, this information will be used to inform priorities and a collaborative approach towards continuous healthcare improvement.

Responses to concerns and complaints have been administered in line with the Local Authority Social Services and National Health Service (England) Complaints Regulations 2009. The CCG, through the contracting arrangements with SCW PACT, ensures that any concern or complaint raised by an individual is dealt with compassionately, effectively and in a timely manner in line with the organisational policy.

In 2021/22, SCW PACT received a total of 168 formal complaints, compared to 79 for the previous year, which is an increase of 113 per cent. Service users have a choice as to who they can provide both positive and negative feedback to, such as the provider organisation, the CCG or NHS England and NHS Improvement.

Complaints or concerns raised with SCW PACT regarding commissioned providers are generally signposted to these organisations. During 2021/22 of the 168 formal complaints received, 47 related to either commissioning or CCG-provided services. The services with the highest number of complaints were:

- Continuing Healthcare (28)
- Prescription Ordering Direct (7)

Most complaints relating to Continuing Healthcare involved communication, while long telephone waiting times was the main theme of those that related to the Prescription Ordering Direct service.

In 2021/22, SCW PACT received 2,067 PALS enquiries, compared with 1,420 received in 2020/21, which was an increase of 46 per cent. The service with the highest number of PALS enquiries was public health, which accounted for 52 per cent (1,085) of all enquires.

In addition to using complaints and comments to support its role in commissioning services, the CCG receives compliments and positive feedback that help to demonstrate where things have gone well. In 2021/2022, SCW PACT received 44 compliments, with public health receiving the most with 17.

The CCG is committed to responding to patient needs and encouraging a culture that seeks and uses people's experiences of care to improve the commissioning of services. The CCG policy and contact details for submitting feedback can be found on the CCG website.

The CCG also has a role in making sure people who wish to submit a complaint regarding a provider are aware of the relevant process. Details of advocacy services can also be found on the CCG website.

Quality improvement

Improving the quality of healthcare provided to local people is at the heart of the CCG's work. We continuously strive to improve the quality of services, enhance patient experience and deliver safe care through collaborative working. The CCG has supported several quality improvement initiatives across different clinical pathways during the year, with each initiative aligned to both national and local priorities. Some examples of these workstreams are:

- Improving learning disability and severe mental illness annual health checks
- Covid-19 vaccination
- Oximetry @Home

During the last year, the CCG launched the BSW Academy, which aims to support continuous quality improvement. The BSW Academy is built around five key pillars, one of which is improvement. This pillar will not only serve as a multi-agency centre of excellence, but will also ensure improvements are developed over time, with the overall ambition being to make continuous quality improvement the golden thread that runs through all services. To deliver this ambition, a BSW Improvement Community of Practice has been established with system-wide membership to take forward the relevant priorities. Further information about the BSW Academy, as well as its role in improvement work, can be found on the BSW Academy website.

Safeguarding children, young people, children looked after, and adults at risk of abuse and neglect

Safeguarding remains at the heart of our commissioning. As a commissioner of significant aspects of healthcare, the CCG is compliant with the Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2019. The CCG ensures that organisations commissioned to provide healthcare services have systems in place that safeguard children, children looked after, young people, and adults at risk in line with section 11 of the Children Act 2004 and Care Act 2014. This includes making sure policies and procedures are clear and accessible, recruitment is safe, training is available and governance systems are monitored by the designated safeguarding professionals and the named GPs for safeguarding.

This coming year will see further changes in the landscape of safeguarding, following the introduction of integrated care systems. The CCG will continue to meet its safeguarding statutory responsibilities, which are firmly embedded in the transformation agenda.

New responsibilities are being prepared in line with the new Mental Capacity (Amendment) Act 2019. The CCG, through its provision of Continuing Healthcare, will become a responsible body for the liberty protection safeguards. As a commissioner and statutory partner, the CCG will work with local authority colleagues, as well as other health partners, to ensure local safeguards are effective for the BSW population.

Safeguarding is most effective when delivered through strategic and organisational multi-agency arrangements, with key partners working collaboratively to achieve a shared vision. The CCG is committed to partnership working and is a statutory member of safeguarding partnerships in the three localities.

Our key safeguarding partnerships within BSW are:

- Bath and North East Somerset: Bath and North East Somerset Community Safety and Safeguarding partnership (BCSSP).
- Swindon: Swindon Safeguarding Partnership (SSP).

- Wiltshire: Safeguarding Vulnerable Peoples Partnership (SVPP) partnership subgroups and working groups.

As an Integrated Care Board (ICB), we will continue to learn and develop our practice, and embed our belief thar everyone has a right to a safe and healthy life in everything we do. As an organisation with a vital role to play in protecting vulnerable people, we are committed to responding quickly and flexibly to new demands as they arise.`

Special educational needs and disability (SEND)
Improving special educational needs and disabilities (SEND) provision remains a priority for the CCG. Significant steps forward have been taken in improving multi-agency working across all localities to ensure that children and young people with SEND have responsive health services to help support diagnosis and assessment, as well as delivering interventions. The CCG is committed to working with colleagues in education and social care to jointly plan and commission services that will support children and young people with SEND to achieve the best possible outcomes and to have their views and experiences heard. Engagement events have taken place with families to truly incorporate the views of service users as new pathways and services are developed. A recent visit from OFSTED and the Care Quality Commission (CQC) to Swindon illustrated that significant improvements have been made in services for SEND.

Together with partners, the CCG is reviewing the recommendations of the recently published national SEND Review paper, Right Support, Right Place, Right Time, with an aim of further improving system processes that offer children and young people with SEND the opportunity to thrive, fulfil their potential, and lead happy, healthy and productive adult lives.

Engaging people and communities

Covid-19
Throughout the pandemic, as well as during the subsequent rollout of the Covid-19 vaccine, the CCG worked with system partners to ensure that everyone living in Bath and North East Somerset, Swindon and Wiltshire, regardless of their faith, cultural background, location, age or ability, had equal access to coronavirus-related care, support and services.

The CCG established an extensive programme of public engagement to help ensure that every person within the local area who wanted to have the vaccine could have it, along with access to the relevant information to help make an informed decision.

The Opening Doors event, which was held virtually in March 2021, kickstarted a period of more than 12 months of in-person and digital engagement relating to the rollout of the Covid-19 vaccine, with this initial event providing an opportunity for people from Black, Asian and minority ethnic communities to ask questions and receive reliable information from a panel of local health and care experts.

The event proved to be a great success, with more than forty attendees putting a diverse array of questions to the panel, which was made up of local clinicians, CCG officials and a director of public health.

A recording of the event has since been made available to view online, which has allowed people unable to take part in the live event to still get involved in the conversation.

A similar online session was held later in the year, which was aimed specifically at pregnant women and new mothers, as local data had shown vaccine uptake among those who were planning to start a family or had given birth to be low.

More than 30 people took part, with the event also being streamed live on Facebook. Some of the region's top maternity experts were on hand to provide facts and reassurance around the Covid-19 vaccine, as well as to answer questions from those who had tuned in.

Although national Covid-19 restrictions, which were in place for much of 2021/22, put a limit on in-person engagement activity, the CCG still, wherever possible, attempted to get out and about to talk with local people.

Drop-in information events for members of the local boating community were held ahead of a series of vaccination sessions that took place on a specially chartered narrowboat, which had been converted into a floating vaccination clinic.

The boat visited many locations along the region's canals and rivers, with the clinics well

attended by people who had previously spoken with the public health teams at the information sessions.

At the same time, the purchase of a dedicated vaccination bus by the CCG enabled a team of mobile vaccinators to visit a wide range of community locations across the region, including high streets, shopping centres, universities, colleges and even the sites of large employers.

Representatives from the CCG's communications and engagement team attended many of the events to not only chat with members of the public, provide information and to gauge feedback, but to also document the vaccination clinics for additional promotion through social media.

During the winter months, when the colder weather prevented the use of the vaccination bus, the CCG opted to hold pop-up vaccination clinics in existing community locations, often in areas that had been highlighted as having low rates of vaccine uptake.

A diverse range of venues, including pubs, places of worship and football stadiums, were used during the first few months of 2022, with each of the sites attracting strong attendance from people living nearby, as well as others from further afield who had chosen to attend due to the locations not having the traditional look and feel of a clinical setting.

All the pop-up clinics were promoted extensively by the CCG, and received additional support from key local partners, including local authorities, charity organisations and community groups.

In March 2022, a total of 36 pop-up clinics were held at more than 20 different locations across the region, with more than 1,000 people coming forward for either their first or second dose, or their booster jab.

Our Health Our Future Panel

The CCG's online citizens' panel is made up of a representative sample of the population from across our region. The panel engages with those living in BSW to get their views on health and care issues. Panel members take part in regular surveys throughout the year, as well as form focus groups from time to time.

Three surveys were carried out during 2021/22, and covered the following areas:

- Keeping well and the coronavirus vaccination
- Remote consultations and remote monitoring technology
- Patient initiated follow-up and mental health services
- Urgent, emergency and primary care
- Shaping a healthier future for BSW
- Long covid

- Digital NHS
- Our Health Our Future panel feedback

Insights gathered from these surveys have been used by the CCG's commissioning teams, as well as operational and engagement leads in the acute trusts, to improve a range of related services and have informed the urgent care strategy and health and care model for the Integrated Care System.

Full results from each of our surveys are available on the CCG website.

Shaping a Healthier Future
In early 2020, the Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership published priorities for the delivery of health and care services across the region. These priorities were the results of discussions with health and care staff and local residents, and were developed into a model that outlined the collective vision for the way forward. Shortly after publication, resources had to be focused on dealing with the pandemic.

In October 2021, the BSW Partnership was able to return to those plans in the light of learnings from the pandemic, and wanted to test with the local population whether the health and care model was still the right one or whether changes needed to be made.

The health and care model has been revised to reflect the feedback from the public surveys held throughout November and December 2021. During this time, a public survey, as well as a series of webinars, workshops, interviews and presentations with health and care staff, users of services and the voluntary, community and social enterprise (VCSE) sector, were held. In addition, two virtual webinars were held that were open to all.

These events were publicised through social media, local networks, community newsletters and presentations to key staff groups and other local organisations. Communities who had experienced health inequalities were engaged with in a very targeted way. Case studies were used to highlight examples of the new ways of working

within the health and care model.

This feedback directly influenced proposed recommendations in the new revision of the health and care model including:

- Digital inclusion and exclusion
- Mental health provision
- Workforce, recruitment, and access to services
- Finance models
- Vulnerable clients and their access to mainstream services
- Role of the voluntary, community and social enterprise sector
- Role of unpaid carers, volunteers, universities, schools, and public health

The completed findings and recommendations are now available to view online:

- Shaping a Healthier Future (full report)
- Shaping a Healthier Future (summary report)
- Shaping a Healthier Future (infographic)

Public engagement forums
Two informal sounding boards were set up during 2021/22 to bring together people's views to help have a better understanding of the people and communities served by the CCG, with a particular focus on health inequalities and seldom-heard communities. The groups met two times during spring 2022, and brought their diverse range of perspectives to contribute to the development of the Integrated Care Board's People and Communities Engagement Strategy.

Elsewhere, the CCG's public engagement forums – Your Health Your Future in Bath and North East Somerset and the Swindon Patient and Public Engagement Group – continued to meet quarterly. The meetings were chaired by the CCG's lay member Julian Kirby and were regularly attended by the locality leadership team to update on local activity, seek feedback on plans and respond to the membership's questions.

Development of the BSW CCG engagement toolkit
In September 2021, the CCG launched an engagement toolkit to support commissioners to plan, implement and evaluate engagement activity. The toolkit provided a checklist of what to consider in terms of engagement activity when planning any kind of service change or transformation project. The toolkit will be reviewed with engagement leads across BSW to develop a version that is relevant for all partner organisations.

The CCG would like to take this opportunity to thank everyone who has given their time to contribute to its engagement activity over the past year, including members of its public engagement groups and individuals with lived experience who have shared their insight and aspirations for health services with transformation teams and Citizens Panel members.

People and Communities Strategy Sounding Boards
An informal sounding board to shape and design the People and Communities' Strategy was introduced during the year and brought together people's views to help the organisation develop a better understanding of the people and communities it serves, with a particular focus on health inequalities and seldom heard communities.

Reducing health inequality
During 2021/2, the CCG has redoubled its efforts with regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved as outlined in the Health and Social Care Act 2012.

A BSW Inequalities Strategy has been produced to provide a framework for system activity to reduce health inequalities. This brings together guidance on healthcare inequalities, as well as the work needed at place to address wider determinants of health. At the core of the BSW Inequalities Strategy is using the Core20PLUS5 approach to ensure target populations reflect those suffering the greatest inequalities in health.

Alongside the 20 per cent most deprived population, the BSW PLUS populations are being defined at a place level for Bath and North East Somerset, Swindon, and Wiltshire separately. This decision was taken to capture the unique populations of each locality and ensure health inequalities aren't exacerbated by reflecting an average of a much larger group. Each PLUS population chosen will be refined further as the refreshed local Joint Strategic Needs Assessments (JSNA) are published in coming weeks.

At present, PLUS populations are outlined as follows:

- Bath and North East Somerset: Socially excluded groups, migrants, vulnerable children and rural communities
- Swindon: BAME populations
- Wiltshire: Routine and manual workers, specifically those in minority groups, such as Polish speakers

The strategy will be implemented in three phases:

- Awareness raising
- Healthcare inequality and Core20+5
- Prevention and social, economic, and environmental factors.

Outcomes from this work are aligned to the five NHS priorities.

The forward plan for the strategy is outlined below:

The following actions are being taken forward to support the Health Inequalities Strategy and the associated actions across the BSW system:

- SRO for health inequalities defined and made co-chair of population health and prevention working group
- Programme manager in place to drive strategy and implementation plan development
- Ongoing regular meeting of ICS-level strategy development group (soon to evolve into strategy implementation group) with key organisations represented, including representation from NHS England and the Office for Health Improvement and Disparities (OHID)
- Thematic leads for each priority of the strategy, including Core20Plus5, have been identified
- Positive use of population health fellows to look at tackling inequality
- Driving system ambition at place by working at ICA level to embed strategy at system, place, and neighbourhood
- Driving forward of the anchor institution charter in three acute hospitals and mental health trust
- Driving forward whole system obesity agenda at place, and building on system level work to tackle obesity
- Agreement to drive forward Making Every Contact Count (MECC) at system and place level
- Successfully distribution funds to a range of organisations to tackle inequalities
- Strategy to be signed off by ICB in the summer, which is currently being promoted via ICA shadow boards
- Implementation plan for awareness raising has been drafted and is currently being consulted on with key partners, with the following ambitions for the forthcoming year:
    - BSW inequalities workshops will be delivered to inform and support colleagues and partners with their work on health inequalities
    - Health inequalities e-modules will be available for all staff and BSW partners to access as part of the BSW Academy
    - Collate resources to support ICS, ICA, PCNs, as well as provider health inequalities SROs, to access training and wider support offer, including utilising the Health Inequalities Leadership Framework, which has been developed by the NHS Confederation
    - Multimedia content will be commissioned to increase understanding of what it is like to live with multiple inequalities
    - An inequalities communication plan will be established to effectively map stakeholders and to ensure inequalities are truly embedded in thinking across BSW
    - Inequalities will be represented across the system at planning groups and networks, and will be coordinated through the BSW Inequalities Strategy Group

    - This group will collate action plans from relevant leads to clarify how inequalities are being addressed throughout the system
- Implementation plans for phase two (tackling health care inequality) and three (tackling the wider determinants) of the strategy are currently being drafted.

The CCG will use the BSW Inequalities Strategy group to regularly review progress against these ambitions, alongside local and national data, such as that from the Health Inequalities Improvement Dashboard.

