NHS Bristol, North Somerset and South Gloucestershire CCG

Annual Report 2021/22

Contents

Chair and Chief Executive's statement

2021/22 has been another exceptional year, as the whole country seeks to recover from the pandemic and learn to live with Covid-19. We know this is more difficult for some people than others, and the development of our Long Covid service for Bristol, North Somerset and South Gloucestershire (BNSSG) is testament to the seriousness of the virus and its ongoing impact on people's lives.

It is also why our vaccination efforts remain so vital. We would like to thank everyone involved in the vaccination programme, including grassroots groups and community leaders, who have been instrumental in busting myths about the vaccine and increasing uptake across our diverse communities. To date, over 2.1m doses have been administered in BNSSG, with 40,000 people vaccinated as part of dedicated outreach work – keeping people and communities safe.

It has also been an exceptional year for the health and care system, with sustained pressure across all services. Impacts of the Omicron wave of Covid-19 combined with staff sickness and increased demand, have meant longer waits for some services. It has also meant that our dedicated staff have had to work very differently at times – something we are hugely grateful for. People have stepped up to significant challenges this year to continue to provide safe and effective care to everyone who needs it.

This year, we have strengthened the Clinical Assessment Service (CAS), within NHS 111, so that a greater range of professionals are available to provide advice online and over the phone. This has helped more people get to the right care for their needs first time and reduced pressure on busy Minor Injuries Units and Emergency Departments. General Practice has also worked differently to overcome the constraints brought about by the pandemic, including the expansion of primary care teams to include a greater range of professionals, and improving remote and online triage. We are proud to say that GP practices in BNSSG have seen more people than ever this year, including 2.86 million face-to-face appointments and administering over 794,000 Covid vaccinations in 21/22.

This focus on working differently and smarter will continue to be a hallmark as we look to the future, getting the best value from every pound we spend. We are committed to working together as an integrated health and care system to bring elective waiting lists down,

particularly for those people waiting over a year for treatment due to the pandemic. We will also be focussing collectively on ensuring that people are supported to stay well and independent in their own homes wherever possible. Alongside strengthening our community services, this also means improving flow through our hospitals, so that people can be discharged home in a timely way – where we know people can recover their independence more fully.

The next stage of our development as an Integrated Care system provides a big opportunity for us to do this. This is our final annual report as a Clinical Commissioning Group (CCG) before we transition to the new statutory Integrated Care Board arrangements from July 1st. The achievements of the CCG this year and since 2018 – to embed locality partnerships, develop Primary Care Networks, secure a single provider of community services for BNSSG, redesign community mental health provision and agree major improvements to stroke services, among many others – gives us a strong foundation for the future. The Integrated Care System will build on this success to join care up around people's needs, improve people's health outcomes and reduce health inequalities.

We would like to take this opportunity to pay tribute to the dedicated CCG staff past and present that have played a role in these achievements. It is our people that will continue to be the driving force within the Integrated Care Board, and as we seek to make a difference in the health, wellbeing and lives of the population we serve.

Shane Devlin, CEO

Jon Hayes, Chair

PERFORMANCE REPORT

Performance Overview

This performance overview provides a short summary of our purpose, the key risks to our objectives in 2021/22 and how we performed during the year.

Chair and Chief Executive's Statement

2021/22 has been another exceptional year, as the whole country seeks to recover from the pandemic and learn to live with Covid-19. We know this is more difficult for some people than others, and the development of our Long Covid service for BRISTOL, North Somerset and South Gloucestershire (BNSSG) is testament to the seriousness of the virus and its ongoing impact on people's lives.

It is also why our vaccination efforts remain so vital. We would like to thank everyone involved in the vaccination programme, including grassroots groups and community leaders, who have been instrumental in busting myths about the vaccine and increasing uptake across our diverse communities. To date, over 2.1m doses have been administered in BNSSG, with 40, 000 people vaccinated as part of dedicated outreach work – keeping people and communities safe.

It has also been an exceptional year for the health and care system, with sustained pressure across all services. Impacts of the Omicron wave of Covid-19 combined with staff sickness and increased demand, have meant longer waits for some services. It has also meant that our dedicated staff have had to work very differently at times – something we are hugely grateful for. People have stepped up to significant challenges this year to continue to provide safe and effective care to everyone who needs it.

This year, we have strengthened the Clinical Assessment Service (CAS), within NHS 111, so that a greater range of professionals are available to provide advice online and over the phone. This has helped more people get to the right care for their needs first time and reduced pressure on busy Minor Injuries Units and Emergency Departments. General Practice has also worked differently to overcome the constraints brought about by the pandemic, including the expansion of primary care teams to include a greater range of professionals, and improving remote and online triage. We are proud to say that GP practices in BNSSG have seen more people than ever this year.

This focus on working differently and smarter will continue to be a hallmark as we look to the future, getting the best value from every pound we spend. We are committed to working together as an integrated health and care system to bring elective waiting lists down, particularly for those people waiting over a year for treatment due to the pandemic. We will also be focussing collectively on ensuring that people are supported to stay well and independent in their own homes wherever possible. Alongside strengthening our community services, this also means improving flow through our hospitals, so that people can be discharged home in a timely way – where we know people can recover their independence more fully.

The next stage of our development as an Integrated Care System provides a big opportunity for us to do this. This is our final annual report as a Clinical Commissioning Group (CCG) before we transition to the new statutory Integrated Care Board arrangements from July 1st. The achievements of the CCG this year and since 2018 – to embed locality partnerships, develop Primary Care Networks, secure a single provider of community services for BNSSG, redesign community mental health provision and agree major improvements to stroke services, among many others – gives us a strong foundation for the future. The Integrated Care System will build on this success to join up care around people's needs, improve people's health outcomes and reduce health inequalities.

We would like to take this opportunity to pay tribute to the dedicated CCG staff past and present that have played a role in these achievements. It is our people that will continue to be the driving force within the Integrated Care Board, and as we seek to make a difference in the health, wellbeing and lives of the population we serve.

Jon Hayes, Chair

Shane Devlin, Chief Executive Officer

Our purpose and activities

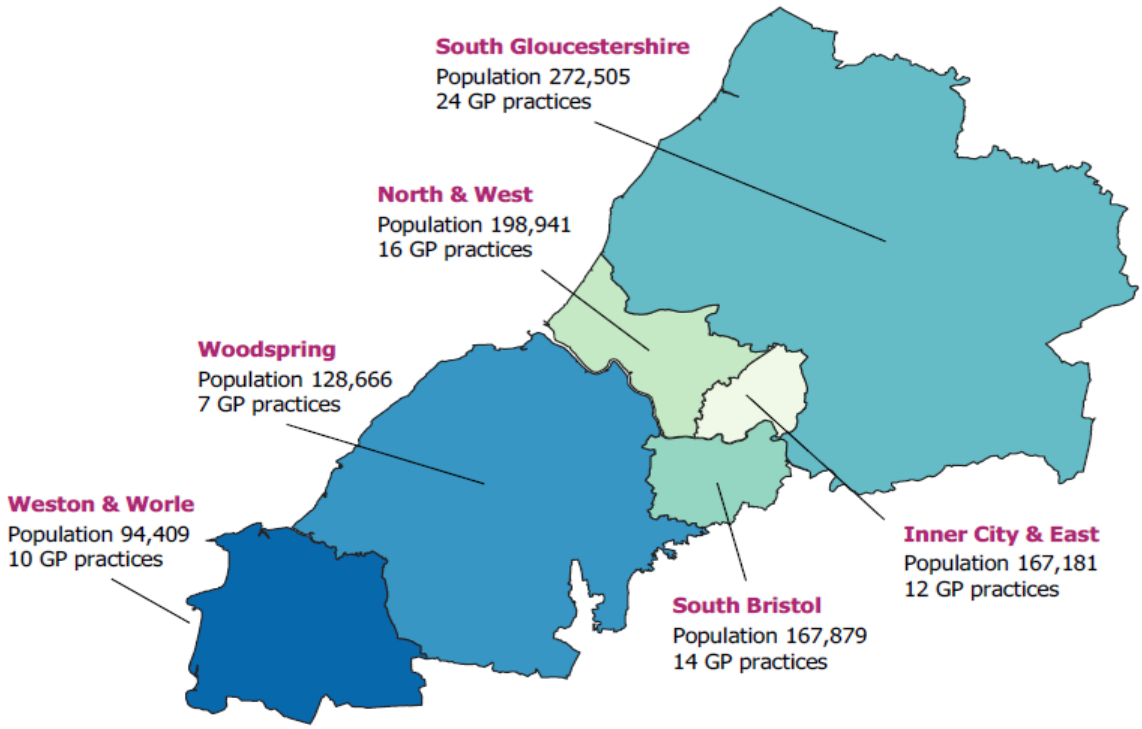
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) is responsible for planning, buying and monitoring the majority of healthcare services for the one million people who live in our area.

We are a membership organisation, led by GPs from the 81 general practices in Bristol, North Somerset and South Gloucestershire. Our practices work across six localities and in 19 Primary Care Networks. Our members use their knowledge of the local population's health needs to guide the services we plan and purchase. Our local GPs provide the clinical leadership for all of our commissioning activities. We work with patients and partners to plan health services for Bristol, North Somerset and South Gloucestershire residents, based on the identified needs of our population. Our Governing Body ensures that we meet our responsibilities and its membership includes three lay members, local GPs, a secondary care doctor, an independent nurse member and executive members. The CCG employs 434 members of staff who work alongside our colleagues in primary and secondary care, and in community services, as part of the Healthier Together system to deliver our plans. The services we are responsible for include:

- Urgent and emergency care, such as NHS 111, A&E and ambulance services
- Planned hospital care, such as operations and treatments
- Community health services, such as community nursing and physiotherapy
- Rehabilitation for those recovering from illness and operations
- Maternity and new born services
- Fertility services
- Children and young people's health services
- Mental health services
- Continuing healthcare for people with on-going health needs, such as nursing care
- We are responsible for commissioning primary care services from local GP practices.

NHS England commissions other primary care services such as dentists, pharmacists and opticians. To ensure that we commission services that meet the needs of our communities we have worked with patients, service users, carers and members of the public to understand what matters to them.

Bristol, North Somerset and South Gloucestershire CCG



Our staff work in and across 7 directorates led by:

- The Chief Executive's office – Julia Ross and from March 2022 Shane Devlin
- Commissioning – Lisa Manson
- Area Teams – Colin Bradbury and David Jarrett
- Medical – Peter Brindle
- Nursing and Quality – Rosi Shepherd
- Transformation – Deborah El-Sayed
- Finance, Intelligence and Corporate Services – Sarah Truelove

Our population

Bristol, North Somerset and South Gloucestershire is a vibrant and dynamic area with a mix of urban and rural populations. Bristol is a largely urban area, whilst both North Somerset and South Gloucestershire are more rural. We have a diverse population with older populations in North Somerset and South Gloucestershire and a younger population living in Bristol. Our population is growing, with increases in the numbers of people aged between 15 and 24 years old and people over the age of 60 years. The population predicted to increase most significantly over the next 25 years is those aged 85 and over. We have an ethnically diverse population, with Bristol having the greatest proportion of Black and Minority Ethnic (BME) people (16%) compared to South Gloucestershire (5%) and North Somerset (2.7%). Our younger people tend to have the greatest number belonging to a BME group. There are significant pockets of deprivation within our area, with around one in ten people living in a deprived location. Average

life expectancy varies between those living in the most and least deprived areas by around six years, with some places seeing a 15-year difference.

If we describe our population as 100 people:

Healthier Together – Our Integrated Care System

Healthier Together is our Integrated Care System (ICS). Ten local health and care organisations sit on the Healthier Together board. The partnership goes beyond these organisations and the views of the public, patients, staff and voluntary sector form a significant role in shaping the future of our local health and care services.

With the passage of the Government's Health and Care Bill, ICBs are set to exist in statute from 1 July 2022. Clinical Commissioning Groups (CCGs) will be dissolved through the same legislation, with the vast majority of CCG staff transferring to the new organisation. Our Bristol North Somerset and South Gloucestershire ICB will form the statutory body within our wider Healthier Together Partnership, with accountability for strategic planning and resource allocation. Jeff Farrar was announced as the Chair Designate of the Bristol, North Somerset and South Gloucestershire ICB in October 2021 and in February 2022 Shane Devlin started in

post as our ICB CEO-designate and Interim Chief Executive for the CCG. Work ensuring that the CCG is properly closed down and there is a robust hand over to the ICB on the 1st July is underway. Programmes of work to ensure that the ICB is properly established are in place and continue at pace.

Summary of activity

Our Governing Body identified the following principal objectives for the CCG in 2021/22:

- Making the transition from STP towards a mature ICS that takes collective accountability and delivers our system aims.
- By April 2022 core services will be delivered by Locality Partnerships. This will be underpinned by population health and value-based principles to reduce variation, tackle health inequalities and ensure high quality care for all
- To be able to respond to the Mental Health needs population, preventing crisis and promoting wellbeing
- To improve the commissioning of services for children
- Delivery of an integrated, efficient, Funded Care service achieving the “leading” level of the CHC Maturity Framework with high levels of positive patient experience and staff satisfaction
- Developing the CCG’s People Plan
- Deliver financial sustainability and improved health outcomes through the use of population health management and a culture of systematically evaluating the value of our services to our population.

We have worked together with our partners to improve physical and mental health, promote wellbeing and reduce inequalities in health outcomes for local people. We have taken this work forward whilst responding to the Covid-19 pandemic which continues to present extreme challenges. These challenges continue to affect our population, our partnerships and our staff. We have seen the rapid transformation of services which has driven forward many of our long-term plans. With the support of strong clinical leadership there continues to be an unprecedented pace of change. 2021/22 has seen:

- The approval of a new model for stroke services taking forward our vision for everyone in our area to have the best opportunity to survive and thrive after stroke.
- The development of Locality Partnerships, bringing together local health, care and community partners to understand what matters most to local people and improve care.

- Partners co-designing a new approach to community mental health services that aims to offer the right support, at the right time, in the right place through the Community Mental Health Programme.
- An overall focus on improving mental health services.
- Improvements to our local NHS 111 service to help avoid unnecessary ambulance dispatches and visits to A&E departments.
- Improvements to support people with Learning Disabilities and Autism.
- A continued prioritisation of cancer care and planned care services to tackle the growth in waiting lists.
- The continued success of our mass vaccination campaign.

There are significant challenges facing our healthcare system including improving performance across planned and urgent care, including our ambulance services and ensuring that mental health services are able to meet the demands placed on them. Performance across these areas has been below expectations and targets in 2021/22 (p12).

Summary of key risks to delivering our objectives

Our risk management framework, described in detail in our Governance Statement (p83) enables our Governing Body to focus on the strategic and most significant risks to achieving our objectives.

Key risks in 2021/22:

- The impact of Covid-19 on our services, staff and the implementation of our long-term plans. There was a particular focus on the impact on waiting times for urgent care, planned care services, diagnostics, mental health services and ambulance services. The risks relating to health inequalities and the impact of Covid-19 were also highlighted.
- The potential impact of the Health and Care Bill on our Integrated Care System, and on our staff as they transfer to a new organisation.
- The potential for increased health inequalities and poor outcomes for people in our community with Learning Disabilities and Autism.

Other risks related to

- the care received by children
- the delivery of care to vulnerable patients
- the delivery of improved population health and financial sustainability

Adoption of the going concern basis

The CCG has reported a small surplus of £964,000 (0.05%) against the In-Year Revenue Resource Limit of £1,859,577,000.

The CCG began the year with an accumulated deficit caused by prior year deficits, including of predecessor bodies, against its Revenue Resource Limit of £117,059,000. Due to the temporary nature of the national finance framework in response to the Covid pandemic it is not expected that the accumulated deficit will be reduced for the small surplus delivered in 2021/22 financial year. This deficit will be carried forward into 2022/23 and into the Integrated Care Board (ICBs) financial framework. However, the emerging financial framework for ICBs states that if the ICB 'system' achieves breakeven or better against the In Year Resource Limit for the next 2 financial years the requirement to repay the accumulated deficit will be withdrawn.

These accounts have been prepared on a going concern basis.

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

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

The Clinical Commissioning Group allocations for 2019/20 to 2023/24 were published in January 2019 and had final approval by the NHS England Board on 31 January 2019. The revenue allocations are backed by cash limits. Throughout this period, the CCG expects to maintain a positive cash flow and continue to meet the Better Payment Performance standard.

Where a Clinical Commissioning Group ceases to exist, it considers whether 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. On this basis, the CCG considers it remains a Going Concern.

Summary of performance 2021/22

Overview of how CCG performance is measured

In 2020/21 the CCG was rated as Good by NHS England. The outcome of the 2021/22 assessment will be published in 2022 at a date yet to be confirmed.

In addition to the CCG rating the Integrated Care System (ICS) is also subject to segment rating under the NHS England and NHS Improvement (NHSEI) System Oversight Framework (SOF) All ICSs and constituent NHS Trusts/Foundation Trusts and CCGs receive a 'segment rating' in 2020/21 to reflect NHSE/I decisions on their relative need for support:

- Segment 1 – Consistently high performing
- Segment 2 – Default rating
- Segment 3 – Mandated support
- Segment 4 – Mandated intensive support

The Bristol, North Somerset, and South Gloucestershire ICS was placed into SOF segment 3 and mandated support due to Avon and Wiltshire Mental Health Partnership NHS Trust, North Bristol NHS Trust and University Hospital Bristol and Weston NHS Foundation Trust each being placed in segment 3, alongside recognised challenges in respect of workforce and Improving Access to Psychological Therapies (IAPT)/Children and Young People (CYP).

In practice this mean the NHSEI regional team will work collaboratively with the ICS to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved.

Activity and NHS constitutional standards

The following table shows Bristol, North Somerset and South Gloucestershire performance against NHS Constitutional Standards.

Key to symbols in table 1 below:

 Better than last year but not achieving standard

 Achieving standard

 Worse than last year and not achieving standard

Table 1:
2021/22 performance compared to 2020/21

			BNSSG		
Indicator	**Page Ref**	**Standard**	**2020/21**	**2021/22**	**Change**
Percentage of patients admitted, transferred or discharged from A&E within 4 hours (BNSSG Acute Trusts Total)	28	95%	81.58%	64.98%	
Percentage of patients on an incomplete RTT Pathway waiting less than 18 weeks	104	92%	70.97%	65.40%	
Number of patients on an incomplete RTT Pathway waiting more than 52 weeks	104	1	4,327	3,779	
Percentage of patients waiting six weeks or more for a diagnostic test (15 key tests)	32	1%	30.50%	37.90%	
Maximum two-week wait for first appointment for patients referred urgently for suspected cancer	30	93%	79.38%	64.90%	
Maximum two-week wait for first appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	30	93%	58.10%	28.20%	
Percentage of patients receiving a diagnosis or ruling out of cancer, or a decision to treat within 28 Days of an urgent referral for suspected cancer (new standard for 2021/22)	30	75%	Data not available	66.80%	Not applicable
Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	30	96%	95.21%	92.50%	
Maximum 31 day wait for subsequent treatment where that treatment is surgery	30	94%	86.31%	81.10%	
Maximum 31 day wait for subsequent treatment where that treatment is anticancer drug regimen	30	98%	99.37%	99.00%	
Maximum 31 day wait for subsequent treatment where that treatment is radiotherapy	30	94%	98.68%	99.70%	
Maximum 62 day wait from urgent GP referral (two-month wait) to first definitive treatment for cancer	30	85%	75.58%	68.80%	
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for cancer	30	90%	72.46%	59.60%	
Total Number of CDIFF Cases	49	191	294	303	
Total Number of MRSA Cases Reported	47	0	31	38	
Eliminating Mixed Sex Accommodation	-	0	Data not available	2	Not applicable

Performance analysis

The following pages provide a more detailed summary of our performance including how we measure it. We look at key activities and programmes of work across our commissioning activities. We look at:

- Work to improve the quality of services
- How we have engaged with people and communities
- Our work to reduce health inequalities and promote equality across our community and workforce
- Our work with our Health and Wellbeing Boards
- Sustainable development
- A summary of our financial position. This is given in detail in the Annual Accounts section of the Annual Report (p143). We describe our actions to tackle fraud and bribery in our Governance Statement (p83)

Performance management is a key role that ensures services delivered to our population achieve the desired outcomes and provide good value for money. Performance is monitored and reported through:

- Finance: detailed financial plans are created to plan for patient care activity and outcomes, and to monitor the in-year performance of our providers
- Performance against NHS Constitutional Standards
- Performance in quality and outcomes: to ensure services are safe, patients have a positive experience of healthcare, and improvements in clinical outcomes are delivered

Risks to achieving our objectives

We identified the following key risks to the delivery of our objectives and Operational Plan during 2021/22. Further details can be found in our Governance Statement in this report (p83).

- The implementation of legislation to establish Integrated Care Systems and the focus on developing a new organisation would impact on the progress made to become a mature ICS and have a wider impact on the delivery of recovery objectives
- Locality Partnerships would not be established by the April 2022 deadline.

- The impact of Covid-19 would result in an increase in demand for mental health services that would result in poorer access and outcomes for people, increased level of mental health crisis and further expenditure on services like out of area placements
- People with learning disabilities would not be able access to Annual Physical Health Checks and ongoing support, resulting in poor health outcomes and increased health inequalities
- The care children received would not be optimised if integrated children's commissioning was not fully developed with Local Authorities
- Demand for Continuing Healthcare Services would outstrip capacity resulting in delays in providing care for patients, financial pressures for the CCG and non-compliance against national framework standards.
- The progress made in developing the culture and staff experience within the CCG would be disrupted and lost as we transition to becoming an ICS.
- There would be a continuing focus on activity rather than value leading to a failure to deliver improved population health and financial sustainability

Other reported risks included:

- Increased waiting times across key services including A&E, 52 week waiting times, access to planned care and diagnostic services and cancer waiting times, waiting times for musculoskeletal services and Attention Deficit Hyperactivity Disorder (ADHD) services
- Risks related to improvements in the delivery of core mental health services
- Patients were at risk of harm due to ambulances being unable to attend calls within required timeframes
- As a result of reducing capacity in domiciliary and residential care provision there is a risk that we will be unable to sustain care delivery to vulnerable and complex patients which may result in unavoidable hospital admission or that needs will not be met safely or in the place of choice at end of life
- Patients were at risk of potential harm through contracting Healthcare Associated Infections
- Increased risk of health inequalities for cancer patients due to delays in diagnosis
- Risk to the delivery of the Long-Term Plan due to the impact of Covid-19
- The delivery of services such as communications due to staff capacity

We explain below our work to mitigate these risks and how the actions we are taking will help improve future performance and are part of our future plans. The risks to our plans from the continuing need to meet the demands created by Covid-19 will continue and we will take forward and build on our actions, and the actions of partner organisations, to reduce the risk of infections and the impact of outbreaks. We have seen the changes in the national financial framework for the NHS have a significant impact on the likelihood of current risks related to finance materialising.

Redesigning Stroke Care

Stroke is the fourth biggest killer in the UK, and a leading cause of disability. Over recent years, there have been significant advances in stroke treatment and care. The growing evidence of the benefits of centralised models of “hyper acute” stroke care forms the basis of a new draft National Stroke Service Model. Better immediate care limits the extent of brain damage after stroke and early intensive rehabilitation reduces disability and preserves post stroke independence.

In Bristol, North Somerset and South Gloucestershire approximately 1,300 new strokes are experienced by local residents each year and in 2019/20, there were 18,706 people living with a previous stroke diagnosis in our area.

We launched a programme to look at the national evidence surrounding best practice and outcomes for stroke care in December 2019. Working with clinicians, patients with lived experience, voluntary organisations to review service provision, we developed and tested proposals to change stroke care for our population. The aim is that:

- Fewer people die from stroke each year
- Expert care is provided in hospital, home and the community
- Services are high-quality and sustainable for the future

We carried out a robust consultation exercise between June and September 2021 to seek the views of members of the public to our proposals. We engaged with 2,202 people and had 1,833 responses. Listening to the views of people and working with partners across the health system enabled proposals to be developed that will deliver significant clinical benefit to stroke patients, support equitable service to the whole of our, increase care provided in the community and deliver the nationally recommended model of care. Our process of engagement was commended by the Joint Health Overview and Scrutiny Committee of Bristol, North Somerset and South Gloucestershire.

The new model for stroke services, agreed by the CCG Governing Body in February 2022, will have:

- A centre of excellence at North Bristol Trust providing a Hyper-Acute Stroke Unit (HASU) and step-down Acute Stroke Unit (ASU)
- Inpatient rehabilitation provided at two Sub-Acute Rehab Units (SSARU) based at South Bristol Community Hospital (SBCH) and at Weston General Hospital.

In the future patients with suspected stroke will be taken directly to North Bristol Trust (NBT) NBT to get the best care possible. Our plans for stroke services include expanding community services for stroke through an Integrated Community Stroke Service. This will provide intensive rehabilitation and wrap-around support to patients within their own homes. This will help people to return to their own home at a much earlier phase of their ongoing recovery.

Our stroke services will improve the outcomes for people that have experienced a stroke and ensure that everyone that lives in our area has the same access to highly specialised life-saving interventions through a single specialist centre. Our vision is for everyone in Bristol, North Somerset and South Gloucestershire to have the best opportunity to survive and thrive after stroke.

Locality Partnerships and Our Community Mental Health Programme

Our ability to stay healthy and well depends on a range of things, including social connections, employment, housing and education. To make a real difference in people's lives, health and care services need to reflect the importance of these 'wider factors of health' and the role they play in our wellbeing.

To help do this, six Locality Partnerships have been established in our area to design services that improve health and wellbeing and fit in with people's lives. Working at a local level, close to their communities, the six Locality Partnerships are:

- South Gloucestershire,
- North and West Bristol,
- Inner City and East Bristol,
- South Bristol,
- Woodspring, and
- Weston, Worle and Villages.

Locality Partnerships are made up of general practice, social care, hospitals, mental health services, councils, volunteer sector, and community services with citizens and communities recognised as equal partners. By working together and understanding what matters most to the communities they serve Locality Partnerships are redesigning services to ensure that everyone's care is person-centred, proactive, and place-based, ensuring that people can stay well, wherever they live.

Our work to develop our Locality Partnerships has included a series of 26 workshops with over 300 people, to understand the challenges our system and Locality Partnerships need to be able to address. We also drew together learning and insights from other systems nationally and around the globe.

Improving the mental health of our population is a critical priority. This has been the starting point for our Locality Partnerships to bring together their local health, care and community partners and representatives of people using mental health services, to understand what matters most to local people and improve care.

Through the Community Mental Health Programme partners are co-designing a new approach that aims to offer the right support, at the right time, in the right place. This means support will be coordinated and tailored to individual needs and consider the wider factors that play a role in our wellbeing, be that physical conditions, social connections, or housing.

To support this, we developed our Community Mental Health Service Target Operating Model. This incorporated the views of more than 1,000 people with Lived Experience, community partners and professionals. People shared that they have experienced stigma; found services siloed; and faced frustration and anxiety in constantly having to repeat their story when trying to get support. As a result, some have ended up on the verge of a crisis with escalating symptoms or without the care they require. Our new model will:

- Leave no-one behind and promote wellbeing and prevent ill health for everyone in the community throughout their lives
- Directly and urgently address the inequalities in health outcomes meeting needs earlier to mitigate against disadvantage and the health impacts of disadvantage
- Work with and mobilise communities to co create health and wellbeing.
- Work with people to promote healthy, fun, safe and caring places where everyone feels that they belong.
- Listen to people to understand what matters to them, their family, carers and their community.
- Be seamless and coordinated around the individual using a single assessment of their needs and a coordinated care plan.
- Identify who needs care and support and offer them help early on, restoring them to best possible health.
- Be available 24 hours, seven days a week to people when they have a crisis or need support urgently.
- Work alongside people when their needs become more complex or urgent so they can easily get the care and support that works for them.
- Ensure that, as far as possible, people receive the care they need close to their home.

Our new model of care is now being implemented through our Locality Partnerships, co-led by people with experience of using services, and providers. This integrated approach will allow services to work together to provide care earlier and closer to home and find solutions that suit the needs of each person. Key developments underway include establishing:

- New integrated mental health teams in each Locality Partnerships, made up of local representatives from the community, care, and health services. These ‘place based’ teams will provide tailored support, offering people more choice and access to resources in their communities, including social activities and local groups.

- Bristol, North Somerset and South Gloucestershire's Integrated Access Hub (111) to create universal access to compassionate mental health support and brief assessment, enabling appropriate triage and signposting.
- Specialist pathways to improve care for people with personality disorders and complex trauma, eating disorders, people in need of community rehabilitation, and support for people with a severe mental illness's physical health.

Implementation began in early 2022 and the programme will continue to evolve and improve, informed by feedback and evaluation.

Mental Health

Improving our support and services for people with mental health problems, has continued to be one of our biggest priorities. During 2020/21 we developed and started to implement a business case to support people, at the height of Covid and as we come out of the pandemic. We know that people's mental health is impacted and continues to be impacted long after an incident has happened and therefore planning ahead for our services has been very important.

Our business case was developed with many partners and people with lived experience of mental health problems. The things that we put in place, that have continued to have an impact in 2021/22 included:

- A 24 hour, seven days a week telephone crisis line
- A Child and Adolescent Mental Health Services (CAMHS) phone line
- A new Recovery Outreach Support & Engagement (ROSE) team for people with complex mental health needs
- An expanded service to support people with personality difficulties and complex needs
- Specific support to people who are refugees and asylum seekers
- Support to our local black led community groups
- Expanded support to people with dementia in care homes

We are pleased that we have been able to make such a difference in so many areas.

In addition to this we have continued to carry out significant improvement and transformation of other services. The delivery of the Community Mental Health Programme delivered by our Locality Partnerships has been our most ambitious piece of work to date.

Other services that we have developed in 2021/22 include:

- The newly commissioned People Who Sleep Rough link team is designed to improve engagement with those who are sleeping rough and experiencing severe emotional

distress, creating a bridge between individuals and the wide range of expertise across the system, whilst providing person-centred, trauma-informed care at every stage of the pathway. It also aims to empower and enable individuals to participate fully in their own care and support, and to move off the streets and into suitable accommodation.

- Expanding and enhancing our mental health support to people experiencing mental health crisis has meant we are now able to support the ambulance service, as well as the police and are able to deploy mental health workers to offer support rapidly.
- A new service in North Somerset with Off the Record, to support young people with mental health problems in the local area, who were not able to access secondary mental health services.
- Our Mental Health in Schools programme of work has been a huge achievement and we now have 4 teams working in this area and will be continuing to expand this.
- We have recently started to provide mental health expertise to people who call 111 at the weekend, meaning that expert clinical advice is available.
- New mental health roles as part of the Additional Roles Reimbursement Scheme, these roles work across GP practices and our secondary mental health specialists.

In 2021 we became one of a small number of places across the country to be awarded funding to deliver Green Social Prescribing. We have been running a grant process to enable small community groups to access funds to encourage people to engage with nature to improve their mental health and wellbeing.

This year we have changed the way we manage and monitor our key performance indicators and have set up a system group to review these.

We are very pleased that we have achieved the Recovery rate of 6- and 18-week waits for our Improving Access to Psychological Therapies service during 2021/22. We have worked hard with our new Provider, Vita Health Group, to address historic waiting lists and reduce the time from referral to access. We are continuing to work towards delivering a 25% access target and expect to achieve this in early 2022/23.

An ongoing challenge is the number of people who are placed in beds outside of the Avon and Wiltshire Mental Health NHS Trust (AWP) footprint. We have focussed our work on having the best possible processes in place and have set up a workstream to really drive improvement here.

Significant numbers of young people are needing to access our CAMHS services, for routine services and for specialist eating disorders. In 2021/22 we have not reached the required ambitions due to a number of factors including work force challenges and the increasing

numbers of people requiring services. We have however invested into these areas significantly and will continue to look at how we transform them in order to reach our targets in 2022/23 and beyond.

For access to perinatal care, we have a mixed model of care with strong support from our voluntary sector and acute providers, who all see women experiencing perinatal problems. We have not been able to achieve the levels of access that we had hoped to in our specialist services, but we are continuing to invest in this area and will do so further in 2022/23 to reach this ambition.

