NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2022/23

1 APRIL 2022 TO 30 JUNE 2022

This annual report was written at a point in time to cover the period 1 April 2022 to 30 June 2022, the last 3 months of NHS Somerset Clinical Commissioning Group, and is reflective of that period.

29 June 2023

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Jonathan Higman
Chief Executive
NHS Somerset Integrated Care Board
29 June 2023

INTRODUCTION

Welcome to the NHS Somerset Clinical Commissioning Group (CCG) Annual Report for 1 April 2022 to 30 June 2022 The report highlights the CCG's progress and performance during the first quarter of 2022/23, which was the last three months of the CCG. NHS Somerset CCG was succeeded by the NHS Somerset Integrated Care Board (ICB) when it was established on 1 July 2022.

I am in a somewhat unique position this year in that I have responsibility for introducing this annual report and am required to sign the annual report and accounts for the last three months of NHS Somerset CCG, even though I was not formally the Chief Executive of the CCG during this time. In discharging these responsibilities, I have received a letter of assurance from James Rimmer, the then Chief Executive of NHS Somerset CCG, regarding the state of governance, risk management, internal control processes and financial management at NHS Somerset CCG as at 30 June 2022, as the organisation's functions were transferred to NHS Somerset ICB on 1 July 2022.

The Somerset health and care system is not new to me as I previously held the role of Chief Executive at Yeovil District Hospital NHS Foundation Trust and therefore have familiarity with NHS Somerset CCG and its performance over this period.

I am also aware of the robust transitional work which NHS Somerset CCG undertook prior to the establishment of the new NHS Somerset ICB. This involved me being provided with the necessary assurances resulting from the due diligence work carried out by the CCG together with my involvement in the readiness to operate work for the Integrated Care Board. This work is described further in the performance report.

Many of the achievements and performance of NHS Somerset CCG continued from 2021/22 into the first three months of 2022/23. I have, therefore, not highlighted anything in particular as part of this introduction. I do, however, want to acknowledge the hard work of NHS Somerset CCG and would like to thank the staff, Governing Body members, GP practices, wider system partners and the voluntary sector for their valued contribution to these successes.

In my role as the Chief Executive of NHS Somerset Integrated Care Board I am excited to build on our past success and look forward to working with you all to discharge the responsibilities of the ICB and develop and implement our health and care strategy with, and for, the people of Somerset.

Jonathan Higman
Chief Executive
NHS Somerset Integrated Care Board
29 June 2023

1 PROFILE OF SOMERSET

1.1 NHS Somerset CCG and the wider Somerset Integrated Care System (ICS) serves a population of approximately 580,000 and is committed to, and passionate about, working closely together to support the people of Somerset. Our vision is:

"to support the people of Somerset to live healthy and independent lives, within thriving communities, and with timely and easy access to high quality and efficient public services when they need them."

1.2 This vision is underpinned by Fit for my Future, Somerset's health and care strategy, sitting under the umbrella of the Health and Wellbeing Board's Improving Lives in Somerset strategy. Our aims are to:

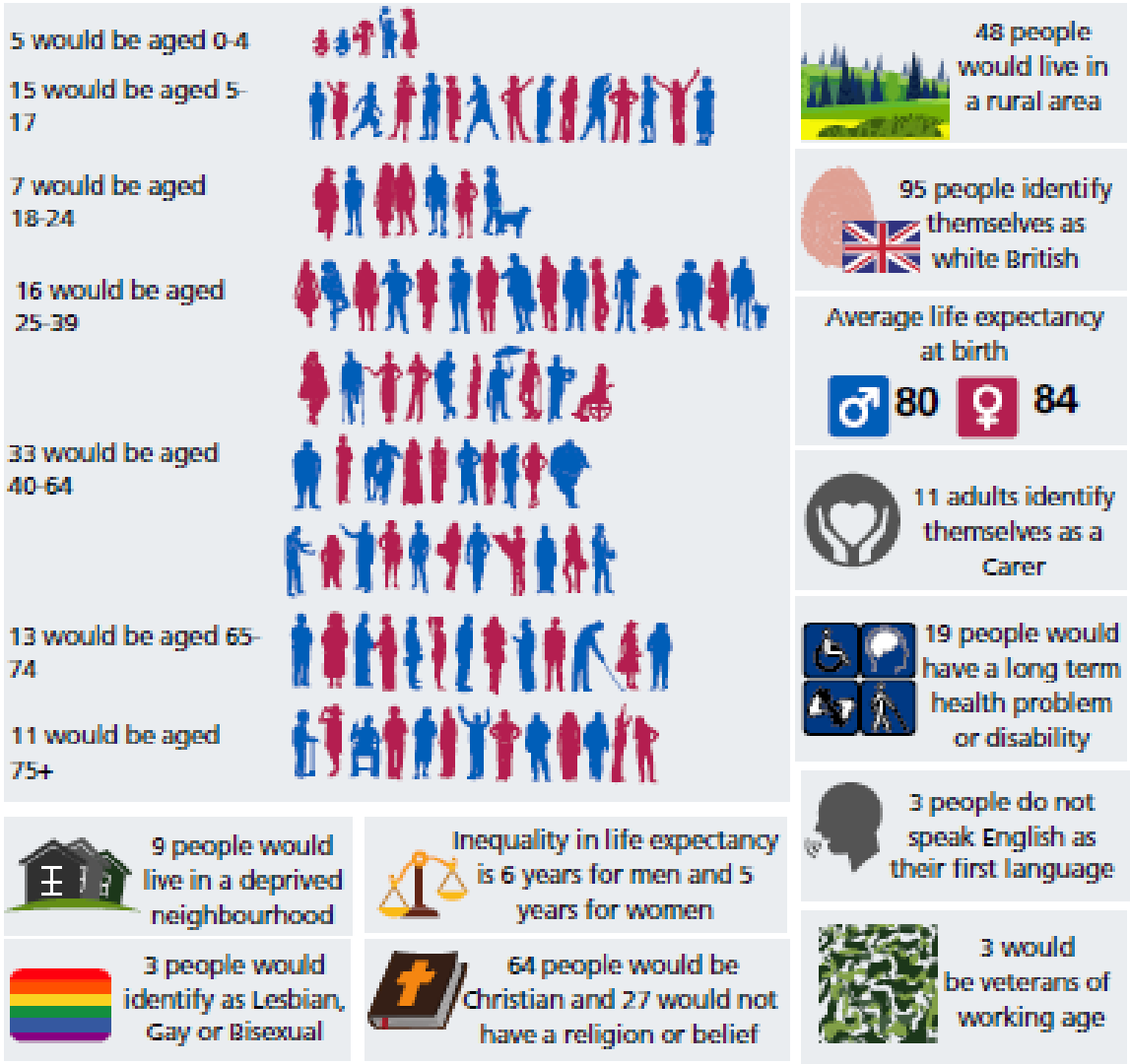
1. IMPROVE THE HEALTH AND WELLBEING OF THE POPULATION	• Enable people to live socially connected, healthy, independent lives, promote early intervention and prevent avoidable illness. ***In children and young people prioritise universal health provision both for physical and mental health and well-planned transitions to prevent longer term high level need or crisis***
2. PROVIDE THE BEST CARE AND SUPPORT TO PEOPLE	• Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.
3. STRENGTHEN CARE AND SUPPORT IN LOCAL COMMUNITIES	• Develop and enhance support in local neighbourhood areas and bring care and support closer to home. ***Utilise the family connections model to build community capacity, support all age health, care and education support. Taking a best start approach for the youngest users of our services and their families.***
4. REDUCE INEQUALITIES	• Value all people alike, ***but ensure care is personalised***, target our resources and attention to where it is most needed, giving equal priority to physical and mental health ***to support positive short and long term outcomes***
5. RESPOND WELL TO COMPLEX NEEDS	• ***Use a Listen, hear and respond approach to*** improve outcomes for people of all ages with complex needs. Through personalised, co-ordinated support ***which is in place at the earliest identification of need***.

1.3 The need to improve health and wellbeing and reduce health inequalities in Somerset has been particularly highlighted by the COVID-19 pandemic and exacerbated further by increasing and sustained operational demand.

1.4 The Somerset population is relatively older than the national average and this trend is expected to increase. Health and care services in Somerset are struggling to meet the increasing demands of this ageing population and the rising number of people with complex or long-term health conditions.

1.5 We have begun work to modernise the model of care in Somerset, but much of our resources are still focused on bed-based care. Joining up our services and changing our historical model of care is vital to improving our population's health.

1.6 If Somerset was a village of 100 people:



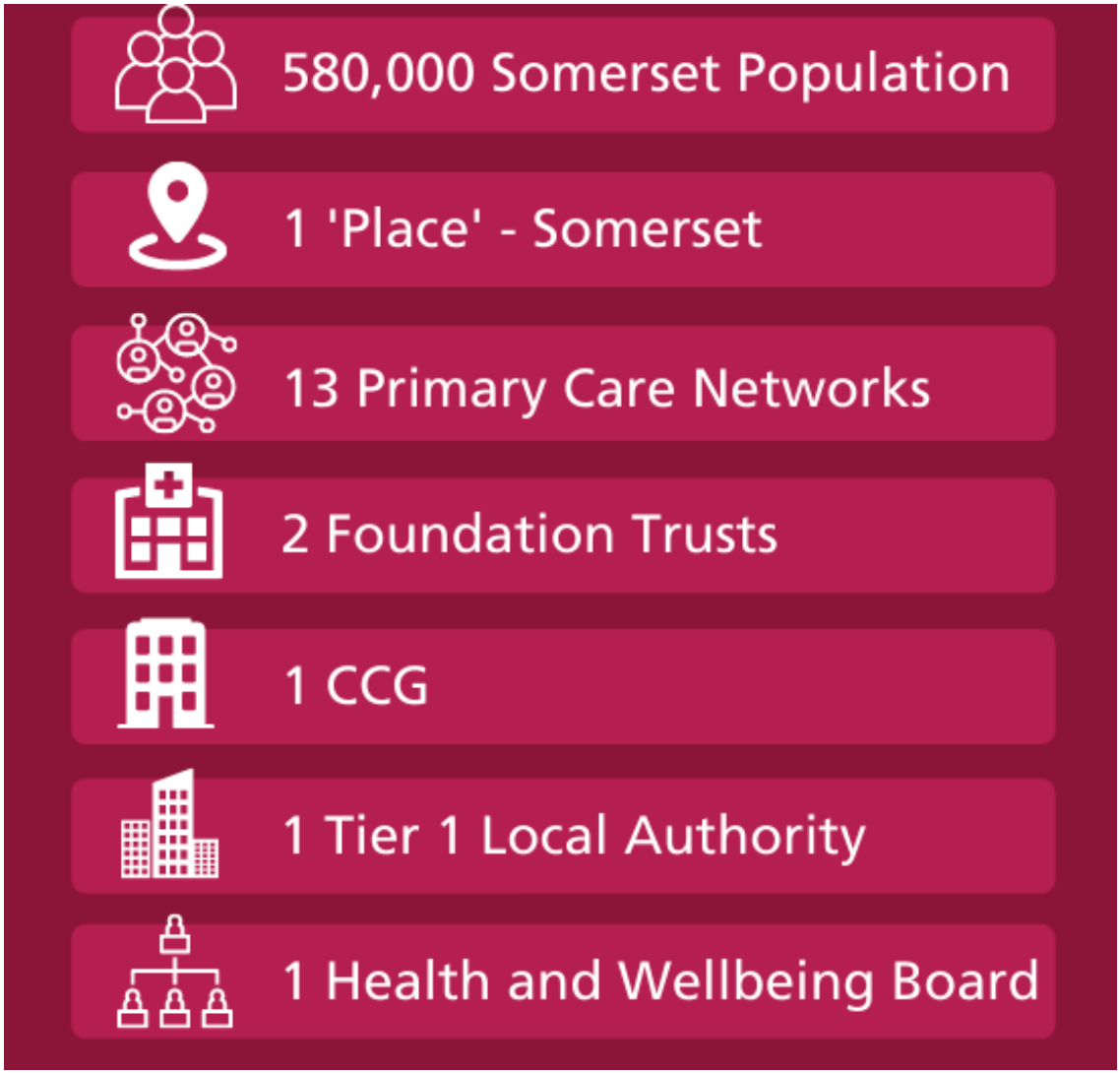
1.7 As an ICS we can go further and faster together to front-end resources and support into prevention and health promotion, tackling health inequalities head on and supporting our communities to thrive. No individual organisation in Somerset has what it takes to respond to these challenges alone.

1.8 We need to bring our skills, knowledge and resources in health together with those of our colleagues in social care, education, housing and the voluntary sector, if we are to tackle health inequalities and enable our communities to thrive, in line with our strategy.

1.9 The organisational landscape in Somerset is of low complexity when compared to other ICSs and has a history of strong and established partnership working. We have one CCG, one tier one county council (Somerset County Council) and four district councils, which are coterminous with the county boundary and broadly relate to a common population. The Secretary of State has approved a bid for Local Government Reorganisation, with all five existing councils in Somerset being replaced by a single Unitary Authority, 'Somerset Council', by April 2023. We have two statutory NHS Foundation Trusts, which are working towards merger. The proposed merger would bring together all of Somerset's acute, community, mental health and

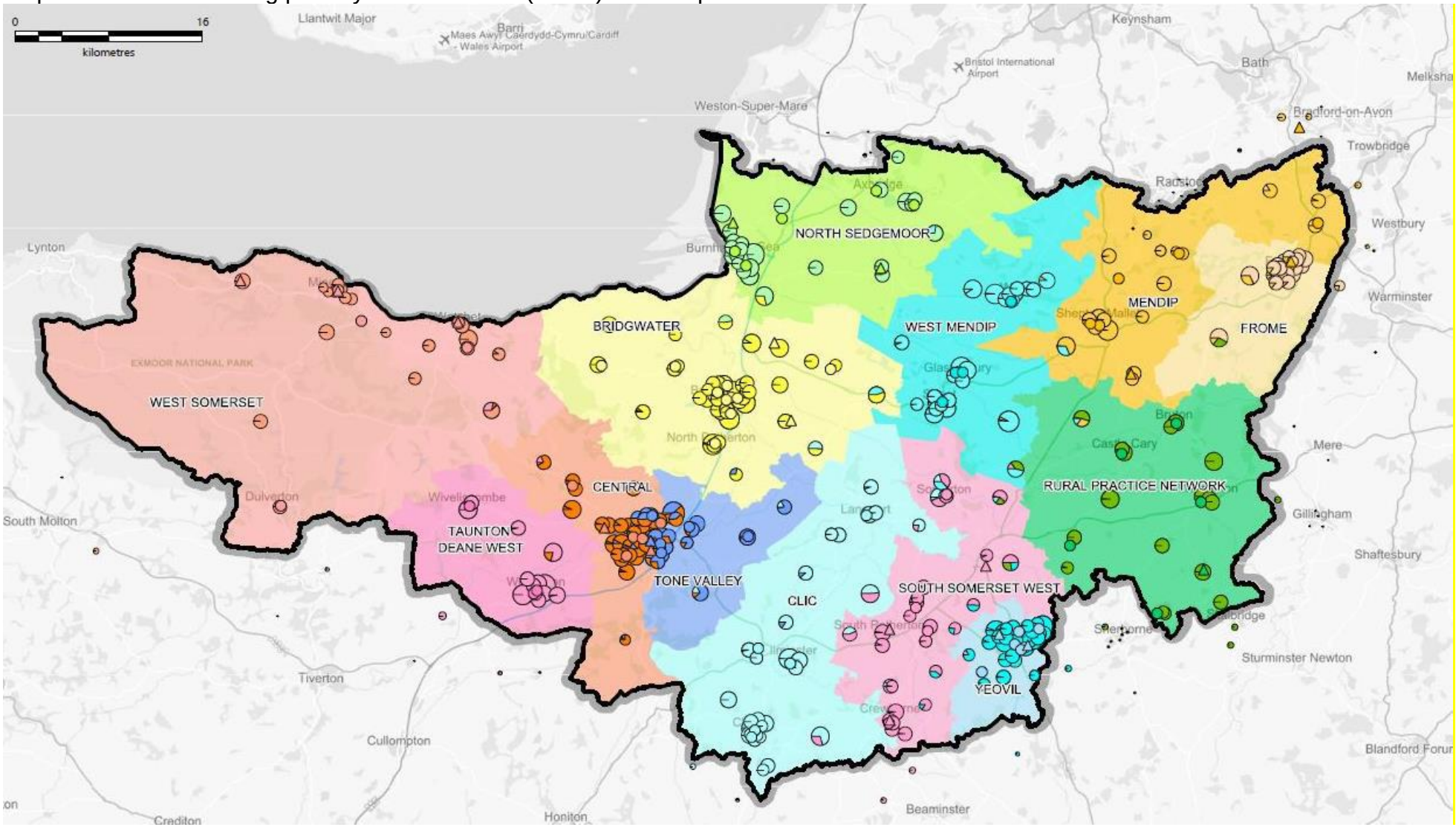
learning disability services, with around a fifth of primary care into a single NHS Foundation Trust.

1.10 We have 13 primary care networks (PCNs)[1] located within 12 neighbourhoods (see figure 1 below) and a single GP Provider Board. Decisions around health and care are made collaboratively across the PCNs with the local providers of health, care, the voluntary, community and social enterprise sector (VCSE) and our communities. This underpins the strong and well-established partnership arrangements within Somerset.



[1] A group of practices working together to focus local patient care

Map of Somerset showing primary care networks (PCNs) and GP practices



2 TRANSITION TO AN INTEGRATED CARE BOARD (ICB)

2.1 Our wider system benefits from strong working relationships between health, social care and voluntary sector partners based on a culture of openness, support and constructive challenge. Integrated Care Systems (ICSs) have grown out of Sustainability and Transformation Partnerships (STPs) – local partnerships formed in 2016 to develop long-term plans for the future of health and care services in their area. From 1 July 2022 ICSs became legal entities due to changes in legislation.

2.2 During 2020/21, the Government published the White Paper 'Integration and Innovation: working together to improve health and social care for all'. This paper set out the legislative proposals for a Health and Care Bill. It aimed to build on the collaborations seen through the COVID-19 pandemic and remove some of the barriers that prevent systems from being truly integrated.

2.3 The Health and Care Bill sets out plans to put ICSs on a statutory footing, empowering them to:

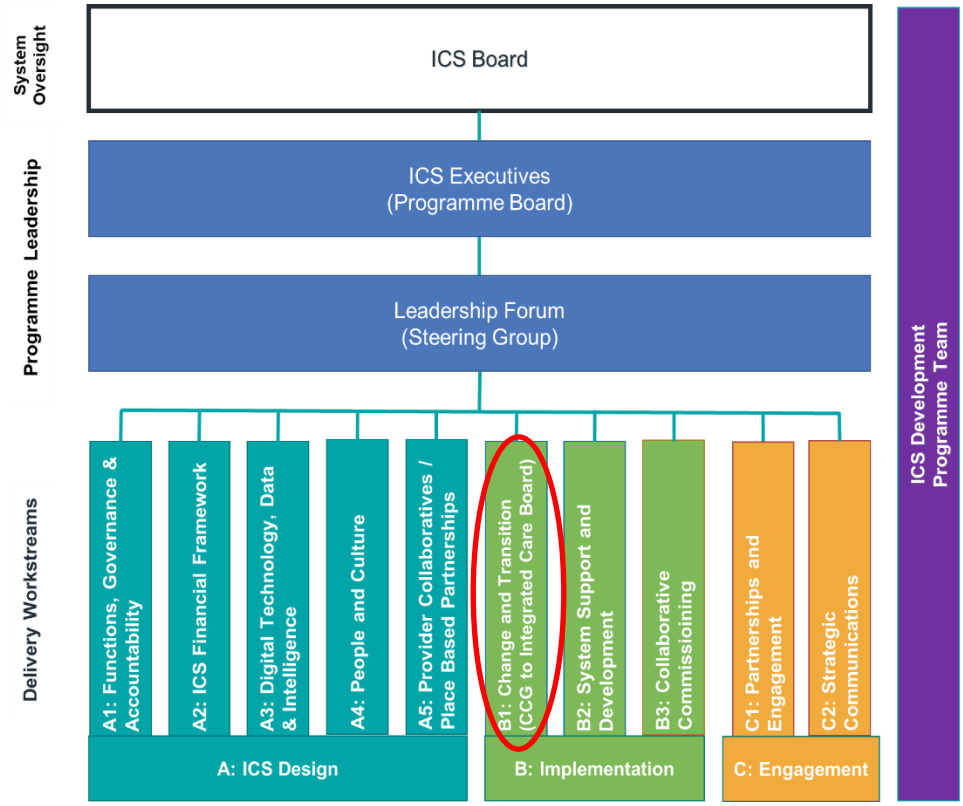
- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experience and access
- Enhance **productivity and value for money**
- Help the NHS support broader **social and economic development**.

2.4 This means that each ICS will be led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy. When ICBs are legally established on 1 July 2022, CCGs will be abolished.

2.5 It was originally expected that these changes would come into effect in April 2022. However, this target date was changed to 1 July 2022 to allow more time for the remaining parliamentary stages and to enable organisations to manage their more immediate pandemic response priorities.

2.6 Robust processes were put in place to ensure appropriate due diligence was carried out to ensure the safe and effective transfer of functions from NHS Somerset CCG to NHS Somerset ICB to ensure that it was ready to operate as a new statutory organisation.

2.7 A workstream was set up as part of the wider Somerset Integrated Care System.



2.8 The responsibilities of the workstream included:

- Input into design of the Integrated Care Board (ICB)
- Actions in respect of close down of the CCG
- Actions in respect of establishment of the ICB
- Actions in respect of Chair, Chief Executive and Board appointments
- Actions in respect of people transfer including consultation
- Assurance to CCG Executive Directors, CCG Governing Body, ICS Programme Board and NHS England
- Assurance through the CCG Audit Committee and involvement of BDO – the CCG internal auditors

2.9 A programme board was set up to oversee the work of the workstream. This was chaired by a Non-Executive Director and regularly reported into the Audit Committee to provide assurances on progress and risk management.

2.10 NHS England (NHSE) oversaw the programme of work and sought assurance throughout the period. In June 2022 the NHS England Regional Director wrote to the accountable officer of NHS Somerset CCG to confirm the transfer of staff, property and liabilities to NHS Somerset ICB and the abolition of NHS Somerset CCG. Following its establishment, NHS Somerset ICB would take on responsibility for any matters relating to the former CCG.

2.11 On 1 July 2022 NHS England, using its powers under the Health and Care Bill, made an Establishment Order to legally establish ICBs. Under the Bill, CCGs were abolished on the same day. NHS England also used its

powers to transfer the staff, property and liabilities from the existing CCG to the ICB by way of a statutory transfer scheme.

2.12 As part of the changes, a commitment was made to support our CCG staff by:

- not making significant changes to roles below senior leadership level
- minimising the impact of organisational change to colleagues
- preserving the terms and conditions to the new organisation (even if not required by law) to help provide stability and to remove uncertainty.

2.13 In Somerset, we were well prepared for these changes.

3 HEALTH AND WELLBEING STRATEGY AND BOARD

3.1 As already mentioned the Somerset Health and Wellbeing Board has developed a Health and Wellbeing Strategy for Somerset 'Improving Lives', which has been agreed by both Somerset County Council and the Somerset Clinical Commissioning Group (you can view a copy of the 'Improving Lives Strategy 2019-2028' at Somerset Health and Wellbeing Board). The Board has an annual programme of work which addresses a number of key priorities which are informed by the Joint Strategic Needs Assessment and by evidence for effective action. This is in line with section 116b of the Local Government and Public Involvement Act 2007.

3.2 NHS Somerset CCG is an active member of the Health and Wellbeing Board which comprised the following membership at 30 June 2022:

- Councillor Bill Revans (Chair), Somerset County Council
- Councillor Adam Dance (Co-Vice Chair), Somerset County Council
- Dr Ed Ford (Co-Vice Chair), NHS Somerset CCG Chair
- Councillor Gill Slocombe
- Councillor Lucy Trimnell
- Councillor Tessa Munt
- Councillor Brian Hamilton, South Somerset District Council
- Councillor Ros Wyke, Mendip District Council
- Councillor Chris Booth, Somerset West and Taunton Council
- Councillor Janet Keen, Sedgemoor District Council
- James Rimmer, NHS Somerset CCG Chief Executive
- Judith Goodchild, Healthwatch
- Sup. Dickon/Richard Turner, Avon and Somerset Police
- Prof Trudi Grant, Director of Public Health, Somerset County Council
- Julian Wooster, Director of Children's Services, Somerset County Council
- Mel Lock, Director of Adults & Health, Somerset County Council

3.3 The overall aim of the Health and Wellbeing Board is that it will provide strategic leadership to improve the health and wellbeing of the residents

of Somerset through the development of improved and integrated health, Public Health and adults and children's Social Care services. In particular, the Board:

- oversees, where appropriate, the use of resources across a wide spectrum of services and interventions, to ensure that the Somerset Health and Wellbeing Strategy and priority outcomes are achieved, and to drive a genuinely collaborative approach to commissioning, including the co-ordination of agreed joint strategies

- supports the inclusion of the public, patients and communities in the setting of strategic priorities, including (but not solely) through the involvement of local Healthwatch

- communicates and engages with local people about how they can achieve the best possible quality of life and be supported to exercise choice and control over their own health and wellbeing and that of the people living around them.

4 HEALTH AND CARE STRATEGY FOR SOMERSET – 'FIT FOR MY FUTURE'

4.1 We have reviewed Fit for my Future, our health and care strategy, to make sure it remains fit for purpose, considering what we have learnt from the Covid-19 pandemic, ensuring it is truly an all-age strategy and that it remains fit for purpose as our organisation transitions into an Integrated Care Board and our partner organisations into an Integrated Care System. This review was undertaken using colleagues representing organisations and professional groups across Somerset as well as informed members of the public.

4.2 Our vision remains the same:

"to support the people of Somerset to live healthy and independent lives, within thriving communities, and with timely and easy access to high quality and efficient public services when they need them."