Core framework that formed this strategy:

- NHS Health Inequalities Improvement Programme Policy Drivers
- NHS Long Term Plan – Chapter two
- Covid Pandemic Phase three Letter – Eight Urgent Actions
- NHSE/I 21/22 Operational/Implementation Planning Guidance – five Key Priorities
- NHS England » 2022/23 priorities and operational planning guidance
- Health Equity in England: The Marmot Review 10 Years On - The Health Foundation
- NHS Race and Health Observatory: Supporting named leads for health inequalities on NHS boards
- Building healthier communities: the role of the NHS as an anchor institution - The Health Foundation

Health and wellbeing strategy
Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which leaders from the local health and care system could work together to improve the health and wellbeing of their local population.

During 2021/22, health and care organisations across Bath and North East Somerset, Swindon and Wiltshire focused on working together as required in response to the pandemic. Work also continued in supporting key commitments, as set out by existing strategies. Specific work to refresh and develop existing health and wellbeing strategies with local authorities is under way, considering transition to working as an integrated care system (ICS) and revisiting the operation of the Health and Wellbeing Boards in the context of the ICS and Integrated Care Alliances.

In Bath and North East Somerset this includes a development programme supported by the Local Government Association which focuses on the vision, strategy and compelling narrative for health and wellbeing, and the role and purpose of the health and wellbeing boards in the context of the new integrated health and care landscape - how the health and wellbeing board operates to ensure it maximises its potential and the contribution of all partners.

In Swindon, work has taken place with the Health and Wellbeing Board during 2021/22 to develop the vision and priorities for the Integrated Care Alliance (ICA) and to understand the relationship between the health and wellbeing board and the ICA. Alongside these

strategic changes, the Joint Strategic Needs Assessment (JSNA) is currently being refreshed and work is planned with the Health and Wellbeing Board to respond to its emerging trends, drawing together the emerging health inequalities strategy, the health and care model and ICA priorities.

In Wiltshire, there have been a number of development sessions and workshops focused on integrated services, reducing health care inequalities, and focussing on prevention. The Board continues to develop its strategy and support for this work, including understanding where there may be opportunity for progress to be made through the ICA and its work programme.

System partners will be working on a new health and wellbeing strategy for BSW later this year aligned with local authority strategies that also includes an update of the JSNA.

Financial review

CCGs have a number of financial duties under the NHS Act 2006 (as amended). Note 24 of the financial statements refers to the financial performance of the CCG in relation to its statutory duties.

The CCG has met all of its statutory financial duties in 2020/21, and its financial control total as set by NHS England.

The CCG has:

- Achieved operational financial balance by delivering a surplus of £43,000
- Achieved its cash target
- Kept its administration costs below its running cost targets

Although the CCG has delivered its statutory financial duties in 2020/21, there will be significant financial challenges over the coming years as the additional funding provided to health systems connected with pandemic measures is withdrawn.

For 2021/22, the CCG expects to see a 43 per cent reduction in Covid-19 funding, as well as further reductions in funding associated with changes to the hospital discharge funding guidance.

The CCG will be working with its stakeholders to manage this reduction as part of its operational planning for 2022/23, while still maintaining the quality and safety of services.

ACCOUNTABILITY REPORT

This section explains the composition and organisation of the CCG's governance structures and how they have supported the delivery of the CCG's objectives.

Sue Harriman

Accountable Officer

16 June 2022

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.
- The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

The purpose of this report is to explain the composition and organisation of the CCG's governance structures, and how they support the achievement of objectives.

Members report
Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group resulted from the formal merger in April 2020 of the three standalone clinical commissioning groups of Bath and North East Somerset (BaNES), Swindon and Wiltshire.

The CCG's constitution outlines how it will deliver its statutory duties, who its members are and how decisions will be made. The CCG's Governance Handbook further explains how the organisation works, and includes the terms of reference of the non-statutory committees of the Governing Body. The CCG's constitution, Governance Handbook, and other key corporate documents can be found on the CCG website.

Member profiles
The CCG is a clinically led statutory NHS body. It is responsible for the planning and commissioning of healthcare services for people living in the areas covered by Bath and North East Somerset Council, Swindon Borough Council and Wiltshire Council. The CCG is a general practice membership organisation. All practices who provide primary medical services to a registered list of patients in the area are eligible for membership of the CCG, and the organisation is accountable to them.

Profiles of the Governing Body members can be found on the CCG website.

Member practices

In 2021/22, the 89 GP member practices worked with local services as 25 primary care networks (PCNs) across Bath and North East Somerset, Swindon and Wiltshire. In its simplest terms, a PCN is a group of GP practices working together across a defined area with a population of between 30,000 and 50,000 people. The complete list of member practices, the PCNs which they belong to and the PCN Directors can be found on the CCG website.

The CCG's membership is represented in the Governing Body by GPs who practice in the localities and who are elected by the membership.

Composition of Governing Body

The Governing Body is in place to ensure the CCG has the appropriate arrangements to discharge its functions effectively, efficiently and economically.

An ongoing role of the Governing Body is to review the CCG's governance arrangements and ensure principles of good governance are adhered to.

Each member of the Governing Body has a responsibility to ensure the CCG performs its duties in accordance with the terms of the constitution, with each member bringing a unique perspective that is informed by their individual expertise and experience.

The membership of the CCG Governing Body between 1 April 2021 and 31 March 2022 was as follows:

Position on the Governing Body		Name
Statutory members	Chair	Dr Andrew Girdher
	Chief Executive Officer	Tracey Cox
	Chief Finance Officer	Caroline Gregory
	Secondary Care Specialist	Dr Paul Kennedy
	Registered Nurse	Maggie Arnold
	Lay Member Audit and Governance (until 30 September 2021)	Peter Lucas
	Lay Member Patient and Public Engagement (PPE)	Julian Kirby
Additional members	Lay Member Finance (until 30 September 2021) Lay Member Audit and Governance (from 1 October 2021)	Ian James

	Lay Member Primary Care Commissioning (PCC)	Suzannah Power
	Locality Clinical Lead for Bath and North East Somerset	Dr Bryn Bird
	Locality Clinical Lead for Swindon	Dr Amanda Webb
	Locality Clinical Lead for Wiltshire	Dr Edward Rendell
	Locality Healthcare Professional for Bath and North East Somerset (until 31 July 2021)	Dr Timothy Sephton
	Locality Healthcare Professional for Swindon	Dr Francis Campbell
	Locality Healthcare Professional for Wiltshire	Dr Catrinel Wright
	Locality Healthcare Professional for Wiltshire	Dr Sam Dominey
	Locality Healthcare Professional for Wiltshire	Dr Nick Ware
	CCG Director of Nursing and Quality	Gill May
	CCG Director of Strategy and Transformation	Richard Smale
	CCG Medical Director	Dr Ruth Grabham

Committees, including Audit Committee

The Governing Body is supported in its work by the statutory Audit Committee, Remuneration Committee and Primary Care Commissioning Committee.

The terms of reference for these statutory committees are included the CCG's Constitution, which is available to view online.

The members of the Audit Committee throughout 2021/22 were as follows:

Lay Member Audit and Governance (Chair) (until 30 September 2021)	Peter Lucas
Lay Member Audit and Governance (Chair) (from 1 October 2021)	Ian James
Lay Member PCC	Suzannah Power
Lay Member PPE	Julian Kirby
Registered Nurse	Maggie Arnold
Locality Healthcare Professional (Wiltshire)	Dr Catrinel Wright

There is more information about the governance arrangements, including details and membership of all other Governing Body committees, in the Governance Statement below. The Remuneration Report includes details of the membership of the Remuneration Committee.

Register of Interests

We recognise that effective handling of conflicts of interest is crucial to ensuring that patients, tax payers, healthcare providers and Parliament are confident that our commissioning decisions are robust, fair, transparent and offer value for money. In managing conflicts of interest, we follow Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), which sets out the minimum requirements of what must been done in terms of managing conflicts of interest, and the NHS England statutory guidance Managing conflicts of interest (2017).

The CCG's Standards of Business Conduct Policy complies with national guidance and sets out our expectations regarding standards of business conduct for the CCG, including the management of conflicts of interest. The policy ensures that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation. The policy also provides guidance to all member practices, staff and Governing Body members on the receipt of gifts and hospitality.

The CCG regularly reviews and publishes a register of our Governing Body members' interests on its website.

Personal data related incidents

During 2021/22, there were 31 identified breaches of data security. Twelve of which have been attributed to acts or omissions of CCG colleagues. The remaining incidents were caused by other organisations. On 14 occasions, CCG colleagues inadvertently or accidentally shared information with an incorrect recipient. All breaches were dealt with internally and, where appropriate, CCG colleagues were directed to guidance and training materials. There were no breaches of a level requiring reporting to the Information Commissioner's Office (ICO). The ICO contacted the CCG regarding two complaints during the year. Following our investigation and response, the ICO confirmed that no further actions were needed. The CCG has not had any data security incidents deemed to be Serious Untoward Incidents during 2021/22

Statement of Disclosure to Auditors

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

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

Relevant audit information means information needed by the CCG's auditor about preparing this report.

Modern Slavery Act

BSW CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on the CCG website.

Statement of Chief Executive's responsibilities as Accountable Officer

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive Officer to be the Accountable Officer of BSW 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 BSW CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

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

Governance Statement

Introduction and context
BSW CCG is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

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

The clinical commissioning group is not subject to any section 30 directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006, and has delivered a breakeven position.

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

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

Governance arrangements and effectiveness
The Members Report above summarises the composition and membership of the Governing Body from 1 April 2021 to 31 March 2022.

The main function of the Governing Body is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with generally accepted principles of good governance.

The constitution sets out the governance and decision-making arrangements of the CCG.

The Governing Body ensures the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically, in accordance with the principles of good governance. The Governing Body has been actively involved in Integrated Care Board transition oversight.

Reporting to the Governing Body, the following committees enable it to discharge its responsibilities, and to oversee and manage the CCG's performance, quality and risk effectively:

Statutory committees (terms of reference are part of, and published in, the CCG's Constitution):

- Audit Committee (see the Members' Report for the committee's membership)
- Remuneration Committee (see the Remuneration Report for details of the membership of the committee)
- Primary Care Commissioning Committee

Non-statutory committees

- Finance Committee
- Quality and Performance Assurance Committee (QPAC)
- At Scale Commissioning Committee (from June 2021)
- Local Commissioning Group Bath and North East Somerset, Local Commissioning Group Swindon, Local Commissioning Group Wiltshire

The Governing Body has worked diligently to carry out its responsibilities as a statutory body. The agenda and papers for public meetings are available on the CCG's website in advance and act as a public record of the decisions taken and performance to date.

The Governing Body understands its responsibility to listen to and engage with its stakeholders, as well as actively seek their opinion.

Audit Committee

The Audit Committee supports the CCG's Governing Body and Accountable Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report. The Audit Committee is accountable to the Governing Body and provides an independent and objective view of the CCG's compliance with its statutory responsibilities. Its terms of reference are included in the CCG's Constitution.

In summary, the Audit Committee is responsible for:

- Reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities

- Ensuring there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017, and provides appropriate independent assurance to the committee, the CCG's Accountable Officer and the CCG's Governing Body
- Reviewing and monitoring the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work
- Reviewing the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation
- Ensuring the CCG has adequate arrangements in place for countering fraud, and reviewing the outcomes of work in this area
- Monitoring the integrity of the financial statements of the organisation
- Reviewing the effectiveness of the arrangements in place for allowing staff to raise concerns in confidence about possible improprieties in financial, clinical or safety matters, as well as ensuring that any such concerns are investigated proportionately and independently

The Audit Committee regularly reviews the CCG's Freedom to Speak Up policy, which is published on the intranet. The Chair of the Audit Committee and the Governing Body's Registered Nurse are the CCG's Freedom to Speak Up Guardians. Their profiles, along with details of how they can be contacted in confidence, are also published on the intranet.

The committee met eight times during the year. Highlights of work undertaken during the year have included a range of internal audit reviews covering such areas as, Continuing Healthcare, conflicts of interest, clinical and professional engagement, data security and protection toolkit and integrated care system development. The committee has also received a series of reports on review of counter fraud and security management and updates from the external auditors.

Remuneration Committee

The Remuneration Committee supports the CCG's Governing Body and Accountable Officer by making recommendations regarding remuneration, fees and other allowances, including pension schemes, for employees and other individuals who provide services to the CCG. Its terms of reference are included in the CCG's Constitution.

The Remuneration Committee met twice during the year.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee (PCCC) was established in accordance with the statutory requirements that came with the delegation of primary care commissioning functions. It enables committee members to make collective decisions on the review, planning and procurement of primary care services in Bath and North

East Somerset, Swindon and Wiltshire under delegated responsibility from NHS England, reporting to the Governing Body and to NHS England. The PCCC oversees the work of the Primary Care Operational Groups (PCOGs) and the primary care work plans as established by the CCG as part of the Five Year Forward View and the General Practice Forward View Plan. The committee's terms of reference are included in the CCG's Constitution.

During the year, the PCCC held six meetings in public. The PCCC considered BSW's continued primary care response to Covid-19, primary care quality and finance reports, the primary care risk register, medicines optimisation and prescribing and primary care network development.

Finance Committee

The Finance Committee sets the strategic direction for finance for the CCG and monitors the delivery of the financial strategy across the organisation. The committee's terms of reference are published in the CCG's Governance Handbook. In summary, the committee monitors the CCG's financial performance, supports the Governing Body in ensuring financial management achieves value for money, efficiency and effectiveness in the use of resources, provides assurance that the productivity plan is effectively managed and outcomes are being delivered, reviews financial risks and sets the framework for the CCG's conduct of procurement, management of estates, IT and information governance and receives assurance of its implementation.

The Finance Committee met 10 times during the year and considered the CCG's Covid-19 spend and financial position, financial performance and position reports including financial risk, financial plans including recovery and transformation, system sustainability and prioritisation process for investments and the Information Governance Framework.

Quality Performance and Assurance Committee

The Quality Performance and Assurance Committee (QPAC) is responsible for providing assurance to the Governing Body regarding the quality and clinical effectiveness of commissioned services, the performance of commissioned services against constitutional standards, compliance with statutory obligations with regards to safeguarding and patient and public involvement in commissioning decisions. The QPAC promotes a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. The committee's terms of reference are published in the CCG's Governance Handbook.

The QPAC met 11 times during the year and considered CCG's Equality and Diversity Strategy, the Public Sector Equality Duty Report, performance and quality reports including safeguarding, the continued response to Covid-19, annual reports on areas including learning disability mortality review, infection prevention and control and safeguarding and CCG clinical policies.

At Scale Commissioning Committee
From June 2021, the Governing Body established the At Scale Commissioning Committee (ASCC). The committee's terms of reference are published in the CCG's Governance Handbook.

The committee oversees procurements for services that are commissioned strategically and do not fall within the remits of the CCG's Locality Commissioning Groups. It considers commissioning proposals that impact both place and at scale, and for which funding from sources other than the Better Care Funds may be required.

The At Scale Commissioning Committee met seven times during the year and considered several place-based proposals, including the Bath and North East Somerset community-based consultant-led skin surgery service and Wiltshire community cardiology, and at scale proposals for the BSW footprint, including the high intensity user service, community ophthalmology service and the hospital ambulance liaison officer.

Locality Commissioning Groups
The Governing Body has established three Locality Commissioning Groups which met in common with groups established by the three local authorities within BSW that have similar remits. The committee's terms of reference are published in the CCG's Governance Handbook.

In summary, the groups have responsibility for commissioning activities in the Bath and North East Somerset, Swindon and Wiltshire localities, including collaborative and joint commissioning arrangements, as permitted with the local authorities. For the avoidance of doubt, primary care commissioning is not included within this remit and remains the responsibility of the Primary Care Commissioning Committee.

The committees regularly considered performance and quality reports regarding commissioned services and pooled budgets including the Better Care Fund.

As set out in the CCG's Constitution, the Governing Body has statutory responsibility for ensuring the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically, as well as for determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG, and the allowances payable under any pension scheme established.

The membership has further delegated to the Governing Body responsibilities for:

- Leading the development of vision and strategy for the CCG
- Overseeing and monitoring quality improvement
- Approving the CCG's commissioning plans and its consultation arrangements

- Approving the CCG's Annual Reports and Accounts
- Stimulating innovation and modernisation
- Overseeing and monitoring performance
- Overseeing risk assessment and securing assurance actions to mitigate identified strategic risk
- Promoting a culture of strong engagement with patients, their carers, members of the public and other stakeholders about the activity and progress of the CCG
- Ensuring good governance and leading a culture of good governance throughout the CCG.

