NHS Bristol, North Somerset and South Gloucestershire CCG

Annual Report

1st April – 30th June 2022

Contents

PERFORMANCE REPORT

Shane Devlin

Accountable Officer

29 June 2023

Performance Overview

This performance overview provides a short summary of the CCG's purpose, the key risks to objectives in the first quarter of 2022/23 and how the CCG performed.

Chief Executive's Statement

The first quarter of 2022/23 continued to reflect the effect of Covid-19 on the local population, staff and services. The pressure felt across all services in 2021/22 continued into 2022/23 and the impact of the Omicron wave of Covid-19 combined with staff sickness and increased demand resulted in longer waits for services. The number of patients in hospital who experienced a delayed discharge increased which had a significant impact throughout the hospital system. A wide range of initiatives were taken forward during the quarter to address these performance challenges. The Discharge to Assess and 'Home First' programmes had an important focus on home-based rehabilitation and reablement and aimed at reducing onward care needs and relieving the pressure on the hospital system.

In June 2022 the CCG Governing Body approved the Healthy Weston Phase 2 Business Case. An important milestone in the development of services for Weston General Hospital the planned developments to expand same day emergency care, provide a one-stop urgent surgical assessment clinic, create a centre of excellence for older people and establish a centre of excellence for planned surgical care will be implemented in 2022/23 and beyond. These plans are part of the long terms ambitions that will see more sustainable services across the area. These long-term system plans will be taken forward by the Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) which came into being on the 1st of July 2022. The ICB will have a key role as part of the local Integrated Care Partnership in ensuring that the wider strategy is delivered for the whole population.

Shane Devlin, Chief Executive Officer

Our purpose and activities

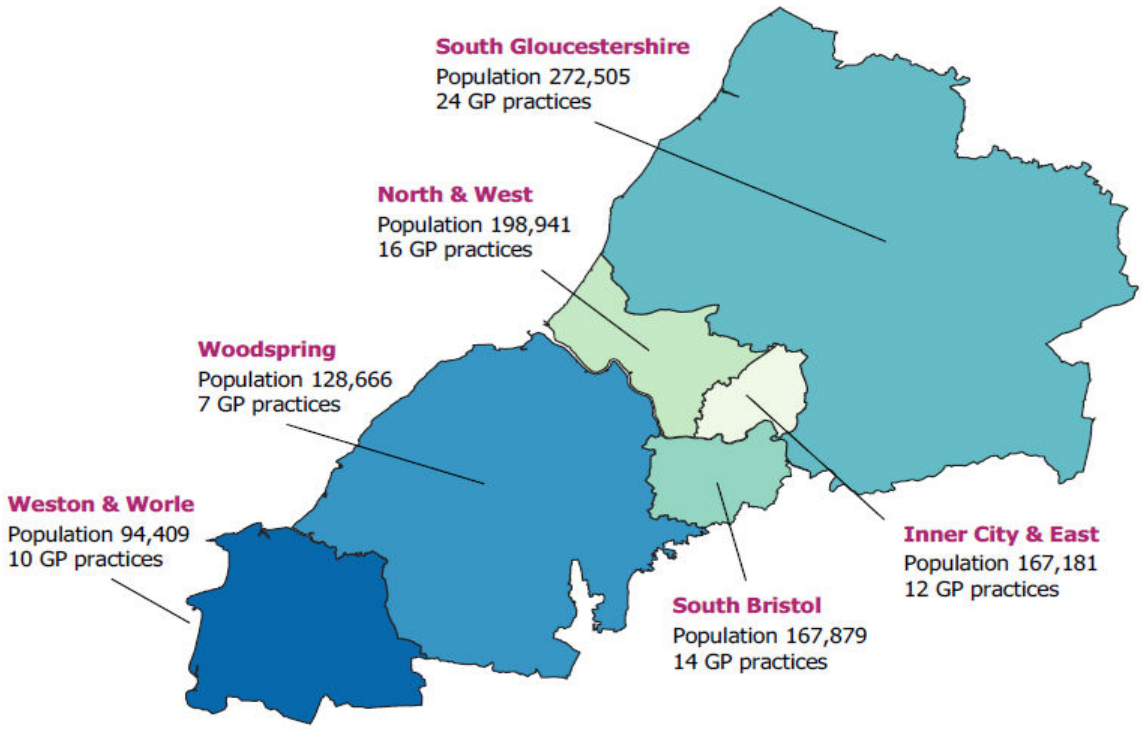
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) was responsible for planning, buying and monitoring the majority of healthcare services for the one million people living in Bristol, North Somerset and South Gloucestershire. From the 1st July 2022 the CCG ceased to exist and was replaced by the Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB). The CCG's functions and duties transferred to the Bristol, North Somerset and South Gloucestershire ICB.

The CCG was a membership organisation, led by GPs from the 81 general practices in Bristol, North Somerset and South Gloucestershire. GPs used their knowledge of the local population's health needs to provide clinical leadership and guide the planning and commissioning of services. The CCG worked with patients and partners to plan health services for local residents, based on the identified needs of the population. The Governing Body ensured that the CCG met its responsibilities and its membership included three lay members, local GPs, a secondary care doctor, an independent nurse member and executive members. More detail is provided in the Accountability Report section The CCG employed 434 members of staff who worked alongside colleagues in primary and secondary care, and in community services, as part of the Healthier Together system. The CCG was responsible for the commissioning of:

- 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
- Primary care services from local GP practices.

NHS England commissioned other primary care services such as dentists, pharmacists and opticians.

Bristol, North Somerset and South Gloucestershire CCG



CCG staff worked in and across 7 directorates led by:

- The Chief Executive's office – 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

About the Bristol, North Somerset and South Gloucestershire 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. The population is with older populations in North Somerset and South Gloucestershire and a younger population living in Bristol. The 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. It is 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%). Younger people tend to have the greatest number belonging to a BME group. There are significant pockets of deprivation within the 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 the population is described as 100 people:

Integrated Care Partnership Board

Healthier Together was the Integrated Care Partnership (ICP) Ten local health and care organisations sat on the Bristol, North Somerset and South Gloucestershire Integrated Care Partnership Board. The partnership went beyond these organisations and the views of the public, patients, staff and voluntary sector had a significant role in shaping the future of local health and care services.

Clinical Commissioning Groups (CCGs) were dissolved on the 1st July and ICBs came into existence and the vast majority of CCG staff transferred to the new organisation. The Bristol North Somerset and South Gloucestershire ICB formed the statutory body within the wider Integrated Care 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 the

ICB CEO-designate and Interim Chief Executive for the CCG. Work ensuring that the CCG was properly closed down and there was a robust hand over to the ICB on the 1st July was completed and more about this can be found the Governance Statement section.

Summary of activity

The Governing Body identified the following principal objectives for the CCG in 2021/22 and carried these over to the first quarter of 2022/23:

- "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."

The CCG worked together with partners to improve physical and mental health, promote wellbeing and reduce inequalities in health outcomes for local people. This work progressed as the country emerged from the Covid-19 pandemic which continued to present extreme challenges. In the first quarter of 2022/23 activities included:

- The approval of the Healthy Weston Phase 2: Outline Business Case. This aimed to provide more same day emergency care, establish a 24-hour acute monitoring unit, a one-stop urgent surgical assessment clinic and a 72-hour older people's assessment unit. These developments would allow rapid assessment and treatment, and reduce the amount of time people need to spend in hospital. The plans included the transfer of patients (other than older people) needing more than a 24-hour inpatient stay to other hospitals in the area, an expansion of care of the elderly services to create a centre of excellence for older people. The capacity created by changes to urgent and emergency

care and unplanned inpatient stays will be used to establish a surgical centre of excellence increasing the amount and type of planned surgery and procedures (such as endoscopies) offered.

- The continued development of Locality Partnerships, bringing together local health, care and community partners to understand what matters most to local people and improve care.
- The delivery of the new approach to community mental health services to offer the right support, at the right time, in the right place through the Community Mental Health Programme.
- A continued focus on improving the 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 the mass vaccination campaign.

Summary of key risks to delivering objectives

There were significant challenges facing our healthcare system including improving performance across planned and urgent care, including ambulance services and ensuring that mental health services were able to meet the demands placed on them. Performance across these areas has been below expectations and targets in 2021/22 and this continued into the first quarter of 2022/23 (p13). Key risks in 2021/22 which continued into the first quarter of 2022/23 included:

- The impact of Covid-19 on services, staff and the implementation of 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 impact of the transition to an ICB on the system, and on CCG staff as they transferred to a new organisation.
- The potential for increased health inequalities and poor outcomes for people in the 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 reported a small surplus of £7.125m against the quarter 1 Revenue Resource Limit of £461,101m.

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. The £7.125m surplus will not reduce the accumulated deficit as this will be carried forward into the BNSSG ICB's financial position in order that the CCG and ICB financial positions in 2022/23 can be monitored on a full year basis.

The accumulated deficit will be carried forward into 2022/23 and into the ICB's 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.

The Health and Care Act received Royal Assent on the 28 April 2022. Following the issue of an establishment order by NHS England the CCG was dissolved on 30 June 2022. On 01 July ICBs took on the commissioning functions of CCGs and the assets, liabilities and operations transferred to 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.

The CCGs 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/ICB 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. The dissolving of the CCG and establishment of ICB demonstrate that services will continue to be provided by the ICB and therefore the financial statements are prepared on the going concern basis. On this basis, the CCG considers it remains a Going Concern.

Summary of performance quarter one 2022/23

Overview of how CCG performance is measured

In 2020/21 the CCG was rated as Good by NHS England. 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 received a 'segment rating' in 2020/21 to reflect NHSEI 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 with 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 means 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 summary

In testing how the CCG is recovering following the COVID-19 pandemic, activity is compared to the same period in 2019/20. There has been less activity overall in the first quarter of 22/23 than the corresponding period in 2019/20, except for total non-elective admissions with a great than 1 day length of stay.

The total number of referrals were 11.06% lower than the same period in 2019/20 and GP referrals were 16.48% lower than in 2019/20. There were fewer first outpatient appointments than in the same period in 2019/20 (15.38% lower) and follow up appointments were 8.87% lower than in 2019/20.

The total number of A&E attendances were 14.01% lower than in 2019/20, with 11,609 fewer attendances (averaging 128 fewer attendances per day). The total number of non-elective admissions was 14.46% lower than in the same period in 2019/20.

The total number of admissions for planned care were 7.56% lower than in 2019/20, with Day Case admissions reduced by 6.74% and ordinary admissions reduced by 13.64%.

Performance 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: Q1 2022/23 performance compared to 2022/21 Year end

		BNSSG		
Indicator	**Standard**	**2021/22**	**Q1 2022/23**	**Change**
Percentage of patients admitted, transferred or discharged from A&E within 4 hours (BNSSG Acute Trusts Total)	95%	64.98%	62.33%	
Percentage of patients on an incomplete RTT Pathway waiting less than 18 weeks	92%	65.40%	66.20%	
Number of patients on an incomplete RTT Pathway waiting more than 52 weeks	1	3,779	4,764	
Percentage of patients waiting six weeks or more for a diagnostic test (15 key tests)	1%	37.90%	38.50%	
Maximum two-week wait for first appointment for patients referred urgently for suspected cancer	93%	64.90%	55.63%	
Maximum two-week wait for first appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	28.20%	30.68%	
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)	75%	66.80%	70.12%	
Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	96%	92.50%	89.02%	
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	81.10%	70.20%	
Maximum 31 day wait for subsequent treatment where that treatment is anticancer drug regimen	98%	99.00%	97.84%	
Maximum 31 day wait for subsequent treatment where that treatment is radiotherapy	94%	99.70%	99.57%	
Maximum 62 day wait from urgent GP referral (two-month wait) to first definitive treatment for cancer	85%	68.80%	57.37%	
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for cancer	90%	59.60%	60.92%	
Total Number of CDIFF Cases	<same period previous year	304	68	
Total Number of MRSA Cases Reported	0	38	7	
Eliminating Mixed Sex Accommodation	0	2	3	

Performance analysis

The following pages provide a more detailed summary of performance including how the CCG measured it. This report looks at key activities and programmes of work including:

- Work to improve the quality of services
- How the CCG engaged with people and communities
- Work to reduce health inequalities and promote equality across the local community and workforce
- Work with local Health and Wellbeing Boards
- Sustainable development
- A summary of the financial position. This is given in detail in the Annual Accounts section of the Annual Report (p97)
- The actions to tackle fraud and bribery are described in the Governance Statement (p44)

Performance management is a key role that ensures services delivered to the 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

As summarised in the previous section key risks in 2021/22 and into quarter one 2022/23 were:

- The impact of Covid-19 on services, staff and the implementation of 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 for increased health inequalities and poor outcomes for people in the community with Learning Disabilities and Autism.
- The potential impact of the Health and Care Act on the Integrated Care System, and on staff as they transferred to a new organisation.

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

Urgent Care

Performance against Standards for Urgent Care was poor throughout the first quarter of 2022/23, however demand remained below 2019/20 levels in

- from ambulances conveyances to Emergency Departments,
- major acuity attendances
- unplanned admissions.

The drivers behind performance challenges related to

- The high levels of No Criteria to Reside patients in acute beds, these are patients who no longer need inpatient care in an acute hospital but haven't been discharged. The numbers of patients with No Criteria to Reside reduced the number of acute hospital beds available for new admissions and limited the flow of patients through the hospital system.
- Covid-19 also continued to impact on urgent care in the first quarter of 2022/23. There was significant staff sickness absence due to COVID-19 across all partners which reflected the infection rates in the community. This primarily affected rates of simple and complex discharge, the ability to staff acute escalation beds, and capacity for admission avoidance and community services. There were also high numbers of acute covid inpatient numbers. The continued need to have in place Covid Infection Prevention and Control measures, zoning and social distancing requirements continued to affect acute bed efficiency.
- The period also saw significant staffing pressures on the 111 service which were related to national contingency pressures driven by virtual call center consolidation in other parts of England, the addition of new demand nationally from new contracts, and increased staffing absence.

A key area of concern during the first quarter of 2022/23 was the number of ambulance handover delays across Bristol, North Somerset and South Gloucestershire. National guidance is that patients arriving by ambulance at an Emergency Department should be handed to hospital staff to care for within 15 minutes. Ambulance activity during the quarter was in line with trends in previous years however the number of handover delays had worsened so that in June 2022 the total number of ambulance handovers within the 15-minute Standard was 21.70%. Handover delays affected ambulance response times in the community, and

performance against both the 7-minute response Standard for Category 1 calls and 18-minute standard for Category 2 calls was below target. Average response times reported in June 2022 were over 9 minutes for Category 1 calls and over 57 minutes for Category 2 calls. Delays in response times in turn had an effect on quality and patient outcomes.

Ambulance handover delays also compromised performance against the Accident and Emergency 4 hour waiting time Standard which declined in the first quarter of 2022/23 compared to the same period in 2021/22 moving from 72.07% to 62.33%.

The number of 12 hour plus delays following decision to admit (12hr+DTA) increased and in June 2022 there were 873 patients who waited over 12 hours in an Emergency Department after a decision to be admitted was made.

The poor performance across these standards was largely driven by the increase in the number of delayed discharges and the high numbers of patients with No Criteria to Reside remaining in acute hospital beds. The delays in discharge resulted in very high acute hospital bed occupancy rates and this, in turn, affected the ability to recover planned care activity. Many of the delays stemmed from more complex discharges that involved patients requiring domiciliary or residential care.

Improving performance was a priority for the CCG and a wide range of initiatives were implemented across the system to improve the quality of services, patients' experiences, and patient outcomes. These initiatives continued to be implemented as the CCG transitioned to the ICB. Actions included:

- A focus on the Discharge to Assess (D2A) business case and 'Home First' programme to expand and promote home-based rehabilitation and reablement and reduce onward care needs.
- Internal Improvement Programmes in both NBT and UHBW to increase the number of non-complex discharges before noon and at weekends.
- Bank holiday weekend planning to anticipate activity surges and workforce challenges.
- Urgent and Emergency Care Collaborative transformation programme, prioritising prevention of admission, developing the general practice urgent care model, expanding community pharmacy referrals.
- Ambulance handover improvement programme focused on the interface between the ambulance service and local Emergency Departments.

Planned Care

Performance against planned care targets was also affected by the same issues as urgent care. The high levels of No Criteria to Reside patients in acute beds, and the significant staff sickness absence due to COVID-19 across all partners and the continued need to have in place Covid Infection Prevention and Control measures, zoning and social distancing requirements continued to affect planned care activity.

The total waiting list size for planned admissions patients in Bristol, North Somerset and South Gloucestershire for the local population increased during the quarter, however when compared to the first quarter of 2021/22 the number of people waiting for planned treatment had reduced from 71.70% to 66.20%. The total number of people waiting for planned treatment in June 2022 was 80,712. The CCG's performance against the standard was ranked 35th out of 102 CCGs nationally, and ranked 2nd out of the six 6 CCGs in the South West.

The number of patients waiting 52 weeks or more for planned treatment increased during the quarter one period to 4,764, which was 5.9% of the total waiting list. The number of patients waiting in the first quarter of 2022/23 was greater than the number of patients waiting over 52 weeks in quarter 1 of 2021/22, (2,676 patients). The number of patients waiting over 52 weeks increased at both University Hospitals Bristol and Weston NHS Foundation Trust and at North Bristol Trust.

The number of patients waiting over 78 weeks for planned treatment decreased during the quarter to 744 in June 2022. The number of patients waiting over 104 weeks for treatment also decreased, in May 2022 there were 112 patients waiting, this had reduced to 69 in June.

Performance against the 2 week wait cancer standard had declined to 48.9%, for the same quarter in 2021/22 performance was also poor at 61.02%. The 93% national standard has not been achieved at population level since June 2020.

Performance against the 28-day faster diagnosis standard for cancer patients also worsened in June 2022 to 69.3% for the local population. The 75% national standard has not been achieved at population level since reporting started in April 2021. There was also a decline in performance against the 62-day referral to treatment time for cancer patients in June 2022 to 53.5%. The 85% national standard has not been achieved at population level since April 2019.

Actions to improve performance included:

- Daily tracking and mutual aid across trusts and regional mutual aid processes of patients waiting over 104 weeks.
- Revision of Access Policy.

- Weekend working, waiting list Initiative payments, and extended working days to increase capacity and delivery mor activity.
- Maximising capacity opportunities with Independent Sector Providers
- Promoting system collaboration across pathways, including dermatology and Ear, Nose and Throat.
- Actions to address diagnostic workforce and cancer services capacity pressures across the system.
- Reviewing patients, validating and prioritising patients on outpatient waiting lists.
- Increasing the availability and use of advice and guidance.
- Focusing on cancer pathways facing specific challenges, reviewing demand and capacity modelling, access to diagnostics and referral management.