4.3 Following our review, we have updated our aims:

1. IMPROVE THE HEALTH AND WELLBEING OF THE POPULATION	• Enable people to live socially connected, healthy, independent lives, promote early intervention and prevent avoidable illness. ***In children and young people prioritise universal health provision both for physical and mental health and well-planned transitions to prevent longer term high level need or crisis***
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5. RESPOND WELL TO COMPLEX NEEDS	• ***Use a Listen, hear and respond approach to*** improve outcomes for people of all ages with complex needs. Through personalised, co-ordinated support ***which is in place at the earliest identification of need***.

4.4 We will achieve this by:

- shifting our focus towards prevention
- delivering improvements to population health
- moving to more personalised integrated services to support independence
- identifying and tackling inequalities wherever they exist
- shifting resources from hospital inpatient services towards community-based services
- making providing the right care at the right time by the right person the simplest option for all.

4.5 As part of the ICS, we plan to transform out of hospital care beyond the traditional primary and secondary care division, and to redesign community-based services in their broadest sense, enabling voluntary sector organisations and the population themselves to define the way we work into the future. We want to blur the boundaries across mental and physical health; across prevention; early intervention; primary and secondary care, working on the basis that 'your bed is the best bed'. We want care to be delivered as close to home as possible, by the right person, at the right time, in the right place, while ensuring that high quality, safe and sustainable care is provided within our community and acute trusts when those services are required.

Mental Health

4.6 We have carried out a detailed review of our mental health services, co-producing a new model for the delivery of mental health services within the community. This has led to national recognition of our model of care and success in gaining trailblazer status from NHS England and the provision of additional funding of £17million over a three-year period. This means we are going to be able to invest extra funds into our community-based services.

4.7 The COVID-19 pandemic has accelerated many of the positive transformational plans we had in place to improve community mental health services for adults in Somerset. Our focus now is firmly on more support being available to more people as early as possible, so that they are supported to manage their mental health at home or in their local community, meaning that people's mental health does not deteriorate to the point where they require in-patient treatment and care. We believe that providing better care locally and supporting people to stay at home wherever we safely can provides the best outcomes and facilitates recovery.

Community Health and Care Services

4.8 We have developed an emerging model for the potential configuration of community-based health and care services. This will support people to live independent, healthier lives by having the right services in the right place for their needs, available at the right time and delivered by the right people.

4.9 The learning from the pandemic will be incorporated into the work NHS Somerset ICB will do in 2022/23 and they will be engaging with the public and wider stakeholders to gather views to help shape and improve the emerging model, ultimately leading to a public consultation on options for the future.

Acute Settings of Care

4.10 Our acute services currently serve 594,000 people (those registered with a GP) across Somerset. During 2021/22 we reviewed our services and considered how best to provide sustainable, safe, effective hospital-based services that meet the needs of our population both now and in the future. This work will now be taken forward by NHS Somerset ICB

Prevention

4.11 It is recognised that population health and prevention, as a way to benefit the health of our population, are important factors in helping us to reduce the demand on, and improve the sustainability of (from both a finance and workforce perspective) our services. We are now reviewing the potential for high impact actions, provided on a system wide basis, to improve the health and wellbeing of our population.

4.12 A major focus for the Somerset Integrated Care System for the future will be on helping people achieve a healthy weight. This is due to the significant links between weight and a wide range of health care conditions, particularly cardiovascular disease (including diabetes and high blood pressure).

Inequalities

4.13 Reducing inequalities has always been important nationally and locally. We value all people alike, target our resources and attention to where it is most needed, and give equal priority to physical and mental health. The COVID-19 pandemic has exposed and amplified existing inequalities, combined with the lockdown impact on our economy and education. We are committed to reducing these inequalities to ensure parity of access and care for all.

5 PERFORMANCE OVERVIEW

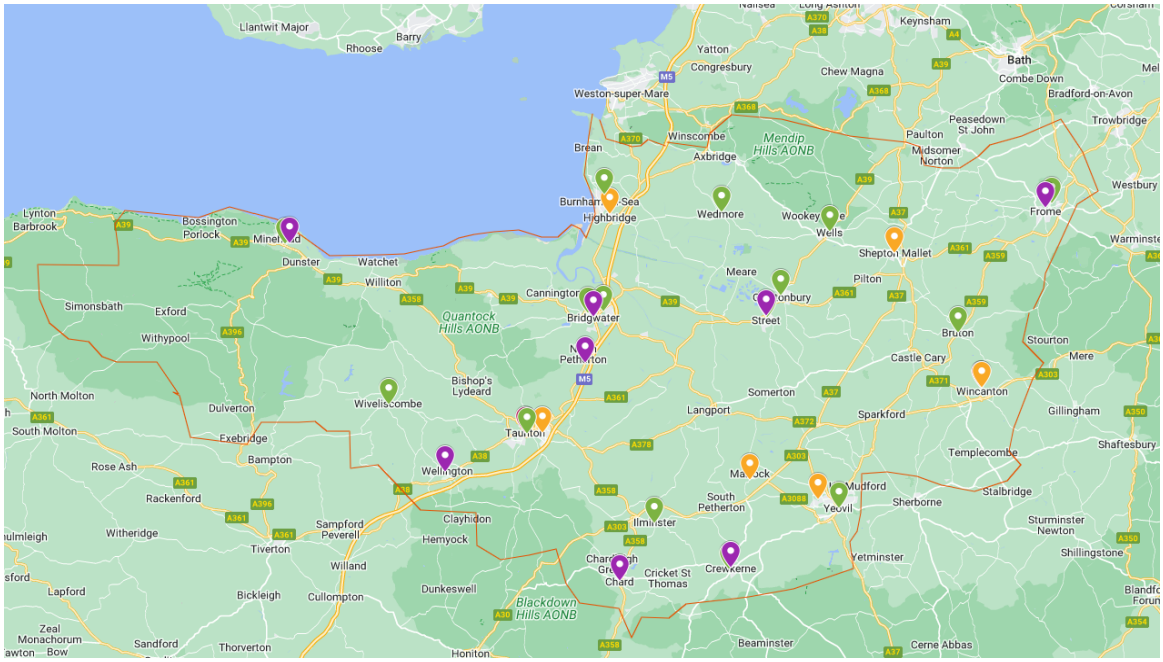
5.1 The following sections provide an overview of the purpose of NHS Somerset CCG, how we have performed during quarter one of 2022/23 in achieving our objectives and the key risks and challenges we have faced.

5.2 The sections include how the organisation has delivered its key workstreams, statutory responsibilities and the overall performance during April to June of 2022/23.

COVID-19 Vaccination Programme - Somerset

5.3 The Somerset Integrated Care System (ICS) has successfully delivered the Spring 2022 Covid vaccination campaign finishing on 5 July 2022.The delivery approach for Somerset is a 'three pillar collaboration' between Somerset NHS Foundation Trust, six opted-in Primary Care Networks (PCNs) and Community Pharmacy. The Spring programme offered a 2nd booster to individuals 75 years and over, older adult care homes and immunosuppressed people aged 12 and over (1). Somerset achieved the highest uptake of the Covid booster vaccine within the south west, with a 74.2% uptake against a national average of 56.79%. During this programme the paediatric 1st dose was offered, resulting in 5,392 5-11 year-olds receiving their first vaccine: this equates to 11.9% against a national average of 10.1% (2). With our two NHS acute providers (Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust) uptake of 3 primary doses is 85.9% and 80.5% (3).

5.4 The COVID-19 vaccination team supported the PCNs to 'pause' throughout August 2022 due to no active delivery programme, with a plan for opted-in to recommence for the Autumn 2022 programme. To ensure a continual offer of the primary course of the COVID-19 vaccination, some community pharmacies continue to deliver along with the Somerset NHS Foundation Trust vaccine team throughout these months.



Key:
Purple = Vaccination centre (Somerset Foundation Trust)
Green = Community Pharmacy
Yellow = PCN

Oximetry at Home/COVID Virtual Wards

5.5 During 2021/22 we centralised our COVID-19 oximetry service, enabling us to provide extended hours coverage as well as respond to the peaks in demand we saw during the Omicron wave earlier this year. During Quarter one (April to June 2022) over 700 people have been supported. Detailed plans have been developed to introduce Hospital at Home (virtual wards) during 2022/23. These will initially focus on respiratory and frailty.

Elective Care and Elective Care Recovery

5.6 2021/22 was a challenging year for delivering elective care and this continued into quarter one (April to June) of 2022/23. We have strived to return activity levels to pre-COVID-19 levels and bring down long waiting times for patients. This has been hampered by ongoing operational pressures and rising levels of COVID-19 in both patients and staff. In quarter one of 2022/23 we also saw winter pressures continue much longer into the Spring, resulting in further performance impacts for the Somerset system.

5.7 For 2022/23 (beginning in quarter one), the Somerset Integrated Care System (ICS) identified the following priority projects:

- musculoskeletal (MSK) pathway redesign and capacity and demand management

- outpatient waiting times including advice first and transporting of outpatient care
- optimising patients for surgery
- theatre productivity
- reducing health inequalities
- sustainable diagnostic services
- service repatriation

5.8 Quarter one of 2022/23 saw the following achievements:

- continued recovery of elective recovery levels around the 94% target for much of the quarter
- outpatient recovery levels around the 97% target for much of the quarter
- maintained levels of virtual outpatient activity
- diagnostic recovery remaining high for the Quarter
- ahead of trajectory for reducing 78 week waits

Diagnostics and Diagnostics recovery

5.9 Diagnostic waiting times grew during 2020/21, but in 2021/22 and into 2022/23 we made significant inroads to reduce them. Access to additional scanning capacity, with mobile vans, along with the opening of the Rutherford Diagnostic centre in Taunton have enabled us to deliver over 100% of pre-COVID diagnostic activity across most modalities in the quarter.

5.10 This work has helped to reduce the number of patients waiting more than six weeks for diagnostics.

Cancer Treatment and restoration

5.11 Somerset continues to work collaboratively with the Somerset, Wiltshire, Avon, Gloucestershire (SWAG) Cancer Alliance and in 2021/22 we agreed a cancer recovery plan, which focused on three main areas of achievement:

- restoring urgent cancer referrals to at least to pre-pandemic levels, where this remains clinically appropriate
- reducing the backlog of over 62 and 104 day plus waiters to at least to pre-pandemic levels
- continuing to ensure cancer patients are appropriately prioritised and treated in a timely way, and that sufficient capacity is in place to manage increased demand moving forward, including follow-up care.

5.12 Following on from our successes in 2021/22 we achieved the following in quarter one of 2022/23:

- continued roll out of symptomatic faecal immunochemical testing (FIT) in primary care, decreasing demand on endoscopy and improving patient experience by providing a non-invasive triage test for those presenting with symptoms of colorectal cancer. We also implemented a colorectal hub to further support primary care in conducting FIT testing pre-referral

- continued provision of personalised care and support for patients living with and beyond cancer including holistic needs assessment and care planning, treatment summaries, cancer care reviews and personalised stratified follow up (PSFU)

- roll-out of 'C The Signs' decision support and referral tool to primary care to further help identify and refer patients earlier in the pathway

- continued to see in excess of 100% of pre-COVID-19 referral levels

Urgent and Emergency Care

5.13 In Somerset we have seen exceptional levels of pressure within our urgent and emergency care system. We have worked together as a Somerset system to respond to the demand and ensure safe services were in place.

Think 111 First

5.14 Think 111 First is a nationally led campaign, which was successfully implemented within Somerset during December 2020 with ongoing system-wide work to embed and develop supporting initiatives further. The campaign was originally designed to help social distancing and infection prevention precautions within waiting areas in emergency departments (A&E) and that focus continues. Think 111 First also supports patients to access the right services for them first time. Given ongoing pressures within urgent and emergency care services, it is even more important to support our population so they make the right healthcare choices and ensure their safety, as well as making sure they get the right treatment in the most appropriate place for their healthcare needs.

5.15 Think 111 First means that Somerset urgent and emergency care services must ensure that:

- emergency departments are reserved for emergency patients: all patients still receive a timely response and are assessed safely and effectively regardless of how they make initial contact with urgent and emergency care services

- patients who do not need to attend an emergency department are directed elsewhere to the full spectrum of available health services (eg. community pharmacy, urgent dental services and voluntary services as appropriate)

- patients can go directly to the centre or clinic they need rather than via an intermediary department

- patients have an overall experience of NHS services that is as good as it can be and provide feedback when it is not

5.16 Building on the successes of last year we have achieved the following in quarter one (April to June) of 2022/23:

- since May 2022 NHS 111 (telephony and online) has become the 'front door' to accessing Somerset's Urgent Dental Helpline (delivered by Smiles Dental Triage). NHS Somerset continues to facilitate discussions between Meddcare Somerset and the NHS England Regional Commissioning Team to support optimum 111 call handling response as well as highlighting system-wide impact of urgent dental care demand

- the Directory of Service (DoS)[2] has ongoing reviews to ensure it is up-to-date and directing patients to the best service according to their clinical need. This year Somerset's DoS Team has benefitted from additional support through the pilot South West DoS Regional Team, which has provided additional benchmarking and networking to supporting continuous improvement in DoS profiling

- NHS Somerset is facilitating regular collaborative discussions with Same Day Emergency Care (SDEC) leads in a bid to enable development of alternative to ED services

- clinical validation of low acuity 999 (category 3 and 4)[3] and ED dispositions continue within the Somerset Clinical Assessment Service. This entails a patient/clinician conversation following an NHS111 initial assessment to check whether such an ambulance dispatch or visit to ED is what is needed, or whether the patient should be referred to another more clinically appropriate service. This process leads to better patient care whilst helping to support and manage overall service pressures. During April 2022 to June 2022 a total of 2,500 low acuity 999 ambulance dispositions were prevented through this process; 1,521 ED dispositions were prevented during the same three month period

- Community Pharmacy Consultation Service (CPCS) utilisation continues at a consistent level of performance. Currently, of calls received by Meddcare Somerset, 71.26% of repeat prescription calls, 67.08% of minor conditions calls and 16.43% of minor ailments calls are directed to community pharmacy

[2] a directory of NHS services

[3] Category 3 An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting – 2 hours. Category 4 – A non-urgent problem such as stable clinical cases, which requires transportation to a hospital ward or clinic – 3 hours

- GP CPCS is a national service but Somerset is optimising this from a local perspective. 59 of our 64 GP practices are currently providing this service where patients are contacted within a 4-hour window, rather than the national standard of 12 hours. Since the service went live in July 2021 there have been 16,750 referrals into pharmacies for low acuity conditions from Somerset GP Practices. Of the referrals that were fully completed:

    - 71.5% were fully resolved within the community by the pharmacy

    - 18.7% were dealt with in the community, with onward signposting to other services ie. dentist, physiotherapy, optometry or non-urgent GP

    - 9.8% of completed referrals were escalated for an urgent GP appointment or Urgent Treatment Centre/Minor Injuries Unit/Emergency Department attendance

High Intensity Users

5.17 High Intensity Users (HIU)[4], while a relatively small percentage of patients, are known to generate a disproportionately high percentage of emergency department (ED) attendances and hospital admissions. In Somerset we have established a HIU Network Group who are taking a strategic view of the HIU offer. This group will be continuing to look at how work with HIUs can bring about improved outcomes.

5.18 NHS Somerset ICB has now funded the Ubuntu Service which is in place to support those people identified as having high intensity use of our emergency services. This is a partnership project where the principles of the service are to de-escalate issues by one-to-one coaching and support services. Following the initial telephone consultation, a process of support will ensue with concordance underpinning changes in behaviour rather than compliance through fear of isolation from supportive services or fear of legal restrictions. The Ubuntu Health Coach will act as an advocate for each patient, guiding them through the complex journey and multifaceted approach which has resulted in appropriate use of unscheduled care.

5.19 The Ubuntu coaches have received 19 referrals this last quarter, with 12 currently engaging. The coaches work on building a trusted and person-centred relationship with each client to try and understand the root cause for their behaviours. They work on setting small achievable goals, supporting their wellbeing. With one client their goal was to open their curtains: a small goal which they managed to achieve and are now shopping for curtains. The Ubuntu coaches are working with Yeovil District Hospital NHS Foundation Trust and Somerset NHS Foundation Trust emergency departments as well as receiving referrals from South Western Ambulance Service NHS Foundation Trust and the NHS 111 service.

[4] High intensity use is defined as attending ED more than five times in a year, and less than 1% of the England population attends ED at this frequency or more.

Models of Urgent Care

5.20 Somerset does not yet have a designated urgent treatment centre. Models of urgent care need to be based on the different needs and infrastructure in our rural county. In February 2022 the decision was taken for the overnight closure of the Minor Injury Unit in Minehead to become permanent. During quarter one of 2022/23 we started engagement with the local community and local providers of care to develop our urgent care services to work collaboratively, based on local need and available resources. This approach will be expanded to review how our different areas can improve patient pathways and outcomes. NHS Somerset ICB has now started work on the development of a same day urgent care workforce strategy, this work will continue into 2022/23. Further work is being undertaken to develop and support primary care led same day urgent care.

Somerset Doctor Ambulance Car (Previously GP 999 Car)

5.21 NHS Somerset CCG commissions the Somerset Doctor Ambulance Car. The overall aims of the service are to provide rapid, effective treatment of patients of all ages in the '999' emergency incident stack, whose urgent care treatment needs may be amenable to management without hospital attendance or admission. The service utilises experienced urgent care specialist doctors, who are used to pragmatically balance 'risk' in the delivery of patient-centred treatment plans, and who have extensive working familiarity of community pathways in Somerset to optimise outcomes.

5.22 The start of the new contract went live on1 July 2022 and notably in Month one (July 2022) our planned activity was 203 incidents and actual was 211 with 80% of cases treated within the community. In Month 2 (August 2022) our planned activity was 182 incidents, and our actual was 188 with 83% of cases treated within the community.

SAVES (Immediate Care and First Responder Enhanced Service)

5.23 The SAVES service is commissioned by NHS Somerset CCG to provide support to the ambulance service in responding to accidents and call outs, such as road traffic collisions. Specialist trained GPs are called out to such incidents to provide additional help, clinical accountability to paramedics and are often first on scene. The service was commissioned initially from remote areas of Somerset to create better outcomes for patients who require emergency services. Currently there are significant pressures on South Western Ambulance Service NHS Foundation Trust (SWASFT) in their delivery of Category 1 and 2 calls. These calls are the most serious and therefore need to be responded to quickly.

5.24 In quarter one (April to June) 2022/23 SAVES were allocated to 23 emergency incidents by SWASFT and were first on the scene for 17.4% of those and travelled around 259 miles to attend patients across Somerset in which the doctors volunteered 31.5 hours treating patients.

The additional benefits that SAVES provided to SWASFT were that nine ambulance resources were stood down, SAVES accompanied 11 patients to hospital and 6 patients were treated / discharged on scene (otherwise normally conveyed by ambulance).

Intermediate Care[5]

5.25 The Somerset hub for co-ordinating care was established in response to the COVID-19 pandemic as a hospital avoidance and discharge service. This service supports both admission avoidance and hospital discharge through one central point. Our acute hospitals facilitate a rapid multi-disciplinary team discharge lounge function and community health and social care co-ordinate all care from the hub, building on existing arrangements. The main components to the service model have been drawn from the lessons learned previously in reducing delayed transfers of care, successfully implementing 'home first' pathways and achieving COVID-19 preparedness. This capacity has been expanded considerably in response to the pandemic:

- an expanded intermediate care service which includes discharge to assess, a central coordination hub and expanded reablement services. This will see the current capacity to support people in their own homes. The services also support discharges from community hospitals

- a significantly enhanced rapid response service with increased capacity. The service is able to support rapid hospital discharge in addition to its established role in preventing admissions. This service also provides provision for the 2-hour urgent community response

5.26 For June 2022 we achieved 94.1% of all discharges from hospital returning home, with 8% of those being supported by Discharge to Assess. 5.4% of people were discharged to an Intermediate Care Bedded facility.

Primary Care including restoring and increasing access

5.27 Primary care forms an integral part of our integrated care model for Somerset and in 2021/22 and continuing into quarter one (April to June) of 2022/23 our priorities were to:

- increase the primary care workforce
- deliver improvements in access, including helping to achieve the national target of 50 million additional appointments
- reduce health inequalities

[5] If you or someone you know has been in hospital or had an illness or fall, you may need temporary care to help you get back to normal and stay independent. This short-term care is sometimes called intermediate care, or aftercare.

5.28 In addition to delivering these priorities, during 2021/22 and into quarter one of 2022/23 we also supported our primary care colleagues to achieve the following:

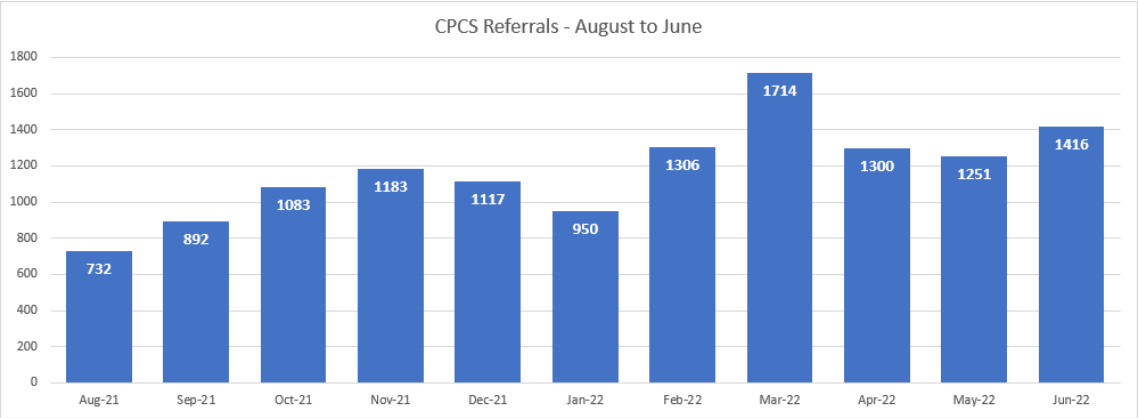
- primary care continued to support the pandemic response, including being able to respond to additional waves of COVID-19 activity
- primary care also delivered the majority of our COVID-19 vaccinations

5.29 Increasing the GP workforce was challenging in Somerset, as elsewhere in the country. However we have maintained stable GP numbers. We increased the primary care workforce in Somerset and delivered our share of the national target of 15,500 additional primary care staff. We continue to support the development of our Primary Care Networks (PCNs), and staff including pharmacists, physiotherapists and health coaches increased from 110 whole-time equivalents in April 2021 to 180.5 in June 2022.

5.30 While the December 2021 COVID-19 wave had a significant impact on primary care appointment activity, we continued to ensure that patients had access to the best possible GP services within the constraints created by the pandemic.

5.31 GP appointment figures were reduced by the first lockdown, changes to service according to national guidance, and patients not coming forward. Including COVID-19 vaccinations, Somerset reached a pre-pandemic level of primary care appointments by January 2021, and from August 2021 until June 2022 we saw an 8.33% growth in appointment numbers.

5.32 Access was also improved by the successful implementation of the community pharmacy consultation scheme (CPCS). This allows patients to be triaged by their GP surgery to a convenient community pharmacy for a consultation with a clinical pharmacist within 4 hours. 59 out of 64 surgeries (92%) in Somerset are now offering this service to their patients, compared with 30% nationally. The graph below shows the increase in patients benefiting from the new service.



Community pharmacy consultation scheme Referrals from August 2021 to June 2022

5.33 Throughout the COVID-19 pandemic period, addressing health inequalities and protecting vulnerable groups of patients was a key priority for the NHS in Somerset. Despite the pandemic, GP surgeries managed to ensure that 83% of people with learning disabilities had a comprehensive annual health check during the 2020/21 contract year, which reported into 2021/22 due to the lag in data submission. This is much higher than the national target of 67%. This priority has continued into 2022/23 for NHS Somerset CCG and then NHS Somerset ICB. Attention was also given to the needs of people with mental health and homelessness issues. A new service called 'Murmurations' was established in Yeovil to serve vulnerable people, delivered by Yeovil Primary Care Network in partnership with Yeovil Community Church.

5.34 Demand has continued to be managed by:

- continuing to ensure the shift of minor conditions to self-care, NHS 111, community pharmacy and voluntary sector was clearly communicated
- optimising the clinical assessment system (CAS) in primary care
- prioritising vital screening, immunisations and vaccination appointments
- ensuring that a digital first approach remained a priority, which included optimisation of triage services with face-to-face appointments where clinically necessary

The Better Care Fund

5.35 The Better Care Fund (BCF) was established by the Government to encourage the integration of health and social care and to achieve specific national conditions and local objectives. These relate to supporting people to live as independently as possible in their own homes and avoid unnecessary admissions to hospital, long-term care placements or avoidably long stays in a treatment or care setting.

5.36 It was a requirement of the BCF that NHS Somerset CCG (and then the ICB) and Somerset County Council establish a pooled fund for this purpose. This is in place and the management of the fund is covered by a signed agreement under Section 75 of the National Health Service Act 2006.

5.37 The BCF has evolved since its inception and now incorporates three budgetary components:

- disabled facilities grant – managed via district councils
- mandated NHS (CCG/ICB) contributions
- improved better care fund (contributions via Somerset County Council)

5.38 Each year, systems are required to provide a plan and progress reports on the use of the BCF. Given the impact of COVID-19, the resources required to manage this and the importance of stabilising local services and plans, the 2020/21 plan was rolled over into 2021/22. For 2022/23 the BCF plans are currently being developed and agreed and will be approved and signed-off by the Somerset Health and Wellbeing Board.

Neighbourhoods and Communities

5.39 The Somerset Integrated Care Service (ICS) together with key voluntary sector partners established new collaborative working arrangements during COVID-19, which introduced a wide variety of new ways of working across organisations to support the most vulnerable people in our community and reduce inequalities. This work built upon pre-existing work, supporting neighbourhoods and localities and linked in the significant voluntary response during the pandemic. It has enabled closer working across the voluntary sector, social care and the wider health community.