Increasing the number of people with severe mental illness, who have received a physical health check has been an area of focus in 2021/22 and we have increased this from below 10% to over 30%, with GPs being instrumental in delivering this work.

The CCG is measured against the requirement that treatment for psychosis can be accessed by patients in line with NICE recommendation that treatment is started within two weeks of referral. We have achieved the highest rating of Level 4 for our early intervention in psychosis services for South Gloucestershire, and we continue to work closely with Avon and Wiltshire Partnership Trust to deliver the same for Bristol and North Somerset, with additional investment being included in 2021/22 and 2022/23.

In 2022/23 driving transformation is fundamental and our plans include:

- Delivering our newly transformed Community Mental Health Services, led by Locality Partnerships, and starting with Mental Health Integrated and Personalised Care Teams
- Delivering an expanded eating disorder service, which will include access to Voluntary sector support
- Helping more people receiving ongoing long term mental health rehabilitation close to home
- Adding in new interventions to support people with complex personality difficulties and trauma
- Expanding our IAPT service to reach more people, our Early Intervention in Psychosis support and increasing the number of people who are able to access our Individual Placement Support services, we will also expand the support we provide to adults in crisis
- Expanding the support available to our refugees and asylum seekers who have experience trauma
- Expanding our perinatal mental health services and setting up new Maternal Mental Health Clinics

- Building on our newly developing 111 mental health support
- Providing additional support to children and young people with eating disorders
- Expanding our Child and Adolescence offer so more people are able to access services quickly
- Moving from 4 to 10 Mental Health Support Teams in Schools across Bristol, North Somerset and South Gloucestershire

We will review all our contracts to understand if they are still fit for purpose or if we should change what they are providing. Going in to 2022/23 we will be meeting the Mental Health Investment Standard and are committed to continually transforming and improving our services.

Learning Disabilities and Autism

Working in partnership with people with learning disabilities and autism, health care and Voluntary, Community and Social Enterprise teams, we have made real progress in supporting our aims for people with a learning disability, Autism or both to live longer, happier and healthier lives; have choice, control and independence and always be treated with dignity and respect.

Improving health

To support our aims of improving people's health, primary care partners have ensured that over 75% of people with a Learning Disability have had an Annual Health Check, with at least 67% receiving an action plan, the highest rate in the South West (detailed further in the sections on Learning Disabilities Mortality Review work (page 24) and Primary Care (page 37). This is important as people with learning disabilities suffer from worse physical health outcomes than the general population and are more likely to die earlier and from preventable causes.

We have also co-produced a range of work to improve people's health and act upon the themes identified in reviews into people's deaths. We describe this below (page 24) in the Learning Disabilities Mortality Review section.

Thriving in our communities

We are focusing on preventing people needing to receive inpatient care through expanding our Autism Intensive Service and Positive Behaviour Support services. We are also helping people in inpatient settings to return to their communities by developing bespoke placements, with housing and care designed around their needs. We are working to strengthen housing support across our area and on providing opportunities for people to access skills and employment, through the 'We Work for Everyone' programme.

Best start in life

We have become an Early Adopter site for the Keyworker Project to provide children and young people with a learning disability, autism or both with a designated keyworker to help them access the support they need. This is being developed in partnership with Parent and Carer Forums. A pilot has also been established to implement a needs-led approach to Autism support for children and young people and their families/carers, without the need for a formal diagnosis.

Voice and influence

To enable people to shape the care they receive, and the decisions taken around how care is provided across our area, we are establishing new self-advocacy groups and an Autism Forum. We have worked in partnership with people who use our services to develop our new projects, and test the quality of current provision (e.g. Secret Shopper audit of A&E departments described below).

With 'Autism Independence' we have sought to understand how access, experience and outcomes can be improved - hearing directly from over 40 families from ethnic minority communities – and will now act on their recommendations.

Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme is designed to develop the quality of services and improve the experience of services for people with learning disabilities.

A review is undertaken when the death of a person with a learning disability is notified, whether they die in hospital or in the community. This involves looking at GP, hospital and community patient notes for the last couple of years of the person's life, against a set enquiry review template designed by the NHS England. During a review any family member, the GP and staff who knew the person well, will be interviewed to get a portrait of the person and the care they received. The reviewer reports on their findings and makes recommendations.

We introduced a Clinical Case Review Panel to strengthen the quality assurance and closure of reviews. We also provide additional support for reviewers, with a 'buddy system' for new reviewers, and a peer support group for all reviewers. We have a monthly LeDeR Governance Group chaired by our Independent Registered Nurse and with representatives from all health providers, local authorities, adult social care providers, the Care Quality Commission, GPs and NHSE regional LeDeR leads. The LeDeR Governance Group provides strategic level oversight to the reviews, driving transformation to improve care.

Involvement of people who have a learning disability in this process is essential to support learning. In February 2020, we established a LeDeR Service User Forum. This ensures people have the opportunity to contribute to LeDeR learning, feeding back their comments and ideas on findings of reviews to help us identify service improvements. Unfortunately, we had to stand down the meetings owing to restrictions introduced in response to Covid, but have continued to engage with North Somerset People First until the group can be safely re-established.

Over the course of 2021/22, we received 63 new notifications and closed 63 cases. Our data shows that people with a learning disability in our area live approximately 8 years longer than the LeDeR national average. The LeDeR national average is that people with learning disabilities live 20 years less than the general population.

Reviews identified the following areas for improvement in the care of people with learning disabilities:

- Completion of annual health checks
- Production of Health Action Plans
- Early detection and access to cancer screening programmes
- Identification and treatment of constipation
- Different presentation of Covid-19 in people with learning disabilities
- Better management of illnesses, such as pneumonia and sepsis
- making reasonable adjustments so people can better access healthcare

Work is underway to address these areas for improvement includes:

Obesity

A growing number of our local LeDeR reported deaths have a BMI over 30. This has increased during lockdown with people eating poorly and taking little exercise and we held a webinar with GPs on Obesity and Constipation including information from dieticians and social prescribing in December 2021.

Our ‘Healthy Me’ cookery school will help people with learning disabilities tackle obesity and constipation, in partnership with Square Food Foundation and housing providers. We want to support people to make connections between what they eat and their health. People with learning disabilities will learn cookery skills. It will include on-line homework, ‘come dine with me’ social element to invite friends and family to dinner, and training and recipe kits outlining the importance of healthy, wholesome foods and the link to people’s health. We plan to link to gardening projects growing herbs & vegetables.

Aspiration Pneumonia

This is caused by breathing in vomit, other harmful substances such as smoke or foreign objects. We are beginning work with Speech and Language Therapists in Sirona to look at how we can raise awareness in primary care and with care homes to reduce the risks of people choking.

Uptake of Cancer Screening

We have found that many patient notes include a comment that the person 'will not tolerate screening'. We held a cancer screening webinar in June for GP's covering reasonable adjustments and other support. We have provided guidance to GP's on 'supporting people with Learning Disabilities who have cancer' developed with Cancer Research UK. We are working with screening colleagues to provide dedicated screening days

Catheter Care

Poor management of catheters can often lead to sepsis and people being admitted to hospital. We have set up a group with Sirona's Continence Service, providers and the University of the West of England to develop easy read information for service users and care home staff.

Improving uptake of Annual Health Checks and increasing Health Action Plans

There are many people who miss out on Annual Health Checks. We are working with the Brandon Theatre Group, actors with learning disabilities, who will produce videos about the Annual Health Check and Health Action Plans. This will promote Annual Health Checks and empower to people to have better understanding of an annual health check, why they are important for keeping healthy and help people to ask their GP about their personal health goals.

53% of Annual Health Checks do not result in a Health Action Plan, the health goals the GP agrees with their patient. This reduced the likelihood of an improvement in a person's health. We know there is huge variation in the types and styles of Health Action Plans used by GP's and we are working with the Brandon Engagement Group, a forum of people with learning disabilities, to develop an easy read template that captures the required elements of a robust Health Action Plan.

Poo Matters

Our mortality reviews showed that 80% of the people whose deaths were reviewed had constipation, some very severely, with impacted bowels that resulted in sepsis. We commissioned a co-produced project with North Somerset People First to find resources that would help raise awareness about constipation with people with learning disabilities. Meal kits

were delivered to people's doorstep and recipes were tested and rated for taste and ease to make 'constipation cookies'; 'move-it muffins' were favourites. In October "Poo Matters" co-produced training was delivered to 40 carers from a range of different providers. We have further funded the project to deliver this awareness training across our area for all of our people with learning disabilities.

Working with Black and Minority Ethnic Communities

People with learning disabilities and/or autism experience health inequalities and those in Black and Minority Ethnic communities are further disadvantaged and underrepresented as users of learning disability health services. We have been working with parents in Somali and Polish communities through focus groups, community meetings, individual and family discussions, to gather lived experiences of the support people need and how people access learning disability or autism services. We wanted to capture people's stories of a family member with a learning disability, to better understand what helped and what hindered.

Rebuilding Self Advocacy

Ensuring people with learning disabilities have voice and influence is a key ambition. This requires a commitment and funding to build systems for people with learning disabilities to be equal partners in our different workstreams. We have secured funding to support our plans to grow and build support for people to speak up for themselves. Elected members and self-advocates with learning disabilities who have 20+ years of experience of speaking up will lead the project, supported by North Somerset People First support workers, working in partnership with Local Authority colleagues.

Improving access to health care for autistic people

We have worked alongside autistic people to develop co-produced workstreams to improve access to health care for autistic people.

Autism Audit of A&E departments

We are working with a group of autistic people to review the emergency pathway experienced by autistic people. We have designed with autistic people an audit tool and have audited three of our A&E Departments with one further audit to be completed. These whole day audits include looking at access to the department, adaptations and interviews with key staff focused on their understanding of autism. Recommendations based on the audit findings are shared with each A&E Department.

Reasonable adjustments

Through the A&E Departments' access audits we have identified recommendations to expand the availability of reasonable adjustment resources for people with learning disabilities and autistic people across all our hospitals. These will be made available in a wide range of clinical areas to support people's access needs and promote a calming environment, for example; ear defenders, soothing lights and smells, 'fidgets', weighted blankets or lap pads, dark glasses or visors for light sensitivity, augmented alternative communication boards, with guidance & training on how to use the resources.

Autism training for A&E department staff

We are developing an autism training programme for 2022/23. Autistic people will be co-trainers, delivering training and paid accordingly on an experts-by-experience rate. The project will provide co-produced short workshops, 'bite sized' video clips tailored for A&E Department staff.

Other aspects of our work programme 2022/23:

- Developing the LeDeR Governance Group work to ensure learning themes and recommendations inform the Learning Disability and Autism Health Providers Network work programme
- Ensure learning identified from reviews informs day-to-day practice of health and social care providers
- Continue to share and drive 'learning into action' with the aim of ensuring all people with a learning disability have good or excellent care
- Greater inclusion of people with learning disabilities in our work, including establishing an independent voice for self-advocates with learning disabilities
- Hosting/contributing to learning events for GPs and other colleagues during 2022/23
- Continue to work with system partners, the West of England Academic Health Science Network Learning Disabilities Collaborative, and other regional groups, to share learning and best practice.

Urgent and Emergency Care

In 2021/22, the response to the covid pandemic dominated our work urgent and emergency care. We directed resources to managing the incident coordination centre (ICC) for the health and care system in Bristol, North Somerset and South Gloucestershire and established a new command infrastructure with providers to enable quicker collective decision-making within the system.

Urgent and emergency care pressures in 2021/22 included the need for increased community rehabilitation services after the delta variant wave peaked at the end of 2020/21, additional demand for walk-in urgent care services generated by Covid-19 following the lockdown of early 2021, and severe staff shortages related to staff sickness and isolation putting pressures on the system's ability to manage the flow of emergency patients from admission to discharge. This flow is also impacted heavily by infection prevention and control measures, such as the social distancing and 'zoning' of beds depending on covid status.

Much of our work focussed on balancing the risks to services and making difficult decisions to reduce these through plans developed with providers. We reviewed nursing ratios in our different wards, stepped down planned treatments for some patients at times of intense emergency care demand, and funded new community beds, including a temporary 'care hotel' facility in Bristol.

Plans to reduce the queueing of ambulances outside Accident and Emergency (A&E) departments were a priority for the CCG. These plans included actions to strengthen flow for example reducing admissions at the front door through same day emergency care services and creating extra capacity in the community to increase discharge. These plans also included our Urgent and Emergency Care Minors Programme which is a multi-faceted programme to enable 'right care first time' for people with minor illness and minor injuries. It is a cross-system collaboration with two main elements explained below:

Clinical Assessment Service (CAS)

Our residents contacting the NHS 111 for help with urgent medical problems can now speak directly to a wider range of healthcare professionals, to avoid unnecessary ambulance dispatches and A&E visits. The 111 System CAS team includes GPs, A&E consultants, community healthcare nurses and will soon include mental health specialists. Clinicians are able to provide remote consultations for people who would otherwise have been referred from 111 to A&E. The staff can carry out consultations via phone or videocall and if needed issue digital prescriptions for collection at a local pharmacy. Initial data suggests about 85% of patients are managed with a non-hospital pathway and 40-45% can have their needs met remotely.

A&E Redirection

A&Es should be for emergencies and life-threatening situations, however there is a group of patients arriving at our A&Es that could, and should, be treated by another service, whether that is at an Urgent Treatment Centre (UTC), by a GP or Pharmacist. A new self-service tool

will be piloted across our local A&Es in March 2022 to help patients to identify the most appropriate healthcare service for their needs. By redirecting patients to more appropriate services, our A&E's can target their finite resource to support those patients with higher needs, that can only be dealt with in a hospital environment.

Patients who arrive in A&E, who do not have a life-threatening condition will be asked to check their symptoms on the new self-service tool on tablets. The self-service tool will ask a series of questions and, based on the information provided, determine the right place and care for their symptoms. The tool will help patients to access the right service quicker and encourage residents to either call NHS 111, or go online before making their way to A&E.

Performance against national standards

Overall, performance against the NHS Constitution target for waiting standards at A&E departments has dropped locally to 65% for 2021/22 and was lower than the national average of 67% for consultant-led A&E departments. Attendances at A&E departments increased by 32% in 2021/22 compared to the previous year, with 69,150 more attendances, averaging 189 more per day. There has been a 43.4% increase in walk-in attendances at Minor Injury Units (MIUs) and the UTC in 2021/22 with 95,588 attendances compared to 66,639 in 2020/21. Transforming services and improving waiting times at our A&E departments continues to be a high priority locally.

Total non-urgent (non-elective) admissions have also increased by 18% compared to the same period last year. Zero-length of stay non-elective admissions, where the patient does not need to stay overnight, increased by 15%, reflecting in part the expansion of hospital-based same day emergency care services that avoid the need for patients to be admitted overnight.

Cancer Care

Performance against cancer standards has been impacted by the pandemic. Cancer patients have been prioritised throughout and all patients on cancer pathways who are waiting for treatment are closely monitored within clinical review and prioritisation processes.

At the end of 2021/22, our performance against the NHS Constitution standards for cancer care, cancer wait time standards was:

- 2-week wait performance was 64.9% against a standard of 93% - activity has remained consistently high, but demand and backlogs have outstripped capacity in some specialisms.

- The 28-day Faster Diagnosis Standard (FDS) – where patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis - was 66.8% against a target of 75%. University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) exceeded this standard consistently since May 2021.
- Achievement against the 31-day first definitive treatment standard – a maximum of 31 days from decision to treat and starting treatment - was 92.5% against a target of 96%.
- The 31-day subsequent treatment standard for surgery was 81.1% against a 94% target.
- The 31-day subsequent standard for drug treatments was achieved for most months throughout 2021/22 and was at 99.0% at year end against a 98% target.
- The 31-day subsequent treatment for radiotherapy was achieved throughout 2021/22 and was at 99.7% at year end against a 94% target.
- Performance against the target 85% 62-day – GP referral to treatment – standard was at 68.8% at year end. Backlogs and delays in earlier elements of the pathway continue to impact on this performance standard. At a System level, gynaecology, Lower Gastrointestinal and Upper Gastrointestinal specialisms had the largest cohorts waiting longer than 63 days. We are working closely with our partner organisations to improve this position.

Treatment volumes and activity remain high, but demand and backlogs have outstripped capacity in some specialisms in 2021/22, notably Breast, Skin, Upper Gastrointestinal tract and Colorectal specialisms. We have worked hard with our Trusts and the Independent Sector to increase capacity through, for example, weekend working, Waiting List Initiatives, recruitment and insourcing support.

In 2021/22 we have:

- Developed a new Non-Specific Symptom pathway for patients with vague symptoms to support earlier diagnosis
- Progressed development of best practice timed pathways in prostate, cervical, and Upper GI specialisms
- Worked on increasing screening uptake among patients with Learning Disabilities
- Continued to improve the colorectal 2 week wait pathway and qFIT to support endoscopy
- Focussed on Cancer Health Inequalities through planning targeted communications; engaged with the SWAG Targeted Lung Health Checks pilot with 3 areas identified in Bristol; Supported the upskilling of primary care colleagues through education events

- Introduced dermatoscopes into primary care to enable more patients to be cared for in the community
- Progressed ‘Personalised Care and Support’ through My Medical Record, a digital platform to support and enable remote monitoring
- Started planning to ensure every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome and that all patients who qualify for liver surveillance under NICE guidance are identified and invited to surveillance

Planned Care

Our healthcare system continues to face significant challenges with long waiting times as a result of the pandemic. At the end of 2021/22, our performance was 65.9% against the NHS Constitution standard of 92% of people waiting no longer than 18 weeks from GP referral to their treatment. 5.1% of the waiting list at year end, were people who have waited over 52 weeks.

We have worked hard in 2021/22 with our partner organisations and the Independent Sector to reduce the number of long waiting patients and ensure that our longest waiting patients of greater than 104 weeks are treated.

The NHS constitution standard related to diagnostics is that less than 1% of patients should wait 6 weeks or more for their diagnostic test. At year-end performance was 37.9%. We have recorded activity levels greater than that which we saw in 2019/20 and outperformed plans across many of the diagnostics modalities, but backlogs and sustained high levels of demand have outstripped capacity, impacting on overall performance. We are working to improve performance and reduce waiting times for all our diagnostic services through weekend working, waiting list initiatives and using capacity in the Independent Sector to ensure our patients have timely access to the tests they need.

We continue to focus on improving the value of planned care activity to reduce risk, ensuring the best possible outcomes for patients and that people are seen at the best place for them.

In 2021/22, we have:

- Worked closely with the Independent Sector to identify opportunities for supporting our elective recovery and make best use of their available capacity to treat our longer waiting patients.
- Implemented an orthopaedic supported discharge pathway in NBT which is reducing length of stay and also a weekend working model utilising medirooms for short stay inpatient and day case activity

- Established six sub-speciality groups with Physio and Consultant reps (hip, knee, shoulder, hand and elbow, foot and ankle and trauma) and they have run 6 educational events for First Contact Physios and GPs. The events are connecting clinicians and sharing knowledge and best practice.
- Developed a system level, single patient tracking list for trauma and orthopaedic patients and implemented waiting list validation
- Implemented My Recovery and My Mobility apps in NBT and UHBW respectively to support prehab and rehabilitation. The development of a musculoskeletal website is underway
- Developed business cases for two Community Diagnostics Centres in Bristol, North Somerset and South Gloucestershire
- Developed a plan for digital support of diagnostics and aligned the Integrated Clinical Environment electronic referral system for requesting imaging and pathology for radiology across our area
- Delivered, through the Heart Failure Transformation project, collaborative triaging process and established a one stop clinic at NBT held once a week and a community clinic at Portishead. We also Re-designed the Cardio-Vascular- Disease programme

Our work focused on supporting people with different kinds of arthritis included:

- An Early Inflammatory Arthritis (EIA) pathway where patients are seen within 3 weeks of referral and started on treatment within 6 weeks
- The Living With Rheumatology remote monitoring app in UHBW and the development of a self-management app is underway.
- A business case for funding for biologic medication for people with moderate rheumatoid arthritis

We also

- Provided education events for primary care colleagues through our Pain teams and provided pain information sessions for patients through NBT colleagues
- Introduced more ESCAPE-pain courses. These courses run in local leisure centres help people self-manage their osteoarthritis hip and knee conditions to reduce the need for surgery.
- Developed and implemented shared decision-making tools and videos and provided awareness training and skills-based training. This included shared decision-making aids for osteoarthritis hip and knee and subacromial shoulder pain.

- Implemented peer shared decision-making support for osteoarthritis hip and knee patients with Versus Arthritis and secured funding to see 1,800 Versus Arthritis patients. We have received 181 self-referrals to date and service user feedback is very positive

Other activity has included

- The One You Health Optimisation service in South Gloucestershire to ensure people are offered support to lose weight, stop smoking and exercise more, with both GPs and First Contact Practitioners (FCPs) referring patients.
- The getUBetter musculoskeletal self-management app. 70 practices are referring patients to the getUBetter app and 6,500 people are using it.
- Rolled out First Contact Physiotherapists in primary care
- Piloted clinical triage of all eye referrals
- Progressed work with the Bristol Eye Hospital and the Local Optical Committee for the follow up of low-risk glaucoma patients by Community Optometrists using a digital platform
- Transformed outpatient services through digital appointments
- Expanded Advice and Guidance services for GPs to a number of clinical specialities and piloted a digital tool in dermatology
- Established the Community Phlebotomy service
- Implemented Digital Patient, led by NBT, which is a patient facing portal for appointments, video-consultations and communication

Medicines Optimisation

Our Medicines Optimisation Team has worked closely with GP practices, acute trusts, local community providers, and community pharmacies to ensure clinically safe and cost-effective prescribing within our system. A system wide medicines formulary ensures national, regional and local guidance is followed. Our Medicine Optimisation Programme links with NHS England's Medicines Value Programme and the World Health Organisation's Patient Safety Programme, alongside multiple local projects and initiatives to ensure safe, cost-effective prescribing linked to the NHS Long Term Plan priorities.

We are responsible for the prescribing budgets of our member GP practices and work closely with practices to support cost effective prescribing. In addition, we support GP practices to undertake quality, safety and evidenced based prescribing tasks to improve outcomes and value.

The Medicines Optimisation Team has been working closely with colleagues from across the system regarding development of pharmacy workforce opportunities, reviewing the number of trainee pharmacists and pre-registration pharmacy technicians' positions, the number of pharmacists undertaking non-medical prescribing and focusing on workforce priority areas. This will support the system and ensure there is a resilient workforce which meets the pharmaceutical needs of the population. Split posts have also been developed between sectors.

This year has seen the development of a greater integrated approach to Medicine Optimisation across Bristol, North Somerset and South Gloucestershire, with a system wide programme of projects in place to improve quality and value. Through our joint working groups, we:

- Manage the introduction of new drugs and shared care medicines across our area so that patients have access to safe, cost-effective medicines that offer good outcomes.
- Focus on medicines safety, supporting the delivery of the NHS Medicines Safety Improvement Programme and the NHS Patient Safety Strategy. We have specifically worked as a whole system focusing on reducing harm from high-risk medicines e.g., Insulin, prescribed dependence forming medicines and anticoagulants. Three system wide multi-professional working groups have been established to understand the issues around prescribing of these medicines and put in place what is required locally to reduce the risks from these medicines.
- We have digital systems in place within GP practices which can be used to help identify patients that may have problems with their medicines

- Work on the implementation and assurance of NICE technology appraisals. A collaborative approach, consultant led, has been undertaken to develop system wide pathways in gastroenterology, ophthalmology, dermatology and rheumatology to ensure value and a consistent approach to treatment for all patients
- Our Integrating NHS Pharmacy and Medicines Optimisation (IPMO) Implementation Plan has been set for 2021 through to 2024
- During the COVID-19 pandemic the Medicines Optimisation Team have provided support to the COVID-19 and flu vaccination programmes and roll out of new COVID-19 treatments
- Work is ongoing looking at overprescribing of medicines particularly in the elderly and our areas of deprivation and looking at social prescribing as a first line approach where possible
- Training, for example on shared decision making and polypharmacy, has been rolled out across the system
- We have embedded referrals from GPs to a community pharmacist for a consultation for a minor condition and are now involved in a national pilot which involves referring patients from Urgent Treatment Centres and A&E departments to a community pharmacist
- In addition, we are working to free up capacity in GP practices and out of hours services by increasing the number of minor conditions that can be treated in community pharmacy without a prescription
- Our Medicines Optimisation Strategy is currently being launched across the system which presents our aims and objectives to our health and care colleagues so that we can work collectively to implement the Medicines Optimisation principles and enhance patient care
- We are supporting the Green Plan for our system

Primary Care

Primary Care has continued to adapt in response to the pandemic and recovery, maintaining a digital first and triage approach but also offering patients face to face appointments as well as other remote consultations. Primary Care faces the same challenges as elsewhere in the system such as remote working and workforce shortages. This is in addition to playing a significant role in the Bristol, North Somerset and South Gloucestershire Covid Vaccination Programme and delivering two thirds of the vaccinations. Primary Care colleagues have continued to work collaboratively and proactively to support system programmes of work:

- Minor Injuries Proposal and System CAS
- Urgent Care Winter Access proposals
- Community Winter Access proposals
- Outpatients Programme and Elective recovery
- Community Phlebotomy
- Oximetry at Home

Primary Care Networks

Our Primary Care Networks (PCNs) have continued the delivery of Phase 3 of the vaccination programme along with responding to NHS England requirements. Our PCNs have worked very hard this year to recover from the effects of the pandemic and prioritised activity included:

- Severe Mental Illness health checks
- Learning disability Annual Health Checks health checks
- 'Best efforts' long term condition reviews focussed especially on people with diabetes or multiple long-term conditions
- 'Best efforts' approach to a longer-term preventative medicine domain, focussed on local population, e.g., smoking cessation, optimising hypertension, non-diabetic hyperglycaemia, or obesity management
- Winter Access Fund schemes
- Measures to support urgent care capacity

Covid Mass Vaccination Programme

Our PCNs have continue to support with delivery of the successful Covid vaccination programme including the booster programme and roll out of vaccination to 12- 15-year-olds. As of February 2022, through 53 GP led sites:

- 682,877 1st Doses

- 655,269 2nd Doses
- 483,404 Boosters

The ‘Maximising Uptake’ programme was developed which identified areas where uptake could be lower. This has helped drive initiatives to support increased uptake including outreach clinics in community centres and mosques as well as targeted communications. This work has been done working closely with community leaders and influencers as well as local authority colleagues. This partnership working continued to support delivery of the flu programme from September 2021.

The Primary Care Strategy

The Primary Care Strategy work has focussed on ensuring we are clear on where there are health inequalities, provide opportunities to improve outcomes and embed preventative, personalised, proactive care in partnership with our voluntary and community colleagues as part of Locality Partnership development.

Covid has significantly challenged our ability to deliver excellent, high quality, accessible care for our patients in a sustainable, joined up way. In addition to what we planned to deliver as part of the Primary Care Strategy, Covid required new ways of working and significant support has been provided:

- to support practices on how to prioritise work during Covid 19 in order to prevent the health inequalities gap widening and poorer outcomes with a RAG rated Primary Care Recovery Prioritisation guide developed in conjunction with GP Clinical Leads, the LMC and our Clinical Cabinet to assist practices to identify patients at risk of harm from Covid and provide suggested actions and tools to support proactive and preventative management of the patients in line with QoF requirements
- to guide identification and management of the most clinically vulnerable patients in the prioritisation of planned activity in general practice

Access to Primary Care

Primary Care activity returned to above pre-pandemic levels in July 2020 and demand continues to exceed pre-pandemic levels. Face to face appointments continue to account for an average 58% of activity which reflects embedding of the new hybrid model of telephone, video, online or face to face options where clinically appropriate.

Our Practices continue to do all they physically can with their resources to meet the significant increase in demand they are facing. Winter Access plans were developed to increase the resilience of our practices and provide additional resource to support general practice over the

winter period. These were developed collaboratively with our local GP federation One Care, Avon LMC, the GP Collaborative Board and practices. These proposals included an expanded Access, Resilience & Quality support programme along with continuation and expansion of Improved Access to support Same Day Urgent Care. In addition, we have built on the successful roll out of the Community Pharmacy Consultation Service, antibiotic prescribing, proxy medication ordering and safety initiatives to develop further local PGDs and accelerating development of PCN prescribing hubs.

Population Health Management (PHM), Prevention and Health Inequalities

Health inequalities work in general practice has continued in collaboration with Public Health, Healthwatch, Building Healthier Communities Group and PHM/Prevention and Health Inequalities Groups. Opportunities for prevention across all providers of primary care continue to be explored in the following priority areas: Public Mental Health & Wellbeing; Healthy Weight; Alcohol; Tobacco and CVD.

Addressing health inequalities and improving the physical health of those people with learning disabilities and severe mental illness is a priority for our system. Below is a summary of some of what we have achieved in 2021/22:

- Development and implementation of a system standard for ethnicity coding including practices recording ethnicity data during Covid vaccination and flu clinics
- Developed and deployed a set of tools and culturally competent communications
- Developed and implemented a pragmatic risk guide for practices to support identification and management of vulnerable patients.
- Worked closely with the Bristol Sight loss Council and Pocklington Trust to develop and launch guidance on management of patients with visual impairment.

Following the achievement of the Learning Disabilities Annual Health Checks (AHC) target of 67% in 2020/21 our GP practices exceeded the 75% target for this year having worked to embed and build on the targeted interventions:

- improved coding to address incorrect coding errors and assist with accurate identification and reporting
- rollout of the Learning Disabilities champions programme to all GP practices supported by Community Learning Disabilities Team staff
- further specific training sessions for practice nurses & other practice staff to ensure completion of high-quality Learning Disabilities Annual Health Checks

Work focused on Severe Mental Illness included:

- dedicated steering group established under the Community Mental Health Programme Board to drive work forward to increase Severe Mental Illness physical health checks
- EMIS coding and template development work for increased numbers of Severe Mental Illness health checks

Access, Resilience and Quality

We have a successful General Practice Resilience Programme which has been delivering tangible results for 2 years. The programme provides individualised support for a small number of practices at any one time which have significant resilience challenges. Practices receive bespoke support from the CCG, OneCare, the LMC and from other partners to meet the individual requirements. The programme is combined with our Quality Programme for general practices and with input from our Primary Care Contracts Team where this is beneficial to practices.

The programme has continued to successfully deliver the following key aims and has supported practices during 2021/22 helping to:

- Increase practice resilience
- Reduce unwarranted variation
- Embed a culture of continuous improvement
- Prevent unmanaged contract hand backs

As part of our winter access proposals, we have developed an Access, Resilience & Quality Support Programme (AR&Q) designed to:

- Have an increased focus on patient access, demand and capacity
- Provide a much greater amount of hands-on support

Real time monitoring of practice resilience is in place through the development of situation reporting.

The Primary Care Development and Quality teams have been working closely on specific areas of inconsistency and unwarranted variation that have been highlighted during Covid. A GP access survey was developed and results from this have been used as the baseline for this work and to inform winter access plans. We have also started on coproduction of the approach to Quality in Primary Care with general practice.

The Patient Safety Strategy is the NHS safety vision to continuously improve patient safety by using two foundations: Patient Safety Culture and Patient Safety System and three strategic

aims: Insight, Involvement, and Improvement. The strategy is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS definition of quality in health care. This is the first NHS wide patient safety syllabus and is applicable to all NHS staff. We are working with our practices to implement Patient Safety Strategy to support the development of a safety culture within primary care.

Of the practices which have undergone a Care Quality Commission inspection:

- 3 Practices have an Overall 'Outstanding' Rating
- 68 Practices have a 'Good' rating
- 5 practices have 'Requires Improvement' overall
- There are no practices which have an Inadequate rating

Our Quality Dashboard Spotlight shows focussed support to practices and we have a Standard Operating Procedure, Quality Stocktake and Escalation Plan which is used to identify issues, highlighting areas quality improvement. Our quality team reviews information provided about incidents and all medication incidents are reviewed by the Medicines Optimisation Team. Medicines related incident trends are monitored and shared in newsletters and networks. We share information about incidents to investigate, feedback or to share the learning. Through these approaches we aim to improve services to patients.