Mental Health

Performance against key measures showed improvement against many targets however performance in many areas continued to be below the standard. The table below provides performance details:

Table 2 Mental Health performance standards

Mental Health, LD & Autism Metrics	Period	Standard	Latest	Previous	Variance	Change	19/20	Variance	Change
Dementia Diagnosis Rate	Jun-22	66.7%	65.4%	65.3%	0.1%	▲	68.5%	-3.1%	▼
EIP - 2ww Referral	May-22	60%	70.0%	76.9%	-6.9%	▼	85.0%	-15.0%	▼
IAPT Roll out (rolling 3 months)	May-22	6.25%	4.7%	4.4%	0.2%	▲	3.6%	1.1%	▲
IAPT Recovery Rate	May-22	50%	51.8%	50.6%	1.2%	▲	N/A	N/A	N/A
IAPT Waiting Times - 6 weeks	May-22	75%	92.4%	93.6%	-1.2%	▼	N/A	N/A	N/A
IAPT Waiting Times - 18 weeks	May-22	95%	99.5%	100%	-0.5%	▼	N/A	N/A	N/A
CYPMH Access Rate - 2 contacts (12m Rolling)	May-22	34%	30.5%	28.1%	2.5%	▲	5.4%	25.2%	▲
CYP with Eating Disorders - routine cases within 4 weeks	Q1 22-23	95.0%	91.4%	88.5%	2.8%	▲	80.2%	11.2%	▲
CYP with Eating Disorders - urgent cases within 1 week	Q1 22-23	95.0%	91.7%	83.3%	8.3%	▲	67.9%	23.8%	▲
SMI Annual Health Checks (12 month rolling)	Q1 22-23	60.0%	56.8%	45.7%	11.1%	▲	42.5%	14.3%	▲
Total Innapropriate Out of Area Placements (Bed Days)	May-22	N/A	470	450	20	▲	643	-173	▼
Percentage of Women Accessing Perinatal MH Services	May-22	8.6%	6.1%	5.8%	0.3%	▲	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in CCG beds	Jul-22	9	14	16	-2	▼	N/A	N/A	N/A
Reliance on inpatient care for people with a LD and/or autism - Adults in NHSE beds	Jul-22	13	19	21	-2	▼	N/A	N/A	N/A
LD Annual Health Checks delivered by GPs aged 14+	Jul-22	1275	795	581	214	▲	N/A	N/A	N/A
AWP Delayed Transfers of Care	Jul-22	3.5%	12.4%	10.6%	1.8%	▲	3.4%	9.0%	▲
AWP Early Intervention	Jul-22	60%	85.0%	63.1%	21.9%	▲	89.0%	-4.0%	▼
AWP 4 week wait referral to assessment	Jul-22	95%	84.33%	76.87%	7.5%	▲	96.30%	-12.0%	▼

Actions taken by the CCG in 2021/22 that continued to have an impact in the first quarter of 2022/23 included:

- A 24 hour, seven days a week telephone crisis line
- A Child and Adolescent Mental Health Services (CAMHS) phone line
- A 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 local black led community groups
- Expanded support to people with dementia in care homes
- A 'People Who Sleep Rough' link team to improve engagement with those who are sleeping rough and experiencing severe emotional distress.
- Support to young people in North Somerset through a joint service with Off the Record.
- Four teams as part of the Mental Health in Schools programme of work
- mental health support to people who call 111 at the weekend.
- New mental health roles as part of the Additional Roles Reimbursement Scheme, these roles work across GP practices and secondary mental health specialists.
- Green social prescribing; 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.

Other work during the first quarter of 2022/23, and continuing under the ICB included:

- Delivering the 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, including 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 the IAPT service to reach more people and expanding the support provided to adults in crisis
- Expanding the support available to refugees and asylum seekers who have experience trauma

- Expanding perinatal mental health services and setting up new Maternal Mental Health Clinics
- Building on the developing 111 mental health support
- Providing additional support to children and young people with eating disorders
- Expanding the 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

Financial Years	2021/22 (£000)	2022/23 Annual Expected Mental Health Investment Spend (£000)	2022/23 Months 1 to 3 Mental Health Investment Spend (£000)
Mental Health Spend	160,072	168,744	41,815
ICB Programme Allocation	1,859,377	1,930,275	453,970
Mental Health Spend as a proportion of ICB Programme Allocation	8.61%	8.74%	9.21%

(2022/23 figures reflect the pre-Mental Health Investment Standard recategorization workings undertaken in September 2022. 2022/23 figures are consistent with 2022/23 Month 3 ICB reported Mental Health Investment Standard plan and expected outturn).

Improve quality

The CCG had 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). The CCG Quality Committee ensured that there was comprehensive oversight and monitoring of the quality of commissioned services.

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

Infection Control Management

Quarter one 2022/23 saw:

- 3% reduction in the number of E.coli bacteraemia (566 against threshold of 667)
- 2.3% reduction in MSSA bacteraemia cases. There were 168 assigned cases.
- 18% increase in Methicillin Resistant Staphylococcus Aureus (MRSA) cases. There were 38 assigned cases.
- 4% increase in Clostridioides Difficile Infections (304 against threshold of 191). A local action plan continued to be monitored to ensure that local processes aligned with best practice
- Increases in Other Bloodstream Infections (BSI's) including an 11% increase in Pseudomonas Aeruginosa bacteraemia cases and a 9% increase in Klebsiella bacteraemia cases. There were 71 Pseudomonas Aeruginosa assigned cases and 168 assigned Klebsiella cases.

During 2021/22 one hundred and three, Healthcare Associated Infections related to Covid 19 were notified to the CCG as Serious Incidents and forty-six Root Cause Analysis were received. Learning reviews for the 46 Root Cause Analysis reports were undertaken and identified themes included:

- long term staff absences/vacancies with staff caring for both Covid 19 positive and negative patients, this created the potential for transmission from staff to patient
- multiple patient bed moves prior to patients testing positive for Covid 19
- patient to patient transmission during outbreaks
- the structural layout of some older sites Hospital contributed in the transmission and some patients were medically fit for discharge (MFFD) before they tested positive for Covid 19 but delays in processing their discharge increased their risk of acquiring Covid 19

During 2021/22 both community and secondary prescribing met antibiotic prescribing targets. Three key areas of work agreed by the Bristol, North Somerset and South Gloucestershire Antimicrobial Stewardship Group included Clostridioides Difficile Infections, antibiotic consumption and prescribing. These continued to be monitored with a focus on urinary tract infections and also on appropriate documentation of penicillin allergies and antibiotic prescribing in children. This work be taken forward by the ICB and will continue throughout 2022/23.

Safeguarding

During quarter one 2022/23 the CCG Safeguarding Team continued to work to deliver the statutory safeguarding duties and deliver an excellent and well received service to in Primary Care colleagues, offering expert safeguarding advice and support. The team also supported

multi-agency programmes of work across Bristol, North Somerset and South Gloucestershire and audits in order to seek assurances that lessons have been learnt and safeguarding processes are robust.

CCGs were legally responsible for the safeguarding elements of the services they commissioned under the "Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework" revised August 2019. The table below illustrates our compliance against what is expected in the Framework

Table 3 Compliance against Safeguarding Accountability and Assurance Framework

AREA	STANDARD	RAG RATING
Leadership and Organisational Accountability	A clear line of accountability for safeguarding, reflected in the CCG governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the organisation's safeguarding arrangements. In addition, a team made up of designated professionals for safeguarding children, looked after children, care leavers and adults.	
Training	Training all CCG staff to recognise and report safeguarding issues supported by a training strategy and compliance percentage in line with Intercollegiate Documents and national guidance for Prevent.	
Safer Recruitment	Clear policies describing the commitment and approach to safeguarding, including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults, as appropriate.	
Inter-agency working	Effective inter-agency working with Local Authorities, the Police and third sector organisations, including appropriate arrangements to co-operate with Local Authorities in the operation of safeguarding children's partnerships, Corporate Parenting Boards, Safeguarding Adults Boards and Health and Wellbeing Boards.	
Implementation	Appropriately engaged with all safeguarding investigations, multi-agency case reviews or safeguarding practice reviews and that the evidence of learning has been embedded into practice	
Patient Engagement	Ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding	
Supervision	Safeguarding supervision is available to staff in line with Intercollegiate Guidance	
Assurance	As a commissioner of local health services, the CCG must be assured that there are effective safeguarding arrangements in	

	place in the services and gain assurance throughout the year to ensure continuous improvement	

Action plans were developed and implemented where an amber rating was given against a standard:

- Development of a training matrix to reflect the requirements for each team
- The creation of a Strategic Safeguarding Health Working Group enabled system health learning conversations to take place and supported implementation and engagement
- Stronger, more robust assurance was sought from providers that effective safeguarding arrangements were in place.

Owing to the Covid 19 pandemic, assurance and quality visits with our main health providers did not take place in quarter one. However, assurance has been sought from;

- Quarterly safeguarding training submissions
- Attendance at partners' Safeguarding Governance Committees/Steering Group
- Updates provided at the BNSSG Safeguarding Providers Forum led by the CCG Safeguarding Team

Quality visits continued in partnership with CGG and Local Authority colleagues to Care and Nursing homes and to the Care Hotel and the Asylum/Refugee hotels

The CCG safeguarding team participated in the completion of a multiagency quality assurance review of selected adult safeguarding cases relating to a theme of exploitation; in particular individuals exploited via rogue traders and online scamming. A learning brief produced by the South Gloucestershire Safeguarding Adults Board was produced as a result of this audit and disseminated to providers and GPs.

A Domestic Abuse Audit regarding the impact on children was undertaken during 2021-22 in Bristol. The audit highlighted the limited services for perpetrators and the increased demand on services for children and families. The audit highlighted that there was good information sharing and the voice of the child was heard and evidenced. The CCG Safeguarding Team disseminated this information to GPs.

The CCG Safeguarding team supported safeguarding events in partnership with other colleagues including our internal communications teams. These events included Stop Adult Abuse (June 2021) and NHSEI National Safeguarding Fortnight- sharing best practice (June 2021)

The CCG Safeguarding Team through the Named GP for Safeguarding Children continued to deliver a number of Level 3 Safeguarding Children Training sessions to Primary Care staff on a virtual platform in quarter one. In order to support their safeguarding training compliance as per the Intercollegiate Guidance documents. Bespoke Level 3 Safeguarding Adult training was also provided to GP Practices. Four Rapid Reviews were undertaken across the footprint, one in each area and also one out of area in 2021/22. In addition to these there were two ongoing Child Safeguarding Practice Reviews which were commissioned the previous year (2020/21); these required significant scrutiny and development of a robust action plan.

The themes identified from these reviews included;

- Professional Curiosity, challenge and escalation
- Working together, sharing information and good quality referrals
- Emotional Health and wellbeing
- Adolescent Care

The CCG Safeguarding Team were involved in 16 Domestic Homicide Reviews. These are at different stages of completion but have included the safeguarding team agreeing final reports and recommendations for learning. 8 DHRs from previous years have been agreed for final reports to be received by the Home Office to await publication. The DHRs have evidenced the complexity of mental ill health, substance misuse and coercive control which will be taken forward in learning for Primary Care. Domestic abuse training sessions with NextLink have been planned for GP Practices. In addition, signposting information on the Domestic Abuse Act (2021) has been made available for GPs and practice staff

Patient Experience Quarter One 2022/23

The CCG recognised that the voice of local people and communities was imperative and continued to engage with them to co-design and co-create new services. One of the main challenges faced was how to use data intelligently to lead to real improvements in patient experience. By continuous analysis of patient experience information and learning encountered along the way, themes and trends can be ascertained to help improve the patient experience.

The Customer Services Team continued to gather feedback from patients through compliments and complaints, advice and liaison enquiries, MP enquiries, feedback from healthcare professionals, patient surveys and Healthwatch reports. The CCG used social media, including Twitter and Facebook, and monitor responses posted on the NHS Choices and Care Opinions websites. The Citizens panel had an important role, providing feedback on their experiences of

healthcare. A customer satisfaction survey was sent to all patients raising a complaint, and this data was regularly reviewed with colleagues across the CCG.

During the first quarter of 2022/23 the CCG received 931 contacts, 777 General Enquiries, 87 formal complaints, 23 Compliments and 44 MP enquiries. No complaints were reported to the Parliamentary and Health Service Ombudsman.

Patient experience was used to improve how the CCG operated across the health system. Feedback and analyse trends or themes were shared with the Quality Committee and Governing Body, to ensure that learnings were shared and patient experience improved.

- The Customer Services Team continued to provide training for CCG staff regarding patient feedback, how this it was used and why it was important to the CCG as service commissioners. This was also explored at the corporate induction for all CCG new starters.
- Customer Services 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 implemented a Clinical Review Team who met weekly to discuss complex cases, process and strategy with a view of giving the best possible patient experience.
- There were regular meetings with external providers to improve services and to facilitate a swifter and smoother process for patients and improve collaborative working.
- Learning and intelligence collected was used to inform and update policies and related documentation, to provide a fair and transparent service for patients.

Funded Care Services

The CCG's Funded Care Services included:

- Both Adult and Children's Continuing Health Care
- Individually funded Mental Health care
- Learning Disability and Autism funded health care

The CCG's teams continued to support some of the most vulnerable people in the population; those with complex physical, psychological and social needs for which cannot be met by universally commissioned services. In quarter one 2022/23 there were many achievements and opportunities to embed the culture of continuous quality improvements:

- A recovery of performance against national Adult Continuing Health Care key performance Indicators; The CCG team was the most improved team in the Southwest.
- The completion of a review of people placed in locked rehabilitation settings.
- Pioneering a new approach to discharges from a locked rehabilitation settings to support the successful discharge of people.
- Optimisation of Care Track, the IT patient record system to improve the management of clinical records.
- Improved oversight and review of individuals subject to care under a Deprivation of Liberty court order.
- The completion of a review of all related policies.
- A suite of 'essential to role' training was commissioned to support all staff in the Funded Care Team.
- All team members invited to attend Supervision training and to attend group supervision.
- The pilot of a 'pooled budget' funding model with Local Authorities, due to end in September 2022.
- A commitment to undertake an increased number of joint assessments with Local Authority colleagues for children with complex needs.

To ensure that Funded Care Services continue to improve the ICB will:

- Continue to work with regional and national colleagues to optimise the use of Personal Health Budgets
- Continue the roll out audit training
- Review the model of care delivery in Adult Continuing Health Care
- Create a suite of standardised documents to support quality/insight visits with providers
- Continue work to ensure individuals placed in locked rehab provision have a well-planned and person-centred discharge

Working with people and communities

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended by Section 14Z45 of the Health and Care Act 2022) to 'make arrangements' to involve the public in the commissioning of services for NHS patients (the 'public involvement duty'). The CCG recognised the importance of working in partnership with people and communities and was committed to:

- Ensuring that people and communities were at the heart of what it did

- Building a two-way dialogue and partnership with residents to co-produce and shape services
- Applying Population Health Management principles to help improve health and care outcomes in different population groups

In the first quarter of 2022/23 insight and engagement activities were heavily driven by the transition to an ICB, and wider system pressures as well as continuing to support Covid-19 vaccination programme feedback. Some examples of these engagement activities included:

- Delivering an eight-week public engagement period to gather feedback on the planned changes at Weston General Hospital. During which over 640 responses were gathered through a variety of channels, including public events (both online and in person), attending existing community meetings, pop up events at hospital sites and an online survey. The final report will be published by the ICB in November 2022.
- Delivering a workshop attended by stakeholders across the health and care system designed to develop and test a micro-level approach to changing behaviour relating to non-essential urgent care walk-ins. An initial in-person workshop was held in May 2022 to share, review and discuss system intelligence around non-essential urgent care in order to identify potential behaviour change pilots to run through 2022/23.
- Preparing the twelve-week 'Have Your Say' engagement exercise in Bristol, North Somerset and South Gloucestershire which launched on July 1 2022. The exercise aims to co-create a population-level vision for the future (2, 5, 10 and 20 years' time), generate a set of 'human statements' that guide prioritisation and strategy development for the ICS and engage with our population and partners 'where they are', building on the collective involvement capability of our system. The ICB will undertake a whole population survey, hosting a series of focus group 'Imagine if' discussions and gathering views from members of the public at face-to-face events led by partner organisations across the region.
- Developing an enhanced understanding of service user experience to support future insight work relating to the delivery of home monitoring as a safe alternative to NHS bedded care. Semi-structured interviews with those who have experienced the acute respiratory home monitoring service, as well carers and staff will lead to the development of an ongoing feedback mechanism for those who receive home monitoring, which is linked to service user outcomes and activity.
- Gathering feedback on Covid-19 and flu vaccine concerns and motivations from public and staff to guide future communications.

- Commencing an evaluation of the covid-19 vaccination programme to provide learning for an evolution to business as usual, as well as identifying wider learning for other health & care projects.

As part of the response to the continuing challenges faced within our healthcare system, the CCG engaged with over 4,000 individuals since April 2022. Examples of where these insights have informed activity include:

- Insights gathered from over 640 individuals on the plans for change of services at Weston General Hospital. The insights gathered will inform how the changes are communicated, and how people affected by the changes can be supported as the programme moves towards implementation.
- Insights obtained prior to – and during – the urgent care behaviour change workshop attended by stakeholders across the health and care system have helped to identify focus areas for behaviour change pilots to run through 2022/23. Further, small-scale workshops will seek to identify and refine targeted interventions, the impact of which will be measured and evaluated. Outputs of this work will feed into future winter planning and activity, with the potential to scale these interventions where required.

Bristol North Somerset South Gloucestershire Covid-19 Vaccination activities

Engagement specific to the COVID-19 vaccination programme continued in the first quarter of 2022/23. From April to June 2022 the focus shifted from post clinic evaluation to inform improvements to gaining more in-depth understanding of people's concerns about the vaccine. Detailed discussions with residents about reasons for deciding to delay having Covid-19 vaccinations are helping to inform future services and communications. The vaccination Insight & Engagement team spent many hours talking to staff, partners, volunteers and community organisations exploring programme learnings which will be combined with insights from feedback from over 15,000 BNSSG residents over the last 18 months to inform an evaluation that will provide input for future vaccination and other health and care programmes. A positive response to vaccine uptake continued with the programme operations and communications being guided by data and insights from residents, partners, staff and community organisations.

BNSSG Healthier Together Citizens' Panel

The Citizen's Panel was launched in 2018, and was refreshed during 2021/22 which 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 supported the delivery of future citizens insights projects by providing a base for

deliberative research projects. In April 2022, the tenth Citizens' Panel survey was launched, focusing on behaviours in an urgent care situation, awareness of NHS 111 and awareness of local NHS communications campaign material. The findings allowed likely and unlikely behaviours panellists would take if faced with an urgent care situation to be compared, following a local urgent care communications campaign which took place between Surveys 9 and 10. While there were no significant differences in likely/unlikely behaviours between the two surveys, results suggested that those who had seen NHS communications or messaging in the previous 6 months would be less likely to contact their GP and more likely to call NHS 111 over the phone or online compared to those who have not seen this communication material or messaging.

Working with People and Communities Strategy

One of the NHS England requirements for Integrated Care Boards was the development and submission of a system wide framework for working with people and communities, which describes how the ICB will work alongside the ICP to ensure that people are at the heart of all we do in our health and care system.

The framework builds on previous work undertaken in January 2021 to develop the 'BNSSG Working with people and communities charter' and sets out some of the principles and approaches we will use to guide us as our partnership evolves and ways in which we will assess our progress and maturity.

In order to develop the framework, an extensive period of engagement with key stakeholders across our system partnership was undertaken, including place-based partners and the local Healthwatch team. This involved an online discussion with 28 system engagement leads followed by a smaller working group of representatives from system partners to work through the detail of the strategy and develop a final draft. Through a combination of individual one-to-one conversations and group discussions we gathered over 100 individual pieces of feedback to help develop the final version, as well as gathering key areas for the focus of our eventual action plan. The framework will be supported by robust activity plans in line with the Integrated Care Board's strategy development for 2022/23.

Reducing Health Inequality and Inequalities

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 was outlined in Section 14T of the Act. During quarter one 2022/23 the CCG continued in its work to reduce health inequalities. The CCG was committed to advancing

equality and reducing health inequalities for the diverse population served. Implementation of the Public Sector Equality Duty 2011 formed the foundation of the CCG equality and diversity activities. This Duty stipulates bodies 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 (this can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/) sets out an ambitious action plan to address inequalities in the workplace and within the population. The four objectives in the strategy were shaped by the legal frameworks provided by the Equality Act 2010 (Public Sector Equality Duty) and the Health & Social Care Act 2012, which directed the CCG to take steps to reduce health inequalities.

- 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

People

The CCG continued to deliver against the People Plan, the single action plan for 2021-22, overseen by the People Plan Steering Group and Inclusion Council, two strategic forums. During March and April 2022, the CCG undertook an audit of its recruitment policy and processes to ensure that recruitment was inclusive and equitable and attracted a diverse talent pool; and managers continued to have access to line manager and recruitment training and resources.

A focus was maintained on building an inclusive culture and offering a range of training and engagement to raise awareness of Equality, Diversity and Inclusion issues affecting the diverse workforce and population, including building cultural competence and emotional intelligence. In addition to the Inclusion Roadshow (embedding inclusion across the organisation) launched in 2021, training to address unconscious bias and micro-aggressions was delivered across the organisation.

A robust wellbeing offer continued to help staff stay physically and mentally well including access to Mental Health First Aiders, culturally appropriate mental health support, a gym onsite and guidance for financial literacy.