The CCG's Scheme of Reservations and Delegations (SoRD) sets out in detail all delegated functions and responsibilities.

The Governing Body met regularly throughout the year to discharge its respective functions. The focus of the majority of meetings was on BSW system working, the CCG's response to the Covid-19 pandemic and the delivery of the vaccination programme, as well as supporting the transition to becoming a statutory integrated care system.

Total number of meetings in 2021/22:	ORANGE = regular attendee, not voting member	7	8	2	6	11	7	10	5	7	10
Position on the Governing Body	**Name**	Governing Body	Audit Committee	Remuneration Committee	PCCC	QPAC	ASCC	Finance Committee	LCG BaNES	LCG Swindon	LCG Wiltshire
Chair	Dr Andrew Girdher	4					4	3			
Accountable Officer	Tracey Cox	7	6		3			10			
Chief Finance Officer	Caroline Gregory	5	8		5		7	10			10
Secondary Care Specialist	Dr Paul Kennedy	7		2							
Registered Nurse	Maggie Arnold	7	6	2	6	10	7				
Lay Member Audit and Governance *(resigned 30 September 2021)*	Peter Lucas	1	5								
Lay Member Patient and Public Engagement (PPE)	Julian Kirby	7	3	2	6	11	6	5			
Additional members											
Lay Member Finance *(became Lay Member Audit and Governance from 1 October 2021)*	Ian James	6	3		3			5			
Lay Member Primary Care Commissioning	Suzannah Power	6	7	2	6						
Locality Clinical Lead for BaNES	Dr Bryn Bird	5			3	10			5		
Locality Clinical Leads for Swindon	Dr Amanda Webb	6			1	7				5	
Locality Clinical Leads for Wiltshire	Dr Edward Rendell	6			4	8					4
Locality Healthcare Professional for BaNES *(resigned 30 July 21)*	Dr Timothy Sephton	2			2						

Total number of meetings in 2021/22:	ORANGE = regular attendee, not voting member	7	8	2	6	11	7	10	5	7	10
Position on the Governing Body	**Name**	Governing Body	Audit Committee	Remuneration Committee	PCCC	QPAC	ASCC	Finance Committee	LCG BaNES	LCG Swindon	LCG Wiltshire
Locality Healthcare Professional for Swindon	Dr Francis Campbell	7			5			8		3	
Locality Healthcare Professional for Wiltshire	Dr Catrinel Wright	4	6		5		3				
Locality Healthcare Professional for Wiltshire	Dr Sam Dominey	5			4						
Locality Healthcare Professional for Wiltshire	Dr Nick Ware	4			3		3				
CCG Director of Nursing and Quality	Gill May	5			4	8	6			6	
CCG Director of Strategy and Transformation	Richard Smale	6			4		7	7			
CCG Medical Director	Dr Ruth Grabham	6			4	7	5				

UK Corporate Governance Code

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

Discharge of Statutory Functions

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

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness

The CCG's Governing Body recognises that sound risk management within the CCG and its partner bodies is essential for meeting objectives and identifying and managing future opportunities. The Governing Body ensures that risk management forms a fundamental element of its philosophy, practices and business, rather than a separate programme, and is committed to ensuring that risk management is embedded throughout the organisation and is part of everyday practice.

We promote and embed a culture of transparency, openness and honesty to ensure that risks are properly identified, evaluated, documented and managed. This is underpinned by a robust framework that reflects the concepts of effective governance and strong internal control, aligned to management systems, corporate planning, clinician-led commissioning and strategy development.

The BSW Risk Management Strategy sets out the overall aims, objectives and processes for risk management across BSW and when working in conjunction with partners and stakeholders. It sets out the Risk Management Framework and how the CCG approaches the consideration of financial, organisational, reputational and project risks, both clinical and non-clinical and for all parts of the organisation. The roles and responsibilities of key individuals and committees including accountability levels with regard to risk management are also included. Risk identification, recording, assessment and scoring are also detailed within the strategy.

BSW's risk appetite is also defined within the strategy and is mapped out to show the level of risk the CCG will tolerate against the categories of risk faced across all business areas. The CCG will not accept levels of risk rated high (scored 16 or above on the risk matrix) and will ensure plans are put in place to lower the level of risk whenever a critical risk has been identified.

A CCG-wide risk management panel is in place to provide more effective oversight and scrutiny of risks across the area. Risk management is the responsibility of everyone within the organisation. The review and maintenance of an effective risk management system involves all staff and, as appropriate, key stakeholders, and is applied to all systems and processes, corporate and financial.

Capacity to handle risk

The CCG's Governing Body is responsible for the performance of the CCG and, as such, needs to be simultaneously entrepreneurial in driving the organisation forward while keeping it under prudent control. It needs to strike a balance between controls, assurance and strategy, risk-taking and delivery.

A risk management audit for the CCG was undertaken by KPMG in October 2021, with an overall assurance rating of significant assurance with minor improvement opportunities. The audit raised three low priority and one medium priority recommendations which relate to:

- Risk reporting enhancements (medium)
- Review of risks (low)
- Documentation of risks and actions (low)
- Updates of risks (low).

The Audit Committee of the CCG is responsible for commissioning internal audits to provide assurance to the Governing Body on the robustness and effectiveness of risk management within the CCG.

The BSW CCG Risk Management Panel was established to:

- Ensure the CCG has adequate arrangements in place for risk management
- Provide assurance on this to the Audit Committee and the Governing Body
- Take action to effectively manage and co-ordinate risk management activity
- Establish a strategic approach to risk management across the CCG and ensure the approach is pro-active.

The panel provides reports to the Audit Committee and Governing Body on assurances relating to the effective operation of risk management systems and controls within the CCG. In the event of a significant risk being identified, the risk will be reported to the BSW panel immediately. The core members of the panel include the Chief Executive Officer (Chair), the Director of Strategy and Transformation (Vice-Chair), the Chief Financial Officer, the Director of Nursing and Quality, the Director of Corporate Affairs, the Director of Commissioning and the Chief Operating Officers for the three localities within the CCG.

The BSW Chief Executive Officer is accountable to the Governing Body for the safe management of risk within the organisation. This responsibility is delegated to the Chief Financial Officer on a day-to-day basis.

The Chief Financial Officer has overall responsibility for the operational management of risk within the CCG.

Senior managers and project managers are empowered to manage the risks within their areas and to escalate risks appropriately. All staff members and contractors working for the CCG have a responsibility for following the approved risk management strategy and are required to report risks to their managers for assessment and subsequent risk scoring, using the approved risk matrix. If a risk is thought to be of corporate significance, the senior manager must apply for the risk to be entered onto the corporate risk register. If approved by the Risk Management Panel, the risk is then subject to the management and escalation processes of corporate risks as shown in the Risk Management Strategy.

The CCG is committed to maintaining a sound system of internal control, including risk management. By doing this, the organisation aims to ensure that it can maintain a safe

environment for patients, minimise financial loss to the organisation and demonstrate to the public that it is a safe, effective and efficient organisation.

Risk assessment

Risk assessment and management are an intrinsic part of the CCG's operation. The Corporate Risk Register is a live document, not a static record, and should be viewed as a communication tool and action plan that gives details of current controls and auditable actions for risk treatment. Actions should always be specific, measurable, achievable, relevant and timebound (SMART). It is a record that aims to illustrate the operational risk profile of the CCG by reflecting the extent to which operational objectives are threatened by the uncertainty that risk presents.

The Corporate Risk Register is subject to regular reviews by several committees including the:

- Governing Body
- Audit Committee
- Risk Management Panel

The Governing Body and the Audit Committee regularly consider whether the sources of assurance that it has for managing and mitigating risks remain effective and sufficiently robust. The CCG has developed a risk matrix which is used for all risks within the organisation.

The Risk Management Panel champions and promotes highly effective risk management and ensures the risk management process and cultures are embedded throughout the CCG. It seeks to satisfy itself, the Audit Committee and the Governing Body that the structures, processes and responsibilities for managing key risks to the organisation are adequate. The Risk Management Panel also monitors, evaluates and scrutinises all risks placed on the CCG's Corporate Risk Register, as well as escalates to the Audit Committee and Governing Body (as appropriate) any unresolved risks or those that pose a significant threat to the operations, resources or reputation of the CCG.

Each risk includes:

- Category of risk
- Description of the risk
- Date entered
- Existing controls and assurances
- Original risk score
- Target risk score
- Strategy to manage risk
- Proposed actions and delivery dates
- Progress

- Date of latest review
- Current risk score (likelihood and impact)
- Confirms who owns and manages the risk

The CCG has a Quality and Equality Impact Assessment (QEIA) process in place which provides the framework to ensure compliance with statutory obligations and to identify any risks to the organisation. Impacts are also assessed through the cover sheets for all reports that are presented to the Governing Body, as well as other committees, to ensure it is integral to planning and implementation. The CCG has an active framework for patient and public engagement and attends the Health and Wellbeing Boards. A network of patient participation groups and regular events seek the views of patients and the public.

The Board Assurance Framework (BAF) records the strategic risks affecting the CCG's strategic objectives. The BAF is a high-level management assessment process and records the strength of, as well as the gaps in, the internal control to manage the risk to the delivery of strategic objectives. By reviewing actual assurances, the adequacy of internal controls can be confirmed or modified.

The BAF allows the CCG to determine where to make the most efficient use of resources and to address identified issues to improve the quality and safety of care. It is the role of the Governing Body to focus on those risks and events which may compromise the achievement of strategic objectives and to support an organisational culture that allows the organisation to anticipate and respond appropriately to adverse events.

The BAF has a different format and lists the:

- Strategic objectives and outcomes that are at risk
- Description of the risk to delivery and risk score
- Controls in place to manage the risk, and any gaps in controls
- Assurance that our controls are working, and any gaps in assurance
- Actions to mitigate risk and fill gaps in controls and assurances
- Level of risk the Board is willing to tolerate for a specific risk.

All identified operational risks are recorded on the CCG's Corporate Risk Register. Where risks cannot be managed within the specific area of responsibility, these are escalated to the next level of governance to be managed appropriately.

The Corporate Risk Register and the BAF are reviewed bi-monthly by the Risk Management Panel, bi-monthly by the Audit Committee and bi-monthly by the Governing Body.

The CCG actively deters risks through the adoption of robust counter fraud and security management methodology. The CCG has a contract with counter fraud specialists TIAA

to provide counter fraud management and the CCG rated itself as green against the national standards for counter fraud and security management in 2021/22. The Audit Committee critically reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities, which supports the achievement of the organisation's objectives.

The highest scoring risks identified during 2020/21 related to:

- COVID-19
- System-wide pressures and seasonal planning
- Financial pressures across the health and social care system

The CCG Risk Management Panel scrutinised the Corporate Risk Register and the BAF at each of its meetings and informed the Audit Committee and the Governing Body on progress against mitigating actions.

Other sources of assurance

Internal Control Framework

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

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

The CCG's system of internal control has been in place for the year ended 31 March 2022, and up to the date of approval of the Annual Report and Accounts.

Annual audit of conflicts of interest management

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

Internal audit carried out an audit on managing conflicts of interest in January 2022, which was presented to the Audit Committee. The audit reviewed the design and operation of controls in place for managing conflicts of interest against NHS England's Best Practice Update on Conflicts of Interest (CoI) Management, issued in February 2019. Conflicts of interest were found on the whole to be managed in accordance with statutory guidance.

The report resulted in an overall rating of significant assurance with minor improvement opportunities. Recommendations were made to consider the implementation of an

automated system to improve the completeness and accuracy of declarations. This action has since been taken forward by the CCG.

Data quality
The Governing Body, in addition to its committees and sub-committees (working groups), receives information provided by the CCG business intelligence team that is sourced from national mandatory returns and NHS Digital information. This data is subject to data quality checks from providers prior to submission, from NHS Digital as part of the national collation process and from the CCG as part of its data management processes. Information is also sourced directly from local providers, and this is validated by the CCG business intelligence team, as well as against national information and guidance, wherever available.

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 a Data Security and Protection Toolkit (DSPT) 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 DSPT submission for 2021/22 demonstrated CCG compliance with the toolkit assertions giving a status of standards met. The CCG is not required to make the next submission against the toolkit until 30 June 2022.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient, CCG colleague and corporate information. We operate an information governance management framework in line with the DSP Toolkit which is reviewed on an annual basis. There is a suite of GDPR compliant information governance policies, and an information governance handbook provides further information to CCG colleagues ensuring that they are aware of their information governance roles and responsibilities.

The CCG has a trained Senior Information Risk Officer (SIRO), a trained Caldicott Guardian and a trained Data Protection Officer (DPO). The CCG also benefits from trained Information Asset Owners (IAO) and Information Asset Administrators (IAA) across the organisation, and all CCG colleagues are required to complete the national data security awareness training on an annual basis. The CCG actively promotes information governance through detailed intranet pages and briefings to CCG colleagues, and this has been particularly important during 2021/22, as colleagues have continued to work from home.

A reporting and investigation framework is utilised for information governance incidents and near misses, supported by information governance expertise provided by NHS

South Central and West Commissioning Support Unit. The CCG demonstrates a strong risk reporting culture.

CCG colleagues understand the importance of privacy by design, and have increased the number of data protection impact assessments (DPIA) undertaken during the year, often leading on these facilitating the legal sharing of information within the ICS to promote patient care.

Business-critical models
The CCG has in place an appropriate and proportionate approach to providing quality assurance of business-critical models. This is in line with the recommendations of the 2013 Macpherson Report.

Third party assurances
As a commissioning organisation, the CCG routinely contracts with third party providers to deliver healthcare services. These services are contracted using NHS standard contracts using national terms and conditions. The CCG places reliance on these contracts to make sure that services remain effective as well as on regular performance monitoring reports and meetings with providers.

The CCG also uses third party providers to deliver some of its back-office processes:

- It is nationally mandated for the CCG to use NHS Shared Business Services for the provision of back office financial services. These services are provided under a contract between NHS England and NHS Shared Business services. The CCG places reliance on NHS England to manage this contract and report back on any control issues identified.
- The CCG sub-contracts the provision of several of its corporate services to the South Central and West Commissioning Support Unit (CSU). The CCG reviews the performance of this service level agreement each month and, in addition, the Audit Committee reviews the findings from the Service Audit Report (SAR) which the CSU commissions from Deloitte to assess the reasonableness of the controls it has in place.
- The CCG has pooled budget arrangements with its three local authorities for the provision of healthcare services. These arrangements are formalised through Section 75 agreements and performance is reviewed in year by all partners.

Control issues

During 2021-22, the CCG formally reported one control issue to NHS England:

- The CCG's performance monitoring processes have identified and continue to report NHS constitution targets not met by providers. Reporting and monitoring processes are in place to track performance of providers against

constitutional targets. This is an ongoing process and regular meetings with providers have taken place and continue to take place to ensure that action plans are being implemented to improve performance.

Review of economy, efficiency and effectiveness of the use of resources
The CCG has met its financial target to break even in-year. Expenditure has been examined in detail by the Finance Committee on a monthly basis. This helped to identify potential financial issues and pressures at the earliest opportunity in order to enable remedies to be taken where necessary.

All spend is subject to the controls laid out in the CCG's Standing Financial Instructions. These controls have been put in place to ensure the CCG delivered value for money.

The CCG has continued to review its running costs to ensure its delivered value for money and has underspent against the allocation in year.

Delegation of functions
The CCG has not delegated any of its statutory functions.

The CCG has had a service level agreement in place with South, Central and West Commissioning Support Unit for the provision of a range of services, including procurement, provider performance management, health intelligence analytics, human resources, health and safety support, freedom of information requests, information governance, IT support, IT programmes and planning, data services management and GP information technology.

