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

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

1 April to 30 June 2022

Contents

PERFORMANCE REPORT

Sue Harriman

Accountable Officer

22 June 2023

Performance Overview

NHS organisations produce an annual report and financial accounts at the end of every financial year. In this report, Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) describes how it fulfilled the duties described in the National Health Service Act 2006 for the first three months of the 2022/23 reporting year, after which the CCG formally transitioned to an integrated care board (ICB).

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.

Accountable Officer's report (June 2022)

The clinical commissioning group for Bath and North East Somerset, Swindon and Wiltshire is still a relatively new organisation, having only formed a little more than two years ago, when the three standalone CCGs in the region came together as part of a formal merger process.

At the time, nobody could have predicted that the organisation's first two years would coincide with a global pandemic that would see services change overnight, staff relocate from offices and the NHS undertake the largest vaccination rollout in its history.

On top of Covid-19 and getting to grips with a newly-merged organisation, staff at the CCG have had to carry out their day job while looking ahead to another period of transition.

This is where we find ourselves in June 2022, with the establishment of the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board now scheduled to take place on Friday 1 July.

While it's another period of change, it should be seen as a positive step forward, and one that will make a real and tangible difference to the way local people receive health and care.

I officially joined the CCG as its Accountable Officer on Friday 1 April 2022, and was thrilled to have the opportunity to lead this vibrant, energetic and dynamic organisation through an exciting change process.

Staff at all levels have shown great enthusiasm for the move towards becoming an integrated care board, and I have really enjoyed speaking with colleagues at our weekly question and answer sessions, all of which have produced lively conversations and a productive two-way dialogue.

But while it would be easy to focus all our attention on the imminent transition, important day-to-day activity within the CCG has continued, with the first quarter of 2022/23 being every bit as busy as the previous 12 months.

At its meeting in May 2022, the CCG Governing Body arrived at the decision not to extend the contract (HCRG) beyond 31 March 2024, though recognising that a fundamental review of community and out of hospital services was needed to ensure BSW could deliver the ambitions of the NHS Long Term Plan. I am certain that when the time comes to work with local people and partners on how to redesign this service, we will be able to shape a new and exciting integrated model for health and social care services that will not only benefit local people, but also allow us to commission at scale.

We arrived at the decision not to extend the contract after carefully considering all available options, and agreeing that this course of action would allow us to continue providing high quality services that meet the needs of our local communities, while ensuring we make the best use of public money.

I am certain that when the time comes to work with local people and partners on how to redesign this service, we will be able to shape a new and exciting integrated model for health and social care services that will not only benefit local people, but also allow us to commission at scale.

Looking at how to provide care in a more joined-up way will be something we do a lot of over as we move to become an ICB, and I'm pleased that current building projects happening in our region will give our colleagues, as well as those from partner organisations, state-of-the-art environments for this new way of working.

One such project nearing completion is the new Devizes Health Centre, which is being built on land opposite the now-outdated Devizes Community Hospital.

This new facility, which will be one of the country's first NHS venues to be carbon net zero, will not only replace the services currently offered at the nearby hospital, but will also house a new on-the-day primary care team. Furthermore, the site will become the home for a range of community-based services, such as phlebotomy, physiotherapy, audiology, podiatry, diabetes and mental health.

Doors to this new centre are expected to open to patients later in the year but before then, a summer of events are planned to give both colleagues and local residents the chance to tour the site ahead of the official ribbon cutting.

Many in Devizes have waited a long time for this new health centre, so it is fantastic to be able to finally deliver this brand new venue, which will be something of a flagship location for local health and care services.

Twenty or so miles north of Devizes, another new healthcare building has recently been unveiled.

The new Tadpole Surgery, located on the northern edge of Swindon, welcomed its first patients on Monday 16 May, after being officially opened by the local MP, Justin Tomlinson.

This new GP practice, which is the first in Swindon for many years, will be a huge benefit for local families, many of whom have long been calling for a surgery in their own community.

I know that Tadpole Garden Village, which is where the new practice is based, is an area that thrives on community values, and it is these same principles that are at the heart of everything we have done as a CCG and will continue to do as an integrated care board.

My thanks go out to all colleagues who have helped bring these two projects to fruition, and I know that many local people would also join me in passing on their appreciation.

Of course, just like the last two years, the first three months of this year have seen Covid-19 continue to affect our day-to-day operations, not least the continued rollout of the vaccine.

Many CCG staff are still occupied with ensuring that those in our region who wish to be vaccinated have the opportunity to do so.

Over the last few weeks, teams have been doing all they can to support the spring booster programme, which provides the over 75s, as well as care home residents and those aged 12 and over with a weakened immune system, with an extra top-up dose, which experts say will help prolong the immune-boosting effects of previous vaccines.

The response from local people to this latest vaccination phase has been phenomenal and, at the time of writing, more than 83,600 people have so far come forward, meaning around 80 per cent of all who are eligible for a spring booster have now been quadruple vaccinated.

Those involved with the vaccination programme have put in a stellar performance since the very first jab was given in December 2020, and it was only right that the recent Thank You Day on Sunday 5 June saw the CCG raise a glass to all those who helped to make the vaccine rollout such a monumental success.

In total, around 2.2 million vaccines have been given out in BSW, and this number will increase as we continue through 2022, with another booster round expected to happen in the autumn.

I know that planning work for this is already taking place behind-the-scenes, and I'd like to say a personal thank you to all colleagues and volunteers whose continued dedication and professionalism has helped our region turn the tide on Covid-19.

So, as we move forward and say goodbye to one organisation, I would like us not to forget all that has been achieved over the last two years, but to take the spirit, determination and resourcefulness of the CCG with us into the integrated care board, and to use these characteristics to ensure our next venture is just as successful as the one we leave behind.

Transition to an integrated care board

Clinical commissioning groups were replaced by integrated care boards on Friday 1 July 2022.

Bath and North East Somerset, Swindon and Wiltshire CCG worked through a comprehensive plan to ensure all colleagues and functions transferred safely to the ICB.

This plan also included the recruitment of the ICB's executive leadership team.

The membership of the new executive leadership team can be seen below:

- Sue Harriman, Chief Executive Officer
- Richard Smale, Director of Strategy and Transformation
- Gill May, Chief Nurse
- Dr Amanda Webb, Chief Medical Officer
- Jasvinder Sohal, Chief People Officer
- Dr Jane Moore, Director of Equalities, Innovation and Digital Enterprise
- Laura Ambler, Director of Place – Bath and North East Somerset
- Gordon Muvuti, Director of Place – Swindon
- Fiona Slevin-Brown, Director of Place – Wiltshire
- Gary Heneage, Chief Finance Officer
- Rachael Backler, Director of Planning and Performance

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 was 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 had been done by assessing local needs, agreeing priorities and strategies, and then buying services on behalf of residents from a range of health and care providers, while constantly responding and adapting to changing local circumstances.

Being led by local clinicians, elected members and lay people, all of whom are close to patients and their needs, enabled the CCG to provide quality care to people living in the area.

Our vision and values

The vision of the CCG was: working together to empower people to lead their best life.

The was underpinned by three core principles:

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

Developed by colleagues, the organisation's five core values described the way the CCG worked, and helped to guide the actions and decisions made for local people.

How we spend our money

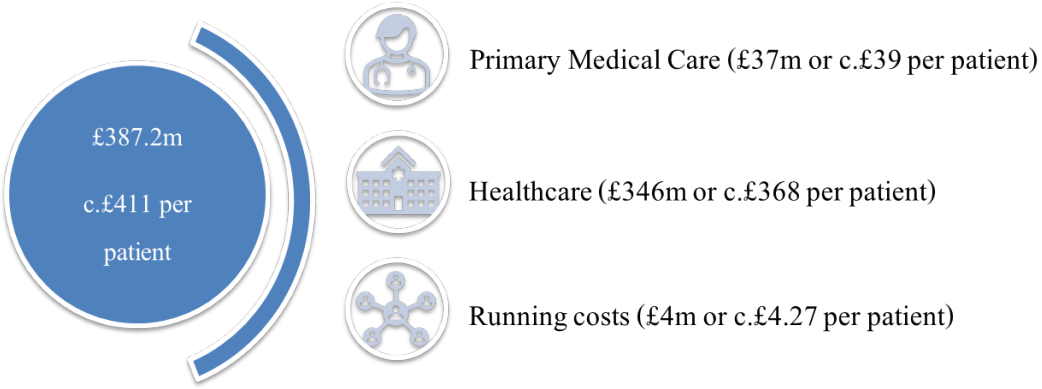
NHS England allocates funding to all CCGs using a standardised approach that takes into account local healthcare needs and health inequalities.

During 2020/21 and 2021/22, temporary changes were made to how CCGs were funded due to the Covid-19 pandemic. This resulted in systems receiving additional funding on a non-recurrent basis.

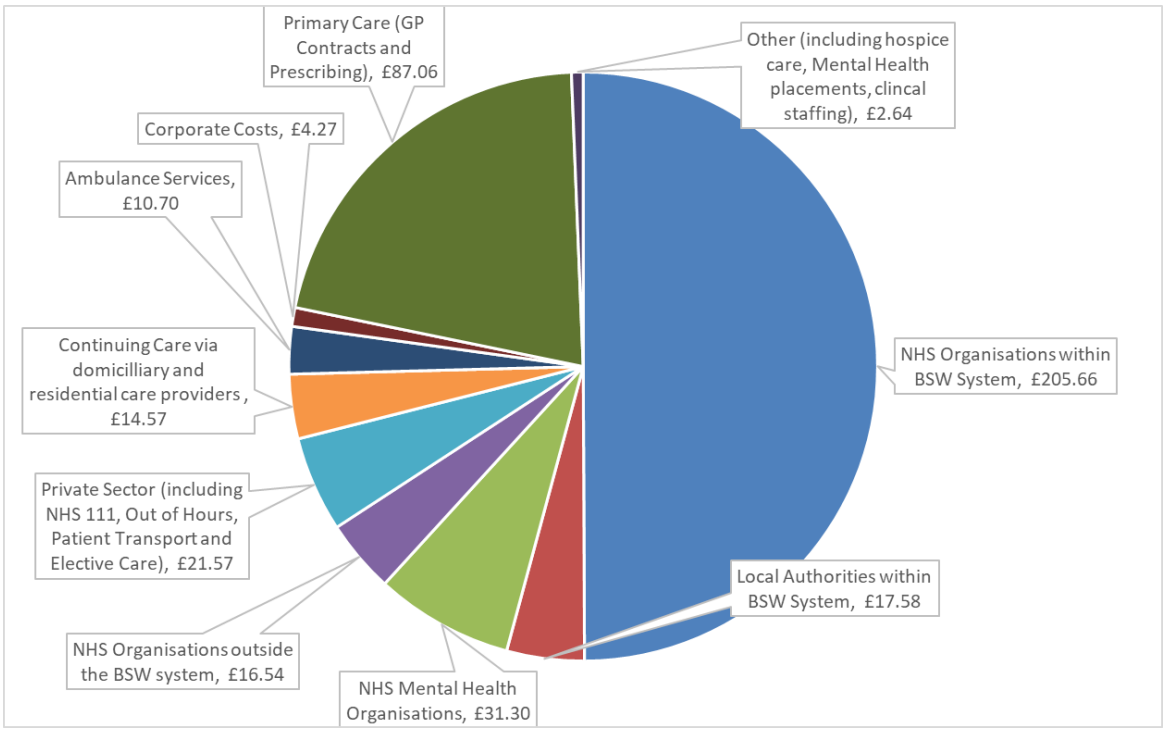
However, as a result of the strong vaccination uptake and the expected reduction in Covid-19 prevalence, these temporary changes are to be phased out during 2022/23. The CCG will continue to receive some Covid-19 funding, but at a reduced rate.

The CCG's funding goes towards developing plans that address the health needs of the population, while also paying for the services used by local people.

Funding received

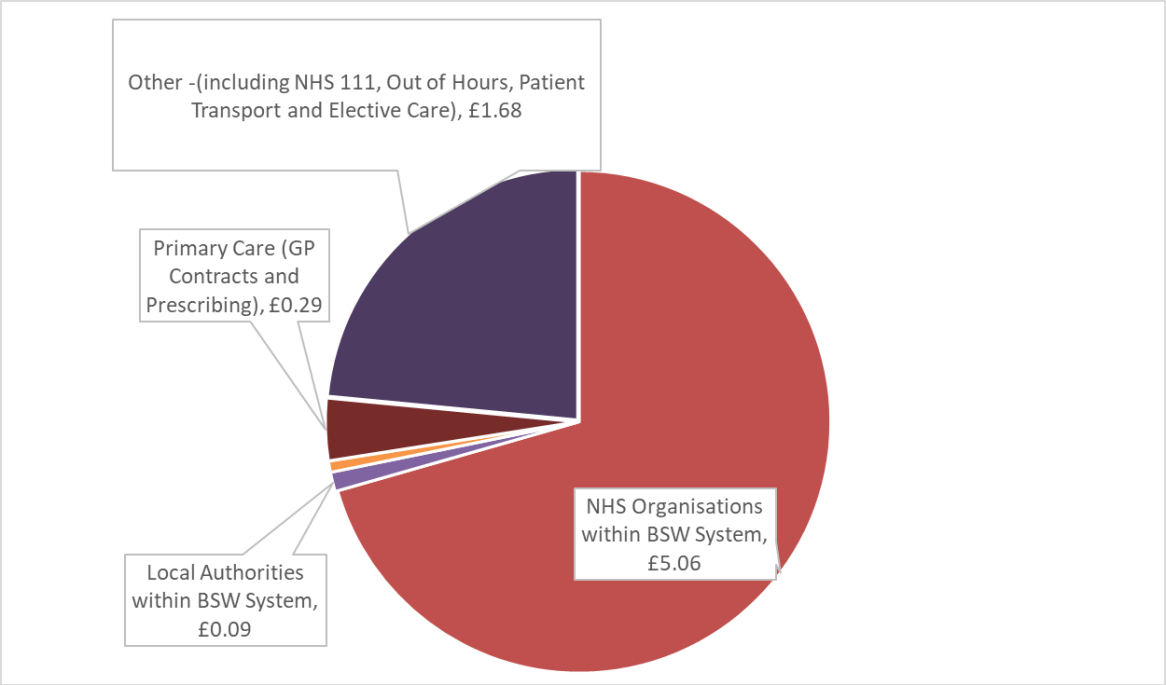


Where the £411 per patient was spent



The CCG spent £6.6 million on its response to Covid-19 during the period, which equates to around £7 per patient.