Work to review Workforce Race Equality Standard (WRES) and Disability Equality Standard (WDES) data to identify opportunities to improve the working life experience of our ethnic minority and disabled staff continued. The CCG remained committed to monitoring and acting on evidence. The CCG's most recent mandatory and statutory reporting can be found in the CCG Equality Annual Report for 2021. Regular temperature checks were taken to ensure that Equality, Diversity and Inclusion initiatives had an impact and supported four staff networks (race, disability, parents and carers and LGBTQ+) who represent the voice of staff at key strategic forums.

Population

The CCG continued to build a robust evidence base to support decision making. The Insights & Engagement team supported consultation and engagement to improve health care services in Weston, improve the take-up of the Covid-19 vaccine and redesign community mental health provision across the region.

The CCG continued to host the Healthier Together Citizen's Panel, made up of 1400 people representing the BNSSG population. Survey 10 took place in April 2022 and focussed on behaviours in an urgent care situation, awareness of NHS 111 and local NHS communications campaign material.

Health Inequalities

Tackling health inequalities was a priority for the CCG and work continued on the established action plan to address health inequalities. This included addressing elective recovery, embedding health inequality into our equality analysis processes, working more closely with communities – building on lessons learned during the pandemic. The CCG staff continued to work with providers and the Voluntary sector to improve data and insights into health inclusion groups including people experiencing homelessness and Gypsy, Roma and Traveller communities; and approaches to 'Make every contact count' continued to be strengthened to increase take up of support and access to physical and mental health services.

In line with national guidance the CCG worked to identify the five clinical areas that the NHS must focus on in terms of health inequalities as part of the national Core20Plus5 approach. This approach requires health systems to focus on the 20% most deprived population nationally plus other parts of the local population who have poorer access, experience and outcomes in the following five clinical areas: maternity; annual health checks for people with a serious mental illness; vaccinations for people with chronic obstructive pulmonary disease; early cancer diagnosis; finding undiagnosed hypertension. This work will be taken forward by the ICB and the ICS.

System Working

The Healthier Together partners adopted a system approach to improving Equality, Diversity and Inclusions across a number of shared objectives including inclusive recruitment, supporting staff networks, BAME talent management and improving the robustness and quality of Equality Impact Assessment. The remit will be expanded in 2022-23 to include delivering the Equality Delivery System (EDS) 2022 at system level. EDS 2022 is a system that helps NHS organisations to have conversations with staff, local partners and population in order to review

and improve performance for people with characteristics protected under the Equality Act 2010 and Public Sector Equality Duty.

Similarly, a system approach to tackle health inequalities is being taken. The transition into integrated care will support organisations at Integrated Care Partnership level to work closely to deliver tailored services that meet the need for the communities that are close to each area and include services that address wider determinants of health. This will include working with specialist services that have existing and strong relationships with communities in health inclusion groups. The ICB will build on the success and lessons learned during the development of a Community Mental Health Framework that brought together commissioners, providers, voluntary and faith sector and lived experience groups to shape a Memorandum of Understanding. The ICB will also work with system partners to establish an Accessible Information Standard Group to collectively improve accessible communications and engagement for patients and establish a working group to deliver EDS 2022 at the system level. The 2022-23 Equality Annual Report which will be published in January 2023 will highlight the breath of EDI achievements over the year.

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

South Gloucestershire Health and Wellbeing Board

The South Gloucestershire Health and Wellbeing Board did not meet formally during the first quarter 2022/23, however meetings took place at the end of the last quarter of 2021/22 and at the start of the second quarter of 2022/23 2. During the first quarter of 2022/23 joint working arrangements between the Health and Wellbeing Board and the South Gloucestershire Locality Partnership continued to develop via a ‘One South Glos Plan’. A joint development session took place on 23rd June to agree a joint vision and shared areas of focus for the year ahead.

Bristol Health and Wellbeing Board

In Bristol the CCG Area Director and three Bristol Locality Partnership leads attended and contributed to monthly Bristol Health and Wellbeing Board meetings. Items included Long Covid, the Fuel Poverty Action Plan, the One City Cost of Living Response, and immunisations. In June they took part in priority-setting for the Board. The Locality Partnerships also gave updates at two of these meetings; this is a standing agenda item at public meetings. The Chair of the Bristol Health and Wellbeing Board is a member of the Integrated Care Partnership and will chair it in 2022/23.

The North Somerset Health and Wellbeing Board

The North Somerset Health and Wellbeing Board last met in late June of 2022. Amongst the main items on the agenda were a refresh of the 21-24 health and wellbeing strategy action plan, an update on the development of the new Integrated Care System in Bristol North Somerset and South Gloucestershire, and a briefing on Healthy Weston, outlining recently agreed plans to secure a dynamic and sustainable future for Weston Hospital. In addition, a proposal was agreed to work with the Local Government Association to provide pier-led support to review the effectiveness and impact of the Health and Wellbeing Board.

Sustainable Development

During the first quarter of 202/23 the sustainability focus was twofold, a readiness to deliver on the Green Plan agenda, and continuity of existing activities with partner organisations with a view that these become integrated in the overall programme of work across the system.

At the end of March 2022, the Healthier Together Executive Group agreed the Green Plan which focused system work over the forthcoming years as high standards of quality health and care are delivered whilst addressing the environmental impact this creates. The sustainability vision is set out as one of the seven ICS strategic aims:

Strategic aim six:

“We will act as leading institutions to drive sustainable health and care by improving our environment, achieving net zero carbon by 2030, improving the quality of the natural environment, driving efficiency of resource use”

The intention is to do more than minimise any negative impact of activities and the Green Plan shows how, through developing sustainably, a significant positive contribution can be made 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.

Improve the environment: We will improve the overall environmental impact and sustainability of our services, especially the damaging local impacts of air pollution. This will create a cleaner, safer, more ecologically sound environment locally and globally, including restoring biodiversity as much as possible

Net zero carbon: We particularly recognise the pressing urgency to address our carbon footprint and will reduce the impact of our services on the environment by achieving net zero carbon across all emissions scopes by 2030

Generate a BNSSG-wide movement: Our sustainability behaviours, actions and innovations as anchor institutions will support a cultural change amongst local citizens and businesses resulting in wider improvements in air quality, biodiversity, and the quality of the natural environment

Working in partnership, the system agreed how it would commit resources to co-ordinate and lead delivery across the system. Acute trust partners have already started to collaborate on matters of mutual interest.

In primary care, GPs have initiated collective working and with support from central resources analysis will take place of some premises of energy consumption and opportunities for reducing demand and environmental impact as a pilot.

NHS property Services has set out its own green plan, and the CCG and system partners were dependent on this landlord for contributions to support the green plan. Commitment was made by NHSPS to replace lighting in premises to reduce energy consumption. Additionally, consultants have been engaged to identify how pilot premises could reduce carbon footprint and the level of investment that would be required.

To promote the importance of sustainability, and in fulfilment of the stated pledge governing capital investments, directors of finance have agreed a revised capital prioritisation matrix which, unless exceptional, makes positive contributions to sustainability a pass/fail requirement.

As a commissioning organisation the CCG continued to use standard NHS contract which requires providers of health care to meet NHS Green Plan responsibilities.

The Weston Villages Primary Care building development continues into 2022/23. This will result in a new building which, through the BREEAM (Building Research Establishment Environmental Assessment Method) standard, will have a positive environmental impact.

Digital infrastructure supplied by the CCG across both GP and Corporate IT estates continues to cater for remote working which reduces the need for travel while enabling connections between patients and clinicians, and also staff and stakeholders. Our Hybrid Way of Working

developed in response to the pandemic remains in place with staff working from home, and this will permit the reduction in or office footprint and associated energy consumption.

Financial review 2021/22

The CCG performance target for the 3 months to the 30 June 2022 was £461.100m and is based on the quarter 1 profile spend of the BNSSG System Annual Plan submitted to NHS England in June 2022. The quarter 2 to quarter 4 profile spend will be the performance target of BNSSG Integrated Care Board (ICB), the CCG successor body.

The goal of the system was to ensure breakeven for each organisation and a commitment to shared system working and management of financial and operational risk.

(Table 4)

2022/23 Total Allocation	Annual Plan - Total Allocation	CCG Q1	Total ICB Q2-Q4
	£000	£000	£000
Total recurrent Allocation	1,736,757	434,188	1,302,569
Total Non-Recurrent Allocation	120,668	26,912	93,756
Total allocation	**1,857,425**	**461,100**	**1,396,325**

Financial performance

The closing position of BNSSG CCG was a surplus of £7.125m. In line with NHS England guidance the CCG made a final adjustment of £7.125m against the revenue allocation which decreased the allocation to £453.975m and therefore reduced the closing position to breakeven. The ICB will make a corresponding adjustment to the opening revenue allocation.

(Table 5)

Financial Position to 30 June 2022	Opening position	Allocation adjustment	Revised allocation
	£000s	£000s	£000s
Allocation	461,100	(7,125)	453,975
Expenditure	453,975	-	453,975
Surplus	**7,125**	(7,125)	-

The surplus of £7.125m primarily relates to the timing of spending against Service Development Funds; release of Elective Service Recovery Funds; the reversal of provisions and an underspend against prescribing costs.

(Table 6)

June 2022 - Month 3	2022/23 YTD Budget	Expenditure	Variance	
Area of Spend	£000s	£000s	£000s	
Acute Care	226,789	225,368	1,421	
Mental Health & Learning Disabilities	53,401	52,893	508	
Non-Acute Contracts	63,041	65,010	(1,969)	
Children's Services	4,685	4,411	274	
Continuing Healthcare	23,846	23,143	703	
Primary Care	79,677	77,726	1,951	
Other Support Costs and Running costs	9,661	5,424	4,237	
BNSSG CCG Total Variance	**461,100**	**453,975**	**7,125**	
Allocation adjustment	(7,125)	-	(7,125)	
BNSSG CCG Total Variance	**453,975**	**453,975**	-	

ACCOUNTABILITY REPORT

Shane Devlin

Accountable Officer

29 June 2023

Accountability Report

The Accountability Report describes how the CCG met 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 the organisation was governed during the first quarter of 2022/23, including membership and the governance structures and how they supported the achievement of the CCG's objectives.

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

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 there were no personal data related incidents in the first quarter of 2022/23. The CCG Modern Slavery Statement is also provided. This is in line with corporate governance best practice.

Members Report

Bristol, North Somerset and South Gloucestershire CCG was responsible for planning and commissioning health services for its local population. The CCG was established by NHS England on 1st April 2018 and it operated in accordance with its Constitution. The Governing Body was made up of local GPs, other clinicians, lay members, and executive directors. Dr Jonathan Hayes was the CCG Chair.

The CCG was a clinically led membership organisation. 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 GP practices can be found at (this can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/)

Composition of Governing Body

The Governing Body was responsible for discharging the functions conferred to it by legislation and through the CCG Constitution. Details of attendance in the first quarter of 2022/23 are in the Governance Statement (p45). During the quarter voting Governing Body members were:

Name	Title	Tenure in Q1 2022/23
Jon Hayes	Clinical Chair	1st April - 30th June 2022
John Cappock	Lay Member Finance	1st April - 30th June 2022
Nick Kennedy	Independent Secondary Care Doctor	1st April - 30th June 2022
Alison Moon	Independent Registered Nurse	1st April - 30th June 2022
John Rushforth	Deputy Chair, Lay Member Audit and Governance	1st April - 30th June 2022
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	1st April - 30th June 2022
Kirsty Alexander	GP Locality Representative Bristol North and West	1st April - 30th June 2022
Julie Boardman	GP Locality Representative Bristol Inner City and East	1st April - 30th June 2022
Matt Cresswell	GP Locality Representative North Somerset Woodspring	1st April - 30th June 2022
James Case	GP Locality Representative South Gloucestershire	1st April - 30th June 2022
Kevin Haggerty	GP Locality Representative North Somerset Weston and Worle,	1st April - 30th June 2022
Caroline Stovell	GP Locality Representative Bristol Inner City and East (nominated deputy for *above)	1st April - 30th June 2022
Shane Devlin	Interim Chief Executive/ICB Designate CEO	1st April - 30th June 2022
Sarah Truelove	Chief Financial Officer	1st April - 30th June 2022

Non-voting executive directors attending the Governing Body:

Name	Title	Tenure in Q1 2022/23
Julie Bacon	Interim Director of People and Transition	1st April - 30th June 2022
Peter Brindle	Medical Director Clinical Effectiveness	1st April - 30th June 2022
Colin Bradbury	Area Director North Somerset	1st April - 30th June 2022
Deborah El-Sayed	Director of Transformation	1st April - 30th June 2022
David Jarrett	Area Director South Gloucestershire	1st April - 30th June 2022
Lisa Manson	Director of Commissioning	1st April - 30th June 2022

Jon Scott	Interim System Chief Operating Officer	1st April - 30th June 2022
Rosi Shepherd	Director of Nursing and Quality	1st April - 30th June 2022

The Governing Body committees were:

- Audit, Governance and Risk
- Remuneration
- Primary Care Commissioning
- Clinical Executive
- Strategic Finance
- Quality

Governing Body committee membership and attendance details, including the Audit, Governance and Risk Committee, are provided in the Governance Statement (p44). Information about the Remuneration Committee can be found in the Remuneration Report. Details of the declared interests of the Governing Body members and the members of Governing Body committees can be found at (this can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/)

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". There were no externally reportable incidents during the first quarter of 2022/23. The CCG's Information Governance Group was 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 supported 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.

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.

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 30th June 2022, 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.

The CCG's roles and responsibilities for commissioning healthcare for people within the Bristol, South Gloucestershire and North Somerset area were set out in the CCG's Constitution. The Constitution described the governing principles, and the rules and procedures in place to ensure probity and accountability in day to day running; to ensure that decisions were taken in an open and transparent manner and that the interests of patients and the public remained central. The CCG Constitution can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/)

Bristol, North Somerset and South Gloucestershire CCG was a membership organisation and details of the Membership were included in the Constitution. The members were collectively responsible for agreeing the CCG's Constitution and governance arrangements, including the responsibilities of the Governing Body and its Members' terms of office.

The Internal Audit function independently audited the systems of internal control and check that the CCG was compliant with legal requirements and good practice.

The Governing Body

The main function of the Governing Body was to ensure that appropriate arrangements were made to ensure the CCG exercised its functions effectively, efficiently and economically, and complied with principles of good governance. The Governing Body membership included local GPs, three independent lay members, an independent secondary care doctor, an independent nurse and the Chief Executive Officer and Chief Financial Officer. All directors attended Governing Body meetings; however, they did not have voting rights. A full list of Governing Body members can be found (p49)

The Governing Body met three time in quarter 1 2022/23 and was quorate for each meeting. These meetings were open to the public and the papers and minutes of the meetings are available (this can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/). See p49 for attendance.

The Governing Body was responsible for:

- Approving any functions of the CCG specified in regulations
- Setting out the vision and strategy of the CCG

- Signing off the annual commissioning plan, and how it would discharge 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

Governing Body Committees

The Governing Body established number of committees and these are listed below with a summary of their purpose and functions. The Governing Body received the minutes of the committees and these and the committee terms of reference are available https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/)

Audit, Governance and Risk Committee

The Audit, Governance and Risk Committee was accountable to the Governing Body and provided an independent objective view of and assurance on controls and governance arrangements. The Committee was responsible for the oversight of financial reporting and disclosure. The Audit, Governance and Risk Committee was chaired by a lay member who was 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 49.

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

- Business was conducted in accordance with the law and proper standards
- Public money was safeguarded and properly accounted for
- Financial statements were prepared in a timely fashion and gave a true and fair view of the financial position for the period in question
- Economic, efficient and effective use of resources was secured
- Adequate arrangements were in place and reasonable steps were taken to prevent and detect fraud and other irregularities

- An effective system of integrated governance, risk management and internal control across the whole of the CCG's activities was established and maintained.

Remuneration Committee

The Remuneration Committee was accountable to the Governing Body making 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 providing services to the CCG. The Remuneration Committee was chaired by the Governing Body Lay Member for Patient and Public Involvement. Committee membership and attendance are detailed in the table on page 49.

Primary Care Commissioning Committee

The CCG had delegated authority for the commissioning of primary medical care, and established a committee to oversee the contracting of general practice services within the context of the CCG strategic plan. The Committee was chaired by the Governing Body Lay Member for Patient and Public Involvement. Membership and attendance at meetings are detailed in the table on page 49.

The Committee received monthly reports on primary care contracts, quality and financial performance. Contractual changes, including requests for mergers, boundary applications and temporary closures were considered by the Committee. Reports on primary care quality included regular 'deep dives' into key aspects of quality.

Clinical Executive

The Clinical Executive was accountable to the Governing Body. The Committee's remit included the development of the commissioning strategy and operational plan, and the CCG procurement strategy. The Committee considered plans for the procurement of new services and disinvestment from existing services making recommendations to the Governing Body where necessary. The Committee considered commissioning policies and individual funding policies and procedures, making recommendations to the Governing Body where appropriate. The Committee reviewed provider performance against contracts, agreeing actions to be taken and monitoring improvement. Attendance at meetings is detailed in the table on page 49.

Quality Committee

The Quality Committee was chaired by the Governing Body Independent Registered Nurse and was accountable to the Governing Body. The Committee was responsible for

ensuring that a cohesive and comprehensive structure was 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 included performance against NHS Constitution Standards. The Committee provided the Governing Body with assurance that CCG quality systems and processes were robust, that commissioned services were being delivered in a high quality and safe manner, and that all relevant statutory and regulatory obligations were met. The Committee provided assurance that effective processes were in place for safeguarding children, young adults and vulnerable people. The Committee considered the CCG Improvement and Assessment Framework Clinical Indicators and assured plans to improve performance against clinical priority areas. The membership and attendance at meetings are detailed in the table on page 49. Details of performance matters can be found in the Performance Report from page 4.

Strategic Finance Committee

The Strategic Finance Committee was accountable to the Governing Body and was chaired by the Lay Member, Strategic Finance. The Committee considered all draft strategic and financial plans prior to their submission to the Governing Body for approval, including the financial plans associated with the Operational Plan and savings plans. The Committee monitored the longer term financial strategic direction of the CCG, the delivery of savings plans and the CCGs in year financial performance, identified key issues and risks requiring discussion and decision by the Governing Body. The Committee had oversight of procurements. The membership and attendance at meetings are detailed in the table on page49.

Table 7 Attendance at Governing Body Meetings and its Committees		number of meetings attended in quarter1 2022/23						
Name	Title	GB	Audit	Rem	Com Exec	Quality	SFC	PCCC
Dr Jonathan Hayes	Clinical Chair, Chair of Commissioning Executive	3/3			1/1			
Dr Kirsty Alexander	GP Locality Representative Bristol North and West	2/3			1/1			
Colin Bradbury	Area Director North Somerset	3/3			1/1			3/3
Julie Bacon	Interim Director of People and Transition	2/3						
Dr Peter Brindle	Medical Director Clinical Effectiveness	3/3			-	3/3		
John Cappock	Lay Member, Chair of Strategic Finance Committee	3/3		2/2			3/3	
Shane Devlin	Chief Executive Office – Interim	3/3			1/1		3/3	3/3
Deborah El-Sayed	Director of Transformation	2/3			1/1			
Dr Kevin Haggerty	GP Locality Representative Weston and Worle	3/3			-			
David Jarrett	Area Director South Gloucestershire	3/3			-			3/3
Dr Nick Kennedy	Independent Secondary Care Doctor	2/3		2/2		2/3		
Dr Julie Boardman~	GP Locality Representative Bristol Inner City and East	1/1						
Dr James Case	GP Locality Representative South Gloucestershire	3/3						3/3
Dr Matthew Cresswell	GP Locality Representative North Somerset Woodspring	2/3						
Dr Katrina Boutin	Clinical Commissioning Locality Lead, Bristol							2/3
Lisa Manson	Director of Commissioning	3/3			1/1	2/3		2/3
Alison Moon	Independent Registered Nurse, Chair of PCCC and Quality Committee	2/3		1/2		3/3	2/3	3/3
John Rushforth	Lay Member, Chair of Audit Governance and Risk Committee	2/3		1/2			2/3	2/3
Rosi Shepherd	Director Nursing and Quality	3/3			1/1	3/3		3/3**
Jon Scott	Interim System Chief Operating Officer	2/3						
Sarah Talbot Williams	Lay Member, Patient and Public Involvement Chair of Remuneration Committee, Patient and Public Involvement Forum and PCCC	1/3		1/2		3/3		2/3
Caroline Stovell*	GP Locality Representative Bristol Inner City and East	1/1						
Ben Burrows	CCG Clinical Lead Clinical for Governance and Quality					-		
Sarah Truelove**	Chief Financial Officer	3/3			-		1/3	3/3**
Christina Gray	Director of Public Health Bristol	2/3						

Andrew Appleton	Clinical Corporate Lead – Digital				1/1		
Sara Blackmore	Director of Public Health, South Gloucestershire Council				-		
Alison Bolam	Clinical Commissioning Area lead – Bristol				-		
Geeta Iyer	Clinical Corporate Lead - Primary Care Provider Development				1/1		
Michael Jenkins	Clinical Care Pathway Lead - Integrated Care				-		
Shaba Nabi	Clinical Corporate Lead – Prescribing				1/1		
David Peel	Clinical Care Pathway Lead - Planned Care				-		
Lesley Ward	GP Locality Representative South Bristol	1/1			-		
	Clinical Care Pathway Lead - Unplanned Care						
Alison Wint	Clinical Care Pathway Lead - Specialised Care				-		

*Nominated deputy for ~

** 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 (this can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/) which has been taken forward as part of the programme of work to transition to an Integrated Care Board.