Counter fraud arrangements
The CCG has a contract in place with a third party for the provision of counter fraud services and security management services. The arrangements include:

- Accredited counter fraud specialist and security management specialist contracted to undertake counter fraud work and security management work proportionate to identified risks.
- The CCG Audit Committee receives a report against each of the standards for commissioners at least annually. There is executive support and direction for a proportionate proactive work plan to address identified risks.
- A member of the executive board is proactively and demonstrably responsible for tackling fraud, bribery and corruption.
- Appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations and progress is overseen by the Audit Committee.
- The CCG undertakes an annual assessment against its compliance with national standards for counter fraud. The CCG has scored itself as green which means it is compliant in most areas.

Proactive reviews of systems, processes and controls by both internal audit and the counter fraud specialist contribute to the identification of the risk of fraud. The counter fraud specialist and security management specialist have regularly attended the Audit Committee meetings.

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

Overall opinion
The overall opinion for the period 1 April 2021 to 31 March 2022 is that significant assurance with minor improvements can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary
The commentary below provides the context for this opinion and together with the opinion should be read in its entirety. The opinion covers the period 1 April 2021 to 31 March 2022 inclusive, and is based on the audits completed in this period.

The four reviews graded as partial assurance with improvements required were in respect to consistency of care packages, learning disabilities, safeguarding and clinical and professional engagement. All of these reviews are risk-based, and known areas of challenge for the CCG. As such, they do not impact on the overall opinion. Furthermore, the CCG has performed positively in the core areas of data quality, finance, risk management and governance.

Further to the above, the CCG has seen through its management action tracking that active steps to implement actions arising from internal audits have been taken.

The design and operation of the Assurance Framework and associated processes
The Assurance Framework reflects the CCG's key objectives and risks, and is regularly reviewed. The Executive reviews the Assurance Framework on a monthly basis and the Audit Committee provides reviews on whether the CCG's risk management procedures are operating effectively.

The range of individual opinions arising from risk-based audit assignments, contained within the risk-based plan that have been reported throughout the year:

Forty-three management actions were raised in 2021/22, of which four were high priority actions. Two actions were from the safeguarding review (clarity of safeguarding and contract reporting requirements and monitoring of safeguarding standards). Two further actions related to the consistency of care packages review. As at 31 March

2022, all of these four high priority actions have agreed action plans in place and agreed deadlines with the executive sponsor. All are on track for completion within 2022/23 and will be monitored through the recommendation tracking in 2022/23.

This does not prevent us from issuing significant assurance with minor improvements overall, as the organisation is implementing the management actions raised as a result of our work to address the issues identified. The status of management actions is reported by management to the Audit Committee. The organisation has directed us towards areas where there have been concerns in terms of operation or performance in year.

KPMG LLP
Chartered Accountants
London
31 March 2022

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

Area of Audit	Level of Assurance Given
Data Protection Security Toolkit	Significant assurance
Continuing Healthcare	Partial assurance with improvements required
GP IT Support	Not applicable – follow up review
Commissioning Governance	Not applicable – follow up review
Learning Disabilities Local Provision	Partial assurance with improvements required
Clinical and Professional Engagement	Partial assurance with improvements required
Use of HR Systems	Significant assurance with improvement opportunities
Risk Management and the Board Assurance Framework	Significant assurance with improvement opportunities
Safeguarding	Partial assurance with improvements required
Conflicts of Interest	Significant assurance with improvement opportunities
Integrated Care System Planning	Significant assurance with improvement opportunities
Delegated Commissioning	Significant assurance
Financial Systems	Significant assurance
Sustainability Discovery Session	Not applicable – advisory review

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

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

I have been advised on the implications of the result of this review by:

- The governing body
- The audit committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion
There was one significant control issue identified in-year, and this was raised with NHS England which related to the non-delivery of the CCG's constitutional targets.

Remuneration and staff report

This section sets out the CCG's remuneration policy for directors and senior managers and how it has been implemented.

Remuneration report

Remuneration Committee

The committee is accountable to the Governing Body and makes recommendations about the remuneration, fees and other allowances, including pension schemes, for employees and other individuals who provide services to the CCG. During 2021/22, its members were:

- Four lay members of the CCG's Governing Body: Suzannah Power, Julian Kirby, Ian James and Peter Lucas (until 30 September 2021)
- Secondary Care Specialist of the CCG's Governing Body: Dr Paul Kennedy
- Registered Nurse of the CCG's Governing Body: Maggie Arnold

Policy on the remuneration of senior managers

The CCG executives are employed with terms and conditions including duration, notice periods and termination payments in accordance with existing Agenda for Change and very senior manager (VSM) arrangements.

Remuneration is designed to fairly reward each individual based on their contribution to the CCG's success, and taking into account the need to recruit, retain and motivate skilled and experienced professionals. Remuneration must take into account considerations of equal pay, value for money in the use of public resources and the CCG's obligation to remain within its financial allocations.

Senior manager remuneration is set through a process that is based on a consistence framework and independent decision-making based on accurate assessments of the weight of roles and individual performance. This ensures a fair and transparent process through 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 director pay is set in accordance with the guidance Clinical Commissioning Groups: Remuneration Guidance for Chief Officers and Chief Finance Officers, existing VSM pay scales, terms and conditions apply.

Amendments to VSM and Governing Body members' salaries are reviewed annually by the Remuneration Committee, which makes recommendations to the Governing Body. Salaries exclude on-call payments. Executives and senior manager performance is monitored through the CCG's formal appraisal process, based on organisational and individual objectives.

When considering and setting the remuneration of appointed and elected members of the Governing Body, other than the CCG's executive directors, who are ex officio members of the Governing Body, the Remuneration Committee and the Governing Body take into account available guidance, and comparative data from other CCGs and NHS organisations. Elected members' remuneration takes into account individuals' salary in their general practitioner role, along with any loss of seniority pay due to the time commitment to the CCG.

The CCG's Constitution determines the composition of the CCG's Governing Body, the ways in which Governing Body members are appointed or elected, and terms of office.

Remuneration of very senior managers

The CCG has taken robust steps to ensure the remuneration of all very senior managers is reasonable and appropriate for the roles they are undertaking, as well as the conditions of the labour market.

Any salary above £150,000 has been approved, noted and endorsed by the CCG Remuneration Committee, and, wherever relevant, is in line with NHS England guidance.

Senior manager remuneration (including salary and pension entitlements) 2021/22 (AUDITED)

Name	Title	Note	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
			£'000s	£s	£'000s	£'000s	£'000s	£'000s
Ruth Grabham	Medical Director		150 - 155	-	-	-	25 - 27.5	180 - 185
Tracey Cox	Chief Executive Officer	4	140 - 155	-	-	-	30 - 32.5	170 - 175
Caroline Gregory	Chief Finance Officer		115 - 120	-	-	-	-	115 - 120
Gillian May	Director of Nursing & Quality		120 - 125	100	-	-	10 - 12.5	130 - 135
Richard Smale	Director of Strategy & Transformation		105 - 110	-	-	-	-	105 - 110
Julie-Anne Wales	Director of Corporate Affairs		110 - 115	-	-	-	222.5 - 225	330 - 335
Corinne Edwards	Chief Operating Officer, BaNES Locality		115 - 120	-	-	-	25 - 27.5	140 - 145
David Freeman	Chief Operating Officer, Swindon Locality		120 - 125	-	-	-	27.5 - 30	145 - 150
Elizabeth Disney	Chief Operating Officer, Wiltshire Locality		115 - 120	-	-	-	70 - 72.5	185 - 190
Sheridan Flavin	Interim Executive Director for People & OD		70 - 75	-	-	-	17.5 - 20	90 - 95
Alison Kingscott	Interim Executive Director for People & OD		65 - 70	-	-	-	12.5 - 15	80 - 85
Andrew Girdher	Clinical Chair		95 - 100	-	-	-	20 - 22.5	120 - 125
Brynn Bird	Locality Clinical Lead (BaNES)		70 - 75	-	-	-	15 - 17.5	90 - 95
Amanda Webb	Locality Clinical Lead (Swindon)		115 - 120	-	-	-	25 - 27.5	140 - 145
Edward Rendell	Locality Clinical Lead (Wiltshire)		115 - 120	-	-	-	7.5 - 10	125 - 130
Timothy Sephton	Locality Healthcare Professional (BaNES)	7	5 - 10	-	-	-	-	5 - 10
Francis Campbell	Locality Healthcare Professional (Swindon)		35 - 40	-	-	-	-	35 - 40
Catrinel Wright	Locality Healthcare Professional (Wiltshire)		30 - 35	-	-	-	5 - 7.5	35 - 40
Samuel Dominey	Locality Healthcare Professional (Wiltshire)		25 - 30	-	-	-	5 - 7.5	35 - 40
Nicholas Ware	Locality Healthcare Professional (Wiltshire)		25 - 30	-	-	-	5 - 7.5	35 - 40
Paul Kennedy	Secondary Care Specialist	8	25 - 30	-	-	-	-	25 - 30
Maggie Arnold	Registered Nurse	8	25 - 30	-	-	-	-	25 - 30
Peter Lucas	Lay Member Audit and Governance	8	15 - 20	-	-	-	-	15 - 20
Julian Kirby	Lay Member Patient and Public Engagement	8	15 - 20	-	-	-	-	15 - 20
Ian James	Lay Member Finance	8	15 - 20	-	-	-	-	15 - 20
Suzannah Power	Lay Member Primary Care Commissioning and Deputy Chair	8	40 - 45	-	-	-	-	40 - 45

Senior manager remuneration (BSW ICB Designates) 2021/22 (AUDITED)

Sue Harriman	Chief Executive (Designate), BSW ICB	5, 6	25 - 30	-	-	-	5 - 7.5	35 - 40
Stephanie Elsy	BSW Independent Chair	8	45 - 50	100	-	-	-	45 - 50

Notes

1. Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.

2. The salary figures shown for senior managers above exclude recharges made to the BSW Sustainability & Transformation Partnership

3. Taxable benefits refer to where senior managers are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with the Agenda for Change guidance on mileage payments.

4. Tracey Cox left the CCG during March 2022.

5. Sue Harriman joined the CCG on 7th February 2022 and was awarded a relocation package of £6k. This funding had not been utilised in full during the financial year.

6. The highest paid director/member on an annualised basis was Sue Harriman, who was contracted at 1 WTE. The annualised banded salary (excluding pension benefits) for this role was £185k-£190k.

7. Timothy Sephton left the CCG on 31st July 2021.

8. Lay Members are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits.

Senior manager remuneration (including salary and pension entitlements) 2020/21 (AUDITED)

Name	Title	Note	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
			£'000s	£s	£'000s	£'000s	£'000s	£'000s
Ruth Grabham	Medical Director		135 - 140	-	-	-	47.5 - 50	185 - 190
Tracey Cox	Chief Executive Officer		140 - 145	-	-	-	27.5 - 30	170 - 175
Caroline Gregory	Chief Finance Officer		120 - 125	-	-	-	55 - 57.5	175 - 180
Gillian May	Director of Nursing & Quality		120 - 125	-	-	-	92.5 - 95	215 - 220
Richard Smale	Director of Strategy & Transformation		110 - 115	-	-	-	92.5 - 95	205 - 210
Julie-Anne Wales	Director of Corporate Affairs		90 - 95	-	-	-	82.5 - 85	175 - 180
Corinne Edwards	Chief Operating Officer, BaNES Locality		115 - 120	-	-	-	70 - 72.5	185 - 190
David Freeman	Chief Operating Officer, Swindon Locality	5	120 - 125	-	-	-	10 - 12.5	130 - 135
Elizabeth Disney	Chief Operating Officer, Wiltshire Locality		110 - 115	-	-	-	25 - 30	135 - 140
Sheridan Flavin	Interim Executive Director for People & OD		65 - 70	-	-	-	7.5 - 10	70 - 75
Alison Kingscott	Interim Executive Director for People & OD		60 - 65	-	-	-	112.5 - 115	175 - 180
Nicola Millin	Executive Director of Strategy and Transformation	6	10-15	-	-	-	-	10 - 15
Andrew Girdher	Clinical Chair	7	105 - 110	-	-	-	22.5 - 25	125 - 130
Brynn Bird	Locality Clinical Lead (BaNES)		70 - 75	-	-	-	32.5 - 35	105 - 110
Amanda Webb	Locality Clinical Lead (Swindon)		95 - 100	-	-	-	150 - 152.5	245 - 250
Edward Rendell	Locality Clinical Lead (Wiltshire)		85 - 100	-	-	-	80 - 82.5	165 - 170
Timothy Sephton	Locality Healthcare Professional (BaNES)		25 - 30	-	-	-	7.5 - 10	35 - 40
Francis Campbell	Locality Healthcare Professional (Swindon)		30 - 35	-	-	-	140 - 142.5	175 - 180
Catrinel Wright	Locality Healthcare Professional (Wiltshire)		30 - 35	-	-	-	30 - 32.5	60 - 65
Samuel Dominey	Locality Healthcare Professional (Wiltshire)		25 - 30	-	-	-	47.5 - 50	75 - 80
Nicholas Ware	Locality Healthcare Professional (Wiltshire)		30 - 35	-	-	-	35 - 37.5	65 - 70
Paul Kennedy	Secondary Care Specialist	3	25 - 30	-	-	-	-	25 - 30
Maggie Arnold	Registered Nurse	3	25 - 30	-	-	-	-	25 - 30
Peter Lucas	Lay Member Audit and Governance	3	30 - 35	-	-	-	-	30 - 35
Julian Kirby	Lay Member Patient and Public Engagement	3	15 - 20	-	-	-	-	15 - 20
Ian James	Lay Member Finance	3	15 - 20	-	-	-	-	15 - 20
Suzannah Power	Lay Member Primary Care Commissioning and Deputy Chair	3	15 - 20	-	-	-	-	15 - 20

Notes

1. Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.

2. The salary figures shown for senior managers above exclude recharges made to the BSW Sustainability & Transformation Partnership

3. Lay Members are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits.

4. Taxable benefits refer to where senior managers are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with the Agenda for Change guidance on mileage payments.

5. David Freeman was on secondment from Somerset CCG for the period 1st April to 30th September and formally joined the CCG from 1st October. The pension-related benefit included within the table relates to all of 2020-21.

6. Nicola Millin was employed by NHS BSW CCG for the month of April 2020 only.

7. The highest paid director/member on an annualised basis was Andrew Girdher, who was contracted at 0.6 WTE. The annualised banded salary (excluding pension benefits) for this role was £165k-£170k.