Covid-19 spending has reduced significantly since 2021/22, as discharge funding arrangements have reverted to pre-pandemic arrangements, with funding responsibility once again being determined by assessment.



Further details on the CCG's financial performance for the year are included within the financial statements.

The CCG publishes details of all payments more £25,000 on its website.

Our population and their health

Approximately 940,000 people live in the CCG's catchment area. Residents are spread out across a large and varied geographical area, which 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 still pockets of high 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 physical and mental health issues.

The three main causes of mortality are cancer, cardiovascular disease and respiratory disease. People living in the more deprived areas face poorer health outcomes in response to these three conditions, as well as many others.

The main contributing factors for these diseases are smoking, being overweight, not getting enough physical activity and regularly consuming a high volume of alcohol. A focus of the integrated care system is to support people in high-risk groups to make healthier lifestyle choices and alter the policy and physical environment around them to make it easier to do so.

Corporate objectives

For the first three months of 2022/23, the CCG identified the following corporate objectives:

- Workforce recovery, health and wellbeing
- Recovering from Covid-19
- Developing the integrated care system to meet expectations set out in the integrating care guidance
- Improving patient safety and embedding system approach
- Ensuring financial sustainability
- Transforming services and developing local priorities
- Running things well
- Enablers

Each objective had 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, were set out in the controls and assurances.

Key risks and issues

During 2021/22, the profile of the organisation's most significant risks changed. These were then carried forward into the first three months of 2022/23.

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**
  This risk centered around seasonal influenza, in that people may mistake Covid-19 for the common cold and not get tested or follow the rules around social isolation. Also, as the government removes all Covid-19 restrictions and the public resume a near normal life, there is the potential for an increase in Covid-19, as well as the emergence of new variants.

  Mitigating actions included:
  - Having a robust 24/7 incident management and on-call structure to manage the CCG's business continuity
  - Putting in place command and co-ordination arrangements to work with NHS England, Public Health England, local councils and NHS providers to plan for current and future requirements
  - Holding a weekly tactical call across the BSW system to providing a touchpoint for partners to monitor impacts and provide a shared situational awareness
  - Planning and responding to calls with local resilience forums

- **Delivery of the Covid-19 vaccine**
  This risk related to the vaccine supply pipeline into BSW, which could fluctuate. This meant it was difficult to plan vaccine clinic capacity and to inform local people of how to access a vaccine. Additional impacts of this included specific population risks, workforce, finance. information and data and operational sustainability.

Mitigating actions included:

- Embedding a BSW governance structure to support this programme of work
- Continuing the outreach programme and making use of population health data and collaborative working to ensure that targeted action could be taken where take up was lower
- Communicating effectively with local people and providing trustworthy information resources, such as an FAQ page on the CCG
- Supporting individual patient queries through the Patient Advice and Liaison Service (PALS)

- **System-wide workforce and resilience**
  This risk involved the CCG workforce not being able to meet the demand of services. As a system, there had not been a process to identify and deploy staff to maximise impact according to patient need. The risk to the CCG was that services could fail to be operate effectively.

  Mitigating actions included:
  - Establishing a local risk management process for staffing
  - Creating a community hub approach
  - Driving forward recruitment initiatives, such as international recruitment
  - Using the Operational People Delivery Group (OPDG) workstream on recruitment, retention and supply to support the whole system
  - Developing system-wide surge plans

- **Seasonal planning**
  This risk involved the CCG not having sufficient capacity to safely manage seasonal surges in demand.

  Mitigating actions included:
  - Planning bed demand and capacity in advance
  - Creating plans specific to surges in demand, and exploring emergency planning, resilience and response (EPRR) initiatives
  - Setting up an Urgent Care and Flow Board
  - Holding regular tactical urgent care meetings

- **Demand on primary care**
  This risk focused on the possibility that an increase in demand on primary care services could impact on its ability to maintain safety and effectively deliver a new operating model.

  Mitigating actions included
  - Ensuring high-risk practices regularly raised concerns with both the CCG and Local Medical Council
  - Contacting practices regularly through dedicated Microsoft Teams calls and webinars
  - Implementing the Winter Access Fund plans in each locality
  - Developing surge plans across primary care
  - Implementing a communication plan that highlighted how both the public and system partners could support primary care services

- **Hospital handover delays and ambulance call stack delays**
  This risk related to ambulance resources not being able to be dispatched, which left patients waiting within the 999 call stack. There was also a risk that the ambulance crew's inability to offload patients at hospital emergency departments within 15 minutes of arrival would lead to delays in responding to new calls. This then posed a risk to patient safety and also the health and wellbeing of ambulance crews, due to staff not being able to take breaks and finish shifts on time.

  Mitigating actions included:
  - Establishing ambulance standard operating procedures and policies, including Handover Standard Operating Procedure, Category 3 and Category 4 validation and Surge Management Policy
  - Holding ambulance governance meetings to review the performance of South Western Ambulance Service NHS Foundation Trust
  - Ensuring the BSW Urgent Care and Flow Board (UCFB) and Quality and Performance Assurance Committee have oversight of ambulance performance
  - Supporting ambulance crews with a dedicated welfare vehicle

- **Delays in hospital discharges**
  This risk related to delays in discharges for hospital patients who no longer required inpatient care. Such patients could be exposed to risks such as hospital acquired infections and increased deterioration.

  Mitigating actions included:
  - Providing governance support through the weekly integrated care alliance response meetings and the BSW incident tactical calls
  - Using these meetings, as well as the daily system flow calls, to manage and monitor actions
  - Producing and monitoring trajectories for reducing the number of no criteria to reside patients
  - Holding regular Multi Agency Discharge Events in each acute hospital
  - Mobilising additional surge capacity

- **Elective recovery**
  There was a risk that elective care capacity would not recover as planned or to the extent it was required to do so, and that the mitigating actions would not deliver results. In turn, this generated a further risk of the system not being able to achieve national waiting list targets.

  Mitigating actions included:

  - Developing a specific workstream led by the chief operating officers at each of the region’s three acute hospitals
  - Reviewing waiting lists on a weekly basis
  - Creating additional activity opportunities

Further information can be found on page 51.

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 was required to assess whether the CCG was a going concern, which related to whether the organisation could 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, the functions undertaken by the CCG would be transferred to an existing public sector entity or one that was 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.

In April 2022, the new Health and Care Act received Royal Assent in Parliament and, as such, it was announced that CCGs would dissolve and be replaced by new organisations known as integrated care boards.

This transition took place on Friday 1 July, and with it the assets, liabilities and duties transferred from BSW CCG to the new Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board.

Performance analysis

Year-end performance summary

Between April and June, the CCG continued to focus on delivering the following key NHS priorities:

- Managing the Covid-19 pandemic, including the vaccination programme
- Supporting patients and services that had been impacted by high pressures in urgent and emergency care
- Working to reopen all services
- Recovering elective care services to reduce waiting lists

This has changed how NHS England has asked organisations to deliver the national access standards, including the NHS constitutional measures.

For example, in elective care, the NHS is focused on reducing waiting lists and the number of people waiting two years for treatment, rather than the 18-week access times. For access to mental health services, the CCG was asked to support an absolute number, 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. Doing so will enable the system to deliver timely access with positive outcomes for the population.

The CCG also worked with providers to ensure that patient safety was not compromised during times of increased pressure and demand for emergency care, and that longer waiting patients were managed in a way that maintained safety and clinical effectiveness.

The organisation consistently aimed to improve the quality of local health and care services. This was carried out in the context of working within the set financial allocation, while also managing the ever-increasing demand for services.

NHS Oversight Framework

The NHS System Oversight Framework for 2021/22 was the regulatory regime being implemented for integrated care systems and NHS provider trusts, which reinforced system-led delivery of integrated care.

There are four ratings or segments that each Integrated Care System (ICS) and trust will be assessed and categorised with, all of which identify the level of support needed by each trust or system.

The most recent ratings were issued in October 2021 and published in the 2021/22 annual report.

Further details on the NHS System Oversight Framework can be found on the NHS England and NHS Improvement website.

The NHS Oversight Framework has been updated for 2022/23, and was published at the end of June for ICBs to use with their systems.

Performance reporting and management

Between April and June, Bath and North East Somerset, Swindon and Wiltshire CCG continued to use the system performance, quality and finance report for both CCG and ICS use.

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 used this reporting in multiple forums as a key tool to provide knowledge and assurance, while also enabling scrutiny and review:

- Governing Body: providing assurance with an integrated view on the quality, performance and finance of the CCG
- BSW system partners and wider system partnerships: including the CCG, local providers (acute and community), local authorities and NHS England and NHS Improvement
- Joint Quality and Performance Assurance Committee: 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 were a number of national standards that enabled the CCG 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. Some of these are included within this report. Between April and June 2022, these measures were reported with a focus on current NHS priorities.

Figures quoted below are taken from the most current benchmarking data.

Performance delivery of the national standards was managed by the quality team who worked with providers to ensure patient safety was not compromised during times of increased pressure in emergency departments, and that waiting lists were managed in a way that maximised patient safety and clinical effectiveness.

This work took on significant importance due to Covid-19, 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 timeline of the process has been impacted by the pandemic.

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 considered 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 in both a hospital and community setting. Since then, there has been a significant focus on managing the subsequent waiting lists.

Demand for urgent and emergency care remained high between April and June 2022, with NHS 111, ambulance services and emergency departments experiencing significant pressure.

In June, the rising prevalence of Covid-19 meant there were more instances of staff and patients having the virus at the same time. This limited people’s access to care.

Primary care played a significant role in simultaneously delivering the Covid-19 vaccination and working to return face-to-face care back to pre-pandemic levels, while also beginning to recover non-urgent patient support, such as clinical reviews.

For elective care, waiting lists continue to increase, 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 an emergency department 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 because of discharge delays. 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 4 hours* (All)	Jun-22	95%	72.1%	61.2%	72.8%		
Ambulance Response Times (minutes) Cat 1 Mean	Jun-22	7	n/a	11.5	11		
Ambulance Response Times (minutes) Cat 1 90th percentile	Jun-22	15	n/a	21	20.1		
Ambulance Response Times (minutes) Cat 2 Mean	Jun-22	18	n/a	69.8	60.1		
Ambulance Response Times (minutes) Cat 2 90th percentile	Jun-22	40	n/a	156.9	133		
Ambulance Response Times (minutes) Cat 3 90th percentile	Jun-22	120	n/a	516.1	402.9		
Ambulance Response Times (minutes) Cat 4 90th percentile	Jun-22	180	n/a	315.1	543		
NHS111 Answered in 60 seconds	Jun-22	95%	72.4%	50.7%	47.1%		
NHS111 % Calls clinically triaged	Jun-22	75%	93.8%	92.4%	80.6%		

* Provider data: BANES – Royal United Hospital (RUH), Swindon – Great Western Hospital (GWH), Wiltshire – Salisbury Foundation Trust (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

Between April and June 2022, the urgent care performance trends from 2021/22 continued, with local systems not able to meet the national A&E four-hour target. However, the national average rate demonstrated that the target had not been achieved across the country.

Following reduced demand during the pandemic, the summer of 2021 saw A&E attendances increase in both volume and complexity, with hospitals becoming full and ambulance services being stretched. This reached a peak during the first three months of 2022, but continued through the subsequent months.

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 continued outside of the national targets between April and June 2022. The ongoing pressure in hospitals resulted in high levels of delayed ambulance handovers, which ultimately reduced the availability of ambulances for new calls.

The number of calls to NHS 111 remained high during the period between April and June, and was 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 remained below target, and dropped to below the England and South West average. The level of clinical triage was above target, though below England and South West average.

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.

National Standard	Period reported	Target	Performance		BSW Total		
			England	South West		vs Eng	vs SW
Referral To Treatment Overall Waiting List % growth in year	Jun 2022		6.2%	8.4%	9.7%		
Patients waiting 18 weeks or less from referral to hospital treatment	snapshot Jun 2022	92%	62.5%	61.3%	64.0%		
Patients waiting over 52 weeks for treatment	snapshot Jun 2022	0	357,577	36,434	3,207		
Patients waiting over 104 weeks for treatment	snapshot Jun 2022	0	3,453	1,154	17		
Patients waiting six weeks or more for Diagnostics	snapshot Jun 2022	1%	27.5%	33.7%	38.7%		
Patients seen within two weeks of a referral for suspected Cancer	Q1 2022/23	93%	79.9%	71.9%	82.7%		
People with urgent GP referral being told of cancer diagnosis outcome within 28 days of referral (FDS)	snapshot Jun 2022	75%	70.4%	71.6%	72.6%		
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q1 2022/23	85%	62.5%	66.1%	69.3%		

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 patient waiting list grew from 78,163 patients in March 2022 to 85,747 patients in June 2022.