Transition from a CCG to an ICB

The CCG established a transition programme to manage the transition from CCG to an ICB in October 2021 and an Interim Director of People and Transition was brought in as Senior Responsible Officer. A Transition Working Group, with identified workstream leads, was established to take the programme forward. The Transition Working Group met regular throughout the transition period and weekly during the first quarter of 2022/23. Attendees included all workstream leads, NHSEI and internal audit. During the transition planning stage highlight reports were completed by each workstream lead. This changed to a Red/Amber/Green status report from 1st January 2022 when the workstream became more delivery focused. Bi-weekly risk submission were made to NHSEI regionally together with periodic submissions of the Readiness to Operate Statement and the Due Diligence Checklist. Regular updates were provided to the Executive Team, Strategic Development Forum and Staff Partnership Forum. Formal status reports were received by the Strategic Finance Committee, the Governing Body and the Audit Committee. The CCG Chief Finance Officer was required to sign off the Due Diligence Checklist and the CCG Accountable Officer was required to send a letter of assurance and readiness to operate to the ICB Chair designate and NHSEI Regional Director on the 1st June 2022.

To support this process the Strategic Finance Committee reviewed and sought assurance on the transition programme and documentation at its meeting of the 27th May 2022.

The Readiness to Operate Statement included narrative evidencing the transition programme and indicating the actions completed or due for completion by 30th June 2022. The Readiness to Operate Statement confirmed the ICB's readiness to operate from 1st July 2022. The Due Diligence Checklist was a more detailed document that Underpinned the Readiness to Operate Statement.

As part of the transition work, an audit of the Due Diligence Checklist was commissioned from the CCG internal audit providers. A less traditional approach was taken to this work and the audit took place in real time as the work was being delivered to provide ongoing advice to programme and workstream leads. Initial commentary received related to the governance and guidance given to the workstream leads. This real time feedback meant that an additional protocol for completion of the due diligence checklist was produced to improve the overall programme management/status reporting. The final draft version of the Audit Report was made available to the meeting of the Strategic Finance Committee, together with the management response to workstream recommendations. These were scrutinised at the meeting.

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

The Risk Management Framework (this can be found at https://webarchive.nationalarchives.gov.uk/ukgwa/20220707110045/https:/bnssgccg.nhs.uk/) defined the structures for the management and ownership of risk and aligns to and complies with the Treasury "Orange Book". It defined how risks were dealt with and by whom. Integrated governance including financial governance was assured through the Audit, Governance and Risk Committee and the Governing Body. The Governing Body received the minutes of all committees, including the Audit, Governance and Risk Committee. The Audit, Governance and Risk Committee was responsible for the oversight of the Risk Management Framework, providing assurance to the Governing Body that the CCG had established an effective system of risk management and internal control. The Quality, Strategic Finance and Clinical Executive Committees had responsibility for the management of risks. These committees were responsible for the review and scrutiny of specific risks and sought assurance that risks were properly managed. If a committee was not assured that concern was escalated to the Governing Body.

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

The Governing Body Assurance Framework identified where there were risks to principal objectives, the controls in place to mitigate these risks, and the assurances available to the Governing Body risks were being managed. The Governing Body Assurance Framework indicated where there are potential gaps in controls and assurances and provided a summary of the actions in place to resolve these gaps. The Governing Body Assurance Framework was reviewed by directors and considered by the Governing Body committees as a standing item at meetings. The Audit, Governance and Risk Committee reviewed the Governing Body Assurance Framework. The Primary Care Commissioning Committee and the Governing Body reviewed the Governing Body Assurance Framework quarterly.

Risks were identified in a number of ways, including risk profiling through a 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 were evaluated and assessed using a risk scoring matrix set out in the Risk Management Framework. Risk was reported through Directorate and Corporate Risk Registers. The Corporate Risk Register held risks on and above the CCG's risk threshold of 15. It was reviewed by directors as a standing item at Executive Team meetings and considered by the Governing Body committees as a standing item. The Audit, Governance and Risk Committee reviewed the Corporate Risk Register, the Primary Care Commissioning Committee, and the Governing Body reviewed the Corporate Risk Register quarterly.

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

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

Patients and members of the public were involved at every stage of the commissioning cycle and ensuring an ongoing opportunity 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 adopted policies for managing conflicts of interest and gifts and hospitality, and tackling fraud and bribery. Agreed detailed financial policies were in place.

Capacity to Handle Risk

The CCG's policy was to identify, minimise, control and, where possible, eliminate risks that could have an adverse impact on patients, staff and the organisation. The Accountable Officer carried ultimate responsibility for all risks within the CCG.

The Risk Management Framework described 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 required 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 was

committed to possessing the attributes associated with an active learning organisation where lessons learned are embedded into the organisation's culture and practice.

Following the findings of an internal audit into the arrangements for the management of risk, these were reviewed and the Risk Management Framework was updated. 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.

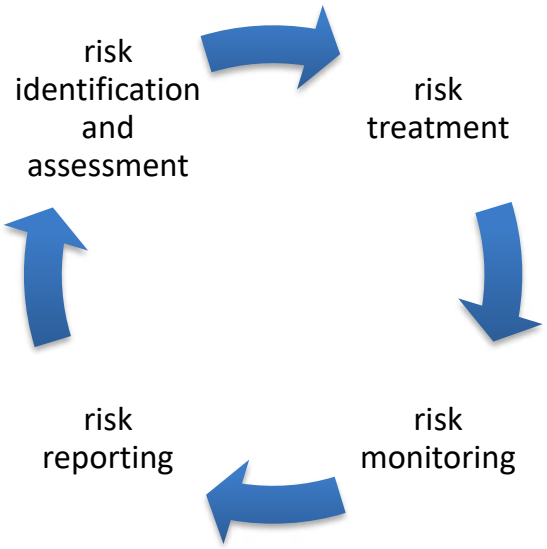
The responsibility for risk management sat with the Interim Chief Executive Officer and the Deputy Chief Executive and Chief Finance Officer who took an active role in managing risk and providing challenge and oversight.

Risk was monitored through a structured reporting cycle for the Governing Body Assurance Framework and the Corporate Risk Register described above. The Governing Body received monthly reports on performance and quality, and finance. These reports provided timely, accurate data, supporting the Governing Body in the assessment of risks to compliance with statutory obligations. The Governing Body's regular review and interrogation of these reports and other ad hoc reports enabled it to have a robust and rigorous oversight of performance.

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

Risk Assessment

The diagram below explains the risk assessment and management process.



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 was through the Governing Body Assurance Framework and the Corporate Risk Register. Major risks to governance, risk management and internal control in 2021/22 and continuing into the first quarter of 2022/23 are detailed below and at page 61 'Control Issues':

- 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 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, and ambulance handover delays
- Risks to sustained care delivery to vulnerable and complex patients potentially resulting 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 continued impact of Covid-19

The systems used to identify, evaluate and manage the principal and emerging risks faced were in place throughout the first quarter of 2022/23 and up to the demise of the CCG on the 30th June.

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.

The system of internal control was described through the Standing Orders, Scheme of Reservation and Delegation, and Detailed Financial Policies for the CCG. These ensured compliance with statutory requirements for the management of governance. Internal audit and the counter-fraud service provided an independent review of internal controls.

The risk assessment component of the internal system of control was contained in the Risk Management Framework as described previously. The Governing Body Assurance Framework provided an overview of controls and assurance in place to achieve the CCG's principal objectives.

The Governing Body had a clear understanding of the key pressures facing the organisation. A key element of control was the provision of assurance through regular reporting to the Governing Body, 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

Procurement activities were carried out within the framework of control set out in legislation and regulation. The CCG had a range of policies relating to information governance, human resources, health and safety, equalities and diversity, and emergency preparedness and resilience, all of which contributed to the internal control environment.

As Accountable Officer, I was responsible for reviewing the effectiveness of the system of control and for providing leadership and direction to staff. Other members of the Executive Team had 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 was to ensure that appropriate arrangements and systems are in place so that risks were:

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

Executive Directors ensured that staff complied with 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) required CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England published a template audit framework. An audit was completed for the financial year 2021/22 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. There was no audit in quarter1 of 2022/23.

Data Quality

The information used by the Governing Body and its Committees enabled 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 were engaged in a continuous cycle of improvement with regard to the quality of the information received. The reports received underwent regular review and improvement. The Governing Body found the quality of data to be acceptable. No risks relating to the quality of data were highlighted in the first quarter of 2022/23.

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 was submitted at the end of June 2022 and achieved a status of 'Standards Met'.

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. The CCG Chief Financial Officer was the Senior Information Risk Owner (SIRO) and responsible for providing assurance to the Governing Body and to me regarding information governance. The SIRO was familiar with, and took ownership of, information risk management, acting as advocate for information risk management on the Governing Body. The Director of Nursing and Quality was 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 was used in the investigation of all information governance related incidents.

Business Critical Models

An appropriate framework and environment were 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 purchased services from the South Central and West Commissioning Support Unit. Services included HR, procurement, IT, and information governance support. Independent assurances on these services were provided through service auditor reports. Day to day assurance of the above services was achieved through regular performance meetings attended by senior members of staff from both organisations. ISAE3402 Assurance Letters of Comfort were received and shared with the Chief Financial Officer, and the Internal Auditors.

- A bridging latter of comfort in respect of Finance and Accounting and Procurement services provided through NHS Shared Business Services. It was confirmed that there had been no changes to the control environment of the stated services
- An ISAE3402 Assurance Letter of Comfort in respect of Primary Care Support England (PCSE) services which were operated by Capita Business Services Ltd for the period 1st April to 30th June 2022. This period included the Transformation of some areas of the PCSE services, which required updates to a number of the

standard operating procedures and controls tested in the 2021/22 service auditor report provided. For 2021/22, the auditors noted exceptions on 8 out of 17 control objectives. The report provided a Qualified Opinion that the exceptions were minor. NHS England continued to work with Capita to assure the control measures in place were applied consistently and to address the improvement actions identified.

- A bridging latter of comfort in respect of Dental Payments, Prescription Payments, Electronic Staff Record (ESR) and Human Resources (HR) Shared Services provided through NHS Business Services Authority was provided. It was confirmed that there had been no changes to the control environment of the stated services

Control Issues

The following control issues and remedial actions were identified and reported to NHS England: The following issues were identified during the period April to June 2022. Details of performance matters can be found in the Performance Report from page 4.

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.

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.

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.

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.

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.

Ambulance services

Mitigation: Whilst maintaining strong resourcing levels, the ambulance service has experienced 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.

Finance, Governance and Control - Finance and Procurement

There was one legal challenge to a procurement in 2021/22 which continued into the first quarter of 2022/23; legal advice was taken. The challenge concerned a joint procurement with other CCGs and the CCG was not responsible for the management of the procurement.

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

The CCG undertook a comprehensive range of contract monitoring, benchmarking and budget monitoring to ensure the robust management of resources.

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

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

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

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

Regular contract management processes were established with main providers to link service quality, performance and financial management.

Financial planning and in-year performance monitoring

The finance regime has progressed towards a system finance framework, in line with the Integrated Care Board regime.

The CCG performance target for the 3 months to the 30 June 2022 was £461.101m and is based on the quarter 1 profile spend of the BNSSG System Annual Plan submitted to NHSEI in June 2022. The quarter 2 to quarter 4 profile spend will be the performance target of BNSSG Integrated Care Board (ICB), the CCG successor body.

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.

The performance monitoring actions for the period to the 30 June 2022 continued to include:

- The Audit, Governance and Risk Committee and Strategic Finance Committee receiving regular briefings
- 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.

Clear and appropriate controls were in place for the planning and monitoring of 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 was established to support delivery of the financial plan.

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

There was 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

Central management costs are contained within the CCG Running Cost Allowance. The CCG running costs to the 30 June 2022 were £5.457m.

Delegation of functions

Where functions were delegated internally feedback was received 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 (p83).

Where the CCG chose to commission business functions from other organisations, services were managed against a service level agreement and subject to regular performance review and independent audit where applicable. The CCG commissioned the South Central and West Commissioning Support Unit to provide a number of services. Feedback was gained on business, use of resources and responses to risk through independent assurance, principally Service Auditor Reports as described previously. The CCG received 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, was overseen by the Audit, Governance and Risk Committee. A Counter Fraud Bribery and Corruption Policy, helping staff to understand in simple terms what fraud, bribery and corruption are and containing useful guides on how to identify fraud, together with details on how to report and how cases will be dealt with, was in place. The policy emphasised that it is the responsibility of all staff to work to prevent fraud and protect the assets of the NHS. The policy was supported by the Management of Conflicts of Interest and Gifts and Hospitality Policies. A Local Counter Fraud Specialist (LCFS) was contracted by the CCG to provide counter fraud training to all staff as part

of the staff induction programme. Counter Fraud training was also a mandatory element of the CCG e-learning programme.

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

The Audit, Governance and Risk Committee received interim reports and an annual report outlining compliance against each of the Government Functional Standard GovS 013: Counter Fraud, and identified risks to be addressed in the annual work plan overseen by the Committee. Appropriate action was 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 quarter one period of 2022/23 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 period, Internal Audit undertook a review of internal audit findings from previous years which had resulted in either negative assurance opinions or high priority actions being raised. The Internal Auditor undertook top up testing in these areas to assess if the action taken as a result of the initial audit had had the desired impact and that risks in these areas were now being well managed and mitigated. The areas of focus were:

- Risk Management

- System Financial Management
- DSP Toolkit
- Continuing Healthcare
- Recruitment and Workforce Data

Audit testing found that the CCG had made reasonable progress in implementing the previous actions with improved controls frameworks observed. One area where less progress was evidenced was in the actions relating to recruitment. This therefore remained ongoing with the initial risk still exposed. Whilst some actions around risk management remained ongoing, it should be noted that the actions for the CCG were implemented, and the new ongoing actions reflect the need for changes within the new Integrated Care Board.

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 had 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.

The assurance framework provided me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives were 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 agreed an annual plan for Internal Audit focusing on areas of particular concern or risk. Reports were made to the Committee on audit findings, with assurance and recommendations. Discussions

were held with the External Auditors regarding audit plans, and regular reports were made to the Audit Committee on progress and findings.

- The Audit, Governance and Risk Committee reported to the Governing Body on the development, implementation and monitoring of integrated governance, providing assurance on the systems and processes by which the CCG lead, directed and controlled its functions to achieve organisational objectives, safety and quality of service.
- Internal Audit and Counter Fraud provided assurances through their reports on various aspects of internal control to the Audit, Governance and Risk Committee. These reports also provided assurances and support for the work undertaken by the external auditors.
- The Governing Body received 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 prior year 2021/22 Month 9 return to NHS England, no significant control issues have been identified during the reporting period April – June 2022.

Shane Devlin

Accountable Officer

29 June 2023

Remuneration and Staff Report

The Remuneration and Staff Report provides information about the remuneration of CCG 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. The section also contains a report on staff sickness absence, key staff policies, staff engagement, and Freedom to Speak Up arrangements. This is in line with corporate governance best practice.

Remuneration Report

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

The Remuneration Committee made 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.

Entities are required to disclose:

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 8 Percentage change in remuneration of highest paid director – 1 April 2022 to 30 June 2022

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	Nil	Nil
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	Nil	(100%)

Table 9 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%	(100%)

The highest paid director in the 3 months to June 2022 and 2021/22 was Shane Devlin, ICB Chief Executive.

The highest paid director in the 3 months June 2022 did not received performance pay (2021/22 Nil). In the financial year 2021-22 only those directors as reported in the salaries and allowances table received performance pay. No performance pay was paid to directors or staff members in the 3 months to June 2022 (2021/22 Nil).

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 reporting period 1 April 2022 to 30 June 2022 was £175,000 (2021-22, £175,000). The relationship to the remuneration of the organisation's workforce is disclosed in the below table:

Table 10 Pay Ratio Information 1 April 2022 to 30 June 2022

	25th percentile	Median	75th percentile
Total remuneration (£)	£31,534	£40,057	£53,219
Salary component of total remuneration (£)	£31,534	£40,457	£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 11 Pay Ratio Information 2021-22

	25th percentile	Median	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

During the reporting period 1 April to 30 June 2022 and in the financial year 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). Remuneration ranged from £12,230 to £374,000 (2021-22 £12,320 to £374,000). 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.

Remuneration of Very Senior Managers

The policy on the remuneration of VSM, including members of the Governing Body, was set using NHS England guidance. National remuneration guidance for VSM pay was applied for 2021/22 and the first quarter of 2022/23.