Pension benefits as at 31 March 2022 (AUDITED)

Name ❶	Title	Real increase in pension at retirement age (bands of £2,500)	pension lump sum at pension age (bands of £2,500)	pension at retirement age at 31 March 2022 (bands of £5,000)	Lump sum at retirement age related to accrued pension at 31 March 2022 (bands of £5,000) ❷	Cash equivalent transfer value at 1 April 2021	Real increase in Cash equivalent transfer value	Cash equivalent transfer value at 31 March 2022 ❸
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Ruth Grabham	Medical Director	0 - 2.5	0 - 2.5	25 - 30	75 - 80	622	33	681
Tracey Cox	Chief Executive Officer	2.5 - 5	0	60 - 65	125 - 130	1,074	36	1,136
Caroline Gregory	Chief Finance Officer	0 - 2.5	0	45 - 50	95 - 100	904	0	925
Gillian May	Director of Nursing & Quality	0 - 2.5	2.5 - 5	55 - 60	175 - 180	1,395	45	1,465
Richard Smale	Director of Strategy & Transformation	0 - 2.5	0	40 - 45	85 - 90	797	0	806
Julie-Anne Wales	Director of Corporate Affairs	10 - 12.5	20 - 22.5	45 - 50	135 - 140	910	239	1,169
Corinne Edwards	Chief Operating Officer, BaNES Locality	0 - 2.5	0	40 - 45	85 - 90	786	29	835
David Freeman	Chief Operating Officer, Swindon Locality	0 - 2.5	0	35 - 40	60 - 65	545	22	586
Elizabeth Disney	Chief Operating Officer, Wiltshire Locality	2.5 - 5	5 - 7.5	5 - 10	5 - 10	39	33	89
Sheridan Flavin	Interim Executive Director for People & OD	0 - 2.5	0	15 - 20	0	204	15	230
Alison Kingscott	Interim Executive Director for People & OD	0 - 2.5	0	40 - 45	95 - 100	826	25	865
Andrew Girdher	Clinical Chair	0 - 2.5	0	10 - 15	25 - 30	198	12	226
Brynn Bird	Locality Clinical Lead (BaNES)	0 - 2.5	0	15 - 20	0	161	6	178
Amanda Webb	Locality Clinical Lead (Swindon)	0 - 2.5	0	10 - 15	30 - 35	180	7	205
Edward Rendell	Locality Clinical Lead (Wiltshire)	0 - 2.5	0	15 - 20	30 - 35	212	0	226
Timothy Sephton	Locality Healthcare Professional (BaNES)	0 - 2.5	0	0 - 5	5 - 10	71	2	74
Francis Campbell	Locality Healthcare Professional (Swindon)	0 - 2.5	0	10 - 15	25 - 30	158	0	162
Catrinel Wright	Locality Healthcare Professional (Wiltshire)	0 - 2.5	0	10 - 15	20 - 25	181	7	193
Samuel Dominey	Locality Healthcare Professional (Wiltshire)	0 - 2.5	0	10 - 15	25 - 30	164	5	174
Nicholas Ware	Locality Healthcare Professional (Wiltshire)	0 - 2.5	0	5 - 10	20 - 25	149	5	159

Pension benefits as at 31 March 2022 (ICB Designates) (AUDITED)

Sue Harriman	Chief Executive (Designate), BSW ICB	2.5 - 5	0 - 2.5	50 - 55	80 - 85	834	70	912

Notes

❶ *Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.*

❷ *There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.*

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

The 2021/22 values for accrued pension, lump sum and CETV have been calculated by NHS Pensions with no allowance for a potential adjustment arising from a legal case known as the McCloud judgement. This case concerned potential age discrimination over the way in which UK public sector pension schemes introduced a Career Average Related Earning benefit design in 2015 for all members excluding the oldest members who remained on a final salary design.

Pension benefits as at 31 March 2021 (**AUDITED**)

Name ❶	Title	Real increase in pension at retirement age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at retirement age at 31 March 2021 (Bands of £5,000)	Lump sum at retirement age related to accrued pension at 31 March 2021 (bands of £5,000) ❷	Cash equivalent transfer value at 1 April 2020	Real increase in Cash equivalent transfer value	Cash equivalent transfer value at 31 March 2021 ❸
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Ruth Grabham	Medical Director	2.5 - 5	7.5 - 10	25 - 30	75 - 80	529	64	622
Tracey Cox	Chief Executive Officer	2.5 - 5	0	55 - 60	125 - 130	1,004	32	1,074
Caroline Gregory	Chief Finance Officer	2.5 - 5	2.5 - 5	45 - 50	100 - 105	815	57	904
Gillian May	Director of Nursing & Quality	2.5 - 5	12.5 - 15	55 - 60	170 - 175	1,227	129	1,395
Richard Smale	Director of Strategy & Transformation	5 - 7.5	7.5 - 10	40 - 45	90 - 95	685	85	797
Julie-Anne Wales	Director of Corporate Affairs	2.5 - 5	12.5 - 15	35 - 40	110 - 115	776	108	910
Corinne Edwards	Chief Operating Officer, BaNES Locality	2.5 - 5	5 - 7.5	40 - 45	85 - 90	688	69	786
David Freeman	Chief Operating Officer, Swindon Locality	0 - 2.5	0	30 - 35	60 - 65	520	7	545
Elizabeth Disney	Chief Operating Officer, Wiltshire Locality	0 - 2.5	0	0 - 5	0 - 5	20	3	39
Sheridan Flavin	Interim Executive Director for People & OD	0 - 2.5	0	10 - 15	0	185	6	204
Alison Kingscott	Interim Executive Director for People & OD	5 - 7.5	12.5 - 15	40 - 45	95 - 100	689	116	826
Nicola Millin	Executive Director of Strategy and Transformation	0	0	40 - 45	115 - 120	1,135	0	0
Andrew Girdher	Clinical Chair	0 - 2.5	0 - 2.5	5 - 10	10 - 15	100	10	128
Brynn Bird	Locality Clinical Lead (BaNES)	0 - 2.5	0	15 - 20	0	134	14	161
Amanda Webb	Locality Clinical Lead (Swindon)	5 - 7.5	15 - 17.5	10 - 15	30 - 35	72	94	180
Edward Rendell	Locality Clinical Lead (Wiltshire)	2.5 - 5	7.5 - 10	10 - 15	35 - 40	146	50	212
Timothy Sephton	Locality Healthcare Professional (BaNES)	0 - 2.5	0 - 2.5	0 - 5	5 - 10	59	6	71
Francis Campbell	Locality Healthcare Professional (Swindon)	5 - 7.5	17.5 - 20	10 - 15	30 - 35	66	86	158
Catrinel Wright	Locality Healthcare Professional (Wiltshire)	0 - 2.5	2.5 - 5	10 - 15	20 - 25	148	26	181
Samuel Dominey	Locality Healthcare Professional (Wiltshire)	0 - 2.5	5 - 7.5	10 - 15	25 - 30	122	36	164
Nicholas Ware	Locality Healthcare Professional (Wiltshire)	0 - 2.5	2.5 - 5	5 - 10	20 - 25	117	26	149

Notes

❶ *Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.*

❷ *There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.*

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

The 2020/21 values for accrued pension, lump sum and CETV have been calculated by NHS Pensions with no allowance for a potential adjustment arising from a legal case known as the McCloud judgement. This case concerned potential age discrimination over the way in which UK public sector pension schemes introduced a Career Average Related Earning benefit design in 2015 for all members excluding the oldest members who remained on a final salary design.

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 (or other allowable beneficiary's) pension payable from the scheme.

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

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

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

Compensation on early retirement of for loss of office
The CCG had none in 2021-22.

Payments to past directors
The CCG had none in 2021-22.

Percentage change in remuneration of highest paid director

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	14.3%	14.3%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	0.3%	0.3%

The figures included within the table above include BSW ICB designate roles.

Pay ratio information (AUDITED)

During quarter four of 2021/22, the CCG hosted staff relating to the Integrated Care Board (ICB). The ICB Chief Executive-designate has been included within pay ratio information for the CCG.

As of 31 March 2022, remuneration ranged from £12,656 to £189,475 (2020/21: £16,068 to £165,750) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The remuneration range increased 18 per cent year-on-year due to the employment of apprentices and the hosting of staff associated with the ICB.

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

The banded remuneration of the highest paid director/member in BSW CCG in the financial year 2021/22 was £185,000 - £190,000 (+12% against 2020/21: £165,000 - £170,000) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2021-22	25th percentile	Median	75th percentile
Total remuneration (£)	£25,655	£40,057	£54,764
Salary component of total remuneration (£)	£25,655	£40,057	£54,764
Pay ratio information	7.3 : 1	4.7 : 1	3.4 : 1
2020-21			
Total remuneration (£)	£24,157	£40,894	£53,168
Salary component of total remuneration (£)	£24,157	£40,894	£53,168
Pay ratio information	6.9 : 1	4.1 : 1	3.2 : 1

In 2021/22, zero (2020/21, zero) employees received remuneration in excess of the highest-paid director/member. The calculations above include the two ICB designate roles.

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

Staff Report

Number of senior managers

The CCG has categorised members of the Governing Body, and the senior leadership team, as being senior managers, and their salaries are included on page 72.

As of 31 March 2022, the number of senior managers by Agenda for Change bands and very senior managers (VSM) were:

Agenda for Change Band	Number of senior managers
Very senior managers (VSM)	11
Band 9	1

The Governing Body of the CCG has one GP Clinical Chair, one Medical Director, eight GP members, one registered nurse and three independent and lay members.

Staff numbers and costs (AUDITED)

As of 31 March 2022, the CCG has 490 employees. The workforce was made up of employees from a wide range of professional groups.

Staff costs	2021-22		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	16.3	0.7	17.0
Social security costs	1.8	-	1.8
Employer contributions to the NHS Pension Scheme	3.4	-	3.4
Apprenticeship Levy	0.1	-	0.1
Employee benefits expenditure	**21.6**	**0.7**	**22.3**

The average number of people employed by the CCG during 2021/22 on a whole-time equivalent basis was 369.

Permanently employed	Other
334	35

Analysed as:	Perm	Other
Scientific, therapeutic and technical staff	33	0
Admin and estates staff	259	28
Medical and dental staff	3	5
Nursing, midwifery and health visiting	39	2
Other healthcare	0	0

Staff composition

The table below shows the gender breakdown as of 31 March 2022:

	Female headcount	Male headcount	Total
Governing Body Members	8	10	18
All other CCG staff	392	90	482
Total	400	100	500

Sickness absence data

Overall staff sickness absence data as of 31 March 2022 for the year was 1.41 per cent. The overall sickness absence figures are a result of 0.77 per cent short term sickness absence and 0.64 per cent long term sickness absence. All sickness absence is managed in line with the CCG Sickness Management policy and colleagues are supported by their manager, occupational health and the Employee Assistance Programme as appropriate. Sickness absence data is reported on a quarterly basis and action taken to address any areas of concern.

Staff turnover percentages

The overall staff turnover percentage for the CCG as of 31 March 2022 for the year was 13.95 per cent. The table below shows the turnover figures for the CCG for the last year. The highest turnover for the year was recorded in March 2022 and partly relates to two colleagues retiring and two fixed term contracts ending.

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Turnover	0.97%	1.20%	0.72%	1.18%	1.41%	1.62%	1.39%	0.68%	1.35%	0.90%	0.84%	1.69%

Staff engagement percentages

From 28 October 2021 to 26 November 2021, the CCG ran a bespoke colleague engagement survey. The CCG received a response rate of 39.5 per cent (171 colleagues responded) and more than 300 verbatim comments were received in addition to the multiple-choice questions.

The survey focused on five key areas: health and wellbeing, work/life balance, transition to the Integrated Care Board, bullying and harassment and equality, diversity and inclusion.

Eighty-eight per cent of colleagues either agreed or strongly agreed that their immediate manager took a positive interest in their health and wellbeing, and 90 per cent agreed or strongly agreed that their manager was supportive in a crisis. Almost 80 per cent of staff who responded agreed or strongly agreed that the CCG is taking positive action on employee health and wellbeing (only four respondents were unaware of the health and wellbeing resources that are available). Nearly 80 per cent of staff surveyed were happy with the opportunities for flexible with only two respondents strongly disagreeing. Sixty per cent of colleagues would recommend the CCG as a place to work with around nine per cent disagreeing with this statement.

More than 90 per cent of colleagues surveyed were aware of the transition to ICS, although 20 per cent reported that their line manager had not yet discussed with them about transferring to the ICB.

Eighty-five per cent of colleagues reported that they had not experienced bullying, harassment or abuse from patients or the public, but eight per cent had. Eighty-seven per cent had not experienced bullying, harassment or abuse from managers but six per cent had. Ninety per cent of colleagues had not experienced bullying, harassment or abuse from colleagues, but six per cent had. With regards to discrimination, 90 per cent had not experienced this from patients or the public, but three per cent had done so, and 88 per cent had not suffered discrimination from managers, but eight per cent had.

Colleagues have increased their knowledge of equality, diversity and inclusion issues over the year (64 per cent) and nearly 80 per cent agree that the CCG respects individual differences, with six per cent disagreeing. Nearly 90 per cent of colleagues would raise any concerns that they became aware of regarding equality, diversity and inclusion issues.

Actions are now being identified to address areas where improvements can be made in relation to each of the five themes and the CCG is developing an Equality, Diversity and Inclusion (EDI) Strategy to co-ordinate this approach. The CCG continues to raise awareness of EDI issues through both mandatory training and other development opportunities.

Staff policies

The CCG continues to have an integrated approach to delivering workforce equality, so there is not a separate policy for disabled employees or for any other protected characteristics, but the CCG does have incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance to discipline.

The CCG's aim is to operate in ways that do not discriminate against potential or current employees with any of the protected characteristics specified in the Equality Act 2010, and to support employees to maximise their performance including making any reasonable adjustments that may be required on a case-by-case basis.

When applying any of the CCG's HR policies, the organisation will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010): age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

Diversity and inclusivity continue to be monitored through the equality impact assessments that have been carried out on all HR policies.

The Ways of Working policy has recently been reviewed to take account of recent legislative changes regarding the rights of employees from day one of employment to request flexible working. This change has been embraced by the CCG as it allows the inclusive culture to continue to be developed.

The Freedom to Speak Up policy has been discussed during colleague briefings by the Freedom to Speak Up Guardian and the Chief Executive, and strongly encourages colleagues to raise reasonable concerns relating to malpractice. The CCG is committed to eliminating unlawful discrimination, promoting equality of opportunity and providing good relations between people of diverse groups.

Policies continue to be reviewed and updated in line with the review cycle. All HR policies are discussed at the Colleague Partnership Forum (CPF) prior to, and after the adoption of, to ensure they are embedded in the organisation.

The CCG is disability confident which means it is committed to carrying out inclusive and accessible recruitment, communicating vacancies, offering an interview to disabled people, providing reasonable adjustments and supporting existing employees.

Any employees who become disabled during their employment with the CCG will be supported by their line manager, HR, occupational health and/or the Employee Assistance Programme. Where possible, reasonable adjustments will be made and training, if appropriate, provided to the individual's line manager and team members to ensure they are able to support the employee in the best way possible. The CCG will also work with Access to Work, if appropriate, to ensure the best possible support is provided. The CCG has a good relationship with Access to Work through supporting previous employees.

All recruitment adverts detail that the CCG is disability confident and will make reasonable adjustments wherever possible during the recruitment and selection process to ensure no individuals are disadvantaged.

The CCG also has an inclusion charter, Everyone Counts, that was co-produced and details how through the charter it is committed to welcoming and embracing equality and diversity, and to actively tackling discrimination in all its forms.

The CCG publishes its employee profile by each of the nine protected characteristics. This helps to identify and address areas of under-representation in a systematic manner as and when opportunities arise. On a six-monthly basis, the Executive Management team receive a report on the workforce profile.

The CCG has submitted and published its Workforce Disability Equality Standards (WDES) report and accompanying action plan. The report showed that 3.8 per cent of colleagues have recorded that they have a disability, compared to 3.5 per cent for the NHS as a whole. This report also found that disabled colleagues felt less engaged than

non-disabled colleagues, and were more likely to suffer bullying, harassment and abuse. However, the analysis of recruitment data showed that disabled applicants were more likely to be appointed from a shortlist than non-disabled applicants. The CCG is committed to better understanding the experiences of disabled staff and is keen to support positive change for all employees by ensuring an inclusive environment for current disabled colleagues and potential disabled colleagues. The WDES action plan is published on the CCG's website and the actions will be carried out throughout the year.

The CCG has also submitted and published its Workforce Race Equality Standard (WRES) report and accompanying action plan. This report shows the proportion of BME staff in the workforce is rising but that there is under-representation in senior leadership positions. BME applicants are less likely than white applicants to be appointed from shortlists, and BME colleagues are less likely than white colleagues to undertake non-mandatory training and development. WRES aims to ensure that employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace and to close the gaps in workplace experience between white and BME colleagues. As well as the internal action plan, the NHS People Plan and the HR Framework for Developing Integrated Care Boards have specific actions relating to equality, diversity and inclusion. Progress against those actions will continue to be monitored by the CCG and, subsequently, the ICB.
The CCG has submitted and published its Gender Pay Gap Report. This report details the differences between the average and median hourly rate of pay for male and female employees and includes an action plan to continue to narrow the gender pay gap. The CCG had an average gender pay gap of 35 per cent and a median pay gap of 28 per cent on 31 March 2021. During the year, this gap had reduced to 30 per cent and 26 per cent respectively by 31 March 2022.

The CCG is committed, and aided through the WRES, WDES and Gender Pay Gap data, to continue to improve diversity, remove barriers and increase inclusiveness of the workforce.