5.40 Examples of this type of working include:

- collaboration and huddles with health, social care, voluntary sector and primary care to support individuals achieve their intended outcomes

- setting up the Somerset Coronavirus helpline with direct links to voluntary sector partners including Citizens Advice, local food banks, and support for medication and food deliveries for vulnerable people

- establishing the county Corona Helpers Volunteers Network which saw over 1000 people come forward and participate in volunteering work with support provided to 100 volunteer groups

- strong links established with the county Somerset Corona Virus appeal which raised over £1 million and distributed funds to support local action

- supporting homeless people into safe accommodation

- agreed county-wide provision of safe sites and more relaxed enforcement approaches in respect of people within gypsy, traveller and the van dwelling community

- collaborative approaches have been evident in relation to communications and information sharing to help protect the most vulnerable people in our communities, as well as close working between health and care providers

- with continued socio-economical pressures within communities there is a focus on continued support for communities through established community and VCSE services. Examples of this included:

- Homes for Ukraine, support for Ukrainians and their hosts to access community support groups, healthcare, education and financial support. This was delivered through Primary Care Networks, VCSE, Public Health teams and Somerset County Council

- ongoing vaccine delivery throughout the county is delivered through a well-established integrated community response involving PCNs, Public Health, and VCSE

- strategic development of Social Prescriber Link Worker (SPLW) role and integration into the wider ICS priorities

- strategic development of Somerset Integrated Care (SIC) Personalised Care

- opportunities to co-commission through the establishment of SIC initially through community services such as the Cares contract and SPLW/Village Agents

Ageing Well Programme

5.41 NHS Somerset CCG has an established programme team to oversee the Ageing Well Programme, which comprises Urgent Community Response (UCR)[6], Anticipatory Care (AC)f[7] and Enhanced Health in Care Homes (EHCH)[8]. In Somerset there has been an increase in patient falls in the community, and several patients with chronic long term and complex health conditions.

5.42 Over the next 12 to 18 months, the Ageing Well Programme will continue to work on a falls' response, working with the care homes and pendant alarm providers to deliver an appropriate response to a person having a non-injury fall, with an expectation of reducing demand on South Western Ambulance Service NHS Foundation Trust (SWAST) services, 111 and conveyance to acute emergency facilities. In addition,, further falls' equipment will be available across all UCR services and care homes to support patients to remain at home where appropriate. The UCR model will also be promoted across the whole system developing integrated pathways to support patients, families, and carers to remain in the place they call home.

5.43 Examples of UCR development to support the reduction in winter pressures include:

[6] UCR teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer.

[7] Anticipatory Care Planning (ACP) is where you talk about what matters most when making plans for your care in the future.

[8] This model moves away from traditional reactive models of care delivery towards proactive care that is centred on the needs of individual residents, their families and care home staff. Such care can only be achieved through a whole-system, collaborative approach

- UCR pilot for a direct referral pathway from Care Homes to UCR services. This pilot will run for 4-6 weeks and if successful, will then be rolled out to all Care Homes within Somerset

- where an ambulance has been requested by a Care Home and there is a delayed response, UCR teams will support Care Home staff whilst waiting for the ambulance to arrive

- working with SWAST and NHS England (NHSE) colleagues to develop a direct referral pathway to take UCR appropriate calls from the ambulance stack

- UCR services will be integrated into Hospital at Home and Anticipatory care pathways to promote the full community integration and avoid hospital admission

5.44 We have some exemplary complex care services in place across Somerset and plan to develop these further in line with the anticipatory care model. Co-production workshops have taken place with primary care colleagues developing processes to identify those people with greatest risks and needs to ensure they are offered support for physical and mental health needs, including holistic assessment, links with community services, musculoskeletal conditions, cardiovascular disease, dementia and frailty.

5.45 We are working with primary care colleagues and establishing communication channels with the care homes and Primary Care Network (PCN) care coordinators to understand the challenges being faced and highlight the great working practices being developed with the Somerset care home network.

5.46 Continued engagement with primary care, voluntary, community and social enterprise (VCSE), social care and community services will take place to ensure a system wide approach to improving health outcomes and addressing inequalities for the whole population.

Prevention

5.47 During 2021/22 and into quarter one of 2022/23 we continued with the following priorities:

- developing more detailed proposals for the use of the £1 million prevention monies to include the procurement of a Tier 2 weight management support offer to the public. A direction of travel and investment in community-based prevention was supported by our Clinical Executive Committee recently

- Smoking cessation and tobacco control

- Healthy Weight and the Healthy Weight Alliance

- Somerset Moves – our countywide physical activity strategy
- Hypertension strategy

5.48 This work programme also links closely to the joint health and wellbeing strategy for Somerset 'Improving Lives' and the Fit for my Future Strategy.

Diabetes

Diabetes Prevention Programme

5.49 Somerset has a nationally commissioned diabetes prevention programme which continued to operate successfully during 2021/22 and into quarter one (April to June) of 2022/23 on a remote basis with video link and telephone sessions for those without access to the internet. Although challenging at times, referral numbers have remained stable and continue to rise. GP Practice participation reached 96% with only one non-referring Practice at the end of June 2022.

5.50 The direct-to-consumer pathway which was brought in to support GP Practices during the pandemic has continued into quarter one of 2022/23 and is responsible for around 25% of our referrals. It allows people to self-refer without the need for a HbA1c blood test, thus reducing pressure on primary care. Unfortunately, it has been announced by NHS England that this referral pathway will now be coming to an end.

5.51 We continue to focus on recruiting more people, with a particular focus on black, Asian and minority ethnic groups and people from the Gypsy, Roma and Traveller community. Our first adapted sessions are due to start soon and we will take learning from these to support other minority groups. We are also prioritising how we can adapt the programme to support age and gender equality and those in areas of rurality.

Diabetes Low Calorie Diet Programme

5.52 In 2021, Somerset was awarded 500 places over two years on the national diabetes low calorie diet programme. The programme gives people with type 2 diabetes who meet specific criteria the opportunity to reverse the effects of their diabetes. Our first patients are being recruited to the programme. The first courses are running in Frome, Mendip area, Langport and Taunton. Over 100 people have been recruited to the programme. Resources including video have been developed to provide information to people and clinicians.

Diabetes Management

5.53 'My Diabetes My Way' is a self-management platform that allows patients to set goals, monitor their results and access education. On 30 June 2022 we had 5,800 users, which is around 16% of the registered diabetes population. Early data from My Diabetes My Way shows a lowered cholesterol, HbA1c and blood pressure in those people using it.

5.54 A pre-operative care programme has developed a pathway for people waiting for surgery but have poorly controlled diabetes. To-date, 25 patients have been supported and achieved an average decrease of 24 mmol/l in HbA1c levels. The programme is expanding to more Practices.

5.55 Our risk stratification programme has developed a package of support for Practices to help manage people with high-risk diabetes. Virtual clinics have been delivered in 15 GP Practices.

5.56 We have collaborated with My Way Diabetes to test the integration of insulin pumps and other technologies with the self-management platform.

5.57 The team has implemented the Minuteful kidney app in Somerset so that patients can do an annual albumin/creatinine(ACR) urine test remotely, using a smartphone. Results go directly to GP patient records and help identify people with early-stage kidney disease. To-date, half the tests are normal which saves on the testing workload in GP Practices. The work is also engaging people who do not usually engage with testing.

Respiratory Management

5.58 In 2021/22 additional funding was obtained to increase capacity to restart face-to-face pulmonary rehabilitation in Somerset. Patients now have a choice of remote access or a face-to-face programme and this continues into quarter one of 2022/23.

5.59 A primary care-based asthma interest group, supporting the management of people in the community using action learning and quality improvement continues to be supported.

5.60 Three respiratory clinical champions were recruited to Primary Care Networks (PCNs) and funded from the South West Respiratory Network. Work has begun on increasing our champions in Somerset during quarter one (April to June) of 2022/23.

5.61 Work has commenced to increase access to fractional exhaled nitric oxide (FeNO) devices in Somerset. Each PCN was offered a device and training so that tests were accessible closer to home and that an accurate diagnosis of asthma can be made.

5.62 Spirometry training has been offered to GP Practices in Somerset, and tests are restarting in community investigation hubs.

Cardiovascular Disease

5.63 A county wide team has reviewed the heart failure pathway in Somerset with a view to improving diagnostic pathways and access to care.

5.64 Somerset Integrated Care System (ISC) participated in the national blood pressure (BP) at home project, where Symphony Healthcare Services Ltd was a trailblazer site, followed by county-wide coverage. Over 2,500 blood

pressure machines have been distributed to people with diagnosed hypertension in Somerset so they can self-monitor at home. Much of the distribution focused on people from deprived areas.

5.65 Blood pressure machines are available from public libraries in Somerset so people can test themselves by borrowing machines.

Somerset COVID-19 Recovery Service

5.66 NHS Somerset CCG established a service for people experiencing the long-term effects of COVID-19 in line with national requirements. The service operates in primary and community care settings with a team of GPs and other clinicians, including occupational therapy, fatigue specialists, mental health, rehabilitation, and social prescribing. People referred to the service are assessed and personalised management plans are then agreed. Management plans will include advice and support, guided self-help resources and referral to specialist services for support/rehabilitation as required.

5.67 The team introduced group sessions for post COVID-19 assessment which has significantly cut waiting times.

5.68 In addition, an awareness campaign using posters on buses aimed at tackling inequalities in coastal areas was run in West Somerset and the area around Hinkley Point, focused on long-COVID symptoms.

End of Life Care

5.69 In Somerset the COVID-19 pandemic created even stronger bonds between key partners, including hospitals, hospices, social care, community health and other teams in working together to ensure end of life care and support is as good as it possibly can be. This was evidenced through the work of the Somerset Integrated Care System End of Life Care Programme Board, which benefited from the expertise, contributions and insights of additional key personnel from all aspects of health and care in Somerset. This allowed partners to share information about what was going on, support each other around pressure points and provide mutual aid where required.

5.70 The Programme Board has continued to make progress on important strategic developments, notably for quarter one (April to June 2022/23):

Advance Care Planning[9]

5.71 The Programme Board continues to progress this agenda recognising that an advance care plan has two important elements. The Programme Board has taken responsibility for supporting the working groups and feeding into the Integrated Care System (ICS) governance:

[9] involves thinking and talking about your wishes for how you're cared for in the final months of your **life**.

- First and foremost, what is important to the person and their family, the human, the legacy? What treatments may or may not offer benefit from a medical perspective, with the decision about ceilings of care informed by what is important to the person? There are two main workstreams which overlap, both of which are undertaken by groups which report to the End-of-Life Programme Board. The first is a collaboration with Social Finance and Marie Curie to allow the person and their family to create a non-medical advance care plan, which is agreed and electronically placed in that person's GP EMIS record.

- Secondly, the creation and sharing across the Somerset community of a Somerset Treatment Escalation Plan (STEP). The group has taken responsibility for supporting these working groups and feeding into the ICS governance.

5.72 A resource has been created (both practical and educational) for the community which can support other workstreams including Aging Well (anticipatory care) and Primary Care Network (PCN) Direct Enhanced Service (DES)[10] contract for Anticipatory Care where there is a requirement to have evidence of a care plan for the individual. The Ageing Well NHS England team identified people living with moderate to severe frailty as a first year priority group. Personalised care and anticipatory care are identified in the ongoing DES contracts.

5.73 Culturally the concept of advance care planning is challenging and the first year of the programme did not achieve the number of plans anticipated; nonetheless the learning on how to involve people in their care has been invaluable.

Just in Case Policy

5.74 The Somerset ICS Just in Case Policy is being updated, building on the work during the COVID-19 pandemic. This policy update will recognise how appropriately trained family members can safely administer these medications to dying relatives mitigating against the distress experienced when acute response services are unable to respond in a timely manner.

Somerset End of Life Care and Bereavement Support Website

5.75 The Somerset End of Life Care and Bereavement Support website was launched on 1 March 2022. The website has been developed to enable patients' families and carers access services within Somerset. The launch was celebrated in the Somerset End of Life Conference in May 2022 attended by over 150 Somerset-based health and social care professionals with keynote speeches from Dr Kathryn Mannix and Dr Lucy Pollock.

[10] Directed Enhanced Services (DES) are nationally negotiated services, which are over and above those provided under GMS/PMS/APMS contracts, which the ICB (delegated by NHSE) are obliged to commission.

5.76 A needs assessment was generated and shared with the group by Public Health colleagues, and raised a question that patients with a life limiting illness from a non-cancer diagnosis may have poorer access to End of Life care in their own home. This is a question which will need to be explored further.

Mental Health – Adults and Children

5.77 Interest and investment into mental health services accelerated because of the COVID-19 pandemic and in line with the commitments made in the NHS Long Term Plan. This has gone some way to addressing the historic underfunding of mental health services and helped us to expand and develop local services to meet the needs of more people.

5.78 Both national and locally, there continues to be a strong emphasis on prevention, earlier intervention, and a better integration of services (health and social care, primary and secondary care, mental health and physical health care). This has increased the focus on community-based support, with emphasis being given to improving the overall mental wellbeing of the population, avoiding crises, and managing them better when they do occur.

5.79 Building on the successes in 2021/22, we continued to make progress towards realising the ambitions set out in the NHS Long Term Plan, ensuring that they are fit-for-purpose for the unique population of Somerset.

5.80 Notably in in quarter one of 2022/23 we have achieved the following:

- increased the uptake of Talking Therapies for adults experiencing mild-moderate anxiety and depression
- increased the capacity of our maternal mental health services so that more people can receive the support they need
- increased the number of children and young people accessing mental health support within schools
- continued to offer a suite of mental health and wellbeing resources for health and care staff in Somerset
- a significant increase of people in Somerset with serious mental illness receiving an annual physical health check
- launched a web-chat option for our 24/7 all age mental health crisis line, to ensure that people can access support in the way best suited to their needs
- worked with partners to introduce a Community Mental Health Treatment Requirements initiative, which will divert people from prison into treatment

- worked with partners to implement control room triage. This aims to aims to decrease the number people with mental health issues who have to be detained by the police under section 136 of the Mental Health Act. The triage service works by placing a team of mental health nurses into the Avon and Somerset Police Control Room.

Autism and Learning Disabilities

5.81 Our over-arching principles are as follows:

- to make health and care services better so that more people with a learning disability, autism or both can live in the community, with the right support, close to home
- to do things with people, not for them or to them
- to promote rights, respect, choice, and control
- to improve equity of access and provision in mainstream services
- to reduce health inequalities for people with a learning disability, autism, or both
- to reduce premature mortality in people with a learning disability, autism, or both.

5.82 Notably in quarter one (April to June) of 2022/23 we have**:**

- continued with the delivery of our three-year plan (from 2021/22 to 2023/24), including phased growth in investment
- continued to maintain stable numbers of people placed in specialist hospital beds and discharge, despite the impact of COVID-19. We continue to have low numbers of people cared for in inpatient settings compared with other regional and national systems
- continued to improve processes around care education and treatment reviews/care treatment reviews (CETRs/CTRs) and the Assuring Transformation (AT) database
- continued to work with partners to make improvements in Learning Disability and Autism services for both adults and children and young people, and continue to work with partners and people with lived experience to develop an all-age Learning Disabilities Strategy and an all-age Autism Strategy
- continued work on the Learning Disabilities Mortality Review (LeDeR) programme.

Women and Children's and Families Services

5.83 The NHS Long Term Plan has provided an opportunity to place the needs of women, infants, children and young people at the heart of England's health services and this has gone some way to support a focus on children and young people within health and care services. There continues to be a strong emphasis on prevention, earlier intervention, and a better integration of services across health and care.

5.84 Building on the successes in 2021/22, we continued to make progress towards realising the ambitions set out in the NHS Long Term Plan, ensuring that they are fit for purpose for the unique population of Somerset.

5.85 The main priority areas for 2022/23 are:

- advocating for and prioritising the need universal health provision for children and young people to support prevention, help at the earliest identification of need and to support healthy long-term outcomes for children and young people as they transition to adults
- supporting the development of system governance including joint commissioning for children and young people
- maternity, where, following the publication of the (Donna) Ockenden's report on the safety of maternity services, there has been an even greater requirement on evidencing the safety and quality of the services offered
- delivering the programme of work within the Children and Young People's Transformation Long Term Plan, that looks from a population base at a range of medical conditions and ways of working
- transitioning into year 2 SEND themes focusing on improvements to properly meet the needs of children and young people with special educational needs and disabilities (SEND)
- continuing to improve support and access to services for vulnerable children and young people, particularly for those with needs that sit outside normal health services
- supporting the COVID-19 pandemic recovery.

5.86 These priority areas are underpinned by a set of principles and vision for care provision that ensures that:

'Every woman, child and their family will have access to the information they need to enable them to make decisions about their care; their needs will be considered and assessed holistically to ensure that support is

focussed on their individual needs and circumstances, no matter where they live in Somerset'.

5.87 Children are ten times less likely than adults to have been hospitalised with the virus, but the wider effects of the pandemic on children and young people have been significant due to large periods of time out of social situations and impacting on development and emotional wellbeing.

5.88 Somerset has invested in a diagnostic clinic for children and young people who are symptomatic of long-COVID as a twelve-month pilot. A joined-up system approach has been taken to support children in education and those unable to access education due to longer-term symptoms.

Local Maternity and Neonatal System Transformation

Workforce

5.89 Workforce remains the main threat to Somerset maternity services. The ongoing national shortage of midwives and obstetricians continues to cause pressure on maternity services. We have been successful in recruiting midwives and obstetricians to start during September and October 2021 to ease some pressure, and a rolling recruitment remains in place. Work continues with NHS England to identify opportunities to attract new staff, including international recruitment, whilst supporting staff retention through wellbeing support.

NHS Foundation Trust merger

5.90 Work continues at pace to align maternity services across the county in line with upcoming merger of Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust. This is supported by a three-year digital maternity strategy to align software systems, with a new Somerset maternity website and single point of access. Pathways and protocols will become county-wide, identifying best practice to support levelling up of care to the highest standards. Supporting staff through this process is a priority and developing the joint working culture will be key.

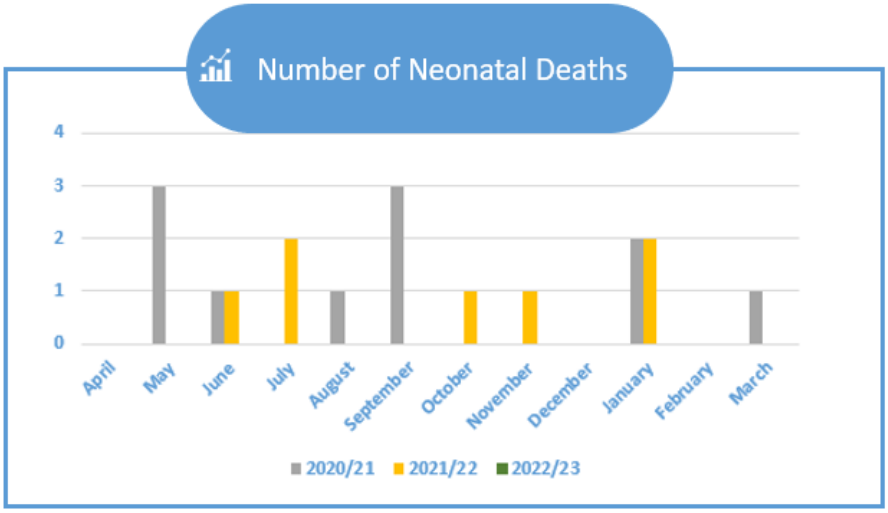
Safety

5.91 Keeping women and babies safe will always be the first aim for Somerset and work continues to meet all safety recommendations including (Donna) Ockenden, Saving Babies Lives[11] and PeriPrem[12], as well British Association of Perinatal Medicine (BAPM) standards. Further guidance is awaited from NHS England around the expectations from Ockenden part 2 and the East Kent report. A joint safety group has commenced with

[11] The Saving babies' lives care bundle provides evidence-based best practice for providers and commissioners of maternity care across England to reduce perinatal mortality.

[12] PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) is a care bundle of 11 interventions that demonstrate a significant impact on brin injury and mortality rates amongst babies born prematurely. PERIPrem also forges new ways of working, where clinicians from obstetrics, midwifery and neonatal join together to drive forward and revolutionise care for pre-term babies.

Somerset and Dorset Integrated Care System to gain external peer review of serious incidents and shared learning, which is giving valuable insight into common themes. Both our acute trusts are rated good for safety by Care Quality Commission (CQC) and a culture of identifying areas for improvement is encouraged.



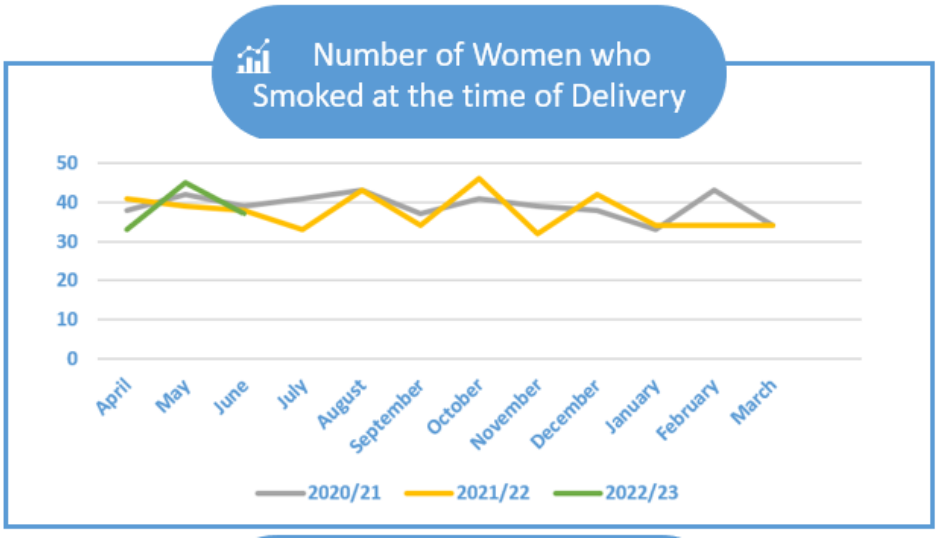
Prevention

5.92 Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage, and pre-term birth. Smoking during pregnancy also increases the risk of children developing several respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity, and diabetes (ASH, 2021):

- in 2021/22 10.3% of pregnant people in Somerset were smoking at time of delivery, however CO monitoring during COVID-19 was paused so we are expecting an increase due to restarting monitoring

- Somerset data shows that women who smoke equate to 18% of stillbirths, 20% of small for gestational age (SGA) babies, 16% of preterm births, 17% of neonatal deaths and 13% of Newborn Intensive Care Unit (NICU) admissions

- Pre-term and Small for Gestational Age (SGA) babies have an increased risk of a number of long-term conditions and having special educational needs



5.93 Obesity is associated with increased risk of almost all pregnancy complications: gestational hypertension, pre-eclampsia, gestational diabetes mellitus, delivery of large for gestational age (LGA) infants, and higher incidence of congenital defects all occur more frequently than in women with a normal BMI. Evidence shows that a child of an obese mother may suffer from exposure to a sub-optimal in-utero environment and that early life adversities may extend into adulthood (Poston, L., Harthoorn, L., van der Beek, E. et al, 2011):

- 24% of pregnant women in Somerset had a BMI of >30 in 2021/2
- women with a BMI>30 in Somerset account for 25% of stillbirths and 31% of preterm births

5.94 A Public Health midwife has been appointed to embed prevention principles across Somerset maternity services with the aim of supporting all women to have a healthy pregnancy. Maternity is included in the NHS Long-Term Plan for tobacco dependency and we work closely with our Public Health colleagues to develop services that meet the needs of Somerset women.

Equity and Equality

5.95 An in-depth analysis of equity in Somerset maternity services has been completed and clearly demonstrates the links between smoking and stillbirth, neonatal death, pre-term birth and small for gestational age babies, with a clear but lesser link between obesity and poorer outcomes:

- the Somerset maternity equity analysis shows women living in deprived areas are more likely to smoke and have a high BMI
- 22% of pregnant women in the most deprived areas smoke at time of delivery, compared to 5% in the most affluent areas

- 35% of pregnant women in the most deprived areas start their pregnancy at a healthy weight, compared to 54% from the most affluent areas

- 58% of women in the most deprived areas breast feed, compared to 90% from the most affluent areas.

5.96 Data for women of Black and Asian heritage is more difficult to analyse as numbers in Somerset are small, albeit increasing. However, indications are that the national findings of increased likelihood of stillbirth and neonatal death are replicated in Somerset, so women from these groups remain a priority, alongside women from the Gypsy / traveller community.

5.97 A maternity equity and equality plan will be submitted to NHS England at the end of September and will contain our targeted actions to improve equity in outcomes across Somerset.

Transformation

5.98 Transformation work continues at pace with particular focus on:

- continuity of carer - targets have been eased due to the ongoing national recruitment issues but remains on our priority list when safe staffing allows

- bereavement support, including implementation of the National Bereavement Care Pathway

- pelvic health – we have successful bid for funding to develop specific pelvic health clinics

- perinatal and maternal mental health clinics are continuing to expand, now supporting partners and women up to 24 months after delivery

- working with NHS England to look at infant mental health, including trauma informed care during and following pregnancy, and attachment

- development of the WREN team (Women Requiring Extra Nurturing) to support our more vulnerable women

- continuing to embed neonatal colleagues into the Local Maternity and Neonatal System (LMNS), with enhanced service user feedback via Somerset Maternity Voices Partnership

Special Educational Needs Disabilities (SEND)

5.99 The SEND written statement of action[13] has now transitioned into year two themes focused on:

- our children and young people and their families, our leadership and our culture
- our joint working arrangements, joint commissioning, neuro-developmental pathways, specifically autism
- inclusive schools, consistency of practice
- timeliness of assessment, quality of education, health and care plans (EHCPs).