Advance approval of the Chief Secretary to the Treasury (CST) is required for remuneration packages at £150,000 or above. Where the CCG had VSM roles that fall into this category, business cases for the posts were completed, 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)

Table 12 Salaries and Allowances 1 April to 30 June 2022

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

		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 8)	Total (Bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Julia Ross (Note 1) – end date 10.4.22	Chief Executive	**0-5**	**-**	**-**	**-**	**-**	**-**
Shane Devlin (Note 2)	ICB Chief Executive	**40-45**	**-**	**-**	**-**	**7.5-10**	**50-55**
Jon Hayes	Clinical Chair	**20-25**	**-**	**-**	**-**	**-**	**20-25**
Jeffrey Farrar (Note 3)	ICB Chair (designate)	**15-20**	**-**	**-**	**-**	**-**	**15-20**
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer	**35-40**	**-**	**-**	**-**	**-**	**35-40**
Lisa Manson	Director of Commissioning	**30-35**	**-**	**-**	**-**	**7.5-10**	**40-45**
Rosalind Shepherd	Director of Nursing and Quality	**25-30**	**-**	**-**	**-**	**42.5-45**	**70-75**
Deborah El-Sayed	Director of Transformation	**25-30**	**-**	**-**	**-**	**15-17.5**	**45-50**
Julie Bacon	Director of People and Transition	**30-35**	**-**	**-**	**-**	**-**	**30-35**
David Jarrett	Area Director – Bristol and South Gloucestershire	**25-30**	**-**	**-**	**-**	**12.5-15**	**40-45**
Colin Bradbury	Area Director – North Somerset	**25-30**	**-**	**-**	**-**	**10-12.5**	**35-40**
Peter Brindle	Medical Director	**25-30**	**-**	**-**	**-**	**0-2.5**	**30-35**
Kirsty Alexander (Note 5)	GP Locality Representative	**5-10**	**-**	**-**	**-**	**-**	**5-10**
Kevin Haggerty	GP Locality Representative	**0-5**	**-**	**-**	**-**	**-**	**0-5**
Jon Evans – end date 31.3.22	GP Locality Representative	**-**	**-**	**-**	**-**	**-**	**-**
Julia Boardman – end date 31.3.22	GP Locality Representative	**-**	**-**	**-**	**-**	**-**	**-**
James Case	GP Locality Representative	**0-5**	**-**	**-**	**-**	**-**	**0-5**
Matthew Cresswell	GP Locality Representative	**0-5**	**-**	**-**	**-**	**-**	**0-5**
Caroline Stovell	GP Locality Representative	**-**	**-**	**-**	**-**	**-**	**-**

John Rushforth	Independent Lay Member - Chair Audit, Governance and Risk	**5-10**	**-**	**-**	**-**	**-**	**5-10**
John Cappock	Independent Lay Member – Strategic Finance	**5-10**	**-**	**-**	**-**	**-**	**5-10**
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	**5-10**	**-**	**-**	**-**	**-**	**5-10**
Alison Moon (Note 6)	Independent Lay Member – Registered Nurse	**5-10**	**-**	**-**	**-**	**-**	**5-10**
Nick Kennedy	Independent Lay Member – Secondary Care Doctor	**5-10**	**-**	**-**	**-**	**-**	**5-10**
Christina Gray (Note 7)	Representative local authority – Public Health	**-**	**-**	**-**	**-**	**-**	**-**

Table 13 Salaries and Allowances 2021-22

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

		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 8)	Total (Bands of £5,000)
Name	**Title**	**£000**	**£**	**£000**	**£000**	**£000**	**£000**
Julia Ross (Note 1)	Chief Executive	**335-340**	**-**	**0-5**	**-**	**52.5-55**	**390-395**
Shane Devlin – start date 14.2.22 (Note 2)	ICB Chief Executive	**20-25**	**-**	**-**	**-**	**95-97.5**	**115-120**
Jon Hayes	Clinical Chair	**80-85**	**-**	**-**	**-**	**-**	**80-85**
Jeffrey Farrar – start date 01.11.21 (Note 3)	ICB Chair (designate)	**25-30**	**-**	**-**	**-**	**-**	**25-30**
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer	**150-155**	**-**	**0-5**	**-**	**-**	**155-160**
Lisa Manson	Director of Commissioning	**130-135**	**-**	**0-5**	**-**	**30-32.5**	**165-170**
Rosalind Shepherd	Director of Nursing and Quality	**110-115**	**-**	**0-5**	**-**	**32.5-35**	**145-150**
Deborah El-Sayed	Director of Transformation	**115-120**	**-**	**0-5**	**-**	**27.5-30**	**150-155**
Julie Bacon – start date 1.10.21	Director of People and Transition	**65-70**	**-**	**-**	**-**	**-**	**65-70**
David Jarrett	Area Director – Bristol and South Gloucestershire	**105-110**	**-**	**0-5**	**-**	**30-32.5**	**140-145**
Colin Bradbury	Area Director- North Somerset	**105-110**	**-**	**0-5**	**-**	**27.5-30**	**135-140**
Peter Brindle	Medical Director	**115-120**	**-**	**0-5**	**-**	**42.5-45**	**160-165**
Kirsty Alexander (Note 5)	GP Locality Representative	**35-40**	**-**	**-**	**-**	**-**	**35-40**
Brian Hanratty – end date 20.8.21	GP Locality Representative	**0-5**	**-**	**-**	**-**	**-**	**0-5**
Kevin Haggerty	GP Locality Representative	**10-15**	**-**	**-**	**-**	**-**	**10-15**
Jon Evans	GP Locality Representative	**10-15**	**-**	**-**	**-**	**-**	**10-15**
Julia Boardman	GP Locality Representative	**10-15**	**-**	**-**	**-**	**-**	**10-15**
James Case	GP Locality Representative	**10-15**	**-**	**-**	**-**	**-**	**10-15**
Matthew Cresswell	GP Locality Representative	**10-15**	**-**	**-**	**-**	**-**	**10-15**
John Rushforth	Independent Lay Member - Chair Audit, Governance and Risk	**20-25**	**-**	**-**	**-**	**-**	**20-25**

John Cappock	Independent Lay Member – Strategic Finance	**20-25**	**-**	**-**	**-**	**-**	**20-25**
Sarah Talbot-Williams	Independent Lay Member – Patient and Public Engagement	**25-30**	**-**	**-**	**-**	**-**	**25-30**
Alison Moon (Note 6)	Independent Lay Member – Registered Nurse	**25-30**	**-**	**-**	**-**	**-**	**25-30**
Nick Kennedy	Independent Lay Member – Secondary Care Doctor	**25-30**	**-**	**-**	**-**	**-**	**25-30**
Christina Gray (Note 7)	Representative local authority – Public Health	**-**	**-**	**-**	**-**	**-**	**-**

Notes:

No senior manager waived his/her remuneration.

1 This employee has been redundant on the closedown of the CCG on 1St July 2022. The package was agreed before 31.3.22 and in the Salaries table for the financial year 2021/22 the salary figure includes redundancy of £126,666 and payment in lieu of notice of £49,455. The package has been agreed in line within HM Treasury rules. This was declared in the Remuneration report for the financial year 2021/22. The figure in the Salaries table for the period from April 2022 to June 2022 is the salary figure excluding the redundancy and lieu of notice.

2 Shane Devlin has been appointed as Chief Executive 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 the financial year 2021/22 in line with 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. No performance payments have been made in the period April 2022 to June 2022.

5 The salary figure includes remuneration for the Governing body role and a boarder clinical role. £3,080 relates to the Governing body role (2021/22 £12,320).

6 In 2021/22 the employee was paid £2,625 for clinical work for the mass vaccination programme which has been charged to North Bristol Trust. The is not include in the table figures for 2021/22. No payments for this work was received in the period April 2022 to June 2022.

7 This is non-remunerated post.

8 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.

The 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 14 Pension benefits as at 30 June 2022

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

		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 30 June 2022 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 30 June 2022 (Bands of £5,000)	Cash Equivalent Transfer Value at 01 April 2022	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022	Employer's contribution to partnership pension
Name	**Title**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Julie Ross	Chief Executive	-	-	45-50	140-145	1,554	-	1,173	-
Shane Devlin	ICB Chief Executive	0-2.5	-	0-5	-	-	4	15	-
Lisa Manson	Director of Commissioning	0-2.5	-	50-55	100-105	891	9	912	-
Rosalind Shepherd	Director of Nursing and Quality	0-2.5	2.5-5	50-55	155-160	1,165	50	1,229	-
Deborah El-Sayed	Director of Transformation	0-2.5	0-2.5	40-45	70-75	686	14	710	-
David Jarrett	Area Director – Bristol and South Gloucestershire	0-2.5	0-2.5	40-45	70-75	615	12	635	-
Colin Bradbury	Area Director – North Somerset	0-2.5	0-2.5	30-35	50-55	519	10	537	-
Peter Brindle	Medical Director	0-2.5	-	45-50	90-95	897	1	911	-

Table 15 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.

		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
Name	**Title**	**£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	-
Shane Devlin (Note1)	ICB Chief Executive	0-2.5	-	5-10	-	-	-	5	-
Lisa Manson	Director of Commissioning	2.5-5	-	50-55	100-105	838	30	891	-
Rosalind Shepherd	Director of Nursing and Quality	0-2.5	5-7.5	45-50	145-150	1081	61	1165	-
Deborah El-Sayed	Director of Transformation	0-2.5	-	35-40	65-70	639	26	686	-
David Jarrett	Area Director – Bristol and South Gloucestershire	0-2.5	0-2.5	35-40	70-75	573	25	615	-
Colin Bradbury	Area Director – North Somerset	0-2.5	-	30-35	45-50	479	22	519	-
Peter Brindle	Medical Director	2.5-5	0-2.5	45-50	90-95	823	44	897	-

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 and Jeffrey Farrar, ICB Chair (designate).

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. No payments for compensation on early retirement were received by any senior managers in the period from 1 April 2022 to 30 June 2022. (Nil in 2021-22). Julia Ross, Chief Executive has been made redundant. Information has been disclosed in the Salaries and Allowances and Exit Packages tables in the 2021-2022 Remuneration report.

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 the period from 1 April 2022 to 30 June 2022 (Nil in 2021/22).

Staff Report

Number of senior managers, staff numbers and costs

Staff Costs 2022

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

Table 16 Staff costs 1 April 2022 to 30 June 2022

	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	2,752	484	3,236	2,347	444	2,791	5,099	928	6,027
Social security costs	356	-	356	266	-	266	622	-	622
Employer contributions to the NHS Pension Scheme	551	-	551	432	-	432	983	-	983
Apprenticeship Levy	24	-	24	-	-	-	24	-	24
Termination Benefits	-	-	-	-	-	-	-	-	-
Gross employee benefits expenditure	**3,683**	**484**	**4,167**	**3,045**	**444**	**3,489**	**6,728**	**928**	**7,656**

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 17 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	10,347	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	2,104	-	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**	**928**	**25,732**

Staff Numbers 2022

There was an average of number 115 Senior Managers between 1 April 2022 and 30 June 2022.

Table 18 Senior Manager Numbers

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	4	9	-	1	1	5	5	10
Band 9	6	2	8	-	-	-	6	2	8
Band 8D	3	6	9	3	-	3	6	6	12
Band 8C	21	11	32	7	6	13	28	17	45
Band 8B	18	17	35	3	2	5	21	19	40
Total	**53**	**40**	**93**	**13**	**9**	**22**	**66**	**49**	**115**

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

Our average number by Staff, by Staff categories between 1 April 2022 and 30 June 2022.

Table 19 Staff Numbers

	Permanent			Other			Total		
Staff Category (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Administrative and Clerical	206	73	279	19	4	23	225	77	302
Medical and Dental	3	4	7	1	-	1	4	4	8
Add Professional. Scientific and Technical	16	7	23	-	-	-	16	7	23
Nursing and Midwifery	49	4	53	-	-	-	49	4	53
Allied Health Professionals	-	-	-	-	-	-	-	-	-
Estates and ancillary	-	1	1	-	-	-	-	1	1
Senior Managers	53	40	93	13	9	22	66	49	115
Total	**327**	**129**	**456**	**33**	**13**	**46**	**360**	**142**	**502**

Staff Numbers 2021/22

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

Table 20 Senior Manager Numbers

	Permanent			Other			Total		
Senior Managers (WTE)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	3	8	-	-	-	5	3	8
Band 9	5	1	6	-	-	-	5	1	6
Band 8D	2	5	7	3	-	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 the 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 21 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	-	1	5	4	9
Add Professional. Scientific and Technical	16	6	22	-	-	-	16	6	22
Nursing and Midwifery	49	6	55	-	-	-	49	6	55
Allied Health Professionals	-	-	-	-	-	-	-	-	-
Estates and ancillary	-	1	1	-	-	-	-	1	1
Senior Managers	45	31	76	10	3	13	55	34	89
Total	**296**	**112**	**408**	**21**	**5**	**26**	**317**	**117**	**434**

The WTE average number of permanently employed staff for the month of March 2022 was 453 and average number of other staff for the month of March 2022 was 48, therefore there are no significant movement in the figures from March 2022 to June 2022.

The permanently employed and other staff figures had gradually increased throughout the financial year 2021/22. The main change was the transfer of the BNSSG Healthier Together Integrated Care System to BNSSG on the 1S January 2022; 339 (number of) staff were TUPE transferred.

Staff Composition 2022

There were 128 Senior Managers (headcount) between 1 April 2022 and 30 June 2022.

Table 22 Senior Manager composition

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	5	4	9	-	1	1	5	5	10
Band 9	6	2	8	-	-	-	6	2	8
Band 8D	3	6	9	3	1	4	6	7	13
Band 8C	24	11	35	10	7	17	34	18	52
Band 8B	21	18	39	4	2	6	25	20	45
Total	**59**	**41**	**100**	**17**	**11**	**28**	**76**	**52**	**128**

Staff Composition 2021/2022

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

Table 23 Senior Manager composition

	Permanent			Other			Total		
Senior Managers (headcount)	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
Very Senior Manager	6	3	9	-	-	-	6	3	9
Band 9	5	1	6	-	-	-	5	1	6
Band 8D	1	6	7	3	-	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**

Sickness absence data

The CCG had a detailed and robust Sickness Absence Policy. A range of services were available to support staff at work or returning to work. These services included access to Occupational Health and an Employee Assistance Programme, including access to counselling sessions. The Human Resources team 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 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 staff concerns were heard and responded to. The Covid-19 response was reduced but the group continued and reported into the People Plan Steering Group.

The Wellbeing Group created and collated a huge portfolio of resources for staff to support health and well-being. These resources were collated into one place to ensure the wide-ranging support available was easily accessible. The resource bank was promoted to staff and managers to help them in signposting to the most appropriate resources if needed.

The CCG was required to annual sickness absence data for the calendar year 2021.

The CCG had an average number of full-time equivalent members of staff (FTE) of 389. The full time equivalent possible working days available was 42,358. The table below has been provided by the NHS Digital, using the Electronic Staff Record Data Warehouse.

Table 24 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	**389**	**1,090**	**42,358**	**2.58**	**2.8**

Staff turnover percentages

Bristol, North Somerset and South Gloucestershire staff turnover was reported via the Electronic Staff Record (ESR). During the period 1st April 2022 to 30th June 2022 38 members of staff joined the CCG and 29 staff members left. Staff turnover measures the number of staff who leave an organisation during a period of time. The CCG staff turnover for the period April to June 2022 was 5.32% based on a headcount of 29 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 was reported as 97.2% of employees were retained during the period April 2022 and June 2022.

Staff engagement percentages

Staff engagement remained important and in 2021 the CCG participated in the Annual NHS Staff Survey. There were 385 responses, which equated to a response rate of 84%. This was consistent to the response rate from 2020 reported at 85% and demonstrated 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 engaged staff and directorate action plans were developed as the CCG transitioned to the ICB.

The CCG maintained staff engagement through a variety of routes including staff networks in the following areas: disability, LGBTQ+, parents and carers. The CCG had an Inclusion Council and a Staff Partnership Forum that met monthly. A variety of communication methods were 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

Work to reduce inequalities in line with the Public Sector Equality Duty 2011 is reported in the Performance section of the Annual Report (p29). The ensured fair and equitable treatment of all staff and applicants applying for any advertised posts. The Recruitment and Selection Policy outlined the requirements for recruiting managers to make reasonable adjustments for disabled candidates where applicable, and this was reinforced through the line management training courses run for all staff with people management responsibilities.

All staff with a declared disability or who became disabled during their employment had access to appropriate training courses, and career development opportunities, and access to appropriate promotion opportunities. Reasonable adjustments were made to support these people with accessing and benefitting from these opportunities. All policies that related to the continued employment and training of disabled staff were equality impact assessed to ensure they were not detrimental to any staff with protected characteristics, including disabled persons. These policies included (but were 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 were developed in line with Agenda for Change Terms and Conditions where applicable. Further information about work related to equality and diversity can be found in the Performance Analysis section of this report (p29).

The CCG continued to review and develop staff policies. All of these were subject to consultation with staff and Trade Union representatives through the Staff Partnership Forum. All policies were developed to ensure the CCG was 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 had an Equality Impact Assessment to ensure they were not detrimental to staff on the basis of any protected characteristics as defined in the Equality Act 2010. The CCG regularly monitored the diversity of its workforce.

The CCG continued its 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. The Governing Body agreed this policy before the CCG was wound up at the end of June.

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 was 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. The CCG reviewed the 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 maintained the mixture of working from home and the office developed during the pandemic. The approach was led by staff insight. 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 was to further embed flexible working in the 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 staff to tailor their workweek around what was best for them, their wellbeing, and their role. To support staff working remotely the CCG developed a range of wellbeing initiatives to help staff remain connected.

The CCG continued review existing policies as it transitioned into the ICB. All of these were subject to consultation with staff and Trade Union representatives through the

Staff Partnership Forum, which continued to meet regularly and provided a constructive space for collaboration between staff representatives, and management.

Freedom to Speak Up

The CCG had in place policies to support staff when raising concerns, including the 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 was hugely important to the CCG which was committed to ensuring that a culture of speaking up was embedded throughout the organisation, and that effective processes were in place to support staff. The Freedom to Speak Up Policy provided a framework that supported a culture where staff felt comfortable to raise concerns. The policy gave guidance and advice to staff on raising a concern. The Freedom to Speak Up network includes the Freedom to Speak Up Guardian, Sarah Talbot-Williams, a Governing Body Lay Member, and two champions, Sarah Truelove and David Jarrett, both Executive Directors. The CCG consistently promoted the opportunity for staff to use the FTSU route to raise concerns in 2021/2022 and Quarter 1 2022/23

Trade Union Facility Time Reporting Requirements

The total number of employees who were relevant union officials during the period 1st April 2022 to 30th June 2022 was:

Table 25

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

Other employee matters

Organisational Development

The CCG maintained its commitment to the development and welfare of its workforce. Access to team and individual development through courses and apprenticeships was 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 2021, the CCG 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. The CCG also used the apprentice levy to support other individual apprenticeships at differing levels.

The Learning and Development Panel approved several professional development opportunities for staff which 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 collaborated with System partners with the NHS Graduate Management Scheme. In 2021/22 the CCG welcomed two graduate trainees taking up roles within Programme Management Office and Integrated Care Partnerships. The orientation programme was held as an exemplar by the Leadership Academy for its wider system partnership approach and included the involvement in NBT, Sirona and Brisdoc exposing the trainee graduates to the life journey of a patient.

Corporate induction continued with sessions being delivered on Teams every other month. Another area of support maintained were appraisal arrangements which, following the input from the internal auditors, were reviewed and relaunched.

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 consisted of staff members across varying levels of the organisation, with each Directorate represented by at least one staff member. Arrangements remained in place for consultation and engagement on matters of mutual interest during the quarter. During the quarter the SPF engaged in the development of Terms of reference for the emergent ICB and its desire to continue the forum.

Health, Safety and Welfare

Recognising the potential impact of organisational change on staff, the CCG retained its focus on clear and regular engagement with staff through its routine channels. In addition, information and support for those in need were made available and broadcast to colleagues using the intranet. Signposting to employee assistance programme, mental health first aider and the staff partnership forum representatives was prevalent. During the period, our temperature check surveys remained live with results used to inform organisational responses. Results indicated that through the transition period levels of engagement were exceptionally high. To mark the end of the CCG, staff were invited to record their reflections on the organisation as part of a 'time capsule'. The CCG continued to make equipment available to individuals to support health and safety while working remotely, including the continued availability of online DSE assessment.

Expenditure on consultancy

The consultancy expenditure for the financial period 1 April 2022 to 30 June 2022 was £504,000 and this can be analysed as follows:

Table 26 Consultancy Expenditure

Consultancy Category	1 April 22 to 30 June 22 £'000	2021/22 £'000
Finance	4	26
Human Resources, Training and Education	15	4
Technical	22	67
Organisation and Change Management	45	804
Procurement	-	12
Property and Construction	-	-
Strategy	418	110
Total	504	1,023

Strategy includes expenditure of £322k from South Central Foundation for the ICB expert development.

Off-payroll engagements

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

Table 27 Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 30 June 2022, for more than £245 per day (Note 1).

	Number
Number of existing engagements as at 30 June 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	1
for between three and four years at time of reporting	1
for four or more years at time of reporting	-

Table 28 Off- payroll workers engaged at any point during the three months to 30 June 2022.

For all off-payroll engagement between 1 April 2022 and 30 June 2022, for more than £245 per day (Note1)

	Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 30 June 2022	34
Of which:	
Number not subject to off-payroll legislation (Note 2)	31
Number subject to off-payroll legislation and determined as in-scope of IR35 (Note 2)	3
Number subject to off-payroll legislation and determined as out of scope of IR35 (Note 2)	-
Number of engagements reassessed for consistency or assurance purposes during the year	-
Of which: the number of engagements that saw a change to IR35 status following review	-

Table 29 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 2022 and 30 June 2022.

Number of off-payroll engagements of Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	-
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	23

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 – 1 April 2022 to 30 June 2022

No exit packages were agreed in the period 1 April 2022 to 30 June 2022.