The CCG and its providers have developed a system plan to deliver the elective recovery programme in 2022/23 to reduce waiting times for patients, especially those who are classed as a long waiter.

Tools were put in place to identify and track the patients at risk of waiting longer than 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 June 2022, there were 17 patients waiting more than 104 weeks. BSW is on target to treat almost all patients, not requesting a delay, by the end of July.

Diagnostic waiting times have continued to be challenging in the BSW system, with 39 per cent of patients now waiting longer than the six-week standard. This figure is higher than March 2022, when 34 per cent of patients were waiting longer than the six-week standard.

Cancer access waiting times between April and June 2022 did not meet the national standards, but performed well against national and regional averages. The CCG worked with the local cancer alliances to put recovery plans in place for the most challenging areas. Access to cancer services in two weeks in June 2023 is 82.7 per cent, which is above the England and South West average.

There is a new national standard to support diagnosis within 28 days, and 72.6 per cent of diagnoses in June 2023 met this standard, which is just below the 75 per cent standard. Of those requiring treatment, 69.3 per cent were treated within 62 days of referral, which is above the England and South West average.

Access to mental health

In recent years, national standards have been developed to enable the CCG to measure waiting times for many mental health services. This allows for a better understanding of the progress made in delivering timely access to mental health services.

The CCG worked with local partners on the BSW THRIVE workstream to develop services, while still 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)	Jun-22	6,018	305,669	27,320	2,715		
Improving Access to Psychological	Jun-22	50%	49.5%	47.0%	30.0%		

Therapies – recovery rate (Qtr)							
Improving Access to Psychological Therapies – treated within 6 weeks of referral (Monthly)	Jun-22	75.0%	88.9%	91.0%	92.5%		
Improving Access to Psychological Therapies – treated within 18 weeks of referral (Monthly)	Jun-22	95.0%	98.4%	100.0%	100.0%		
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral (Qtr)	Jun-22	60%	67.8%	70.2%	68.3%		
Access to Children and Young People's Mental Health Services (1 contact) rolling 12 month	Jun-22	12,798	691,935	49,925	8,770		
Children and Young People Eating Disorders: seen within four weeks for non-urgent cases.	Jun-22	95%	69.1%	35.9%	67.3%		
Estimated diagnosis rate for people with dementia (diagnoses as % of prevalence)	Jun-22	66.7%	62.0%	57.3%	56.6%		

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 national target for growth in access to community talking services, both in a group and one-to-one setting, is set on an estimated expected prevalence. A review is under way to support the service to meet the new expected demand. Patients who may have reached out during the pandemic, but now choose not to engage with the service, are being discharged without completing treatment, hence why the recorded recovery rate is below normal levels.

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. Overall, the CCG had good performance in this area, with only minor fluctuation due to the low numbers of people needing the service.

Access to children and young people's mental health services is measured against an expected prevalence of need. The CCG developed a range of services to sit alongside the traditional Child and Adolescent Mental Health Service (CAMHS), such as an online support service, as well as group and one-to-one sessions provided by smaller local providers.

These providers have not previously reported activity nationally and are being supported to meet the technology and data standards needed to submit data that can be included in these standards.

Performance for the access standard for eating disorder services for children and young people has been impacted by the pandemic and a recovery plan is being put in place to support the waiting list.

The CCG is not meeting the national standard for dementia diagnosis rates but is performing similar to the South West. A recovery plan is being developed.

Covid-19

As had been the case throughout 2021/22, the new financial year began with a continued focus on providing local people with access to the Covid-19 vaccine and, in particular, the spring booster jab for those who were eligible.

During the first three months of 2022/23, a total of 74,289 vaccinations were carried out across Bath and North East Somerset, Swindon and Wiltshire. Included in this total were 51,260 spring booster jabs, which were provided to people over the age of 75, as well as any person over the age of 12 with a weakened immune system. Care home residents were also offered this top-up vaccination, which was rolled out to help prolong immunity to Covid-19 among those people most at risk of falling seriously ill.

At the end of June, approximately 800,000 people across the region had received at least one Covid-19 vaccination, which was up around 10,000 on where the total stood at the end of March. On top of this, more than 760,000 local residents have had a second jab, and a further 637,000 have also had the recommended first booster vaccine.

This strong performance means that, for the whole of BSW, more than three quarters (77 per cent) of the local population have been double-vaccinated.

Looking ahead, the teams who work behind the scenes of the vaccination programme will spend the summer months supporting colleagues on the ground to plan for the next round of booster vaccinations, which is due to take place in the autumn.

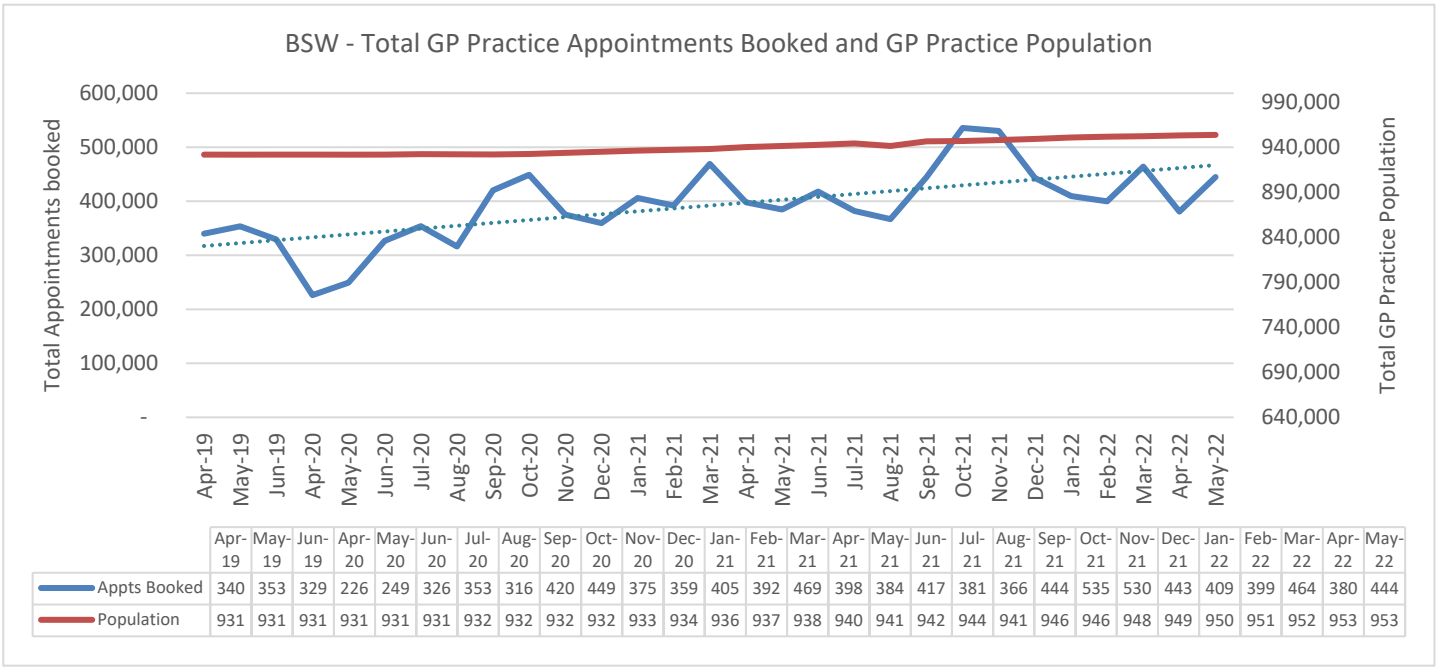
Primary care

GP practices across BSW have continued to maintain a high level of service to patients throughout the unprecedented and challenging times during and following the pandemic.

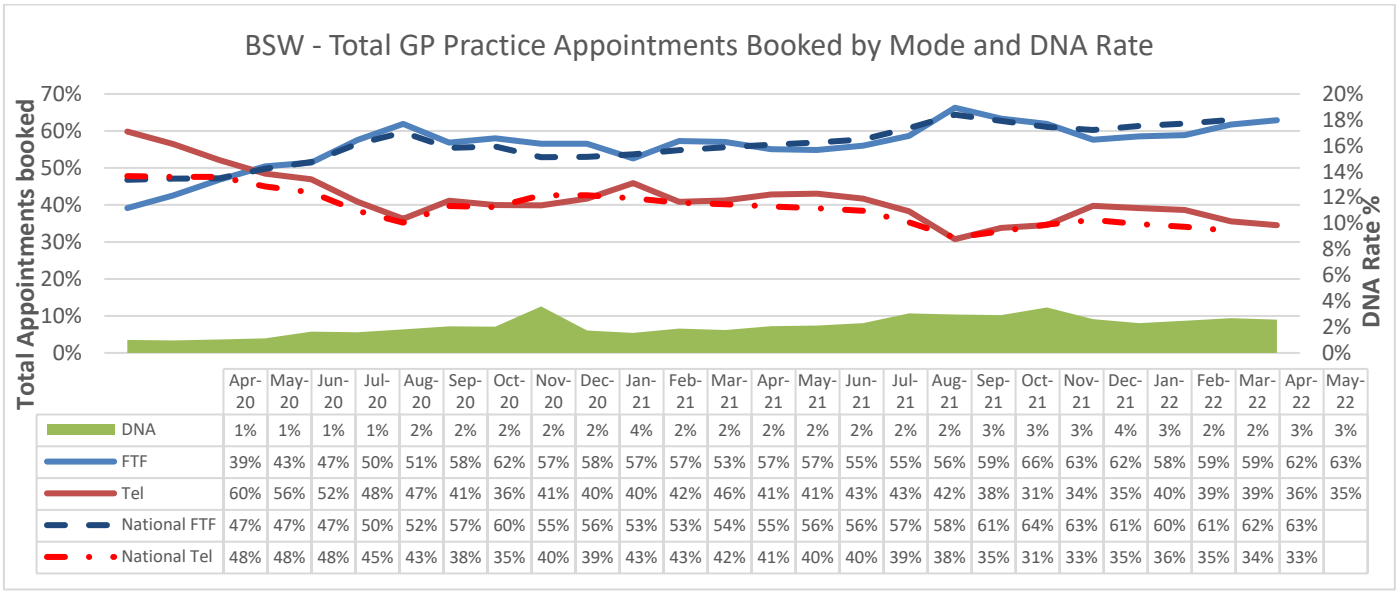
Teams have provided as comprehensive a range of services as possible, using digital technology and maintaining a risk-based approach, as set out in the national operating models.

Throughout the last year, the Primary Care Commissioning Committee has reviewed the appointments offered to the local population, and whether the consultations took place in-person, on the phone or via a videocall. More than five million appointments were offered in the 11 months between June 2021 and May 2022. Sixty-three per cent of all appointments in May 2022, which represents the most recent data, happened face-to-face.

A more detailed breakdown of the appointment data can be seen in the tables below.



	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	Apr-22	May-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	380	444
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	953	953



	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	Apr-22	May-22
DNA	1%	1%	1%	1%	2%	2%	2%	2%	2%	4%	2%	2%	2%	2%	2%	2%	2%	3%	3%	3%	4%	3%	2%	2%	3%	3%
FTF	39%	43%	47%	50%	51%	58%	62%	57%	58%	57%	57%	53%	57%	57%	55%	55%	56%	59%	66%	63%	62%	58%	59%	59%	62%	63%
Tel	60%	56%	52%	48%	47%	41%	36%	41%	40%	40%	42%	46%	41%	41%	43%	43%	42%	38%	31%	34%	35%	40%	39%	39%	36%	35%
National FTF	47%	47%	47%	50%	52%	57%	60%	55%	56%	53%	53%	54%	55%	56%	56%	57%	58%	61%	64%	63%	61%	60%	61%	62%	63%	
National Tel	48%	48%	48%	45%	43%	38%	35%	40%	39%	43%	43%	42%	41%	40%	40%	39%	38%	35%	31%	33%	35%	36%	35%	34%	33%	

Network contract DES

In April, the new network contract Directed Enhanced Service (DES) started. The priority for this year is to maintain stability and limit change for general practice, while bolstering investment for the workforce and leadership, supporting communities to recover, and ensuring patients continue to receive timely, high-quality care.

Most of the proposals build on the investment and evolution five-year contractual framework, which was previously agreed with the British Medical Association's General Practice Committee England in January 2019.

The amended DES introduces changes to the following areas:

- Increases to the Additional Roles Reimbursement Scheme (ARRS)
- Increased funding for leadership and management
- Enhanced access (combining the two funding streams currently supporting extended access to fund a single, combined and nationally consistent access offer with updated requirements, to be delivered by Primary Care Networks (PCNs))
- Limited expansion of PCN services, including the cardiovascular disease prevention and diagnosis service, early cancer diagnosis, phased introduction of the anticipatory care and personalised care services, and three new Investment and Impact Fund (IIF) indicators, which are focused on direct oral anticoagulants prescribing and faecal immunochemical testing for cancer referrals.

PCN estates toolkit

The PCN toolkit is a national framework with practical tools for use and application to support PCNs and the integrated care system to identify primary care estate changes, needs and investment requirements.

The framework dovetails into works already undertaken by PCNs, including the information from the 2021 Primary Care Data Gathering Programme (PCDG), which was accessible via the Strategic Health Asset Planning and Evaluation (SHAPE) tool. Locally, PCNs are also being provided with training on how to use the SHAPE tool.

The CCG collaborated closely with Community Health Partnership (CHP) to launch the toolkit in May 2022, and has since secured the use of the National Association of Primary Care (NAPC) to provide support where it is needed.