The WDES, WRES and Gender Pay Gap reports for 2021 detail the current position relating to the experiences of disabled and BME colleagues, as well as the differences in pay. As a result of this, action plans have been developed and will continue to be progressed during the year. These action plans aim to remove any barriers and improve the experience of disabled and BME colleagues, as well as narrowing the gender pay gap with the aim of creating a more diverse and inclusive workforce, where colleagues with protected characteristics are not only welcomed, but also feel welcomed.

The CCG workforce has recently increased its headcount by 45 colleagues following recent TUPE transfers and this has therefore impacted on the diversity of the workforce. The individuals have been welcomed to the CCG and had a bespoke induction programme and included in all CCG colleague engagement activities from the transfer date.

The CCG has produced and submitted its first WDES Report and first Gender Pay Gap Report. Both reports illustrate current performance and have action plans to improve annual scores. Once the second reports have been produced for 2022, the CCG will be able to measure its progress against the targets set. Many of these targets will be measured by the completion of the national staff survey in the autumn of 2022. The CCG also has a broader EDI strategy that aims to improve the experiences of our staff across all the nine protected characteristics.

Outstanding Contribution Awards

To celebrate the achievements and contributions of colleagues throughout 2021/22, the CCG ran a virtual awards event. The Outstanding Contribution Awards provided an opportunity to celebrate colleagues who went above and beyond in a number of areas, and were inclusive of all colleagues directly involved in CCG business during the year.

Overall, more than 60 nominations were made in the following six categories:

- Hit the Ground Running Award
- Innovation Award
- Collaborating for Success Award
- Team of the Year Award
- Outstanding Role Model Award
- Unsung Hero Award

Nominations were independently reviewed by a judging panel of colleague representatives and the process was led by the wellbeing guardian.

The virtual award ceremony took place on Thursday 21 April, and was attended by more than 200 colleagues.

Colleague Partnership Forum

The CCG has a Colleague Partnership Forum (CPF) made up of colleague representatives from across the organisation. The CPF aims to provide regular and effective means of joint discussion between senior management and colleague representatives on issues of mutual interest or concern. It also fosters maximum involvement of all partners in effective communication, engagement and consultation on working practices and employment.

Trade Union Facility Time Publication Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires the CCG to publish the following information:

The total number of relevant union officials employed by the CCG	0
Percentage of time spent on union facility time	0
Percentage of pay bill spend on union facility time	0
Paid trade union activities	0

Facility time is paid time-off for union representatives to carry out trade union activities. The reporting requirements apply to all departments and a defined list of arm’s length

bodies within Statutory Instrument 328.

Other employee matters

Covid-19 has continued to affect all colleagues, and it is not underestimated what a difficult year it has been and the significant impact it has had on the system. The CCG has continued to support colleagues through a range of initiatives and support mechanisms while the majority of colleagues continue to work from home. Although the CCG has a very low sickness absence rate, the organisation is not complacent about the health and wellbeing of its workforce.

The CCG is aware of the potential for long-term psychological effects of having worked through the pandemic, and its health and wellbeing support to staff aims to deal with such scenarios. In addition to the traditional occupational health services for staff who have become ill or are recovering, the CCG has access to preventative inputs and dedicated support, as described in the My Health and Wellbeing area of the intranet.

The CCG has implemented agile working through the Ways of Working Programme, which focuses on people and culture change, as well as empowering colleagues in a trust-based working culture. Agile working aims to provide greater flexibility, and more than 71 per cent of colleagues have stated they would rather work from home. Agile working and ways of working will continue to be reviewed as this becomes the norm.

The CCG continues to be focused on colleague health and wellbeing and has a wealth of resources available. There is a wellbeing group that works to promote wellbeing activities, as well as regular group newsletters that focus on a range of matters, including menopause, display screen equipment assessments, wellbeing checklists, stress risk assessments and flexible working. The CCG has more than 25 colleagues trained as mental health first aiders, all of whom can act as a point of contact for anyone experiencing a mental health issue or emotional distress.

CCG colleagues also have access to the BSW Wellbeing Matters Service, which provides mental health support. The service offers direct access to psychologies and registered mental health clinicians, who can use their expertise to assist health and social care key workers in accessing support.

Alongside this, colleagues have access to an occupational health service and employee assistance programme, which offers free confidential counselling services.

The CCG continues to be a member of Mindful Employer, and has signed the employer charter, which outlines a set of voluntary aspirations about supporting mental health. The CCG is also a member of Mindful Employer Plus, which provides colleagues with access to a confidential staff helpline.

The CCG commissioned workshops during the year for colleagues and managers to develop their understanding of mental health, and for managers to be aware of how they can support their team members who may be experiencing poor mental health.

The BSW People Strategy was reviewed and updated in August 2021, and focuses on three main areas:

- Colleague experience and development
- Engagement and culture
- Leadership capability and capacity.

When reviewed in August 2021, progress had already been made against the People Strategy. However, in some areas, this is slower than anticipated due to external factors, such as Covid-19 and the delay to the formation of the ICB. The People Strategy will be reviewed again in the near future. It is recognised that people are the organisation's greatest asset and as the CCG moves towards becoming a statutory ICB on 1 July 2022, it is even more important that colleagues are supported.

It is recognised that the equality, diversity and inclusion agenda is substantial, and the CCG is committed to improving in these areas. The CCG is a member of the BSW ICS Equality, Diversity and Inclusion Network, which allows staff to draw on best practice and work collaboratively across the system.

The CCG has also strengthened its publication of the commitment to equality, diversity and inclusion within advertising and recruitment. Workshops have been available to all recruiting managers regarding best practice when carrying out values-based recruitment, as well as how to eliminate unconscious bias.

Unconscious bias and equality and diversity workshops have been commissioned and are available to all CCG colleagues to increase their individual understanding and awareness.

As mentioned previously, the CCG publishes its WRES, WDES and gender pay gap reports, as well as action plans, and strives to implement the identified actions.

An equality, diversity and inclusion strategy for CCG colleagues is in development to ensure focused impactful action is able to be achieved throughout the year.

The CCG continues to have a committed Colleague Partnership Forum, which meets on a monthly basis to discuss CCG activities, such as policy reviews and consultations. The forum is made up of colleagues from across the organisation at all levels.

The CCG will be abolished on 30 June 2022 and integrated care boards will be formed on 1 July 2022.

As a result of this, a consultation has been carried out with the CCG Executive Directors regarding their roles no longer existing. A consultation will be carried out with all colleagues in scope in April 2022 regarding the transfer from the CCG to the ICB on 1 July 2022. Colleagues will be fully consulted with, and will be encouraged to fully engage with the process. The Colleague Partnership Forum reviewed and provided feedback on the consultation document and will be available to support colleagues through the transition.

Colleagues continue to be updated on activity taking place within the CCG and the Integrated Care System through the monthly colleague briefing sessions held by the chief executive, as well as through regular email communications.

The CCG continues to maintain good working relationships with trade unions, and is an active member of the Social Partnership Forum.

Expenditure on consultancy
The CCG has spent around £290,000 on consultancy services during the year. Consultants were engaged to support analysis and benchmarking activities.

Off-payroll engagements
NHS bodies are required to include disclosures about their off-payroll engagements.

Details of off-payroll engagements for more than £245 per day, and which lasted longer than six months, can be seen below:

- The CCG did not have any off-payroll engagements in the year.

Table One: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

Number of off-payroll engagements of board members or senior officers with significant financial responsibility during the financial year (1)	0
Total number of individuals on payroll and off-payroll that have been deemed board members or senior officials with significant financial responsibility during the financial year. This figure should include both on-payroll and off-payroll engagements. (2)	28

Exit packages, including special (non- contractual) payments (AUDITED)
The CCG had no exit packages, including special non-contractual payments, in 2021/22.

Parliamentary Accountability and Audit Report

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

Financial Statements and Audit Report

Audit opinion

Overview

This section provides an overview of how the CCG worked, what it did, the risks it was exposed to and how it performed during the course of 2021/22.

NHS organisations produce an annual report and financial accounts at the end of every financial year. In this report, the CCG described how it fulfilled its duties as laid out in the National Health Service Act 2006 for the 2021/22 reporting year.

Independent auditor's report to the members of the Governing Body of NHS Bath and North East Somerset, Swindon and Wiltshire CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Bath and North East Somerset, Swindon and Wiltshire CCG (the 'CCG') for the year ended 31 March 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of 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, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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 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 – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that, under the Health and Care Act 2022 the commissioning functions, assets and liabilities of NHS Bath and North East Somerset, Swindon and Wiltshire CCG to due to transfer to NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board on 1 July 2022.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the CCG to cease to continue as a going concern.
In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the

CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.
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 ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.
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.
The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.
In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.
We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial

statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, 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.
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 they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.
The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.
The Governing Body is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.
A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.
We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to journals, accounting estimates and critical judgements made by management.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on management override of controls;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of prescribing accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to prescribing accruals;
- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates

- understanding of the legal and regulatory requirements specific to the CCG including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

Report on other legal and regulatory requirements – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.
Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2022.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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.
We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and

- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Bath and North East Somerset, Swindon and Wiltshire CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG 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 CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Julie Masci, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

21 June 2022

ANNUAL ACCOUNTS

Sue Harriman

Accountable Officer

16 June 2022

Entity name:	NHS Bath and North East Somerset, Swindon and Wiltshire CCG
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

The figures presented within these accounts have been prepared in millions (£m) rather than thousands (£k). Where appropriate, disclosure notes may include figures in thousands.

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The Primary Statements:

No. Notes to the Accounts

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

	Note	2021-22 £m	2020-21 £m
Income from sale of goods and services	2	(6.8)	(4.4)
Other operating income	2	(0.0)	(0.0)
Total operating income		**(6.8)**	**(4.4)**
Staff costs	3	22.3	20.0
Purchase of goods and services	4	1,676.7	1,493.5
Depreciation and impairment charges	4	0.2	0.6
Provision expense	4	4.3	8.1
Other Operating Expenditure	4	4.7	3.1
Total operating expenditure		**1,708.2**	**1,525.3**
Net Operating Expenditure		**1,701.4**	**1,520.9**
Finance expense	13	-	0.1
Net expenditure for the Year		**1,701.4**	**1,521.0**
Net (Gain)/Loss on Transfer by Absorption	7	-	89.6
Total Net Expenditure for the Financial Year		**1,701.4**	**1,610.6**
Comprehensive Expenditure for the year		**1,701.4**	**1,610.6**

The notes on pages 107 to 112 and 117 form part of this statement.

The CCG has delivered a net surplus of £43k against its allocation for the year. See Note 24 for further information.

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £m	2020-21 £m
Non-current assets:			
Property, plant and equipment	9	1.0	0.6
Intangible assets	10	0.2	0.0
Total non-current assets		**1.2**	**0.6**
Current assets:			
Trade and other receivables	11	8.3	10.8
Cash and cash equivalents	12	0.6	0.0
Total current assets		**8.9**	**10.8**
Total current assets		**8.9**	**10.8**
Total assets		**10.1**	**11.4**
Current liabilities			
Trade and other payables	14	(149.1)	(128.2)
Borrowings	15	-	(7.2)
Provisions	16	(11.1)	(8.6)
Total current liabilities		**(160.2)**	**(144.0)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(150.1)**	**(132.6)**
Non-current liabilities			
Provisions	16	-	(2.2)
Total non-current liabilities		**-**	**(2.2)**
Assets less Liabilities		**(150.1)**	**(134.8)**
Financed by Taxpayers' Equity			
General fund		(150.1)	(134.8)
Total taxpayers' equity:		**(150.1)**	**(134.8)**

The notes on pages 114 to 119 form part of this statement.

The financial statements on pages 98 to 128 were approved by the Governing Body on 16th June 2022 and signed on its behalf by:

Chief Executive Officer Designate - BSW ICB
Sue Harriman

Chief Financial Officer
Caroline Gregory

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

		General fund £m	Total reserves £m
Changes in taxpayers' equity for 2021-22			
Balance at 01 April 2021		(134.8)	(134.8)
Transfer between reserves in respect of assets transferred from closed NHS bodies	7	-	-
Adjusted NHS Clinical Commissioning Group balance at 01 April 2021		**(134.8)**	**(134.8)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22			
Net operating expenditure for the financial year		(1,701.4)	(1,701.4)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year		**(1,701.4)**	**(1,701.4)**
Net funding		1,686.1	1,686.1
Balance at 31 March 2022		**(150.1)**	**(150.1)**

		General fund £m	Total reserves £m
Changes in taxpayers' equity for 2020-21			
Balance at 01 April 2020		-	-
Opening transfer by absorption	7	(89.6)	(89.6)
Adjusted NHS Clinical Commissioning Group balance at 01 April 2020		**(89.6)**	**(89.6)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21			
Net operating costs for the financial year		(1,520.9)	(1,520.9)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year		**(1,520.9)**	**(1,520.9)**
Net funding		1,475.8	1,475.8
Balance at 31 March 2021		**(134.8)**	**(134.8)**

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £m	2020-21 £m
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,701.4)	(1,520.9)
Depreciation and amortisation	4	0.2	0.4
Impairments and reversals	4	0.0	0.1
Other Gains & Losses		0.0	0.1
(Increase)/decrease in inventories		0.0	1.5
(Increase)/decrease in trade & other receivables	11	2.5	3.0
Increase/(decrease) in trade & other payables	14	20.9	29.7
Provisions utilised	16	(3.9)	(0.1)
Increase/(decrease) in provisions	16	4.3	8.1
Net Cash Inflow (Outflow) from Operating Activities		**(1,677.4)**	**(1,478.1)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(0.7)	0.0
(Payments) for intangible assets		(0.2)	0.0
Net Cash Inflow (Outflow) from Investing Activities		**(0.9)**	**0.0**
Net Cash Inflow (Outflow) before Financing		**(1,678.3)**	**(1,478.1)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,686.1	1,475.8
Net Cash Inflow (Outflow) from Financing Activities		**1,686.1**	**1,475.8**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**7.8**	**(2.3)**
Cash & Cash Equivalents at the Beginning of the Financial Year		(7.2)	(4.9)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**0.6**	**(7.2)**

The notes on pages 110, 116 and 118 to 119 form part of this statement.

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis.
The Health and Care Act received Royal Assent on 28 April 2022. The Act 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 from 1 July 2022. On this date the CCG's functions, assets and liabilities will transfer to NHS Bath and North East Somerset, Swindon and Wiltshire ICB.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated.
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 31 March 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 Joint arrangements

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Aligned/Pooled Budgets

The CCG has entered into separate joint arrangements with Swindon Borough Council, Wiltshire Council and Bath and North East Somerset Council in accordance with Section 75 of the NHS Act 2006. Under each arrangement all funds are hosted by the local authorities.
The CCG accounts for its share of assets, liabilities, income and expenditure in accordance with the respective Section 75 agreements. The CCG determines which party has control over the services being delivered in accordance with IFRS 11.
Note 21 provides further details on the individual arrangements.

1.6 Operating Segments

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

1.7 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 CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The CCG is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the CCG to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for NHS BSW CCG is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.

1.8 Employee Benefits

1.8.1 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.

1.8.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the CCG of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Notes to the financial statements

Employees not eligible to join the NHS Pension Schemes are eligible to join an alternative defined contribution scheme (see Note 3.4.3). costs of the scheme are recognised in the period in which service is received.

The NHS Pension scheme is subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **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.

1.1 **Property, Plant & Equipment**

1.10.1 **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.

1.10.2 **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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

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.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

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

1.11 **Intangible Assets**

1.11.1 **Recognition**

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

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

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

Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

1.11.2 **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.

Notes to the financial statements

1.11.3 **Depreciation, Amortisation & Impairments**

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

At each reporting period end, the CCG 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.

1.12 **Leases**

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

1.13.1 **The CCG as a Lessee**

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

1.14.1 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.15 **Inventories**

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula. This is considered to be a reasonable approximation of fair value due to the high turnover of stocks.