Exit packages, including special (non-contractual) payments – 2021/22

Table 30 Exit Packages 2021/2022

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 a Special Severance payment.

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	-	-	1	5,389	1	5,389	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	-	-	1	49,445	1	49,445	-	-
£50,001 - £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	1	126,666	-	-	1	126,666	-	-
£150,001 – £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	**1**	**126,666**	**2**	**54,834**	**3**	**181,500**	**-**	**-**

Agrees to Table 31 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 CCG agreed early retirements, the additional costs were met by the CCG 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 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 2021/22

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 30**

* 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.

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 98 onwards. An audit certificate and report is also included in this Annual Report at page 171.

ANNUAL ACCOUNTS

Shane Devlin

Accountable Officer

29 June 2023

CONTENTS

Statement of Comprehensive Net Expenditure for the three months ended 30 June 2022

	Note	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Income from sale of goods and services	3	(3,151)	(10,106)
Other operating income	3	-	(50)
Total operating income		**(3,151)**	**(10,156)**
Staff costs	4	7,656	25,732
Purchase of goods and services	5	448,707	1,826,217
Depreciation and impairment charges	5	147	151
Provision expense	5	(786)	7,852
Other operating expenditure	5	1,401	8,817
Total operating expenditure		**457,125**	**1,868,769**
Net Operating Expenditure		**453,974**	**1,858,613**
Finance expense	7	1	-
Comprehensive Net Expenditure for the year		**453,975**	**1,858,613**

There were no finance income and expenditure or gains and losses on transfer by absorption reported in the three months to 30 June 2022 and in 2021-22.

The notes on pages 104 to 150 form part of this statement.

Statement of Financial Position as at 30 June 2022

	Note	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Non-current assets			
Property, plant and equipment	8	176	198
Right-of-use Assets	9	416	-
Intangible assets	10	64	85
Total non-current assets		**656**	**283**
Current assets			
Trade and other receivables	11	11,839	11,968
Cash and cash equivalents	12	102	46
Total current assets		**11,941**	**12,014**
Total assets		**12,597**	**12,297**
Current liabilities			
Trade and other payables	13	(95,917)	(117,877)
Lease liabilities	9	(416)	-
Provisions	14	(8,230)	(9,016)
Total current liabilities		**(104,563)**	**(126,893)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(91,966)**	**(114,596)**
Total Assets less Total Liabilities		**(91,966)**	**(114,596)**
Financed by Taxpayers' Equity			
General fund		(91,966)	(114,596)
Total taxpayers' equity		**(91,966)**	**(114,596)**

The notes on pages 104 to 150 form part of this statement.

The financial statements on pages 100 to 150 were approved by the Audit, Governance and Risk Committee on 20 June 2023 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 three months ended 30 June 2022

	General fund reserves £'000
Balance at 01 April 2022	**(114,596)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2022-23	
Net recognised expenditure for the three months	(453,975)
Net funding	476,605
Balance at 30 June 2022	**(91,966)**

	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 30 March 2022	**(114,596)**

The notes on pages 104 to 150 form part of this statement.

Statement of Cash Flows for the three months ended 30 June 2022

	Note	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(453,975)	(1,858,613)
Depreciation and amortisation	5	147	151
Finance costs	14	-	306
(Increase)/decrease in trade & other receivables	11	129	37,769
Increase/(decrease) in trade & other payables	13	(21,961)	52
Increase/(decrease) in provisions	14	(786)	7,546
Net Cash Inflow (Outflow) from Operating Activities		**(476,446)**	**(1,812,789)**
Cash Flows from Investing Activities			
Interest paid	7	1	-
(Payments) for property, plant and equipment	8	-	(357)
Net Cash Inflow (Outflow) from Investing Activities		1	(357)
Net Cash Inflow (Outflow) before Financing		**(476,445)**	**(1,813,146)**
Cash Flows from Financing Activities			
Net Funding Received		476,605	1,811,504
Repayment of lease liabilities	9	(104)	-
Net Cash Inflow (Outflow) from Financing Activities		**476,501**	**1,811,504**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**56**	**(1,642)**
Cash & Cash Equivalents at the Beginning of the Financial Year		46	1,688
Cash & Cash Equivalents (including bank overdrafts) at the 30 June 2022		**102**	**46**

The notes on pages 104 to 150 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 Act was introduced into the House of Commons on 6 July 2021. The Act allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG) on 30 June 2022. From the 01 July 2023 ICBs took on the commissioning functions of CCGs with assets and liabilities transferring to ICBs.

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.

Bristol North Somerset and South Gloucestershire CCG ceased to exist from 30 June 2022 with services continuing to be provided by Bristol North Somerset and South Gloucestershire ICB and therefore the financial statements have been drawn up at 30 June 2022 on a going concern basis.

1.2 Accounting Convention

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

1.3 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.

1.4.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements that management has made in the process of applying the 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

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.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 two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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 Integrated Care Board 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.

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

1.11 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

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

1.12.1 The Clinical Commissioning Group as Lessee

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

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

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

Lease payments included in the measurement of the lease liability comprise

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

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

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

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

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

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

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the

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

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

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.

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.

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.

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 30 June 2022. 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 are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 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 Contingent liabilities

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

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

1.26 Adoption of new standards

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

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

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

Impact assessment

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

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient

and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 a 1 April 2022.

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

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

As of 1 April 2022, the group recognised £520k for right-of-use assets and lease liabilities of £519k. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and an adoption of IFRS 16 there was an £1k impact to tax payers' equity.

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

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

	Total £000
Operating lease commitments at 31 March 2022	589
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	(6)
Operating lease commitments discounted used weighted average IBR	**583**
Less: Short term leases (including those with <12 months at application date)	(64)
Lease liability at 1 April 2022	**519**

1.27 New and revised IFRS Standards in issue but not yet effective

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

2 Financial Performance

2.1 Financial Performance three months ended 30 June 2022

The CCG performance target for the 3 months to the 30 June 2022 is £461.100m and is based on the quarter 1 profile spend of the BNSSG System Annual Plan submitted to NHS England in June 2022. The quarter 2 to quarter 4 profile spend will be the performance target of BNSSG Integrated Care Board (ICB), the CCG successor body.

The goal of the system was to ensure breakeven for each organisation and a commitment to shared system working and management of financial and operational risk.

2022/23 Total Allocation	Annual Plan - Total Allocation	CCG Q1	Total ICB Q2-Q4
	£000	£000	£000
Total recurrent Allocation	1,736,757	434,188	1,302,569
Total Non-Recurrent Allocation	120,668	26,912	93,756
Total allocation	**1,857,425**	**461,100**	**1,396,325**

Financial performance

The closing position of BNSSG CCG, before was a surplus of £7.125m.

Financial Position to 30 June 2022	£000s
Allocation	461,100
Expenditure	453,975
Surplus	**7,125**

The surplus of £7.125m primarily relates to the timing of spending against Service Development Fund, release of Elective Service Recovery Funds, the reversal of provisions and an underspend against prescribing costs

June 2022 - Month 3	2022/23 YTD Budget	Expenditure	Variance
Area of Spend	**£000s**	**£000s**	**£000s**
Acute Care	226,789	225,368	**1,421**
Mental Health & Learning Disabilities	53,401	52,893	**508**
Non-Acute Contracts	63,041	65,010	**(1,969)**
Children's Services	4,685	4,411	**274**
Continuing Healthcare	23,846	23,143	**703**
Primary Care	79,677	77,726	**1,951**
Other Support Costs and Running costs	9,661	5,424	**4,237**
BNSSG CCG Total Variance	**461,100**	**453,975**	**7,125**

In line with NHS England guidance the CCG made a final adjustment of £7.125m against the revenue allocation which decreased the allocation to £453.975m and therefore reduced the closing position to breakeven. The ICB will make a corresponding adjustment to the opening revenue allocation.

2.2 Financial Performance targets three months ended 30 June 2022

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). NHS Clinical Commissioning Group performance against those duties was as follows:

2022-23	Target £'000	Performance £'000	Variance £'000	Target Achieved
Expenditure not to exceed income	457,126	457,126	-	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	453,975	453,975	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	5,457	5,457	-	Yes

2021-22	Target £'000	Performance £'000	Variance £'000	Target Achieved
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

There were no capital or revenue resources on specified matters in the three months to 30 June 2022 and 2021-22.

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

3.1 Operating Income

	2022-23 30-Jun-22 Total £'000	2021-22 31-Mar-22 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies - *note 1*	2,390	7,950
Other contract income	761	2,156
Total income from sale of goods and services	**3,151**	**10,106**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	-	50
Total other operating income	**-**	**50**
Total Operating Income	**3,151**	**10,156**

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. £1.3m (£7.8m 2021-2022) of this revenue figure relates to income from the Department of Health for Research and Development.

3.2 Disaggregation of Income – Income from sale of goods and services (contracts)

	2022-23	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Source of Revenue		
NHS	246	205
Non NHS	2,144	556
Total	**2,390**	**761**

	2022-23	
	Non-patient care services to other bodies	Other Contract income
	£'000	£'000
Timing of Revenue		
Point in time	2,390	761
Over time	-	-
Total	**2,390**	**761**

	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**

4. Employee benefits and staff numbers

4.1 Employee benefits

	2022-23		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee benefits			
Salaries and wages	5,099	928	6,027
Social security costs	622	-	622
Employer contributions to NHS Pension scheme	983	-	983
Apprenticeship levy	24	-	24
Termination benefits	-	-	-
Gross employee benefits expenditure	**6,728**	**928**	**7,656**

	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**

There were no capitalised staff costs in the three months ended 30 June 2022 and in 2021-22.

4.2 Average number of people employed

	Permanently employed Number	Other Number	Total Number
2022-23	456.00	45.60	501.60
2021-22	408.20	25.62	433.82

The WTE average number of permanently people employed for the month of March 2022 was 453 and average number of other staff for the month of March 2022 was 48, therefore there are no significant movement in the figures from March 2022 to June 2022.

The permanently employed and other figures had gradually increased throughout the financial year 2021/22. The main change was the transfer of the BNSSG Healthier Together Integrated Care System to BNSSG CCG on the 1 January 2022; 39 (number of) staff were TUPE transferred.

4.3 Staff annual leave accrual balances

	Permanent Staff £'000
Employee accrued benefits liability at 30 June 2022	(367)
Employee accrued benefits liability at 31 March 2022	(142)

The accrued benefits liability balance related to permanent staff only; no temporary or agency staff accrued annual leave benefits.

The increase in the accrued benefits liability reflects the change in the financial year end date with the main holiday period being July and August.

4.4 Exit packages agreed in the financial year

There were no exit payments for the three months ending 30 June 2022.

	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**

	Departures where special payments have been made	
	No.	£
Less than £10,000	-	-
£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	**-**	**-**

Analysis of Other Agreed Departures

	2021-22 Other agreed departures	
	No.	£
Contractual payments in lieu of notice	1	49,445
Non-contractual - special severance payments	1	5,389
Total	**2**	**54,834**

* 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

	2022-23 30-Jun-22 Total £'000	2021-22 31-Mar-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,059	7,615
Services from foundation trusts	125,214	479,743
Services from other NHS trusts	141,559	543,746
Services from Other WGA bodies	290	1,266
Purchase of healthcare from non-NHS bodies	102,403	435,661
Purchase of social care	1,792	38,728
Prescribing costs	32,539	135,083
GPMS/APMS and PCTMS	39,579	168,257
Supplies and services – clinical	894	3,370
Supplies and services – general	778	201
Consultancy services	504	1,023
Establishment	491	4,305
Transport	4	21
Premises	954	4,401
Audit fees - *notes 1, 2*	123	101
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	12
Other professional fees - *note 3*	250	1,425
Legal fees	86	425
Education, training and conferences	188	834
Total Purchase of goods and services	**448,707**	**1,826,217**
Depreciation and impairment charges		
Depreciation	126	66
Amortisation	21	85
Total Depreciation and impairment charges	**147**	**151**
Provision expense		
Change in discount rate	-	306
Provisions	(786)	7,546
Total Provision expense	**(786)**	**7,852**
Other Operating Expenditure		
Chair and Non Executive Members - *note 4*	63	269
Grants to Other bodies	-	525
Research and development (excluding staff costs)	1,357	8,043
Expected credit loss on receivables	(19)	(25)
Other expenditure	-	5
Total Other Operating Expenditure	**1,401**	**8,817**

Total Operating Expenditure	**449,469**	**1,843,037**

Notes

1. External audit liability is capped at £2m.

2. External audit fees, including VAT, £123,060 (£101,160 2021-2022). This includes £3,060 additional costs in relation to the 2021/22 audit which were not accrued. The external audit fees are based on the quote received in June 2022 (£120,000 including VAT) and are higher than the final tendered price from the appointed auditors received in October 2022 (£72,000 including VAT).

3. Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees totaled £15,600 net of VAT (£64,480 2021-22).This is included in Other professional fees.

4. The Chair and Non Executive Members costs also include the ICB Chair Designate of BNSSG ICB salary from 01 January 2022.

5. CCG Expenditure on Covid totalled £3.8m (£26.3m 2021-22)

6.1 Better Payment Practice Code

Measure of compliance	2022-23 30-Jun-22		2021-22 31-Mar-22	
	No.	£'000	No.	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,039	186,146	25,372	668,373
Total Non-NHS Trade Invoices paid within target	6,907	180,575	24,610	631,170
Percentage of Non-NHS Trade invoices paid within target	**98.12%**	**97.01%**	**97.00%**	**94.43%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	213	254,289	746	1,015,178
Total NHS Trade Invoices Paid within target	199	254,095	727	1,015,166
Percentage of NHS Trade Invoices paid within target	**93.43%**	**99.92%**	**97.45%**	**100.00%**

In the financial year 2021/22 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. Finance Costs

	2022-23 30-Jun-22 Total £'000	2021-22 31-Mar-22 Total £'000
Interest on lease liabilities	1	-
Total finance costs	**1**	**-**

8. Property, plant and equipment

2022-23	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	907	100	1,007
Disposals other than by sale	(158)	(100)	(258)
Cost/Valuation at 30 June 2022	**749**	**-**	**749**
Depreciation 01 April 2022	709	100	809
Disposals other than by sale	(158)	(100)	(258)
Charged during the year	22	-	22
Depreciation at 30 June 2022	**573**	**-**	**573**
Net Book Value at 30 June 2022	**176**	**-**	**176**
Purchased	176	-	176
Total at 30 June 2022	**176**	**-**	**176**
Asset financing:			
Owned	176	-	176
Total at 30 June 2022	**176**	**-**	**176**

8.1 Cost of valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Information technology	447	542
Furniture & fittings	-	102
Total	**447**	**644**

8.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	1	5

9. Leases

9.1 Right-of-use assets

2022-23	Buildings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-
IFRS 16 Adjustment	520	520
Cost/Valuation at 30 June 2022	**520**	**520**
Depreciation 01 April 2022	-	-
Charged during the year	104	104
Depreciation at 30 June 2022	**104**	**104**
Net Book Value at 30 June 2022	**416**	**416**

9.2 Lease liabilities

2022-23	Leased from NHS Property Services £'000	Total £'000
Lease liabilities at 01 April 2022	-	-
IFRS16 Transition Adjustment	519	519
Interest expense relating to lease liabilities	1	1
Repayment of lease liabilities (capital and interest)	(104)	(104)
Lease liabilities at 30 June 2022	**416**	**416**

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

2022-23	Obligations Leased from NHS Property Services 30-Jun-22 £'000	Obligations Total 30-Jun-22 £'000
Within one year	(416)	(416)
Between one and five	-	-
After five years	-	-
Total	**(416)**	**(416)**

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2022-23	SoCNE 30-Jun-22 £'000
Depreciation expense on right-of-use asset	104
Interest expense on lease liabilities	1

9.5 Amounts recognised in cashflow

2022-23	30-Jun-22 £'000
Total cash outflow on leases under IFRS 16	(104)

9.6 Impact of IFRS 16 as at 1st April 2022

	£'000
Operating lease commitments at 31 March 2022	589
Impact of discounting at 1 April 2022 using the weighted average	(6)
Incremental borrowing rate of 0.95%	-
Operating lease commitments discounted using weighted Average IBR	**583**
Add: Finance lease liabilities at 31 March 2022	-
Add: Peppercorn leases revalued to existing value in use	-
Add: Residual value guarantees	-
Add: Rentals associated with extension options reasonably certain to be exercised	-
Less: Short term leases (including those with< 12 months at application date)	(64)
Less: Low value	-
Less: Variable payments not included in the valuation of the lease liabilities	-
Lease liability at 1 April 2022	**519**

10. Intangible non-current assets

2022-23	Computer software: purchased £'000
Cost or valuation at 01 April 2022	232
Disposals other than by sale	(62)
Cost / Valuation at 30 June 2022	**170**
Amortisation 01 April 2022	147
Disposals other than by sale	(62)
Charged during the year	21
Amortisation at 30 June 2022	**106**
Net Book Value at 30 June 2022	**64**
Purchased	64
Total at 30 June 2022	**64**

10.1 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Computer software: purchased	-	62
Total	**-**	**62**

10.2 Economic Lives

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

11.1 Trade and other receivables

	Current 2022-23 30-Jun-22 £'000	Current 2021-22 31-Mar-22 £'000
NHS receivables: Revenue	1,187	4,573
NHS prepayments	706	706
NHS accrued income	746	19
Non-NHS and Other WGA receivables: Revenue	2,444	2,851
Non-NHS and Other WGA prepayments	2,570	2,681
Non-NHS and Other WGA accrued income	3,927	749
Expected credit loss allowance-receivables	(3)	(22)
VAT	253	405
Other receivables and accruals	9	6
Total Current trade & other receivables	**11,839**	**11,968**

There are no non-current trade receivables.
There are no prepaid pensions contributions in the three months to 30 June 2022 (2021-22 Nil).
The majority of trade is with NHS England. As NHS England is funded by Government no credit scoring is considered necessary.

11.2 Receivables past their due date but not impaired

	2022-23	
	DHSC Group Bodies	Non DHSC Group Bodies
	£'000	£'000
By up to three months	297	151
By three to six months	-	-
By more than six months	-	-
Total	**297**	**151**

	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**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies
	£'000
Balance at 01 April 2022	(22)
Lifetime expected credit losses on trade and other receivables-Stage 2	19
Allowance for credit losses at 30 June 2022	**(3)**

11.4 Provision matrix on lifetime credit loss

Non NHS Debt	% Lifetime expected credit loss rate	30-Jun-22 £'000 Gross Carrying amount	£'000 Lifetime expected credit loss
Current	-	-	-
1-30 days	-	-	-
31-60 days	-	-	-
61-90 days	20	1	1
Greater than 90 days	100	2	2
Total expected credit loss		**3**	**3**

Non NHS Debt	% Lifetime expected credit loss rate	31 March 22 £'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**

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 30 June 2022.

12. Cash and cash equivalents

	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Balance at 01 April 2022	46	1,688
Net change in year	56	(1,642)
Balance at 30 June 2022	**102**	**46**
Made up of:		
Cash with the Government Banking Service	101	45
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**102**	**46**

13. Trade and other payables

	Current 2022-23 30-Jun-22 £'000	Current 2021-22 31-Mar-22 £'000
NHS payables: Revenue	12,036	1,594
NHS accruals	3,563	293
NHS deferred income	-	50
Non-NHS and Other WGA payables: Revenue	22,459	51,114
Non-NHS and Other WGA payables: Capital	-	-
Non-NHS and Other WGA accruals	55,036	61,309
Non-NHS and Other WGA deferred income	-	475
Social security costs	371	342
Tax	296	292
Other payables and accruals	2,156	2,408
Total Current Trade & Other Payables	**95,917**	**117,877**

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 £1,966,713 outstanding pension contributions at 30 June 2022.

14. Provisions

	Current 2022-23 30-Jun-22 £'000	Current 2021-22 31-Mar-22 £'000
Restructuring	419	943
Legal claims	4,948	5,210
Other	2,863	2,863
Total	**8,230**	**9,016**

There are no non-current provisions.