5.100 Significant work has occurred at a system level to improve the service provided to children and young people with SEND and their families. Specifically for health this includes:

- SEND structure and roles now established in NHS Somerset CCG following move from NHS Somerset CCG
- investment in increased capacity and roles in SEND Designated Clinical Officer (DCO) Health team
- pilot of DCO role across CCG and Somerset NHS Foundation Trust (SFT)
- revised process on supporting medical needs in schools from September 2022
- review of medical tuition criteria and referral underway to improve clarity for all partners
- single point of contact email for DCO team for schools, Assessment and Reviewing Officers, partners and parents
- training rolled out to health providers on EHCPs, the Graduated Response Tool, report-writing and Section 23 duty and process
- new report template and guidance for therapies to ensure that provision is specific and is included in the correct part of the Education and Health Plan (EHCP)[14]

[13] The SEND Written Statement of Action is a detailed plan to improve key areas identified in the SEND Ofsted/CQC inspection

[14] An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health and social needs and set out the additional support to meet those needs

- quality Improvement project underway to improve health input into Annual Reviews of EHCPs

- audit of quality of health contributions to EHCPs has given a baseline for improvement work and can be repeated to measure progress

- currently mapping projected future demand and capacity to include staffing and resource required to meet future demand through business planning

- pre-assessment and assessment aspects of the Autism Spectrum Disorder/Attention Deficit Hyperactivity Disorder (ASD/ADHD) pathway have been published

- work progressing to establish robust joint commissioning governance for children and young people

Children and Young People's Transformation Programme

5.101 Children and young people (CYP) represent a third of our country and their wellbeing will determine our future and are a key area of focus for prevention, early intervention and supporting a best start approach. Children and young people need services that support them to be able to live happy and healthy childhoods and to grow through adolescence into resilient adults who live long and healthy lives.

5.102 Based on commitments made in the NHS Long Term Plan, the Children and Young People's Transformation Programme has been established to improve outcomes and reduce health inequalities for all those aged 0 to 25. Key regional areas of focus are:

Integration

5.103 Key delivery area across programme, successful funding to pilot test site in Chard, building into system response around family connections. Key local and system issues identified through engagement with professionals and service users and being progressed through separate workstreams. Key areas of focus include communication, pathways, parenting support and reducing inequalities.

Palliative care

5.104 A monthly working group is in progress with good representation from clinical and operational teams. Work is progressing on a joint post with Children's Hospice Southwest, an innovative project to support personalised care for our children, young people, and their families. Key workstreams are psychology provision, transition into adult health services and co-production. Successful national funding bid to support an innovative way of providing psychology to our most vulnerable children, support resilience and retention in a highly specialist service.

Diabetes

5.105 Children's and Young People's (CYP) transformation work is now underway with support from NHS England regional team. Specific areas of focus include technology to support management of care, workforce and transitioning into adult health services.

Asthma

5.106 A clinical team is now in place to support implementation of the national paediatric asthma care bundle. Key work and collaboration with system colleagues in health, social care, public health, and education to ensure a system wide approach around the management of asthma, training for professionals and an understanding of environmental factors which impact on children's health. Current focus specifically on smoking cessation for adults and children over the age of 12.

Healthy Weight

5.107 A family focused approach joint working with public health to secure a 12-month project manager to lead all-age healthy weight system focus supporting an early intervention approach to weight management and tacking environmental factors which impact on healthy weight. A Tier 3 pilot project is currently underway at Somerset NHS Foundation Trust. This is a test project which will support identification of learning to inform the future model.

Transitions

5.108 Transitioning into adult health services is a key area of focus across all transformation workstreams. Work is underway with secondary care providers to support a system-wide approach to transitions focusing on specific clinical pathways and clinical engagement across paediatric and adult specialist areas.

Children and Young People in Urgent Care

5.109 Six clinical conditions of focus have been identified, supporting clinical pathways across primary and secondary care. The HandiApp has now been commissioned across Somerset, linked in with Think 111 and urgent care meetings. We are working on an integration project to look at test and learn around care of CYP in the community to ensure care in the right place at the right time.

Women's Health Services

5.110 Women live on average for longer than men but spend more of their life in poor health, often limiting their ability to work and participate in day-to-day activities. Closing the gender health gap and supporting women to live well will not only benefit the health and wellbeing of women, but the health of the economy.

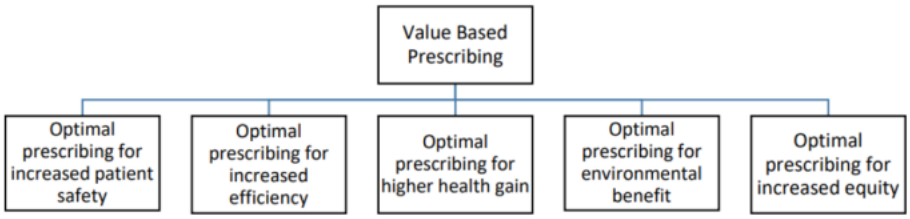
5.111 A 10-year strategy was launched in July 2022 that sets out a range of commitments to improve the health of women everywhere, including a plan to transform women's health content on the NHS website, a definition of trauma-informed practice for the health sector and plans to increase female participation in vital research. The strategy sets out an approach to priority areas related to specific conditions or areas of health where the call for evidence highlighted particular issues or opportunities:

- menstrual health and gynaecological conditions
- fertility, pregnancy, pregnancy loss and postnatal support
- menopause
- mental health and wellbeing
- cancers
- the health impacts of violence against women and girls
- healthy ageing and long-term conditions

Medicines Optimisation

5.112 The annual medicines spend in Somerset accounts for over £100 million of the overall NHS budget. Somerset continues to promote getting value for money from that spend,at the same time identifying unmet need and getting the best outcomes for patients from their prescribed medication.

5.113 During 2021/22 and into quarter one (April to June) of 2022/23, NHS Somerset CCG continued to implement its medicines optimisation strategy for high quality value-based prescribing.



5.114 Quarter one of 2022/23 saw the launch of the annual primary care prescribing and quality improvement incentive scheme, with a number of new and amended indicators – highlighted in Red. GP practices have already started to make changes to deliver improvements supported by the Medicines Management team and PCN staff.

5.115 Improvement in the indicators improves the outcomes for patients and the utilisation of the prescribing budget, so supporting the system priorities.

2022-23 Scorecard indicators

1. Achievement of National antimicrobial prescribing targets and has an identified sepsis lead
2. Eclipse- Reduction in Radar Red and Amber alerts per 1000 Astro PU (<0.50 per 1000 Astro Pu)
3. Percentage LD and Dementia patients prescribed antipsychotic medication (<8%)
4. 50% reduction in Percentage of patients on same inhaler type (just MDI or just DPI)
5. Cost effective MDI combo / single inhalers (60%)
6. Cost effective DPI combo / single inhalers (60%)
7. BG test strips £9.25 or less per pack of 50 (75%)
8. Gliflozins as a % of gliflozins+gliptins (60%)
9. Reduction in plain vit D / calcium and vit D prescribing no bone sparing agent (<4.05 patients per 1000 Astro Pu)
10. % Patients with all 8 diabetes care processes undertaken (70%)
11. CCG Formulary preferred opiate formulations (80%)
12. Reducing Opiate prescribing (excluding injectables) (opiate ADQ/1000 astroPU <43 (or Jan - March 2023 data has reduced by 10% compared to baseline)
13. 50% reduction in oral morphine solution for all patients (<150ml per 1000 analgesia star PU)
14. Potential generic savings(<0.25%)
15. NHSE OTC selfcare indicators including hayfever (<£375 per 1000 patients)
16. Cumulative sip feed spend per 1000 patients over 3 months (<£500 per 1000 patients (current CCG average) or reduce spend by 10%)
17. Reduction in hypnotic and anxiolytic prescribing (<215 ADQ per 1000 patients)
18. Spend on preferred products as % spend on all emollients (40%)
19. % solifenacin (>65%)
20. Reduction in anti-cholinergic burden prescribing (below Target 0.76% current CCG average)

Quality and Patient Safety

5.116 Quality and patient safety is a key strategic and operational priority for NHS Somerset CCG to ensure the safe and effective delivery of health and care services, with quality improvement being the first of our core values. Our key focus is to ensure quality and patient safety is built into our everyday practice, assurance processes, commissioning structures, and business processes through an annual cycle of quality improvement activity and system led quality improvement programmes of work to improve health and care services.

5.117 Quality improvement is also a key priority for NHS England and the National Quality Board and is also a key strategic priority for the formation of NHS Somerset ICB and our Integrated Care System (ICS). To support the move to an ICS, NHS England has issued expectations for the delivery of a quality function, supported by the six key elements below, which have been incorporated into the developing ICS Quality Strategy and Framework which commenced this year:

1. **Strategic quality requirements** – Implementation of National Quality Board Position Statement and National Guidance on System Quality Groups

2. **Operational quality systems and assurance** – Independent investigations (including mental health homicides); regulation 28 reports; professional standards; controlled drugs Accountable Officer function; whistleblowing and freedom to speak-up; quality accounts; infection prevention and control and antimicrobial resistance

3. **Patient safety** – Insight, involvement and improvement (including medical examiners, patient safety improvement programmes, Patient Safety Incident Response Framework , Learn from Patient Safety Events service)

4. **Experience** – Improving patient, service user and unpaid carer experience of care; insight and feedback

5. **Effectiveness** – National clinical audits; NICE technologies appraisals and guidance; getting it right first time (GIRFT) [15]

6. **Safeguarding** – Safeguarding assurance and accountability, including children in care / looked-after children; child death responsibilities

5.118 A significant amount of work has been undertaken by the Quality and Nursing directorate within NHS Somerset CCG during the year to prepare us for the move to an ICB in July 2022 and to ensure quality improvement and patient safety is at the front and centre of developments. Relationships with providers and CCG directorates / colleagues have been fostered and nurtured to ensure a collaborative and proactive approach to quality is undertaken which recognises the importance of creating cultures of open learning and improvement, and working together across health, social care, housing, employment and wider services to ensure high-quality care. This is described in more detail within the ICS Quality Improvement and Accountability Framework which has been developed collaboratively with system providers during 2021/22.

5.119 Equally in 2021/22 and into quarter one of 2022/23 we have undertaken a significant amount of work on the national Patient Safety Strategy implementation which was published in 2019 and sets out a new approach by recognising the influence human behaviour and systems can have upon patient safety.

5.120 Our safety vision is to continuously improve patient safety and to do this we will need to build on two foundations: a patient safety culture and a patient safety system. The three strategic aims to support the development of both are to:

[15] Getting It Right First Time (GIRFT) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

- improve understanding of safety by drawing intelligence from multiple sources of patient safety information **(insight)**

- equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(involvement)**

- design and support programmes that deliver effective and sustainable change in the most important areas **(improvement).**

5.121 Responsibilities of NHS Somerset CCG and then for NHS Somerset ICB, and Somerset ICS in delivering the national patient safety strategy are as follows:

- **Collaborate in the development of PSIRF (Patient Safety Incident Response Framework) Policy and PSIRF Plan** – the quality and nursing team will be holding a system wide PSIRF workshop in May 2022 with health providers to start developing this plan, involving provider trusts that have been part of the pilot sites for shared learning

- **Develop new processes to support oversight of effectiveness of systems in place to respond to patient safety incidents** –contract and quality review meetings (CQRM) are held monthly with our providers to seek assurance. However, the quality team would like to work more closely with our providers to review, improve and enhance oversight with an aim to implementing a more collaborative approach

- **Ensure training/competency standards are met for those in oversight roles** – as part of the national patient safety strategy a key aim was the delivery of a standardised patient safety training syllabus which was launched by Health Education England (HEE) during the year. The quality improvement team have formulated a plan on how this can be rolled-out to all staff, and a presentation was provided to the Somerset CCG Board and Council of Governors by the quality improvement team alongside the national patient safety lead at HEE

- **Support cross system response** – the quality improvement team are keen for multi-agency and end-to-end reviews to take place where appropriate and have been working collaboratively with our providers via the Somerset Patient Safety Specialists Forum to implement this. An end-to-end review is particularly suited to a case where a number of agencies are involved in an incident and provides an excellent opportunity to identify learning, quality improvement opportunities and actions to prevent future events occurring, with a particular focus on practice and/or process

- **Establish supportive learning system across the ICS itself; reflecting the spirit of partnership and collaboration** - In September 2021 we established a Review, Learn and Improve

Group to triangulate information received via the Patient Advice and Liaison Service (PALS), complaints we receive, health professional feedback, incidents and serious incidents for primary care, community, acute and independent providers. An example is learning from multiple health professional feedback regarding discharge summaries. A continuous quality improvement measure has now been included in the contract quality schedule 2022/23 to review at least 10 discharge summaries each month for both NHS Trusts.

Our Quality Improvement and Accountability Framework

5.122 As a wider Integrated Care System (ICS) we have developed a quality framework setting out our shared commitment for a single vision for quality, based on the need to provide high-quality, evidence based, personalised care for all.

5.123 This will enable us to join up planning, delivery, improvement and assurance of services across primary, community and acute hospital care to meet the physical health, mental health, and social care needs of our population.

5.124 This framework will also set our priorities to promote self-care and prevention, to enable people in Somerset to live healthier and more independent lives. To do this, we will ensure our quality of care in Somerset is:

- **Well-led** - we will lead by example in displaying the values of our ICS. We will promote a 'just' culture that always learns and not blames.

- **Sustainably resourced** – we will deliver optimal health outcomes within our ICS financial envelope, reducing impact on the environment.

- **Safe** – from the point at which a patient is referred for assessment and treatment, we will provide choice and advice to keep people safe from avoidable harm.

- **Effective** - we will apply a quality improvement approach to ensure our services are evidence-based and deliver the best outcomes for patients.

- **Experience** – we will provide services based on insights from our population's preferences and strengths, ensuring our services are inclusive and equitable.

5.125 Our Quality Improvement and Accountability Framework was published at the end of June 2022.

Monitoring Quality

5.126 We continued our quality monitoring activities under a reduced minimum quality monitoring framework set out in national directions *Reducing the Burden and Releasing Capacity** for most of the year.

Coronavirus » Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic (england.nhs.uk)

5.127 The quality and safety of commissioned health services continued to be monitored through our arrangements for governance with our system partners via the existing CQRM meetings, with an assurance and exception reporting route to the Somerset Quality Surveillance Group (QSG). This ensures quality and safety issues are taken into account in strategic decision-making.

5.128 Membership of the Somerset QSG comprises representation of senior clinical leaders including medical and nursing directors from the CCG, secondary care NHS services, local authority social care leaders, NHS England, the Care Quality Commission (CQC) and a strong patient voice through Somerset Healthwatch membership. The developing ICS Quality Improvement and Accountability Framework has been presented to QSG to ensure effective co-production and creation.

5.129 In addition to QSG, three key system wide forums were set up in 2021/22 to monitor quality issues and identify system wide quality improvement initiatives, details of which can be found below:

- **Somerset Patient Safety Specialists Forum** – established to support nominated patient safety specialists within the county to lead and

influence co-ordinated efforts to implement and deliver the national patient safety strategy, and to provide dynamic senior leadership, visibility and expert support to the patient safety work within health organisations, with shared responsibility and accountability.

- **Somerset Learning from Deaths Network** – established to help develop and monitor the effectiveness and potential outcomes of mortality review processes across providers in Somerset, with a strong focus on a system-wide approach to identification of themes and quality improvement opportunities. The network has representation from the Somerset Medical Examiner (ME) service and the CCG's quality improvement team is contributing to the community ME service implementation plan to support the statutory implementation of reviewing community deaths as well as hospital deaths.

- **Somerset Medical Devices Group** – established with the aim to co-ordinate and have oversight of medical devices equipment issued to community services during COVID alongside creating a governance and assurance process for issuing equipment into the community. Other key areas of focus surround horizon scanning for new products and digital opportunities, and training and competency considerations for end users.

5.130 In addition, in September 2021 NHS Somerset CCG established a Review, Learn and Improve Group, as described above. Other examples of system wide collaboration can be found below:

Patient Safety & Risk Management Current System wide Collaboration
1. Somerset Patient Safety Partners Forum
2. Somerset Learning from Deaths Network
3. QCRM meetings with providers
4. Regular meetings with providers to discuss serious incidents and learning
5. Regular meetings with providers to discuss quality and learning
6. Attendance SWAST's Quality Assurance committee with 6 other CCGs
7. Attendance at Managing Acute Medical Conditions in Children
8. Attendance and representation at the South West Patient Safety Network led by NHSEI
9. Attendance and representation at the South West Quality Network led by NHSEI

Infection Prevention and Control Current System wide Collaboration
1. SIPAAC quartlerly meetings (Someerset Infection, Prevention, Anti-microbial Assurance Committee)
2. Anti-microbal meeting
3. Health Protection Board
4. Outbreak meetings across the system
5. NHSE/I Collaborative workstreams
6. Quarterly peer review meetings
7. Monthly senior IPC leads across the system (incl non NHS providers, hospices)
8. In house Q&N huddle and team meetings and collague briefing
9. Hydration workstream is collaborative across the system

Equality and Diversity Current System wide Collaboration
1. SEOG - Somerset Equality Officer Group - involves District Council , County Council,. Blue light, CCG, Acute providers, Local Authority
2. Collaboration with YDH
3. Bridgwater and Yeovil 'Together' group - community events celebrating diversity in different towns. Yeovil group has a focus on encouraging GP registration for non UK nationals. Future plan is to involve Healthwatch
4. Glastonbury outreach - wellbeing days are run via presence at the festival. SWISH, MH, dental access centre, housing, police, Somerset drug and alcohol service, Healthwatch, CAB, DWP come together to provide information and access to services.
5. SWEP (severe weather emergency plan) planning with the local authority housing officers for the homeless community
6. Gypsy liaison collaboration - service that runs out of County Hall undertaking joint visits to pick up health needs
7. Yeovil PRIDE planning - involved for 3 years for health to have strong presence at the event and reduce barriers the community have with health services. Services such as SLT, A&E, PALS and PRIDE ambulance attend for information and inclusion
8. Chair Equality Steering Group (NED) - representation from CCG, both Trusts, LA. Co-Chaired by Beaumont Society which is a group representing the Trans community
8. Use of TeamNet for EDI Care pathways for Trans individuals

Primary Care Current System wide Collaboration
1. Collaboration with the Commissioning team regarding practices of concern
2. Working with the PCN Board
3. Working with Somerset GP Education Trust
4. Collaborating with the Local Medical Council (LMC) in supporting practices of concern
5. Attend meetings with our system wide contractors, Symphony and Diamond
6. Attend SW AHSN forums in relation to deteriorating of patients and RESTORE2
7. Attend SW General Practice Nurse Forum led by NHS England
8. Attend the Somerset Armed Forces Covenant Partnership – Health and Social Care Working Group
9. Contribution to Somerset Quality Improvement Faulty (SQIF)

Quality Improvement Initiatives

5.131 In recent years we have been working more closely with our service providers to reduce organisational and professional boundaries. The COVID-19 pandemic has fostered closer ties between services to achieve the best possible outcomes for our Somerset population. This has been especially prominent in the way we worked with our care home service providers to continue to train and upskill them in managing deteriorating patients and infection, prevention and control practices/outbreaks during the year. The introduction of quality improvement lead nurses within the Primary Care Networks (PCNs) has also helped to enable quality improvement priorities and projects to be taken forward for their local populations.

5.132 This continues to be strengthened by participating in the Somerset Quality Improvement Faculty (SQIF), a collaboration with our local partner services and agencies, being part of the delivery of the Somerset Bronze and Silver quality improvement training programme and presenting the Somerset quality improvement journey to the Somerset People Board. During 2021/22 and into quarter one of 2022/23 we continued our support of our capacity and capability for continuous quality improvement through training and coaching our local workforce. To comply with social distancing, SQIF continued to provide quality improvement training through video conferencing.

5.133 All of this has continued to create a foundation for us to work across health and social care services to improve the quality of care for our population. Below are some examples of excellent system wide collaboration and improvements during quarter one of 2022/23. A key priority for 2022/23 and for NHS Somerset ICB moving forward, and the

wider ICS, is to create a repository of quality improvement work within Somerset to both showcase the great work being undertaken and to enable the spread of quality improvement initiatives across providers.

5.134 During 2021/22 and into quarter one of 2022/23 it has still been important to ensure that transfer of care for people (requiring movement and contact) happens only when needed. We continued with the roll-out of an existing programme for the early recognition and escalation of treatment for rapidly deteriorating patients. This was expanded from pilot sites to Somerset-wide and was able to utilise the RESTORE2 (*RESTORE2™*[16] *official westhampshireccg.nhs.uk)* and RESTORE mini tools, which support building system capacity to identify, respond and escalate deterioration using a common language. This means communication about people whose health is deteriorating is carried out using a high reliability system to support clinical decision making about hospital admission. This was especially critical during the COVID-19 pandemic surges to both ensure swift transfer to hospital when needed, or to remain and be cared for at home when hospital treatment is not necessary

Complaints

5.135 NHS Somerset CCG values complaints, which are vital to continuously improve the quality of local health services and a measure of how services interact and are co-ordinated across the patient pathway. Formal complaints are captured, investigated, analysed and categorised.

5.136 The following figures reflect the number of formal complaints which have been managed by NHS Somerset CCG during quarter one (April to June) of 2022/23. It should be noted that NHS England have retained responsibility for managing primary care complaints and therefore any complaints solely relating to this are not included in this report.

5.137 During quarter one of 2022/2023 we closed 10 formal complaints. The themes arising from these complaints were:

- access to services (three formal complaints), specifically:
    - access to services for dementia patients
    - delays with access to urgent and emergency care
    - access to adult ADHD (attention deficit hyperactivity disorder) assessment
- quality of care (three formal complaints):
    - two concerns with the quality of in-patient care
    - delays with out-patient follow up

[16] RESTORE2 is a physical deterioration and escalation tool for care/nursing homes. It is designed to support homes and health professionals to: Recognise when a resident may be deteriorating or at risk of physical deterioration.

- dissatisfaction with the NHS Continuing Healthcare assessment process and funding decisions (three formal complaints)

- access to medical devices for children (Continuous Glucose Monitoring)

5.138 The outcomes from complaints which involve a patient who has died are shared with the Somerset Learning from Deaths Forum for wider learning across the system.

5.139 The NHS Somerset CCG Continuing Healthcare team use learning from complaints to improve communication with patients/families/their representatives and to improve training for community services.

5.140 Further analysis about closed formal complaints will be available in the NHS Somerset CCG and NHS Somerset ICB Annual Complaints Report 2022/2023 when published later in the year.

Safeguarding[17]

Safeguarding Children

5.141 Everyone has the right to live their lives free from abuse and neglect. The core business of NHS Somerset CCG is to safeguard and promote the welfare of children and young people in Somerset. Safeguarding is about protecting an individual's right to live in safety, free from abuse and neglect, as per the Human Rights Act 1998.

5.142 We are also responsible for ensuring that statutory responsibilities to safeguard and promote the welfare of children are embedded in the services we commission in Somerset. We make sure that we and the services we commission work within legislation and national, regional, and local guidance to safeguard and promote the welfare of children.

5.143 The CCG's Safeguarding Children Team strive to ensure all safeguarding children processes and systems put in place by 'health' and partner agencies are robust and effective. A huge amount of work and developments to improve and build on existing relationships, systems and procedures has been undertaken.

Training

5.144 Working collaboratively with local and regional safeguarding partnerships continued while striving to improve quality and strengthen safeguarding. The Safeguarding team has delivered Level 3 Safeguarding training to Primary Care as well as members of the CCG who require Level 3 Safeguarding training, including the Continuing Health Care team.

[17] *NB: for the purposes of this annual report safeguarding includes but is not limited to: Safeguarding Children, Safeguarding Adults, Children Looked After, Care Leavers, Domestic Abuse, Prevent, Exploitation, Serious Violence, Mental Capacity, Deprivation of Liberty, and Liberty Protection Safeguards.

Another all-day training session is planned which will focus on domestic abuse, mental health and safeguarding, and has been extended to members of CCG staff who require Level 3 training. TA multi-agency half day training session was held with Police and children's social care which focused on Child Exploitation and Contextual Safeguarding. The Safeguarding team continues to deliver the Safeguarding aspect of the CCG induction process to ensure all staff have the appropriate level of knowledge to support in identifying safeguarding concerns and to be aware of whom to contact if they have safeguarding concerns.

Supervision

5.145 The Safeguarding Children team has also continued providing virtual supervision to CCG Continuing Health Care Clinical staff, Public Health Nursing, Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust Safeguarding Named Nurses, Primary Care, Devon Doctors (our urgent care provider), Designated Doctors for Children Looked After and Child Death. There is continued recognition of the importance of attending regional meetings, GP best practice meetings, National Network for Designated Professionals, GP Safeguarding Network Meetings, Chanel Panel, TOPAZ, Health Safeguarding Children Partnership (HSCP) meeting as well as all other meetings to fulfil the CCG's statutory responsibilities. The Designated Doctor also represented the safeguarding team on the CCG's Clinical Executive Committee to ensure safeguarding is considered and threaded through all CCG policies and projects. This has resulted in the addition of a safeguarding section to the front sheet of all papers that go before the Board and has resulted in several requests for safeguarding information relevant to commissioning decisions.

Reviews

5.146 There has been a strong partnership approach to conclusion of the Thematic Review into non-accidental injuries in children, with a focus on actions to be taken to address the learning. There has been one rapid review this quarter, where the panel took the view that a local child safeguarding practice review or national review was not required. This will be discussed and reviewed by the Child Safeguarding Practice Review Panel who will respond and inform if they are in agreement with the decision made. There have also been two learning reviews for this quarter, which had strong multi-agency input with recommendations to ensure safeguarding procedures within the partnership are robust and preventative. The wider health system has been working more closely with the police and Children's Social Care at the local authority, to consider how, as tripartite partners, we can work more effectively to safeguard children. This included development of an action plan and allocation of tasks to fit with ongoing workstreams which is being supported by the Safeguarding Quality Lead.