1.16 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.17 **Provisions**

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.18 **Clinical Negligence Costs**

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

1.19 **Non-clinical Risk Pooling**

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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.

1.20 **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.

Notes to the financial statements

1.21 **Financial Assets at Amortised cost**

Financial assets are recognised when the CCG 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 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.

The only classification of financial assets held by the CCG are assets at amortised cost.

1.21.1 **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 CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG 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 CCG 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 CCG 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.

1.22 **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.

1.22.3 **Other Financial Liabilities**

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

1.23 **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.

1.24 **Foreign Currencies**

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

1.25 **Losses & Special Payments**

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

The CCG has made no critical accounting judgements and has not identified any areas of estimation uncertainty.

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

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

● IFRS 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.

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

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

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

Notes to the financial statements

On transition to IFRS 16 on 1 April 2022, the CCG will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the CCG's incremental borrowing rate. The CCG's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.
For leases commencing in 2022/23, the CCG will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

Only the adoption of IFRS 16 will have an impact on the CCG's accounts.
At 31 March 2022, the CCG had concluded that its occupation of the offices at the Pierre Simonet Building and Jenner House, met the IFRS 16 definition of a lease, and thus would require recognition on the CCG's Statement of Financial Position (SoFP), in line with the IFRS 16 requirements. In 21/22, the rental of £260k is charged as an expense in the SoCNE. After the introduction of IFRS 16, the charge to the SoCNE will be a mix of deprecation and interest, plus a reduction in the lease liability on the SoFP.
On transition to IFRS 16 on 1 April 2022 a Right of Use asset £1.18m and Right of Use liability £(1.18m) will be recognised.
Work on the introduction of IFRS 16 identified that the following properties (subject to contract finalisation) would be recognised under IFRS 16 as leases:

- Trowbridge Office - Wiltshire Council; Annual Rent est. £51k excluding any applicable VAT.
- Devizes - NHS Property Services; Annual Rent est. £55k excluding any applicable VAT.
- Salisbury Health Clinical - NHS Property Services; Annual Rent est. £3k excluding any applicable VAT.
- Lewis House - Bath and North East Somerset Council; Annual Rent est. £50k excluding any applicable VAT.

2 Other Operating Revenue

	2021-22 Total	2020-21 Total
	£m	£m
Income from sale of goods and services (contracts)		
Education, training and research	1.3	0.9
Non-patient care services to other bodies	3.7	1.8
Other Contract income	1.8	1.7
Total Income from sale of goods and services	**6.8**	**4.4**
Other operating income	0.0	0.0
Total Other operating income	**0.0**	**0.0**
Total Operating Income	**6.8**	**4.4**

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

	Education, training and research	Non-patient care services to other bodies	Other Contract income
	£m	£m	£m
Source of Revenue			
NHS	-	1.9	1.7
Non NHS	1.3	1.7	0.1
Total	**1.3**	**3.7**	**1.8**

	Education, training and research	Non-patient care services to other bodies	Other Contract income
	£m	£m	£m
Timing of Revenue			
Point in time	-	-	-
Over time	1.3	3.7	1.8
Total	**1.3**	**3.7**	**1.8**

2.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date

	2021-22 Total	Revenue expected from Non-DHSC Group Bodies	2020-21 Total	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	0	-	0.1	0.1
Later than 1 year, not later than 5 years	0	-	0.0	0.0
Later than 5 Years	-	-	-	-
Total	**0**	**-**	**0.1**	**0.1**

3. Employee benefits and staff numbers

3.1 Employee benefits

	Total 2021-22		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	16.3	0.7	17.0
Social security costs	1.8	-	1.8
Employer Contributions to NHS Pension scheme	3.4	-	3.4
Apprenticeship Levy	0.1	-	0.1
Employee benefits expenditure	21.6	0.7	22.3

3.1 Employee benefits

	Total 2020-21		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	15.0	0.5	15.5
Social security costs	1.5	-	1.5
Employer Contributions to NHS Pension scheme	2.9	-	2.9
Apprenticeship Levy	0.1	-	0.1
Gross employee benefits expenditure	19.5	0.5	20.0

3.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	334	35	**369**	310	29	**339**

3.3 Exit packages agreed in the financial year

The CCG had no exit payments payable to individuals in 2021-22.

3.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. 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 below.

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

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

3.4.2 Full actuarial (funding) valuation

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

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

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

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

For 2021-22, employer's contributions of £2,377k were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. During 2021-22, NHS England funded NHS Pension contributions totalling £1,014k (6.3%) on behalf of the CCG. Both the funding and cost of this are shown within the CCGs accounts.

3.4.3 Defined Contribution Pensions

The CCG contributed to an alternative pension scheme during 2021-22 as a result of "auto enrolment" under the Pensions Act 2008. This pension is offered to staff who are not eligible to join the NHS Pension scheme. These staff are enrolled in a defined contribution pension scheme called "NEST". In 2021/22 employee contributions were 5% and employer contributions 3%.

4. Operating expenses

	2021-22 Total £m	2020-21 Total £m
Purchase of goods and services		
Services from other CCGs and NHS England	4.8	3.6
Services from foundation trusts	854.8	727.4
Services from other NHS trusts	107.4	101.4
Services from Other WGA bodies	55.2	53.6
Purchase of healthcare from non-NHS bodies	315.4	263.8
Purchase of social care	19.0	11.3
Prescribing costs	140.3	139.8
Pharmaceutical services	0.1	0.0
GPMS/APMS and PCTMS	159.3	148.6
Supplies and services – clinical	2.9	2.5
Supplies and services – general	1.9	24.1
Consultancy services	0.3	0.5
Establishment	2.8	4.6
Transport	6.2	5.8
Premises	4.6	4.4
Audit fees	0.1	0.1
Other non statutory audit expenditure		
· Internal audit services	0.1	0.1
· Other services	-	0.1
Other professional fees	0.4	0.3
Legal fees	0.7	0.4
Education, training and conferences	0.7	1.1
Total Purchase of goods and services	**1,676.7**	**1,493.5**
Depreciation and impairment charges		
Depreciation	0.2	0.3
Amortisation	0.0	0.2
Impairments and reversals of property, plant and equipment	-	0.1
Total Depreciation and impairment charges	**0.2**	**0.6**
Provision expense		
Provisions	4.3	8.1
Total Provision expense	**4.3**	**8.1**
Other Operating Expenditure		
Chair and Non Executive Members	0.9	0.8
Grants to Other bodies	3.5	0.4
Expected credit loss on receivables	0.2	0.4
Inventories consumed	-	1.5
Other expenditure	0.1	0.0
Total Other Operating Expenditure	**4.7**	**3.1**
Total operating expenditure	**1,685.8**	**1,505.3**

The external audit fee for 2021/22 excluding VAT was £89,750. The external auditor carried out a separate audit of the Mental Health Investment Standard (MHIS) during the financial year and were reimbursed £25,000.

The external auditor's liability for external audit work carried out for the financial year 2021/22 is limited to £2,000,000.

To the 31st March 2022, the CCG recognised £87.1m of Covid-19 and Hospital Discharge Programme (HDP) related expenditure (2020/21 £82.6m).

5.1 Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £m	2020-21 Number	2020-21 £m
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	34,035	581.9	29,088	550.2
Total Non-NHS Trade Invoices paid within target	33,622	581.7	28,505	542.8
Percentage of Non-NHS Trade invoices paid within target	**98.79%**	**99.97%**	**98.00%**	**98.65%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,194	973.0	2,638	865.9
Total NHS Trade Invoices Paid within target	1,171	972.9	2,547	864.5
Percentage of NHS Trade Invoices paid within target	**98.07%**	**99.99%**	**96.55%**	**99.84%**

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

The CCG had no Late Payment of Commercial Debts (Interest) to report in 2021-22 or 2020-21.

6 Other gains and losses

	2021-22 £m	2020-21 £m
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	-	0.1
Total	**-**	**0.1**

7. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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.

The CCG had no transfers by absorption in 2021-22.

Net gain/(loss) on transfer by absorption in 2020-21:

The table below identifies the Statement of Financial Position as at 1.4.2020 for NHS Bath and North East Somerset Clinical Commissioning Group, NHS Swindon Clinical Commissioning Group and NHS Wiltshire Clinical Commissioning Group and the consolidated position transferred to NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group.

	Total **1.4.2020** **£m**	BaNES CCG **1.4.2020** **£m**	Swindon CCG **1.4.2020** **£m**	Wiltshire CCG **1.4.2020** **£m**
Transfer of property plant and equipment	0.9	0.2	0.7	-
Transfer of intangibles	0.3	-	0.3	0.0
Transfer of inventories	1.5	-	1.5	-
Transfer of cash and cash equivalents	0.1	0.1	-	-
Transfer of receivables	13.8	1.6	2.6	9.6
Transfer of payables	(103.4)	(21.0)	(24.6)	(57.8)
Transfer of provisions	(2.8)	-	(0.7)	(2.1)
	(89.6)	**(19.1)**	**(20.2)**	**(50.3)**

On 1st April 2020, the cash balances below totalling -£4,855k were transferred to NHS Bath and North East Somerset, Swindon and Wiltshire CCG from legacy organisations:

- NHS BaNES CCG £87k
- NHS Swindon CCG -£4,045k
- NHS Wiltshire CCG -£897k

The cash transferred from legacy organisations in has been split over the "Transfer of cash and cash equivalents" and "Transfer of payables" rows in line with the accounting of an Government Banking Service (GBS) overdraft. The following amounts are recognised on the "Transfer of payables" row:

	Total **1.4.2020** **£m**	BaNES CCG **1.4.2020** **£m**	Swindon CCG **1.4.2020** **£m**	Wiltshire CCG **1.4.2020** **£m**
Transfer of payables	(98.5)	(21.1)	(20.5)	(56.9)
Transfer of GBS overdraft	(4.9)	-	(4.0)	(0.9)
	(103.4)	**(21.1)**	**(24.5)**	**(57.8)**

8. Operating Leases

8.1 As lessee

8.1.1 Payments recognised as an Expense

	2021-22			2020-21		
	Buildings £m	Other £m	Total £m	Buildings £m	Other £m	Total £m
Payments recognised as an expense						
Minimum lease payments	0.5	0.0	**0.5**	0.5	0.0	**0.5**
Contingent rents	-	-	**-**	-	-	**-**
Sub-lease payments	-	-	**-**	-	-	**-**
Total	**0.5**	**0.0**	**0.5**	**0.5**	**0.0**	**0.5**

8.1.2 Future minimum lease payments

	2021-22			2020-21		
	Buildings £m	Other £m	Total £m	Buildings £m	Other £m	Total £m
Payable:						
No later than one year	0.3	-	**0.3**	0.4	-	**0.4**
Between one and five years	0.2	-	**0.2**	0.3	-	**0.3**
After five years	-	-	**-**	-	-	**-**
Total	**0.5**	**-**	**0.5**	**0.7**	**-**	**0.7**

8.2 As lessor

The CCG had none in 2021-22 or 2020-21.

9 Property, plant and equipment

2021-22	Plant & machinery £m	Information technology £m	Furniture & fittings £m	Total £m
Cost or valuation at 01 April 2021	0.1	1.3	0.1	1.5
Additions purchased	0.1	0.6	-	0.7
Cost/Valuation at 31 March 2022	**0.2**	**1.9**	**0.1**	**2.2**
Depreciation 01 April 2021	0.1	0.8	0.1	1.0
Charged during the year	-	0.2	-	0.2
Depreciation at 31 March 2022	**0.1**	**1.0**	**0.1**	**1.2**
Net Book Value at 31 March 2022	**0.1**	**0.9**	**-**	**1.0**
Purchased	0.1	0.9	0.0	1.0
Total at 31 March 2022	**0.1**	**0.9**	**0.0**	**1.0**
Asset financing:				
Owned	0.1	0.9	0.0	1.0
Total at 31 March 2022	**0.1**	**0.9**	**0.0**	**1.0**

The CCG had no Revaluation Reserve for Property, Plant and Equipment.

9.1 Economic lives	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	5	10
Information technology	5	8
Furniture & fittings	5	6

10 Intangible non-current assets

2021-22	Computer Software: Purchased £m	Total £m
Cost or valuation at 01 April 2021	0.2	0.2
Additions purchased	0.2	**0.2**
Cost / Valuation At 31 March 2022	**0.4**	**0.4**
Amortisation 01 April 2021	0.2	0.2
Amortisation At 31 March 2022	**0.2**	**0.2**
Net Book Value at 31 March 2022	**0.2**	**0.2**
Purchased	0.2	0.2
Total at 31 March 2022	**0.2**	**0.2**

10.1 Economic lives

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

11.1 Trade and other receivables

	Current 2021-22 £m	Current 2020-21 £m
NHS receivables: Revenue	1.4	2.2
NHS prepayments	0.4	0.0
NHS accrued income	0.4	0.2
Non-NHS and Other WGA receivables: Revenue	2.0	1.1
Non-NHS and Other WGA prepayments	1.5	1.5
Non-NHS and Other WGA accrued income	3.0	6.1
Expected credit loss allowance-receivables	(0.6)	(0.4)
VAT	0.2	0.1
Other receivables and accruals	0.0	0.0
Total Trade & other receivables	**8.3**	**10.8**
Total current and non-current	**8.3**	**10.8**
Included above:		
Prepaid pensions contributions	-	-

11.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £m	2021-22 Non DHSC Group Bodies £m	2020-21 DHSC Group Bodies £m	2020-21 Non DHSC Group Bodies £m
By up to three months	1.2	1.3	0.0	0.1
By three to six months	-	0.1	0.0	0.1
By more than six months	0.1	0.4	0.2	0.3
Total	**1.3**	**1.9**	**0.2**	**0.5**

11.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £m	Total £m
Balance at 01 April 2021	(0.4)	(0.4)
Lifetime expected credit losses on trade and other receivables-Stage 2	(0.2)	(0.2)
Total	**(0.6)**	**(0.6)**

12 Cash and cash equivalents

	2021-22 £m	2020-21 £m
Balance at 01 April 2021	(7.2)	(4.9)
Net change in year	7.9	(2.3)
Balance at 31 March 2022	**0.6**	**(7.2)**
Made up of:		
Cash with the Government Banking Service	0.6	-
Cash in hand	-	0.0
Cash and cash equivalents as in statement of financial position	**0.6**	**0.0**
Bank overdraft: Government Banking Service	-	(7.2)
Total bank overdrafts	**-**	**(7.2)**
Balance at 31 March 2022	**0.6**	**(7.2)**

13 Analysis of impairments and reversals

13.1 Analysis of impairments and reversals: property, plant and equipment

	2021-22 £m	2020-21 £m
Impairments and reversals charged to the statement of comprehensive net expenditure		
Loss or damage resulting from normal operations	-	(0.1)
Total charged to departmental expenditure limit	**-**	**(0.1)**

13.2 Analysis of impairments and reversals: Intangible assets

	2021-22 £m	2020-21 £m
Impairments and reversals charged to the statement of comprehensive net expenditure		
Loss or damage resulting from normal operations	-	(0.1)
Total charged to departmental expenditure limit	**-**	**(0.1)**
Total impairments and reversals charged to the statement of comprehensive net expenditure	**-**	**(0.1)**
Impairments and Reversals charged to the revaluation reserve		
Total impairments and reversals of intangible assets	**-**	**(0.1)**

14 Trade and other payables	Current 2021-22 £m	Current 2020-21 £m
NHS payables: Revenue	1.5	5.4
NHS accruals	0.9	1.8
Non-NHS and Other WGA payables: Revenue	32.7	17.0
Non-NHS and Other WGA accruals	105.0	96.1
Non-NHS and Other WGA deferred income	0.1	0.1
Social security costs	0.3	0.2
Tax	0.2	0.2
Other payables and accruals	8.4	7.4
Total Trade & Other Payables	**149.1**	**128.2**
Total current and non-current	**149.1**	**128.2**

There are no liabilities due in future years under arrangements to buy out the liability for early retirement.
References to "WGA" relate to balances included in the Governments Whole of Government Accounts exercise.
Other payables include £392k outstanding pension contributions at 31 March 2022.