	Restructuring £'000	Legal Claims £'000	Other £'000	Total £'000
Balance at 01 April 2022	**943**	**5,210**	**2,863**	**9,016**
Arising during the year	-	-	-	**-**
Utilised during the year	-	-	-	**-**
Reversed unused	(524)	(262)	-	**(786)**
Unwinding of discount	-	-	-	**-**
Change in discount rate	-	-	-	**-**
Balance at 30 June 2022	**419**	**4,948**	**2,863**	**8,230**
Expected timing of cash flows:				
Within one year	419	4,948	2,863	**8,230**
Between one and five years	-	-	-	**-**
After five years	-	-	-	**-**
Balance at 30 June 2022	**419**	**4,948**	**2,863**	**8,230**

The Restructuring provision of £419k relates to restructuring associated with the impact of the Health and Social Care Act of the 06 July 2021 for the establishment of Integrated Care Boards across England which will abolish Clinical Commissioning Groups.

The reversal of £524k relates to the reassessment of the early cancellation of the head office lease arising from the home first hybrid working policy. There will be no early cancellation ahead of renewal in June 2023. The unused provision was recognised in the comprehensive net expenditure.

The Legal provisions relate to outstanding contract challenges with providers. The provision for the cost of a judicial review arising from major service changes that would require public consultation was not required and reversed to comprehensive net expenditure.

The Other provision relates to;
- £2,107k for General Practitioner service charge payments disputed with NHS Property Services
- £756k for dilapidations associated with the Head Office and a GP practice.

15. Financial instruments

15.1 Financial risk management

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

Because 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.

15.1.1 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.

15.1.2 Interest rate risk

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

15.1.3 Credit risk

Because the majority of the 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.

15.1.4 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.

15.1.5 Financial Instruments

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

15.2 Financial assets

	Financial Assets measured at amortised cost 2022-23 £'000	Financial Assets measured at amortised cost 2021-22 £'000
Trade and other receivables with NHSE bodies	1,093	3,846
Trade and other receivables with other DHSC group bodies	893	1,557
Trade and other receivables with external bodies	6,326	2,795
Cash and cash equivalents	102	46
Total at 30 June 2022	**8,414**	**8,244**

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2022-23 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000
Trade and other payables with NHSE bodies	943	1,009
Trade and other payables with other DHSC group bodies	15,612	1,293
Trade and other payables with external bodies	78,694	114,417
Other financial liabilities	416	-

Total at 30 June 2022	**95,665**	**116,719**

15.4 Maturity of Financial liabilities

	2022-23		
	Payable to DHSC	**Payable to Other bodies**	**Total**
	£'000	**£'000**	**£'000**
In one year or less	16,555	79,110	95,665
Total at 30 June 2022	**16,555**	**79,110**	**95,665**

	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**

16. Operating segments

	2022-23 Commissioning Healthcare	2021-22 Commissioning Healthcare
	£'000	£'000
Gross expenditure	457,126	1,868,769
Income	(3,151)	(10,156)
Net expenditure	453,975	1,858,613
Total assets	12,597	12,297
Total liabilities	(104,563)	(126,893)
Net assets	(91,966)	(114,596)

16.1 Reconciliation between Operating Segments and SoCNE

	2022-23	2021-22
	£'000	£'000
Total net expenditure reported for operating segments	453,975	1,858,613
Total net expenditure per the Statement of Comprehensive Net Expenditure	453,975	1,858,613

16.2 Reconciliation between Operating Segments and SoFP

	2022-23	2021-22
	£'000	£'000
Total assets reported for operating segments	12,597	12,297
Total assets per Statement of Financial Position	12,597	12,297

	2022-23	2021-22
	£'000	£'000
Total liabilities reported for operating segments	(104,563)	(126,893)
Total liabilities per Statement of Financial Position	(104,563)	(126,983)

17. Related party transactions

Details of related party transactions with individuals are as follows:

	2022-23				2021-22			
	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), 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, Kirsty Alexander & Jonathan Hayes are partners in organisations that are shareholders in GP Care.	336	-4	115	-8	1,255	-91	123	-
Alison Moon (Independent Lay member-Registered Nurse) - St Peter's Hospice. Alison Moon is a Trustee of St Peter's Hospice	-	-	-	-	2,938	-	95	-
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	154	-1	-	-	150	-31	153	-2
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 Developments 1 Ltd is part of Bristol Infracare LIFT Ltd.	9	-	-	-	37	-	6	-
James Case (LLG Commissioning Lead) - Allpharm Ltd. James case is Director of Allpharm Ltd. BNSSG has transactions with Allpharm Ltd TA Concord Pharmacy	-	-	-	-	1	-	-	-

	2022-23				2021-22			
	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
Kirsty Alexander (Co Chair N&W Partnership Board - CCG GB member and Clinical Lead for Children and Families), Kevin Haggerty (Weston, Worle and Villages Locality Lead & North Somerset Governing Body Representative), Jonathan Hayes (Clinical Chair) - One Care Ltd. Kirsty Alexander is a partner in an organisation that is a shareholder in One Care, 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 One Care Consulting & Services Ltd. These transactions are for One Care (BNSSG) Ltd.	5,139	-5	362	-205	7,319	-	3,758	-
Kirsty Alexander (Co Chair N&W Partnership Board - CCG GB member and Clinical Lead for Children and Families), Kevin Haggerty (Weston, Worle and Villages Locality Lead & North Somerset Governing Body Representative), Jonathan Hayes (Clinical Chair) - One Care Ltd. Kirsty Alexander is a partner in an organisation that is a shareholder in One Care, 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 One Care Consulting & Services Ltd. These transactions are for One Care Consulting & Services Ltd.	1,298	-	-	-	1,985	-	1,987	-

	2022-23				2021-22			
	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
Caroline Stovell (Governing Body Inner and East locality Representative)- BrisDoc Healthcare Services Ltd. Caroline Stovell is GP and Deputy Medical Director at BrisDoc.	4,401	-	857	-2	-	-	-	-

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 party North Bristol NHS Trust;
• NHS Litigation Authority; and,
• NHS Business Services Authority.

The Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies during Q1 2022/2023. The transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a net spend of £24.3m and the main services this relates to are: Better Care Fund and Other (£9.3m); Funded Nursing Care (£5.7m); and all groups of Complex Care clients (£9.3m). For the BCF, the figures are as coded in the ledger as at 30 June 2022.

Expenditure with Local Authorities

Local Authority	**2022-23**	**2021-22**
	£m	**£m**
Bristol City Council	13.9	58.2
North Somerset Council	5.8	44.6
South Gloucestershire Council	4.6	30.2
Total	**24.3**	**133**

18. 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.

At the 30 June 2022, the BCF plans had not received assent by Health & Wellbeing Boards. The following table shows the pro-rata spend for each BCF for the 3 months to 30 June.

Bristol City Council	**2022-23**
	£'000
Funding provided to partnership budgets	9,211
Additional NHS contribution	327
ASC discharge funding	1,143
ICB funding to council for protection of adult social care	(4,789)
Expenditure from partnership arrangement	**5,892**

North Somerset Council	**2022-23**
	£'000
Funding provided to partnership budgets	4,371
Additional NHS contribution	344
ASC discharge funding	787
ICB funding to council for protection of adult social care	(1,915)
Expenditure from partnership arrangement	**3,587**

South Gloucestershire Council	**2022-23**
	£'000
Funding provided to partnership budgets	4,481
Additional NHS contribution	188
ASC discharge funding	842
ICB funding to council for protection of adult social care	(1,621)
Expenditure from partnership arrangement	**3,890**

19. Losses and special payments

19.1 Losses

There were no losses in the three months to 30 June 2022 (2021-2022 nil).

19.2 Special payments

There were no severance payments in three months ended 30 June 2022.

	2021-22 Number	2021-22 £'000
Special Severance Payments	1	5
Total	**1**	**5**

The special severance payment in the financial year 2021/22 was for the dismissal from the CCG on the grounds of capability due to ill health.

20. Contingences

Contingent Liabilities

	2022-23 30-Jun-22 £'000	2021-22 31-Mar-22 £'000
Continuing Healthcare	354	527

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.

21. Events after the reporting period

The CCG was dissolved on 30 June 2022 and on 01 July 2022 the assets, liabilities and operations transferred to NHS Bristol, North Somerset and South Gloucestershire ICB.

NHS BRISTOL, NORTH SOMERSET & SOUTH GLOUCESTERSHIRE ICB

Annual internal audit report 2022/23

Draft

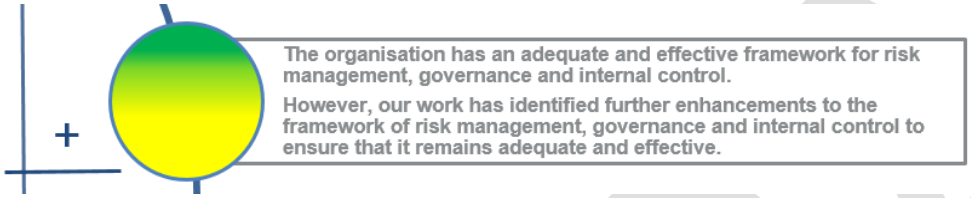
13 June 2023

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 nine months ended 31 March 2023 the head of internal audit opinion for NHS Bristol North Somerset South Gloucestershire (BNSSG) ICB 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 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 an organisation-led assurance framework (initially inherited from the Clinical Commissioning Group). 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;
- 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; and
- 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.

FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

Based on the work undertaken during 2022/23 since the transition from the CCG to the ICB on 1 July 2022, there are a number of areas of internal control where improvements could be made to ensure the control frameworks in place are designed to meet the ICB's objectives, and controls are generally being applied consistently. Despite this, we have seen significant progress in embedding of system working, and system processes being adopted.

We have provided two **reasonable assurance** opinions, one in the annual **Key Financial Controls** review and one in an audit of **System Performance Management** that was complete as part of the 2022/23 internal audit plan. The financial controls review found a sound control framework with actions agreed around regular review of finance system access; and formally documenting the debt collection process. The system performance management audit highlighted that whilst there is not a formal system performance management framework in place, this was being worked on via a consultancy review to align to the system operational plan. We also agreed improvement actions around providing regular updates on the project to embed new systems and live data sets across the ICS to ensure progress remains on track and effective; as well as an action to review some of the governance forums attendance in light of new place based governance structures being rolled out to ensure performance is monitored by the right people at the right time to be most effective.

During the year we undertook a review of **Financial Sustainability**, reviewing the ICB's self-assessment against the HFMA guidance. The self-assessment itself identified a number of areas where the ICB recognised the need for improvement, and this is being monitored via an action plan which is presented to the Audit, Governance and Risk Committee for scrutiny and assurance. We confirmed that the self- assessment had been completed accurately and appropriately.

We also undertook a review of the ICB's **risk management and governance** arrangements, which resulted in a management letter which identified three suggested areas of improvement, to feed into the development of the new Risk Management Framework which was still in progress at year end. Whilst we were able to see that directorate and corporate risk was being monitored via the executive team and the Committees, there was no presentation of the Corporate Risk Register to the Board during the year. We did however evidence that the ICB was enabling system wide engagement in system risk management and assurance which forms the basis of the new framework.

We were requested by management to undertake an audit of the ICB's use of agency staff, which resulted in a partial assurance opinion. 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.

Agency Arrangements

Our audit fieldwork concluded that there had been a lack of a centralised process and definition of responsibilities for managing agency usage and spend across the ICB. This was validated through evidence / records either not existing or staff not being able to find the necessary documents to support that agency staff had been engaged at the right costs and had the right paperwork in place. We found that information was being owned and held by different teams and individuals across the ICB, and at the time of audit it was unclear exactly where responsibility and ultimate oversight for any of the associated processes sits. This is borne of a historic lack of internal HR resource within the CCG previously. However, in the ICB there is now a People Directorate meaning these responsibilities can be more directly actioned. Without such central oversight and ultimate ownership of processes, for example budget holders having adequate training and guidance of how to engage agency staff and at what rate, detailed scrutiny of pay rates agreed with agencies and knowing exact levels of agency spend, the Board cannot take assurance that this area is being appropriately controlled. Two 'high' and five 'medium' priority

actions were agreed with management to address the weaknesses and risks identified during the audit. We will follow these up to confirm when implemented and report back to the Audit Committee.

Throughout the year internal audit has tracked the implementation of previously agreed management actions and reports the position to each Audit, Governance and Risk Committee. **Reasonable progress** has been made in implementing management actions, with three 'high', seven 'medium' and two 'low' priority actions currently ongoing in the following areas:

- Risk Management
- Safeguarding
- Recruitment
- Appraisals
- Financial Controls
- Agency Arrangements

Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken to date on the ICB's system on 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 ICB may wish to consider any issues raised around the Agency Arrangements review, referred to above, when determining whether anything should be highlighted within the Annual Governance Statement. The ICB should also consider whether any other issues have arisen as well as recognise the challenging environment within which the ICB is operating, including the results of any external reviews, as well as the reduced reporting to Board on risk management and assurance in year.

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.

Implementation of internal audit management actions

Throughout the year internal audit has tracked the implementation of previously agreed management actions and reports the position to each Audit, Governance and Risk Committee. **Reasonable progress** has been made in implementing management actions, with three 'high', seven 'medium' and two 'low' priority actions currently ongoing.

Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers other than through consideration of the service auditor reports received. We have liaised with the Local Counter Fraud Specialist and External Audit as appropriate during the course of the year. The service auditor reports considered are 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 ICB. This was an unqualified report.

We reviewed the Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering financial, payroll and non-clinical procurement services, and noted one exception was identified relating to HR / Payroll access to ESR. Despite this exception, the service auditors did not feel this impacted on the effectiveness of the control framework; therefore this has not impacted on our opinion. .

We reviewed the Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering CQRS (calculating quality reporting systems) services. Whilst the report resulted in a qualified opinion due to four exceptions identified around infrastructure service account passwords; approval for national system changes; and a changed interface not having a documented technical specification, it was note felt the findings were of sufficient significance to undermine our overall opinion for the ICB.

The Service Auditor Report from the internal auditors for NHS England in regard to GP Payments highlighted two control exceptions but was otherwise satisfactory. Neither exception was sufficiently significant to impact the Head of Internal Audit Opinion for the ICB.

We reviewed the Service Auditor Report from the internal auditors for the NHS Business Services Authority for Prescriptions Payments Process. The report identified one exception around ineffective processes to ensure access to applications was appropriate by deactivating leavers in a timely manner. Despite this finding, this report has not impacted on our opinion.

We reviewed the Service Auditor Report in relation to Capita for Primary Care Support Services. The report showed a significantly reduced number of exceptions from 93 in 2021/22 to 11 in 2022/23 and a reduced number of control objectives qualified from 4 to 2, therefore this has not impacted 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 ICB. Three qualifications to the opinion were noted regarding 1) authorisation and revocation of logical access; 2) tracking and resolution of NHS Hub availability issues; and 3) weaknesses around the physical security and maintenance of a data centre.

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.
Data Analytics	We used data analytics in our financial controls work, 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 2022/23 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 – System Risk	We facilitated an ICS Workshop in January 2023 on system risk management. This was a workshop involving a number of employees, Non-Executive members, Board members and other key stakeholders in the BNSSG system. The event was used to assist with the population and identification of the high level risks in the system.
Healthcare benchmarking	We have shared benchmarking information with the ICB 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 ICB benefits from wider input, in order to strengthen its governance arrangements.
Webinars	We have invited the ICB to various webinars across the year to share sector and wider good practice and help to communicate emerging risks and issues.
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 2022/23 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

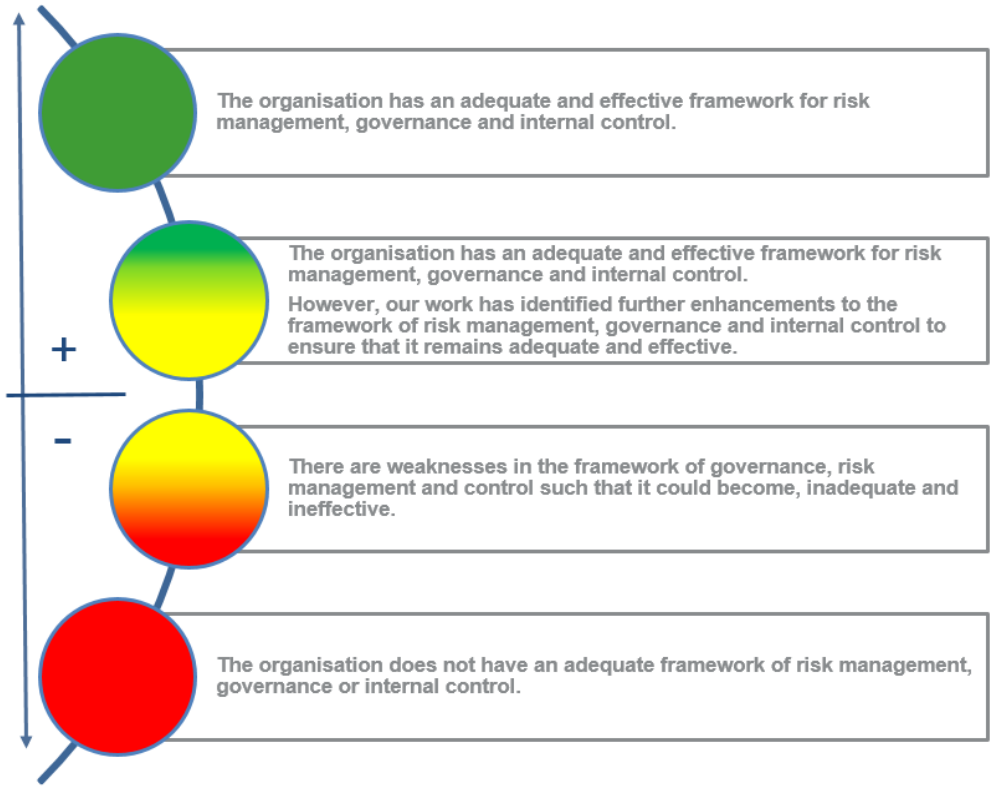
To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

Resulting from the programme in 2022/23, 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 2022/23

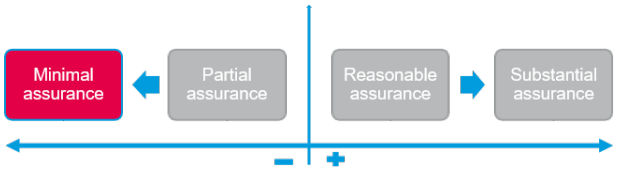
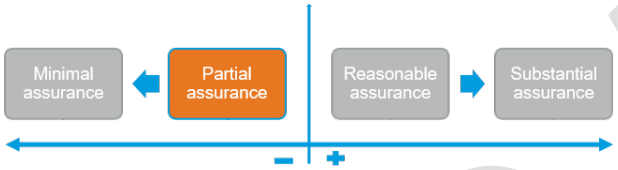
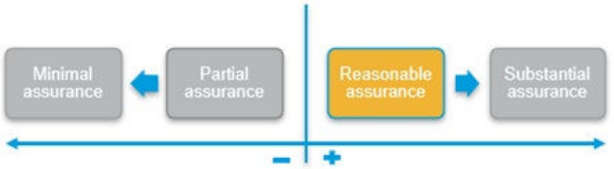
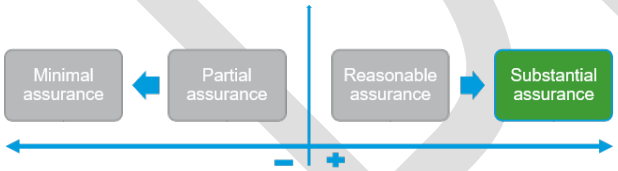
All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

Assignment	Executive lead	Assurance level	Actions agreed			
			A	L	M	H
Financial Sustainability (2.22/23)	Sarah Truelove - CFO	Advisory [●]	0	-	-	-
Agency Arrangements (3.22/23)	Julie Bacon – Interim Chief People Officer	Partial Assurance [●]	-	0	5	2
Financial Controls (4.22/23)	Sarah Truelove - CFO	Reasonable Assurance [●]	-	1	2	0
Risk Management Letter (5.22/23)	Sarah Truelove - CFO	Advisory [●]	3	0	0	0
System Performance Management (6.22/23)	Lisa Manson – Director of Performance & Delivery	Reasonable Assurance [●]	-	5	2	0

** Report 1.22/23 refers to the **Top Up Testing** audit which was undertaken as part of the three-month CCG Internal Audit programme to 30 June 2023, therefore does not impact on this head of internal audit opinion and annual report.*

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

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EXECUTIVE SUMMARY – SYSTEM PERFORMANCE MANAGEMENT

Assignment	Opinion issued	Actions agreed		
		L	M	H
System Performance Management (6.22/23)	Reasonable Assurance	3	2	0

Background

Following the passing of the 2022 Health and Care Act, Integrated Care Systems (ICSs) (also referred to within this report as the 'System') were formalised as legal entities with statutory powers and responsibilities, that bring together NHS organisations, local authorities and others to collectively improve health and reduce inequalities across geographical areas. ICSs comprise of two key components consisting of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs).