GP Patient Survey Results

The response rate for the Bristol, North Somerset and South Gloucestershire 2020 GP Patient Survey was 38% (10,115 responses) which is higher than the national average. 84% of respondents described their experience of their GP practice as good which was above the national average (83%) whilst 6% described their experience as poor, below the national average (7%). The survey asked about patients' experience at their last general practice appointment:

- Ease of getting through on the phone – 67% (68%) respondents rated this as good or very good
- Helpfulness of reception – 90% (89%) respondents rated this as good or very good
- Ease of use of Online Services 75% (75%) respondents rated this as good or very good
- Overall experience of making an appointment 72% (71%) respondents rated this as good or very good
- Support with managing LTC 73% (74%) respondents rated this as good or very good
- Giving you enough time – 90% (90%) respondents rated this as good or very good
- Listening to you – 91% (91%) of respondents rated this as good or very good

- Treating you with care and concern – 90% (90%) of respondents rated this as good or very good
- Felt involved in decisions about care and treatment – 94% (93%) respondents rated this as good or very good
- Had confidence and trust in the healthcare professional – 96% (95%) respondents rated this as good or very good
- Felt their needs were met – 94% (94%) respondents rated this as good or very good

Supporting Communication and Engagement

We have worked collaboratively to develop a robust proactive and positive communication and engagement plan for our practices and patients through communication and engagement workshops. We aimed to:

- Increase public understanding and acceptance of changes to general practice and primary care
- Combat perception that GPs and teams 'just don't want to' see patients face-to-face
- Restore faith in local primary care services
- Reduce incidences of abuse
- Reduce patient complaints and increase patient satisfaction
- Boost workforce morale and retention
- Support practices in handling complaints

Developing the Primary Care Workforce

Our primary care workforce has faced significant challenges during Covid including staff shortages due to lack of workforce or locum cover, sickness and isolation at a time when practices were experiencing an increase in demand for their services; some of the work to support is outlined below:

- Developing staff sharing agreements to support mutual aid across the system including general practice
- Increasing use of system staff bank to support the vaccination programme and expand its application beyond the Covid vaccination programme
- Project commenced to develop and implement a Community, Primary Care and Social care collaborative bank with an initial focus in general practice
- Continued support Primary Care Networks to recruit to additional roles to support the expansion of the wider primary care team and manage the current shortage of workforce in this area along with work to understand the impact

- Establishment of an Electronic Staff Record programme of work to support Primary Care workforce reporting

PCNs submitted their workforce plans at the end of August and October with details of the additional roles they have in place from 2020/21 and indicative recruitment for 22/23 and 23/24. Ongoing support is being developed to manage the current shortage of workforce in this area along with work to understand the impact.

Staff Health and Wellbeing

We are committed to maintaining the health and wellbeing of staff. Across our whole system, all staff have access to our Bristol, North Somerset and South Gloucestershire Healthier Together Support network, which provides confidential wellbeing and mental health support including talking therapies, psychological therapy for work-related trauma and training and resources for individuals and managers. Support has been provided through wellbeing webinars and education and training for managing difficult conversations following the significant increase in abuse received by frustrated patients. We secured funding for an Enhanced Health and Wellbeing Offer for community and social care staff and for a Health and Wellbeing Support Offer for staff working across Primary Care. The two projects have built on the success of the Mental Health and Wellbeing Hub.

Other Support to Primary Care

Primary Care Business Intelligence

Primary Care data is complex, and it is challenging to get timely, accurate and complete data with many different sources. Crucial to ensure this happens and it is tested with Primary Care colleagues has been the establishment of the Primary Care Outcomes and Activity Group by our Primary Care BI Team, led by one of our Clinical Directors with representation across localities and OneCare. This group is important to be able to demonstrate the value of Primary Care to the wider system and do so in a way that system colleagues understand in terms of activity, impact of Primary Care investment and support for addressing the backlog and understanding the impact of urgent, elective and planned care programmes.

Digital

Considerable work has been carried out to support the new ways of working and models of care during the pandemic including:

- Renewed communications sent out on access to digital support for remote working during isolation

- Ongoing support for Primary Care input into System Digital Strategy, ICP development and Digital Inclusion work
- Ongoing work to support use of online consultations
- Tools to support proactive and preventative management of patients e.g., remote monitoring through eConsult templates, accuRx Florey/Pathways.
- 111 and IUC direct booking implemented
- Resource Publisher framework finalised to support standardised, clinical led development of EMIS templates for system pathways
- Elemental implementation across practices to support Social Prescribers accessing patient records and providing signposting to services for patients
- ORCHA implementation to support quality and safety assurance of the increasing use of Apps across the system

Estates

We have worked to prepare out-of-hospital PCN, Locality Partnerships and wider system level Infrastructure Plans. This is a four-phase process that started in 2021 and is due for completion by March 2022:

- Phase 1 Develop Baseline Locality Workbooks: Individual Locality Baseline Workbooks that confirms the baseline condition and capacity within the existing primary care estate as well as working with wider health and social care providers to understand their estates plans and any opportunities arising from them.
- Phase 2 Develop individual PCN Estate Strategies: Completion of a structured template to collect a range of information.
- Phase 3 Where do we want to be and how do we get there? Completion of locality and ICS wide estates strategies
- Phase 4 Completion of the ICS Wide Estates Strategy: To prioritise options against investment objectives and develop the overarching strategy.

Improve quality

Quality is at the heart of everything we do as system leaders and commissioners. We have a duty to commission safe, high quality, and effective health services for the people of Bristol, North Somerset and South Gloucestershire, and a duty to support primary care services to continually improve under Sections 14R and 14S of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012). Our Quality Committee ensures that there is comprehensive oversight and monitoring of the quality of our commissioned services.

Strong clinical leadership and engagement with partners is fundamental to improving quality and improving outcomes for patients. We work with the providers of our commissioned services to support continual improvement in the safety, experience and the effectiveness of care.

Improving Quality during a pandemic

Managing Safety and Quality during the COVID pandemic has presented challenges and required the CCG to look at alternative ways of working whilst continuing to offer support to system partners and ensure that patients receive high quality care.

It is a priority that patients receive safe high-quality care and that when things don't go according to plan, it is essential that they are reported and investigated, and that learning is taken forward to minimise the risk that a similar incident will reoccur.

Serious incidents in health care are defined as "adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified."

Collaborative working with providers is key to ensuring that improvements resulting from serious incidents is continuous and that system wide learning is communicated.

The Patient Safety Strategy 2019 was released to sit alongside the NHS Long Term Plan and its implementation framework and is concerned with "maximising things which go right and minimising things which go wrong for people experiencing healthcare"

A key element of the Patient Safety Strategy is the implementation of the Patient Safety Incident Response Framework which outlines how providers should respond to patient safety incidents and how and when an investigation should be undertaken. This will replace the current Serious Incident Framework and will require all partners to approach patient safety investigations with a completely different approach based on a no blame culture of learning.

During 2021/22, the Quality team continued to maintain oversight and assurance through the embedded processes for review of serious incident reports and action plans.

Reported by providers in 2021/22					
Serious incidents	227	Downgraded incidents	7	Never Events	6

In Summer 2021 the Quality team began to look at the requirements for Patient Safety Incident Response Framework and in mid-January 2022, our Quality team implemented a framework which will support the identification themes and trends for learning from reports which will underpin system wide learning improvement projects in collaboration with system providers and the internal transformation team. Themes and trends for improvement are discussed and going forward will include learning from complaints and primary care concerns.

Our Quality team worked with our Primary Care Transformation team to implement the Quality and Resilience Framework to identify practices who would benefit from support. This work has provided us with enhanced surveillance and assurance across primary care and helped us support practices to improve services. We will continue this collaborative work throughout 2022/23.

Further work undertaken within Primary Care includes the groundwork for implementation of key elements of the PSS; this includes the introduction of the Medical Examiner service which is being taken forward by the CCG Clinical Quality Lead in collaboration with the regional lead for this project. Work will continue into 2022/23 and GPs will be trained to undertake the Learning from Deaths reviews as part of the Medical Examiner workstream. The resulting learning from these reviews will be used to promote patient safety within the system across all providers which will result in safer care for patients within the system.

In the second quarter of 2022/23, we will begin the process for producing a Quality strategy in line with the commitments of the Healthier Together ICS. The Quality strategy will be based upon a culture of continuous improvement to facilitate delivery of safe and responsive services for our population and will be coproduced with key stakeholders, service users, carers and staff.

Patient Experience

We recognise that the voice of local people and communities is imperative to what we do. We continue to engage with them to co-design and co-create new services, and as we develop our system quality strategy, we will identify ways in which the voice of the patient and public is heard more prominently throughout our work. One of the main challenges we face is how to use our data intelligently to lead to real improvements in patient experience. By our continuous analysis of patient experience information and working with partner organisations, learning is identified and shared to help improve health services across Bristol, North Somerset and South Gloucestershire.

The Customer Services Team continues to gather feedback from patients through compliments and complaints, advice and liaison enquiries, MP enquiries, feedback from healthcare professionals, patient surveys and Healthwatch reports. Through use of social media such as Twitter and Facebook, and responses posted on the NHS Choices and Care Opinions websites we are able to engage with the public in a variety of ways. Our Citizens panel has an important role, providing feedback on their experiences of healthcare services in the area. We also have a customer satisfaction survey that is sent to all patients who raise a complaint, and this is regularly reviewed with colleagues responsible for commissioning services across the CCG.

In 2021/22 we received 8214 contacts, 6657 General Enquiries, 1150 formal complaints, 214 Compliments and 193 MP enquiries. In 2021/22 no complaints were reported to the Parliamentary and Health Service Ombudsman.

We collate all feedback and analyse trends or themes and share these with the Quality Committee and Governing Body where assurance that learning is being shared to improve services is sought. The Customer Services Team continue to provide training for CCG staff regarding patient feedback, how this is used and why it is important to the CCG as service commissioners. This is also talked through at the corporate induction for all new starters within the CCG.

The team have implemented regular meetings with key service providers within the CCG, to discuss feedback from patients and to facilitate a swifter and smoother process for people contacting the Customer Services Team.

Customer services have implemented a new process whereby a weekly meeting is held with a Clinical Review Team to discuss new complaints that have come in. These meetings are crucial in determining the most effective way to resolve issues as well as helpful in identifying any urgent areas that need addressing quickly to ensure services are safe and effective.

We have recently procured some new functionality to our data reporting system “Datix” which will improve the quality of information we can report from.

There are regular meetings with our colleagues from other providers to facilitate a smooth as possible complaints response process. We recognise the challenges our healthcare providers are currently facing and so try and support them as much as possible to manage patient feedback in a timely manner. Learning and intelligence collected is used to inform and update policies and related documentation, with the aim of providing a fair and transparent service for patients.

Infection Prevention and Control

Healthcare associated infections

Tackling preventable healthcare-associated infections continues to be one of Bristol, North Somerset and South Gloucestershire’s key priorities. The onset of the Coronavirus (COVID-19) pandemic during 2020/21 and into 2022 has required additional focus and a dedicated COVID Infection Prevention Control (IPC) cell was created to support care settings in the community and manage spread of the virus through good infection control practice (see page 48). There has been continued partnership working with service providers and BNSSG has hosted quarterly meetings of the Healthcare Associated Infection (HCAI) Working Group. Membership for this group includes acute and community providers, Public Health England, and Public Health representatives from the three Local Authorities. A system wide Antimicrobial Resistance Strategy Group with representatives from across the system meets quarterly to support and enable the delivery of the UK 5-year Antimicrobial Resistance national action plan 2019-24 which includes an aim to halve healthcare associated gram-negative blood stream infections by 22/23 and to reduce the number of specific drug-resistant infection in people by 2025.

Methicillin Resistant Staphylococcus Aureus Blood Stream Infections (MRSA BSI)

The local healthcare system continues to be challenged by the number of reported MRSA BSI cases. During 2020/21, the total number of cases reported across BNSSG CCG was 31. The total reported cases for 2021/22 is 38.

Indicator	Threshold	BNSSG CCG Assigned Cases 2021/22	BNSSG CCG Assigned Cases 2020/21	BNSSG CCG Assigned Cases 2019/20
Total Number of MRSA cases reported across Bristol, North Somerset and South Gloucestershire	0	38	31	42

The definition of a community acquired infection is an MRSA infection which started no longer than two days after a patient's admission to hospital, whilst a hospital acquired infection is defined as having started more than two days after the patient's admission to hospital.

It is a national requirement that all MRSA cases are reviewed by the CCG and a robust thematic review is undertaken to identify learning and key risks so that future infections can be prevented. Due to the COVID pandemic and staff redeployment there have been delays in undertaking these reviews, but it is anticipated that the identified learning for all cases will be presented to the Methicillin Resistant Staphylococcus Aureus (MRSA) Task and Finish Group/Healthcare Associated Infection (HCAI) Working Group in Q1 2022/23.

As part of a pilot community wide project coordinated by the Quality team at BNSSG during April/May 2021, Chlorhexidine wipes are being provided to intravenous drug users to clean their skin prior to injecting drugs with the intent that infection will be prevented.

The Chlorhexidine pilot project will be evaluated to understand the outcomes and benefits delivered by the provision of wipes and the potential reduction in infections seen. There is anecdotal evidence to suggest that this intervention is having positive effects on the reduction in numbers of MRSA amongst the PWID population in BNSSG. The pilot results will be available in Q2/3 2022/23 and will be presented to the HCAI Working group. Alongside this work, business planning is being undertaken to support this intervention going forward.

Clostridioides difficile (CDI)

BNSSG CCG continues to work towards achieving the *Clostridiodes difficile* (CDI) reduction targets. During 2018/19 and 2019/20, CDI cases assigned to BNSSG CCG were static at 196 and 195 respectively, remaining under the national threshold of 309 and 201 cases, however during 2021/22, a 50% increase in assigned cases has been seen, with a total of 294 cases in the BNSSG area. An increase in CDI cases was also seen at a regional level and continues to be monitored by the Regional Infection Control Network. The BNSSG HCAI meeting continues to oversee the implementation of the system wide CDI improvement action plan which resulted

from the CDI improvement driver diagram published by the Southwest CDI Collaborative. The driver diagram was produced by examining the data for CDI cases, with the aim to reduce population harm from CDI in the Southwest region. Providers continue to receive support in the delivery of the required improvements via the BNSSG C Diff Task and Finish Group which was set up to facilitate collaborative working across the system to understand the contributing factors to the increase in CDI rates and how to work towards reversing them.

Early output from the group includes production of a system-wide patient information leaflet which will be completed and released in early 2022/23. All areas of the system have introduced the new NICE guidelines for CDI treatment which includes a change to the first line treatment in the community. Following a review of antibiotics leading to community associated CDI a new cellulitis pathway has been produced and released for implementation to support the reduction of CDI cases.

All Quarter 1 community assigned CDI cases were reviewed using our community onset CDI reporting tool, which helps to identify learning that can be used to support prevention of future cases. Cases of CDI identified as hospital onset are reviewed within individual providers with CCG involvement, however during the pandemic CCG involvement has not been possible, although it will recommence in 2022/23. The reviews consider any lapse in the quality of care provided from acute, community and primary care providers and whether the case was avoidable. If there has been a lapse in care, an action plan is put in place to prevent this happening again.

In 2021/22 BNSSG have had 303 CDIs reported (Table below). Going into 2022/23 a reduction in CDI cases will remain a focus for the HCAI team who will continue to work collaboratively with the medicines optimisation team and system partners to reduce CDI numbers

Indicator	Threshold of permitted number of CDI infections for 2021/22	BNSSG CCG Assigned Cases 2021/22	BNSSG CCG Assigned Cases 2020/21	BNSSG CCG Assigned Cases 2019/20
Total Number of C-diff cases reported across Bristol, North Somerset and South Gloucestershire	191	303	294	195

Escherichia coli (E. coli)

Improvements have been made in achieving the Escherichia coli (E. coli) NHS reduction targets following implementation of an improvement plan which built upon the reductions achieved at the end of 2019/20. During 2020/21, the total number of BNSSG apportioned cases was 585, whilst to date in 2021/22 there have been 516 cases (Table below).

The use of a catheter passport has been implemented within Bristol, North Somerset and South Gloucestershire for several years which allows vital information sharing, improving communication between hospitals, community services, GPs and practice nurses and patients. A final audit of the interventions which form part of the catheter passport will be undertaken during 2022/23 to evaluate the effectiveness of the tool in reducing the numbers of reported E-coli infections.

As part of infection control mandatory training care providers are required to include information on bacterial infections, including E-coli to raise awareness and oversight of prevention strategies, including the suggested benefits for the use of the catheter passport.

The BNSSG infection control team continue to work towards achieving the NHS reduction targets for Klebsiella Pseudomonas, Methicillin-susceptible Staphylococcus bacteremia's and Pseudomonas Aeruginosa. The Table below demonstrates the BNSSG position against the targets and shows that the thresholds have been achieved. There was a reported reduction of 8% in MSSA cases.

Indicator	**Threshold of permitted number of infections for 2021/22**	**BNSSG CCG Assigned Cases 2021/22**	**BNSSG CCG Assigned Cases 2020/21**	**BNSSG CCG Assigned Cases 2019/20**
Total Number of E-coli cases reported across Bristol, North Somerset and South Gloucestershire	667	516 to date (month 11 Feb 2022)	585	662
Total Number of Klebsiella Pseudomonas cases reported across Bristol, North Somerset and South Gloucestershire	137	149 to date (month 11 Feb 2022)	153	146
Total Number of MSSA bacteremia cases reported across Bristol, North Somerset and South Gloucestershire	NA	152 to date (month 11 Feb 2022)	172	189
Total Number of Pseudomonas aeruginosa cases reported across Bristol, North Somerset and South Gloucestershire	61	63 to date (month 11 Feb 2022)	61	64

Influenza (Flu)

The table below shows the uptake of the influenza vaccine by population category and compares the figures for 2020/21 with the figures for 2021/22.

Cohort	National ambition	BNSSG uptake 2021/22 (end Feb 22)	BNSSG uptake 2020/21	SW region uptake 21/22 (end Feb 22)
Over 65 years	85%	86%	83%	85%
Clinically at risk (6 months to <65yrs)	75%	56%	56%	58%
Pregnant women (all)	75%	44%	45%	44%
2/3 year olds (all)	75%	55%	64% (2 yrs olds) 65% (3 yrs old)	57%
50-64years	75%	58%	53% (only allowed from 01/12/20)	59%

The Seasonal Influenza Vaccination Rates for frontline staff national target for 2021/22 was set at 100% uptake of flu vaccinations for front line staff. The table below shows compliance against this target by provider for frontline staff with patient contact. The data for Primary care is still being collated at the time of writing this report.

Provider	Compliance
University Hospitals Bristol and Weston UHBW	84%
Sirona Care and Health	73%
Avon and Wiltshire Mental Health Partnership	57%
North Bristol Trust	59%*
*Data to be validated	

COVID-19 and Infection Prevention and Control

When the COVID-19 pandemic started in early 2020 it was identified that there was a need for the CCG to support care settings in the community to manage spread of the virus through good infection control practice. An operational response team was created which could provide advice, support and teaching to care homes, domiciliary care providers, GP practices and other settings. In the last year this service has continued to be delivered by two highly specialised infection control experts. With their skills they have managed to work directly with these organisations to ensure infection spread is reduced to a minimum. It has meant for example that care homes have been able to reopen quickly and effectively following outbreaks to ensure residents can return or be admitted. In addition, the team have delivered infection prevention and control training across the region, creating a network of “champions” who can provide advice and support in their own settings or localities. A wealth of expert guidance and risk assessment documents have also been produced, much of which has also been adopted by other services in the southwest (with the work also recognised and commended by NHSE/I). During the winter months of this year the team also provided infection prevention and control support to a new care hotel in Bristol, where patients who were nearly ready for discharge were transferred to temporarily while services and adaptions for them to safely return home were arranged.

In addition to the response team a wider group of infection control and public health professionals have been meeting on a regular basis to work through solutions to problems, sharing good practice, interpreting research and guidance and agreeing wider approaches to infection control across the area. Known as the Infection Prevention and Control (IPC) Cell, this group has been co-chaired by representatives from the CCG and partners in local authorities and our NHS providers. In addition to focusing mainly on responding to the COVID-19 pandemic the group has started to widen its remit to look at other strategic areas of improving practice. There are currently plans in place to collaborate with other organisations across the southwest on a pilot to look at what evidence is available on demonstrating that an increase in fluid intake can prevention urine infections. The project will also be looking at antibiotic prescribing and other practices that can reduce urine infections including how to prevent resistance to antibiotics.

At the time of writing the recent rise of the Omicron strain means that the response team and cell’s focus will continue to be heavily weighted to managing the COVID-19 pandemic by continuing to provide excellent professional advice and support to our partners. However, we know that there are other infections apart from COVID-19 that need to be prevented or

controlled (as outlined in our health care associated infections section of this report) and therefore the spotlight on infection prevention and control will continue to remain broad with collaboration needed across all our partners in the health and care system for Bristol, North Somerset and South Gloucestershire.

BNSSG CCG have received 94 HCAI COVID-19 related incidents awaiting post-infection reviews; a schedule to review these incidents as part of a robust thematic analysis begins in Q1 of 2022/23 and identified learning will be shared and associated actions implemented to mitigate any identified risk.

Safeguarding

The CCG safeguarding team has continued to contribute to the partnership arrangements across the system and deliver our statutory duties for safeguarding in this reporting period. During 2021/22 the system has reported an increase in self-neglect cases as a result of the Covid-19 Pandemic, with over 11 Safeguarding Adults Reviews commissioned across the footprint with this as a theme, this was also a topic of a multi-agency audit in Quarter 4. For children, there has been a significant increase in the demand on services for children and adolescent mental health services driven by the impact of Covid-19- due to isolation and reduced primary and secondary socialisation in education and other extra curriculum clubs. This has therefore resulted in an escalation of safeguarding concerns for this cohort of young people and extreme pressure on the acute system owing to lack of capacity of Tier 4 specialist provision available. The team has worked closely with contracting colleagues, NHSEI and system partners to develop creative solutions to this which is an ongoing challenge.

In November 2021, the Cross-border Peer to Peer Child Criminal Exploitation thematic review was published with nine systemwide strategic recommendations which key partners are responding to as part of a joint action plan. The key recommendation for health has been to develop a public health approach to tackling serious young violence considering how gaps in therapeutic provision might be addressed.

As part of the CCG's statutory duties, the team has participated in a variety of multi-agency audits during 2021/22 including; domestic abuse in lockdown, adults at risk of exploitation including those with learning difficulties, child exploitation and self-neglect. Learning briefs have been shared across the system as a result of these exercises and through the One Care bulletin with Primary Care. These key messages have also been reiterated and discussed at Safeguarding LINK GP meetings to ensure changes to practice are embedded.

The CCG Safeguarding Team were nominated for the Captain CCG Integrity Award as part of the BOSCARs (BNSSG outstanding staff celebrated and recognised) this year which was a testament to their hard work with partner agencies to safeguarding children, young people and adults from abuse and harm. The team were recognised by this nomination for the work they had undertaken inside and outside of the organisation; supporting staff members with personal safeguarding issues and raising the awareness of domestic abuse, cybercrime, child exploitation and the impact of gambling as well as advocating the voice of those most vulnerable in our communities for the safeguarding they required.

Looked After Children

To reflect statutory guidance, Looked After Children should receive an initial health assessment to evaluate the child's physical health and any requirement for access to specialist behavioural, mental, and emotional health assessment. The looked after children health team has a responsibility to ensure oversight of the child's health assessment. Delivering review of the health action plan and coordinating communication with involved professionals, when placed out of area, to ensure connectivity with local health and safety resources, to optimise safety, health, educational and life outcomes. Clearly identifying the child's needs and resources required to support the health action plan improves the child's experience of being in care. This comprehensive assessment also offers carers the opportunity to improve engagement with the child. Providing a nurturing environment that delivers on the child's individual needs, understanding the child's life experience and journey into care.

Rates of mental health disorders in the general children's population aged 5 – 15 is 10%. In the looked after children population it is 45 – 72%. In 2017, 56.3% of looked-after children had a special educational need, compared with 45.9% of children in need and 14.4% of all children. Looked after children are more likely to become a single parent and are at greater risk of teenage pregnancy and poor pregnancy-related outcomes. These include smoking during pregnancy, having a low-birth-weight baby, and depression. Local authorities have a duty to support looked-after children and young people. This includes providing support to improve mental and emotional health and wellbeing and producing individual care plans covering any identified health requirements. NICE guideline NG205 (October 2021).

Sirona Health and Care are now the main provider of statutory health assessment for the BNSSG Looked After Children population unless the child is placed out of area. The external peer review 2020, resulted in an action plan to support the development of a health services provided to this vulnerable population. Sirona was responsive to the pandemic, moving to deliver remote health assessment and recognise when there was a need for face-to-face

assessment. In 2021/ 22 the provider and CCG have created an opportunity to focus increased delivery of specialist services that are able to respond to a population with a higher level of clinical and education needs. There is consensus around the training needs of the health team, reviewing reporting on KPIs and statutory indicators aimed at improving health outcomes. The aim is to improve early access to health resources as required and evaluation of impact. At present the provider is unable to report on number of completed health assessment, the ambition is that this will be resolved by April 2022. It has not possible to report upon review health assessment rates in North Somerset due to inconsistencies with access to health databases.

Initial health assessment figures 2021/22

	Q1	Q2	Q3	Q4
Carried out within 20 working days of started care episode	40 / 62	43/ 61	38/ 58	Jan 11/ 23
KPI 85%	66%	70.49%	65.5%	58.3%

- Sirona have organised an information sharing agreement to allow the Designated Nurse Looked After Children to access their databases and provide year-round assurance and support in delivery of timely health assessment.
- Focused workshops are being delivered to enhance CCG/ Sirona collaboration and development of datasets capturing service activity and the needs of the looked after children population to reflect statutory guidance.
- The ambition and spirit of working together is positive and constructive.
- There is recognition that the service is not meeting KPI's, an action plan to deliver service improvements will underpin continued development.
- The report will be split into local authority areas ongoing.

Continuing Health Care (CHC) and Funded Nursing Care (FNC)

Our CHC and FNC teams have continued to work flexibly to support people in BNSSG living with complex health needs.

2021/22 has been a year when we have consolidated our 'one team' approach across the BNSSG area and implemented new approaches to support service delivery. These have included:

- The roll out of a new IT system to support the functions of the service
- A dedicated lead to oversee the community of people with a community Deprivation of Liberty court order

- Actions plans arising from internal and external audits and formal and informal complaints
- Commissioning additional capacity to recover the impact of the pandemic restrictions on funded care assessments and reviews
- Lessons learned approach to incidents
- Masterclasses by legal colleagues around specific areas related to funded care
- A reassessment against a national maturity framework indicating a consistent improvement across the service
- Flexible approach to support system pressures
- Innovative approach to supporting the Assuring Transformation cohort to move to their own home
- Creation of a pooled budget approach to support children with complex lives and needs

To ensure that we continue to improve our CHC and FNC services we plan to:

- Work with regional and national colleagues to optimise the use of a Personal Health Budgets
- Roll out an improved model of supervision for all colleagues in the service
- Continue to grow the areas where audit will add value in improvement and assurance
- Review and improve the support functions within the service

SEND (Special Educational Needs and Disabilities) Children and Young Adults

The Children and Families Act (2014) and SEND Code of Practice (2015) aims to improve services for children, young people and families with special educational needs and disabilities, including those with complex health needs, in three main ways:

- Identifying children and young people (up to the age of 25) who have special educational needs and disabilities. This includes the timeliness of identification, and the effective use of information from neonatal and new born screening and early health checks
- Assessing and meeting their needs. This includes securing health input to Education Health and Care (EHC) Plans and information about health services through the Local Offer
- Improving their outcomes in the transition to adulthood

We are committed to improving the lives and outcomes for children and young people with special educational needs and disabilities and the legislative framework underpins our work and plans for this group of young people. We work with our local authority partners and jointly commission services for children and young people up to age 25 with special educational

needs and disabilities and contribute to the Local Offer of services available. We co-produce services for children, young people and families with SEND to enable them to participate in shared decision-making about their care and have in place mechanisms to ensure practitioners and clinicians support the integrated Education Health and Care (ECH) needs assessment & plan process and.

Ofsted and the CQC have an inspection framework and each local area is expected to demonstrate a good understanding of how effective they are in meeting their duties, and the aspects of their responsibility requiring further development. Following a Local Area Review, Ofsted and the CQC write a joint outcome letter. This explains the main findings, highlighting strengths but also making recommendations for improvement by identifying areas of significant weakness. The outcome letters are published on the Ofsted and CQC websites.

Each local area within Bristol, North Somerset and South Gloucestershire has had a Local Area Review by Ofsted and the CQC, and we have worked with our local authority partners to develop Written Statements of Action, Accelerated Progress Plans, or Improvement Plans in response to the inspection findings. These plans detail the actions that we are taking as individual organisations, and jointly together, to improve those areas where there are weaknesses.

Local Area	Local Area Review date	Re-inspection date	Plan status
Bristol	2019	Awaited	Written Statement of Action
North Somerset	2018	2021	Improvement Plan
South Glos.	2017	2020	Accelerated Progress Plan

Plans can be found on the relevant Local Authority websites.

Working with people and communities

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to ‘make arrangements’ to involve the public in the commissioning of services for NHS patients (the ‘public involvement duty’). For CCGs, this duty is outlined in Section 14Z2 of the Act. As an organisation we are committed to going beyond our mandatory duties to engage with the people and communities we serve.

The Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System recognises the importance of working in partnership with people and communities and the

impact it can have. Through the combination of data and insight from across the system, including the input of those with lived experience, we can supply detailed and varied intelligence to support an enhanced understanding of the root causes of existing health inequalities. This intelligence also enables the development of effective strategies to address and resolve these inequalities.

As an organisation we believe that the best solutions come from working with those who are closest to the services or issue, and we are committed to:

- Ensuring that people and communities are at the heart of what we do
- Building a two-way dialogue and partnership with our residents to co-produce and shape services
- Applying Population Health Management principles to help improve health and care outcomes in different population groups across our area

This has allowed us to hear from a broad range of individuals including:

Over the past year, our engagement activities have been heavily driven and influenced by the impacts of the COVID-19 pandemic. Some examples of these engagement activities include:

- Supporting the delivery of the COVID-19 mass vaccination programme, ensuring we are listening to people and communities to deliver both information and vaccination clinics in a way that meets the needs of local people. By gathering feedback and working with key

community stakeholders, we have been able to target specific community groups to address concerns and support increased vaccine uptake.

- Delivering a 12-week public consultation for the reconfiguration of stroke services during the pandemic. Due to restrictions enforced by COVID-19, we had to adapt the way in which the consultation was delivered, whilst also ensuring that those from specific community groups also had the opportunity to share their views. During the consultation we gathered almost 2000 pieces of feedback through various channels, including public events (both online and in-person), attending existing meetings, pop up events, door to door interviews and an online feedback form.
- Listening to those with long COVID via the approach of ethnography (home video diaries) and interviews. The purpose of this was to understand the effects of long COVID and how best to support those with it. We also worked with individuals to review the current long COVID service offer to understand how accessibility of these services could be improved for those from community groups most effected by long COVID.
- Working closely with BNSSG CCG's Business Intelligence (BI) team to map data around uptake of the Pulse Oximetry service. This data was then used to inform the NHS Healthier Together @home communications strategy by highlighting geographic and demographic groups requiring further targeting in order to drive service uptake.

In addition to the work carried out directly related to the COVID-19 pandemic, engagement activity has also been delivered in response to wider system pressures which have intensified during the pandemic. Some examples include:

- Providing insights on minor attendances at urgent and emergency care (UEC) settings through on-site interviews delivered throughout August 2021. Feedback was gathered on the individual's presentation, their journey, as well as their reflections and perceptions of this journey. These insights have helped to shape and inform the work being delivered as part of the UEC Minors Programme.
- Delivering public workshop sessions to support the design of a bespoke BNSSG communications campaign for NHS 111, linking closely with community and voluntary sector partners to support the distribution and delivery of campaign messaging.

As part of our response to the continuing challenges faced within our healthcare system, we have engaged with over 25,000 individuals. Some of the examples of where these insights have informed activity have included:

- Insights gathered from over 250 individuals with lived experience of stroke, carers and staff have helped us to design our plans for the reconfiguration of stroke services across

Bristol, North Somerset and South Gloucestershire. Public consultation feedback, gathered between June and September 2021, has been used to inform service design, including that of a new Integrated Community Stroke Service.