15 Borrowings	Current 2021-22 £m	Current 2020-21 £m
Bank overdrafts:		
· Government banking service	-	7.2
Total overdrafts	**-**	**7.2**

16 Provisions

	Current 2021-22 £m	Non-current 2021-22 £m	Current 2020-21 £m	Non-current 2020-21 £m
Restructuring	1.8	-	1.0	0.1
Continuing care	3.8	-	3.4	-
Other	5.5	-	4.2	2.0
Total	**11.1**	**-**	**8.6**	**2.2**
Total current and non-current	**11.1**		**10.8**	

	Restructuring £m	Continuing Care £m	Other £m	Total £m
Balance at 01 April 2021	**1.1**	**3.4**	**6.2**	**10.8**
Arising during the year	1.1	1.1	2.6	**4.8**
Utilised during the year	(0.5)	(0.1)	(3.4)	**(3.9)**
Reversed unused	-	(0.6)	-	**(0.6)**
Balance at 31 March 2022	**1.8**	**3.8**	**5.5**	**11.1**
Expected timing of cash flows:				
Within one year	1.8	3.8	5.5	**11.1**
Between one and five years	-	-	-	**-**
After five years	-	-	-	**-**
Balance at 31 March 2022	**1.8**	**3.8**	**5.5**	**11.1**

Restructuring provision recognised to reflect the accommodation and contract costs associated with an outsourced contract and premises re-organisation.

Continuing Care - This category relates to three separate provisions:

- £917k Those existing Continuing Healthcare retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the CHC panel.
- £2,432k Identified funded nursing care cases which may demonstrate eligibility based upon the outcome of the nationally set application and review process.
- £535k Ongoing Continuing Healthcare cases where the CCG has a commitment to fund a care home stay post death.

Under the Accounts Direction issued by NHS England for 2015-16, NHS England is responsible for accounting for liabilities relating to NHS Continuing healthcare claims relating to periods of care before the establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of the legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2022 is £0.51m. NHS England is responsible for meeting any Income Tax payments relating to these claims.

Other provisions reflect a risk share on a third party contract and an onerous contract expiring in 2022-23 and provisions for legal claims.

Where appropriate a provision for legal claims may be calculated from the number of claims currently lodged with the NHS Resolution, and the probabilities provided by them. There are currently no claims logged with NHS Resolution, hence no provision is included in the accounts.

There is a requirement for NHS bodies to note the value of provisions carried in the books of NHS Resolution in regard to ELS (Existing Liabilities Scheme) and CNST (Clinical Negligence Scheme for Trusts) claims as at 31 March 2022.

The provision for ELS claims is £0, and for CNST claims is £0.

17 Contingencies

	2021-22 £m	2020-21 £m
Contingent liabilities		
Continuing Healthcare	3.1	2.3
Net value of contingent liabilities	**3.1**	**2.3**

The contingent liability relating to Continuing Healthcare (CHC) applies to those CHC retrospective cases where eligibility of a case has not yet been determined by a clinical panel at the CCG or NHS England but where a commitment may arise subject to eligibility criteria being met.

18 Commitments

18.1 Capital commitments

The CCG had none in 2021-22 or 2020-21.

18.2 Other financial commitments

The NHS clinical commissioning group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2021-22 £m	2020-21 £m
In not more than one year	115.5	109.6
In more than one year but not more than five years	58.4	1.0
In more than five years	1.7	1.9
Total	**175.6**	**112.5**

19 Financial instruments

19.1 Financial risk management

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

Because the CCG 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 CCG 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 CCG in undertaking its activities.

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

19.1.1 Currency risk

NHS Bath and North East Somerset, Swindon and Wiltshire CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations and therefore has low exposure to currency rate fluctuations.

19.1.2 Interest rate risk

When required the CCG receives capital resource from NHS England for fund capital expenditure and has no powers to borrow. The CCG draws down cash to cover expenditure as the need arises, and does not need to borrow to finance its business. The CCG therefore has low exposure to interest rate fluctuations.

19.1.3 Credit risk

Because the majority of the CCGs revenue comes from parliamentary funding, the CCG 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.

19.1.4 Liquidity risk

NHS Bath and North East Somerset, Swindon and Wiltshire CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arise, and is not, therefore, exposed to significant liquidity risks.

19.1.5 Financial Instruments

As the cash requirements of the CCG 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 the CCG's expected purchase and usage requirements and the CCG is therefore exposed to little credit, liquidity or market risk.

19 Financial instruments cont'd

19.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £m	Total 2021-22 £m	Financial Assets measured at amortised cost 2020-21 £m	Total 2020-21 £m
Trade and other receivables with NHSE bodies	0.8	0.8	1.6	1.6
Trade and other receivables with other DHSC group bodies	4.2	4.2	6.7	6.7
Trade and other receivables with external bodies	1.9	1.9	1.2	1.2
Cash and cash equivalents	0.6	0.6	0.0	0.0
Total at 31 March 2022	**7.5**	**7.5**	**9.5**	**9.5**

19.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £m	Total 2021-22 £m	Financial Liabilities measured at amortised cost 2020-21 £m	Total 2020-21 £m
Loans with external bodies	-	-	7.2	7.2
Trade and other payables with NHSE bodies	0.4	0.4	2.5	2.5
Trade and other payables with other DHSC group bodies	9.3	9.3	33.4	33.4
Trade and other payables with external bodies	138.9	138.9	91.8	91.8
Total at 31 March 2022	**148.6**	**148.6**	**135.0**	**135.0**

The CCG has determined that carrying values is a reasonable proxy for the fair value for short term payables and receivables.

20 Operating segments

	Net expenditure £m	Total assets £m	Total liabilities £m	Net assets £m
BaNES Locality Commissioning	412.9	-	-	-
Swindon Locality Commissioning	440.3	-	-	-
Wiltshire Locality Commissioning	476.1	-	-	-
BSW Commissioning	372.0	10.2	(160.2)	(150.0)
Total	**1,701.3**	**10.2**	**(160.2)**	**(150.0)**

The CCG considers it has four commissioning segments:
- Bath and North East Somerset locality
- Swindon locality
- Wiltshire locality
- BSW wide commissioning

The Net expenditure disclosed within this note has been reported in line the internal monitoring and management of CCG expenditure. Total assets and liabilities are recorded solely against BSW as management does not monitor this at locality level.

21 Joint arrangements

The CCG has entered into arrangements with three local authorities during 2021-22. The detail of these are reported below.

		Better Care Fund			
BaNES Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**	**Adult Services (Learning Disabilities)**	**Children's Services**
	£m	**£m**	**£m**	**£m**	**£m**
Contribution					
Bath & North East Somerset Council	57.3	28.5	0.2	26.0	2.6
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	49.3	41.2	0.5	7.3	0.4
Income from client contributions	-	-	-	-	-
Grant Funding	-	-	-	-	-
Total Funding	**106.6**	**69.6**	**0.7**	**33.3**	**3.0**
Expenditure	**114.5**	**69.6**	**0.7**	**33.4**	**10.8**
Net overspend/(underspend) as detailed below					
Bath & North East Somerset Council	6.8	-	-	0.1	6.7
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	1.1	-	-	0.0	1.1
Total Overspend/(Underspend)	**7.9**	**-**	**-**	**0.1**	**7.8**

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs was signed on 13th April 2022 and all the other accounts were signed on 19th April 2022 by the Chief Financial Officer of Bath & North East Somerset Local Authority.

These statements confirm that the Memorandum Accounts accurately disclose the income received and expenditure incurred in accordance with the Partnership Agreement, as amended by subsequent agreed variations, entered into under section 75 of the NHS Act of 2006.

The net contribution by the CCG to the Joint Arrangement was £50.4m of which £1.1m was a net overspend.

During the year, In addition to the above, the CCG has provided £6.7m of financial support to the Local Authority to support the COVID pandemic. The Local Authority has been the lead on contracting to deliver the national requirements relating to the enhanced hospital discharge programme for residents of Bath and North East Somerset.

21 Joint arrangements cont'd

		Better Care Fund				
Swindon Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**	**Other Adult Services**	**Children's Services**	**Public Health**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Contribution						
Swindon Borough Council	129.3	29.7	-	44.6	44.6	10.3
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	68.2	29.2	0.7	35.7	2.5	-
Income from client contributions	-	-	-	-	-	
Grant Funding	-	-	-	-	-	-
Total Funding	**197.5**	**59.0**	**0.7**	**80.4**	**47.2**	**10.3**
Expenditure	**201.6**	**59.9**	**0.7**	**80.8**	**50.0**	**10.3**
Net overspend/(underspend) as detailed below						
Swindon Borough Council	1.2	1.0	-	(2.7)	2.8	-
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	2.9	(0.2)	0.0	3.0	(0.0)	-
Total Overspend/(Underspend)	**4.1**	**0.9**	**0.0**	**0.4**	**2.8**	**-**

The Clinical Commissioning Group has aligned budget arrangements with Swindon Borough Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Swindon Borough Council.

Any over/underspend on health services sit with the Clinical Commissioning Group and over/underspends on social care services sit with the Local Authority. Over/underspends on community equipment are shared according to fixed percentages.

The net contribution by the CCG to the Joint Arrangement was £68.2m of which £2.9m was a net overspend.

During the year, In addition to the above, the CCG has provided £11.8m of financial support to the Local Authority to support the COVID pandemic. The Local Authority has been the lead on contracting to deliver the national requirements relating to the enhanced hospital discharge programme for residents of Swindon.

21 Joint arrangements cont'd

		Better Care Fund	
Wiltshire Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**
	£m	**£m**	**£m**
Contribution			
Wiltshire Council	18.7	16.9	1.8
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	36.3	32.6	3.7
Income from client contributions	-	-	-
Grant Funding	-	-	-
Total Funding	**55.0**	**49.5**	**5.5**
Expenditure	**50.4**	**45.6**	**4.8**
Net overspend/(underspend) as detailed below			
Wiltshire Council	(5.1)	(3.9)	(1.2)
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	0.5	-	0.5
Total Overspend/(Underspend)	**(4.6)**	**(3.9)**	**(0.7)**

The Clinical Commissioning Group has aligned budget arrangements with Wiltshire Council pursuant to Section 75 of the National Health Service Act 2006. The budgets are hosted by Wiltshire Council.

Overspends and underspends on the Better Care Fund are managed by the Local Commissioning Board in accordance with the S75 agreement. If all remedial options to correct an overspend are exhausted, that the overspend will be recovered from the parties to the Fund in proportion to their respective financial contributions. Underspends are divided equally between the partners, unless a different arrangement is agreed by the Local Commissioning Board. The community equipment budgets are not pooled, and any overspend or underspend is attributed to the party that was responsible.

The final contribution by the CCG to the Joint Arrangement was £36.8m, of which £0.5m was a net overspend on Community Equipment.

During the year, in addition to the above, the CCG has provided £9.35m of financial support to the Local Authority to support the COVID pandemic. The Local Authority has been the lead on contracting to deliver the national requirements relating to the enhanced hospital discharge programme for residents of Wiltshire.

22 Related party transactions

Details of related party transactions with individuals are as follows:

The CCG has made payments under General Medical Contracts with GP practices for which members of the Governing body are partners of. These payments are to an organisation and not individuals. The CCG has also reimbursed practices for Locum and related costs. The figures below reflect financial transactions between the CCG and GP practices and not between governing body members and the CCG. Details of payments made to GPs for their services to the CCG are included in the Remuneration report. The amounts disclosed below relate to the period up to 31st March 2022.

	Payments to Related Party £m	Receipts from Related Party £m	Amounts owed to Related Party £m	Amounts due from Related Party £m
Dr Andrew Girdher, Clinical Chair - Transactions for Box Surgery	1.2	-	0.0	-
Dr Ruth Grabham, Medical Director - Transactions for Heart of Bath Medical Partnership	4.3	-	0.2	-
Dr Brynn Bird - Locality Clinical Lead (B&NES), GP Partner Cadbury Heath Healthcare, Sessional GP St Augustines Healthcare.	1.9	-	0.1	(0.0)
Dr Amanda Webb - Locality Clinical Lead (Swindon) - Transactions for Westrop Medical Practice	7.0	-	1.0	(0.0)
Dr Edward Rendell - Locality Clinical Lead (Wiltshire) - Transactions for The Orchard Practice	3.5	-	0.0	-
Dr Tim Sephton - Locality Healthcare Professional (B&NES) - Transactions for Chew Valley Medical Practice	3.0	-	0.2	(0.0)
Dr Francis Campbell - Locality Healthcare Professional (Swindon) - Transactions for Elm Tree Surgery	1.3	-	0.1	(0.0)
Dr Catrinel Wright - Locality Healthcare Professional (Wiltshire) - Transactions for Lovemead Practice	2.3	-	0.0	(0.0)
Dr Sam Dominey - Locality Healthcare Professional (Wiltshire) - Transactions for Three Chequers Medical Practice	4.8	-	0.0	(0.0)
Dr Nick Ware - Locality Healthcare Professional (Witlshire) - Transactions for Northlands Surgery	1.9	-	0.0	-

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department of Health is regarded as the parent Department.
Great Western Hospitals NHSFT
Royal United Hospitals Bath NHSFT
Salisbury NHSFT
South Western Ambulance NHSFT
Oxford University Hospitals NHSFT
Gloucestershire Hospitals NHSFT
Avon and Wiltshire Partnership NHS Trust
North Bristol NHS Trust
NHS England
South Central and West CSU
NHS Property Services

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Swindon Borough Council, Wiltshire Council and Bath and North East Somerset Council. As part of BSW STP in 2021-22, the CCG has been both the host and recipient for funding which has been allocated to the STP.
The CCG considered all employees involved in the award of contracts, however, under the Scheme of Delegation, only Executive Directors are able to award contracts, within Delegated limits. The CCG has therefore only included Related Party Notes for Governing Body Members and Directors.

The CCG has detailed in this note all declarations of interest for Governing Body Members, however, only related party transactions have been disclosed where they meet the criteria of having (i) control or joint control over the reporting entity, (ii) have significant influence over the reporting entity or (iii) are a member of the key management personnel.

23 Events after the end of the reporting period
The accounts were authorised for issue by the Chief Financial Officer on 16/06/2022.

The Health and Care Act received Royal Assent on 28 April 2022. Subject to the issue of an establishment order by NHS England the CCG will be dissolved on 30 June 2022. On 1 July the assets, liabilities and operations will transfer to NHS Bath and North East Somerset, Swindon and Wiltshire ICB.

24 Financial performance targets
NHS Bath and North East Somerset, Swindon and Wiltshire CCG has a number of financial duties under the NHS Act 2006 (as amended).
NHS Bath and North East Somerset, Swindon and Wiltshire CCGs performance against those duties was as follows:

	2021-22 Target £m	2021-22 Performance £m	2020-21 Target £m	2020-21 Performance £m
Expenditure not to exceed income	1,709.0	1,709.0	1,525.4	1,525.3
Capital resource use does not exceed the amount specified in Directions	0.9	0.9	-	-
Revenue resource use does not exceed the amount specified in Directions	1,701.3	1,701.3	1,521.0	1,520.9
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	18.6	17.2	17.7	17.6

The CCG has met all of the financial performance targets for 2021-22.

NHS England set the CCG a Revenue Resource Limit of £1,701m for 2021-22 and the CCG achieved an underspend of £43k against this target.

The target for administration costs for 2021-22 was at £18.6m and the CCG achieved an underspend of £1,417k. The underspend on administration costs has been reinvested into healthcare services.

During 2021-22 the CCG hosted the funding for the Thames Valley Cancer Network. All funding received has either been transferred to other NHS Organisations or will be paid across in 2022-23. At the 31st March 2022, £1.805m has been accrued. The CCG has received £0k for its roles on the alliance and for project management.

25 Losses and special payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £m	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £m
Administrative write-offs	-	-	5	0.1
Fruitless payments	-	-	1	0.0
Total	**-**	**-**	**6**	**0.1**

24.1 Special payments

	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £m	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £m
Compensation payments	1	0.0	-	-
Total	**1**	**0.0**	**-**	**-**