The toolkit has two objectives:

- To enable each PCN to identify and prioritise estate optimisation, disinvestment and subsequent investment requirements to address population health priorities and future service needs
- To support the production of investment plans for PCNs and places, and to help ICSs to aggregate and prioritise local primary care investment requirements against other system demands for capital

The outcome at the end of this process will be a robust, evidence-based PCN Service and Estate Investment Plan, which will be supported by a population health-led clinical vision and based on current PCN estates information.

The production of investment plans will mean the integrated care board can aggregate and prioritise primary care investment requirements alongside wider system demands. For the first time, this will help the national team understand the level of challenges and financial investments needed in the community in future, such as the level of information regularly provided by our acute providers.

Additional Roles Reimbursement Scheme

PCNs 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 DES and the Additional Roles Reimbursement 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 NHS Foundation Trust (SWAST) and the mental health practitioner roles that are jointly appointed with Avon and Wiltshire Mental Health Partnership NHS Trust.

As of the end of May, there have been 289 appointments under ARRS across Bath and North East Somerset, Swindon and Wiltshire. The additional staff have proved to be invaluable during the past year and have provided much-needed support to both practices and Covid-19 vaccination clinics.

Diabetes

Complications from diabetes not only continue to be a major cause of premature mortality, but also pose a substantial cost to the NHS.

To reduce this, diabetes services across Bath and North East Somerset, Swindon and Wiltshire have come together to develop a single care model, which will be focused on ensuring patients see the right clinician close to their home, that they are supported and empowered to manage their own condition and that primary care colleagues are given appropriate support to develop services.

Over the coming year, the model will be developed to include options and proposals for implementation. The self-management focus of diabetes care means that patient groups engage differently with different diabetes treatments, and this can result in some groups having poorer outcomes.

The new model will seek to understand specific groups and explore how services need to adapt accordingly, particularly around ensuring there is consistent access to new technologies, such as continuous blood glucose monitoring.

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 Bath and North East Somerset, Swindon and Wiltshire, the CCG and its partner

organisations have worked together to consider and plan how this ambition can be met.

Locally, there is an overarching NHS BSW Green Plan, which is supplemented by all NHS trusts in the region having a plan of its own.

This CCG annual report reflects this shared mission and the work happening with partners across the region.

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 of 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
- Reduce the use of desflurane
- Prescribe lower carbon inhalers
- Increase virtual outpatients and primary care appointments
- Develop plans to support active travel
- 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
- Collaborating 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 BSW Green Plan sets out in more detail what has been achieved to date, by both NHS trusts and wider partner organisations.

Some important developments due to happen throughout 2022 include:

- Sustainability training will be delivered to the new ICB Board by the Centre for Sustainable Healthcare
- 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
- All partners will undertake a review of their current vehicle fleet, lease car schemes and travel policies
- The BSW health and care model will be embedded into strategy and operational planning, which will support the development of more sustainable ways of working
- Targeted projects and interventions to reduce the impact of inhalers and anaesthetic gases will be delivered

- The digital strategy will continue to support the rollout of projects that help to reduce the need for travel and support the delivery of care, such as the Integrated Care Record, virtual consultations, patient-held records and remote working for staff

Progress between April and June

The CCG has identified a sustainability lead and has also received board-level endorsement. During the transition from CCG to ICB, the board-level leader and sustainability lead will be reviewed, along with governance.

Staff continued to work predominantly from home in this period, and the organisation has used this time to further embed its agile working policies, along with reviewing and reducing office accommodation and space shared with partners. Work has also continued on reviewing the volume of waste produced by the CCG.

Moving forward, the ICB will be looking at ways to keep travel to a minimum. Where staff do need to travel, sustainable modes of transport will be promoted and encouraged. The CCG's lease car salary sacrifice scheme now only offers zero emission vehicles, and this will continue in the ICB.

Quality, engagement, health inequality and strategy

The CCG has worked to ensure that it complies with the statutory duties outlined in the National Health Service Act 2006 (as amended).

This section of the report covers:

- Improvement in quality 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. Commissioners of healthcare have an important role in driving quality improvement and gaining assurance around the quality of care delivered by provider organisations. Over the last year, the CCG has been further developing a collaborative approach to quality assurance and quality improvement to help ensure the delivery of compassionate and high-quality care, 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, and work has taken place with provider organisations to develop new methods of quality assurance. The CCG has 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, as well as 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 learning informs improvement and reduces 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. The CCG monitors 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 the use of patient stories.
Workforce, staff health and wellbeing	The CCG monitors staff turnover, vacancy and sickness rates, mandatory training and appraisal compliance. Agency and bank staffing usage is also monitored. This has been of particular importance recently, due to high levels of community transmission of Covid-19, which has led 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)

The use of CQUIN to support quality improvement has been reinstated for 2022/23, and the CCG has worked with eligible partners to select which CQUIN their organisation can take part in.

There has been a change in the eligibility criteria for 2022/23, and the organisations that will complete CQUINs are:

- Great Western Hospitals NHS Foundation Trust
- Salisbury NHS Foundation Trust
- Royal United Hospitals Bath NHS Foundation Trust
- Wiltshire Health and Care
- HCRG Care Group (formerly Virgin Care Services)
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South Western Ambulance Service NHS Foundation Trust

Patient safety

The CCG has a responsibility to ensure the services it commissions are safe, and it strives to ensure that individuals are not exposed to harm when receiving healthcare. However, it is acknowledged that a serious incident or patient safety incident may occasionally occur.

All serious incidents are reported in line with the National Serious Incident Framework, and are subsequently reviewed by serious incident panels to ensure that a robust investigation has been undertaken. This helps to inform learning and prevent similar incidents from 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

Preparation for transition to the Patient Safety Incident Response Framework (PSIRF) has continued in the first three months of 2022/23, despite the publication of the final framework being delayed until the end of July 2022.

A system-wide patient safety community of practice has been established to support and take forward PSIRF as a shared learning space. The PSIRF is a key part of the NHS Patient Safety Strategy, which 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, and its updated guidance will inform how NHS organisations should respond to patient safety incidents, as well as how and when a patient safety investigation should be conducted.

System-wide risks are shared and monitored within the Quality Performance and Assurance Committee (QPAC) and multi-agency System Quality Group (SQG).

Infection prevention and control

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

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, the CCG and its provider organisations work together to support quality improvement initiatives aimed at delivering safer services.

The CCG sets, agrees, monitors and reviews surveillance data against nationally-set objectives for specific organisms, as well as other locally-agreed indicators. Learning identified and shared from post-infection reviews and root cause analyses is used to inform key improvement areas and address other potential risks.

During quarter one of 2022/23, infection prevention and control specialists from across the region continued to work collaboratively to ensure that updates to national guidance were implemented and understood as a system. Risk assessments were also undertaken to ensure patient safety remained a priority and that changes had been monitored.

The BSW infection prevention and control peer network continued to work collaboratively during the first quarter of 2022/23, and will continue to do so throughout the year, with the aim of reducing healthcare-associated infections and minimising outbreaks to support flow and patient safety.

During quarter one, collaboratives for Clostridium difficile and Gram-Negative Blood Stream Infection (GNBSI) have been set up to create specific action plans to reduce incidence. 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, as well as take a preventative approach to ensuring the local population is not harmed by avoidable healthcare-associated infections.

A more detailed Annual Infection Prevention and Control Report for 2021/22 will be available later 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, impartial, widely publicised and accessible to all. Since February 2021, the CCG Patient Advice and Liaison Service (PALS) and Complaints service has been managed by South, Central and West Patient Advice and Complaints Team (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, the CCG works proactively with providers to ensure that service improvements are implemented. The CCG reports 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 organisational policy.

Between 1 April and 28 June, SCW PACT received a total of 29 formal complaints. Service users have a choice as to who they provide their feedback to, such as the provider organisation, the CCG or NHS England.

Complaints or concerns raised with SCW PACT regarding commissioned providers are generally signposted to these organisations. During the period 1 April to 28 June, five of the 29 formal complaints received related to either commissioning or CCG-provided services.

The service with the highest number of complaints was Continuing Health Care, which received three complaints.

Processing delays was the main theme of the complaints that related to Continuing Health Care.

Between 1 April and 28 June, SCW PACT received 289 PALS enquiries.

The services with the highest number of PALS enquiries were primary care, which accounted for 24 per cent (69) of all enquires, and public health, which accounted for 18 per cent (53) of all enquiries.

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. Between 1 April and 28 June, SCW PACT received seven compliments, with SCW PACT and the Prescription Ordering Direct service receiving three and two compliments respectively.

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.

The organisation continuously strives to improve the quality of services, enhance patient experience and deliver safe care through collaborative working. The CCG has continued to support several quality improvement initiatives across different clinical pathways, with each initiative aligned to both national and local priorities.

Some of the workstreams that will continue within the ICS throughout 2022/23 include:

- Improving learning disability and severe mental illness annual health checks
- Alternative to fall conveyance to hospital
- Supporting care homes with falls management
- Access to urgent diagnostic pathways for care home residents who have fallen without conveying to ED

The coming year will see the continued development of 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 is fundamental to the work of the CCG and remains at the heart of commissioning responsibilities. The CCG has been compliant with the revised Safeguarding Vulnerable People in the NHS Accountability and Assurance Framework 2019.

Organisations commissioned to provide healthcare services must 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.

The CCG's Safeguarding and Children Looked After team have worked closely with provider organisations to seek assurances that policies and procedures are current, clear and accessible. Assurances have also been sought around safe recruitment and the availability of training, with governance systems monitored by the designated safeguarding professionals and the named GPs for safeguarding.

In addition, designated professionals have worked in collaboration with named professionals to design assurance reporting schedules that represent the current priorities for safeguarding and children looked after.

The CCG's Safeguarding and Vulnerability Strategy has been updated and sets out a vision of how safeguarding arrangements can make a positive contribution to help protect those who are vulnerable, as well as how this can be supported through working closely with health providers and other local agencies.

Bespoke training has been delivered across the organisation to educate and promote safeguarding for those who are most vulnerable. Training has also been delivered to members of the ICB Board in preparation for July 2022.

The CCG has worked closely with local authority colleagues, as well as other health partners, to ensure that local safeguards are effective for the BSW population. With plans for acute trusts, mental health trusts and integrated care boards to become responsible bodies for patients who require Liberty Protection Safeguards (LPS), an LPS Health Steering Group, which is chaired by the Designated Adult Lead, has supported local health partners to work together to maximise combined resources in preparing for these new responsibilities.

In addition, the NHS England and NHS Improvement audit on LPS has been completed quarterly to support benchmarking of progress within the BSW system.

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 has continued to be a statutory member of each of the three safeguarding partnerships in BSW.

The contribution to, and dissemination of, learning from reviews is a key safeguarding function.

During 2021/22, the partnerships published four safeguarding adult reviews, five safeguarding children practice reviews and three domestic homicide reviews.

As an organisation that plays a vital role in protecting vulnerable people, the CCG has continued to promote a safeguarding culture that embeds the belief that everyone has a right to a safe and healthy life.

Special educational needs and disability (SEND)

Improving the outcomes for children, young people and their families with special educational needs and disabilities remained a high priority for the CCG.

Across all locality areas, the CCG continued to work collaboratively with partners and agencies across education, social care and the voluntary sectors to plan and deliver high quality services that support children and young people with SEND to achieve their potential.

It is recognised that participation and co-production is essential to ensure that children, young people and their families feel listened to and valued. In turn, this supports the CCG to prioritise, plan and deliver accessible health services that meet the needs of those with SEND.

Legislative compliance and SEND inspections

Compliance against SEND legislation is reviewed and evaluated at local area SEND inspections, in which inspectors from the Department of Education and the Care Quality Commission consider how effective the local area is at identifying, meeting the needs of and improving the outcomes of the wide range of different groups of children and young people who have special educational needs and disabilities.

Bath and North East Somerset, Swindon and Wiltshire have all been inspected at least once.

During the inspections, the CCG and local authorities worked closely together to provide required assurance and to identify opportunities for continuous quality improvement. There is good engagement across all areas and stakeholders, including young people, schools, parents, carers and service providers.

Engaging people and communities

A key output from the past three months has been the development of the CCG's People and Communities and Engagement Strategy. This sets out how the future ICB will engage with local people, particularly on issues relating to health inequalities and self-care.

The draft of this strategy has been developed by drawing on learnings from previous engagement activity, by seeking the views of engagement leads from partner organisations,

and consulting members of the CCG's patient engagement forums and citizens sounding board panels. Current national guidance on engagement also helped to shape the draft strategy.

This initial blueprint for engagement has been approved by health and care leads from across the region, and was submitted to NHS England for review at the end of May.

The document will continue to develop and evolve over the next three to six months, as partner organisations and local communities are invited to contribute. It is important that the strategy draws on, recognises and is adaptive to all the great work already going on, and that the expertise and skills which exist across all organisations and geographies are rightfully acknowledged.

Our Health Our Future Panel

The CCG's online citizens' panel is made up of a representative sample of the population. 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, and are also invited to join occasional focus groups.

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 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 online.

Public engagement forums

Two informal sounding boards have been set up and have helped the CCG better understand the people and communities it serves.

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 and were regularly attended by the locality leadership team, who were able to update on local activity, seek feedback on plans and respond to the membership's questions.

Both engagement forums will continue to meet following the CCG's transition to an integrated care board in July.

Reducing health inequality

During 2021/22, the CCG stepped up efforts to reduce inequalities among patients in how they access health and care services, as well as the outcomes outlined in the Health and Social Care Act 2012.