- In response to challenges in attracting candidates into social care roles, we have worked with our three local authorities' 'Proud to Care' teams to commission a qualitative research project to gain an understanding of three key target groups. This enhanced understanding has informed the development of a local recruitment marketing strategy for the sector to increase awareness and interest in social care roles. The detailed insights from this project have informed the development of a new segmented recruitment marketing strategy, including tailored positioning, messaging and creative treatments for each target group. Beyond this, operational recommendations have also informed discussions between local authorities and social care providers, to help shape broader strategic changes to facilitate longer term transformation of the social care sector.
- Each of our six place-based partnerships worked alongside the Design Council to help shape the development of their Community Mental Health Implementation and Mobilisation plans. Each of the localities formed their own co-design team, drawing on representation from the CCG, local authorities, representatives from Voluntary, Community and Social Enterprise (VCSE) sector organisations, our community services provider (Sirona) and our mental health trust (AWP). Critically, the co-design teams also included individuals with lived experience and / or their carers. These co-design teams took part in Design Council workshops to work through the 'Double Diamond' industry standard design process and apply this to their response to the Community Mental Health Target Operating Model. As well as helping locality teams to develop people-centred mental health services at place level, the programme has left a legacy of learning around applying design thinking to service design and delivery across all of the partners involved in the work.

BNSSG COVID-19 Mass Vaccination activities

Engagement specific to the COVID-19 vaccination programme has continued throughout 2021 and early 2022. The programme operations and communications have been guided by insights from residents throughout this process.

Over 13,500 people have responded to post COVID-19 vaccination surveys across a variety of settings, including primary care clinics, mass vaccination centres, schools and outreach clinics.

The insights have helped to inform improvements to operations, services, locations and communications.

To build on insights gathered just prior to the start of the vaccination programme in 2020, we have continued, in the last year, to canvas residents regarding their views of the COVID-19 vaccine, receiving feedback from nearly 2,000 people. This has helped inform events, discussions, and communications on our website and in the wider media to respond to concerns and answer questions about the vaccines and vaccination process.

Insights gathered from the people and communities continue to be a vital element of the BNSSG mass vaccination programme. We continue to be encouraged by the positive response we have seen in vaccine uptake across the broad diversity of the population we serve.

BNSSG Healthier Together Citizens' Panel

Our Citizen's Panel was launched in 2018, and to ensure that we continue to have a robust representative sample, we undertook a refresh of the panel during 2021. This refresh increased the overall panel size from 1,048 to 1,400 members. While predominantly increasing the sustainability of the panel through providing a representative cohort for future survey waves, this also supports the delivery of future citizens insights projects by providing a base for deliberative research projects.

In November 2021 we returned to our regular approach to surveying, following the deployment of a shorter 'pulse' survey format during the initial phases of the COVID-19 pandemic. The latest survey focused on urgent care, digital health and care and long COVID.

- The findings allowed us to understand in more detail how our resident's defined "routine", "urgent" and "emergency" healthcare needs. We were also able to identify key differences between demographic groups, with those aged 25-44 years old, males, those with long term conditions, and those living in Weston, Worle and Villages being more likely to escalate healthcare needs quicker than other groups. It also provided us with a baseline understanding of usage and perceptions of different healthcare support options, including NHS 111 which informed a GP Winter Access campaign and will allow us to evaluate winter communications activities relating to urgent care.
- Building on the insights gathered from two public engagement events, we sought the views of the panel to understand if and how perceptions and usage of digital formats have changed since the pandemic began, along with attitudes towards the use of apps and devices for self-monitoring and management. There were significant levels of

comfort among panellists in receiving health and social care in various digital formats, including video consultations. These comfort levels had increased since the start of the pandemic. These insights are supporting the development of a new digital strategy for the ICS and have informed the focus for a GP Winter Access campaign.

- We also learned that there was an opportunity to raise awareness of the key resources available to support those experiencing long COVID, despite a high level of awareness of the condition among panellists.

Reducing Health Inequality

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to reduce inequalities. For CCGs, this duty is outlined in Section 14T of the Act. During 2021/22 the CCG has continued in its work to reduce health inequalities using a number of existing and new pieces of work.

We are committed to advancing equality and reducing health inequalities for the diverse population we serve. Implementation of the Public Sector Equality Duty 2011 forms the foundation of our equality and diversity activities. This Duty stipulates we must have due regard to eliminate discrimination and any other conduct prohibited by the Act, advance equality and foster good relations between one group and another and between the public and the CCG.

The CCG equality, diversity and inclusion strategy (https://bnssgccg.nhs.uk/library/equality-diversity-and-inclusion-strategy/) sets out an ambitious action plan to address inequalities in the workplace and within the population we serve and as a result we have undertaken a range of initiatives to improve data quality, listen to our communities, develop an inclusive leadership mindset and create an inclusive working environment for our staff. There are two important legislations that provide a legal framework for the CCG, the Equality Act 2010 (Public Sector Equality Duty) that sets out a legal duty to have due regard to eliminate unlawful discrimination, advance equality for groups who do not fully participate in 'public life' and foster good relationships between people who hold one protected characteristic and another; and the Health & Social Care Act 2012, which directs us to take steps to reduce health inequalities.

These frameworks have helped us to shape our four objectives set out in the equality, diversity and inclusion strategy:

- Objective 1: To improve the use of equality analysis data in our commissioning cycle
- Objective 2: To build strong relationships with protected characteristic groups and communities to better understand their needs and improve our equality data

- Objective 3: To promote workforce equality and improve representation through effective employment practices
- Objective 4: To develop inclusive leadership throughout the CCG

These objectives steer our equality, diversity and inclusion (EDI) efforts within the CCG and inform how we work with partner organisations and our population to co-produce services across the Healthier Together system (a partnership of organisations that service the Bristol, North Somerset and South Gloucestershire area).

This year, we introduced a new action plan, the People Plan, which is overseen by the People Plan Steering Group and the Inclusion Council, two strategic forums. This has enabled us to focus attention internally and take a holistic approach to support our workforce's health and wellbeing, improve our recruitment processes to ensure we attract diverse talent and shape cultural change. We have also focussed on strengthening inclusion in-house and have increased the training offer; we have improved Equality Impact Assessment training and introduced an Inclusion Roadshow to increase equality literacy, raise awareness about issues our staff and communities face and help staff to identify individual and team actions that they can undertake to drive change. We have also introduced the Health Equity Assessment Tool, which was developed by Public Health, to help staff to identify health inequalities, their causes and develop approaches to tackle them. Health Equity Assessment Tool (HEAT) - GOV.UK (www.gov.uk)

We recognise that our staff are also patients and members of the communities we serve and we are proud to host four staff networks. Our networks have been instrumental in supporting cultural change in the organisation, they actively engage with the organisation and deliver training and other initiatives that help us to identify the needs of various staff groups and to identify and address systemic barriers. We are working with our networks to strengthen them and ensure they are sustainable and able to strategically represent the groups they support.

Having a strong evidence base helps us to make the best use of resources, provide value for money and to commission services that are inclusive of the needs of a diverse population. We have continued to improve Population Health Management (PHM), this is a database that combines data from a number of systems that helps us to build a wider picture of population health needs. PHM was a key driver for the successful outcome of our Covid vaccine programme, the insights from this tool, alongside the hard work of the Voluntary Sector and staff from across health and care organisations helped us to reach communities who are often described as 'seldom heard'. You can read more about this work in the Insights and Engagement section of this report (p58).

Qualitative data is just as important as quantitative data and listening has helped us to understand the perspective and needs of communities. We have held listening events and undertaken major consultations around reconfiguring Stroke services for example. The CCG also hosts a Citizen Panel, which is made up of over 1000 people who are representative of the BNSSG population and they have helped us to understand the impact of Covid 19 and how patients have navigated and experience healthcare during these unprecedented times. We will continue to strengthen our listening and build on the relationships that we have cultivated over the past two years.

Our Inclusion Roadshow, mentioned earlier, is also helping us to further embed inclusion in the CCG, we are keen to enable every member of staff to become inclusion practitioners, to do so, we must first have a shared understanding of equality, diversity and inclusion (EDI), a common language and awareness of the issues we are trying to solve. Our EDI framework links the organisation mission "to make health better for all the people of Bristol, North Somerset and South Gloucestershire" with our vision, values and EDI objectives to team action plans and creates a consistent approach to embedding EDI work.

The CCG will transition into an Integrated Care Board in July 2022, which will also herald improvements in the way we work together across the system, including how we measure, monitor and shape an equality, diversity and inclusion agenda. System EDI work will mean we can share resources and expertise and collectively address systemic barriers at community level.

You can read more about the 2020/21 equality, diversity and inclusion initiatives, the EDI framework and our ambitions for the future in the equality annual report 2021 NHS Bristol, North Somerset and South Gloucestershire CCG (bnssgccg.nhs.uk)

Vaccinations and learning the lessons

Each area within BNSSG has done work to increase both flu and Covid-19 vaccination uptake in groups that had lower uptake with statutory organisations often being led by communities to do this work.

The evaluation of the Covid-19 'maximising uptake' work that was completed in 2021/22 recommended we

"Continue to strive for equity of health outcomes for the BNSSG population, using and developing on effective ways of working within the maximising uptake programme:

- Co-production with communities – giving them ownership to develop engagement and deliver outreach

- Working across the BNSSG integrated care system, combining strategic oversight with professionals with in depth knowledge, experience and trusted relationships with underserved groups
- Providing governance that supports flexible, innovative, rapid ways of working
- Investing in insight work, communications expertise and use of population health management data tools”

These efforts are continuing and the lessons that are being learnt about how to listen and respond to communities to better understand need and any barriers to care will and are being taken into other work.

Long term conditions

General practice is continuing its proactive work in supporting people with long term conditions that began during the beginning of the Covid-19 pandemic. Support material continues to be developed for general practice, including the recent publication of the BNSSG Visual Impairment Awareness Guidance.

Diabetes - There has been local targeted action to increase National Diabetes Prevention Programme uptake among people from deprived neighbourhoods and from parts of the ethnic minority community, e.g. community language workshops, male only and female only sessions, developing more culturally appropriate healthy eating resources for parts of our ethnic minority communities.

Hypertension (high blood pressure) - We are taking part in the national Blood Pressure Monitors at Home programme and have sent blood pressure monitors to people (via their practice) who have uncontrolled hypertension and who are living in the most deprived areas in BNSSG. We have also expanded the programme so that practices in those areas can use the monitors for diagnosis of hypertension.

Annual Health Checks for people with a learning disability and for people with a serious mental illness

We have supported general practice to increase the number of people with Learning Disabilities who have Annual Health Check. In 2021/22 over 75% of people registered on GP learning disability registers who were eligible for a check had one. In addition, we have increased the number of people who have a Health Action Plan following on from their check. These plans are important as because they describe what should happen next as a result of the person’s health check.

Our area has been one of the poorest performing CCG areas in the Southwest and country for completing full sets of physical health checks for people on GP practice serious mental illness registers. The checks are not an end in themselves, but their results should direct onward referrals, treatments and positive health improvement interventions/activities. Our primary care incentive scheme provides an extra payment to PCNs for each set of health checks undertaken and properly recorded. There has been a significant improvement from 12% in August to 26% at end November 2021.

Restoring NHS services inclusively

During 2021/22 our business intelligence team has supported work to understand whether there are differences in which groups of our population are on waiting lists. This is to support work during 2022/23 to ensure that people who need care and support who haven't come forward during the pandemic, do so. They are also supporting work to understand whether there are differences in how long people are waiting for care between different groups of our population. Both of these pieces of work are initially looking at ethnicity and people who live in 'deprived' neighbourhoods.

Working with Health and Wellbeing Boards and the Health and Wellbeing Strategies

South Gloucestershire Health and Wellbeing Board

The South Gloucestershire Health & Wellbeing Board (HWB) has held five formal meetings during 2021/22. The HWB approved the new South Gloucestershire Joint Health & Wellbeing Strategy (JHWS) for 2021/25 and signed off the Better Care Fund 2021/22 arrangements. In addition, members have discussed a range of topics, including the changing health and care landscape and the relationship between the HWB and newly forming South Gloucestershire Locality Partnerships; health protection updates, particularly in relation to Covid-19 response; and suicide prevention work, which was a key area of focus for the HWB in 2020/21.

The meeting papers can be viewed here: Browse meetings - Health & Wellbeing Board - South Gloucestershire Council (southglos.gov.uk)

One of the HWB's main achievements was the approval of the new JHWS for 2021/25. The purpose of the JHWS is to provide the future strategic vision for health and wellbeing in South Gloucestershire, setting out key strategic priorities for action and clear outcomes as identified in the South Gloucestershire Joint Strategic Needs Assessment (JSNA).

The JHWS for 2021/25 has an overarching theme of reducing inequalities and taking a place and community-based approach, and four strategic objectives, which are illustrated below:

Each of the priorities has an associated action plan and nominated lead(s) from across the HWB membership. Progress will be monitored through 'deep dives' at HWB meetings throughout 2022-23.

The HWB has held two development sessions during 2021/22. The first one, in May 2021, focused on the developing health and care system population health outcomes framework and the South Gloucestershire JSNA. The second one, in September 2021, provided an opportunity to discuss the newly emerging South Gloucestershire ICP and the relationship with the HWB, with an initial discussion about draft principles and ways of working. Since then, a joint working group has been established to further develop a shared vision and priorities and a joint development session for the HWB and ICP is planned for May 2022 to finalise arrangements and publish a 'One South Glos Plan'.

There have also been joint seminars for the three Bristol, North Somerset and South Gloucestershire HWBs. These have focused on the following topics:

- Health and care integration
- HWB and ICP alignment, principles and ways of working
- Use of data and the JSNA
- Community Mental Health Operating Model
- Approaches to trauma
- Healthy Ageing

Bristol Health and Wellbeing Board

We have made good progress with the Bristol Health and Wellbeing Board during 2021/22 despite the ongoing impact of Covid-19. The following are of note:

- Our priority – Support community assets (such as community centres and groups) to reduce social isolation and improve mental wellbeing, particularly focusing on communities with mental health inequalities, was voted one of the top three City priorities at the City Gathering. We have worked with the City Fellows to consider bringing voices of our communities into city wide discussions and decision making.
- We have more cohesive engagement with the other One City Boards and are an integral part of the One City multi board meetings.
- Induction pack for new members of the board.
- The three Bristol ICP Chairs have become members of the Health and Wellbeing Board.
- Updated our Performance Framework.
- Health and Wellbeing Board Development Sessions every other month in between formal boards providing opportunity to explore issues in depth. Examples include how to embed the JSNA in the Performance framework, mental health, environment and health, housing and health.
- The LGA provided support to the Health and Wellbeing Board in August 2021, specifically thinking about successful integration with the wider system. The board received positive feedback on our journey to date.

The North Somerset Health and Wellbeing Board

In October 2002 the North Somerset Health and Wellbeing Board launched its Joint Health and Wellbeing Strategy for 2021/24. The strategy set out a shared aim to reduce health inequalities, improve the health and wellbeing of people living and working in North Somerset, and to enable organisations, communities, and residents to come together around a single vision for North Somerset. The strategy and its action plan were developed in partnership with organisations across North Somerset. The strategy aims to bring about improvements in key priority areas of mental health, food and healthy eating, physical activity, substance use (including alcohol and tobacco use) and the wider determinants of health. The action plan targets these areas to improve health and wellbeing for people of all ages.

Sustainable Development

The second year of the pandemic has seen positive developments associated with the important sustainability agenda and we continue to maintain our commitment to reducing the impact on the environment through the way we manage, with our stakeholders, our operational business and our commissioning of system partners.

Like many organisations driven by the pandemic to changing approaches to working remotely, our workforce has continued to embrace the benefits of working from home. Whilst for some, this has not been an easy transition, through the use of new technology and shifting from the traditional model of office working, colleagues have remained connected and delivering outputs. This has resulted in reduced travel for work.

With our staff and learning from our initial response to our pandemic, we have started Our Hybrid Way of Working which promotes the empowerment of individuals to determine the most appropriate venue for working with most choosing to continue to work from home.

Offices have remained open and our main office in Bristol has undergone a lengthy refurbishment which has resulted in developments to support sustainable travel. Electoc charging points have been installed and additional bike racks have been installed which recognise the shift to greener travel initiatives. We have maintained our offer of discounted access to cycle equipment through our participation in the Cycle to Work Scheme.

We have been working with our landlord, NHS Property Services, to determine how we can reduce our estate requirement and reconfigure retained space to reflect the move away from the traditional office working model. Meanwhile we maintain arrangements for recycling materials through existing contracts.

Our responsibilities for the provision of IT equipment and infrastructure for General Practice has also been impacted by the pandemic. We have continued to supply more equipment to support digital connections between patient and clinicians and this is set to continue.

The Weston Villages Primary Care Development has continued with building works that will result in a new building which, through the Building Research Establishment Environmental Assessment Method (BREEAM) standard, will have a positive environmental impact.

BREEAM is the leading and most widely used environmental assessment method for buildings and communities. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe a building's environmental performance. BREEAM provides clients, developers, designers and others with the following:

- Market recognition for low environmental impact buildings;
- Assurance that best environmental practice is incorporated into a building development;
- Inspiration to find innovative solutions that minimise the environmental impact;
- A benchmark that is higher than regulation;
- A tool to help reduce running costs, improve working and living environments;
- A standard that demonstrates progress towards corporate and organisational environmental objectives.

BREEAM addresses wide ranging environmental and sustainability issues and enables developers and designers to prove the environmental credentials of their buildings to planners and clients. It:

- Uses a straightforward scoring system that is transparent, easy to understand and supported by evidence-based research;
- Has a positive influence on the design, construction and management of buildings;
- Sets and maintains a robust technical standard with rigorous quality assurance and certification.

The pre-construction BREEAM assessment for the development indicates a score of 74.04% meaning that it falls into the Excellent category.

We have continued our involvement in the Healthier Together Partnership which binds local system partners across our area to delivering our shared agenda including for the reduction of our carbon foot print in line with our responsibilities set out in the NHS Green Plan.

As a commissioning organisation we maintain our use of the standard NHS contract which requires providers of health care to meet NHS Green Plan responsibilities and our NHS Trusts have published their organisational Green Plans as required.

The Healthier Together Executive Group has agreed our Green Plan which will focus our system work over the forthcoming years as high standards of quality health and care are delivered whilst addressing the environmental impact this creates. We want to do more than just minimise any negative impact of our activities and our Green Plan shows how, through developing sustainably, we can make a significant positive contribution to the local economy, society and environment. We have set out the commitments we have made to deliver three key outcomes for our population which we will do by holding a shared ambition, establishing the enabling conditions for change including the allocation of resources, co-ordinating highest impact projects, and creating assurance of delivery of actions.

Financial review 2021/22

As per 2020/21, and in response to the Covid-19 pandemic, the financial performance management of NHS bodies continued to operate under a temporary financial framework. Funding was provided to enable all CCGs and Integrated Care Systems to deliver a breakeven position. To achieve this baseline allocations were set which broadly continued to fund the run rate expenditure as per 2019/20 (pre-Covid). In addition to this some specific targeted allocations were then made:

- System wide allocation to fund direct additional costs of Covid, most notably increases in staff absence and cost premium of infection, prevention & control measures
- Targeted growth in line with the NHS Long Term Plan priorities, notably investment in Primary Care and Mental Health Services
- A smaller number of key funding streams were subject to retrospective reimbursement, in line with the Government response to Covid pandemic. Most notably the Hospital Discharge Programme (to support NHS and Local Authority Social Care Services to create additional capacity to support earlier discharge from hospital), Elective Recovery Fund (linked to elective activity delivery) and Covid Mass Vaccination costs (via a lead provider funding model and not CCG allocations)
- Non-Contract Activity with NHS provider Trusts below £200,000 was not chargeable and providers were reimbursed nationally via a 'top up' regime

Again, as per 2021/22 the financial year was split into two halves, with separate allocations made for each half of the year and two NHS budgeting and operational planning rounds. The H2 allocation, from October-March, set at a time when Covid levels were subsiding during Summer 2021, reflected a higher level of efficiency saving requirement and a higher threshold to achieve elective recovery funding as the NHS sought to return to pre-pandemic productivity and funding levels.

The finance regime also continued to make progress towards a 'system by default' finance framework as envisaged under the Integrated Care Board regime. For 2021/22 NHS standard contracts with NHS providers remained suspended and, most targeted allocations, for example, Covid costs and Provider Top Up funding, were allocated at system level with discretion given to the system to allocate to providers. NHS England financial performance focussed on total system financial performance (aggregate of CCG and NHS providers variance against revenue resource limit and capital allocations) rather than individual organisations.

Taken in the round these changes ensured that:

- Unplanned additional costs of the Covid-19 pandemic were able to be funded and decisions made promptly
- Inter-NHS commissioning and contracting did not become a barrier or additional burden on the service
- There remained a mechanism for ensuring value for money
- Progress was made on the Long-Term Plan objective of 'system by default' working

These are welcome initiatives, aligned to the NHS and CCG long-term financial objectives, but caution should be taken when making year-on-year comparisons of expenditure, or relative activity and performance levels. Within this context the CCG has reported a small surplus of £964,000 (0.05%) against the In-Year Revenue Resource Limit of £1,859,577,000. The total system revenue financial position was £9,018,000, as analysed below:

	2021/22 Outturn £000s	
CCG	964	
AWP	780	(whole Trust basis)
NBT	2,203	
UHBW	5,071	
System total	**9,018**	

The goal of the system was to ensure breakeven for each organisation and a commitment to shared system working and management of financial & operational risk. UHBW targeted a small surplus in order to maintain cash to finance repayment of historic investment loans.

The total system capital envelope was £86.575m and the outturn position was £74.635m, as shown below:

	2021/22 Envelope £000's	2021/22 Outturn £000's	Variance £000's
AWP	3,802	3,787	(15)
NBT	31,731	32,514	783
UHBW	51,042	38,334	(12,708)
System total	**86,575**	**74,635**	**(11,940)**

Financial performance and outlook

The CCG spent £1.858billion on behalf of the patient population during 2021/22. This is 0.05% lower than the notified allocation, achieving a small surplus of £0.964m. This primarily arose due to delays in planned investment and activity recovery caused by the impact of the Covid pandemic. The CCG operates within a System Financial Envelope, together with other

partners in Healthier Together. As well as delivering a small £0.964m surplus position for the CCG; the CCG contributed a key leadership role to delivering surplus positions in all key partner organisations (UHBW, NBT, AWP and Sirona), and an overall NHS surplus position of £9.018m. This required maintaining financial control and meeting budget targets; and operating in a new, and arguably more complex, 'system' finance environment.

System partners worked together to set a balanced financial plan for both H1 and H2 at both organisation and system level. For the CCG, this financial plan required cash releasing savings of £8.9m and this was delivered in full, with £9.1m savings achieved.

	2021/22 Year End		
Control Centre	**Net planned**	**Actual**	**Variance to plan**
Funded Care	£2,200,000	£2,967,697	£767,697
Medicine Optimisation	£4,600,000	£4,671,763	£71,763
Mental Health	£1,200,000	£890,460	(£309,540)
Running Cost	£600,000	£600,000	-
Grand Total	**£8,600,000**	**£9,129,920**	**£529,920**

System partners also developed and approved a refreshed a medium-term financial plan during Summer 2021, using parameters as set out in the NHS Long Term Plan.

As the financial year developed the Covid Omicron variant created further waves of infections, leading to increased hospital admissions for Covid, albeit with a lower mortality and ICU demand. This reduced productivity & operational flow due to infection prevention and control measures in all hospital and care settings and increased staff absence rates. The short-term financial impact of this was largely felt by lower levels of activity and expenditure, most notably in elective care and nursing homes. Although, it should be noted that recurrently additional costs of managing the Covid pandemic have been incurred and lower annual efficiency savings have been realised than were planned. The net impact of this meant that in the short-term resources were available and responding to this, the CCG took decisions to re-invest underspends and contingencies in projects and programmes aimed at accelerating long-term, strategic transformation, in line with the Long term Plan. Importantly, most investment was made jointly with local authority partners. Notable examples include:

- Investing in £1.5m Delivery Capacity for six localities (Locality Partnerships),
- £1.1m capacity to support development of a Population Heath Management approach including availability of the system-wide dataset and public health clinicians and managers, workforce transformation capacity and capability,

- £15m transitional funding to move from the Government funded Hospital Discharge programme to a core funded model of Discharge to Assess capacity, and
- £10m Matched Funding Grants with three Local Authorities to support prevention, investing in voluntary and community sector and upstream demand management projects.

March 2022 - Month 12	2021/22 Budget	Expenditure	Under / (Over) spend
Area of Spend	**£000s**	**£000s**	**£000s**
Acute Care	896,593	892,081	**4,512**
Mental Health & Learning Disabilities	207,757	210,379	**(2,622)**
Non-Acute Contracts	283,933	293,200	**(9,267)**
Children's Services	17,997	18,393	**(396)**
Continuing Healthcare	91,335	89,395	**1,940**
Primary Care	23,972	22,975	**997**
Medicines Management	140,927	140,607	**320**
Primary Care Co-Commissioning	151,147	151,544	**(397)**
Other Support Costs	25,462	25,327	**135**
HQ Running Costs	19,277	19,250	**27**
Reserves	978	-4,539	**5,516**
BNSSG CCG Total Variance	**1,859,377**	**1,858,612**	**764**

Therefore, whilst the NHS has exited the financial year in a worse operational and financial position then envisaged before the impact of Omicron; the foundations have been laid to deliver improved performance, quality, and financial outcomes over the next few years as the CCG transitions to the ICB, and the NHS and the country learn to 'Live with Covid' and recover care backlogs accrued during the last two disrupted years.

		Of which, direct Covid expenditure
Bristol, North Somerset and South Gloucestershire CCG Programme Expenditure 2021-22	**£m**	**£m**
Acute Services	931	-
Mental Health Services	211	1
Community Health Services	186	9
Continuing Care Services	94	-
Primary Care Services	183	3
Primary Care Co-Commissioning	152	-
Other Programme Services	82	13
Total Commissioned Services	1,839	26
Running Costs	19	-
TOTAL CCG NET EXPENDITURE	1,859	26

ACCOUNTABILITY REPORT

Shane Devlin

Accountable Officer

17th June 2022

Accountability Report

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

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

The Corporate Governance Report provides information about the composition of the Governing Body, the statement of disclosure, and explains we had no personal data related incidents in 2021/22. We also provide our Modern Slavery Statement. This is in line with corporate governance best practice.

Members Report

Bristol, North Somerset and South Gloucestershire CCG is responsible for planning and commissioning health services for its local population. We were established by NHS England on 1st April 2018 and we operate in accordance with our Constitution. Our Governing Body is made up of local GPs, other clinicians, lay members, and executive directors. Our Chair is Dr Jonathan Hayes.

We are a clinically led membership organisation. Our member practices provide primary care services across Bristol, North Somerset and South Gloucestershire and are organised into six localities described in the Performance section of this report (p6).

A list of our GP practices can be found at https://bnssgccg.nhs.uk/about-us/our-members/.

Composition of Governing Body

Our Governing Body is responsible for discharging the functions conferred on to it by legislation and through our Constitution. Our Governing Body met online during 2021/22; details of attendance throughout the year are in our Governance Statement (p83). During 2021/22, and up to the signing of this annual report and accounts, our voting Governing Body members were:

Name	Title	Tenure in 2021/22
Jon Hayes	Clinical Chair	2021/22 to present
John Cappock	Lay Member Finance	2021/22 to present
Nick Kennedy	Independent Secondary Care Doctor	2021/22 to present
Alison Moon	Independent Registered Nurse	2021/22 to present
John Rushforth	Deputy Chair, Lay Member Audit and Governance	2021/22 to present
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	2021/22 to present
Kirsty Alexander	GP Locality Representative Bristol North and West	2021/22 to present
Julie Boardman	GP Locality Representative Bristol Inner City and East	2021/22 to present*
Matt Cresswell	GP Locality Representative North Somerset Woodspring	2021/22 to present
James Case	GP Locality Representative South Gloucestershire	2021/22 to present
Jon Evans	GP Locality Representative South Gloucestershire	April 2021 - March 2022
Kevin Haggerty	GP Locality Representative North Somerset Weston and Worle,	2021/22 to present
Brian Hanratty	GP Locality Representative Bristol South	April 2021 – July 2021
Caroline Stovell	GP Locality Representative Bristol Inner City and East (nominated deputy for *above)	April 2022 to present
Julia Ross	Chief Executive	April 2021 - March 2022
Shane Devlin	Interim Chief Executive/ICB Designate CEO	March 2022 – present
Sarah Truelove	Chief Financial Officer	2021/22 to present

Non-voting executive directors attending the Governing Body:

Name	Title	Tenure in 2021/22
Peter Brindle	Medical Director Clinical Effectiveness	2020/21 to present
Colin Bradbury	Area Director North Somerset	2020/21 to present
Deborah El-Sayed	Director of Transformation	2020/21 to present
David Jarrett	Area Director South Gloucestershire	2020/21 to present
Lisa Manson	Director of Commissioning	2020/21 to present
Rosi Shepherd	Director of Nursing and Quality	2020/21 to present

Our Governing Body committees are:

- Audit, Governance and Risk
- Remuneration
- Primary Care Commissioning
- Clinical Executive
- Strategic Finance
- Quality
- Patient and Public Involvement Forum

Details of the membership of our Governing Body committees and attendance, including the Audit, Governance and Risk Committee, are provided in the Governance Statement in this report (p83). Further information about our Remuneration Committee can be found in the Remuneration Report in this report. Details of the declared interests of our Governing Body members and the members of Governing Body committees can be found at https://bnssgccg.nhs.uk/library/bnssg-ccg-register-interests/

Personal data related incidents

All information governance incidents are assessed in line with the NHS Digital "Guide to the Notification of Data Security and Protection Incidents". We have not had any externally reportable incidents during 2021/22. The CCG's Information Governance Group is routinely updated on any issues and remedial activities with learning cascaded to Information Asset Owners and materials published for staff.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

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

Shane Devlin

Accountable Officer

17th June 2022

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 Interim Chief Executive to be the Accountable Officer of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts

are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Bristol, North Somerset and South Gloucestershire 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.

Shane Devlin

Accountable Officer

17th June 2022

Governance Statement

Introduction and context

Bristol, North Somerset and South Gloucestershire CCG is a body corporate established by NHS England on 1 April 2018 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006

Scope of responsibility

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

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

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

Our Constitution sets out the CCG's roles and responsibilities for commissioning healthcare for people within the Bristol, South Gloucestershire and North Somerset area. We describe in our Constitution our governing principles, and the rules and procedures we have in place to ensure probity and accountability in our day to day running; to ensure that decisions are taken in an open and transparent manner and that the interests of patients and the public remain central to our aims. Our Constitution is available on our website.

Bristol, North Somerset and South Gloucestershire CCG is a membership organisation. Our members include all providers of primary medical care services to the registered list of patients, under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Service (APMS) contract. Our Constitution includes details of our Membership and is available on our website https://bnssgccg.nhs.uk/library/bristol-north-somerset-and-south-gloucestershire-ccg-constitution/. Our members are collectively responsible for agreeing the CCG's Constitution and the governance arrangements it describes, including the responsibilities of the Governing Body and its Members' terms of office.

We use our Internal Audit function to independently audit our systems of internal control and check that we are compliant with legal requirements and good practice.

The Governing Body

The main function of the Governing Body is to ensure that appropriate arrangements have been made for ensuring the CCG exercises its functions effectively, efficiently and economically, and that we comply with principles of good governance. Our Governing Body membership includes local GPs, three independent lay members, an independent secondary care doctor, an independent nurse and the CEO and CFO. All directors attend Governing Body meetings but do not have voting rights. A full list of Governing Body members can be found (p78)

Throughout 2021/22, our Governing Body met on-line due to the restrictions in place in response to the Covid-19 pandemic. These meetings were open to the public and the papers and minutes of the meetings are available on our website https://bnssgccg.nhs.uk/events/ . The Governing Body met 12 times during 2021/22 and was quorate for each meeting. The membership and attendance at meetings is in the table on page 91.