On the 1 July 2022, all Clinical Commissioning Groups (CCGs) were abolished and ICBs were legally established. Whilst an ICB may choose to delegate some of its functions to place-based committees, the ICB is directly and formally accountable to NHS England (NHSE) for NHS spend and performance within the System.

The objectives of the 'Healthier Together' System (ICS), are to work together with local partner organisations (including local authorities in the BNSSG area, NHS Trusts, GP providers and the ICB) to improve health and wellbeing, reduce inequalities and provide integrated services for the people living in the BNSSG area. The ICS have a draft Joint Forward Plan that aims to:

- Improve the health and wellbeing of the BNSSG population;
- Provide high-quality services that are fair and accessible to everyone; and
- To make the health and social care system more efficient and sustainable.

The Joint Forward Plan details the deliverables, metrics and sets out how the System will measure success, that meets the requirements for the NHS Long Term Plan and NHS Planning Guidance. The ICB uses the Systems Outcomes Framework to measure its progress, using outcome indicators that link back to the systems' strategic objectives.

The purpose of this audit was to review the ICB processes in place that ensure effective performance management of the BNSSG System. This includes a review on the framework that supports the delivery of performance across operational areas, quality and finance.

The Business Intelligence (BI) team are responsible for reporting on key National Statistics which are used to report through the ICB's governance structure. Key performance metrics include indicators from various frameworks, plans and standards (such as the Oversight Framework, NHS Long Term Plan and Operational Plan).

Nationally reported data (validated data) is used to formally report performance and is pulled from NHS Digital, National Statistics and provider Board papers. Unvalidated data (live data) is used in the ICB's daily performance management of operational areas using an external system 'Alamac' that collates System data from partners EPR (electronic patient records) systems such as South Western Ambulance Service NHS Foundation Trust (SWAST) and RiO. This provides live dashboard information (daily) on key metrics that include: calls coming through 999, the position of the SWAST ambulance service, section 136 beds available (for mental health) and Decision to Admit (DTA).

Currently the main key performance indicators (KPIs) tracked through the System focus on NHSE's Urgent and Emergency Care (UEC) recovery action plan, and six national winter metrics. The UEC recovery action plan sets out how the System will work together to ensure UEC services have resilience by:

Supporting 999 and 111 services	Improving in-hospital flow and discharge (System wide)
Supporting primary care and community health services to help manage the demand for UEC services	Supporting adult and children's mental health needs
Supporting greater use of Urgent Treatment Centres (UTCs)	Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response
Increasing support for Children and Young People	Reviewing staff Covid isolation rules
Using communications to support the public to choose services wisely	Ensuring a sustainable workforce

The six national winter metrics report on:

- category 2 ambulance response times, (category 2 incidents are serious incidents including strokes or chest pain and the response target is 18 minutes);
- average hours lost to ambulance handover delays per day (ambulances stuck outside A&E can't respond to incidents in the community, impacting response times);
- percentage of beds occupied by patients who no longer meet the criteria to reside (delays to discharging patients to the care sector or community, impacting the number of beds available to receive new patients in ambulances);
- adult general and acute type 1 bed occupancy adjusted for void beds 2. (inability to discharge patients in a timely manner, having a knock on effect to bed occupancy);
- 111 call abandonment (where callers abandon their calls due to increased waiting times); and
- mean 999 call answering times (the increase in the number of 999 ambulance calls received and the increase to the duration of time it is taking to answer those calls compared to previous years).

The governance over performance management within the ICB, includes various groups and committees responsible for reviewing operational performance data from across the System, where assurances or risks are reported to the ICB's Outcomes Quality and Performance Committee (OQPC) (an ICB established meeting attended by System partners) and to the Board.

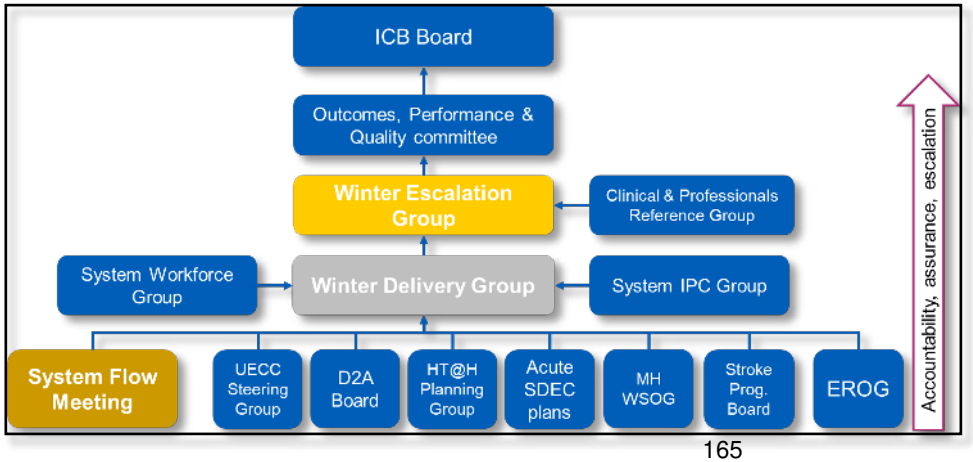
Conclusion

The ICB has developed clear reporting lines within the System (as shown in the Healthier Together flow chart included in Appendix A) where performance management takes place, System partners are engaged and analytical data utilised to support decision making (for the most part). The ICB has room to develop this further by:

- clarifying roles and responsibilities of individuals contributing to System meetings;
- clearly identifying all performance metrics, the ICB have oversight of and highlighting the links and interdependencies metrics have with various workstreams and frameworks;
- applying a structured approach to all performance monitoring meetings and ensuring analytical performance data is used for decision making;
- ensuring consistent attendance from System partners to key performance meetings to ensure effective governance and oversight; and
- continuing to develop how the ICB collates and presents operational data to enable faster and more reliable reporting.

Although nationally we have not seen a formal performance management framework in place for ICBs, we identified good practice in how the ICB applies kitemarking to the data used in reporting, to easily identify the current RAG status of key performance indicators (KPIs).

Whilst there is currently no formal System performance management framework in place, we found evidence that the controls in place were effective, with room for improvement.



Key findings

We identified the following findings:

The ICB manages system performance through various groups and delivery Boards but does not currently have a performance management framework in place.

The ICB's BI team are responsible for collating performance data and presenting it in workbooks, dashboards and reports that are used in System meetings. We noted that whilst the ICB does not have a process for assuring itself that data and information is complete, the Director of Performance and Delivery has access to live system data (such as the Emergency Department and Ambulances) that refreshes every 15 minutes, and there is a balance to having real time data to respond to, and having validated but delayed data. From attending a meeting of the Winter Delivery Group (WDG) on 8 February 2023, it materialised that AWP was missed off the data dashboard. We identified the reason behind this was due to the fact AWP does not currently have a live system that can provide rapid data but instead provide monthly data, however, work is being undertaken to enable this from August 2023. Due to the manual nature in how unvalidated data is recorded by providers, there is a risk to the accuracy and reliability of the data being used to inform daily operational decisions but the ICB are in the process of rolling out a new system that will enable all providers to access live rapid data.

BNSSG ICB has established a System Flow Meeting (SFM) to manage the day-to-day operational pressures associated with winter. Alongside the Winter Escalation Framework, the aim of the SFM is to ensure the System keep on track with winter plans (covering the six national winter metrics) and UEC action plan. The SFM meet daily and escalate operational issues to the Winter Delivery Group. The metrics include (but are not limited to):

- 111 calls;
- 999 call answering times and call handler rota;
- category 2 ambulance activity and resourcing;
- ambulance handover delays and acute queuing capacity;
- bed occupancy and discharge metrics; and
- no criteria to reside.

We observed the performance metrics reported on (by exception) were listed and covered the six national winter metrics as required and found SFM and System escalation call notes evidenced how operational pressures were managed within meetings. Each System partner reported on metrics relevant to them which included numbers in the emergency department (ED), number of ambulances and the waiting times, staffing, discharges and bed mapping. We observed the ICB were able to clearly demonstrate how it used daily performance data, extracted from a web-based tool 'Alamac', (accessible to all System providers), to inform and escalate operational issues.

We noted that whilst this data is unvalidated data, (due to it being live real-time data input by System providers daily), the ICBs BI team actively chase providers for their daily submissions (by 10am) to ensure all data is available for an operational SFM at 11am.

The Winter Delivery Group (WDG) is formed of representatives from each System provider and meets weekly to provide assurance or escalate issues on whether winter plans are kept on track. We identified the action logs used to track progress of the group's actions (relating to winter metrics tracking ad escalations) did not include a completion deadline to aid monitoring.

The Winter Escalation Group (WEG) is responsible for reviewing key performance metrics, taking strategic decisions when variances are likely to impact other elements of System plans or impact patient care, and provide assurance that outcomes and performance of services are being delivered. The WEG's aim is to ensure the delivery of the System's key priorities for 2022/23. We identified the group (attended by key leaders from across the System partners) have access to the live operational data to support decision making. We acknowledged the ICB's preference to have a non-structured agenda to enable exception reporting (on national winter metrics), to ensure escalations to be reactive to live performance / issues can be addressed timely and minimise duplication on reporting.

Performance and delivery across the System is also managed through a number of ICB led groups / delivery boards that provide updates and recommendations to the Planning and Oversight Group (POG). Whilst we can see the ICB are engaging System partners in performance monitoring it was not clear on the roles and responsibilities of individuals responsible for providing the data or escalating to POG.

The Planning and Oversight Group (POG) oversee the operational and financial delivery and planning aspects of System. The POG report to the Healthier Together (System) Executive Group in accordance with the Systems Governance structure. Whilst we found POG meetings to be effective for the system areas being discussed and evidenced the use of relevant data to support decision making (provided by the BI team), the ICB cannot be assured that POG are ensuring all system areas cycled for review, are receiving the appropriate level of operational oversight over performance as proposed in the forward planner. We identified the reason planned system area reviews had not been included in agendas in line with the forward plan, was due to the challenge of getting the relevant area leads to provide updates and attend meetings as planned.

The System Outcomes Quality and Performance Committee (OQPC) has been established by the ICB and are responsible for scrutinising and providing assurance on the System's quality and performance governance and internal control, to effectively deliver its strategic objectives. We identified, not all System representatives were in regular attendance to OQPC meetings but noted the OQPC ToR did not state the minimum requirements for attendance by its members. Without attendance from all System partners, the meeting cannot be effective. Additionally, we found that actions raised from meetings were not consistently added to both the committee action log and clearly documented within the minutes.

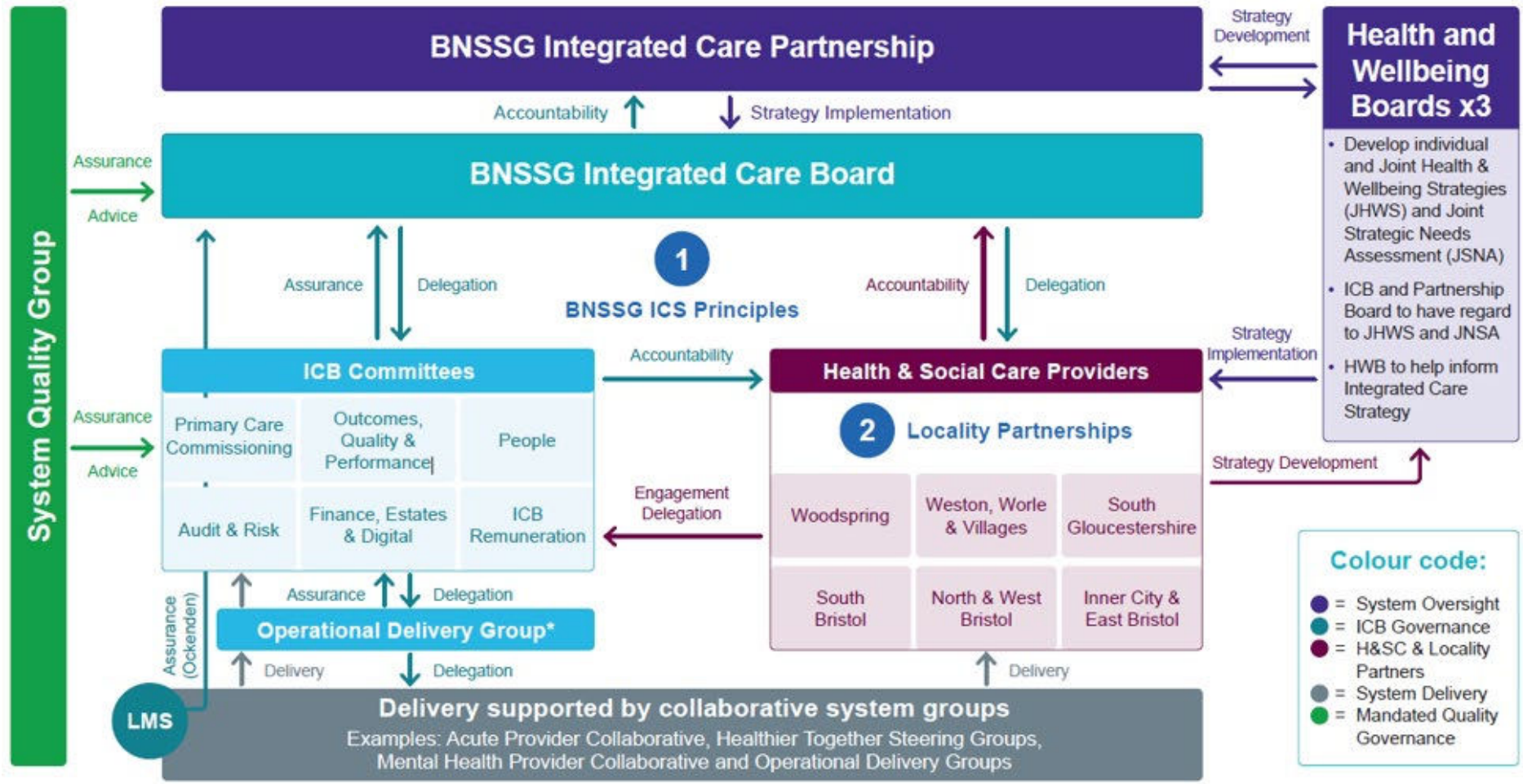
ACTION PLAN

		Responsible Owner:	Date:	Priority:
Management Action 1	Following the work of consultancy firm 29 Forward, the ICB will have a formal performance management framework or performance reporting and management guidance that sets out: • KPI metrics the System should be monitoring and reporting on (with clear links to the various frameworks each metric is associated with); • Where source data and data validation comes from for each KPI; • the role and responsibilities of stakeholders responsible for providing or reporting on KPI data (including any timescales that need adhering to); • defining mandatory meeting attendance to enable effective triangulation of information; • the forums and governance for where KPI performance data is used for decision making and where responsibility for performance sits, aligned to the System Operational Plan; • the requirements for how KPI performance data should be presented in reports; and • ensure its forward planning of how it oversees delivery of System priorities is realistic to ensure each System area receives the appropriate level of oversight required to take assurance over its operational performance.	Lisa Manson – Director of Performance and Delivery	31 March 2024	**Medium**

Management Action 2	The ICB will provide regular updates on the roll out of the Care Traffic Control Centre (CTCC) and provide insight into the reliability of data currently utilised until the new system is embedded and working as intended. This project will be an ongoing development over the next two year and is reliant on System partners.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** Ongoing – six monthly check-ins on progress	**Priority:** **Low**
Management Action 3	The ICB will issue a reminder to ensure all action logs used to track progress of actions through to completion will include a proposed completion deadline to aid monitoring.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 30 September 2023	**Priority:** **Low**
Management Action 4	ICB management will review attendance at POG meetings and the ability to deliver against the original set forward plan for areas covered by the Group. This will be reviewed against the developing ICS governance structure (introduction of Health Improvement Boards) to ensure the forums remain appropriate and best use of time for key personnel from the ICB and System partners.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 30 September 2023	**Priority:** **Medium**
Management Action 5	The ICB will review the ToR for the OQPC to include the minimum mandatory requirements expected from its members for attending meetings. The OQPC Chair will monitor attendance (as required by the ToR) and escalate individuals who breach the terms.	**Responsible Owner:** Lisa Manson – Director of Performance and Delivery	**Date:** 30 September 2023	**Priority:** **Low**

APPENDIX A: HEALTHIER TOGETHER 'SYSTEM' GOVERNANCE AND OPERTING MODEL

The flow chart below shows where System quality sits across the BNSSG ICS.



Independent auditor's report to the members of the Board of Bristol, North Somerset and South Gloucestershire Integrated Care Board in respect of Bristol, North Somerset and South Gloucestershire Clinicial Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Bristol, North Somerset and South Gloucestershire CCG (the 'CCG') for the period ended 30 June 2022, which comprise the Statement of Comprehensive Net Expenditure for the three months ended 30th June 2022, the Statement of Financial Position as at 30th June 2022, the Statement of Changes in Taxpayers Equity for the three months ended 30th June 2022, the Statement of Cash Flows for the three months ended 30th June 2022 and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 30 June 2022 and of its expenditure and income for the period then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that the Health and Care Bill allowed for the establishment of Integrated Care Boards (ICBs) and abolished Clinical Commissioning Groups (CCGs). The functions, assets, and liabilities of Bristol, North Somerset and South Gloucestershire CCG transferred to Bristol, North Somerset and South Gloucestershire ICB on 1 July 2022. When Bristol, North Somerset and South Gloucestershire CCG ceased to exist on 1 July 2022, its services continued to be provided by Bristol, North Somerset and South Gloucestershire ICB.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

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

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, set out on pages 43 to 44, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).

We enquired of management and the Audit and Risk Committee concerning the CCG's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:

- High risk journals including consideration of closing entries, entries posted after year end, manual journals and journals that have a material impact on reported outturn along with a number of other risk factors. We considered whether there was any potential management bias in accounting estimates or any significant transactions with related parties which could give rise to an indication of management override.

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 unusual journal entries using criteria based on our knowledge of the entity and the risk factors identified.
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of the 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 communicated with management and the Audit and Risk Committee in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to the prescribing accrual.

Our assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
- knowledge of the health sector and economy in which the CCG operates
- understanding of the legal and regulatory requirements specific to the CCG including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.

In assessing the potential risks of material misstatement, we obtained an understanding of:

- the CCG's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account

balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.

- the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework**.**

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities . This description forms part of our auditor's report.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 30 June 2022.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources were operating effectively during the three month period ended 30 June 2022..

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG planned and managed its resources to ensure it could continue to deliver its services;
- Governance: how the CCG ensured that it made informed decisions and properly managed its risks; and
- Improving economy, efficiency and effectiveness: how the CCG used information about its costs and performance to improve the way it managed and delivered its services.

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

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of NHS Bristol, North Somerset and South Gloucestershire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Board of NHS Bristol, North Somerset and South Gloucestershire ICB, as a body, in respect of the CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of NHS Bristol, North Somerset and South Gloucestershire ICB those matters we are required to state to them in an auditor's report in respect of the CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Bristol, North Somerset and South Gloucestershire ICB and the CCG and the members of the Board of both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

JD Roberts

Jon Roberts, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

29 June 2023