Health System Safeguarding Representative

5.147 The Department for Education six-month project to embed two Health System Safeguarding Representatives (HSSR) into the Family Front Door continues, with the project due to end in September 2022. A business case is being put forward for the post to become substantive, as this will improve children's long-term outcomes and reduce the need for referral into child protection services, with the ability to attend Multi-agency Safeguarding Hub (MASH) discussions where required.

5.148 Other work undertaken by the Safeguarding Children Team in Quarter 2022/2023 includes:

- completion of a Termination of Pregnancy quality assurance visit by members of the CCG Commissioning, Safeguarding, Contracts and Quality teams to ensure the services commissioned are safe and suitable for those who may require it. Termination of pregnancy pathway for under 13s is in development, led by the Designated Doctor for Safeguarding Children, in conjunction with the police, British Pregnancy Advisory Service (BPAS), Trust representatives, The Bridge, Children's Social Care (CSC) and CCG/ICB commissioners

- a review of the recently published Child Protection Medical Pathway has improved the access for clinicians to high quality safeguarding advice when there is uncertainty about whether to proceed with a referral to CSC. There is a plan to extend this to an Integrated Care System (ICS) wide policy

- discussions are ongoing with Somerset NHS Foundation Trust and the Somerset Safeguarding Children Partnership (SSCP) about how we can extend the training offer across the wider ICS to ensure a multi-agency approach wherever possible

- the team provides regular support to professionals working across the system and give safeguarding advice and signposting. The Designated Doctor has supported with the escalation of several cases to CSC where professionals were concerned that the needs of a child were not being met

Children Looked After (CLA) and Care Leavers

5.149 Under the Children Act 1989, a child is looked after by a Local Authority if he or she falls into one of the following:

- is provided with accommodation, for a continuous period of more than 24 hours (Children Act 1989, Section 20 and 21)
- is subject to a Care Order (Children Act 1989, Part IV)
- is subject to a Placement Order

5.150 NHS Somerset CCG is the Responsible Commissioner for health services provided to Somerset Children Looked After (CLA), whether they are resident within Somerset or outside. The statutory guidance *promoting the health and well-being of looked-after children*, (DoH, DfE, 2015), must be considered when CCGs exercise their functions in respect of CLA.

5.151 Care leavers are those children who have previously been Looked After by the Local Authority and are now being supported to live independently. Following the Children and Social Care Act (2017), Local Authority responsibility for care leavers changed from 18-21 years to 18-25 years, enabling care leavers to request support up to the age of 25, regardless of whether they are in education.

5.152 We work with Somerset County Council to ensure that effective plans are in place to enable Looked After children aged 16 or 17 to make a smooth transition to adulthood, and that they can continue to obtain the health advice and services they need into adulthood and beyond.

5.153 NHS Somerset CCG gains assurance that its healthcare services to CLA and care leavers meet the standards laid down in the statutory guidance by ensuring that high quality, statutory initial and review health assessments and associated health care plans are delivered to CLA and care leavers in a timely way. Similarly robust performance monitoring of CLA access to dental services and immunisation rates and completed strengths and difficulties questionnaires (SDQs) provide assurance that CLA health needs are identified and met.

Assurance mechanisms in place

5.154 Two multi-agency governance groups, both led by the NHS Somerset CCG, met regularly during 2021/2022 and into quarter one of 2022/23. The CLA and Care Leavers Operational Management Group met virtually on a six-weekly basis and included representatives from health providers, Somerset County Council Children's Social Care and Public Health. The purpose of the Children Looked After Operational Management Group is to provide assurance that robust operational processes are in place across the Somerset system to ensure the health needs of CLA and care leavers are met.

5.155 The Health and Wellbeing sub-group of the Corporate Parenting Board, of which NHS Somerset CCG is a member, met virtually on a quarterly basis in 2021/2022 and into quarter one of 2022/23. In addition to multi-agency partners and designated health professionals with a strategic lead for CLA and care leavers, this group also includes elected Somerset County Councillors to ensure additional scrutiny and oversight. A main objective of the Health and Wellbeing sub-group is to develop and monitor actions that deliver the health and wellbeing elements of the Corporate Parenting Board Strategy.

Progress 2022/2023 Quarter one

Adoption

5.156 Additional in-year funding has been secured for further development of the health component of the local adoption service following a final High Court ruling in March 2022. The previous adoption backlog, due to the pause in proceedings following identification of regulatory irregularities, has been cleared. Thirteen children have now been awarded Adoption Orders with 11 more cases planned for final hearings in July 2022. Sixty-one updated adoption reports have been completed. New processes for referrals from Adopt South West to the Agency Medical Advisor have been agreed and referrals are processed through the adoption weekly meeting. Work is continuing on provider clinical records to ratify them post Adoption.

Statutory Health Assessments

5.157 Previous work to improve the pathways for Initial Health Assessments has led to significant improvements in performance. In March 2022, 100% of Initial Health Assessments were offered, and 93.3% were provided within 20 working days.

5.158 Capacity issues within Public Health School Nursing, leading to delays in completing statutory Review Health Assessments for Children Looked After. This is having an impact on the CLA Nursing Team and the issue is being scoped by Public Health Nursing to better understand the gaps and consider solutions. Year 3 CLA Transformation investment is now available to Somerset NHS Foundation Trust and will provide two additional Band 6 CLA Nurses in 2022/2023 which will improve the CLA Health teams' capacity to deliver more RHAs themselves. RHA performance was 84.3% on 30 June 2022.

Emotional Health and Wellbeing

5.159 Agreement has been reached to recruit a senior Speech and Language Therapist to support the work of the Emotional Health and Wellbeing Team, specifically focusing on better access to therapy. Recruitment will take place in Quarter 2 2022/2023 (July to September 2022).

Therapeutic Placement Access

5.160 During 2021/22, NHS Somerset CCG was involved in several cases where suitable placements for complex CLA were not available, leading to delayed discharges from acute paediatric wards and emergency departments. This is a national issue and Somerset County Council are developing a new local offer to provide suitable crisis placements and avoid unnecessary admission to paediatric units. The first beds are scheduled to open in September 2022. In the interim multi-agency processes are in place to manage such cases when they arise.

Dental Assessments for Children Looked After

5.161 Previous dental assessment COVID-19 recovery has stalled due to ongoing gaps and pressures in Somerset dental services. This has been escalated to NHS England South West (NHSE SW) as the Dental Commissioner. Meetings are planned in Quarter two of 2022/23 with NHS England Specialist Commissioners to look at what further measures can be implemented to mitigate the gap. Individual cases are currently escalated to the Dental Commissioner for resolution.

Homes for Ukrainian Guests

5.162 There is a risk that Somerset will experience placement of unaccompanied Ukrainian refugee children and young people with Somerset residents who have volunteered to host an individual or group from Ukraine. There is a concern that these children will become Looked After if the host arrangement fails. Safeguards are being developed and as at 30 June 2022 no unaccompanied children had arrived in Somerset.

Safeguarding Adults

5.163 Everyone has the right to live their lives free from abuse and neglect. Some adults are unable to protect themselves from abuse or neglect because they have needs for care and support. Others are unable to protect themselves because of the severe level of coercion, control, exploitation and/or violence they experience. Our key aim is to ensure that both NHS Somerset CCG and its commissioned providers protect the rights of adults to live free from abuse and neglect, in a way that supports them in making choices and having control about how they want to live. The NHS Somerset CCG safeguarding adults team provides expert advice and guidance in order that we fulfil our duties. This includes:

- safeguarding adults as described in the Care Act (2014)
- domestic abuse
- the Mental Capacity Act (2005) and Deprivation of Liberty / Liberty Protection Safeguards
- Prevent
- exploitation and serious violence

5.164 The Named GP for Safeguarding Adults post became vacant in October 2021 when the current post holder was successfully appointed into the role of Designated Doctor for Safeguarding Children. The Named GP post has remained vacant despite a number of recruitment attempts. The Designated Doctor for Safeguarding Children has provided one session a week temporary support to the Named GP role since June 2022.

5.165 The Named GP and Designated Nurse for Safeguarding Adults support primary care through the provision of training and safeguarding supervision sessions to GP Practices to support their knowledge and understanding of safeguarding adults, domestic abuse and the Mental Capacity Act. GP Practices continue to contact the CCG safeguarding

team for advice and support about people living in complex circumstances. The Named GP and Designated / Deputy Designated Nurse for Safeguarding Adults have supported GP Practices and enabled them to work with other agencies to take steps to either prevent or stop abuse and/or neglect occurring, including through the provision of regular updates shared via the CCG Safeguard newsletter and regular contributions to the Local Medical Committee (LMC) weekly newsletter.

5.166 As well as providing specialist advice and support, the safeguarding adults team maintains a positive working relationship with our NHS hospitals, community services and other providers, monitoring how all of NHS Somerset CCG's commissioned services support adults who need safeguarding. We also monitor how they work with other agencies. We do this by requiring our provider Trusts to provide monthly information on a safeguarding dashboard. Our smaller providers and GP Practices are required to complete an annual safeguarding report. We also attend provider Trusts' and other providers' safeguarding committee meetings. Performance and risk is reported to the CCG's Patient Safety and Quality Assurance Committee.

5.167 Despite the additional pressures on our provider Trusts during the post pandemic recovery period, they have continued to send us the safeguarding dashboard monthly information, so we have been able to continue to monitor performance in relation to safeguarding adults, Mental Capacity Act and Prevent. The information on the dashboard confirms that, despite the extreme pressures continuing to be experienced across the system, most staff have been able to stay up-to-date with their basic safeguarding adults training.

5.168 We have also been able to support colleagues working in GP Practices to maintain their safeguarding knowledge by providing virtual safeguarding training, best practice meetings and supervision. These sessions have been well attended, demonstrating commitment across GP Practices to provide effective support to adults who need safeguarding.

5.169 NHS Somerset CCG is a member of the Somerset Safeguarding Adults Board (SSAB). The SSAB is made up of senior people from organisations who have a role in preventing neglect and abuse happening to adults who need care and support. The SSAB ensures agencies all work together to minimise the risk of abuse to adults at risk of harm. The SSAB also monitors how effectively agencies work together.

5.170 During 2021/22 and into quarter one (April to June) of 2022/23, the safeguarding adult team contributed to the work of the SSAB through its attendance at meetings, including all five sub-groups. The CCG completed the bi-annual SSAB safeguarding adults self-audit for 2021/22 and has an ongoing health system-wide action plan in relation to aspects of this audit outcome.

5.171 The CCG safeguarding adults team has continued, throughout the ongoing pandemic and recovery, to provide expert advice and support,

ensuring the statutory and strategic safeguarding functions of the CCG are fulfilled. The Designate Nurses for Safeguarding Adults / Children and Children Looked After have led discussions with partner agencies within the Somerset health and social care system on progressing safeguarding work within an ICS. We have met regularly to identify shared statutory responsibilities and priorities for safeguarding, and more generally for the wider health and social care system.

5.172 The Liberty Protection Safeguards (LPS), which were originally planned to be implemented in April 2022, have been delayed. The consultation on the changes to the MCA Code of Practice and implementation of the LPS commenced on 17 March 2022 and ran for 16 weeks. LPS implementation is still unknown but is now anticipated to take place in either late 2023 or early 2024. T The implementation of LPS (to replace the current Deprivation of Liberties Safeguards) will have a significant impact on health providers (the NHS providers and the CCG CHC Team) as they become responsible bodies with statutory responsibilities. The Designated Nurse for Safeguarding Adults is working with NHS providers / Continuing Healthcare (CHC) team about plans for implementation, and with the wider Somerset health and social care system to agree areas of shared working. A CCG LPS business case for additional funding for LPS-specific roles in the CCG Continuing Healthcare (CHC) team was submitted to the CCG Board but was declined. This will be revisited again later in quarter two 2022/2023.

Domestic Abuse

5.173 Guidance produced by the Department of Health has established domestic abuse as a major concern for all health care professionals and identifies the NHS as the one service that almost all victims of domestic abuse come into contact with regularly within their lifetime (either as their first or only point of contact with professionals). The Domestic Abuse Act 2021 introduced the role of Domestic Abuse Commissioner (DAC) to improve the quality and quantity of domestic abuse support services. The first Commissioner has described the crucial role health services play in domestic abuse, saying they must be central to strategic thinking because they are trusted environments in which people from every background can be reached.

5.174 NHS Somerset CCG's safeguarding adults team continues to support the work of the Domestic Abuse Board, and have participated in 10 active domestic homicide reviews and four informal learning reviews (a significant rise in cases since the start of the pandemic). Themes emerging across the system have included recognition of men as victims, older people and domestic abuse, recognition and a need for an alternative approach regarding disclosure and ongoing support and increase in female suicides and links to domestic abuse.

5.175 Our NHS Trusts have also invested in this area by each employing a Domestic Abuse Co-ordinator who works in partnership with the Health Advocates. Through 2021 to 2022, we have monitored the referral rates

to our domestic abuse services from the Trusts and GP Practices, and will be evaluating if this work has improved the identification of and response to domestic abuse and violence in Somerset by the end of quarter one (June) 2022/2023.

Prevent

5.176 Prevent is part of the Government's counter terrorism strategy and aims to provide support to people who are groomed/radicalised before any crime is committed. Radicalisation is comparable to other forms of exploitation.

5.177 During 2021/22 and into quarter one (April to June) of 2022/23, NHS Somerset CCG's safeguarding adults team has:

- provided a link between the GP practices and the Channel panel
- attended all Channel panels within the Somerset areas and provided health advice and support to panel
- monitored the progress of compliance with Prevent training within the provider Trusts and the CCG

5.178 Compliance with Prevent training has continued to but has still not, as an average, reached the target of 85%. Our Trusts have ongoing action plans in place and the continuing pressures experienced across the system are widely acknowledged as a significant factor in the delay in reaching this target.

Violence Reduction Unit

5.179 NHS Somerset CCG has been working with the Avon and Somerset Violence Reduction Unit to develop how we will work with other agencies to prevent the occurrence of serious violence across Somerset. This will enable us to respond effectively to the proposed new duties in relation to serious violence. The CCG safeguarding team ensures representation at NHS England's South West Serious Violence and Contextualised Safeguarding Group and contributed to the 2021 review of the Avon and Somerset Serious Violence Strategic Needs Assessment.

LeDeR – Learning from Lives and Deaths

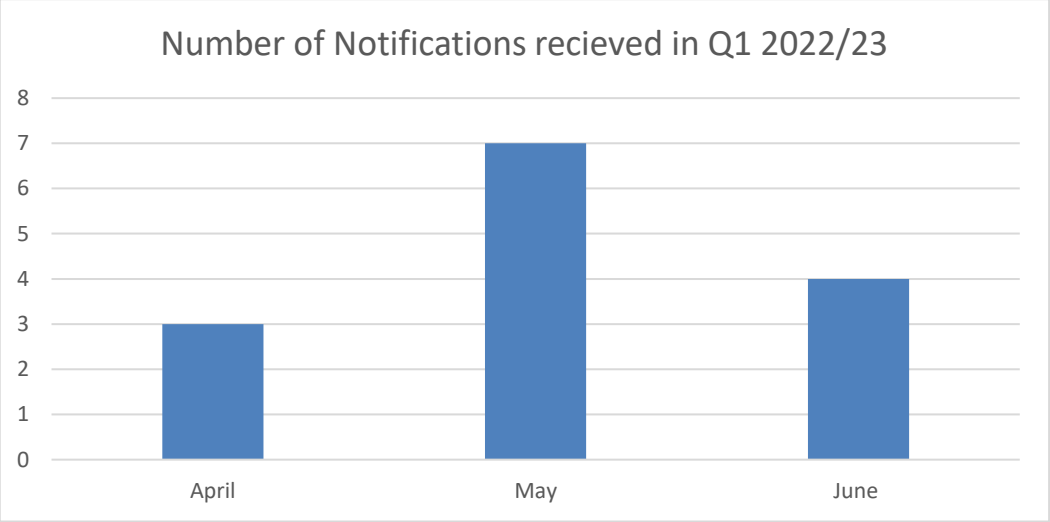
5.180 LeDeR was formed as a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with learning disabilities and/or autistic people.

5.181 LeDeR reviews the deaths of people with learning disabilities and/or autistic people to identify areas of good practice and highlight areas for improvement. A LeDeR review looks at a person's death as well as significant episodes of health and social care relevant to the person's overall health and wellbeing. The information from reviews is then used to improve services both locally and nationally.

5.182 NHS Somerset CCG is responsible for the implementation of LeDeR reviews in Somerset. However, there is system-wide responsibility for implementation of actions from those reviews, which will be led by the ICS going forward.

LeDeR Reviews

5.183 During quarter one (April to June) of 2022/2023 the LeDeR team received 14 new notifications, one of which was considered out of scope.



5.184 Ten reviews were completed by the LeDeR Team during quarter one of 2022/23.

Key Performance Indicators

5.185 NHS England have set two targets against which we are measured:

- requiring all LeDeR notifications to have been allocated to a reviewer within three months of receipt
- requiring all LeDeR reviews to be completed within six months of the notification date.

5.186 Since the completion of substantive recruitment to the LeDeR team and the clearer establishment of our quality assurance and governance processes, the team has consistently met these key performance indicators.

Notable Achievements for Quarter One 2022/2023

5.187 Our achievements as a team are very much led by the learning arising from our reviews and the plan of work identified in our three- year strategy. Notably for quarter one of 2022/23, LeDeR achievements include the following:

- publication of our LeDeR Annual Report in June 2022. This details themes emerging from reviews and the actions being taken forward as a consequence. The report can be viewed here: Learning Disabilities and Autism - NHS Somerset

- initiation of two engagement projects working with people with lived-experience, to improve our governance processes and explore people's understanding of death and dying

- improved compliance with Key Performance Indicators (KPIs) following appointment of the substantive team

- development of the TeamNet Page to share resources and learning with colleagues in Primary Care

Continuing Health Care (CHC) and Children and Young People's Continuing Care[18]

5.188 Continuing healthcare (CHC) and Children and Young People's Continuing Care continue to exceed the national service delivery requirements.

Adult CHC

5.189 Key Performance Indicators set by NHS England for adults referred for CHC have been achieved:

- decisions about eligibility for CHC with 28 days are set at 80% and NHS Somerset CHC exceeds this expectation

- the target to ratify fast track cases within 48 hours has been met following amendments to data reporting tools

Children's and Young People's Continuing Care

5.190 Unlike CHC, there are no current requirements by NHS England (NHSE) to provide assurance reports for activity and spend, and there are no quality premiums against continuing care; therefore, there is no regional or national benchmarking data to support any comparative analysis. As such, data for NHS Somerset CCG's continuing care activitie is limited to local data only, but the caseload and spend remains stable and a service improvement project has been implemented. CHC's aim is to ensure that every eligible patient can benefit from measurably improved outcomes through access to personalised, tailored support and consistent and good quality information, putting the patient in control of how their needs are met.

[18] Some people with long term complex health needs qualify for free social care arranged and funded solely by the NHS. This is known as NHS continuing health care.

5.191 Our programme of transformation has continued into quarter one (April to June) of 2022/23, focusing particularly on the new digital technology available to support the service - moving to using an end-to-end patient management solution, as well as the implementation of the new and national data collection system (PLDS). The positive working relationships with our Local Authority colleagues have also ensured that good quality delivery, financiallyproportionate spend and our interventions in patients' lives continue to be legally robust, with the CHC safeguarding team continuing to drive quality improvements at a local and national level. Regular assurance calls with NHS England continue, to support Somerset CCG' s position as a regional example of good practice and service delivery.

Infection Prevention and Control

5.192 COVID-19 was declared as a pandemic on 11 March 2020. During 2021/22, the NHS Somerset CCG infection prevention and control (IPC) team provided support to primary care and the provider care sector.aThe team also supported the emergency planning team, which conducted daily operational and strategic meetings, and implemented the diversion of infection prevention and control team resources to support incident response. This has continued into quarter one of 2022/23. Somerset CCG works in agreement with the Somerset Memorandum of Understanding (MoU) (2015) that outlines how key partners work together to reduce morbidity and mortality associated with outbreaks.

5.193 Preventing and controlling the spread of COVID-19 continued to be Somerset CCG's infection prevention and control priority throughout 2021/2022 and into 2022/23, responding to variants of concern, eg. Delta and Omicron. The Somerset CCG IPC team continued to work collaboratively across health and social care, communicating and providing training on infection prevention and control measures, in line with national guidance, to be applied within their settings to protect the population against transmission of the virus. This included the provision of training around personal and protective equipment (PPE).

5.194 NHS Somerset CCG IPC key priorities for 2021/22, and into 2022/23, included: deep dive of the methicillin-sensitive staphylococcus aureus (MSSA); blood stream infections (BSIs), and monitoring and reviewing GramNegative BSIs (GNBSIs). A more robust post-infection review (PIR) process was introduced for community-onset / community-acquired (COCA) health care infections, to identify any themes or trends. The themes/trends identified will lead to focusing on quality improvement work across the system.

5.195 The implementation of the anti-microbial stewardship five-year plan and improving IPC measures in care homes, through the creation ofa Somerset Care Homes Infection Prevention and Control Link Practitioner Group workstream, have been identified as a priority for 2022/23. Monitoring continued as part of the Somerset Infection Prevention Anti-

microbial Assurance Committee (SIPAAC) and has been added to the IPC work plan. Notably in quarter one of 2022/23, we have achieved the employment of a consultant pharmacist to work across the Somerset system. The Somerset Anti-microbial strategy is currently under development ensuring we align with the regional strategy.

5.196 During 2020/21 it was identified that nationally there had been a rise in Clostridiodes difficile (C.diff) cases. The CCG IPC team are part of both the regional HCAI CDI Collaborative and the regional IPC Collaborative, the focus of which is to understand the increase in C.diff infections. This includes reviewing the data captured to broaden the scope of risk factor information obtained and reviewing the post-infection review process.

5.197 There has been a reduction in E-coli BSI rates per 100,000 from the benchmark year of the National GNBSI Reduction Strategy, launched in 2017. However, NHS Somerset CCG does remain an outlier, with higher rates against regional peers. In response, a Consultant Microbiologist from Gloucester was employed to provide support to the CCG to continue to drive improvement in 2022/2023. In quarter one of 2022/23, we achieved funding from Health Education England to support quality improvement work relating to reducing urinary tract infections (UTIs), to identify if the impact of reducing UTIs across the system will impact on our E-coli BSI rates. A deep dive in 30 E.coli BSI patients was performed to identify any themes or trends.

5.198 Mandatory Healthcare Associated Infections (HCAI) surveillance is carried out by providers, with the following infections reported on the United Kingdom Health Security Agency (UKHSA) National Data Capture System (DCS) for Healthcare Associated Infection. The following organisms are subject to mandatory surveillance on the UKHSA DCS Portal: MRSA BSIs, MSSA BSIs, C.diff and GNBSIs.

Personal Protective Equipment

5.199 Whilst personal protective equipment (PPE) has always been utilised by healthcare workers and social care personnel, the COVID-19 pandemic continued to require a further level of protection against the virus in accordance with requirements set nationally. Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust PPE requirements were met during 2021/22 and into quarter one of 2022/23 via an online Somerset portal. This process was also in place for our other areas of health and social care. During 2021/22 and into quarter one of 2022/23, NHS Somerset CCG and Somerset County Council continued to work together through a multi-disciplinary team comprising health and Government personnel through a PPE Cell. Its remit was to:

- provide a strategic overview of PPE across the whole Somerset system

- co-ordinate mutual aid requests for PPE once all other sourcing routes had failed (applying when necessary, a risk-based assessment of need approach to inform decision-making)

- ensure the effective management and distribution of the limited stocks received from different sourcing arrangements, including: donations and mutual aid, Local Resilience Forum and locally sourced/purchase items

- signpost to Public Health and SCCG internal resources ie. infection prevention and control (IPC) for specific advice and guidance on PPE

- ensure that communications and reporting processes included internal and external requirements

5.200 Somerset continues to hold mutual aid stocks for those organisations not able to utilise the portal, and will continue to do so, in line with national guidance.

Workforce/Our People

5.201 The complexity of service demand, workforce supply overlaid with the pandemic, and the amount of change happening in our system (NHS Trust merger, Local Government Reform) continue to pose a challenge to Somerset. Our system People Plan and our collaborative working across the health and care system, however, provides a robust response to these challenges, identifying priority actions which focus on eight strategic aims that are aligned to both the NHS and adult social care people plans. These cover:

'Whole system' workforce planning

5.202 Identifying our top workforce shortages and where growth needs to happen to meet our current and future demands. We continue to expand our international recruitment offer to support workforce shortages, including those within social care. We have a good understanding of our current workforce gaps and have developed workforce supply strategies for nursing/midwifery and allied health professional (AHP) roles, and we are expanding the number of trainee pharmacists and pharmacy technicians across all sectors of practice. In terms of developing our NHS Somerset Integrated Care Board (ICB) functions, particularly around population health management, programme management and business intelligence, there is an opportunity to ensure integration of workforce data requirements so we can develop a 'workforce supply dashboard' to provide strategic assurance of workforce sustainability and growth for critical workforce groups across the system.

Social and Economic Growth

5.203 Working in partnership across our system, building on our core purpose as anchor organisations, our work relating to developing sector-based work academies (SWAPs)[19] has had more than 500 referrals since its inception in May 2021. These figures are comparably larger than other ICS' with roles deployed in NHS Somerset ICB, Trusts, primary care networks and social care, meeting our aims around widening participation and improving social mobility across our system. High vacancies in our social care workforce continue to be of concern. We further developed our Proud to Care brand over recent months through targeted marketing and advertising (led by Somerset County Council).

5.204 We have focused on initiatives to improve retention, eg. the implementation of a 'retention bonus' for workers in registered care, and pay uplifts (domiciliary care only) in December 2021. Anecdotal feedback from our care providers has suggested this has improved retention within the sector.

5.205 Youth engagement work has begun in collaboration with Young Somerset and SPARK, with the view of re-designing roles in health and care to make them more attractive to young people, based on their feedback.