The Governing Body is responsible for:

- Approving any functions of the CCG that are specified in regulations
- Setting out the vision and strategy of the CCG
- Signing off the annual commissioning plan, which sets out how it proposes to discharge its financial duties.
- Monitoring performance against plan
- Receiving assurance against strategic risks
- Receiving assurances about the quality of commissioned services
- Ensuring engagement with Members, the public and partners

Throughout the year the Governing Body received specific reports about the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase.

Governing Body Committees

A number of committees of the Governing Body have been established and these are listed below with a summary of their purpose and functions. The Terms of Reference of these committees can be found at https://bnssgccg.nhs.uk/about-us/constitution-and-governance-handbook/ The Governing Body receives the minutes of the committees and these are available on our website at https://bnssgccg.nhs.uk/events/. During 2021/22 our committees met on-line and these arrangements will continue for the foreseeable future.

Audit, Governance and Risk Committee

The Audit, Governance and Risk Committee is accountable to the Governing Body and provides an independent objective view of and assurance on our controls and governance arrangements. The Committee is responsible for the oversight of financial reporting and disclosure. The Audit, Governance and Risk Committee is chaired by a lay member who is a qualified accountant and with experience at Director of Finance level. Membership of the Committee and attendance at meetings are detailed in the table on page 91.

The Audit, Governance and Risk Committee provides assurance to the Governing Body that an appropriate system of internal control is in place, so that:

- We conduct our business in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Financial statements are prepared in a timely fashion and give a true and fair view of the financial position for the period in question
- We secure economic, efficient and effective use of resources
- Adequate arrangements are in place and that reasonable steps are taken to prevent and detect fraud and other irregularities
- We have established and maintain an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities

During 2021/22, the Committee reviewed a number of internal audit reports and action plans; these are listed in the Head of Internal Audit Opinion section of this Governance Statement. In addition, the Committee has oversight of and receives regular reports on:

- The management of risk including the Governing Body Assurance Framework and Corporate Risk Register
- Counter fraud
- The management of interests including gifts and hospitality
- The management of Freedom of Information requests
- Waivers of standing orders and standing financial instructions

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body and makes recommendations about the remuneration fees and other allowances (including pension schemes) for employees not covered by Agenda for Change terms and conditions and other individuals who provide services to the CCG. Our Remuneration Committee is chaired by the Governing Body Lay Member for Patient and Public Involvement. Membership of the Committee and attendance are detailed in the table on page 91.

Primary Care Commissioning Committee

As a CCG with delegated authority for the commissioning of primary medical care, we have established a committee that oversees the contracting of general practice services within the context of the CCG strategic plan. The Committee is chaired by the Governing Body Lay Member for Patient and Public Involvement. The Committee met

on-line due to the restrictions in place in response to the Covid-19 pandemic. The meetings were open to the public and the papers for these meetings are available on our website. Membership and attendance at meetings are detailed in the table on page 91.

The Committee receives monthly reports on primary care contracts, quality and financial performance. Contract reports cover all core contracts and performance relating to improved access and enhanced services. Contractual changes, including requests for mergers, boundary applications and temporary closures are considered by the Committee. Reports on primary care quality include regular 'deep dives' in key aspects of quality. Throughout the year the Committee received specific reports about the Bristol, North Somerset and South Gloucestershire Primary Care response to the Covid-19 pandemic and the recovery phase.

Our Internal Auditors gave our primary care delegated commissioning arrangements an audit opinion of substantial assurance.

Clinical Executive

The Clinical Executive is accountable to the Governing Body. The Committee's remit includes development of the CCG's commissioning strategy and operational plan, and the CCG's procurement strategy. The Committee considers plans for the procurement of new services and disinvestment from existing services making, recommendations to the Governing Body where necessary. The Committee considers commissioning policies and individual funding policies and procedures, making recommendations to the Governing Body where appropriate. The Committee reviews provider performance against contracts, agreeing actions to be taken and monitoring improvement. The Committee's membership is primarily made up of CCG Clinical Leads and the Executive Team. Attendance at meetings is detailed in the table on page 91. The Committee received specific reports about the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase.

During 2021/22 the Committee received monthly reports on urgent care and the schemes established to support performance, Individual Funding Requests and the Corporate Risk Register and Governing Body Assurance Framework. The minutes of the Committee are available on our website (https://bnssgccg.nhs.uk/events/).

Quality Committee

The Quality Committee is chaired by the Governing Body Independent Registered Nurse and is accountable to the Governing Body. The Committee is responsible for ensuring that there is a cohesive and comprehensive structure in place for the oversight and monitoring of the quality of commissioned services, including patient safety, safeguarding children and young people and vulnerable adults and patient experience. This includes performance against NHS Constitution Standards. The Committee provides the Governing Body with assurance that CCG quality systems and processes are robust, that commissioned services are being delivered in a high quality and safe manner, and that all relevant statutory and regulatory obligations are met. The Committee provides assurance that effective processes are in place for safeguarding children, young adults and vulnerable people. The Committee considers the CCG Improvement and Assessment Framework Clinical Indicators and assures plans to improve performance against clinical priority areas. The membership and attendance at meetings are detailed in the table on page 91.

During 2021/22 the Committee received monthly reports from the Quality Surveillance Group, provider organisation risk registers, quality and performance, the Corporate Risk Register and the Governing Body Assurance Framework. Quarterly reports on Safeguarding for both Children and Adults, and Looked After Children were received. Other quarterly reports included patient experience reports, primary care quality reports, Individual Funding Requests, Serious Incident Reports, and Healthcare Acquired Infections. Regular reports were received focusing on mental health service provider quality assurance, Healthcare Acquired Infections, South West Ambulance Service performance, the review of Continuing Healthcare, Serious Case reviews and Domestic Homicide Reviews, Learning Disability Mortality Review reports, SEND activities, care home quality, updates on Contract Performance Notices, workforce assurance reports, and reports on the Improvement and Assessment Framework. The Committee received specific reports about the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase. The minutes of the Committee are available on our website (https://bnssgccg.nhs.uk/events/).

Strategic Finance Committee

The Strategic Finance Committee is accountable to the Governing Body and is chaired by the Lay Member, Strategic Finance. The Committee considers all draft strategic and financial plans prior to their submission to the Governing Body for approval, including the financial plans associated with the CCG's Operational Plan and savings plans. The Committee monitors the longer term financial strategic direction of the CCG, the delivery of savings plans and the CCG's in year financial performance, identifies key issues and risks requiring discussion and decision by the Governing Body. The Committee has oversight of procurements.

During 2021/22 the Committee received monthly reports on the financial position, the Financial Recovery Plan which included Control Centre deep dives, procurement plans and the Corporate Risk Register and Governing Body Assurance Framework. The Committee received specific reports about the strategic financial impact of the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase. The membership and attendance at meetings are detailed in the table on page 91. The minutes of the Committee are available on our website (https://bnssgccg.nhs.uk/events/).

Patient and Public Involvement Forum

The Patient and Public Involvement Forum was placed on hold due to organisational pressures relating to COVID-19 in March 2020. In the absence of a full Patient and Public Involvement Forum governance process, a working group was convened, chaired by the Governing Body Lay Member for Patient and Public Involvement. The working Group included the chairs of each of the Area Patient and Public Involvement Forum, and the key anchor organisations as outlined in the Terms of Reference of the Patient and Public Involvement Forum. The group has met regularly through 2021/22, and discussed key topics including:

- the planning, delivery, and results of the public consultation for the reconfiguration of Stroke Services
- Urgent and Emergency care insights
- NHS 111 communications campaign development and distribution of campaign materials
- updates on BNSSG Healthier Together Citizen's Panel

The PPIF have also been a key stakeholder in discussions around our transition to becoming an Integrated Care System and the associated work to be done by pace-based partnerships. This has included the working group reviewing the memorandum of understanding and the communications and engagement framework as they have developed. The group has also been involved in the development of our Integrated Care Board (ICB) constitution, and our ICB's "Working with people and communities' strategy". This strategy will set out how we will continue to assure the work of the ICB in this area, as well as broader principles for the way we will work with the population we serve and how we place the voice of our citizens at the centre of decision-making and governance.

Attendance at Governing Body Meetings and its Committees		number of meetings attended in 2021/22						
Name	Title	GB	Audit	Rem	Com Exec	Quality	SFC	PCCC
Dr Jonathan Hayes	Clinical Chair, Chair of Commissioning Executive	10/12			10/10			
Dr Kirsty Alexander	GP Locality Representative Bristol North and West	12/12			8/10			
Colin Bradbury	Area Director North Somerset	11/12			5/10			8/11
Dr Peter Brindle	Medical Director Clinical Effectiveness	12/12			8/10	7/12		
John Cappock	Lay Member, Chair of Strategic Finance Committee	10/12	6/8	4/4			10/11	
Deborah El-Sayed	Director of Transformation	10/12			9/10			
Dr Jon Evans	GP Locality Representative South Gloucestershire	1/11			-			
Dr Kevin Haggerty	GP Locality Representative Weston and Worle	11/12			6/10			
Dr Brian Hanratty	GP Locality Representative Bristol South	4/4						
David Jarrett	Area Director South Gloucestershire	10/12			5/10			8/11
Dr Nick Kennedy	Independent Secondary Care Doctor	11/12	6/8	2/4		9/12		
Dr Julie Boardman	GP Locality Representative Bristol Inner City and East	11/12						
Dr James Case	GP Locality Representative South Gloucestershire	10/12						7/11
Dr Matthew Cresswell	GP Locality Representative North Somerset Woodspring	11/12						
Dr Katrina Boutin	Clinical Commissioning Locality Lead, Bristol							6/11
Lisa Manson	Director of Commissioning	12/12			10/10	12/12		10/11
Alison Moon	Independent Registered Nurse, Chair of PCCC and Quality Committee	11/12		4/4		12/12		9/11
Julia Ross	Chief Executive	11/11			8/10		7/10	9/10
John Rushforth	Lay Member, Chair of Audit Governance and Risk Committee	9/12	8/8	2/4			10/11	9/11
Rosi Shepherd	Director Nursing and Quality	12/12			6/10	10/12		10/11
Sarah Talbot Williams	Lay Member, Patient and Public Involvement Chair of Remuneration Committee, Patient and Public Involvement Forum and PCCC	10/12		4/4		12/12		9/11
Ben Burrows	CCG Clinical Lead Clinical for Governance and Quality					3/12		6/11
Sarah Truelove	Chief Financial Officer	11/12			8/10		11/11	0/11
Christina Gray	Director of Public Health Bristol	10/12						

Attendance at Governing Body Meetings and its Committees		number of meetings attended in 2021/22						
Name	Title	GB	Audit	Rem	Com Exec	Quality	SFC	PCCC
Andrew Appleton	Clinical Corporate Lead – Digital				9/10			
Sara Blackmore	Director of Public Health, South Gloucestershire Council				0/10			
Alison Bolam	Clinical Commissioning Area lead – Bristol				3/10			
Geeta Iyer	Clinical Corporate Lead - Primary Care Provider Development				8/10			
Michael Jenkins	Clinical Care Pathway Lead - Integrated Care				6/10			
Shaba Nabi	Clinical Corporate Lead – Prescribing				9/10			
David Peel	Clinical Care Pathway Lead - Planned Care				10/10			
Lesley Ward	Clinical Care Pathway Lead - Unplanned Care				7/10			
Alison Wint	Clinical Care Pathway Lead - Specialised Care				9/9			

*Or nominated deputy

Annual Assessment of Effectiveness

The CCG commissioned Deloitte to conduct a review of its governance arrangements in January 2021. This independent review was part of a planned three cycles of review that was agreed prior to the announcement of the national move to create Integrated Care Systems. The review was taken forward on the understanding that it would support the transition to a new system and provide learning for successor organisations. The Well-Led Review measured the CCG leadership and governance against the NHSE/I Well-Led Framework and the eight Key Lines of Enquiry. The reviewers found that the CCG demonstrated good performance against the well-led framework overall. A number of positive attributes of governance and leadership arrangements were identified as were a number of areas for further focus. The Governing Body agreed an action plan at its September 2021 meeting (Governing Body paper 7 September 2021: Item 6.3 | NHS Bristol, North Somerset and South Gloucestershire CCG (bnssgccg.nhs.uk) which has been taken forward as part of the programme of work to transition to an Integrated Care Board.

UK Corporate Governance Code

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

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG 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 and powers, supported where appropriate by resources commissioned from South Central and West Commissioning Support Unit (SCWCSU).

Risk management arrangements and effectiveness

Our Risk Management Framework defines the structures for the management and ownership of risk and aligns to and complies with the Treasury "Orange Book". It

encapsulates our attitude to risk and defines how risks are dealt with and by whom. Integrated governance including financial governance is assured through the Audit, Governance and Risk Committee and the Governing Body. The Governing Body receives the minutes of all of its committees, including the Audit, Governance and Risk Committee. The Audit, Governance and Risk Committee is responsible for the oversight of the Risk Management Framework, providing assurance to the Governing Body that the CCG has established an effective system of risk management and internal control. Key committees with responsibility for the management of risks are the Quality Committee, Strategic Finance Committee and Clinical Executive Committee. These committees are responsible for the review and scrutiny of specific risks and seek assurance that risks are properly managed. If a committee is not assured that risks are being properly managed that concern is escalated to the Governing Body.

The Risk Management Framework includes a statement on Risk Appetite. The Governing Body reviewed its Risk Appetite Statement in September 2021.

The Governing Body Assurance Framework identifies where there are risks to our principal objectives, the controls in place to mitigate those risks, and the assurances available to the Governing Body that risks are being managed. The Governing Body Assurance Framework indicates where there are potential gaps in controls and assurances and provides a summary of the actions in place to resolve these gaps. Our Governing Body Assurance Framework is reviewed by directors and is considered by the Governing Body committees as a standing item at their monthly meetings. The Audit, Governance and Risk Committee reviews the Governing Body Assurance Framework at its meetings. The Primary Care Commissioning Committee and the Governing Body review the Governing Body Assurance Framework quarterly.

Risks are identified in a number of ways, including risk profiling through our programme management approach, incident reporting, complaints and litigation, data analysis, staff concerns/whistle blowing, and external and internal audit reports and other regulatory reporting mechanisms.

Risks are evaluated and assessed using a risk scoring matrix which is set out in our Risk Management Framework. Risk is reported through our Directorate and Corporate Risk Registers. Our Corporate Risk Register holds risks that have reached the CCG's risk threshold of 15 and above. It is reviewed by directors as a standing item at Executive Team meetings and is considered by the Governing Body committees as a standing item at their monthly meetings. The Audit, Governance and Risk Committee

reviews the Corporate Risk Register at its meetings, the Primary Care Commissioning Committee, and the Governing Body review the Corporate Risk Register quarterly.

The assessment of risk is embedded within the reporting arrangements for the Governing Body and its committees as part of our standard template, which requires risks to be highlighted. Equality Impact Assessments are used to assist with the identification and mitigation of risks linked to inequalities. Equality Impact Assessments also form part of the standard template for papers to our Governing Body and committees.

There is a process in place for the reporting, investigation, management and learning from incidents. All serious incidents and risks are reported through incident reporting procedures, and the Risk Management Framework refers to our incident reporting procedures and Serious Reporting Policy. Incident reports and trends are used to identify risks, and this is detailed in the Risk Management Framework.

There is commitment to involving patients and members of the public at every stage of the commissioning cycle and this ensures ongoing opportunities for public stakeholders to highlight relevant risks and engage in discussions around how to mitigate them.

In support of the Risk Management Framework and Policy, the CCG has adopted policies that describe its arrangements for managing conflicts of interest and gifts and hospitality, and our approach to tackling fraud and bribery. We have agreed detailed financial policies and have in place a Fraud and Bribery Policy.

Capacity to Handle Risk

It is the policy of the CCG to identify, minimise, control and, where possible, eliminate risks that may have an adverse impact on patients, staff and the organisation. As Accountable Officer, I carry ultimate responsibility for all risks within the CCG.

Our Risk Management Framework describes the governance structures and responsibilities for risk management within the organisation including the roles of the Governing Body and its committees. The Risk Management Framework requires the identification, management and minimisation of events or activities that could result in unnecessary risks to patients, staff, visitors and members of the public. The CCG is committed to possessing the attributes associated with an active learning organisation where lessons learned are embedded into the organisation’s culture and practice.

The Risk Management Framework is available on our website https://bnssgccg.nhs.uk/library/risk-management-framework/. Following the findings of an internal audit into our arrangements for the management of risk, we reviewed and significantly updated our Risk Management Framework. This strengthened and highlighted the responsibilities of the CCG committees for the oversight of risk and the roles of the executives in ensuring risks are reviewed, monitored and updated.

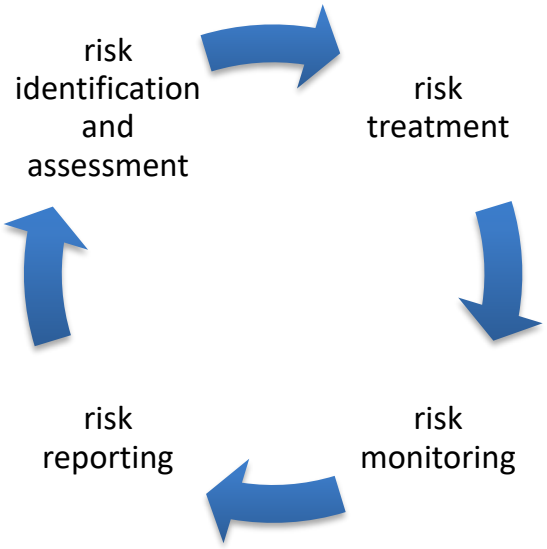
The responsibility for risk management sits with me and the Deputy Chief Executive and Chief Finance Officer who takes an active role in managing risk and provides challenge and oversight.

Risk is monitored through a structured reporting cycle. The Governing Body receives monthly reports on performance and quality, and finance. These reports provide timely, accurate data, which supports our Governing Body in the assessment of risks to our compliance with statutory obligations. The Governing Body and Primary Care Commissioning Committee review quarterly the Governing Body Assurance Framework and the Corporate Risk Register. The Governing Body is supported in its monitoring of risk by the Audit Governance and Risk, Quality Committee, Strategic Finance Committee, and Commissioning Executive. The Governing Body's regular review and interrogation of these reports and other ad hoc reports enable it to have a robust and rigorous oversight of performance.

Staff are required to undertake training for the management of risk where relevant. In addition to core risk management training, training sessions are held and e-learning is available for key topics such as health and safety, manual handling, basic life support, infection control, fire safety, conflict resolution and information governance. Our employees must attend the courses or undertake e-learning on an annual, bi-annual, or three-yearly basis, as appropriate to their role. Learning is taken from good practice, performance management, continuing professional development where relevant, audit and the application of evidence-based practice.

Risk Assessment

Our risk assessment and management process, as described above, is set out in the diagram below.



Risks are identified and assessed using a risk-scoring matrix, risks are analysed, the actions required to mitigate them are identified and implemented and the impact of these mitigations is monitored. Risk reporting to the Governing Body and its committees is through the Governing Body Assurance Framework and the Corporate Risk Register. Major risks to governance, risk management and internal control in 2021/22 that have affected the CCG are detailed below and at page 103 'Control Issues':

- As a result of the impact of Covid-19 there is a risk that the need to focus capacity to meet the demands on the system may result in the system and the CCG not delivering the objectives identified in the Governing Body Assurance Framework
- As a result of the White Paper there is a risk that the progress that was being made on becoming a mature ICS falter due to the distraction caused by the change in organisation form which may result in the systems not delivering the recovery objectives agreed
- The complexity and extent of the change required to set up integrated care partnerships that are capable of holding core service contracts is significant. There is a delivery risk that this opportunity will not be fully realised before the April 2022 deadline.
- As a result of COVID 19 there is a risk that demand for MH services will increase which may result in poorer access and outcomes for people, increased level of mental health crisis and further spend on aspects of services like out of area placements and S117

- People with learning disabilities may lack access to Annual Physical Health Checks and ongoing support, which will result in premature mortality and a widening of health inequalities. People with learning disabilities and/or autism may be admitted to specialist inpatient settings which will reduce their life chances.
- Integrated children's commissioning with Local Authorities is not fully developed, there is a risk that we are not optimising the care children receive and impacting on their life course
- There is a risk that capacity and demand in the CHC service are not aligned, due to increased demand, complexity of cases and capacity and process issues within the team. This has the potential to result in delayed access to the right care for patients, financial pressures for the CCG and non-compliance against national framework standards.
- There is a risk that the progress made in developing the culture and staff experience within the CCG may be disrupted and lost as we transition to becoming an ICS resulting in falling staff satisfaction and increased turnover.
- As a result of the current culture driven by Payment by Results there is a risk that there will be a continuing focus on activity rather than value which may result in failure to deliver improved population health and financial sustainability for the CCG and the system.

Other reported risks included:

- Increased waiting times across key services including A&E, 52 week waiting times, access to planned care and diagnostic services and cancer waiting times, waiting times for MSK services and ADHD services
- Risks related to improvements in the delivery of core mental health services
- Patients were at risk of harm due to ambulances being unable to attend calls within required timeframes
- As a result of reducing capacity in domiciliary and residential care provision there is a risk that we will be unable to sustain care delivery to vulnerable and complex patients which may result in unavoidable hospital admission or that needs will not be met safely or in the place of choice at end of life
- Patients were at risk of potential harm through contracting Healthcare Associated Infections
- Increased risk of health inequalities for cancer patients due to delays in diagnosis

- Risk to the delivery of the Long-Term Plan due to the impact of Covid-19
- The delivery of services such as communications due to staff capacity

The systems used to identify, evaluate and manage the principal and emerging risks faced have been in place throughout 2021/22 and up to the date of the approval of the Annual Report and Accounts.

Other sources of assurance

Internal Control Framework

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

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

Our system of internal control is described through our Standing Orders, Scheme of Reservation and Delegation, and Detailed Financial Policies. These ensure compliance with our statutory requirements for the management of governance. Internal audit and the counter-fraud service provide an independent review of our internal controls.

The risk assessment component of our internal system of control is contained in our Risk Management Framework and Policy. The Governing Body Assurance Framework provides an overview of controls and assurance in place to achieve the CCG's principal objectives.

Our Governing Body has a clear understanding of the key pressures facing the organisation. A key element of our control is providing assurance through regular reporting to the Governing Body, which includes a range of reports including but not limited to:

• Audit and assurance reports

• Minutes of committees of the Governing Body and other key groups

• Strategic planning

• Reports on patient safety and quality of clinical care

• Performance management

• Financial management

Our procurement activities are carried out within the framework of control set out in legislation and regulation. The CCG has a range of policies relating to information governance, human resources, health and safety, equalities and diversity, and emergency preparedness and resilience, all of which contribute to the internal control framework.

As Accountable Officer, I am responsible for reviewing the effectiveness of the system of control and for providing leadership and direction to staff. Other members of the Executive Team have lead responsibility for the specific systems of control as set out below:

Deputy Chief Executive/Chief Finance Officer:

- Governance framework and risk management framework,
- Financial controls and financial risk
- Management of information governance and related risks as the Senior Information Risk Officer (SIRO)

Director of Nursing and Quality:

- Quality of commissioned services
- Patient safety and safeguarding
- Customer experience and complaints

The Director of Commissioning:

- Arrangements for commissioning of services, including procurement
- Performance of commissioned services

The role of all of our Executive Directors is to ensure that appropriate arrangements and systems are in place so that risks are:

- identified and assessed
- eliminated or reduced to an acceptable level
- effectively managed

Executive Directors ensure that staff comply with our policies and procedures and statutory as well as regulatory requirements.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework. I can confirm that the annual internal audit of Conflicts of Interest has been completed and the CCG received an internal audit opinion of 'Substantial assurance'. There were no areas where the CCG was found to be either partially compliant or non-compliant.

Data Quality

The information used by the Governing Body and its Committees enables the CCG to carry out its responsibilities and discharge its statutory functions. Information is strategic operational, financial, or relates to performance, quality and patient experience. The Governing Body and its Committees are engaged in a continuous cycle of improvement with regard to the quality of the information received. The reports received have undergone regular review and improvement. The Governing Body has found the quality of data to be acceptable. No risks relating to the quality of data were highlighted in 2021/22.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The Data Security and Protection Toolkit for 2021/22 is on track to achieve the status of 'Standards Met' by the 30th June 2022 deadline.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient, staff and corporate information. We have established an Information Governance Management Framework and have developed information governance processes and procedures in line with the Information Governance Toolkit. We have ensured all staff undertake annual

information governance training and have implemented a staff Data Security and Information Governance Handbook to ensure staff are aware of their information governance roles and responsibilities.

Information risk management is considered to be the responsibility of all staff. Our Chief Financial Officer is the Senior Information Risk Owner (SIRO) and is responsible for providing assurance to the Governing Body and to me regarding information governance. The SIRO is familiar with, and takes ownership of, information risk management, acting as advocate for information risk management on the Governing Body. The Director of Nursing and Quality is our Caldicott Guardian, actively supporting the CCG and enabling information to be shared where appropriate.

There are processes in place for incident reporting and the investigation of serious incidents and this encompasses information governance. The NHS Digital Guide to the Notification of Data Security and Protection Incidents is used in the investigation of all information governance related incidents.

Business Critical Models

I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models, in line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models.

Third party assurances

The CCG purchases services from the South Central and West Commissioning Support Unit. These services include HR, procurement, IT, and information governance support. Independent assurances on these services are provided through service auditor reports. Day to day assurance of the above services is achieved through regular performance meetings attended by senior members of staff from both organisations. The Service Auditor Reports are shared with the CCG's Chief Financial Officer, and reviewed, and reported through the Audit, Governance and Risk Committee via the Internal Auditors. The Internal Auditor reviewed:

- The Service Auditor Report from the internal auditors of NHS Shared Business Services who provide services to the CCG. Testing for one of the controls, Controls exist to provide reasonable assurance that equipment and facilities are protected from damage by fire, flood and other similar environmental hazards and that physical security is adequate, identified exceptions, but there was no significant impact for the CCG on its overall control environment.

- The Service Auditor Report from the internal auditors for NHS Digital in regards to GP Payments. Testing for two of the controls, controls are in place to provide reasonable assurance that system change cannot be undertaken unless valid, authorised and tested and Controls are in place to provide reasonable assurance that access to systems is controlled identified exceptions, but there was no significant impact for the CCG on its overall control environment.
- The Service Auditor Report from the internal auditors for NHS Business Services Authority in regard to prescription payments. The opinion was qualified in a single area in that controls were not in place to provide appropriate periodic review of user access, and in a number of instances the controls related to timely removal of leavers' access to applications and the network did not operate effectively. No other exceptions were identified and we do not consider this sufficient to impact on our overall Head of Internal Audit Opinion.
- The Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering financial and payroll services. This received a Qualified Opinion as two controls, invoices raised are valid, accurate and processed in a timely manner and Credit notes raised are valid, accurate and processed in a timely manner were found not to operate effectively during the period from 1st April 2021 to 31st March 2022. There was no significant impact for the CCG on its overall control environment.
- Capita Business Services Ltd provides primary care support services for processing GP, ophthalmic and pharmacy payments and pensions administration. Assurance is provided within an Independent Service Auditor's ISAE 3402 third party assurance report, which informs the CCG's Annual Governance Statement. Four out of the 17 control objectives were qualified by the service auditor. In each instance Management has set out improvements to controls to help prevent a recurrence and to mitigate the risk going forwards. Whilst noting the exceptions, we do not consider these sufficiently significant to impact on our overall Head of Internal Audit Opinion.
- We reviewed the Service Auditor Report from the internal auditors of ESR (Electronic Staff Record Programme) who provide a single payroll and Human Resources management system to the CCG. One qualification to the opinion was noted regarding the controls necessary to ensure that access to the development and production areas of the NHS hub was appropriately restricted for a limited

period of the year. This issue was resolved once identified and it does not impact our overall assessment of the controls in operation at the CCG. No other qualifications were noted.

Control Issues

The following control issues and remedial actions were identified and reported in the 2021/22 Month 9 return to NHS England:

Issue: Quality and Performance – Access to services/capacity

Mitigation: action plans to provide additional capacity were put in place, including weekend working, waiting list initiatives, in and out sourcing activity and increased use of the independent sector. Other initiatives included a diagnostic clinical prioritisation programme, a system wide shared endoscopy patient tracking list, regional support for echocardiography and Paediatric MRI. The development of a business case for a BNSSG Community Diagnostic Centre.

Issue: Quality and Performance – Other – Cancer

Mitigation: - actions include insourcing, outsourcing, weekend activity, waiting list initiatives and recruitment across specialist, clinical and administrative roles. The recovery of cancer referral rates in areas below baseline/expected levels is being tackled through campaigns encouraging patients to report to primary care with cancer symptoms and for screening as well as focussed work with primary care. A BNSSG wide non site-specific rapid diagnostic service pilot for patients with “vague symptoms” and who do not meet the criteria for established 2 week wait referrals. Trusts are engaging with System and Cancer Alliance inequalities groups to address screening uptake among people with learning disabilities and serious mental illness. Pathways are being reviewed including system collaborative work on the colorectal pathway to place patients back onto straight-to-test pathways.

Issue: Quality and Performance – Mental Health and Dementia

Mitigation: weekly system wide performance meetings to review progress against Long Term Plan indicators the indicators of the LTP. Board to Board meetings continue to take place on a regular basis.

Issue: A&E Performance is not delivered to NHS Constitution Standards

Mitigation: An agreed winter plan is refreshed monthly to mitigate forecast bed deficits, with a focus on community admission avoidance and discharge schemes, including

extra investment in community beds. The number of COVID cases increased at the end of 2021 and beginning of 2022 and a Level 4 incident was declared nationally. A number of actions were agreed to help manage the system including Personal Health Budgets to support discharge, greater use of the care hotel, and additional beds in all parts of the system. Strategic IPC support is in place and has been supporting providers to manage outbreaks and system and organisational IPC processes.

Issue: RTT is not delivered to NHS Constitution Standards

Mitigation: A system level governance structure enabling sight and scrutiny of RTT position and specialities of concern, the proactive micro-management of long waiting patients, comprehensive waiting list validation and clinical prioritisation and work focused on optimising the use of the independent sector. Other actions include securing additional bed capacity, weekend working, speciality patient tracking lists providing system view of demand and capacity, and initiatives looking at waiting list validation, and supporting or releasing capacity through introducing or enhancing digital and remote capabilities.

Issue: Ambulance services

Mitigation: Whilst maintaining strong resourcing levels, the ambulance service has experienced increased levels of activity and high levels of hospital handover delays, which increased the number of cases waiting in the clinical call stack and affected performance levels, especially Category 2 and Category 3 performance. To mitigate the handover delays and improve performance, actions taken have included increasing ambulance validation in 111, developing access to 24/7 mental health crisis services, developing direct referral protocols and alternative destinations to ED, developing the directory of services, and the implementation of safely reducing avoidable conveyance schemes such as improved access to care plans. A new process has also been agreed at regional level to establish learning from incidents in cases where the SWAST incidents may have been associated with wider system pressures rather than just the organisation.

Issue: Finance, Governance and Control - Finance and Procurement

There were two legal challenges to procurements in 2021/22. Legal advice was taken and both challenges were managed. Both procurements were joint with other organisations and the CCG was not responsible for the management of the procurement in either case.

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

We undertake a comprehensive range of contract monitoring, benchmarking and budget monitoring to ensure the robust management of our resources.

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance.

Detailed performance, quality and finance reports, which include the use of comparative analysis to assess performance, are presented at each Governing Body meeting. These reports provide an overview of progress against key indicators and financial objectives.

Our Audit, Governance and Risk Committee oversees internal and external audit, reviews financial and information systems and monitors the integrity of the financial statements. The Audit, Governance and Risk Committee receives regular reports from Internal and External Audit as well as Counter Fraud. External Audit, as part of its audit plan, reviews the CCG's governance arrangements to identify whether it has in place appropriate arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our Standing Orders, Scheme of Reservation and Delegation and Detailed Financial Policies underpin the use of economic, efficient and effective resources. These are supplemented by budgetary controls and commissioning and other policies and procedures. The Internal Audit Reports relating to our main accounting process have provided assurance regarding these arrangements.