In May 2022, the BSW Inequalities Strategy was approved and provided a framework for system activity to help reduce health inequalities. This brought together guidance on healthcare inequalities, as well as the work needed at place to address wider determinants of health. At the core of this strategy is the Core20PLUS5 approach, which ensures target populations reflect those suffering the greatest inequalities in health.

Alongside the 20 per cent most deprived population, the BSW PLUS populations are defined at a place level for Bath and North East Somerset, Swindon, and Wiltshire separately.

This decision captures the unique populations of each locality and ensures health inequalities are not exacerbated by reflecting an average of a much larger group. Each PLUS population chosen will be refined further in the very near future when the refreshed local Joint Strategic Needs Assessments (JSNA) are published.

At present, PLUS populations are outlined as follows:

- Bath and North East Somerset: Socially excluded groups, migrants, vulnerable children and rural communities
- Swindon: Black, Asian and minority ethnic 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:

As of June 2022, strategy development and implementation remains on track. The strategy was signed off in May and the first implementation plan – phase one: Raising Awareness – is expected to be ready as a final draft by the end of June.

The following actions have been taken forward during 2021/22 to support the Health Inequalities Strategy, as well as the associated actions across the BSW system:

- Senior responsible owner (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, which will soon evolve into a 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 integrated care alliance 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
- Successful distribution of funds to a range of organisations to tackle inequalities
- Strategy, which is currently being promoted via integrated care alliance shadow boards, to be signed off by the integrated care board during the summer months
- 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 through the new BSW Academy
    - Collate resources to support integrated care system, integrated care alliance and primary care networks, as well as provider health inequalities SROs, to access training and wider support, including 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 phase 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.

The core framework that helped to form this strategy include:

- 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 the first three months of 2022/23, 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 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.

In Swindon, work has taken place with the health and wellbeing board to develop the vision and priorities for the integrated care alliance 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 on integrating services, reducing health care inequalities and prioritising prevention. The health and wellbeing 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 continue working on a new health and wellbeing strategy for Bath and North East Somerset, Swindon and Wiltshire throughout 2022/23, and will ensure the document is aligned with local authority strategies and the updated Joint Strategic Needs Assessment.

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

22 June 2023

Accountability Report

The Accountability Report describes how the CCG meets key accountability requirements and embodies best practice to comply with corporate governance norms and regulations.

It comprises three sections:

1. The **Corporate Governance Report** sets out how the CCG has governed the organisation during the period 1 April to 30 June 2022, including membership and organisation of governance structures and how they supported the achievement of objectives.
2. The **Remuneration and Staff Report** describes remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on workforce, remuneration and staff policies.
3. 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 which provide primary care 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

During the reporting period, the 88 GP member practices worked as 26 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 to 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 2022 and 30 June 2022 was as follows:

Position on the Governing Body		Name
Statutory members	Chair	Dr Andrew Girdher
	Chief Executive Officer	Sue Harriman
	Chief Finance Officer	Caroline Gregory
	Secondary Care Specialist	Dr Paul Kennedy
	Registered Nurse	Maggie Arnold
	Lay Member Audit and Governance	Ian James
	Lay Member Patient and Public Engagement (PPE)	Julian Kirby
Additional members	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 *(Appointed as the BSW Integrated Care Board Chief Medical Officer Designate from 1 May 2022)*	Dr Amanda Webb
	Locality Healthcare Professional for Wiltshire	Dr Catrinel Wright
	Locality Healthcare Professional for Wiltshire	Dr Sam Dominey
	Locality Healthcare Professional for Wiltshire	Dr Nick Ware
	Director of Nursing and Quality	Gill May

	CCG Director of Strategy and Transformation	Richard Smale
	CCG Medical Director *(until 3 June 2022)*	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 for the period 1 April to 30 June 2022 were as follows:

Lay Member Audit and Governance (Chair)	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

It is recognised that effective handling of conflicts of interest is crucial to ensuring that patients, tax payers, healthcare providers and Parliament are confident that commissioning decisions are robust, fair, transparent and offer value for money.

In managing conflicts of interest, the CCG follows 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 for managing conflicts of interest (2017).

The CCG's Standards of Business Conduct Policy complies with national guidance and sets out 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

From April 2022 to June 2022, there were 11 identified breaches of data security. Four of which have been attributed to acts or omissions of CCG colleagues. The remaining incidents were caused by other organisations. On all four 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) and the ICO had not contacted the CCG regarding any complaints during this period.

The CCG has not had any data security incidents deemed to be Serious Untoward Incidents during this period.

Statement of Disclosure to Auditors

Each individual, who is a member of the CCG at the time that 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. The Slavery and Human Trafficking Statement for the year ending 31 March 2022 is published on the CCG website.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each clinical commissioning group shall have an Accountable Officer, and that officer shall be appointed by the NHS Commissioning Board (NHS England).

NHS England has appointed the Chief 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 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 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
- Prepare the accounts on a going concern basis
- 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.

Governance Statement

Introduction and context

BSW CCG is a corporate body 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.

Between 1 April 2022 and 30 June 2022, 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, while 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 BSW CCG Accountable Officer Appointment Letter.

I am responsible for ensuring that BSW CCG 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 to 30 June 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
- At Scale Commissioning Committee
- 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 three times during the reporting period. Highlights of work undertaken during the period included a review of the annual report and accounts for 2021/22, an internal audit review covering consistency of care packages, and a review of the CCG corporate registers. The committee also received reports from 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 three times during the reporting period.

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 Group 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 reporting period, the PCCC held two meetings in public. The PCCC considered the primary care work programme, primary care quality and finance reports, the primary care risk register, primary care flexible staff pool and practice applications.

Finance Committee

The Finance Committee sets the CCG's strategic direction for finance 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 and supports the Governing Body in ensuring financial management achieves value for money. In addition, the committee ensures there is efficiency and effectiveness in the use of resources, while also providing assurance that the productivity plan is effectively managed and outcomes are being delivered. Furthermore, the committee reviews financial risks, sets the framework for the CCG's conduct of procurement and management of estates, IT and information governance and receives assurance of its implementation.

The Finance Committee met three times during the reporting period and considered the financial performance, risks and position reports, the system wide recovery programme, the Information Governance Framework, and the Data Security Protection Toolkit.

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 three times during the reporting period and considered the BSW Learning Disability Mortality Review (LeDeR) Annual Report, performance and quality reports, Special Educational Needs and Disabilities (SEND) Annual Report, and CCG clinical and operational policies.

At Scale Commissioning Committee

The At Scale Commissioning Committee (ASCC) 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 committee's terms of reference are published in the CCG's Governance Handbook.

The At Scale Commissioning Committee met twice during the reporting period and considered several place-based proposals, including the Bath and North East Somerset crisis accommodation programme and the mental health support team trailblazer project in Swindon, and at scale proposals for the BSW footprint, including the community vasectomy service.

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 Bath and North East Somerset, Swindon and Wiltshire, 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 modernization
- 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 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 and the operational plan for 2022/23, the BSW response to the Ockenden review and the CCG's people and organisational development programme, as well as supporting the transition to becoming a statutory integrated care system.

Total number of meetings 1 April to 30 June 2022:	ORANGE = regular attendee, not voting member	3	3	3	2	3	2	3	1	2	2
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	1					1	2			
Accountable Officer	Sue Harriman	2	2	3	1			1			
Chief Finance Officer	Caroline Gregory	3	3		2			3			2
Secondary Care Specialist	Dr Paul Kennedy	3		2							
Registered Nurse	Maggie Arnold	3	3	3	2	2	1				
Lay Member Audit and Governance	Ian James	3	2					3			
Lay Member Patient and Public Engagement (PPE)	Julian Kirby	3		3	1	3	2	3			
Additional members											
Lay Member Primary Care Commissioning	Suzannah Power	3	3		1						
Locality Clinical Lead for BaNES	Dr Bryn Bird	3			1	2			1		
Locality Clinical Leads for Swindon	Dr Amanda Webb	3			0	1					
Locality Healthcare Professional for Wiltshire	Dr Catrinel Wright	2	2		2		2				
Locality Healthcare Professional for Wiltshire	Dr Sam Dominey	3			2						
Locality Healthcare Professional for Wiltshire	Dr Nick Ware	3					0				
CCG Director of Nursing and Quality	Gill May	3			2	2	1			0	
CCG Director of Strategy and Transformation	Richard Smale	3					1	3	1		
CCG Medical Director *(until 3 June 2022)*	Dr Ruth Grabham	1			1	1	2				

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 the 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.

The CCG promotes and embeds 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, where 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 still 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 proactive

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 immediately to the BSW panel.

The core members of the panel include the Director of Nursing and Quality (Chair), the Director of Strategy and Transformation (Vice-Chair), the Chief Finance Officer, the Acting 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 Finance 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, where 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, including likelihood and impact
- Confirmation of 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 of each local authority. 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 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 the reporting period related to:

- Further waves of Covid-19
- Delivery of the Covid-19 vaccine
- 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

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 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 reporting period ending 30 June 2022.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs, which was published in 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.

An internal audit on managing conflicts of interest was carried out in January 2022, the results of which were 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, which was issued in February 2019. On the whole, conflicts of interest were found 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, 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, particularly that which is personal identifiable, about patients and employees. 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 CCG made a closing DSPT submission for 30 June 2022. The submission provided a status of standards met.

High importance is placed on ensuring there are robust information governance systems and processes to help protect patient, CCG colleague and corporate information. The CCG operated 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 to ensure that all are aware of information governance roles and responsibilities.

The CCG had a trained Senior Information Risk Officer (SIRO), a trained Caldicott Guardian and a trained Data Protection Officer (DPO).

The CCG also benefited 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 2022/23, as colleagues have continued to work from home.

A reporting and investigation framework is utilised for information governance incidents and near misses, and is supported by information governance expertise from 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, have increased the number of data protection impact assessments (DPIA) undertaken, and often lead on 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 under national terms and conditions. The CCG places reliance on these contracts, as well as on regular performance monitoring reports and meetings with providers, to make sure that services remain effective.

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 NHS 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 the reporting period, 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 and efficiency and effectiveness of the use of resources

The CCG has met its financial target to break even for this period. Expenditure has been examined monthly in detail by the Finance Committee. 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 it 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 the CSU for the provision of a range of services, including procurement, human resources, health and safety support, Freedom of Information requests, information governance 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 and to embed counter fraud measures in line with the NHS Counter Fraud Strategy for 2020-2023

- The CCG Audit Committee receives a regular progress report and an annual report against each component of NHS Counter Fraud Authority requirements and the Government Functional Standard 013. 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 and NHS requirements for counter fraud by submitting a Counter Fraud Functional Standard Return to the NHS Counter Fraud Authority at the end of the year. The CCG has scored itself as green for the 2021/22 year 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, for the period 1 April 2021 to 30 June 2022, 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 30 June 2022 inclusive and is based on the audits completed in this period.

The five reviews graded as partial assurance with improvements required were in respect to consistency of care packages, learning disabilities, safeguarding, primary workforce planning 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, through its management action tracking, seen that the active steps have been taken to implement actions arising from internal audits.

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 team 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 CCG has raised 52 management actions in the period that covers 1 April 2021 to 30 June 2022, of which five are high priority actions:

- One action related to primary workforce: Ensuring there was a clear strategy over primary workforce
- Two actions were from the safeguarding review: Clarity of safeguarding and contract reporting requirements, and monitoring of safeguarding standards
- Two actions related to the consistency of care packages review: Consistent approach to complex needs decisions and decision-making and quoracy around children's continuing care

As of 30 June 2022, all five of these high priority actions have agreed action plans in place and deadlines agreed 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 issuing significant assurance with minor improvements overall, as the organisation is implementing the management actions raised to address the issues identified. The status of management actions is reported by management to Audit Committee. The organisation has provided direction to areas where there have been concerns in terms of operation or performance in year.

KPMG LLP
Chartered Accountants
London
30 June 2022

During the reporting period, Internal Audit issued the following audit report:

Area of Audit	Level of Assurance Given
Consistency of Care Packages	Partial assurance with improvements required

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 and assurance mechanisms

Conclusion

There was one significant control issue identified in the reporting period, which related to the non-delivery of the CCG's constitutional targets, as referenced on page 58. This was raised with NHS England.

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 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 the reporting period, its members were:

- Three lay members of the CCG's Governing Body: Suzannah Power, Julian Kirby and Ian James
- 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 consistent 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 for clinical commissioning groups, Remuneration Guidance for Chief Officers and Chief Finance Officers and existing VSM pay scales.

Amendments to VSM and Governing Body member 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 an individual's 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.

During May and June 2022, five substantive directors who were appointed to the integrated care board commenced in post within the CCG.

NHS England published the ICB Executive Pay Framework in February 2022, which detailed the minimum and maximum operational salary ranges for the mandated and other board executive roles. The salaries for four of these roles were offered within the salary range. For one role, which was above the operational maximum, the requisite approvals were sought from NHS England as per the pay framework guidance.

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 being undertaken, as well as the conditions of the labour market.

For any salary above £150,000, the Remuneration Committee is to note and endorse the proposals and, where necessary, approval is sought from NHS England and HM Treasury, in line with NHS England guidance.