5.206 We have strengthened our partnership with the Local Enterprise Partnership[20] and Department for Work and Pensions to deliver system-wide initiatives such as Bootcamps, Restart, and Employment Hubs as new ways to engage and develop the workforce.

Looking After Our People

5.207 Somerset has a strong reputation with internal and external partners for looking after our colleagues. We have an ambitious system-wide Health and Wellbeing Strategy delivering a number of projects, including our Mental Health Resilience Hub, and have partnered with Dundee University to develop our evaluation methodology for the programme. We have extended our offer for primary care colleagues through the Somerset Training Hub to increase coaching provision and sustainability.

5.208 Funding received from NHS England (NHSE) has enabled us to recruit an ICS Retention Lead and a People Promise Manager, both hosted by Somerset NHS Foundation Trust. Our ICS Retention Lead is also the manager of our Talent Hub and has provided an assessment of retention data across the system and identified the primary drivers to improve retention to feed into our system retention plan.

[19] Sector-based work academies (SWAP) help prepare those receiving unemployment benefits to apply for jobs in a different area of work. Placements are designed to help meet employers immediate and future recruitment needs as well as to recruit a workforce with the right skills to sustain and grow a business. SWAP is administered by Jobcentre Plus and available in England and Scotland.

[20] Local enterprise partnerships (LEPs) are non-statutory bodies responsible for local economic development in England. They are business-led partnerships that bring together the private sector, local authorities and academic and voluntary institutions.

Creating Clear Career Pathways and New and More Flexible Ways of Working

5.209 We are developing stronger links with colleges and universities as well as creating more clinical placement capacity and introducing new pathways for education and learning. We continue to work closely with education providers to promote and develop educational offers such as apprenticeships and degree courses, and work with providers and employers to develop other courses such as T Levels. We have received significant funding to improve clinical placements (CPEP), improve Enhanced and Advancing Practice, and to further develop a direct entry nursing associate programme, including supporting nursing in social care

5.210 With NHSE funding we have developed a Somerset Workforce Talent Hub which aims to recruit, retain and develop talented people within our communities – nurturing and preparing our future workforce to work across the health and care system in an agile way. The Talent Hub is managing the Reservists Programme for the ICS as well as supporting a number of other programmes such as SWAPs (Sector Work Based Academies), Mass Vaccination Retention, Career Coaching and work with the Prince's Trust targeting younger people aged 1 -25. The Talent Hub also contains a social care training team, developed during COVID-19 as a result of an identified need to develop the skills of the social care workforce. From April to June 2022, 120 people have been trained, in areas such as gastrostomy, catheter care, simple wound care and sub-cutaneous injections.

Developing System Wide Learning and Development Offers

5.211 We are developing our 'One Workforce' culture through a programme of work to develop a systems leadership competency framework, working closely with the South West Leadership Academy and colleagues from across the whole care system. The framework will describe the knowledge, skills and behaviours needed for our care workforce. Our ambition is that the framework will be integrated with our quality improvement offer, which is already well established in practice, to strengthen our approach to systems' thinking and improvement.

5.212 Work has been commissioned to support the development of the NHS Somerset Integrated Care Board (ICB) to ensure a strong leadership team from the point of establishment. This work is based on the Outward Mindset[21] model. Furthermore, the CCG has put in place an organisational development programme to support the transition from a CCG to ICB.

Creating a More Inclusive and Equitable Culture

5.213 Through work on recruitment and retention – including supporting our system goal of achieving Gold Military Covenant status – and following

[21] The key points of outward mindset model are to: See others' needs, goals, and challenges; Adjust your efforts to become more helpful to other ; and Measure your impact on others and hold yourself accountable for your impact

our work on reviewing our recruitment and promotion practices, we now have a system group focusing on equality diversity and inclusion (EDI). We continue to identify best practice, including sharing training across the system, and have formed a system EDI action plan.

Digital

5.214 The Digital Portfolio has continued to evolve, building on the early foundations of core infrastructure and digital transformation for shared care records. More recently, there have been an expanding network and collaborative working opportunities across Somerset, to understand and address the wider determinants of health through our digital, data and intelligence approach.

5.215 During the last three years, the scale, pace and engagement in a digital first approach has led the focus into a period of digital acceleration. We have needed to consider motivation, capability and opportunity and be mindful of differences in local people and workforce in their curiosity and confidence in the use of digital tools and services.

5.216 The NHS Somerset CCG Digital Team has continued to proudly work on an increased range of programmes and projects during 2021/22 and into quarter one of 2022/23, further extending working with local groups and organisations in Somerset on digital inclusion, as well as linking with neighbouring communities across the South West. We have continued with a #OneTeam approach of matrix working, as both a core behaviour and a core value, always seeking to further develop and engage with clinical, executive, operational and patient groups. Our ethos of 'Clinically Led, Digitally Enabled' has guided us through priority work, whilst maintaining strategic direction.

5.217 The Somerset Digital footprint includes the following core organisations:

- NHS Somerset CCG
- Somerset GP Practices
- Somerset County Council
- Yeovil District Hospital NHS Foundation Trust
- Somerset NHS Foundation Trust
- St Margaret's Hospice
- Devon Doctors Out Of Hours

5.218 Other organisations engaged that are vital to delivery of effective care are:

- Somerset Care Homes
- SPARK Somerset
- Dorothy House Hospice
- Weston Hospice care
- Marie Curie
- Children's Hospice South West
- Practice Plus Group
- Bristol Connecting Care
- Royal United Hospitals Bath
- University Hospitals Bristol and Weston NHS Foundation Trust
- Governing Bodies including Somerset Local Medical Committee (LMC), Local Optical Committee (LOC) and Local Pharmacy Committee (LPC)

5.219 We also continue to expand our engagement and involvement with local people, representative groups and more local community and voluntary sector organisations (such as SPARK Somerset), particularly around digital inclusion and capturing lived-experiences to inform our transformation work. The Digital People's Champion Group has been extended, alongside stronger links established with the CCG Equality and Diversity lead, our Communication and Engagement Team, and the associated networks of local contacts.

COVID-19 Response and Elective Care Recovery

5.220 The digital team has continued to support the ongoing need for remote working in both corporate and GP teams, with flexibility in service locations for the vaccination programme and COVID-19 response activities. This has been essential to provide a safe virtual environment for both patient care services, system-wide planning and operational work.

5.221 In late Autumn 2021, an opportunity arose for digital funding via the Elective Care Recovery programme, and we are working to establish new shared opportunities for digital and data sharing improvements as an Integrated Care System. These projects have continued into the implementation stages during the first quarter of 2022 and include collaborative discussions around Virtual Wards and Care at Home.

5.222 Notably, for quarter one 2022/23, and as of June 2022, we are pleased to note that 117 of our care homes (56%) have achieved the data protection toolkit. We have also continued to steadily increase the number of homes using secure email, which includes NHS Mail or other secure or accredited systems (currently up to 87% of our providers). Digital and Information Governance Team resources continue engagement to understand the need for information sharing in a virtual cross-organisational environment and establishing a virtual platform for multi-disciplinary teams to safely and securely exchange information to support delivery of care services.

Our Digital Core

5.223 The core foundations of our digital portfolio have seen a range of new and continued initiatives, including work on:

- roll-out of MS Teams to the CCG and our 65 General Practices and continuing our developmental work with Microsoft on new ways of working together with the tools required to support virtual team working
- support for online and video consultations across General Practice
- promotion of the NHS App and digital access to primary care through online consultations and GP online services
- supporting technical development of, and promoting, the Think 111 service
-
- engaging with and chairing a Digital Forum of operational leads across partner organisations to share learning and promote good practice
- engaging and working with the Digital People's Champion's Group
- improving social media platforms and communications to the public (via "Your Somerset" the Somerset County Council newsletter, Facebook, Twitter and Instagram)
- ensuring local residents and groups are supported to engage in digital access to services, health records and information
- continuing to fund Health Connections Mendip for employing digital connectors

5.224 In recognition of the role of digital in system transformation, and in support of digital workforce development, the CCG Digital Team a now members of the British Computer Society, The Chartered Institute of IT. This recognises their professional status, skills and experience, and supports their development and potential in enabling transformed delivery of our health and care services.

Digital Inclusion and Digital First

5.225 The COVID-19 pandemic highlighted the divide between those able and willing to access support digitally and those digitally excluded. Big steps forward have been taken, so it is important we continue to move forward with this impetus. With the increased opportunity for thinking 'digital first', we need to ensure a level of equality and equity in access to our health and care services, noting people need capability (access, digital literacy), opportunity and motivation to engage. With the need for a priority focus on digital inclusion requested by the NHS Somerset CCG Governing Body in September 2020, we have continued to build on inclusion work across the digital portfolio, with factors for inclusion considered and regular liaison with the CCG Equality and Diversity Lead, and Engagement Lead, to ensure links are made to relevant forums and community groups.

5.226 Building on our successes for 2021/22 we have achieved the following in quarter one (April to June) of 2022/23:

- the NHS Directory of Services (DoS) have embedded the Somerset Apps Library link on their system and the NHS 111 service has also engaged with us around this tool. We have recorded a podcast for the Somerset Emotional Wellbeing Service and at the end of March 2022, launched a South West social media campaign with Dorset. This will be ongoing throughout the first quarter of 2022/23. Placement for T Level student offered through Bridgwater and Taunton College, due to start September 2022 for 12 months

- GP IT leads have been provided with a checklist for good quality websites, and reviews have been undertaken using this checklist by local Healthwatch volunteers

- the CCG has obtained funded licences for the Digital Unite platform and has made an offer to each Primary Care Network (PCN) in Somerset to enable them to take part in a pilot project, to improve communication and learning between professionals who work to combat digital exclusion, using a proven digital solution. Project licences have now been extended for a further year

- Nine champions across three PCNs have been identified, plus a link with the Frome social prescribing team to train six volunteers. SPARK Somerset are being supported by the Digital Team to maximise the use of Digital Unite: we have funded a role for 24 months for a co-ordinator to support this work. In addition, funding has been provided to create two digital inclusion hubs in Somerset - one at Yeovil and one in Bridgwater

Digital Transformation

5.227 We continue to deliver our Somerset integrated digital electronic record (SIDeR) programme, alongside our technology partner Black Pear, to join up specific records and stakeholder organisations to create a 'single

version of the truth' for direct care. Building on our achievements in 2021/22 these include:

- the SIDeR Shared Care Record (SSCR) is currently live, connecting data provided by Somerset Foundation Trust, Yeovil District Hospital, Somerset County Council Adult Social Care, St Margaret's Hospice and 63/64 GP Practices. SSCR has been used over 200,000 to-date

- in excess of 3,800 End of Life Care Plans have been completed on SIDeR by primary, secondary and hospice care staff

- over 10,000 special patient notes have been created in Primary Care and shared through Black Pear integration of EMIS with the Out of Hours service

- 1,900 acute records have been updated to flag people with a learning disability (LD) and / or autism following formal assessment, to better support them as and when they next present for treatment in a hospital setting

- more than 10,000 Treatment Escalation Plans have been digitally shared with GP Practices

- the Advanced Care Plan primarily created by Marie Curie is now live with nearly 50 plans created

- the NHS Somerset Foundation Trust Open Mental Health Service has three live forms on SIDeR, with over 160 First Contact (referral) forms, 1,750 Dialogue+ (assessment) forms, together with an Update (outcome) form

- User Acceptance Testing for community pharmacy access to the GP record via SIDeR continues, with rollout planned for summer 2022

- work has begun to enable access to EMIS free text and documents via SIDeR

- evaluation of a Patient Information Portal (PIP) model is offered by Black Pear, which could enable cross-population of shared forms and empower patient access to their forms via NHS login

- children's education and social care data will be added in Summer 2022, thanks to support and funding secured from NHS X

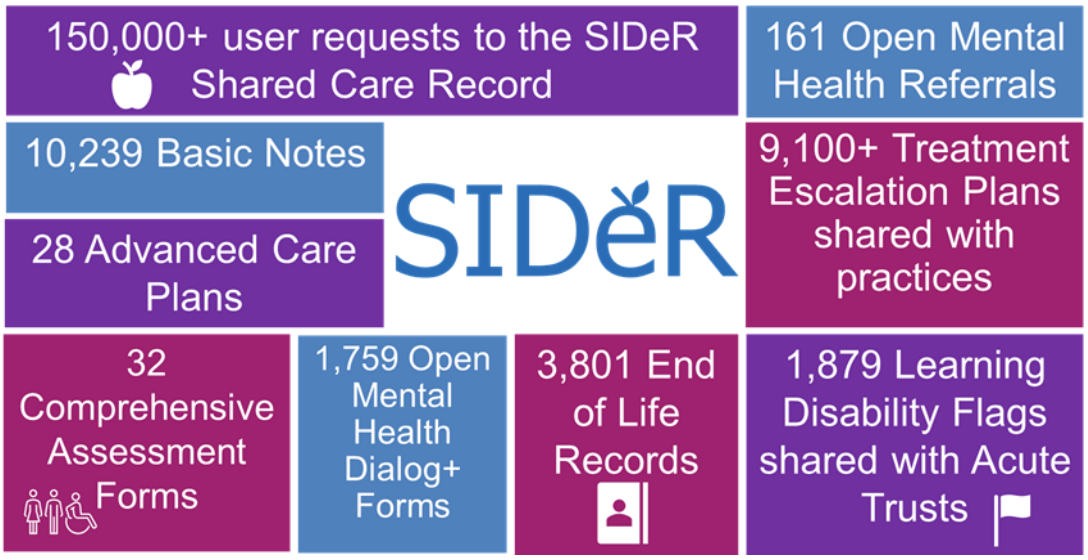
- NHS X has funded the development of a Personalised Care and Support Plan (PCSP), and 'About Me' first person forms, aligned to PRSB standards

- a pilot has started, to support multi-disciplinary team (MDT) working, to enable a number of Somerset Care Homes to access a Comprehensive Assessment Form via SIDeR

- activity has begun to create links to other shared care records and out-of-area GP records, recognising bi-directional patient flow access the Somerset borders

- Somerset FT are working with Black Pear to enable more effective prescribing and medicines' reconciliation through the use of QuickFHIR interoperability services; this will allow medication data to pass between different systems and care settings

- completion of the digital Somerset Treatment Escalation Plan (STEP). This is ready pending clinical adoption into local care pathways and processes



5.228 Other Digital Transformation work includes:

- significant reduction of paper correspondence flowing out of secondary care services into primary care. An example is migration of Talking Therapies correspondence to digital format
- continued engagement with the Digital People's Champion's Group
- improving social media platforms and continued communications to the public (in particular, via "Your Somerset" SCC newsletter, Facebook, Twitter and Instagram)
- assisting with national transfer of care pilot with Dorset County Hospital NHS Foundation Trust
- evaluating and scoping implementation of Transfer of Care using new FHIR standards across Somerset organisations
- working with LPC to embed community pharmacists who will support digital progression between PCNs and other providers

- Yeovil District Hospital has gone live with the Discharge Medicines Service, linked to community pharmacy. Somerset NHS Foundation Trust will go live imminently

- roll-out of the GP Community Pharmacy Consultation Service (CPCS).

5.229 We will soon begin re-procurement of the SIDeR contract, as the existing contract with Black Pear comes to a natural end in 2023. This important work will run in parallel with the active SIDeR programme. It is imperative that all SIDeR stakeholder organisations actively support and contribute to both aspects of work, to continue to support the Somerset Integrated Care System.

Data Security and Protection

5.230 A key element for digital transformation is to ensure that good information governance and safe, secure digital systems are established, such as the following, which took place during quarter one of 2022/23:

- DocuSign as core system for all electronic data and information sharing agreements where CCG and General Practices are involved; this has been completed and is now managed and maintained by Corporate Team

- ongoing promotion of the Data Security and Protection (DSP)[22] toolkit across core and new organisations to support information flow, including new suppliers

- an established focus on cyber security and improvements through the Cyber Security Action Plan, with CCG Governing Body engagement during 2021/22 and the first quarter of 2022/23

- Cyber Security Workshops, internal communications and creation of the Cyber Champions MS Teams group to improve cyber awareness across the CCG. Going forward, the aim is to go out to GP Practices with cyber awareness materials

- projects facilitated by the South, Central and West Commissioning Support Unit to support cyber security risk management

- Endpoint Protector software has gone live with all users across the Somerset CCG and GP estate. This helps to protect the network from unapproved and unencrypted removable media devices

[22] The DSP Toolkit is an online self-assessment tool that allows organisation to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data must use the toolkit to provide assurance that they are practising good data and security and that personal information is handled correctly.

- Privileged Access Management (PAM) software project to restrict administrative rights is in progress within the GP estate and work is in progress to deploy to the corporate estate

- reviewing the starter and leaver process so that the process is completed correctly, to ensure that only authorised persons can access CCG systems

- reviewing acceptable user policy to ensure technology is used correctly. Working with the Information Governance and Corporate Business teams to update both the acceptable use policy and form for users to review on a regular basis

- digital actively review the quarterly software and cyber security reports to ensure the system is consistently reviewed

Digital Connectivity

5.231 One of the key building blocks for successful transformation of services is the provision of reliable and secure technology. During 2021/22 and into quarter one (April to June) of 2022/23, this has remained a core programme, with the following highlights as part of GP IT and CCG corporate IT service delivery, supported by our South Central and West Commissioning Support Unit colleagues:

- N365[23] has been rolled out across CCG and GP estate and new apps and ways of working are being considered. A pilot is underway within the CCG with 20 people trailing two apps each

- continuing to encourage new ways of working and supporting the High Performing Organisation (HPO) team to realise the benefits and advantages N365 offers

- Axe the Fax work is completed, and we are actively reviewing with all partner organisations

- continuing to route electronic messages via MESH (National data standard). We are linking with the contracts team to support them in ensuring providers are meeting their NHS contractual requirements

- community and mental health inpatient settings are now paper light across the Somerset system

- continuing to contribute to regional discussions relating to the 'One South West' Local Health and Care Record Programme

- enabling development of digital skills / capabilities in the workforce through a range of projects and training

[23] The N365 programme is the implementation of Microsoft Office 365 across the NHS

Digital Social Care and Care at Home

5.232 During 2021/22, there was considerable growth in work required to support a system-wide approach to care provision, with a key requirement for connectivity and information sharing across health and social care, and the more direct provision of care to people in their own homes. During quarter one of 2022/23 we have continued our work to embed an effective digital social care programme, by promoting digital maturity within care homes, domiciliary care and other CQC-registered social care providers. Alongside this we have explored and begun to measure the benefits of our Care at Home pilot projects, enabling people to stay in their own homes, be supported in access and use of digital tools, that enable remote monitoring and self-managing of health conditions.

5.233 Of note for quarter one (April to June) of 2022/23, the following initiatives in collaboration with Somerset County Council, are highlighted:

- significant progress has been made in rolling-out proxy access to care homes, providing hands on support to get systems in place for homes. As of July 2022, we have achieved significant roll-out across four of our 13 primary care networks, with plans to use this success to rollout peer-led best practice approaches to the others in the near future

- as an example of this success, in one of our Primary Care Network areas (Tone valley) we have supported 24 of the 27 homes to implement proxy ordering of medications. The benefits of this are already being felt in the PCN in terms of time saved for GP and care home staff, and better service for residents

- implementation of a digital tool to support people with a learning disability to better manage their wellbeing outcomes and improve the quality of the LD annual health check. An evaluation of this pilot is planned for August 2022

- implementation of home monitoring via MiiCare for patients living with symptoms of mild dementia, to enable them to stay in their own homes and to provide proactive care before clinical problems or adverse events occur, particularly supporting discharge to assess services. Thirty systems are in place in the homes of people, many of whom are being supported post-discharge to maintain their wellbeing and avoid readmission. Case studies of five individuals who have achieved significant benefits are being collated and will be used to examine how MiiCare could be used within our system, at scale, in future

- improved digital support for people living with a learning disability, mental health condition or autism to manage their anxiety. Seventy people are being supported using Brain in Hand to manage anxiety and maintain their wellbeing this year. We are exploring how to

continue provision and funding of Brain in Hand for clients within Somerset in future, as we move to ICS system working

- provision of digital inclusion to support to people most at risk of digital exclusion via a co-ordinated group of inclusion champions which span Health Connections Mendip, SPARK Somerset, Somerset libraries, the voluntary, community faith and social enterprise (VCFSE) groups and Yeovil Primary Care Network (PCN)

- working with our libraries to fund and promote the provision of iPads and data connections for 12 months to any Somerset resident who wishes to use technology to improve their wellbeing but lacks resources to access support

- implementation of the Comprehensive Assessment Form to improve multi-disciplinary team (MDT) working with care home residents

- continuing to fund Health Connections Mendip for employing Digital Connectors

- employing four Digital Outreach Team Communicators to work county-wide, following the successful pilot project across the Taunton PCNs, to promote digital tools to the public and educate Practice staff on enabling and encouraging the Digital First approach, with plans to recruit two more

- enabling HSCN access to Somerset Care Homes, piloting the Comprehensive Assessment Form

Data Analytics and Population Health Management

5.234 The first quarter of (April to June) 2022/23 has seen us continue forward with the primary care data analytics programme, with an initial focus on GP data, working with and supporting General Practices. We continue to work with Somerset Local Medical Committee (LMC) and GP leads to explore and extend the use of EMIS enterprise search and reports, to support and streamline analytics for required data returns. A key application has been for the COVID-19 vaccination programme, developing and running searches on behalf of all Practices, to identify relevant cohorts of the population to be invited for vaccination. This process continues with some automation and new searches created in response to national and local plans.

5.235 To extend this functionality, plans are underway to replace the historical use of MIQUEST for physical health-checks for people with severe mental illness searches, which are starting to run centrally to reduce the burden for Practices. Further plans and priorities are also being scoped to address other requests over the coming year, working alongside colleagues in primary care, business intelligence, safeguarding, women and children's teams in the CCG.

5.236 Early discussions are underway with Somerset Local Pharmacy Committee as part of our ongoing digital engagement work to include community pharmacies as part of the growing primary care analytics programme.

5.237 During 2021/22, there has been a significant shift in recognition for the need for a population health management approach (PHM) as we develop as an Integrated Care System (ICS), and this continues in 2022/23. The focus has been on Data and Information Governance Readiness for the Optum PHM Development Programme, for which it has taken time to develop our local delivery model. Action Learning Sets have been established for System, Place, PCN and Analytics to begin to investigate the findings from the Optum Development Programme analysis and to identify the actionable insights to be implemented.

5.238 The need for data and PHM approach is now established as a core requirement for Somerset, notably as part of the Operational Plan and ICS Development for Digital, Data and Intelligence. National and local models of delivery for Somerset continue to be explored, with clear involvement across all organisations in our ICS. This work will form a significant strategic programme for 2022, in a similar way to how SIDeR for shared care records for direct care was developed and implemented over the last five years. This will build on the previous data strategy, noting key themes of people (analytics skills across workforce), place (whole system, community and cohorts), process (governance and access) and technology (tools and systems), with a collaborative approach to joining data sets, shared analytics and actionable insight.

5.239 To achieve the ambitions, it is anticipated that an over-arching intelligence function will enable a #OneTeam approach to engaging key leads in collaboration with shared purpose. A new strategic plan and development of a population health transformation programme, with development of skills for analysts and non-analysts to share in discussion and application of data, intelligence and insight.

5.240 Notable progress has been achieved during 2021/22 across these themes, with continued commitment to COVID-19 related demands and establishing new foundations for GP analytics and system-wide population health management PHM approach,. For Quarter one of 2022/23 the following is highlighted:

- maintained analyst leads forum to explore strategic data discussions, priorities and share requests and learning as an Integrated Care System (ICS)

- extended use of artificial intelligence for predictive analytics to support multi-disciplinary team in four PCNs to improve direct care and care planning through BRAVE AI tool

- growth in use of EMIS Search and Reports, notably for the mass vaccination programme and national reporting requirements

- development of PHM approaches being embedded within the forming ICS

- ongoing commitment to expanding and developing GP analytics alongside the Local Medical Council (LMC) and Primary Care Network (PCN) leads.

Estates

5.241 The wider Somerset Integrated Care system (ICS) has in place a mature Strategic Estates Group, which includes representation from Providers, CCG, Somerset County Council, NHS Property Services and NHS England. The group meets regularly to push forward the ICS Estates Strategy. The overarching aim of the estates strategy is to enable development of a modern, functional estate that can support the delivery of new service models that is aligned to capacity and demand modelling predictions, enabling better delivery of care for patients through a modern, fit for purpose estate.

5.242 The principles the group and estates strategy are founded on are that Somerset's estates will:

- work for the people that use them
- help to deliver our clinical strategy
- be safe, well maintained, effective and welcoming
- support our aim to value all people alike
- reflect our design aspirations

5.243 This commitment will be delivered through all organisations ensuring that the following principles form the basis for the management and planning of current and future estate:

- ensuring that the health estate meets the objectives of the clinical strategy through promoting safe, effective, high-quality care delivered in the most appropriate setting and through enhancing health and wellbeing

- ensuring that the health estate promotes colleague wellbeing and productivity

- ensuring the current health estate is fully and effectively utilised and reducing estate where it is not required or not cost effective to maintain

- ensuring that current health estate is fit for purpose

- reducing the running costs of the health estate to enable better use of resources including promoting sustainable practices

- ensuring that future estate planning is centred on these guiding principles.

5.244 The work programme focusses on:

- supporting the Fit For My Future health and care services strategy review, system alignment and enablement of Long Term Plan delivery
- oversight and monitoring of capital delivery programmes (New Hospital Programme £450m, STPW1-4b capital £98m), along with other smaller centrally and locally funded programmes
- development of a primary care estates strategy and forward capital pipeline
- development of the estates strategy to ensure that it incorporates the ongoing review of services across all the community, mental health and acute services
- system wide prioritised capital pipeline to support future funding opportunities
- working towards a Net Zero Carbon NHS Estates, including ensuring delivery through Modern Methods of Construction, standardisation of design and intelligent procurement
- oversight of estates efficiencies initiatives in line with requirements from Lord Carter review
- disposal of surplus land with a view to reinvest proceeds in local NHS wherever possible
- optimisation of gains through Section 106 and Community Infrastructure Levy
- working with partners across Somerset through the Integrated Care System (ICS) and One Public Estate Programme
- reviewing and updating the ICS Estates Strategy.