Regular contract management processes are established with main providers to link service quality, performance and financial management; these have been adapted to reflect the system response to the Covid-19 pandemic.

Financial planning and in-year performance monitoring

As per 2020/21, and a consequence of the Covid-19 pandemic, the financial performance management of NHS bodies continued to operate under a temporary financial framework. Funding was provided to enable all CCGs and Integrated Care Systems to deliver a breakeven position. To achieve this baseline allocations were set

based broadly on continuing to fund the run rate expenditure as per 2019/20 (pre-Covid). In addition to this specific targeted allocation were then made:

- System wide allocation to fund direct additional costs of Covid, most notably increases in staff absence and cost premium of infection, prevention & control measures
- Targeted growth in line with NHS Long Term Plan priorities, notably investment in Primary Care and Mental Health
- A smaller number of key funding streams were subject to retrospective reimbursement, in line with Government response to Covid pandemic. Most notably Hospital Discharge Programme (to support NHS and Local Authority Social Care to create additional capacity to support earlier discharge from hospital), Elective Recovery Fund (linked to elective activity delivery) and Covid Mass Vaccinations costs (via lead provider funding model and not CCG allocation)
- Non-Contract Activity with NHS provider Trusts below £200,000 was not chargeable and providers were reimbursed nationally via a 'top up' regime

Again, as per 2021/22 the financial year was split into two halves, with separate allocations made for each half and two NHS budgeting and operational planning rounds. The H2 allocation, from October-March, set at a time when Covid levels were subsiding during Summer 2021, reflected a higher level of efficiency saving requirement and higher threshold to achieve elective recovery funding as the NHS sought to return to pre-pandemic productivity and funding levels.

The finance regime also continued to make progress towards a 'system by default' finance framework as envisaged under the Integrated Care Board regime. For 2021/22 NHS standard contracts with NHS providers remined suspended, most targeted allocations, such as for Covid costs and Provider Top Up funding, were allocated at system level with discretion in the system to allocate to providers. NHS England financial performance focussed on total system financial performance (aggregate of CCG and NHS providers variance against revenue resource limit and capital allocations) rather than individual organisations.

Taken in the round these changes ensured that:

- Unplanned additional costs of the Covid-19 pandemic were able to be funded and decisions made promptly

- Inter-NHS commissioning and contracting did not become a barrier or additional burden on the service
- There remained a mechanism for ensuring value for money
- Progress was made on the Long-Term Plan objective of 'system by default' working

These are welcome initiatives, aligned to the NHS and CCG long-term financial objectives, but caution should be taken when making year-on-year comparisons of expenditure, or relative activity and performance levels.

In response to this, the actions taken continue to include:

- The Audit Governance and Risk Committee and Strategic Finance Committee receiving regular briefings on these changes
- Routine reviews and updates of the Finance, Information and Corporate Services (FICS) Directorate Risk Register
- Periodic reviews of the CCG's financial governance arrangements
- Provision of greater levels of information on the provider sector financial position

Alongside this, where practicable and proportionate, existing financial control mechanisms were maintained.

We have clear and appropriate controls in place for the planning and monitoring of our financial activity including the development and monitoring of savings programmes through a robust programme management approach.

A detailed internal budgeting process and reconciliation to the Long-Term Financial Plan has been established to support delivery of the financial plan.

Regular financial monitoring and reporting arrangements exist and these are accompanied by actions to address emerging financial risks, and development and delivery of recovery plans.

There is robust challenge from the Strategic Finance Committee on the CCG's financial performance, including contract monitoring and the delivery of savings programmes, along with further review from the Governing Body.

Central management costs

Our central management costs are contained within our Running Cost Allowance. The CCG identified and delivered savings to achieve the Running Cost Allowance of £19.3million in 2021/22.

Delegation of functions

Where functions are delegated internally the CCG receives feedback through bottom-up information such as performance reports, the evaluation and assessment of processes, the review of the Governing Body Assurance Framework, evidence from internal audit reports highlighting failures in internal controls and or the poor management of risk and also from feedback from whistle-blowers through its Freedom to Speak Up arrangements (p132).

Where the CCG has chosen to commission business functions from other organisations, services are managed against a service level agreement and subject to regular performance review and independent audit where applicable. The CCG commissions the South Central and West Commissioning Support Unit to provide a number of services. Feedback is gained on business, use of resources and responses to risk through independent assurance, principally Service Auditor Reports. The CCG receives general ledger services from Shared Business Services Limited, and payroll services from North Bristol Trust.

Counter fraud arrangements

The CCG's annual Counter Fraud Plan, focussing on risk-based prevention and deterrence, is overseen by the Audit, Governance and Risk Committee. We have a Counter Fraud Bribery and Corruption Policy, which helps staff to understand in simple terms what fraud, bribery and corruption are and contains useful guides on how to identify fraud, together with details on how to report and how cases will be dealt with. The policy also emphasises that it is the responsibility of all staff to work to prevent fraud and protect the assets of the NHS. The policy is supported by the Management of Conflicts of Interest and Gifts and Hospitality Policies, which set out the honest, transparent and accountable culture that the Clinical Commissioning Group expects. A Local Counter Fraud Specialist (LCFS) is contracted by the CCG to provide counter fraud training to all staff as part of the staff induction programme. Counter Fraud

training is also a mandatory element of the CCG e-learning programme and has recently been updated to improve outcomes.

The Chief Finance Officer is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the organisation, and is also assisted by the Chair of the Audit, Governance and Risk Committee who acts as the Counter Fraud Champion. The LCFS works in consultation with the Chief Finance Officer to identify and report cases of actual or suspected fraud and will ensure that learning identified from any subsequent investigation is implemented.

The Audit, Governance and Risk Committee receives interim reports and an annual report which outlines compliance against each of the Government Functional Standard GovS 013: Counter Fraud, and identified risks are addressed in the annual work plan that is overseen by the Committee. Appropriate action is taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations, in line with NHSCFA Standards.

Head of Internal Audit Opinion

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

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

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

Area of Audit	**Level of Assurance Given**
Complaints Management	Reasonable Assurance
Workforce Sustainability	Reasonable Assurance
Recruitment and Workforce Data	Reasonable Assurance
Conflicts of Interest	Substantial Assurance
Business Continuity (EPRR_	Reasonable Assurance
Financial Controls	Reasonable Assurance
Primary Care Commissioning	Substantial Assurance
Continuing Health Care	Not yet completed
Health Inequalities (advisory)	(advisory audit completed – no opinion given)

Based on the work undertaken on the CCG's system on internal control, the Internal Auditor did not consider that there were issues to be flagged as significant control issues within the Governance Statement.

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 CCG 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 CCG achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, and Audit, Governance and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place:

- The Audit, Governance and Risk Committee agrees an annual plan for work to be undertaken by Internal Audit focusing on areas of particular concern or risk. Reports are made to the Committee on audit findings, with assurance and recommendations being given. Discussions are also held with the External Auditors regarding audit plans, and regular reports are made to the Audit Committee on progress and findings.
- The Audit, Governance and Risk Committee reports to the Governing Body on the development, implementation and monitoring of integrated governance by providing assurance on the systems and processes by which the CCG leads, directs and controls its function in order to achieve organisational objectives, safety and quality of service.
- Internal Audit and Counter Fraud provide assurances through their reports on various aspects of internal control to the Audit, Governance and Risk Committee. These reports also provide assurances and support for the work undertaken by the external auditors.
- The Governing Body receives reports on significant risk identified through the risk register and Governing Body Assurance Framework reports

Conclusion

With the exception of the control issues identified and reported in the 2021/22 Month 9 return to NHS England, no significant control issues have been identified during the year.

Shane Devlin, CEO

Remuneration and Staff Report

The Remuneration and Staff Report provides information about the remuneration of our directors and senior managers, and other matters such as compensation on early retirement or for loss of office, any payments to past directors, the fair pay disclosure and staff numbers and costs. We also report on staff sickness absence, key staff policies, how we engage with staff, and our Freedom to Speak Up arrangements. This is in line with corporate governance best practice.

Remuneration Report

Remuneration Committee and our policy on the remuneration of senior managers and Very Senior Managers

The Remuneration Committee makes recommendations to the Governing Body about the remuneration and allowances for Very Senior Managers (VSM) and persons in senior positions within the CCG. Details of the members of the Committee are given in the Governance Statement in this report.

The policy on the remuneration of VSM, including members of the Governing Body, has been set using NHS England guidance. We have applied national remuneration guidance for VSM pay for 2021/22 and will continue to apply this guidance for the foreseeable future.

Remuneration of Very Senior Managers

Advance approval of the Chief Secretary to the Treasury (CST) is required for remuneration packages at £150,000 or above. Where we have VSM roles that fall into this category we have to complete business cases for the posts, taking into consideration:

- Influence and impact of role
- The specialist nature of the role including the skills and experience required
- Labour market considerations
- Relevant supporting benchmarking data
- The package of the previous incumbent or any obvious comparators
- Only when appropriate, biographical information

Senior manager remuneration (including salary and pension entitlements)

This statement is audited by the external auditors and is covered by the Audit Opinion issued on the CCG's financial statements.

Table 7 Salaries and Allowances 2021-22

		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000) (Note 4)	Long term performance pay and bonuses (bands of £5,000)	All Pension-related benefit (bands of £2,500) (Note 9)	Total (bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Julia Ross (Note 1)	Chief Executive	335-340	0	0-5	0	52.2-55	390-395
Shane Devlin Start date 14/02/2022 (Note 2)	ICB Chief Executive	20-25	0	0	0	95-97.5	115-120
Jon Hayes	Clinical Chair	80-85	0	0	0	0	80-85
Jeffrey Farrar Start date 01/11/2021 (Note 3)	ICB Clinical Chair designate	25-30	0	0	0	0	25-30
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer	150-155	0	0-5	0	0	155-160
Lisa Manson	Director of Commissioning	130-135	0	0-5	0	30-32.5	165-170
Rosalind Shepherd	Director of Nursing and Quality	110-115	0	0-5	0	32.5-35	145-150
Deborah El-Sayed	Director of Transformation	115-120	0	0-5	0	27.5-30	150-155
Julie Bacon Start date – 01/10/2021	Director of People and Transition	65-70	0	0	0	0	65-70

		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000) (Note 4)	Long term performance pay and bonuses (bands of £5,000)	All Pension-related benefit (bands of £2,500) (Note 9)	Total (bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
David Jarrett	Area Director - South Gloucestershire and Bristol	105-110	0	0-5	0	30-32.5	140-145
Colin Bradbury	Area Director - North Somerset	105-110	0	0-5	0	27.5-30	135-140
Peter Brindle	Medical Director	115-120	0	0-5	0	42.5-45	160-165
Kirsty Alexander (Note 5)	GP Locality Representative	35-40	0	0	0	0	35-40
Brian Hanratty End date 20/0/8/2021 (Note 6)	GP Locality Representative	0-5	0	0	0	0	0-5
Kevin Haggerty (Note 6)	GP Locality Representative	10-15	0	0	0	0	10-15
Jon Evans (Note 6)	GP Locality Representative	10-15	0	0	0	0	10-15
Julie Boardman Start date 01/04/2021	GP Locality Representative	10-15	0	0	0	0	10-15
James Case Start date 01/04/2021	GP Locality Representative	10-15	0	0	0	0	10-15
Matthew Cresswell Start date 01/04/2021	GP Locality Representative	10-15	0	0	0	0	10-15

		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000) (Note 4)	Long term performance pay and bonuses (bands of £5,000)	All Pension-related benefit (bands of £2,500) (Note 9)	Total (bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
John Rushforth	Independent Lay Member - Chair Audit, Governance and Risk	20-25	0	0	0	0	20-25
John Cappock	Independent Lay Member - Strategic Finance	20-25	0	0	0	0	20-25
Sarah Talbot-Williams	Independent Lay Member - Patient and Public Engagement	25-30	0	0	0	0	25-30
Alison Moon (Note 7)	Independent Member - Registered Nurse	25-30	0	0	0	0	25-30
Nick Kennedy	Independent Member - Secondary Care Doctor	25-30	0	0	0	0	25-30
Christina Gray (Note 8)	Representative local authority - Public Health	0	0	0	0	0	0

Table 8 Salaries and Allowances 2020-21

		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000) (Note 4)	Long term performance pay and bonuses (bands of £5,000)	All Pension-related benefit (bands of £2,500) (Note 9)	Total (bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Julia Ross (Note 1)	Chief Executive	160-165	0	0	0	0	30-35
Jon Hayes	Clinical Chair	80-85	0	0	0	0	80-85

		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000) (Note 4)	Long term performance pay and bonuses (bands of £5,000)	All Pension-related benefit (bands of £2,500) (Note 9)	Total (bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer	150-155	0	0	0	0	150-155
Lisa Manson	Director of Commissioning	130-135	0	0	0	25-27.5	160-165
Rosalind Shepherd	Director of Nursing and Quality	105-110	0	0	0	150-152.5	255-260
Deborah El-Sayed	Director of Transformation	115-120	0	0	0	25-27.5	145-150
David Jarrett	Area Director - South Gloucestershire and Bristol	105-110	0	0	0	22.5-25	130-135
Colin Bradbury	Area Director - North Somerset	105-110	0	0	0	25-27.5	135-140
Peter Brindle	Medical Director	115-120	0	0	0	0	100-105
Martin Jones End date - 01/12/2020	Medical Director - Commissioning and Primary Care	55-60	0	0	0	2.5-5	60-65
David Soodeen End date – 07/07/2020	GP Locality Representative	55-60	0	0	0	0	55-60
Kirsty Alexander (Note 5)	GP Locality Representative	55-60	0	0	0	0	55-60

		Salary (bands of £5,000)	Expense payments (taxable) (Rounded to the nearest £100)	Performance pay and bonuses (bands of £5,000) (Note 4)	Long term performance pay and bonuses (bands of £5,000)	All Pension-related benefit (bands of £2,500) (Note 9)	Total (bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Brian Hanratty (Note 6)	GP Locality Representative	50-55	0	0	0	0	50-55
Kevin Haggerty (Note 6)	GP Locality Representative	35-40	0	0	0	0	35-40
Jon Evans (Note 6)	GP Locality Representative	35-40	0	0	0	0	35-40
John Rushforth	Independent Lay Member - Chair Audit, Governance and Risk	20-25	500	0	0	0	20-25
John Cappock	Independent Lay Member - Strategic Finance	20-25	0	0	0	0	20-25
Sarah Talbot-Williams	Independent Lay Member - Patient and Public Engagement	25-30	0	0	0	0	25-30
Alison Moon (Note 7)	Independent Member - Registered Nurse	25-30	0	0	0	0	25-30
Nick Kennedy	Independent Member - Secondary Care Doctor	25-30	0	0	0	0	25-30
Christina Gray (Note 8)	Representative local authority - Public Health	0	0	0	0	0	0

Notes:

No senior manager waived his/her remuneration.

1 This employee has been made redundant due to the impending closedown of NHS Bristol, North Somerset and South Gloucestershire CCG. The package was agreed before 31 March 2022 and payment includes redundancy of £126,666 and payment in lieu of notice of £49,445. The package has been agreed in line with HMT Treasury rules. This will be paid in April 2022 and is included in the figures above.

2 Shane Devlin has been appointed as Chief Executive Designate of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board which will be taking over the functions of the CCG from 1st July 2022 in line with a national re-organisation of Health Services.

3 Jeffrey Farrar has been appointed as Chair Designate of NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board which will be taking over the functions of the CCG from 1st July 2022 in line with a national re-organisation of Health Services.
4 A performance award was paid to the directors in line with the letter from the Chief People Officer for the NHS dated 8 September 2021. The payments were approved at the Remuneration Committee on 2 November 2021.
5 The salary figure combines remuneration for the Governing body role and a broader clinical leadership role, £12,320 relates to the Governing Body role
6 The salary figures for 2020/21 included earnings for Local leadership and/or clinical leads roles which ceased in the financial year 2021/22
7 The employee was paid £2,625 for clinical work for the mass vaccination programme which has been recharged to North Bristol Trust. This is not included in the figure above

8 This is non-remunerated post.

9 All Pensions Related Benefits
The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.
This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
The pension benefit table provides further information on the pension benefits accruing to the individual
Factors determining the variation in the values recorded between individuals include but is not limited to :

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual.

Table 9 Pension benefits as at 31 March 2022

This statement is audited by the external auditors and is covered by the Audit Opinion issued on CCG's financial statements.

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 01 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Julia Ross	Chief Executive	2.5-5	5-7.5	60-65	185-190	1439	84	1554	0
Shane Devlin (Note 1)	ICB Chief Executive	0-2.5	0	5-10	0	0	0	5	0
Lisa Manson	Director of Commissioning	2.5-5	0	50-55	100-105	838	30	891	0
Rosalind Shepherd	Director of Nursing and Quality	0-2.5	5-7.5	45-50	145-150	1081	61	1165	0
Deborah El-Sayed	Director of Transformation	0-2.5	0	35-40	65-70	639	26	686	0
David Jarrett	Area Director - South Gloucestershire & Bristol	0-2.5	0-2.5	35-40	70-75	573	25	615	0
Colin Bradbury	Area Director - North Somerset	0-2.5	0	30-35	45-50	479	22	519	0
Peter Brindle	Medical Director	2.5-5	0-2.5	45-50	90-95	823	44	897	0

Table 10 Pension benefits as at 31 March 2021

This statement is audited by the external auditors and is covered by the Audit Opinion issued on CCG's financial statements.

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 01 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£000
Julia Ross	Chief Executive	0	0	55-60	175-180	1499	0	1439	0
Lisa Manson	Director of Commissioning	0-2.5	0	45-50	100-105	780	25	838	0
Rosalind Shepherd	Director of Nursing and Quality	5-7.5	20-22.5	45-50	140-145	877	171	1081	0
Deborah El-Sayed	Director of Transformation	0-2.5	0	35-40	65-70	589	23	639	0
David Jarrett	Area Director - South Gloucestershire & Bristol	0-2.5	0	35-40	70-75	529	20	573	0
Colin Bradbury	Area Director - North Somerset	0-2.5	0	25-30	45-50	437	20	479	0
Peter Brindle	Medical Director	0-2.5	0	40-45	85-90	790	0	823	0

Notes:

1 The pension figures are only for this employment. The individual was previously a member of the North Ireland NHS Pension scheme and the membership does not automatically transfer.

2 The CCG has no pension liabilities for Sarah Truelove, Deputy Chief Executive and Chief Finance Officer, Julie Bacon, Head of People and Transition, Jeffrey Farrar, ICB Chair Designate and Dr K Haggerty. None of these employees are contributing to the NHS Pension Scheme.

3 Independent Lay Members do not receive pensionable pay.

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 or for loss of office

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements. Julia Ross, Chief Executive has been made redundant; information has been disclosed in the Salaries and Allowances and Exit Packages tables. No payments for compensation on early retirement were received by any senior managers in 2021/22 (Nil in 2020/21).

Payments to past directors

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements. No compensation was paid to any former senior manager in 2021/22 (nil 2020/21).

Fair Pay Disclosure

This statement is audited by the external auditors and is covered by the Audit Opinion issued on CCG's financial statements. Reporting bodies are required to disclose pay ratio information and detail concerning percentage change in remuneration concerning the highest paid director.

Percentage change in remuneration of highest paid director

The single total figure table (11) reports on the following components, salary and allowances, and performance pay and bonuses. Entities are required to disclose separately for each single total figure table component:

a - The percentage change from the previous financial year in respect of the highest paid director, and;

b - The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole.

Two percentage figures will therefore be provided for each single total figure component, giving a total of four percentages to be disclosed for each financial year under this requirement. The calculation for salaries and allowances shall be based on the mid-point of the band for each salary and performance pay and bonuses payable.

The calculation for salaries and allowances is the total for all employees on an annualised basis, excluding the highest paid director, divided by the FTE number of

employees (also excluding the highest paid director). The calculation in respect of performance pay and bonuses payable is the total for all employees, excluding the highest paid director, divided by the FTE number of employees (also excluding the highest paid director).

Table 11 Percentage change in remuneration of highest paid director

2021/22	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	6.15%	Nil
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	7.23%	Nil

The highest paid director in 2021-22 is Shane Devlin, ICB Chief Executive, in 2020-21 the highest paid director was Julia Ross, CCG Chief Executive. The remuneration package for the ICB Chief Executive is greater than the CCG Chief Executive to reflect the enhanced role.

The highest paid director in 2021-22 did not receive performance pay. In the years 2021-22 and 2020-21 only those directors as reported in the salaries and allowances table received performance pay. No performance pay was paid to staff members.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The banded remuneration of the highest paid director/member annualised salary in NHS Bristol, North Somerset and South Gloucestershire CCG in the financial year 2021-2022 was £175,000 (2020-21, £160,696). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

Table 12 Pay Ratio Information 2021-22

	25th percentile	Median Salary	75th percentile
Total Remuneration (£)	£31,534	£40,057	£53,219
Salary component of total remuneration (£)	£31,534	£40,057	£53,219
Ratio to highest paid director – Total remuneration	5.47	4.31	3.24
Ratio to highest paid director - Salary component of total remuneration	5.47	4.31	3.24

Table 13 Pay Ratio Information 2020-21

	25th percentile	Median Salary	75th percentile
Total Remuneration (£)	£26,970	£37,890	£45,753
Salary component of total remuneration (£)	£26,970	£37,890	£45,753
Ratio to highest paid director – Total remuneration	6.03	4.29	3.55
Ratio to highest paid director - Salary component of total remuneration	6.03	4.29	3.55

In 2021-22 a contractor was engaged as System Chief Operating Office for the ICB on an annualised salary of £374,000 which is higher than the highest paid director (£175,000). In 2020-21 no employees or contractors pay exceeded the salary of the highest paid director. Remuneration ranged from £12,320 to £374,000, (2020-21 £12,320 - £160,696). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The ratio of salary and remuneration to the highest paid director at each percentile point reflects two issues:

1 - the midpoint of the annualised salary for the highest paid director in 2021/22 is higher and;

2 - the salary banding for each percentile has increased in 2021/22, so the salary movement reflects the pay award and banding increase.

The salary mix has been impacted by the transfer of the Healthier Together team and increased use of agency staff.

Staff Report

Number of senior managers, staff numbers and costs

Staff Costs 2021/22

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements.

Table 14 Staff costs 2021/22

	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	10,347	762	11,109	7,287	1,694	8,981	17,634	2,456	20,090
Social security costs	1,203	-	1,203	771	-	771	1,974	-	1,974
Employer contributions to the NHS Pension Scheme	2104	-	2,104	1,355	-	1,355	3,459	-	3,459
Apprenticeship Levy	82	-	82	-	-	-	82	-	82
Termination Benefits	127	-	127	-	-	-	127	-	127
Gross employee benefits expenditure	**13,863**	**762**	**14,625**	**9,413**	**1,694**	**11,107**	**23,276**	**2,456**	**25,732**

Staff Costs 2020/21

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements.

Table 15 Staff costs 2020/21

	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	10,286	587	10,873	5,555	839	6,394	15,841	1,426	17,267
Social security costs	1,170	-	1,170	577	-	577	1,747	-	1,747
Employer contributions to the NHS Pension Scheme	2,096	-	2,096	1,051	-	1,051	3,147	-	3,147
Apprenticeship Levy	73	-	73	-	-	-	73	-	73
Gross employee benefits expenditure	**13,625**	**587**	**14,212**	**7,183**	**839**	**8,022**	**20,808**	**1,426**	**22,234**

Staff Numbers 2021/22

There was an average of number 89 Senior Managers between 1 April 2021 and 31 March 2022.

Table 16 Senior Manager Numbers

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	3	8	0	0	0	5	3	8
Band 9	5	1	6	0	0	0	5	1	6
Band 8D	2	5	7	3	0	3	5	5	10
Band 8C	19	9	28	5	1	6	24	10	34
Band 8B	14	13	27	2	2	4	16	15	31
Total	**45**	**31**	**76**	**10**	**3**	**13**	**55**	**34**	**89**

This statement is audited by the external auditors and is covered by the Audit Opinion issued on CCG's financial statements with the exception of the gender analysis.

Our average number by Staff, by Staff categories between 1 April 2021 and 31 March 2022.

Table 17 Staff Numbers

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	182	64	246	10	2	12	192	66	258
Medical and Dental	4	4	8	1	0	1	5	4	9
Add Professional. Scientific and Technical	16	6	22	0	0	0	16	6	22
Nursing and Midwifery	49	6	55	0	0	0	49	6	55
Allied Health Professionals	0	0	0	0	0	0	0	0	0
Estates and ancillary	0	1	1	0	0	0	0	1	1
Senior Managers	45	31	76	10	3	3	55	34	89
Total	**296**	**112**	**408**	**21**	**5**	**26**	**317**	**117**	**434**

Staff Numbers 2020/21

There was an average of number 76 Senior Managers between 1 April 2020 and 31 March 2021.

Table 18 Senior Manager Numbers

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	3	8	0	0	0	5	3	8
Band 9	4	1	5	3	1	4	7	2	9
Band 8D	1	5	6	1	1	2	2	6	8
Band 8C	18	9	27	1	0	1	19	9	28
Band 8B	14	8	22	0	1	1	14	9	23
Total	**42**	**26**	**68**	**5**	**3**	**8**	**47**	**29**	**76**

This statement is audited by the external auditors and is covered by the Audit Opinion issued on CCG's financial statements with the exception of the gender analysis.

Our average number by Staff, by Staff categories between 1 April 2020 to 31 March 2021.

Table 19 Staff Numbers

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	162	59	221	3	1	4	165	60	225
Medical and Dental	5	5	10	1	0	1	6	5	11
Add Professional. Scientific and Technical	14	6	20	0	0	0	14	6	20
Nursing and Midwifery	53	7	60	1	0	1	54	7	61
Allied Health Professionals	1	0	1	0	0	0	1	0	1
Senior Managers	42	26	68	5	3	8	47	29	76
Total	**277**	**103**	**380**	**10**	**4**	**14**	**287**	**107**	**394**

Staff Composition 2021/22

There were 97 Senior Managers (headcount) between 1 April 2021 and 31 March 2022.

Table 20 Senior Manager composition

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	6	3	9	0	0	0	6	3	9
Band 9	5	1	6	0	0	0	5	1	6
Band 8D	1	6	7	3	0	3	4	6	10
Band 8C	21	9	30	6	1	7	27	10	37
Band 8B	16	14	30	3	2	5	19	16	35
Total	**49**	**33**	**82**	**12**	**3**	**15**	**61**	**36**	**97**

Staff Composition 2020/21

There were 83 Senior Managers (headcount) between 1 April 2020 and 31 March 2021.

Table 21 Senior Manager composition

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	4	9	0	0	0	5	4	9
Band 9	4	1	5	5	1	6	9	2	11
Band 8D	1	5	6	1	1	2	2	6	8
Band 8C	19	9	28	1	0	1	20	9	29
Band 8B	16	9	25	0	1	1	16	10	26
Total	**45**	**28**	**73**	**7**	**3**	**10**	**52**	**31**	**83**

The Bristol, North Somerset and South Gloucestershire Healthier Together Integrated Care System staff team transferred to the CCG on the 1st January 2022. A total of 39 staff TUPE transferred to the CCG.

The number of agency workers has increased in the period due to the CCG hosting the Bristol, North Somerset and South Gloucestershire Healthier Together Integrated Care System staff team and an increase in specific, on-off, projects.

Sickness absence data

We have a detailed and robust Sickness Absence Policy. A range of services are available to support staff at work or returning to work. These services include access to Occupational Health and an Employee Assistance Programme, which includes access to

counselling sessions. The Human Resources team have worked with managers on best practice for managing sickness absence, how to identify and manage stress, how to support employees with disabilities in the workplace and how to increase wellbeing amongst staff.

In order to fully support our staff as we went into lockdown on 22 March 2020 the CCG set up a wellbeing working group to support its Business Critical Response Centre. This was an integral part of ensuring that we were listening to and responding to staff concerns and providing a comprehensive wellbeing support offer to staff. The Covid-19 response has now reduced but this group has continued and now reports into the People Plan Steering Group.

The Wellbeing Group have created and collated a huge portfolio of resources for staff to support health and well-being. These resources have been collated in one place to ensure that everyone can easily access all of the wide-ranging support available. This resource bank has been promoted to staff and managers to help them in signposting to the most appropriate resources if needed.

We are required to report annual sickness absence data for the calendar year 2021.

The CCG had an average number of full time equivalent members of staff (FTE) of 391 over the period January 2021 to December 2021. The full time equivalent possible working days available was 145,030. The table below has been provided by the NHS Digital, using the Electronic Staff Record Data Warehouse.

Table 22 FTE Members of Staff

	Number of FTE staff (average 1 January 2021 to 31 December 2021)	Sum of FTE Days Sick	Sum of FTE Days Available	FTE sickness absence %	Average Annual Sick Days per FTE
NHS Bristol, North Somerset and South Gloucestershire CCG	391	3,885	145,030	2.7%	6.0

Staff turnover percentages

Bristol, North Somerset and South Gloucestershire staff turnover is reported via NHS digital, (NHS Workforce Statistics - December 2021 (Including selected provisional statistics for January 2022) - NHS Digital), a series of official statistics publication

complying with the UK Statistics Authority's Code of Practice. During the period December 2020 to December 2021 there have been 101 members of staff join the CCG and 79 staff members who have left. Staff turnover measures the number of staff who leave an organisation during a period of time. The CCG staff turnover for the period December 2020 to December 2021 is reported as 168% based on a headcount of 79 leavers.

Whilst the turnover rate measures the outflow of people from an organisation and is expressed in terms of the number of people who leave over a period of time, the stability rate calculates the proportion of the workforce who remain employed for a specified period and measures how effectively the organisation is retaining staff. The CCG's stability index is reported as 82.8% of employees were retained during the period December 2020 and December 2021.

Staff engagement percentages

Staff engagement remains important and in 2021 the CCG participated in the Annual NHS Staff Survey. There were 385 responses, which equates to a response rate of 84%. This was consistent to the response rate from 2020 reported at 85% demonstrating good staff engagement. The CCG performance was higher than the 79% national average from similar organisations. The full Staff survey can be found at NHS Staff Survey Results 2021. The CCG is engaging staff and directorate action plans are being developed as the CCG transitions to the ICB.

The organisation maintains staff engagement through a variety of routes including our staff networks in the following areas: disability, LGBTQ+, parents and carers. The CCG also has an Inclusion Council and a Staff Partnership Forum that meet monthly. A variety of communication methods are used to maintain staff engagement including the weekly Have We Got News For You sessions with the Chief Executive and the Voice, a weekly email bulletin, monthly line manager briefings, staff survey engagement sessions, regular staff temperature checks and the Chief Executive's blog/vlog.

Staff policies

We describe in detail our work to reduce inequalities in line with the Public Sector Equality Duty 2011 in the Performance section of the Annual Report (p63). We ensure fair and equitable treatment of all staff and applicants applying for any advertised posts. Our Recruitment and Selection Policy outlines the requirements for recruiting managers

to make reasonable adjustments for disabled candidates where applicable, and this is reinforced through the line management training courses run for all staff with people management responsibilities.

All staff with a declared disability or who become disabled during their employment will have access to appropriate training courses, and career development opportunities, and access to appropriate promotion opportunities. Reasonable adjustments are made to support these people with accessing and benefitting from these opportunities. All our policies that relate to the continued employment and training of disabled staff have been equality impact assessed to ensure they are not detrimental to any staff with protected characteristics, including disabled persons. These policies include (but are not restricted to) the Managing Sickness Absence Policy, Bullying and Harassment Policy, Disciplinary and Grievance Policy, Managing Performance (Capability Policy), Flexible Working Policy and Equality and Diversity in Employment Policy. All policies are developed in line with Agenda for Change Terms and Conditions where applicable. Further information about our work related to equality and diversity can be found in the Performance Analysis section of this report (p64).

We continue to review and develop staff policies. All of these are subject to consultation with staff and Trade Union representatives through the Staff Partnership Forum. All policies are developed to ensure we are able to recruit and retain a diverse workforce whilst ensuring equal treatment of staff and meeting the organisation's duty of care around staff health and safety at work. All new policies have an Equality Impact Assessment to ensure they are not detrimental to staff on the basis of any protected characteristics as defined in the Equality Act 2010. We regularly monitor the diversity of our workforce.