Senior manager remuneration (including salary and pension entitlements) 2022/23 (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)	Other (bands of £5,000) *8*	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
			£'000s	£s	£'000s	£'000s	£'000s	£'000s	£'000s
Ruth Grabham	Medical Director		25 - 30	-	-	-	-	-	25 - 30
Sue Harriman	Chief Executive Officer	2	45 - 50	-	-	-	0 - 5	20 - 22.5	65 - 70
Tracey Cox	Chief Executive Officer (to 10th April)	2	5 - 10	-	-	-	-	-	5 - 10
Caroline Gregory	Chief Finance Officer	3	25 - 30	-	-	-	-	30 - 32.5	60 - 65
Gary Heneage	Chief Finance Officer (from 20th June)	3,6	0 - 5	-	-	-	-	-	0 - 5
Gillian May	Director of Nursing & Quality		30 - 35	-	-	-	-	37.5 - 40	65 - 70
Richard Smale	Director of Strategy & Transformation		25 - 30	-	-	-	-	20 - 22.5	45 - 50
Julie-Anne Wales	Director of Corporate Affairs		0 - 5	-	-	-	-	-	0 - 5
Corinne Edwards	Chief Operating Officer, BaNES Locality		25 - 30	-	-	-	-	-	25 - 30
David Freeman	Chief Operating Officer, Swindon Locality	5	30 - 35	-	-	-	-	7.5 - 10	35 - 40
Elizabeth Disney	Chief Operating Officer, Wiltshire Locality	4	20 - 25	-	-	-	-	7.5 - 10	25 - 30
Sheridan Flavin	Interim Executive Director for People & OD	5	10 - 15	-	-	-	-	-	10 - 15
Alison Kingscott	Interim Executive Director for People & OD		15 - 20	-	-	-	-	-	15 - 20
Andrew Girdher	Clinical Chair	5	20 - 25	-	-	-	-	-	20 - 25
Brynn Bird	Locality Clinical Lead (BaNES)	5	15 - 20	-	-	-	-	-	15 - 20
Amanda Webb	Locality Clinical Lead (Swindon)		35 - 40	-	-	-	-	10 - 12.5	45 - 50
Edward Rendell	Locality Clinical Lead (Wiltshire)		0 - 5	-	-	-	-	-	0 - 5
Francis Campbell	Locality Healthcare Professional (Swindon)		5 - 10	-	-	-	-	0 - 2.5	5 - 10
Catrinel Wright	Locality Healthcare Professional (Wiltshire)	5	15 - 20	-	-	-	-	-	15 - 20
Samuel Dominey	Locality Healthcare Professional (Wiltshire)	5	5 - 10	-	-	-	-	-	5 - 10
Nicholas Ware	Locality Healthcare Professional (Wiltshire)	5	15 - 20	-	-	-	-	-	15 - 20
Jane Moore	Director of Equalities & Innovation	6	10 - 15	-	-	-	-	10 - 12.5	20 - 25
Gordon Muvuti	Place Director	6	0 - 5	-	-	-	-	-	0 - 5
Stephanie Elsy	BSW Independent Chair	7	15 - 20	300	-	-	-	-	15 - 20
Paul Kennedy	Secondary Care Specialist	7	5 - 10	-	-	-	-	-	5 - 10
Maggie Arnold	Registered Nurse	7	5 - 10	-	-	-	-	-	5 - 10
Julian Kirby	Lay Member Patient and Public Engagement	7	0 - 5	-	-	-	-	-	0 - 5
Ian James	Lay Member Finance	7	0 - 5	-	-	-	-	-	0 - 5
Suzannah Power	Lay Member Primary Care Commissioning and Deputy Chair	7	10 - 15	-	-	-	-	-	10 - 15

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, but include recharges out to other NHS organisations.

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. Elizabeth Disney left the CCG during May 2022.

5. The Senior managers identified above left the CCG during or at the end of June 2022.

6. The Senior managers identified above joined the CCG during June 2022.

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

8. Other relates to those senior managers in receipt of a relocation allowance. The banded figures disclosed relate to the amounts claimed under those arrangements.

9. 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.

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.

Pensions benefits as at 30 June 2022 (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 2023 (Bands of £5,000)	Lump sum at retirement age related to accrued pension at 31 March 2023 (bands of £5,000) ❷	Cash equivalent transfer value at 1 April 2022	Real increase in Cash equivalent transfer value	Cash equivalent transfer value at 31 March 2023 ❸	Employers contribution to stakeholder pension
		£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Tracey Cox	Executive Director of People & Culture	0 - 2.5	0	65 - 70	130 - 135	1,136	1	1,236	0
Sue Harriman	Chief Executive (Designate), BSW ICB	0 - 2.5	0 - 2.5	55 - 60	85 - 90	912	20	1,049	0
Caroline Gregory	Chief Finance Officer	0 - 2.5	2.5 - 5	55 - 60	105 - 110	925	32	1,099	0
Gary Heneage	Chief Finance Officer	0 - 2.5	0	20 - 25	0	209	1	262	0
Jane Moore	ICB Director of Equalities & Innovation	0 - 2.5	0	75 - 80	0	1,115	12	1,309	0
Gillian May ❹	Director of Nursing & Quality	0 - 2.5	2.5 - 5	65 - 70	200 - 205	0	5	39	0
Richard Smale	Executive Director of Strategy & Transformatio	0 - 2.5	0 - 2.5	50 - 55	95 - 100	806	21	930	0
Corinne Edwards	Chief Operating Officer, BaNES Locality	0 - 2.5	0	45 - 50	90 - 95	835	2	887	0
David Freeman	Chief Operating Officer, Swindon Locality	0 - 2.5	0 - 2.5	40 - 45	60 - 65	586	7	649	0
Elizabeth Disney	Chief Operating Officer, Wiltshire Locality	0 - 2.5	0 - 2.5	10 - 15	5 - 10	89	3	130	0
Sheridan Flavin	Executive Director of Workforce	0 - 2.5	0	15 - 20	0	230	0	248	0
Alison Kingscott	Executive Director of Workforce	0	0	40 - 45	100 - 105	865	1	910	0
Andrew Girdher	Clinical Chair	0 - 2.5	0	10 - 15	25 - 30	226	0	239	0
Brynn Bird	Locality Clinical Lead (BaNES)	0 - 2.5	0	15 - 20	0	178	0	192	0
Amanda Webb	ICB Medical Director	0 - 2.5	0 - 2.5	15 - 20	30 - 35	205	5	253	0
Edward Rendell	Locality Clinical Lead (Wiltshire)	0	0	15 - 20	30 - 35	226	0	234	0
Francis Campbell	Locality Healthcare Professional (Swindon)	0 - 2.5	0	10 - 15	25 - 30	162	0	173	0
Catrinel Wright	Locality Healthcare Professional (Wiltshire)	0 - 2.5	0	10 - 15	20 - 25	193	0	204	0
Samuel Dominey	Locality Healthcare Professional (Wiltshire)	0	0	10 - 15	25 - 30	174	0	181	0
Nicholas Ware	Locality Healthcare Professional (Wiltshire)	0 - 2.5	0	5 - 10	20 - 25	159	0	168	0

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.

The CETV values included in the table above have been prepared by NHS Pensions as at 31st March 2023. The figures have not been pro-rated to reflect the CCG to ICB transition as at 30th June 2022.

❹ *The Cash equivalent transfer values disclosed for Gill May relates to the 2015 Scheme only. The member is over the Normal Retirement Age in the existing schemes and therefore no CETV figures have been provided by NHS Pensions.*

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

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.

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 this reporting period.

Payments to past directors

The CCG had none in this reporting period.

Fair pay disclosure (AUDITED)

Percentage change in remuneration of highest paid director

1 April to 30 June 2022	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	2.7%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-1.4%	0%

Pay ratio information

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director or 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 or member in BSW CCG in the financial period 2022/23 was £190,000 - £195,000 (+2.7 per cent against 2021/22: £185,000 - £190,000) and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

1 April to 30 June 2022	25th percentile	Median	75th percentile
Total remuneration (£)	£24,904	£40,057	£54,764
Salary component of total remuneration (£)	£24,904	£40,057	£54,764
Pay ratio information	7.7 : 1	4.8 : 1	3.5 : 1
2021/22			
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

During the reporting period 1 April to 30 June 2022, 0 (2021-22, 0) employees received

remuneration in excess of the highest-paid director or member. Remuneration ranged from £18,870 to £190,157 (annualised), (2021-22 £12,656 to £189,475).

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 64.

As of 30 June 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)	12
Band 9	1

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

Staff numbers and costs (AUDITED)

As of 30 June 2022, the CCG has 490 employees excluding bank colleagues. The workforce was made up of employees from a wide range of professional groups.

Staff costs	2022-23		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	4.5	0.1	4.7
Social security costs	0.5	-	0.5
Employer contributions to the NHS Pension Scheme	0.9	-	0.9
Apprenticeship Levy	0.0	-	0.0
Employee benefits expenditure	**6.0**	**0.1**	**6.1**

The average number of people employed by the CCG during the reporting period on a whole-time equivalent (WTE) basis was 422.5. Permanent WTE average was 379.7 and other equated to 42.8 WTE.

Permanently employed	Other
379.7	42.8

Analysed as:	Perm	Other
Scientific, therapeutic and technical staff	30.1	1.9
Admin and estates staff	294.6	32.8
Medical and dental staff	2.3	4.9
Nursing, midwifery and health visiting	52.7	3.2
Other healthcare	0	0

Staff composition

The table below shows the gender breakdown as of 30 June 2022:

	Female headcount	Male headcount	Total
Governing Body Members	8	8	16
All other CCG staff	396	94	490
Total	404	102	506

Sickness absence data

Overall, staff sickness absence data as of 30 June 2022 was 1.5 per cent. The overall sickness absence figures are a result of 0.52 per cent short term sickness absence and 0.98 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 Staff Support 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 30 June 2022 was 6.58 per cent. The table below shows the turnover figures for the CCG for the reporting period. The highest turnover for the three month period was recorded in June 2022, and this was due to fixed term contracts ending and natural turnover.

CCG	Apr-22	May-22	Jun-22
Turnover	1.67%	2.77%	3.35%

Staff engagement percentages

The last bespoke colleague engagement survey ran from 28 October 2021 to 26 November 2021. 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 ICB
- Bullying and harassment
- 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 available.

Nearly 80 per cent of staff surveyed were happy with the opportunities for flexible working, with only two respondents strongly disagreeing. Agile working has continued to be embedded within the CCG between April and June 2022, and colleagues have been able to work from BSW offices should they wish.

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 transferring to the ICB.

Colleagues were fully consulted on the transfer to the ICB throughout April 2022. During and after the 30-day consultation period, colleagues had the opportunity to have one-to-one meetings with their line manager, had avenues to raise any questions or queries via email, had access to HR and Colleague Partnership representatives and monthly transition meetings with the transition workstream leads.

A consultation outcome document and FAQs were shared with colleagues, as well as trade union and colleague partnership representatives.

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. Eighty-eight per cent had not suffered discrimination from managers, but eight per cent had.

A workshop was run for all colleagues with regards to how to respond to bullying and harassment and highlighted the CCGs commitment to creating a work environment free of bullying and harassment, and where everyone is treated with dignity and respect.

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 and to embed this within the overarching People Strategy. The CCG continues to raise awareness of EDI issues through both mandatory training and other development opportunities.

The actions identified will be carried forward to ensure the ICB continues to be a great place to work.

The ICB will be participating in the national NHS Staff Survey in October and November 2022. Through participation in the national survey, benchmarking will be able to be undertaken against other ICBs and organisations within BSW.

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. The CCG has incorporated equalities issues into all policies covering 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 by 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, to promote equality of opportunity, and to 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.

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

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 interviews to disabled candidates, 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 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.

All recruitment adverts detail that the CCG is part of the disability confident scheme 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 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 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 the subsequent 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 feel welcomed.

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. The completion dates for the WDES and WRES report for 2022 have been postponed due to the establishment of the ICB, however the reports will be produced later in 2022. 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 staff across all 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 2022, 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 Reporting 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

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, and its resources focus on a range of matters, including menopause, display screen equipment assessments, wellbeing checklists, stress risk assessments and flexible working. The CCG has trained mental health first aiders and provides regular opportunities for more colleagues to undertake this training, 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 psychologists and registered mental health clinicians, who can use their expertise to assist health and social care key workers in accessing support. The BSW Wellbeing Matters Service also runs some focused sessions on a variety of topics and these are actively promoted to all colleagues.

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 BSW People Strategy will be reviewed following the formation of the ICB to ensure it is aligned with the new organisation and incorporates the 10 people function outcomes that have been focused on across the system.

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.

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 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 £44,000 on consultancy services during the reporting period. Consultants were engaged to support analysis and benchmarking activities.

Off-payroll engagements

NHS bodies are required to include disclosures about 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 period

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 30 June 2022 for more than £245* per day:

	Number
Number of existing engagements as of 30 June 2022	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	0
Of which:	
No. not subject to off-payroll legislation[2]	0
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	0
the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	24

Exit packages, including special (non-contractual) payments (AUDITED)

The CCG had no exit packages, including special non-contractual payments in the financial period.

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, fees and charges are included as notes in the Financial Statements of this report.

An audit certificate and report is also included in this 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 reporting period of 1 April to 30 June 2022.

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 reporting period.

Independent auditor's report to the members of the Board of NHS Bath and North East Somerset, Swindon and Wiltshire ICB in respect 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 period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and 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 2022-23.
In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period 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 2022-23; 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 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of NHS Bath and North East Somerset, Swindon and Wiltshire CCG transferred to NHS Bath and North East Somerset, Swindon and Wiltshire ICB on 1 July 2022. When NHS Bath and North East Somerset, Swindon and Wiltshire CCG ceased to exist on 1 July 2022, its services continued to be provided by NHS Bath and North East Somerset, Swindon and Wiltshire ICB.

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.
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 2022-23 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 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 2022) 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.
In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.
Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.
Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.
Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of 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:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and

- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period 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

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 51 and 52, 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.

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.

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.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2022-23).

- 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 other 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**.**

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.