5.245 The projects to implement the re-provision of new theatre and critical care facilities and an acute assessment and ambulatory care centre on the Musgrove Park Hospital site have continued. The existing facilities are provided from outdated buildings that require investment in order to provide compliant premises. Somerset NHS Foundation Trust were successful in obtaining funding of £83.5 million through the Wave 3 ICS capital bidding process and the full business case has been approved by NHSE/DHSC. In addition, they were successful in the wave 4 ICS capital bidding with a proposal to centralise acute assessment and ambulatory care services on the Musgrove Park Hospital Site (£11.5 million). This scheme has been prioritised as it is not subject to the Health and Care Strategy outcome and consultation. Furthermore, the scheme supports delivery of recurrent savings across the ICS. Construction on both

schemes commenced in August 2020 and have continued with the Acute Assessment Hub due for completion by the end of 2022 and the surgical centre due for completion in Autumn 2024.

Sustainable Development

5.246 NHS Somerset CCG adopted a system wide Somerset ICS Green Plan 2022-2025 at its Governing Body meeting on 31 March 2022. The Somerset Integrated Care System (ICS) recognises the climate emergency and is committed to achieving the national NHS target of net zero by 2040 and contributing to the goal of making Somerset a carbon neutral County by 2030. The Green Plan sets out how the system would work towards delivering the targets of the national strategy 'Delivering a 'Net Zero' NHS'. The Plan sets out the follow priority areas for the coming years:

- leadership and governance: how this Plan will be delivered
- awareness and engagement: it is critical that we engage with our employees to deliver this Green Plan
- sustainable healthcare: how our services will evolve to meet the sustainability challenge
- public health and wellbeing: how improved public health will mean a smaller carbon footprint
- estates and facilities: we will aim for net zero carbon emissions and zero waste from our estates
- travel and transport: we will aim for net zero carbon emissions for all aspects of travel relating to NHS
- supply chain, procurement and commissioning decisions: how we will drive sustainability down through our supply chain and commissioned services
- adaptation and offsetting: we will prepare for locked in climate impacts and offset or inset our residual carbon emissions once we have reduced them as far as possible
- decarbonisation through digitisation: a cross-cutting theme of this plan.

5.247 In Somerset, we have made some good progress on sustainability. NHS Somerset CCG has led the way on prescribing Easyhaler®, the first certified carbon neutral inhaler. Frome Medical Practice and Primary Care Network (PCN) has received a national award for Sustainability from the Royal College of General Practitioners (RCGP) three years running and is regarded as a forerunner in primary care sustainability. Our two

Hospital Trusts have developed a joint green plan setting out how they will meet national NHS targets.

5.248 We have continued to support its commitments as a socially responsible employer. This includes initiatives to:

- support the cycle to work scheme which also helps to improve the health and well-being of staff as well as supporting initiatives amongst staff to increase walking and running
- help the national NHS target of reducing carbon emissions through employee travel
- work with the waste management service provider to increase the amount of recycled materials and promote these opportunities with our staff
- reduce the use of printers and consumables and promote a paperless environment and ensure recycling of the printer consumables through the service provider
- continue to integrate the principles of sustainability across the organisation, including reducing use of single use plastics where possible
- recycle our electrical and IT equipment
- promote greater flexible working from home and use of technology to reduce travel across the county.

5.249 The requirement to work from home has introduced new ways of working at pace which have been found to be both effective whilst also helping to reduce travel and other consumables. The aim is to take the learning from the pandemic and build it into our strategies moving forward.

Engaging People and Communities

5.250 This section describes our commitment to engage people and communities and shows how we discharge our duty to engage and involve under Section 14Z2 of the Health and Social Care Act 2006 (as amended 2012).

5.251 NHS commissioning organisations have a legal duty under the National Health Service Act 2006 to make arrangements to involve the public in the commissioning of services for NHS patients (‘the public involvement duty’).

5.252 The voice of the patient and public should be at the heart or everything we do. We are committed to taking into account the views and ideas of patients, carers the public and staff, working across health and care, community and voluntary services. Our intention is always to develop

potential solutions to challenges and opportunities with local people, so that the services we commission can be truly responsive to the people and communities who use them and the staff and partners who deliver them.

5.253 During 2021/22 and into quarter one of 2022/23 we have been working on developing the NHS Somerset ICB engagement strategy – working with people and communities. The strategy builds on our existing good work and learning and outlines how we aim to develop this as we move to an ICB and Integrated Care System.

5.254 Working with stakeholders across Somerset we developed our ten principles for effective public involvement. These principles build on the ten principles outlined in the working with people and communities section of the ICS design framework by NHS England and Improvement.

5.255 Somerset ICS ten principles of working with people and communities:

1. Put the voices of people and communities at the centre of decision making and governance.
2. Understand our community's needs, experience and aspirations for health and care, with a strong focus on underrepresented communities.
3. Involve people at the start in developing plans and feedback how their engagement has influenced decision-making and ongoing service improvement, including when changes cannot be made.
4. Ensure that insight from groups and communities who experience health inequalities is sought effectively and used to make changes in order to reduce inequality in, and barriers to, care.
5. Build relationships with underrepresented groups, especially those affected by inequalities, ensuring their voices are heard to help address health inequalities.
6. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.
7. Through partnership working, co-production, insight and public engagement address system priorities in collaboration with people and communities, demonstrating accountable health and care.
8. Use community development approaches that empower people and communities, building community capacity.
9. Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
10. Learn from what works and build on the assets of all ICS partners – networks, relationships and activity in local places - to maximise the impact of involvement.

Somerset Engagement Advisory Group (SEAG)

5.256 SEAG continued to meet to check and challenge our commissioning decisions, plans and engagement. Gillian Keniston-Goble, Manager at Healthwatch Somerset, is the Independent Chair of SEAG.

5.257 Members have been asked for their views on a number of programmes of work including:

- the future shape of SEAG meetings
- Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust merger
- insights on our continuous engagement plans
- a thematic overview of our PALS insights.

5.258 We have also continued to work with our SEAG members to better understand the impact that the COVID-19 pandemic is having on our communities and work in partnership to address inequalities. This has included partnership working to promote and deliver the COVID-19 vaccination programme.

Somerset Citizens' Panel

5.259 Our Citizens' Panel[24] launched in 2020. The panel offers an opportunity for people across the county to get involved in our engagement work and have their say. The panel helps to ensure that the voice of the local population is heard and influences developments. Some of the activities a member may be involved in include: filling in a survey, attending a focus group (in person or online), or giving feedback on proposed changes to healthcare. By sharing their views, members help us to provide better quality care in a way that matters the most to local residents.

5.260 We have continued to focus on the development and ongoing recruitment to our Somerset Citizens' Panel. Using insights from the Citizens' Panel and learning from other areas, we are redesigning and developing our Citizens' Panel website.

Carers Strategic Partnership Board and The Carers' Engagement Service

5.261 In partnership with Somerset County Council, Healthwatch Somerset, and voluntary and community sector organisations, we formed a multi-agency partnership. The partnership brings together key agencies that commission and deliver services supporting unpaid carers in Somerset. The partnership works to ensure that the voice of the carer is used to develop services, and that key agencies work together to ensure that unpaid carers support is joined up.

[24] Somerset's Citizens' Panel are a group of local residents who volunteer to share their experiences and ideas on local health and care services.

5.262 Somerset County Council and NHS Somerset CCG have jointly commissioned a carers' engagement service. The carers' engagement service supports and empowers a broader range of individuals from the unpaid caring community in Somerset to have their voices heard by the commissioners and deliverers of health and care services.

Our Patient Advice and Liaison Service (PALS)[25]

5.263 Our Patient Advice and Liaison Service (PALS) offers advice and support to patients, their families and carers. We listen and respond to concerns, suggestions or queries. During the pandemic our PALS has adapted to ensure that patients, carers are families have been able to access the support they require.

5.264 We continued to listen to stakeholder and public feedback about the COVID-19 vaccination programme and provided people with answers to their questions and communications they can share. We used these queries and feedback to develop our communications and responses to frequently asked questions.

5.265 In Quarter one (April to June) of 2022/23 our PALS supported 147 people to find the information they needed about NHS services and COVID-19 vaccinations in Somerset.

5.266 The PALS team works closely with our patient safety and primary care colleagues to ensure PALS reports are shared. Learning from PALS is used to inform our wider engagement, commissioning decisions and improve the patient experience.

Engagement Bulletin

5.267 Our weekly engagement bulletin has 480 subscribers. The bulletin provides details of engagement opportunities and shares relevant information from our partners. Throughout the year we have reviewed and refined our bulletin to ensure the content is informative and engaging.

Engagement support to GP practices

5.268 The CCG engagement team supports GP practices and Patient Participation Groups (PPGs)[26] to engage with their practice population about changes and developments such as branch closures, staff changes and premises developments. In addition to our weekly GP bulletin, we also provide communications resources for our practices to utilise to support them in their communications to their patients. This includes social media resources available on our website.

[25] The PALs offers confidential advice, support and information on health related matters. They provide a point of contact for patients, their families and their carers.

[26] A patient participation group is a group of patients, carers and GP practice staff who meet to discuss practice issues and patient experience to help improve the service. Since April 2015, it has been a contractual requirement of NHS England for all GP practices to have a PPG and to make reasonable efforts for this to be representative of the practice population.

5.269 In Somerset, we have a county-wide network of active PPG Chairs who meet on a bi-monthly basis. The CCG continued to support and work with our PPG Chairs' Network, which continued to meet virtually.

Working together

5.270 We continued to work closely with a number of local organisations. They play a significant role in helping us to reach out to our local communities and groups, sharing insights, providing information and opportunities to be involved. The community and voluntary sector plays an important role in enabling meaningful public engagement to help shape services and improve health outcomes for the population of Somerset.

5.271 NHS Somerset CCG continued to work with Healthwatch Somerset to discuss and inform our engagement work. We have partnered with Healthwatch on several projects this year, including West Somerset same day urgent care engagement. Healthwatch Somerset also share their reports with the CCG which helps us better understand our local population and provides insights regarding health and care services in Somerset.

5.272 We continued our funded agreements with Spark Somerset and Diversity Voices to support our engagement work. Close working with these organisations enabled us to actively promote opportunities for involvement to their members, supporting us to reach communities we do not engage with enough.

5.273 We are members of the Consultation Institute. They are the best practice institute for public consultation and provide us with specialist engagement advice and guidance.

Involvement Opportunities Quarter One 2022/23

5.274 Public engagement to support specific programmes, enabling the public to have their say to improve and inform services, was undertaken. We were mindful of the changing restrictions due to COVID-19 and the continued need to communicate and engage in different ways. We worked with our NHS partners, Somerset County Council and our voluntary and community sector organisations to publicise our engagement activities.

5.275 Opportunities to get involved are promoted via our Citizen's Panel, the engagement bulletin and the CCG website. We continue to grow our social media presence to engage and promote opportunities to have your say to a wide audience.

5.276 Engagement highlights in Quarter one (April to June) of 2022/23 include:

- as part of work on the transformation of hyper acute stroke services we held two public and patient stakeholder reference groups. The provided the group with an opportunity to provide insights and feedback on the programme of work and the developing solutions.

We have also gathered further insights from people with lived experience and community organisations to further inform this work

- 449 people completed our survey providing feedback on the community pharmacy consultation service in Somerset. The feedback has been analysed and the insights report has been shared with the programme team for consideration

- we joined Healthwatch Somerset on their roadshow to engage with local people. The roadshow visited community venues across the county. Healthwatch Somerset gathered feedback on GP websites and digital access and asked people what health and care issues matter to them most. We asked for feedback on our community pharmacy consultation service.

5.277 Feedback received from public engagement and consultation is reported and heard at multiple levels of the CCG's governance structure, from sub-committees and boards up to the Governing Body. These reports promote discussions, ensuring patient and public voices influence decisions about the development and commissioning of services.

5.278 NHS Somerset CCG Governing Body holds meetings in public on a bi-monthly basis. For each Governing Body meeting we produce a communications and engagement report which highlights the engagement which has taken place.

5.279 Our engagement team advises the CCG on active ways to engage our local community; seek feedback on services, plans and proposals; and ensures that the CCG complies with current legislation relating to engagement. To support our colleagues to carry out meaningful engagement, we developed and ran equality and engagement internal training sessions to support staff to undertake engagement activities. We also developed key templates and documents to share with colleagues to support them when carrying out engagement activities.

Health Inequalities

5.280 In Somerset, as nationally, COVID-19 has further exposed some of the health and wider inequalities that persist in our population. Recovery across our health and care system has focused and continues to be planned in a way that inclusively supports those in greatest need, through working with communities and our NHS Trusts, Somerset County Council and other partners through the equality, populational health management and health inequalities workstreams.

5.281 To better understand the scope of our challenge in tackling health inequalities, we have gathered insights and intelligence, as listed below:

- scoped current access and uptake to both urgent and planned services by Index pf Multiple Deprivation (IMD) score for Somerset

- applied population health management methods using primary care records to identify at risk individuals of health inequalities (South Somerset pilot)

- reached out to migrant, homeless and traveller communities in offering preventative health interventions, including COVID-19 vaccination

- provided unconscious bias training to midwives to enable our maternity services to be more accessible to black, ethnically diverse parents and LBGTQ+ communities.

Work on the Social Determinants of Health and Anchor Institutions in Somerset

5.282 It is recognised that 80% of health and wellbeing is attributable to the wider determinants of health (education, housing and employment).

5.283 In Somerset, we have created a sector-based work academy programme (SWAPS) for health and care. SWAPS provides an entry level to clinical and non-clinical employment opportunities at Agenda for Change Band 2 or 3 level.

5.284 SWAPS consists of two weeks training with Weston College (virtually) and week 3 is spent with Somerset NHS Foundation Trust in Taunton. Future employees complete virtual and face-to-face training that will provide them with the foundation skills needed to enter the NHS. Depending on future employees' interests and goals, SWAPS can include but is not limited to:

- roles within administration and logistics
- patient facing roles such as health care assistants and support workers
- roles within the COVID-19 vaccination service
- roles within our primary care networks (general practice and pharmacy)
- roles within our wider health and social care system (such as home care in the community)

5.285 With regard to health inequalities and the offer of employment opportunities, we are working with employment hubs across the county, including Somerset West, Taunton and Sedgemoor District Councils to facilitate virtual events to promote and improve access to the SWAPs programmes for potential candidates in these areas. These include some of our most deprived communities. We are also running similar events for tenants within Abri Housing Association.

5.286 As a Somerset health and care system, we want to take the opportunities we have available to us as some of the largest employers in the county to become anchor institutions during 2022/23. This work will include:

- supporting our Somerset-based small and medium sized organisations with provision of goods and services opportunities. We want to become social value-based organisations

- building on the SWAPS model, continue to target those who are subject to inequalities in offering employment opportunities

- use our land and buildings as community assets for local populations, including green social prescribing offers

- create stronger partnerships with communities, use of community assets and grants to support people on preventive health. To do this in an effective, meaningful, and sustainable way, will require active collaboration and co-production with local communities, some of which we will do through working alongside our voluntary, community and social enterprise partners

Maternity Continuity of Care

5.287 Every parent and their baby in Somerset should have the opportunity to live a full and healthy life. Maternity care provides a window of opportunity to mitigate some of the factors that perpetuate health and social inequalities and to contribute to improvements in population health. This can be achieved through:

- early identification and intervention in cases of clinical or social concerns

- promotion of positive health behaviour change

- provision of information, care and support necessary for recovery from birth

- advice and support for good parenting

5.288 During 2021/22 we developed our Maternity Equity Strategy (which was published in September 2022) setting out how every parent accessing our maternity care should have a fair and just opportunity to have a healthy pregnancy and a healthy baby. Where you live, what race/religion you are, what your living circumstances are, should not affect how you are treated or how you access care.

5.289 Our aim is for a safe, personalised, physically and mentally healthy pregnancy with a safe birth, healthy parent, and baby for all. This includes parents from black, minority and ethnic communities and those from deprived communities.

5.290 Yeovil District Hospital NHS Foundations Trust's maternity service has championed the delivery of a training programme to midwives to help understanding of implicit bias and care of Black and Brown babies. This training programmed has been commended nationally and was presented

at the National Maternity and Midwifery Festival. We are in the process of rolling-out this training across Somerset.

Restoring NHS Services Inclusively

5.291 To reduce the number of patients waiting over 52 weeks for planned surgery or treatment we have carried out analysis to better understand the needs of our population against those waiting for planned surgery/treatment. From this analysis we plan to do the following:

Peri-operative Care

5.292 Additional staff are being appointed to expand our Somerset peri-operative pathway service. The pilot project was established in 2021/22 with the aim of optimising patients for surgery to improve outcomes, reduce length of stay and provide alternatives to surgery for those where the risks outweigh the benefits.

5.293 During the first year at Somerset NHS Foundation Trust, it was identified that a relatively high proportion of patients have anaemia or uncontrolled diabetes. The intention is to intervene earlier in the surgical referral pathway to ensure patients are fit and ready for surgery.

Applying composite risk factor for patients on the waiting list

5.294 Our system has an active programme of work on health inequalities which aims to understand how patients in Somerset are accessing health care. We know that patients from more socially deprived areas are more likely to present via emergency departments than those from the least socially deprived and are also more likely to not attend appointments. Analysis is underway to identify potential drivers, so that interventions to improve access can be co-designed.

5.295 We are developing a set of composite risk factors for patients on the surgical waiting list, which will include measures of social deprivation, mental health and co-morbidities. The score will indicate the extent to which a patient's surgical outcome or wellbeing will be negatively impacted by delays. We will use this risk score to expedite patients' surgery ahead of their otherwise clinically equivalent cohort.

5.296 The wider Somerset system is also supporting military veterans in accessing healthcare, with the Gold and Silver standards having been achieved at Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust respectively.

Equality Impact Assessments

5.297 We have had a long-standing process around the production of equality impact assessments (EIA) to ensure that any negative impacts on minority or vulnerable groups, and the protected characteristics under the Equality Act 2010, are avoided or mitigated. Historically, this process has been

undertaken by way of an understanding that this will be part of any activity to introduce, change or terminate a given service. In June 2021, we received approval for a policy to underpin this requirement, which is designed to ensure we are compliant with our Public Sector Equality Duty (PSED). To complement the policy, we have designed a training package for colleagues to incorporate both PSED (and other equality duties) along with our requirements to engage with public and colleagues.

Engagement to Further Address Inequalities

5.298 The following is a summary of engagement events and work to address health inequalities we have undertaken during quarter one (April to June) 2022/23.

Refugees and asylum seekers

5.299 Somerset County Council formed a working group looking specifically at the needs of Somerset's refugee and asylum-seeking communities. This focuses on various needs, such as housing, family, etc. This working group also looks at many aspects of health such as access to primary care, pharmacists, etc. We are a member of this group to represent health and have also arranged for Healthwatch Somerset to attend.

5.300 The formation of the Refugee and Asylum Seekers Working Group was particularly timely as the national government's resettlement scheme (which was implemented specifically to support Syrian migrants) has recently come to an end. It is being replaced by a new scheme which widens its scope to include other countries in addition to Syria. We work closely with Somerset County Council through this group to ensure that anyone arriving in Somerset is supported in accessing services.

Afghan resettlement

5.301 We continue to work with our partners at Somerset County Council and the four District Councils to support people moving to Somerset under the government resettlement schemes for Afghan nationals. Somerset has seen a very low number of people as it does not currently have any Bridging Hotels (temporary accommodation for people arriving in the UK). Placements into more permanent accommodation in Somerset have also been relatively low. We continue to monitor this and are prepared should the position change and we see higher numbers of people arriving in the county.

Ukrainian guests

5.302 Somerset had one of the highest number of people and families opening their homes to Ukrainian guests. Arrivals are managed by Somerset County Council and we have worked with them to ensure that the health requirements are met for those arriving. This has included a specific clinic for Ukrainian guests which launched in June 2022. This clinic was GP led, with health assessments undertaken by a nursing team.

5.303 We have created a central resource of information for all GPs using the TeamNet platform, which guides GPs to national and local information to ensure support is available to staff and patients.

Training

5.304 We have continued to provide training on equality impact assessments (EIAs) and have now extended this to include engagement to ensure that our EIAs are fully informed in terms of barriers (both perceived and actual) and that experiences are considered.

"Lunch & Learn" sessions

5.305 Earlier in the year we launched our monthly "lunch and learn" sessions. These are designed as taster sessions for colleagues across a range of topics. We will continue to hold these in 2022/23.

Gypsy, Roma and Traveller (GRT) Communities

5.306 With the step-down of COVID-19 response cells within the county, we have been considering the future of the Cell that was created for transient and nomadic communities. The Cell has representation from Somerset CCG, all District Councils, Somerset County Council, the Gypsy Liaison Service, Avon and Somerset Police, and Devon & Somerset Fire Service. There is an appetite to continue with the working group to retain the traction gained around temporary sites, approaches to enforcement, access to health, fire safety, and much more.

GP Access Cards

5.307 GP access cards is a national initiative to improve people's experiences of registering with a GP where they do not have an address, proof of ID or evidence of their immigration status:

5.308 These cards are being delivered to local Healthwatch organisations to be distributed. We are now able to access our own supply of these cards directly from the provider. These continue to be given to our homeless population, Gypsy, Roma, Traveller (GRT) communities, sex workers, refugees and asylum seekers, and anyone who might find barriers to registration. We have provided information to primary care around the existence of these cards in case someone arrives to register and produces one.

Cancer Inequalities

5.309 Our Cancer Transformation Project has been undertaking work to look at where inequalities exist in terms of diagnosis and treatment of cancers. They have established which communities see poorer outcomes or barriers in engagement with cancer services and are initially focussing on three areas:

- Learning disability
- Mental health
- Autism

5.310 Our aim is to better understand the needs of each of these through proactive engagement with the communities and to use these findings to remove barriers or perceived barriers to ensure that everyone receives equitable access to appropriate treatments. The plans are to widen this work to look at other areas of concern, for example, lesbian, gay, bisexual and/or trans (LGBT+), Gypsy, Roma and Traveller (GRT), and many more.

Advancing Mental Health Equality

5.311 Somerset NHS Foundation Trust has commissioned the Royal College of Psychiatry to run a project to look at how mental health services in Somerset can be made more inclusive for minority groups and communities that are known to experience poorer outcomes. The Group has representation from statutory services and community providers and will run for three years.

5.312 The Group has reviewed each group and collectively decided that the Gypsy, Roma and Traveller (GRT) communities were to be its first focus, and in particular, early intervention and suicide prevention specifically in respect of GRT men.

5.313 Working with national GRT community and charitable organisations, we are looking to provide a list of recommendations to SFT on how to improve engagement with services and how to retain people for the duration of their treatment.

5.314 The project group had agreed that another focus area would be LGBT+ and a sub-group was formed to take this work forward. However, there were a number of failed starts with this group as representation from the public fluctuated making it difficult to make any progress. This sub-group has been paused with a view to changing the approach. It will be restarted over the coming months.

5.315 The third area of focus is rural communities, beginning by looking at the challenges faced by our rural residents, including agricultural workers. A list of priorities is being drawn up by the sub-group and work should be underway soon to begin tackling these.

Emergency Planning

5.316 All NHS organisations work together with the emergency services and local authorities to overcome potential disruption to civil life caused by major incidents, outbreaks of infection, severe weather or acts of terrorism. The responsibilities for emergency planning are set out in the Civil Contingencies Act 2004, Section 46 of the Health and Social Care

Act 2012 and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

5.317 NHS Somerset CCG is part of the Avon and Somerset Local Resilience Forum and the Local Health Resilience Partnership (LHRP) that covers Bristol, North Somerset, Somerset and South Gloucestershire. Planning is co-ordinated through the LHRP and we have been an active member of both the executive and tactical steering groups. We have worked in partnership with NHS England during 2022 to ensure there was a co-ordinated response to escalation pressures and emergency planning by health services in Somerset. In addition, organisations across Somerset work closely together to ensure that plans are as integrated and effective as possible. We have been working closely with NHS England to manage the transition of the CCG into an ICB from a Category 2 to Category 1 responder.

5.318 Our CCG has emergency response plans in place, which are fully compliant with the NHS England Emergency Preparedness, Resilience and Response Framework 2015. We regularly review and makes improvements to our incident response and business continuity plans and there is a programme in place for regularly testing these plans, the results of which are reported to the Clinical Executive Committee and Governing Body. We carried out our annual self-assessment assurance process with NHS England to assess our plans and procedures and we met with our two key providers to review their plans. We were assessed as being fully compliant with the standards, and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust were both assessed as being substantially compliant. Assurance was provided to NHS England between April and June 2022 in terms of the readiness of the organisation to become a Category 1 responder and assume responsibilities for the system from NHS England.

5.319 The focus of the Somerset emergency planning and preparation during the first quarter of 2022/23 has been concentrated on supporting the significant system pressures across health and social care, developing plans and exercises for cyber attacks, and the planning and response required for the Glastonbury Festival which was held at the end of June 2022. Cases of avian flu have recently been detected in wild birds in the south west. The wider health system works closely with public health colleagues to ensure each case is followed up with testing and appropriate treatment.

5.320 The Incident Management Team is led by the Incident Director and supported out of hours by the 24/7 on-call director rota. All communication is managed through telephone and email single points of contact, and all action and decisions are logged through a team of operational managers and supporting administrative staff. The Incident Director and On-Call Director are supported by a loggist. The ICC process and action cards have been refined to reflect the current incident and the need to manage it virtually. A common Future NHS workspace is

being used by NHS Somerset CCG and system partners to log and share important information.