We have continued our policy development programme reflecting the Terms and Conditions of Employment set out under Agenda for Change. During 2020/21 we reviewed our Appraisal Policy and Disciplinary Policy taking in to account the requirement to review CCG practice following the response to findings from an Independent Inquiry and NHS England and NHS Improvement Task and Finish Advisory Group, into a tragic event that occurred at Imperial College Healthcare NHS Trust.

NHSE/I formally wrote to all NHS organisations asking them to review the guidance and recommendations and assess against their current procedures and processes, and

importantly, adjust where required, to bring the organisation in line with best practice. Each policy is accompanied by an Equality Impact Assessment to identify and mitigate any risks to staff on the basis of any protected characteristics as defined in the Equality Act 2010. We have also reviewed our Flexible Working policy to support the movement to the CCG's hybrid working model and to implement the legislative changes in accordance with the Agenda for Change Handbook. Communication and engagement were key in launching the CCG's hybrid working model which maintains the mixture of working from home and the office developed during the pandemic. The approach was led by staff insight and how staff told us they wanted to work. Using results from previous survey engagement, focus groups and feedback gathered via staff representatives, the hybrid working model was developed. The aim of the model is to further embed flexible working in our organisational culture, increase staff autonomy over their working patterns, incorporate the most valuable aspects of home- and office-working into one way of working, and empowering our staff to tailor their workweek around what is best for them, their wellbeing, and their role. To support staff working remotely we have also developed a range of wellbeing initiatives to help staff remain connected.

We will continue to develop new staff policies and review existing policies as we transition into the ICB. All of these will be subject to consultation with staff and Trade Union representatives through the Staff Partnership Forum, which continues to meet regularly and provides a constructive space for collaboration between staff representatives, and management.

Freedom to Speak Up

We have in place policies to support staff when raising concerns, including our Freedom to Speak Up Policy, Fraud and Bribery Policy, and Bullying and Harassment Policy. Freedom to Speak Up was introduced by Sir Robert Francis following a 2015 review into NHS 'whistleblowing' processes. It incorporates whistleblowing and extends beyond that to develop cultures where concerns are identified and addressed at an early stage before people feel the need to 'blow the whistle'.

Freedom to Speak Up is hugely important to us and we are committed to ensuring that a culture of speaking up is embedded throughout our organisation, and that effective processes are in place to support staff. Our Freedom to Speak Up Policy provides a framework that supports a culture where staff feel comfortable to raise concerns. The

policy gives guidance and advice to staff on raising a concern. Our Freedom to Speak Up network includes our Freedom to Speak Up Guardian, Sarah Talbot-Williams, a Governing Body Lay Member, and two champions, Sarah Truelove and David Jarrett, both Executive Directors.

We have consistently promoted the opportunity for staff to use the FTSU route to raise concerns in 2021/2022

Trade Union Facility Time Reporting Requirements

The total number of employees who were relevant union officials during the period 1st April 2021 to 31st March 2022 is:

Table 23

Number of employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

Other employee matters

Organisational Development

We have maintained our commitment to the development and welfare of its workforce. Access to team and individual development through courses and apprenticeships is facilitated through the executive-led Learning and Development Panel.

Line management leadership training was offered to all staff in Bands 5 – 8a with line management responsibility. It was delivered remotely over 4 workshops which included themes of leading self, leading others, leading change, and HR Toolkit and was well attended.

In June, we launched of a cohort of 13 junior project managers across Healthier Together who began the Level 4 Associated Project Manager Apprenticeship. This is a significant investment for the CCG in valuing the development of staff through an 18 month, 'on the job' training programme. We have also used our apprentice levy to support other individual apprenticeships at differing levels.

The Learning and Development Panel has approved several professional development opportunities for staff which has included: business modules with the Open University, Elizabeth Garret Anderson Masters level qualification with the NHS Leadership

Academy, Rosalind Franklin with the NHS Leadership Academy, Knowledge Mobilisation with UWE and Economic Evaluation with Bristol University.

The CCG is collaborating with System partners with the NHS Graduate Management Scheme. This year we welcomed two graduate trainees to the CCG taking up roles within Programme Management Office and Integrated Care Partnerships. The orientation programme is held as an exemplar by the Leadership Academy for its wider system partnership approach and includes the involvement in NBT, Sirona and Brisdoc exposing the trainee graduates to the life journey of a patient.

Corporate induction has continued with sessions being delivered on Teams, every other month to ensure new starters are onboarded well.

Another area of support that we have maintained has been our appraisal arrangements which, following the input from our internal auditors, have been reviewed and relaunched.

Moving to hybrid working

In August 2021 we launched our hybrid working model; a significant organisational development linked to our response to the pandemic. Communication and engagement were key to this work. The approach was led by staff insight and how staff told us they wanted to work. Using results from previous survey engagement, focus groups and feedback gathered via staff representatives, the hybrid working model was developed. The aim of the model is to further embed flexible working in our organisational culture, increase staff autonomy over their working patterns, incorporate the most valuable aspects of home- and office-working into one way of working, and empowering our staff to tailor their workweek around what is best for them, their wellbeing, and their role.

After the launch of the hybrid working model, initial feedback indicated that staff sought more clarity over: the model and how it applied to them; situations in which it would be appropriate to work from the office; whether working patterns or environments would be assigned; and concerns over Covid-19.

To facilitate a widespread understanding of the fundamentals of hybrid working, we created a short graphic video to explain what hybrid working meant, what it didn’t mean, situations where staff might want to work in the office, and finally what was expected of all staff and line managers. After the launch of this video explainer, we included targeted questions in the regular temperature check survey to test staff understanding of the hybrid working model and uncover areas of concern that had not yet been

addressed. The results of this survey showed that 76% of staff either “definitely” or “pretty much” understood what hybrid working meant and how this applied to them.

Staff Partnership Forum

The Staff Partnership Forum (SPF) was established in 2018/19 as the CCG’s engagement forum with staff around any organisational development plans and actions, as well as any formal consultations and policy changes. The SPF consists of staff members across varying levels of the organisation, with each Directorate represented by at least one staff member. Arrangements have remained in place for consultation and engagement on matters of mutual interest during this year.

Health, Safety and Welfare

Despite our staff mainly working remotely, we have maintained our relationships with our building landlords to ensure that offices remain Covid Secure and that there are common ways of working between tenants accessing facilities. We have ensured that there are enhanced cleaning regimes and, social distancing and PPE available. Communication is maintained and government guidance is regularly reviewed.

We have undertaken risks assessments of staff to support access to offices and balanced the risks of infection with other issues including isolation and any adverse effects caused by working from domestic settings.

Wellbeing Working Group

The work of the Wellbeing Group has remained during this year having been established in the early stages of our pandemic response.

Staff have been really receptive to the wellbeing programme, the group has two staff co-chairs, there are seven members from various roles and grades across the CCG. The group also has senior oversight with an Executive Senior Responsible Officer, David Jarrett, Area Director – South Gloucestershire and Bristol. The group devises a theme to focus wellbeing activities on and they plan, collate and share resources, staff blogs and/or digital learning / activity sessions to support these themes. Members work in a buddy system and divide the months between them to ensure that workload is manageable and shared.

In the year that this group has been operating they have created and collated a huge portfolio of resources for staff. These have been collated in one place to ensure that

everyone can easily access all of the wide-ranging support available. This stocktake has been promoted to staff and managers to help them in signposting to the most appropriate resources if needed.

During the lockdowns various regular activities were established to ensure staff were connected, some of these were extremely popular and continued into this year, for example ‘Virtual Kitchen Club’ (VKC) – a weekly ‘tea break’ hosted by staff who want to connect online. The Round the World Challenge an online group who share their personal steps achieved by walking, running, cycling and the group chart their progress around the world to encourage exercise.

The group used the internal communication weekly temperature check to ask staff questions about the wellbeing support they wanted, any gaps or any challenges they would like the organisation to support with. This insight helped inform and guide the wellbeing activity that took place. It also helped us to better understand how well supported and connected staff were to the CCG. It was used to identify key areas of concern so that the organisation could respond in real time. This also has continued and provides valuable insight on staff concerns and feeling. It now runs monthly to ensure that staff do not get survey fatigue and to ensure that we are responding and acting on what staff tell us.

The wellbeing working group introduced monthly themes to help target support around topical issues. For example, Getting Active, relaxation and self-care and parental back to school support in September. A compendium of support including access to formal arrangements such as Occupational Health and our Employee Assistance Programme are advertised on our intranet. The temperature checks provide benchmarking and enabled us to better understand how supported staff continued to feel.

Expenditure on consultancy

The consultancy expenditure for the financial year 2021/22 was £1,023,000 and this can be analysed as follows:

Table 24 Consultancy Expenditure

Consultancy Category	2021/22 £'000	2020/21 £'000
Finance	26	11
Human Resources, Training and Education	4	0
Technical	67	62
Organisation and Change Management	804	136
Procurement	12	0
Property and Construction	0	0
Strategy	110	52
Total	1,023	261

The consultancy Organisation and Change Management spend relates to the Healthy Weston programme, the Peloton Development programme and General Practice Integration at ICP/ICB level. The Strategy Consultancy spend relates to the Stroke programme and the Healthy Weston programme.

Off-payroll engagements

NHS bodies are required to include disclosures in 2021/22 about their off-payroll engagements, and the details for the CCG are set out in the tables below.

Table 25 Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day (Note 1).

	Number
Number of existing engagements as at 31 March 2022	3
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at time of reporting	
for between two and three years at time of reporting	
for between three and four years at time of reporting	2
for four or more years at time of reporting	

Table 26 Off- payroll workers engaged at any point during the financial year

For all off-payroll engagement between 1 April 2021 and 31 March 2022, for more than £245 per day (Note1)

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 22	36
Of which:	
Number not subject to off-payroll legislation (Note 2)	35
Number subject to off-payroll legislation and determined as in-scope of IR35 (Note 2)	1
Number subject to off-payroll legislation and determined as out of scope of IR35 (Note 2)	0
Number of engagements reassessed for consistency or assurance purposes during the year	0
Of which: the number of engagements that saw a change to IR35 status following review	0

Table 27 Off-payroll Governing Body member/senior official engagements

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

Number of off-payroll engagements of Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year. This figure includes both on payroll and off -payroll engagements	25

Notes

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 CCG must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Exit packages

This statement is audited by the external auditors and is covered by the Audit Opinion issued on CCG's financial statements.

Exit packages, including special (non-contractual) payments

Exit packages were agreed for two individuals in the financial year 2021-22, one included redundancy and lieu in notice payment and the second package was for Special Severance payment.

Table 28 Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000**	0	0	1	5,389	1	5,389	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000*	0	0	1	49,445	1	49,445	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000*	1	126,666	0	0	1	126,666	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**1**	**126,666**	**2**	**54,834**	**3**	**181,500**	**0**	**0**

Agrees to Table 29 below

Redundancy and other departure cost have been paid in accordance with the provisions of The NHS Terms and Conditions of Service (Agenda for Change). Exit costs in this note are the full costs of departures agreed in the year. Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not include in the table.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Table 29 Analysis of Other Departures 2021/2022

Type of Other Departures	Agreements Number	Total Value of Agreements £000s	
Contractual payments in lieu of notice	1	50	
Non-contractual - special severance payment	1	5	
Total	**2**	**55**	**Agrees to total in Table 28**

* As single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in this Note which will be the number of individuals. The exit package for J Ross includes redundancy of £126,666 and payment in lieu of notice of £49,445

** This payment has been classified as Special Severance payment and is reported in Losses and Special payment note in the accounts.

There are no non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Table 30 Exit Packages 2020/2021

There were no exit packages in 2020/21 but two payments in lieu of notice.

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	0	0	2	6,235	2	6,235	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**0**	**0**	**2**	**6,235**	**2**	**6,235**	**0**	**0**
				Agrees to Table 31 below				

Redundancy and other departure costs have been paid accordance with provisions of the NHS Terms and Conditions of Service (Agenda for Change).

Exit costs in this note are the full costs of departures agreed in the year. Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not include in the table.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Table 31 Analysis of Other Departures 2020/2021

There were no exit packages in 2020/21 but two payments in lieu of notice.

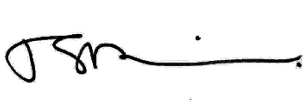
Type of Other Departures	Agreements Number	Total Value of Agreements £000s	
Contractual payments in lieu of notice	2	6	
Total	**2**	**6**	**Agrees to total in Table 30**

There are no non-contractual payments in lieu of notice.

Parliamentary Accountability and Audit Report

Bristol, North Somerset and South Gloucestershire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at page 147 - 187. An audit certificate and report is also included in this Annual Report at page 200.

ANNUAL ACCOUNTS



Shane Devlin

Accountable Officer

17th June 2022

Data entered below will be used throughout the workbook:

Entity name:	NHS Bristol, North Somerset and South Gloucestershire CCG
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

NHS Bristol, North Somerset and South Gloucestershire CCG - Annual Accounts 2021-22

CONTENTS **Page Number**

The Primary Statements:

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

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	3	(10,106)	(5,665)
Other operating income	3	(50)	-
Total operating income		**(10,156)**	**(5,665)**
Staff costs	4	25,732	22,234
Purchase of goods and services	5	1,826,217	1,589,875
Depreciation and impairment charges	5	151	112
Provision expense	5	7,852	1,106
Other operating expenditure	5	8,817	7,261
Total operating expenditure		**1,868,769**	**1,620,588**
Net Operating Expenditure		**1,858,613**	**1,614,923**
Comprehensive Net Expenditure for the year		**1,858,613**	**1,614,923**

There were no finance income and expenditure or gains and losses on transfer by absorption reported in 2020-21 and 2021-22.

The notes on pages 154 - 187 form part of this statement.

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	8	198	159
Intangible assets	9	85	170
Total non-current assets		**283**	**329**
Current assets:			
Trade and other receivables	10	11,968	49,737
Cash and cash equivalents	11	46	1,688
Total current assets		**12,014**	**51,425**
Total assets		**12,297**	**51,754**
Current liabilities			
Trade and other payables	12	(117,877)	(118,077)
Provisions	13	(9,016)	(1,164)
Total current liabilities		**(126,893)**	**(119,241)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(114,596)**	**(67,487)**
Total Assets less Total Liabilities		**(114,596)**	**(67,487)**
Financed by Taxpayers' Equity			
General fund		(114,596)	(67,487)
Total taxpayers' equity		**(114,596)**	**(67,487)**

The notes on pages 154 - 187 form part of this statement.

The financial statements on pages 150 to 187 were approved by the Audit, Governance and Risk Committee on 14 June 2022 with delegated authority from the Governing Body and signed on its behalf by:

Chief Accountable Officer
Shane Devlin

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

	General fund reserves £'000
Balance at 01 April 2021	**(67,487)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22	
Net recognised expenditure for the financial year	(1,858,613)
Net funding	1,811,504
Balance at 31 March 2022	**(114,596)**

	General fund reserves £'000
Balance at 01 April 2020	**(70,517)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21	
Net recognised expenditure for the financial year	(1,614,923)
Net funding	1,617,953
Balance at 31 March 2021	**(67,487)**

The notes on pages 154 - 187 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,858,613)	(1,614,923)
Depreciation and amortisation	5	151	112
Finance costs	13	306	14
(Increase)/decrease in trade & other receivables	10	37,769	(32,001)
Increase/(decrease) in trade & other payables	12	52	29,378
Increase/(decrease) in provisions	13	7,546	1,092
Net Cash Inflow (Outflow) from Operating Activities		**(1,812,789)**	**(1,616,328)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	8 &12	(357)	-
Net Cash Inflow (Outflow) from Investing Activities		**(357)**	-
Net Cash Inflow (Outflow) before Financing		**(1,813,146)**	**(1,616,328)**
Cash Flows from Financing Activities			
Net Funding Received		1,811,504	1,617,953
Net Cash Inflow (Outflow) from Financing Activities		**1,811,504**	**1,617,953**
Net Increase (Decrease) in Cash & Cash Equivalents	11	**(1,642)**	**1,625**
Cash & Cash Equivalents at the Beginning of the Financial Year		1,688	63
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**45**	**1,688**

The notes on pages 154 - 187 form part of this statement.

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis.

The Health and Social Care Bill 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 are due to take on the commissioning functions of CCGs from 01 July 2022. On this date the CCG's functions, assets and liabilities are due to transfer to the Bristol, North Somerset and South Gloucestershire 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 31 March 2022 on a going concern basis.

1.2 Accounting Convention

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

1.3 Better Care Fund Budgets

The CCG and Bristol City Council, North Somerset Council and South Gloucestershire Council have agreed to treat the Better Care Fund as a non-pooled fund. The terms of this are set out in the section 75 agreement. Both parties have chosen to contract with individual providers without reference to each other using their own sources of funding alone and it is for this reason that neither party considers they are operating a pooled budget.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

Notes to the financial statements

1.4.1 Critical Judgements in Applying Accounting Policies

Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

The Clinical Commissioning Group has implemented the Better Care Fund Initiative via partnership arrangements under Section 75 of the NHS Act 2006 with Bristol City Council, North Somerset Council and South Gloucestershire Council.

1.4.2 Key Sources of Estimation Uncertainty

The impact of Covid on delivery of healthcare was significant and led to changes in the financial framework. The consequence of this is that when arriving at estimates there is less scope to rely on precedent and historic trends.
There are no other sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year that require disclosure.

1.5 Operating Segments

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

1.6 Revenue

The Clinical Commissioning Group's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such the Clinical Commissioning Group's income from other activities is very limited with the most significant element being R&D income. The Clinical Commissioning Group does not enter into long term revenue contracts (most income arises from recharging past performance) and so the assessment indicates that there is no impact on income recognition from adopting IFRS 15.

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.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

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

1.7.2 Retirement Benefit Costs

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

Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

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

1.8 Purchase of Goods, Services and Other Expenses

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

1.9 Property, Plant & Equipment

1.9.1 Recognition

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

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

1.9.2 Measurement

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

1.9.3 Subsequent Expenditure

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

1.10 Intangible Assets

1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Clinical Commissioning Group's business or which arise from contractual or other legal rights. They are recognised only:
- When it is probable that future economic benefits will flow to, or service potential be provided to, the Clinical Commissioning Group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

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

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

1.10.2 **Measurement**

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

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 **Depreciation, Amortisation & Impairments**

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

This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

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

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

1.12 **Leases**

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

Notes to the financial statements

1.12.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Clinical Commissioning Group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.13 Cash & Cash Equivalents

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

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

1.14 Provisions

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

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

- short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- medium-term rate of 0.70% (2020-21: 0.18%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- long-term rate of 0.95% (2020-21 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- very long-term rate of 0.66% (2020-21: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

Notes to the financial statements

1.15 Clinical Negligence Costs

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

1.16 Non-clinical Risk Pooling

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

1.17 Continuing healthcare risk pooling

Claims that have arisen since April 2013 with a retrospective element dating back to a maximum of 1.4.2013, have been assessed and, if appropriate, paid from the current year budget. Therefore, in each accounting period there may be some costs relating to previous years but the budget has funding for this (based on historical spend being built into the baseline) which obviates the need for a provision. It is also very difficult to estimate the level of retrospective liabilities as cases are not known until a claim is made and an estimate cannot be made with any certainty.

1.18 Financial Assets

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

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.18.1 Financial Assets at Amortised cost

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

1.18.2 Financial assets at fair value through other comprehensive income

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

1.18.3 Financial assets at fair value through profit and loss

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

Notes to the financial statements

1.18.4 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 months expected credit losses (stage 1).

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

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

1.19 Financial Liabilities

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

1.19.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.19.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.19.3 Other Financial Liabilities

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

Notes to the financial statements

1.20 Value Added Tax

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

1.21 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.

1.22 Losses & Special Payments

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

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

1.23 Gifts

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.

1.24 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Clinical Commissioning Group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.25 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

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

1.25.1 IFRS 16 Leases – IFRS 16 Leases has been deferred until 01 April 2022 as adapted and interpreted by the FReM

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 01 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

Notes to the financial statements

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

On transition to IFRS 16 on 1 April 2022, the Clinical Commissioning Group will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Clinical Commissioning Group's incremental borrowing rate. The Clinical Commissioning Group's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 01 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Clinical Commissioning Group will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

It is estimated that the implementation of IFRS 16 Leases will not have a significant impact on the accounts. It is anticipated that the leases will be valued at £1,190,000 with matching liability obligations to the lessor.

1.25.2 **IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 01 January 2021**

Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2. Financial Performance

2.1 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2021-22			Target
	Target	Performance	Variance	Achieved
	£'000	£'000	£'000	
Expenditure not to exceed income	1,869,838	1,868,874	964	Yes
Capital resource use does not exceed the amount specified in Directions	106	105	1	Yes
Revenue resource use does not exceed the amount specified in Directions	1,859,577	1,858,613	964	Yes
Revenue administration resource use does not exceed the amount specified in Directions	19,341	19,335	6	Yes

	2020-21			Target
	Target	Performance	Variance	Achieved
	£'000	£'000	£'000	
Expenditure not to exceed income	1,640,878	1,620,839	20,039	Yes
Capital resource use does not exceed the amount specified in Directions	252	252	-	Yes
Revenue resource use does not exceed the amount specified in Directions	1,634,962	1,614,923	20,039	Yes
Revenue administration resource use does not exceed the amount specified in Directions	19,496	19,362	134	Yes

There were no capital or revenue resources on specified matters in 2021-22 and 2020-21.

It is allowable to use Running Costs allocations to support programme expenditure.

2.2 Financial Performance 2021-22

The CCG achieved an in-year surplus of £964k against its overall revenue funding in 2021-22 of £1,859,577k, and has therefore met its statutory duty to at least break-even. The CCG has a historic accumulated debt of £117,059k.

To achieve this baseline allocations were set based broadly on continuing to fund the run rate expenditure as per 2019/20 (pre COVID-19). In addition to this specific targeted allocation were then made:

- System wide allocation to fund direct additional costs of COVID-19, most notably increases in staff absence and cost premium of infection, prevention & control measures
- Targeted growth in line with NHS Long Term Plan priorities, notably investment in Primary Care and Mental Health
- A smaller number of key funding streams were subject to retrospective reimbursement, in line with Government response to the COVID-19 pandemic. Most notably Hospital Discharge Programme (to support NHS and Local Authority Social Care to create additional capacity to support earlier discharge from hospital), Elective Recovery Fund (linked to elective activity delivery) and COVID-19 Mass Vaccinations costs (via lead provider funding model and not CCG allocation)
- Non-Contract Activity with NHS provider Trusts below £200,000 was not chargeable and providers were reimbursed nationally via a 'top up' regime.

2. Financial Performance

2.2 Financial Performance 2021-22 (continued)

As per 2020/21 the financial year was split into two halves, with separate allocations made for each half and two NHS budgeting and operational planning rounds. The H2 allocation, from October-March, set at a time when COVID-19 levels were subsiding during Summer 2021, reflected a higher level of efficiency saving requirement and higher threshold to achieve elective recovery funding as the NHS sought to return to pre-pandemic productivity and funding levels.
The finance regime also continued to make progress towards a 'system by default' finance framework as envisaged under the Integrated Care Board regime. For 2021/22 NHS standard contracts with NHS providers remined suspended, most targeted allocations, such as for COVID-19 costs and Provider Top Up funding, were allocated at system level with discretion in the system to allocate to providers. NHS England financial performance focussed on total system financial performance (aggregate of CCG and NHS providers variance against revenue resource limit and capital allocations) rather than individual organisations.

Taken in the round these changes ensured that:
- Unplanned additional costs of the COVID-19 pandemic were able to be funded and decisions made promptly
- Inter-NHS commissioning and contracting did not become a barrier or additional burden on the service
- There remained a mechanism for ensuring value for money
- Progress was made on the Long-Term Plan objective of 'system by default' working.

	2021-22 £'000	2020-21 £'000
Programme Expenditure	1,849,445	1,601,191
Administration Expenditure	19,324	19,397
Total Expenditure	**1,868,769**	**1,620,588**
Programme Income	(10,106)	(5,630)
Administration Income	(50)	(35)
Total Income	**(10,156)**	**(5,665)**
Total Net Expenditure for the year	**1,858,613**	**1,614,923**
Revenue Resource Limit (RRL)	**1,859,577**	**1,634,962**
Surplus	**964**	**20,039**
Surplus % of Revenue Resource Limit	**0.05%**	**1.23%**

3.1 Operating Income

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies - *note 1*	7,950	5,588
Other contract income - *note 2*	2,156	77
Total income from sale of goods and services	**10,106**	**5,665**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	50	-
Total other operating income	**50**	**-**
Total Operating Income	**10,156**	**5,665**

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

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no money from sale of goods.

Notes

1. £ 7.8m (£5.5m 2020-2021) of this revenue figure relates to income from the Department of Health for Research and Development.

2. Other contract income has increased due to the transfer of Healthier Together (BNSSG Intergrated Care System Partnership) to the CCG on 01 January 2022. The funding for Healthier Together is received from the partner organisations.

The BNSSG Integrated Care System (ICS) partnership is represented by ten local health and care organisations and is commited to work together to realise the shared ambition to improve the health and wellbeing of local people. The partnership is funded by the partner bodies and hosted by a partner body. On the 01 January 2022 the hosted body transferred from University Hospitals Bristol and Weston NHS Foundation Trust to BNSSG CCG. As a result of this transfer there has been an increase in contracted income relating to the Healthier Together Partnership.

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

	2021-22	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Source of Revenue		
NHS	141	1,228
Non NHS	7,809	928
Total	**7,950**	**2,156**

	2021-22	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Timing of Revenue		
Point in time	7,950	2,156
Over time	-	-
Total	**7,950**	**2,156**

	2020-21	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Source of Revenue		
NHS	100	-
Non NHS	5,488	77
Total	**5,588**	**77**

	2020-21	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Timing of Revenue		
Point in time	5,588	77
Over time	-	-
Total	**5,588**	**77**

4. Employee benefits and staff numbers

4.1 Employee benefits

	2021-22		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	17,634	2,456	20,090
Social security costs	1,974	-	1,974
Employer contributions to NHS Pension scheme	3,459	-	3,459
Apprenticeship levy	82	-	82
Termination benefits	127	-	127
Gross employee benefits expenditure	**23,276**	**2,456**	**25,732**

	2020-21		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	15,841	1,426	17,267
Social security costs	1,747	-	1,747
Employer contributions to NHS Pension scheme	3,147	-	3,147
Apprenticeship levy	73	-	73
Gross employee benefits expenditure	**20,808**	**1,426**	**22,234**

There were no capitalised staff costs in 2021-22 and 2020-21.

4.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2021-22	408.20	25.62	433.82
2020-21	380.00	14.04	394.04

The BNSSG Healthier Together Integrated Care System transferred to BNSSG CCG on the 01 January 2022; 39 (number of) staff were TUPE transferred.

The increase in agency staff relates to the resourcing required to deliver specific one off projects.

4.3 Staff annual leave accrual balances

	Permanent Staff £'000
Employee accrued benefits liability 2021-22	(142)
Employee accrued benefits liability 2020-21	(206)

The accrued benefits liability balance related to permanent staff only; no temporary or agency staff accrued annual leave benefits at 31 March.

4.4 Exit packages agreed in the financial year

	2021-22					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	-	-	1	5,389	1	5,389
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000 *	-	-	1	49,445	1	49,445
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000 *	1	126,666	-	-	1	126,666
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**126,666**	**2**	**54,834**	**3**	**181,500**

	2020-21					
	Compulsory redundancies		Other agreed departures		Total	
	No.	£	No.	£	No.	£
Less than £10,000	**-**	**-**	2	6,235	**2**	**6,235**
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**2**	**6,235**	**2**	**6,235**

There were no departures where special payments were made in 2021-22 (2020-21 Nil).

NHS Bristol, North Somerset and South Gloucestershire CCG - Annual Accounts 2021-22
Analysis of Other Agreed Departures

	2021-22 Other agreed departures		2020-21 Other agreed departures	
	No.	**£**	**No.**	**£**
Contractual payments in lieu of notice	1	49,445	2	6,235
Non-contractual - special severance payments	1	5,389	-	-
Total	**2**	**54,834**	**2**	**6,235**

* As a single exit package can be made up of several components, each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS terms and conditions of service (Agenda for Change).

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

The Annual Report includes the Remuneration Report, which includes the disclosure of exit payments payable to individuals named in that report.

4.5 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 Clinical Commissioning Group of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 07 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating Expenditure

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	7,615	6,762
Services from foundation trusts - *note 1*	479,743	417,139
Services from other NHS trusts - *note 1*	543,746	455,785
Services from Other WGA bodies	1,266	1,221
Purchase of healthcare from non-NHS bodies	435,661	392,575
Purchase of social care	38,728	6,652
Prescribing costs	135,083	139,329
GPMS/APMS and PCTMS	168,257	152,828
Supplies and services – clinical	3,370	4,498
Supplies and services – general	201	259
Consultancy services	1,023	261
Establishment	4,305	6,435
Transport	21	14
Premises	4,401	3,935
Audit fees - *notes 2, 3 & 4*	101	93
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	12	-
Other professional fees - *note 5*	1,425	1,269
Legal fees	425	422
Education, training and conferences	834	398
Total Purchase of goods and services	**1,826,217**	**1,589,875**
Depreciation and impairment charges		
Depreciation	66	112
Amortisation	85	-
Total Depreciation and impairment charges	**151**	**112**
Provision expense		
Change in discount rate	306	14
Provisions	7,546	1,092
Total Provision expense	**7,852**	**1,106**
Other Operating Expenditure		
Chair and Non Executive Members - *note 6*	269	239
Grants to Other bodies - *note 7*	525	1,418
Research and development (excluding staff costs)	8,043	5,560
Expected credit loss on receivables	(25)	44
Other expenditure	5	-
Total Other Operating Expenditure	**8,817**	**7,261**
Total Operating Expenditure	**1,843,037**	**1,598,354**

5. Operating expenses (continued)

Notes

1 During 2021/22 financial year the CCG reimbursed NHS Trust and Foundation Trusts providers within Healthier Together ICS for direct Covid costs (£60.6m), elective recovery fund costs (£18.3m) and provider 'top up' deficit support funding (£89.5m) During 2020/21 Apr-Sep these costs were not passed through the CCG but reimbursed directly from NHS England.

2 External audit liability is capped at £2m.

3 External audit fees, including VAT, £101,160 (£84,960 2020-2021). This includes £10,800 additional costs in relation to the 2020/21 audit which were not accrued.

4 External audit fees for Mental Health Investment Standard £12,000 including VAT (£12,000 2020-21).

5 Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees for 2021-2022 totalled £64,480 net of VAT (£62,400 2020-21).This is included in Other professional fees.

6 The Chair and Non Executive Members costs also include the ICB Chair Designate of BNSSG ICB salary from 01 January 2022.

7 Grants to other bodies relate to Capital Grants with funding specifically allocated by NHS England.

8 CCG Expenditure on Covid totalled £26.3m (£48.4m 2020-21) of which £16.0m (£32.6m 2020-21) related to the Hospital Discharge Programme.

6.1 Better Payment Practice Code

Measure of compliance	2021-22 No.	2021-22 £'000	2020-21 No.	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	25,372	668,373	21,370	580,734
Total Non-NHS Trade Invoices paid within target	24,610	631,170	20,879	572,781
Percentage of Non-NHS Trade invoices paid within target	**97.00%**	**94.43%**	**97.70%**	**98.63%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	746	1,015,178	1,596	905,247
Total NHS Trade Invoices Paid within target	727	1,015,166	1,565	904,895
Percentage of NHS Trade Invoices paid within target	**97.45%**	**100.00%**	**98.06%**	**99.96%**

The CCG failed to achieve the 95% target in the Non- NHS expenditure parameter due to the late payment of 3 monthly contract invoices to a Community Services Provider. However, the invoices were still paid in the correct month.

6.2 There were no payments made from claims under Late Payment of Commercial Debts (Interest) Act 1998.

7. Operating Leases

7.1 As lessee

The Clinical Commissioning Group occupies and commissions services in properties owned and managed by NHS Property Services Ltd and Community Health Partnerships Ltd. The costs incurred in relation to NHS Property Services Ltd and Community Health Partnerships are shown on Note 7.1.1 below.