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 made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.
We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer was 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 were operating effectively during the three month period ended 30 June 2022..
We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. 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 planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

We have documented our understanding of the arrangements the CCG had 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 have considered whether there is evidence to suggest that there were significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS Bath and North East Somerset, Swindon and Wiltshire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of NHS Bath and North East Somerset, Swindon and Wiltshire ICB, as a body, in respect of the CCG, 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 Board of NHS Bath and North East Somerset, Swindon and Wiltshire ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Bath and North East Somerset, Swindon and Wiltshire ICB and the CCG and the members of the Board of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Julie Masci

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

Bristol

29 June 2023

ANNUAL ACCOUNTS

Sue Harriman

Accountable Officer

22 June 2023

Entity name:	NHS Bath and North East Somerset, Swindon and Wiltshire CCG
This period:	2022-23
Last year:	2021-22
This period ended:	30 June 2022
Last year ended:	31-March-2022
This period commencing:	01-April-2022
Last year commencing:	01-April-2021

The comparative figures included within this set of accounts relate to the twelve month accounting period 2021-22 (1st April 2021 to 31st March 2022).

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.

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the 3 month period ended 30 June 2022

	Note	2022-23 £m	2021-22 £m
Income from sale of goods and services	2	(1.7)	(6.8)
Other operating income	2	-	(0.0)
Total operating income		**(1.7)**	**(6.8)**
Staff costs	3	6.1	22.3
Purchase of goods and services	4	382.6	1,676.7
Depreciation and impairment charges	7, 9	0.2	0.2
Provision expense	13	(0.4)	4.3
Other Operating Expenditure	4	0.4	4.7
Total operating expenditure		**388.9**	**1,708.2**
Net Operating Expenditure		**387.2**	**1,701.4**
Comprehensive Expenditure for the period		**387.2**	**1,701.4**

The notes on pages 105 to 110 and 115 form part of this statement.

The CCG has delivered a breakeven position against its allocation for the period. See Note 21 for further information.

Statement of Financial Position as at 30 June 2022

	Note	2022-23 £m	2021-22 £m
Non-current assets:			
Property, plant and equipment	7	1.0	1.0
Right-of-use assets	8	1.2	0.0
Intangible assets	9	0.2	0.2
Total non-current assets		**2.3**	**1.2**
Current assets:			
Trade and other receivables	10	11.9	8.3
Cash and cash equivalents	11	9.3	0.6
Total current assets		**21.2**	**8.9**
Total current assets		**21.2**	**8.9**
Total assets		**23.5**	**10.1**
Current liabilities			
Trade and other payables	12	(105.8)	(149.1)
Lease liabilities	8	(0.2)	-
Provisions	13	(8.6)	(11.1)
Total current liabilities		**(114.7)**	**(160.2)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(91.1)**	**(150.1)**
Non-current liabilities			
Lease liabilities	8	(0.9)	0.0
Total non-current liabilities		**(0.9)**	**-**
Assets less Liabilities		**(92.1)**	**(150.1)**
Financed by Taxpayers' Equity			
General fund		(92.1)	(150.1)
Total taxpayers' equity:		**(92.1)**	**(150.1)**

The notes on pages 104 to 109 form part of this statement.

The financial statements on pages 90 to 118 were approved by the BSW Integrated Care Board on 22nd June 2023 and signed on its behalf by:

Chief Executive Officer
Sue Harriman

Chief Financial Officer
Gary Heneage

Statement of Changes In Taxpayers Equity for the 3 month period ended 30 June 2022

	General fund £m	Total reserves £m
Changes in taxpayers' equity for 2022-23		
Balance at 01 April 2022	(150.0)	(150.0)
Changes in NHS Clinical Commissioning Group taxpayers' equity for the period		
Net operating expenditure for the financial year	(387.2)	(387.2)
Net Recognised NHS Clinical Commissioning Group Expenditure for the period	**(387.2)**	**(387.2)**
Net funding	445.1	445.1
Balance at 30 June 2022	**(92.1)**	**(92.1)**

	General fund £m	Total reserves £m
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(134.8)	(134.8)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating costs 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)**

Statement of Cash Flows for the 3 month period ended 30 June 2022

	Note	2022-23 £'m	2021-22 £'m
Cash Flows from Operating Activities			
Net operating expenditure for the financial period		(387.2)	(1,701.4)
Depreciation and amortisation	4	0.2	0.2
(Increase)/decrease in trade & other receivables	10	(3.5)	2.5
Increase/(decrease) in trade & other payables	12	(43.3)	20.9
Provisions utilised	13	(2.1)	(3.9)
Increase/(decrease) in provisions	13	(0.4)	4.3
Net Cash Inflow (Outflow) from Operating Activities		**(436.4)**	**(1,677.4)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	7	-	(0.7)
(Payments) for intangible assets	9	-	(0.2)
Net Cash Inflow (Outflow) from Investing Activities		**-**	**(0.9)**
Net Cash Inflow (Outflow) before Financing		**(436.4)**	**(1,678.3)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		445.1	1,686.1
Repayment of lease liabilities	8	(0.1)	-
Net Cash Inflow (Outflow) from Financing Activities		**445.0**	**1,686.1**
Net Increase (Decrease) in Cash & Cash Equivalents	11	**8.6**	**7.8**
Cash & Cash Equivalents at the Beginning of the Financial Period		0.6	(7.2)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period		**9.3**	**0.6**

The notes on pages 102 to 112 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.
The Health and 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, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 30 June 2022 on a going concern basis.

1.2 **Accounting Convention**

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

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

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

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

1.4 **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 18 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.

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.

1.10 **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 CCG;
- 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.

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**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 **The CCG as Lessee**

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

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

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

Lease payments included in the measurement of the lease liability comprise

-Fixed payments;

-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;

-The amount expected to be payable under residual value guarantees;

-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and

-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

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

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

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

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

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

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

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

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

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

1.13 **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.

1.14 **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.

1.15 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 3.51% (2021-22 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 3.00% (2021-22: 0.66%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.16 **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.

1.17 **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.

1.18 **Contingent liabilities and contingent assets**

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

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

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

1.19 **Financial Assets at Amortised cost**

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

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

1.20 **Impairment**

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

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

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

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

1.21 **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.

1.21.1 **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.

1.22 **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.

1.23 **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.

1.24 **Losses & Special Payments**

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

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

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

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

1.26 **Gifts**

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

1.27 **Adoption of new standards**

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

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

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

Impact assessment

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

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

The CCG has utilised three further practical expedients under the transition approach adopted:

a) The election to not make an adjustment for leases for which the underlying asset is of low value.

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

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

As of 1 April 2022, the CCG recognised £1.2m or right-of-use assets and lease liabilities of £1.2m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £0m impact to tax payers' equity.

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

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

	Total £m
Operating lease commitments at 31 March 2022	(0.6)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	-
Operating lease commitments discounted used weighted average IBR	**(0.6)**
Add: Rentals associated with extension options reasonably certain to be exercised	(0.9)
Less: Short term leases (including those with <12 months at application date)	0.2
Lease liability at 1 April 2022	**(1.2)**

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

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

2 Other Operating Revenue

	2022-23 Total £m	2021-22 Total £m
Income from sale of goods and services (contracts)		
Education, training and research	0.5	1.3
Non-patient care services to other bodies	1.0	3.7
Other Contract income	0.3	1.8
Total Income from sale of goods and services	**1.8**	**6.8**
Other operating income	0.0	0.0
Total Other operating income	**0.0**	**0.0**
Total Operating Income	**1.8**	**6.8**

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

	Education, training and research £m	Non-patient care services to other bodies £m	Other Contract income £m	Recoveries in respect of employee benefits £m
Source of Revenue				
NHS	0.0	0.1	0.0	0.0
Non NHS	0.5	0.9	0.3	0.0
Total	**0.5**	**1.0**	**0.3**	**0.0**

	Education, training and research £m	Non-patient care services to other bodies £m	Other Contract income £m	Recoveries in respect of employee benefits £m
Timing of Revenue				
Point in time	0.0	0.0	0.0	0.0
Over time	0.5	1.0	0.3	0.0
Total	**0.5**	**1.0**	**0.3**	**0.0**

3. Employee benefits and staff numbers

3.1 Employee benefits

	Total 2022-23		
	Permanent Employees £m	Other £m	Total £m
Employee Benefits			
Salaries and wages	4.6	0.1	4.7
Social security costs	0.5	0.0	0.5
Employer Contributions to NHS Pension scheme	0.9	0.0	0.9
Gross employee benefits expenditure	**6.0**	**0.1**	**6.1**

	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	0.0	1.8
Employer Contributions to NHS Pension scheme	3.4	0.0	3.4
Apprenticeship Levy	0.1	0.0	0.1
Gross employee benefits expenditure	**21.5**	**0.7**	**22.3**

3.2 Average number of people employed

	2022-23 Permanently employed Number	Other Number	Total Number	2021-22 Permanently employed Number	Other Number	Total Number
Total	380	43	**423**	334	35	**369**

3.3 Exit packages agreed in the financial period

The CCG had no exit payments payable to individuals in the 3 month period to 30 June 2022.

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:

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 actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

For 2022-23, employer's contributions of £616k were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. During 2022-23, NHS England funded NHS Pension contributions totalling £288k (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 2022-23 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 2022/23 employee contributions were 5% and employer contributions 3%.

4. Operating expenses

	2022-23 Total £m	2021-22 Total £m
Purchase of goods and services		
Services from other CCGs and NHS England	0.7	4.8
Services from foundation trusts	204.7	854.8
Services from other NHS trusts	29.6	107.4
Services from Other WGA bodies	14.7	55.2
Purchase of healthcare from non-NHS bodies	56.4	315.4
Purchase of social care	0.4	19.0
Prescribing costs	33.5	140.3
Pharmaceutical services	0.0	0.1
GPMS/APMS and PCTMS	41.0	159.3
Supplies and services – clinical	0.8	2.9
Supplies and services – general	0.7	1.9
Consultancy services	0.0	0.3
Establishment	0.6	2.8
Transport	0.9	6.2
Premises	(2.0)	4.6
Audit fees	0.1	0.1
Other non statutory audit expenditure		
· Internal audit services	0.0	0.1
· Other services	0.0	-
Other professional fees	0.1	0.4
Legal fees	0.2	0.7
Education, training and conferences	0.1	0.7
Total Purchase of goods and services	**382.6**	**1,676.7**
Depreciation and impairment charges		
Depreciation	0.1	0.2
Amortisation	0.1	0.0
Total Depreciation and impairment charges	**0.2**	**0.2**
Provision expense		
Provisions	(0.4)	4.3
Total Provision expense	**(0.4)**	**4.3**
Other Operating Expenditure		
Chair and Non Executive Members	0.2	0.9
Grants to Other bodies	(0.0)	3.5
Expected credit loss on receivables	0.1	0.2
Other expenditure	0.1	0.1
Total Other Operating Expenditure	**0.4**	**4.7**
Total operating expenditure	**382.8**	**1,685.8**

The external audit fee for the 3 month period end 30th June 2022 excluding VAT was £89,750. The external auditor carried out a separate audit of the Mental Health Investment Standard (MHIS) during the period and were reimbursed £30,000.

The external auditor's liability for external audit work carried out for the financial year 2022/23 is limited to £1,000,000.

5.1 Better Payment Practice Code

Measure of compliance	2022-23 Number	2022-23 £m	2021-22 Number	2021-22 £m
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,428	585.2	34,035	581.9
Total Non-NHS Trade Invoices paid within target	9,348	584.1	33,622	581.7
Percentage of Non-NHS Trade invoices paid within target	**99.15%**	**99.81%**	**98.79%**	**99.97%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	251	238.1	1,194	973.0
Total NHS Trade Invoices Paid within target	241	237.3	1,171	972.9
Percentage of NHS Trade Invoices paid within target	**96.02%**	**99.66%**	**98.07%**	**99.99%**

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

The CCG had no Late Payment of Commercial Debts (Interest) to report in 2022-23 or 2021-22.

6. 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 2022-23.

7 Property, plant and equipment

2022-23	Plant & machinery £m	Information technology £m	Furniture & fittings £m	Total £m
Cost or valuation at 01 April 2022	0.2	1.9	0.1	2.2
Disposals other than by sale	(0.1)	(0.6)	(0.0)	(0.7)
Cost/Valuation at 30 June 2022	**0.1**	**1.3**	**0.0**	**1.5**
Depreciation 01 April 2022	0.1	1.0	0.1	1.1
Disposals other than by sale	(0.1)	(0.6)	(0.0)	(0.7)
Charged during the year	0.0	0.1	0.0	0.1
Depreciation at 30 June 2022	**0.0**	**0.4**	**0.0**	**0.5**
Net Book Value at 30 June 2022	**0.1**	**0.9**	**0.0**	**1.0**
Purchased	0.1	0.9	0.0	1.0
Total at 30 June 2022	**0.1**	**0.9**	**0.0**	**1.0**
Asset financing:				
Owned	0.1	0.9	0.0	1.0
Total at 30 June 2022	**0.1**	**0.9**	**0.0**	**1.0**

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

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

8 Leases

8.1 Right-of-use assets

2022-23	Buildings excluding dwellings £m	Total £m
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	1.2	1.2
Cost/Valuation at 30 June 2022	**1.2**	**1.2**
Depreciation 01 April 2022	-	-
Charged during the year	0.1	0.1
Depreciation at 30 June 2022	**0.1**	**0.1**
Net Book Value at 30 June 2022	**1.2**	**1.2**

8.2 Lease liabilities

2022-23	2022-23 £m	2021-22 £m
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	1.2	-
Repayment of lease liabilities (including interest)	0.0	-
Lease remeasurement	(0.1)	-
Lease liabilities at 30 June 2022	**1.2**	**-**

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2022-23 £m	2021-22 £m
Within one year	(0.2)	-
Between one and five years	(0.7)	-
After five years	(0.3)	-
Balance at 30 June 2022	**(1.2)**	**-**
Effect of discounting	0.0	-
Included in:		
Current lease liabilities	(0.2)	-
Non-current lease liabilities	(0.9)	-
Balance at 30 June 2022	**(1.2)**	**-**

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	2022-23 £m	2021-22 £m
Depreciation expense on right-of-use assets	0.1	-
Interest expense on lease liabilities	0.0	-
Expense relating to short-term leases	(0.0)	-
Expense relating to leases of low value assets	0.0	-

8.5 Amounts recognised in Statement of Cash Flows

	2022-23 £m	2021-22 £m
Total cash outflow on leases under IFRS 16	(0.1)	-

8.6 Revaluation

There were no revaluations of lease assets or liabilities in 2022-23
The CCG was not party to any sale and lease-back transactions in the period.
The leases recognised relate to the CCGs office sites at the Pierre Simonet Building, Jenner House and Salisbury Medical Clinic.