Whilst our arrangements with Community Health Partnerships Ltd and NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed.

7.1.1 Payments recognised as an Expense	2021-22 £'000	2020-21 £'000
Payments recognised as an expense		
Minimum lease payments	2,473	2,856
Contingent rents	-	-
Sub-lease payments	-	-
Total	**2,473**	**2,856**

Operating lease expenses relate solely to buildings, there are no other lease expenses.

There are no future minimum lease payments to be disclosed.

8. Property, plant and equipment

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	802	100	902
Additions purchased	105	-	105
Cost/Valuation at 31 March 2022	**907**	**100**	**1,007**
Depreciation 01 April 2021	643	100	743
Charged during the year	66	-	66
Depreciation at 31 March 2022	**709**	**100**	**809**
Net Book Value at 31 March 2022	**198**	**-**	**198**
Purchased	198	-	198
Total at 31 March 2022	**198**	**-**	**198**
Asset financing:			
Owned	198	-	198
Total at 31 March 2022	**198**	**-**	**198**

8.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22 £'000	2020-21 £'000
Information technology	542	584
Furniture & fittings	102	102
Total	**644**	**686**

8.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	1	5

9. Intangible non-current assets

2021-22	Computer software: purchased £'000
Cost or valuation at 01 April 2021	232
Additions purchased	-
Cost / Valuation at 31 March 2022	**232**
Amortisation 01 April 2021	62
Charged during the year	85
Amortisation at 31 March 2022	**147**
Net Book Value at 31 March 2022	**85**
Purchased	85
Total at 31 March 2022	**85**

9.1 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2021-22 £'000	2020-21 £'000
Computer software: purchased	62	62
Total	**62**	**62**

9.2 Economic lives

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

10.1 Trade and other receivables

	Current 2021-22 £'000	Current 2020-21 £'000
NHS receivables: Revenue	4,573	25,280
NHS prepayments	706	391
NHS accrued income	19	29
Non-NHS and Other WGA receivables: Revenue	2,851	3,608
Non-NHS and Other WGA prepayments	2,681	20,133
Non-NHS and Other WGA accrued income	749	-
Expected credit loss allowance-receivables	(22)	(47)
VAT	405	336
Other receivables and accruals	6	7
Total Current trade & other receivables	**11,968**	**49,737**

There are no non-current trade receivables.

There are no prepaid pensions contributions in 2021-22 (2020-21 Nil).

The majority of trade is with NHS England. As NHS England is funded by Government no credit scoring is considered necessary.

£6,420,319 of the amount above has subsequently been recovered post the statement of financial position date.

10.2 Receivables past their due date but not impaired

	2021-22	
	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000
By up to three months	1,013	1,953
By three to six months	-	-
By more than six months	-	-
Total	**1,013**	**1,953**

	2020-21	
	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000
By up to three months	-	909
By three to six months	30	44
By more than six months	141	2
Total	**171**	**955**

10.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies
	£'000
Balance at 01 April 2021	(47)
Lifetime expected credit losses on trade and other receivables-Stage 2	25
Allowance for credit losses at 31 March 2022	**(22)**

10.4 Provision matrix on lifetime credit loss

	31st March 2022		
Non NHS Debt	**% Lifetime expected credit loss rate**	**£'000 Gross Carrying amount**	**£'000 Lifetime expected credit loss**
Current	-	209	-
1-30 days	-	100	-
31-60 days	2	3	-
61-90 days	20	2	-
Greater than 90 days	100	22	22
Total expected credit loss		**336**	**22**

	31st March 2021		
Non NHS Debt	**% Lifetime expected credit loss rate**	**£'000 Gross Carrying amount**	**£'000 Lifetime expected credit loss**
Current	-	89	-
1-30 days	1	10	-
31-60 days	2	9	-
61-90 days	20	-	-
Greater than 90 days	100	47	47
Total expected credit loss		**155**	**47**

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2022.

11. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	1,688	63
Net change in year	(1,642)	1,625
Balance at 31 March 2022	**46**	**1,688**
Made up of:		
Cash with the Government Banking Service	45	1,687
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**46**	**1,688**

12. Trade and other payables	Current 2021-22 £'000	Current 2020-21 £'000
NHS payables: Revenue	1,594	2,624
NHS accruals	293	130
NHS deferred income	50	-
Non-NHS and Other WGA payables: Revenue	51,114	16,859
Non-NHS and Other WGA payables: Capital	-	252
Non-NHS and Other WGA accruals	61,309	95,076
Non-NHS and Other WGA deferred income	475	460
Social security costs	342	278
Tax	292	230
Other payables and accruals	2,408	2,168
Total Current Trade & Other Payables	**117,877**	**118,077**

There are no non-current trade and other payables.

There are no liabilities included in the above for any person due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £1,574,378 outstanding pension contributions at 31 March 2022.

13. Provisions

	Current 2021-22 £'000	Current 2020-21 £'000
Restructuring	943	911
Redundancy	-	-
Legal claims	5,210	253
Other	2,863	-
Total	**9,016**	**1,164**

There are no non-current provisions.

	Restructuring £'000	Legal Claims £'000	Other £'000	Total £'000
Balance at 01 April 2021	**911**	**253**	**-**	**1,164**
Arising during the year	-	4,780	2,766	**7,546**
Utilised during the year	-	-	-	**-**
Reversed unused	-	-	-	**-**
Unwinding of discount	-	-	-	**-**
Change in discount rate	32	177	97	**306**
Balance at 31 March 2022	**943**	**5,210**	**2,863**	**9,016**
Expected timing of cash flows:				
Within one year	943	5,210	2,863	**9,016**
Between one and five years	-	-	-	**-**
After five years	-	-	-	**-**
Balance at 31 March 2022	**943**	**5,210**	**2,863**	**9,016**

The Restructuring provision consists of;
- £506k for the early cancellation of part of the head office lease arising from home first hybrid working policy.
- £405k restructuring associated with the impact of the Health and Social Care Bill of the 06 July 2021 for the establishment of Integrated Care Boards across England which will abolish Clinical Commissioning Groups.

The Legal provisions relate to outstanding contract challenges with providers, and cost of judicial review arising from major service changes that expect to require public consultation.

The Other provision relates to;
- £2,036k for General Practitioner service charge payments disputed with NHS Property Services, which was reported as an accrual at 31 March 2021 and corrected to a provision in 2021-22.
- £730k for dilapidations associated with the Head Office and a GP practice.

14. Financial instruments

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

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

14.1.1 Currency risk

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

14.1.2 Interest rate risk

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

14.1.3 Credit risk

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

14.1.4 Liquidity risk

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

14.1.5 Financial Instruments

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

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Financial Assets measured at amortised cost 2020-21 £'000
Trade and other receivables with NHSE bodies	3,846	1,437
Trade and other receivables with other DHSC group bodies	1,557	24,314
Trade and other receivables with external bodies	2,795	3,172
Cash and cash equivalents	46	1,688
Total at 31 March 2022	**8,244**	**30,611**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Financial Liabilities measured at amortised cost 2020-21 £'000
Trade and other payables with NHSE bodies	1,009	1,101
Trade and other payables with other DHSC group bodies	1,293	26,007
Trade and other payables with external bodies	114,417	90,001
Total at 31 March 2022	**116,719**	**117,109**

14.4 Maturity of Financial liabilities

	2021-22		
	Payable to DHSC	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	2,303	114,416	116,719
Total at 31 March 2022	**2,303**	**114,416**	**116,719**

	2020-21		
	Payable to DHSC	Payable to Other bodies	Total
	£'000	£'000	£'000
In one year or less	3	117,106	117,109
Total at 31 March 2021	**3**	**117,106**	**117,109**

15. Operating segments

	2021-22 Commissioning Healthcare £'000	2020-21 Commissioning Healthcare £'000
Gross expenditure	1,868,769	1,620,588
Income	(10,156)	(5,665)
Net expenditure	1,858,613	1,614,923
Total assets	12,297	51,754
Total liabilities	(126,893)	(119,241)
Net assets	(114,596)	(67,487)

15.1 Reconciliation between Operating Segments and SoCNE

	2021-22 £'000	2020-21 £'000
Total net expenditure reported for operating segments	1,858,613	1,614,923
Total net expenditure per the Statement of Comprehensive Net Expenditure	1,858,613	1,614,923

15.2 Reconciliation between Operating Segments and SoFP

	2021-22 £'000	2020-21 £'000
Total assets reported for operating segments	12,297	51,754
Total assets per Statement of Financial Position	12,297	51,754

	2021-22 £'000	2020-21 £'000
Total liabilities reported for operating segments	(126,893)	(119,241)
Total liabilities per Statement of Financial Position	(126,893)	(119,241)

16. Related party transactions

Details of related party transactions with individuals are as follows:

	2021-22				2020-21			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Peter Brindle (Medical Director -Clinical Effectiveness), Jon Evans (GP Locality Representative), Kirsty Alexander (Chair N&W Locality - CCG GB member and Children and Young Person Clinical Lead support), Jonathan Hayes (Clinical Chair) - GP Care Peter Brindle is shareholder a GP Care, Jon Evans belongs to a GP Practice that is a shareholder in GP Care and Kirsty Alexander & Jonathan Hayes are partners in organisations that are shareholders in GP Care.	1,255	-91	123	-	1,481	-	6	-
Alison Moon (Indpendent Lay member- Registered Nurse) - St Peter's Hospice. Alison Moon is a Trustee of St Peter's Hospice	2,938	-	95	-	1,985	-	7	-
Kevin Haggerty (Weston, Worle and Villages Locality Lead & North Somerset Governing Body Representative) - Pier Health Group Ltd. Kevin Haggerty is a Director of Pier Health Group Ltd	150	-31	153	-2	-	-	65	-
Sarah Truelove (Deputy Chief Executive Officer and Chief Finance Officer) - Bristol Infracare Developments 1 Ltd Sarah Truelove is Director of Bristol Infracare LIFT Ltd. Bristol Infracare Developmenmts 1 Ltd is part of Bristol Infracare LIFT Ltd.	37	-	6	-	47	-	-	-
James Case (LLG Commissioning Lead) - Allpharm Ltd. James case is Director of Allpharm Ltd. BNSSG has transactions with Allpharm Ltd TA Concord Pharmacy	1	-	-	-	-	-	-	-
Kevin Haggerty (Weston, Worle and Villages Locality Lead & North Somerset Governing Body Representative), Jonathan Hayes (Clinical Chair) - One Care Ltd. Kevin Haggerty is part of a Member Practice of One Care Ltd, Jonathan Hayes is a partner of a practice that is a member of One Care and has been appointed as chair of the GP Collaborative Board, hosted by One Care Ltd. Note that One Care Ltd appears under two names, One Care (BNSSG) Ltd and Once Care Consulting & Services Ltd. These transactions are for One Care (BNSSG) Ltd.	7,319	-	3,758	-	-	-	-	-
Kevin Haggerty (Weston, Worle and Villages Locality Lead & North Somerset Governing Body Representative), Jonathan Hayes (Clinical Chair) - One Care Ltd. Kevin Haggerty is a Member Practice of One Care Ltd, Jonathan Hayes is a partner of a practice that is a member of One Care and has been appointed as chair of the GP Collaborative Board, hosted by One Care Ltd. Note that One Care Ltd appears under two names, One Care (BNSSG) Ltd and Once Care Consulting & Services Ltd. These transactions are for Once Care Consulting & Services Ltd.	1,985	-	1,987	-	-	-	-	-

The Department of Health and Social Care is the parent department and 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 is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts - significant parties University Hospitals NHS FT & South Western Ambulance FT;
- NHS Trusts - significant parties Weston Area Health NHS Trust & North Bristol NHS Trust;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies during 2021/2022. The transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a total net spend of £133m in 2021/22 (£109.6m in 2020/21) and the main services this relates to are: Better Care Fund (£36.8m); Funded Nursing Care (£19.3m); North Somerset Adult Continuing Healthcare (£12.1m) and all groups of Complex Care clients (£64.8m). See table below for further details.

Expenditure with Local Authorities

Local Authority	2021-22 £m	2020-21 £m	Movement £m
Bristol City Council	58.2	44.4	13.8
North Somerset Council	44.6	37.8	6.8
South Gloucestershire Council	30.2	27.4	2.8
Total	**133**	**109.6**	**23.4**

17. Partnership arrangements

The CCG has partnership arrangements with Bristol City Council, North Somerset Council and South Gloucestershire Council for the delivery of the Better Care Fund for the provision of community and mental health services together with continuing and social care. The arrangements are made in accordance with S75 of the NHS Act 2006 and any surplus or deficits are the responsibility of the respective partners. Each of the partner bodies is responsible for managing the individual schemes for which they have lead responsibility.
The funding and expenditure for each BCF are:

	2021/22			2020/21		
Bristol City Council	**CCG**	**BCC**	**Total**	**CCG**	**BCC**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Funding provided to partnership budgets	34,869	48,632	83,501	33,048	47,142	80,190
CCG funding to council for protection of adult social care	(18,129)	18,129	-	(17,181)	17,181	-
Expenditure from partnership arrangement	**16,740**	**66,761**	**83,501**	**15,867**	**64,323**	**80,190**
South Gloucestershire Council	**CCG**	**SG**	**Total**	**CCG**	**SG**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Funding provided to partnership budgets	16,962	6,836	23,798	16,075	6,558	22,633
CCG funding to council for protection of adult social care	(6,135)	6,135	-	(5,814)	5,814	-
Expenditure from partnership arrangement	**10,827**	**12,971**	**23,798**	**10,261**	**12,372**	**22,633**
North Somerset Council	**CCG**	**NS**	**Total**	**CCG**	**NS**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Funding provided to partnership budgets	16,549	14,533	31,082	15,684	12,709	28,393
CCG funding to council for protection of adult social care	(7,251)	7,251	-	(6,872)	6,872	-
Expenditure from partnership arrangement	**9,298**	**21,784**	**31,082**	**8,812**	**19,581**	**28,393**

18. Losses and special payments

18.1 Losses

There were no losses in 2021-22 (2020-2021 nil).

18.2 Special payments

There were no severance payments in 2020-21.

	2021-22 Number	**2021-22 £'000**
Special Severance Payments	1	5
Total	**1**	**5**

The special severance payment for was dismissal from the CCG on the grounds of capability due to ill health.

19. Contingencies

Contingent Liabilities

	2021-22 £'000	**2020-21 £'000**
Continuing Healthcare	527	1,707

The contingent liability relates to continuing healthcare claims. The uncertainty relates to the eligibility of outstanding appeals claims. Whilst possible, it has been deemed unlikely these amounts will be reimbursed. It is not practical to provide an estimate of the financial effect.

20. Events after the Reporting period

The Health and Care Act received Royal Assent on the 28 April 2022. Subject to the issue of an establishment order by NHS England the CCG is due to be dissolved on 30 June 2022. On 01 July the assets, liabilities and operations will transfer to Bristol, North Somerset and South Gloucestershire ICB.

BRISTOL, NORTH SOMERSET & SOUTH GLOUCESTERSHIRE CCG

Annual internal audit report 2021/22

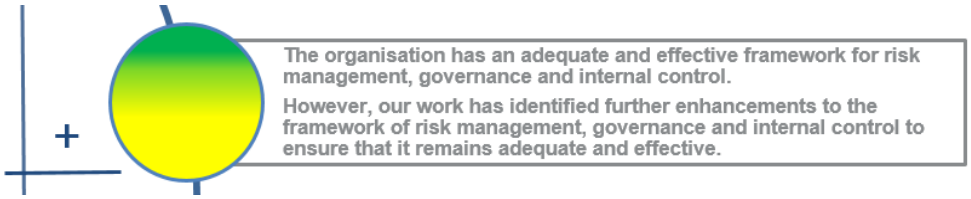
31 May 2022

THE ANNUAL INTERNAL AUDIT OPINION

This report provides an annual internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance reporting.

The opinion

For the 12 months ended 31 March 2022 the head of internal audit opinion for Bristol North Somerset South Gloucestershire (BNSSG) CCG is as follows:



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

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

Scope and limitations of our work

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

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management / lead individual;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention; and
- our internal audit work for 2021/22 has continued to be undertaken through the operational disruptions caused by the Covid-19 pandemic. In undertaking our audit work, we recognise that there has been some impact on both the operations of the organisation and its risk profile; and our annual opinion should be read in this context.

FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

Based on the work undertaken in 2021/22 there is a generally sound system of internal control, designed to meet the CCG's objectives, and controls are generally being applied consistently.

We have provided substantial assurance opinions in two areas and a reasonable assurance opinion in a further five audit areas. The key exception was a partial assurance opinion assigned to the review of Continuing Healthcare undertaken early in the year. This means the Governing Body can take partial assurance that the controls to manage risks were suitably designed and consistently applied, and that action was needed to strengthen the control framework to manage the identified risks.

Continuing Healthcare

NHS Continuing Healthcare (CHC) is a funded package of care for adults, who have long-term complex health needs and are eligible for free social care arrangements funded by the NHS. CHC packages are put in place for individuals who have been assessed by a team of healthcare professionals (multidisciplinary team) and deemed eligible based on the individuals' assessed needs, diagnosis or condition. The CCG are only able to commission care for those people who qualify for CHC.

During this audit, held over from 2020/21, we identified weaknesses and areas of non-compliance with the CCG's framework of controls in place to manage and monitor CHC activity and report on performance across localities. Areas of non-compliance with both NHSE and internal KPIs for CHC and fast track assessments were found, as well as weaknesses in the data reported from system generated reports for fast-track assessments that were overdue.

We identified gaps in the control framework around how the Brokerage team are instructed to carry out their roles, the review of CHC providers and the checks around service delivery before invoices are paid. The findings resulted in eight 'medium' and one 'low' priority management actions.

We raised a high priority management action in the **Recruitment and Workforce Data** audit around non compliance with recruitment policies around the requirement for a certain make-up of panels, and evidencing the interview process so that assurance can be gained that the right and ethical recruitment decisions are being made. This high action has been implemented in full by year end.

Across all of the audit assignments, we have agreed one 'high' and 27 'medium' and 12 'low' priority management actions with management for 2021/22. Some of the themes were around recording application of the required recruitment processes, ensuring consistency in learning from complaints across the directorates, capacity, and sharing of information between CCG directorates and teams. Our action tracking shows that at year end, there were two actions still in progress, with management sharing recent updates on progress, and three of the CHC actions were outstanding without a recent update from management.

We have listed below the areas where a positive (substantial or reasonable) level of assurance was given:

Assignment	Opinion issued
Complaints Management	Reasonable assurance
Workforce Sustainability	Reasonable assurance

Assignment	Opinion issued
Recruitment and Workforce Data	Reasonable assurance
Conflicts of Interest	Substantial assurance
Business Continuity (EPRR)	Reasonable assurance
Financial Controls	Reasonable assurance
Primary Care	Substantial assurance

We also undertook an advisory review of Health Inequalities and a compliance review of the CCG's application of the NHS Due Diligence Checklist in its planning and delivery of the transition programme to the Integrated Care Board from 1 July 2022. Both reviews highlighted positive areas of compliance and planning, but also areas for improvement. The main future learning points and continuous improvement is carried forward in the Health Inequalities audit, and since its conclusion the CCG has confirmed it is looking to take this forward into CCG and ICS workshops on how to work better as a system to deliver the five urgent actions on Health Inequalities as set out in the NHS Long Term Plan.

Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken to date on the CCG's system of internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS). The CCG may wish to consider any issues raised around the high priority management action, when determining whether anything should be highlighted within the Annual Governance Statement. The CCG should also consider whether any other issues have arisen as well as recognise the challenging environment within which the CCG is operating, including the results of any external reviews.

THE BASIS OF OUR INTERNAL AUDIT OPINION

As well as those headlines previously discussed, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

Acceptance of internal audit management actions

Management have agreed actions to address all of the findings reported by the internal audit service during 2021/22.

Implementation of internal audit management actions

Where actions have been agreed by management, these have been monitored by Internal Audit through the monthly action tracking process in place. During the year progress has been reported to the audit, governance and risk committee.

The position reported at year end showed only four actions as ongoing, with updated provided by management but the implementation date extended, and three actions requiring further update from management.

Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers. We have liaised with the Local Counter Fraud Specialist and External Audit as appropriate during the course of the year and have considered the content of service auditor reports as follows.

Service Auditor reports

We reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services who provide services to the CCG. Only one exception was identified from the 27 controls reviewed and this was not considered to represent a significant risk to the CCG.

We reviewed the Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering financial and payroll services. Whilst the report resulted in a qualified opinion due to two exceptions identified around invoices and credit notes, it was not felt the findings were of sufficient significance to undermine our overall opinion for the CCG.

We reviewed the Service Auditor Report from the internal auditors for NHS Digital in regard to GP Payments. Testing for two of the controls identified an exception but there was no significant impact for the CCG on its overall control environment.

We reviewed the Service Auditor Report from the internal auditors for the Business Services Authority – Prescriptions Payments Process. The opinion was qualified in a single area in that controls were not in place to provide appropriate periodic review of user access, and in a number of instances the controls related to timely removal of leavers' access to applications and the network did not operate effectively. No other exceptions were identified and we do not consider this sufficient to impact on our overall Head of Internal Audit Opinion.

We reviewed the Service Auditor Report in relation to Capita and four out of the 17 control objectives were qualified by the service auditor. In each instance, management has set out improvements to controls to help prevent a recurrence and to mitigate the risk going forwards. Whilst noting the exceptions, we do not consider these sufficiently significant to impact on our overall Head of Internal Audit Opinion.

We reviewed the Service Auditor Report from the internal auditors of ESR (Electronic Staff Record Programme) who provide a single payroll and Human Resources management system to the CCG. One qualification to the opinion was noted regarding the controls necessary to ensure that access to the development and production areas of the NHS hub was appropriately restricted for a limited period of the year. This issue was resolved once identified and it does not impact our overall assessment of the controls in operation at the CCG. No other qualifications were noted.

OUR PERFORMANCE

Wider value adding delivery

Area of work	How has this added value?
Internal Audit agility	To ensure internal audit continues to be focused and reflects changes in risk prioritisation we made a number of in-year changes to the internal audit plan. All changes were reported to and agreed by the audit, governance and risk committee and management.
Liaison with NHS England	We liaised with NHS England to help confirm the CCG's compliance with the NHS England IA Framework for Primary Care audits, based on work previously undertaken.
Data Analytics	We used data analytics in our financial controls work to look at supplier data, not only to provide holistic assurance and identify significant outliers but to help improve the centralised controls. This also made the audit process more efficient and required less burden on the finance staff.
Health Matters	As part of our client service commitment, during 2021/22 we have issued our NHS sector client briefings and provided our quarterly NHS publication 'Health Matters' which provides insights into topical issues within the sector.
ICS Workshop – Leadership and Governance in the ICS	We held our first ICS Workshop in July 2021 some of the key learnings were as follows: • Developing clear lines of accountability and transparency around how and where decisions are made. • Ensuring marginal and smaller bodies will have their voice heard within the ICS. • Maximising the link between health and social care. • Accountability for local capital plans. • Managing conflicting roles and interests of ICS board members. • Working closely with local communities in shaping services and improving population health and wellbeing. For our second workshop we explored leadership and governance within ICS. RSM were commissioned by NHSE&I to look at Hospital Discharge Policy and Discharge to Assess Processes across ten Integrated Care Systems in England. We used this project as a case study for exploring the key learnings and best practice on what effective leadership and governance might look like across the ICS and how the NHS and LA can make partnership working more effective. We held our third ICS workshop on 3 March 2022 focusing on how partners can work together in collaboration, principles to support local decision-making, identifying shared goals, appropriate membership and governance and alignment of activities with ICS priorities.
Healthcare benchmarking	We have shared benchmarking information with the CCG including our annual report on the outcomes of Internal Audit opinions across our NHS client base. We have also shared benchmarking and good practice in each audit assignment, whether in the body of the report or via conversation and feedback during audit meetings.

Audit Committee involvement	We contributed to the discussions at the Audit, Governance and Risk Committee on various items on the agenda to ensure that the Trust benefits from wider input, in order to strengthen its governance arrangements.
SBS Ledger Project	During the year RSM has provided ongoing project assurance and support on the SBS ledger project, in recognition of the closure of the CCG ledger and the transfer to a new ICB ledger.
Webinars	We have invited the CCG to various webinars including the following: • Employment and HR update webinar, which focused on employment tax update, HR update and employment law update. • Embracing the future of work webinar, which focused on the key considerations of hybrid working from a people management, employment tax, employment legal and global mobility perspective. • Procurement and contract management network webinar, which provided an update on current developments including new procurement thresholds. • Health Matters Webinars, which explored how organisations can collaborate to deliver change and key considerations for private healthcare businesses for workforce planning in a post Covid economy.
RSM's NED Network	We have launched RSM's NED Network to provide the non-executive director and interim community a place to network, share ideas, attend insightful and relevant events and read key content.

Conflicts of interest

RSM has not undertaken any work or activity during 2021/22 that would lead us to declare any conflict of interest.

Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS).

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2021 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF), and the Internal Audit Code of Practice, as published by the Global Institute of Internal Auditors (IIA) and the Chartered IIA, on which PSIAS is based.

The external review concluded that RSM 'generally conforms* to the requirements of the IIA Standards' and that 'RSM IA also generally conforms with the other Professional Standards and the IIA Code of Ethics. There were no instances of non-conformance with any of the Professional Standards'.

* The rating of 'generally conforms' is the highest rating that can be achieved, in line with the IIA's EQA assessment model.

Quality assurance and continual improvement

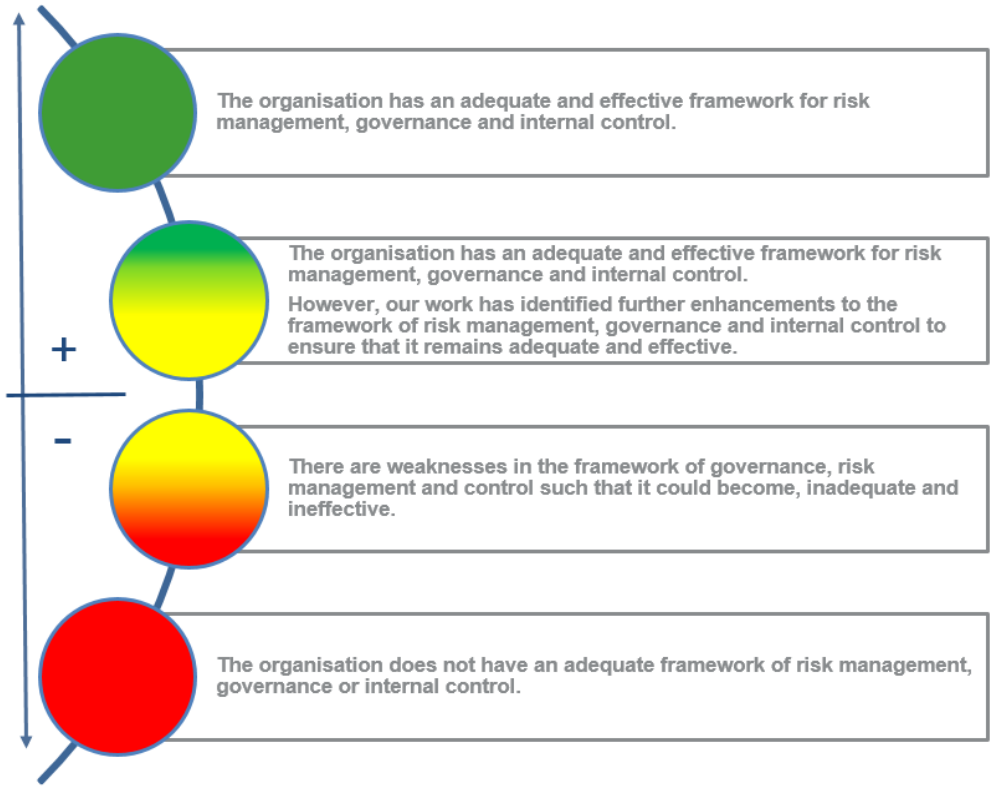
To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

Resulting from the programme in 2021/22, there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

In addition to this, any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments is also taken into consideration to continually improve the service we provide and inform any training requirements.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • limitations in the individual audit assignments; • the adequacy and effectiveness of the risk management and / or governance control framework; • the impact of weakness identified; • the level of risk exposure; and • the response to management actions raised and timeliness of actions taken.

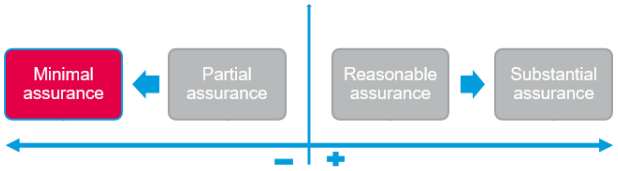
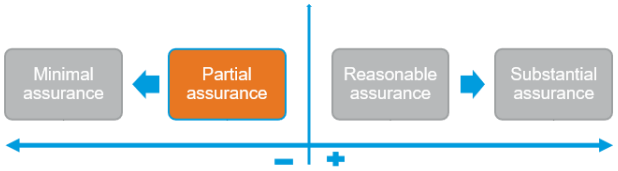
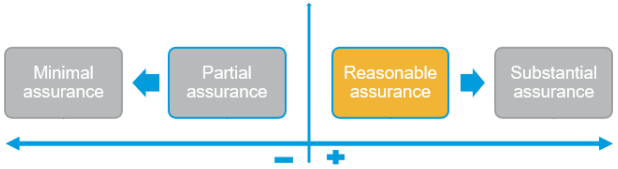
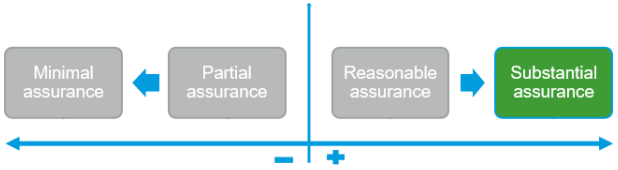
APPENDIX B: SUMMARY OF INTERNAL AUDIT WORK COMPLETED 2021/22

All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

Assignment	Executive lead	Assurance level	Actions agreed		
			L	M	H
Continuing Healthcare	Rosi Shepherd – Director of Nursing and Quality	Partial Assurance [●]	1	8	0
Complaints Management	Sarah Truelove - CFO	Reasonable Assurance [●]	2	1	0
Workforce Sustainability	Sarah Truelove - CFO	Reasonable Assurance [●]	0	2	0
Recruitment and Workforce Data	Sarah Truelove - CFO	Reasonable Assurance [●]	2	4	1
Conflicts of Interest	Sarah Truelove - CFO	Substantial Assurance [●]	2	0	0
Business Continuity (EPRR)	Lisa Manson – Director of Commissioning	Reasonable Assurance [●]	2	4	0
Financial Controls	Sarah Truelove - CFO	Reasonable Assurance [●]	2	1	0
Health Inequalities	Peter Brindle – Medical Director	Advisory [●]	0	7	0
Primary Care	Lisa Manson – Director of Commissioning	Substantial Assurance [●]	1	0	0
CCG Close Down and ICB Establishment Due Diligence	Julie Bacon – Interim Director of	Advisory [●]	-	-	-

APPENDIX C: OPINION CLASSIFICATION

We use the following levels of opinion classification within our internal audit reports, reflecting the level of assurance the board can take:

	Taking account of the issues identified, the board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

YOUR INTERNAL AUDIT TEAM

Nick Atkinson

Nick.atkinson@rsmuk.com

07730 300307

Vickie Gould

Victoria.gould@rsmuk.com

07740 631140

Independent auditor's report to the members of the Governing Body of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion on financial statements

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

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

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

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the

CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

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

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

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

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

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

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

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

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

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

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

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management 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 and fraud risks in relation to income recognition and expenditure. We determined that the principal risks were in relation to:
  - material year end journals and manual journals posted during the year with high risk characteristics
  - potential management bias in determining estimates for the year end prescribing accrual.
- 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 the material year end transactions and manual journals posted during the year with high risk characteristics**;**
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of the year-end prescribing accrual**;**
  - 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 expenditure recognition, and the significant accounting estimates related to prescribing accruals.

- Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these

arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

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

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

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

Use of our report

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

Signature: *JD Roberts*

Name: Jon Roberts, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

20 June 2022