9 Intangible non-current assets

2022-23	Computer Software: Purchased £m	Total £m
Cost or valuation at 01 April 2022	0.4	0.4
Disposals other than by sale	(0.2)	(0.2)
Cost / Valuation At 30 June 2022	**0.2**	**0.2**
Amortisation 01 April 2022	0.2	0.2
Disposals other than by sale	(0.2)	(0.2)
Charged during the year	0.1	0.1
Amortisation At 30 June 2022	**0.1**	**0.1**
Net Book Value at 30 June 2022	**0.2**	**0.2**
Purchased	0.2	0.2
Total at 30 June 2022	**0.2**	**0.2**

9.1 Economic lives

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

10.1 Trade and other receivables

	Current 2022-23 £m	Current 2021-22 £m
NHS receivables: Revenue	0.5	1.4
NHS prepayments	0.8	0.4
NHS accrued income	0.2	0.4
Non-NHS and Other WGA receivables: Revenue	3.7	2.0
Non-NHS and Other WGA prepayments	4.1	1.5
Non-NHS and Other WGA accrued income	3.0	3.0
Expected credit loss allowance-receivables	(0.7)	(0.6)
VAT	0.1	0.2
Total Trade & other receivables	**11.9**	**8.3**
Total current and non current	**11.9**	**8.3**

10.2 Receivables past their due date but not impaired

	2022-23 DHSC Group Bodies £m	2022-23 Non DHSC Group Bodies £m	2021-22 DHSC Group Bodies £m	2021-22 Non DHSC Group Bodies £m
By up to three months	0.2	1.4	1.2	1.3
By three to six months	0.1	0.3	-	0.1
By more than six months	0.1	0.5	0.1	0.4
Total	**0.4**	**2.2**	**1.3**	**1.9**

10.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £m	Total £m
Balance at 01 April 2022	(0.6)	(0.6)
Lifetime expected credit losses on trade and other receivables	(0.1)	(0.1)
Total	**(0.7)**	**(0.7)**

11 Cash and cash equivalents

	2022-23 £m	2021-22 £m
Balance at 01 April 2022	0.6	(7.2)
Net change in year	8.7	7.9
Balance at 30 June 2022	**9.3**	**0.6**
Made up of:		
Cash with the Government Banking Service	9.3	0.6
Cash and cash equivalents	**9.3**	**0.6**
Balance at 30 June 2022	**9.3**	**0.6**

12 Trade and other payables	Current 2022-23 £m	Current 2021-22 £m
NHS payables: Revenue	5.9	1.5
NHS accruals	4.8	0.9
Non-NHS and Other WGA payables: Revenue	9.0	32.7
Non-NHS and Other WGA accruals	79.7	105.0
Non-NHS and Other WGA deferred income	0.3	0.1
Social security costs	0.3	0.3
Tax	0.2	0.2
Other payables and accruals	5.5	8.4
Total Trade & Other Payables	**105.8**	**149.1**
Total current and non-current	**105.8**	**149.1**

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
Other payables include £0.4m outstanding pension contributions at 30 June 2022

13 Provisions

	Current 2022-23 £m	Current 2021-22 £m
Restructuring	1.3	1.8
Continuing care	3.8	3.8
Other	5.0	5.5
Total	**10.1**	**11.1**
Total current and non-current	**10.1**	**11.1**

	Restructuring £m	Continuing Care £m	Other £m	Total £m
Balance at 01 April 2022	**1.8**	**3.8**	**5.5**	**11.1**
Arising during the year	-	0.1	-	**0.1**
Utilised during the year	(0.1)	(0.0)	(1.9)	**(2.1)**
Reversed unused	(0.4)	(0.1)	-	**(0.5)**
Balance at 30 June 2022	**1.3**	**3.8**	**3.6**	**8.6**
Expected timing of cash flows:				
Within one year	1.3	3.8	3.6	**8.6**
Balance at 30 June 2022	**1.3**	**3.8**	**3.6**	**8.6**

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.

14 Contingencies

	2022-23 £m	2021-22 £m
Contingent liabilities		
Continuing Healthcare	2.7	3.1
Mental Health	5.6	-
Net value of contingent liabilities	**8.3**	**3.1**

15 Commitments

15.1 Capital commitments
The CCG had none during the 3 month period to 30th June 2022.

15.2 Other financial commitments

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

	2022-23 £m	2021-22 £m
In not more than one year	121.0	115.5
In more than one year but not more than five years	87.4	58.4
In more than five years	1.7	1.7
Total	**210.1**	**175.7**

16 Financial instruments

16.1 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 clinical commissioning group in undertaking its activities.

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

16.1.1 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.

16.1.2 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.

16.1.3 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.

16.1.4 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.

16.1.5 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.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £m	Total 2022-23 £m	Financial Assets measured at amortised cost 2021-22 £m	Total 2021-22 £m
Trade and other receivables with NHSE bodies	0.2	0.2	0.8	0.8
Trade and other receivables with other DHSC group bodies	5.1	5.1	4.2	4.2
Trade and other receivables with external bodies	2.2	2.2	1.9	1.9
Cash and cash equivalents	9.3	9.3	0.6	0.6
Total at 30 June 2022	**16.8**	**16.8**	**7.5**	**7.5**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £m	Total 2022-23 £m	Financial Liabilities measured at amortised cost 2021-22 £m	Total 2021-22 £m
Trade and other payables with NHSE bodies	0.4	**0.4**	0.4	0.4
Trade and other payables with other DHSC group bodies	12.6	**12.6**	9.3	9.3
Trade and other payables with external bodies	93.2	**93.2**	138.9	138.9
Total at 30 June 2022	**106.1**	**106.1**	**148.6**	**148.6**

17 Operating segments

	Gross expenditure £m	Income £m	Net expenditure £m	Total assets £m	Total liabilities £m	Net assets £m
BaNES Locality Commissioning	96.8	(0.0)	**96.8**	-	-	**-**
Swindon Locality Commissioning	107.6	(0.1)	**107.5**	-	-	**-**
Wiltshire Locality Commissioning	103.5	(0.1)	**103.4**	-	-	**-**
BSW Commissioning	80.9	(1.4)	**79.5**	23.5	(115.6)	**(92.1)**
Total	**388.9**	**(1.7)**	**387.2**	**23.5**	**(115.6)**	**(92.1)**

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.

18 Joint arrangements

The CCG has entered into arrangements with three local authorities during 2022-23. The detail of these for the three month period ending 30th June 2022 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	14.2	7.1	0.1	6.4	0.7
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	12.5	10.5	0.1	1.8	0.1
Income from client contributions	-				
Grant Funding	-				
Total Funding	**26.7**	**17.6**	**0.2**	**8.2**	**0.8**
Expenditure					
Bath & North East Somerset Council	16.0	7.1	0.1	6.4	2.4
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	12.8	10.5	0.1	1.8	0.4
Total Expenditure	**28.7**	**17.6**	**0.2**	**8.2**	**2.8**
Net overspend/(underspend) as detailed below					
Bath & North East Somerset Council	1.8	-	-	-	1.8
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	0.3	-	-	-	0.3
Total Overspend/(Underspend)	**2.0**	**-**	**-**	**-**	**2.0**

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs and all the other accounts were approved 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 £12.5m of which £0.3m was a net overspend.

18 Joint arrangements cont'd

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	33.0	8.1	-	11.9	10.4	2.7
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	19.3	9.2	0.2	9.2	0.7	-
Income from client contributions	-	-				
Grant Funding	-					
Total Funding	**52.3**	**17.3**	**0.2**	**21.1**	**11.0**	**2.7**
Expenditure						
Swindon Borough Council	34.4	8.1	-	12.4	11.2	2.7
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	19.3	9.2	0.2	9.2	0.7	-
Total Expenditure	**53.7**	**17.3**	**0.2**	**21.6**	**11.9**	**2.7**
Net overspend/(underspend) as detailed below						
Swindon Borough Council	1.4	-	-	0.5	0.9	-
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	0.1	-	-	0.0	0.0	-
Total Overspend/(Underspend)	**1.4**	**-**	**-**	**0.5**	**0.9**	**-**

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 £19.3m of which £0.01m was a net overspend.

18 Joint arrangements cont'd

		Better Care Fund	
Wiltshire Locality arrangement	**Total**	**Better Care Fund**	**Community Equipment**
	£m	**£m**	**£m**
Contribution			
Wiltshire Council	6.9	6.4	0.5
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	9.8	8.7	1.1
Income from client contributions	-	-	-
Grant Funding	1.5	1.5	-
Total Funding	**18.2**	**16.6**	**1.6**
Expenditure			
Wiltshire Council	8.4	8.3	0.1
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	9.6	8.4	1.2
Total Expenditure	**18.0**	**16.7**	**1.3**
Net overspend/(underspend) as detailed below			
Wiltshire Council	(0.1)	0.3	(0.4)
NHS Bath and North East Somerset, Swindon & Wiltshire CCG	(0.2)	(0.3)	0.1
Total Overspend/(Underspend)	**(0.3)**	**-**	**(0.3)**

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 £9.8m, of which £0.2m was a net underspend.

19 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 30th June 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	0.3	-	0.0	-
Dr Ruth Grabham, Medical Director - Transactions for Heart of Bath Medical Partnership	1.1	-	0.2	(0.0)
Dr Brynn Bird - Locality Clinical Lead (B&NES), GP Partner Cadbury Heath Healthcare, Sessional GP St Augustines Healthc	0.5	-	0.0	(0.1)
Dr Amanda Webb - Locality Clinical Lead (Swindon) - Transactions for Westrop Medical Practice	2.0	-	1.1	(0.1)
Dr Francis Campbell - Locality Healthcare Professional (Swindon) - Transactions for Elm Tree Surgery	0.4	-	0.1	(0.0)
Dr Catrinel Wright - Locality Healthcare Professional (Wiltshire) - Transactions for Lovemead Practice	0.8	-	0.0	(0.0)
Dr Sam Dominey - Locality Healthcare Professional (Wiltshire) - Transactions for Three Chequers Medical Practice	1.3	-	0.0	-
Dr Nick Ware - Locality Healthcare Professional (Witlshire) - Transactions for Northlands Surgery	0.5	-	0.0	-
Dr Edward Rendell - Locality Clinical Lead (Wiltshire) - Transactions for The Orchard Practice	1.0	-	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 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.

20 Events after the end of the reporting period

The accounts were authorised for issue by the Chief Financial Officer on 22nd June 2023

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. The amounts transferred from BSW CCG to BSW ICB are listed below and can be found on the Statement of Financial Position.

- Non-current assets: £2.3m
- Current assets: £21.2m
- Non-Current liabilities: £0.9m
- Current liabilities: £114.7m

Post Balance Sheet Event

On 29th July 2022, Mr Justice Kerr issued a judgement against the ICB in respect of a procurement challenge in the High Court made by Consultant Connect Limited.
This has resulted in a civil penalty against the ICB of £8,000 and damages of £881k.
NHS Bath and North East Somerset, Swindon and Wiltshire CCG, NHS Gloucestershire CCG and NHS Bristol, North Somerset and South Gloucestershire CCG all jointly ran a procurement exercise during 2020 and 2021 for an advice and guidance service. The procurement resulted in a contract award to Nonmedical Limited (t/a Cinapsis).
Consultant Connect Limited were the incumbent provider of a service for NHS Bath and North East Somerset, Swindon and Wiltshire CCG and have successfully challenged the procurement and its compliance with the Public Contracts Regulation 2015.

21 Financial performance targets
NHS BSW CCG has a number of financial duties under the NHS Act 2006 (as amended).
NHS BSW CCGs performance against those duties for the three month period ending 30th June 2022 was as follows:

	2022-23 Target £m	2022-23 Performance £m	2021-22 Target £m	2021-22 Performance £m
Expenditure not to exceed income	388.9	388.9	1,709.0	1,709.0
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	387.2	387.2	1,701.3	1,701.3
Revenue administration resource use does not exceed the amount specified in Directions	4.0	4.0	18.6	17.2

22 Losses and special payments

22.1 Losses

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £m
Fruitless payments	1	0.9
Total	**1**	**0.9**

The CCG had one fruitless payment in 2022-23 and no losses in 2021-22.

22.2 Special payments

	Total Number of Cases 2022-23 Number	Total Value of Cases 2022-23 £m	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £m
Compensation payments	-	-	1	0.0
Total	**-**	**-**	**1**	**0.0**

The CCG had one special payment in 2021-22.