5.321 NHS Somerset CCG worked closely with all its partners across Somerset and the wider South West region to respond to all these pressures and provide assurance that local health services were responding effectively. In particular, we have worked in close collaboration with colleagues in the Somerset County Council Public Health Team and Civil Contingencies Units to ensure our response to all emergencies are both well co-ordinated and effective. The system has assumed responsibility for managing a Local Health Resilience Partnership (LHRP) from 1 July 2022 and this forum has been established based on the existing Somerset emergency planning group and its multi-agency membership.

Risk Management

5.322 NHS Somerset CCG's policy and approach to risk management is set out in detail in the Governance Statement (pages 135 to 137 refer). The risk management process underpins the successful delivery of our strategy, achievement of our objectives and the management of our relationships with key partners.

5.323 We are committed to maintaining a sound system of internal control based on risk management and assurance. By doing this, the organisation aims to ensure it can maintain quality and safety for patients, staff and visitors through the services it commissions, and minimise financial loss to the organisation.

Overview of NHS Somerset CCG Risks

5.324 2021/22 and into Quarter one (April to June) of 2022/23 saw the continuation of the response to the COVID-19 pandemic. The approach established at the start of the pandemic, to integrate the CCG risk management process with the incident control centre, continued, with regular review of risks generated. Where these risks impacted the aims or objectives of the CCG they were brought into the CCG risk management process. The risk monitoring activities, as specified within the CCG risk management strategy and policy, were then used to enable timely reporting of risk within the CCG governance structure.

5.325 The main areas of risk managed by us during quarter one of 2022/23 were broadly a continuation of those managed in 2021/22 and have included the following which describes key areas of risk rated at 12 and above and the actions taken in mitigation.

COVID-19 pandemic – increased demand on mental health services, and preventable deaths from suicide in relation to Covid-19 and aftermath

5.326 The health and socio-economic impacts of COVID-19 during 2021/22, including further national lockdowns, raised the risk of increased demand

for mental health services and those services being overwhelmed. In response to this we took a variety of actions including:

- Established additional capacity via community mental health services transformation workstream
- developed a demand and capacity model
- promotion of the prevention agenda (emotional wellbeing, resilience and wider determinants of health) included in mental health response
- working with the Mental Health and Learning Disabilities Response Cell and Public Health team
- meetings with NHS England
- investment of funding made available nationally to support anticipated rise in demand in the year
- investment of dedicated winter pressures funding to support systems
- increase in funding for suicide prevention for Somerset (in line with the mental health investment standard)
- development of the Somerset NHS Foundation Trust and volunteer providers' earlier intervention programme (long term plan, community, mental health services expansion - primary care focus) with growing numbers of referrals
- attended meetings of the Suicide Prevention Strategic Partnership Board (quarterly)
- delivery of crisis home treatment services

COVID-19 pandemic – Nosocomial transmission

5.327 As the pandemic continued our response around infection prevention and control across community and acute settings saw us undertake the following:

5.328 The CCG took its role as a lead for infection prevention and control (IPC) across the Somerset system by taking a collaborative approach with:

- quarterly Infection prevention and control (IPC) Committee meeting
- fortnightly meetings of directors with responsibility for IPC across Somerset
- fortnightly meetings of operational IPC leads from across Somerset

- weekly COVID-19 Health Protection Board meetings across Somerset
- membership of the South West IPC Steering Group
- attendance at outbreak meetings
- supporting the COVID-19 vaccination programme across the community and healthcare sector.

5.329 From a preventative perspective, the following steps were taken:

- dissemination of Public Health England guidance on the use of personal protective equipment (PPE) for staff and where appropriate for patients and visitors in health and care settings
- development of a protocol for restriction of non-essential visitors to health and care settings
- development of a protocol for the practice of social distancing principles, especially where PPE is not being used in health and care settings
- oversight of and support to outbreak management plans from system providers
- continued development and implementation of our IPC action plan
- expansion of the IPC workforce
- continued roll-out of the COVID-19 vaccination programme including preparation for autumn booster campaign.

Sustainability of and Access to Health Care Services

5.330 We have continued to manage several risks relating to growth in demand for services across the system such as urgent and emergency care and performance covering waiting times such as referral to treatment, cancer targets and ambulance waiting times. As examples, the actions taken to mitigate risks in these areas have included:

- Somerset Surge Planning Group meeting regularly
- escalation calls held regularly to provide a collaborative response to peaks in demand across the system
- Somerset Quality Surveillance Group
- Somerset ICS Executives meetings

- contract, activity and performance meetings
- Somerset Urgent Care Operation Group and Somerset A&E Delivery Board oversee urgent and emergency care planning and activity
- Somerset Elective Care and Cancer Delivery Boards
- rapid response service – intermediate care service team support to enable patients to remain at home
- GP 999 Car - hospital avoidance scheme
- Monitor and Review Framework - Somerset Operational Pressures Escalation Levels (OPEL) Framework[27]
- clinical assessment service revalidation - Devon Doctors
- summer incentive scheme (covering both Somerset and Devon Integrated Urgent Care Services) to support shift fill live from June 2021
- 12-week clinical workforce plan completed
- Cancer Alliance plans
- system operational plans

Patient Safety

5.331 In 2021/22 and into Quarter one of 2022/23 we continued to ensure that patient safety is central to delivery of all services. We have managed a range of risks relating to patient safety, including special educational needs and disabilities (SEND), Harms from falls, longer waiting times and health checks. Some of the actions taken included:

- building falls prevention into a range of services across Somerset, such as home safety checks, medication reviews, strength and balance classes
- Somerset Falls Network participation
- care home de-conditioning exercise programme in partnership with Somerset Activity and Sports Partnership (SASP)
- work on commissioning a new system neuro-developmental pathway
- Somerset Quality Surveillance Group meetings

[27] Operations Pressure Escalation Levels (Opel) is a method used by the NHS to measure the stress, demand and pressure a hospital is under

- CCG Patient Safety and Quality Assurance Committee meetings
- contract and performance meetings
- weekly review of patient treatment list to review urgency and escalation of any patients identified as at risk of clinical harm
- continued work on the SEND written statement of action
- Crisis café, a non-medical alternative to mental health (virtual options)
- 24/7 crisis line expansion mental health services
- two full-time Trusted Assessors in post (Yeovil District Hospital and Musgrove Park Hospital) to aide acute hospital flow
- LARCH[28] (listening and responding to care homes) collaborative is Somerset wide – preventing avoidable hospital admission from care homes (inc. use of RESTORE2 and treatment escalation plans)
- same-day emergency care – admission avoidance.

Workforce Sustainability

5.332 We have continued to manage risks around sustainability of workforce across the Somerset system where risks were identified of planning not delivering the required workforce capacity against patient activity. The range of actions taken to address these risks have included:

- Somerset People Board established to oversee system workforce
- CCG Sustainability Policy used to monitor, engage and support GP practices experiencing critical workforce challenges
- Social Care Network Forum and Primary Care Workforce Implementation Groups set up under People Board to identify priorities and actions needed across the system
- workforce planning groups
- independent review workforce analysis conducted to inform the Somerset People Board and local providers with recommendations
- early adopter site for maternity care assistants and working with universities to assist

[28] A countywide resource helping people to live their life in nursing and residential homes.

- local pathways development programme by providers to support staff into registrant roles
- strategic apprenticeships plan
- nurse degree training access via local provider
- Breaking Barriers project
- Clear project
- Health Education England - Pooled training allocation budgets
- long-term workforce plan
- degree pathway
- career pathways for critical roles
- one year system workforce / NHS People Plan.

Financial management and achievement of efficiency savings

5.333 The Somerset Integrated Care System (ICS) submitted a balanced plan for H1 (the first six months of 2022/23), aside from non-pay inflation pressures and Quarter 1 COVID-19 cost pressures, which were classed as accepted variances.

5.334 Regular meetings are held across the ICS to discuss and identify actions, including savings and investment plans, to enable the delivery of balanced financial plans across the Somerset health system.

5.335 Through a robust financial management, monitoring and reporting process within the CCG and the wider ICS the following approach is taken:

- System Finance Group regularly monitors progress against the system savings programme
- strategic financial issues are identified and reported
- arrangements are in place to ensure sound financial control.
- monthly finance reports are produced to inform the NHS Somerset CCG Governing Body and Finance and Performance Committee of the latest financial position
- joint system financial reporting monthly to the ICS to identify any financial/performance issues and variance and to inform discussions to identify plans for mitigating actions

- regular dialogue with NHS England and Improvement in respect of actions required to mitigate any financial pressures.

Access to services including constitutional waiting time standards and ambulance performance standards

5.336 Our risk register contains risks covering performance on waiting times such as referral to treatment standards and ambulance waiting times. During the past year with the continued response to COVID-19, impacts on waiting time and performance standards have continued to be significant. We continue to monitor and mitigate these impacts by taking a range of actions, including:

- Somerset Quality Surveillance Group
- A&E and Elective Care Delivery Boards
- Somerset Cancer Delivery Board
- contract and performance meetings
- operational planning 2021/22
- improvement plans and trajectories
- 999 and emergency department (ED) validation within Integrated Urgent Care Clinical Assessment Service
- NHS 111 online – validation of ED and 999 (lower acuity) dispositions
- high intensity users– 6-weekly Steering and Implementation Group
- GP 999 Car – hospital avoidance scheme.
- two full-time Trusted Assessors in post (Yeovil District Hospital and Musgrove Park Hospital) to aide acute hospital flow.
- LARCH (listening and responding to care homes) collaborative is Somerset wide – preventing avoidable hospital admission from care homes [inc. use of RESTORE2 and treatment escalation plans])
- same-day emergency care – admission avoidance.
- Trusted Assessor project
- Somerset, Wiltshire, Avon, Gloucestershire (SWAG) Cancer Alliance plans
- 24/7 Crisis line expansion for mental health services.

Integrated Care System Transition

5.337 With Royal Assent having been given to the proposed changes to the Health and Care Act, CCGs will be abolished on 1 July 2022 with duties and functions moving to Integrated Care Boards (ICBs). Final preparation work for the transition was completed during quarter one of 2022/23 which was undertaken in line with national guidance to mitigate the risks to the Somerset health and care system of not being ready to operate as an ICB. The following actions and work programme took place:

- development of the NHS Somerset ICB Constitution - structure and decision-making processes
- completion of required due diligence through specified workstreams
- development of a people transition HR process to ensure the CCG workforce is transferred to the ICB
- appointment and recruitment processes for ICB Chair, Accountable Officer and senior leadership roles
- scoping transfer of CCG functions to ICB and future delegation of functions from NHS England and Improvement
- preparation of handover of final CCG risk register to the ICB.

5.338 There is more detail on our risk management framework and arrangements included in the Governance Statement, which features later in this report as part of the accountability Report.

6 FINANCIAL AND PERFORMANCE REVIEW

Finances

6.1 NHS England has directed, under the National Health Service Act 2006 (as amended), that CCGs prepare financial statements in accordance with the 'Group Accounting Manual (GAM)' issued by the Department of Health. The GAM is drafted to meet the requirements of the Government Financial Reporting Manual (FReM). The financial information included in this section of the Annual Report is taken from the financial statements for the period 1 April 2022 to 30 June 2022.

Financial Duties

6.2 During 1 April 2022 to 30 June 2022, our performance against our financial duties is outlined in the table below:

Target Performance	Achieved
Expenditure not to exceed income	✓
Capital resource use does not exceed the amount specified in Directions	✓
Revenue resource use does not exceed the amount specified in Directions	✓
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	N/A
Revenue administration resource use does not exceed the amount specified in Directions	✓

Overview

6.3 The NHS financial arrangements for 2022/23 continue to support a system-based approach to planning and delivery and align to the ICS boundaries agreed during 2021/22. Integrated Care Systems have been issued with one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25.

6.4 The 2022/23 financial framework signals a change from the frameworks in operation during 2020/21 and 2021/22, with a move back towards population-based funding in the context of system collaboration. Key aspects of the 2022/23 financial framework include:

- maintaining system funding allocations and collaborative planning, with the CCG/ICB and its partner trusts having a financial objective to deliver a breakeven position
- re-introducing population-based funding based on fair share allocations, with funding on a glidepath from previous system revenue envelopes to a fair share of the affordable recurrent NHS settlement (known as the convergence adjustment)
- system funding envelopes now include sustainability funding previously allocated through the Financial Recovery Fund
- returning to local ownership for payment flows under simplified rules. To restore the link between commissioning and funding flows, commissioners and trusts will have local ownership for setting payment values on simplified terms. There is an expectation that elective activity flows will have a variable component to payment mechanisms
- funding to tackle the elective activity backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding is available to support elective activity recovery, with access to further additional revenue where systems exceed target levels
- continuation of the requirement to deliver the Mental Health Investment Standard (MHIS)

- final year of separate COVID-19 allocation, based on an assumption that Covid-19 levels return to early summer 2021 levels.

6.5 The Somerset system submitted balanced financial plans for 2022/23.

6.6 NHS Somerset CCG delivered a surplus of £7.17m against its planned resource for the period 1 April to 30 June 2022. This resource allocation was subsequently adjusted to ensure a financial break-even position for the period and the surplus has consequently transferred into the ICB resource allocation for the period 1 July 2022 to 31 March 2023.

Analysis of Revenue Performance

	1 April – 30 June 2022 £'000
Final Revenue resource limit for the period	275,096
Variance against revenue resource limit	0
Percentage variance against revenue resource limit	0%

6.7 The Finance and Performance Committee and Governing Body receive regular reports on the financial performance of the CCG, which provide considerable assurance and documentary evidence of financial performance. Other reports include risk register reviews, financial plans and ad-hoc reports and information as required. We also submit monthly and quarterly information to NHS England as part of the CCG assurance process.

6.8 The Finance and Performance Committee meets monthly to review the financial position and identify mitigating actions to ensure we strive to deliver to our financial targets.

6.9 The CCG has an established Audit Committee whose role is centred on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee is appointed by the Governing Body and comprises two Lay Members. Lou Evans (V ice Chair of the Governing Body) chaired the CCG Audit Committee. Two meetings were held between 1 April and 30 June 2022, and the committee members considered:

- governance, risk management and internal control
- internal audit
- external audit
- counter fraud
- the work programme associated with the CCG to ICB transition
- the CCG 2021/22 Annual Accounts and Annual report
- other assurance functions.

6.10 Through the work of the Audit Committee, the Governing Body has been assured that effective internal control arrangements are in place.

Going Concern

6.11 The annual accounts of NHS somerset CCG are prepared on the basis that the organisation is a going concern and that there is no reason why it should not continue operating on the same basis for the foreseeable future.

6.12 Within the accounts, the CCG is required to make a clear disclosure that the individuals responsible for financial governance for the CCG have considered this position, and that given the facts at their disposal, the CCG is a going concern. Where there are material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the CCG, these should be disclosed as part of the disclosure notes supporting the annual accounts.

6.13 The Department of Health Group Accounting Manual for 2021/22 has the following recommendation as the standard accounting policy for going concern:

- The Government Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 of International Accounting Standard (IAS) 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context:

    * for non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern

    * a trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up

    * sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate

    * where an entity ceases to exist, it must consider 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 in its final set of financial statements

- while an entity will disclose its demise in various areas of its Annual Report and Accounts such as in the Performance Report and cross reference this in its going concern disclosure, this event does not prevent the accounts being prepared on a going concern basis or give rise to a material uncertainty in relation to the going concern of the entity

- Department of Health and Social Care (DHSC) group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity

- where a DHSC group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved

- should a DHSC group body have concerns about its going concern status (and this will only be the case if there is a prospect of services ceasing altogether), or whether a material uncertainty is required to be disclosed (which will only arise in exceptional circumstances), it must raise the issue with its sponsor division or relevant national body as soon as possible

- consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risk disclosures included in the wider performance report but is a separate matter from the going concern assessment.

Criteria

6.14 IAS 1 requires management to assess the entity's ability to continue as a going concern when preparing the financial statements. The standard stipulates that in assessing if the going concern assumption is appropriate then management should consider all available information about the future.

6.15 The period of review covered should be at least 12 months from the date of approval of the financial statements, but it should not be limited to the same. The assessment of the validity of the going concern assumption involves judgement about the outcome of events and conditions which are uncertain. The uncertainty increases significantly the further into the future a judgement is being made about the outcome of an event or condition.

Therefore, usually the 12 month period from approval of the accounts is considered appropriate.

6.16 Financial statements should not be prepared on a going concern basis if management determines after the end of the reporting period either that it intends to liquidate the entity or to cease trading or that it has no realistic alternative to do so. In these circumstances the entity may, if appropriate, prepare its financial statements on a basis other than that of a going concern.

6.17 The Financial Reporting Council, in their publication 'Guidance on the Going Concern Basis of Accounting and Reporting on Solvency and Liquidity Risks April 2016' has set out a number of areas Boards, or in CCGs, Governing Bodies, may wish to consider. Those relevant to CCGs in the NHS are as follows:

- forecast and budgets
- timing of cash flows
- contingent liabilities
- products, services and markets
- financial and operational risk management
- financial adaptability
- developments in policy or public finance which may affect the solvency or liquidity of the organisation

6.18 Where there are particular points or risks to report, these are reported to the CCG Clinical Executive Committee, and to the Governing Body as part of the regular quarterly update, at the public meetings.

Financial Assumptions for the period 1 April to 30 June 2022

Budgets and Outturn

6.19 The Somerset system submitted balanced financial plans for 2022/23.

6.20 NHS Somerset CCG delivered a surplus of £7.17m against its planned resource for the period 1 April to 30 June 2022. This resource allocation was subsequently adjusted to ensure a financial break-even position for the period and the surplus has consequently transferred into the ICB resource allocation for the period 1 July 2022 to 31 March 2023.

Establishment of Integrated Care Boards (ICBs)

6.21 On 1 July 2022 CCGs were abolished and Integrated Care Boards (ICBs) were established. Statutory functions, like those exercised by CCGs, were conferred on ICBs from 1 July 2022, along with the transfer of CCG staff, assets, and liabilities (including commissioning responsibilities and contracts). Therefore, the functions carried out by NHS Somerset CCG have consequently been conferred on NHS Somerset ICB from 1 July 2022.

6.22 This transition has not affected the going concern status of the CCG given that its services continue to be provided (using the same assets), by NHS Somerset ICB.

Cash Flow

6.23 The CCG's cash position is reported monthly to the Finance and Performance Committee, and to the Governing Body at each public meeting. In addition, detailed cash flow monitoring and forecasting is in place with NHS England on a monthly basis.

Contingent Liabilities

6.24 The CCG has a contingent liability for the period 1 April to 30 June 2022 relating to continuing healthcare (CHC) cases - to reflect a risk associated with the provisions estimate made for pending CHC eligibility assessments and appeals

6.25 A contingent liability is a possible obligation depending on whether some uncertain future event occurs or a present obligation where payment is not probable, or the amount cannot be measured reliably.

Services

6.26 The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is important evidence of going concern. We are not aware of any plans that would fundamentally affect the services provided to an extent that the organisation would not continue to be a going concern.

Operational Financial Planning 2022/23

6.27 The NHS's financial arrangements for 2022/23 continue to support a system-based approach to planning and delivery and align to the new ICS boundaries agreed during 2021/22. Integrated Care Systems have been issued with one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25. NHS England intend to publish the remaining two-year revenue allocations to 2024/25 before the end of this financial year. It is in this context that systems have been asked to focus on the following priorities for 2022/23:

- invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

- respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19

- deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

- improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays

- improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level

- improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access

- continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities

- exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems

- make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this

- establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

6.28 All systems were expected to report a balanced financial position within their submitted plans for 2022/23.

6.29 The CCG needs to ensure that through actions agreed with partners across the Somerset system, the CCG will not breach its statutory duties as detailed in sections 223H(1) and 223I(3) of the NHS Act 2006 (as amended) which state that CCGs have to ensure that:

- expenditure in a financial year does not exceed income
- revenue resource use does not exceed the amount specified in directions

6.30 The operational plan for 2022/23 has been presented to the ICS Board to ensure cross-system support and to the CCG Governing Body for final approval. Moving forward, monthly finance reports will specifically highlight progress against the plans with analysis of any variances.

Financial Arrangements During the Coronavirus Pandemic

6.31 In March 2020 a global pandemic was declared, caused by a novel coronavirus, COVID-19. The impact on healthcare delivery in direct response to this virus, changes in demand and capacity for other healthcare and the impact on wider society (through social distancing and lockdowns) and the economy has been dramatic. Of particular relevance was a significant overhaul of the financial architecture of the NHS, and the CCG, as a statutory body in the NHS, has had its finances supported by the Government for the period of the pandemic.

6.32 NHS England have emphasised the importance of maintaining financial control and stewardship of public funds during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards have been required to continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance.

6.33 In response to this, Somerset CCG undertook a review of financial governance to ensure that decisions to commit resources in response to COVID-19 were robust.

6.34 The CCG tested the resilience of its finance functions and business continuity plans to ensure that the most important elements could continue throughout the pandemic and considered the resilience of its fraud prevention arrangements in conjunction with the Local Counter Fraud service.

6.35 As advised by NHS England, the CCG established a process to carefully record any costs incurred in responding to the COVID-19 outbreak and was required to report on actual costs incurred on a monthly basis.

Recommendation

6.36 On the basis of the above, NHS Somerset CCG considers that it remains a going concern.

6.37 Having considered the going concern guidelines, the financial reporting and governance arrangements of the CCG, approach to the development of operating plans for 2022/23 as set out above and the continued focus by the CCG and Somerset system partners to drive improvements to the financial position, it is recommended that management prepare the final

accounts for the CCG for the period 1 April to 30 June 2022 on a going concern basis.

Revenue Resource Limit 1 April to 30 June 2022

6.38 NHS Somerset CCG has a statutory duty to maintain expenditure within the revenue resource limits set by NHS England.

6.39 Revenue expenditure covers general day-to-day running costs and other areas of ongoing expenditure. The CCG has met its statutory duty to operate within its revenue resource limit for the period 1 April to 30 June 2022.

6.40 The CCG's performance for the period was as follows:

	1 April to 30 June 2022 £'000
Total net operating cost for the financial year	275,096
Final in year revenue resource limit for the year	275,096
Under/(over) spend against revenue resource limit	**0**

6.41 This table highlights that for the period 1 April to 30 June 2022 NHS Somerset CCG operated within its revenue resource limit.

Better Payment Practice Code

6.42 The CCG is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry (CBI) Better Payment Practice Code. The target is to pay non-NHS and NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

6.43 Our performance for the period 1 April to 30 June 2022 is summarised below:

Measure of compliance	**Q1 2022/23 Number**	**Q1 2022/23 £000**	**2021/22 Number**	**2021/22 £000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,652	39,856	9,723	210,244
Total Non-NHS Trade Invoices paid within target	2,652	39,856	9,723	210,244
Percentage of Non-NHS Trade invoices paid within target	**100.00%**	**100.00%**	**100.00%**	**100.00%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	195	189,629	672	731,378
Total NHS Trade Invoices Paid within target	195	189,629	672	721,378
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**100.00%**	**100.00%**

6.44 The CCG achieved the required 95% target to pay NHS and Non-NHS trade payables within 30 days (unless other terms had been agreed).

Running Costs

6.45 NHS Somerset CCG was initially funded a total of £2.800 million for the period 1 April to 30 June 2022 to support headquarters and administration costs. This included additional funding of £0.167 million released in-year to support an increase in employers' pension contributions. Total expenditure recorded against running costs for the period was £2.778 million, delivering an under-commitment against resource of £0.022m. The CCG running cost resource allocation was subsequently adjusted to ensure a financial break-even position for the period and the surplus has consequently transferred into the ICB resource allocation for the period 1 July 2022 to 31 March 2023.

6.46 To facilitate the effective running of the organisation, the CCG continues to review those functions which it provides in-house and those which are provided by South, Central and West Commissioning Support Unit (SCW CSU). The services commissioned via the SCW CSU covers Business Intelligence support, Information Technology and Information Governance support, Procurement Services support, Care Navigation Services, GP IT Services, and additional consultancy and project support.

Performance Summary

6.47 NHS England assesses Somerset CCG's performance against the Single Oversight Framework. It assesses both Providers and Commissioners against five themes: quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability resulting in an overall performance rating at the end of the year. There are four domains to the framework with four rating categories: outstanding, good, requires improvement and inadequate.

6.48 Performance against the key NHS Constitution requirements has continued to be closely monitored during 2022/23; however patterns of emergency demand, patients staying longer in hospital or waiting longer for elective treatment continue to be effected by both the ongoing impact of the covid-19 pandemic and operational pressures in Quarter one 2022/23.

6.49 The performance summary below assesses Somerset Clinical Commissioning Group against 2021/22.

Performance Analysis

Emergency and Urgent Care

Emergency and Urgent Care Performance Scorecard between 1 April 2022 and 30 June 2022

Emergency Care	Standard	21/22 (Full Year)	22/23 Q1	Variance to Standard +/-	Variance to 2021/22 +/-
Cumulative percentage of Trustwide MPH & YDH patients spending no more than four hours in A&E from arrival to admission, transfer or discharge	95%	73.4%	64.4%	-30.58%	-9.02%
Cumulative percentage of Somerset CCG patients spending no more than four hours in A&E from arrival to admission, transfer or discharge (inclusive of MIU activity)	95%	81.7%	76.5%	-18.50%	-5.18%
Cumulative number of MPH & YDH patients spending greater than twelve hours in A&E from decision to admit to admission	0	466	274	274	-192
Percentage of ambulance handovers to A&E department that exceed 15 minutes	35%	37.5%	48.8%	13.80%	11.35%
Percentage of ambulance handovers to A&E department that exceed 30 minutes	5%	12.0%	21.7%	16.70%	9.67%
Percentage of ambulance handovers to A&E department that exceed 60 minutes	0%	4.0%	10.2%	10.24%	6.24%
Percentage of emergency admissions who stay less than 1 day	-	33.2%	33.0%	-	-0.20%
Number of patients with "No Right To Reside" in an Acute Hospital (Period End Position)	-	258	212	-	-46

6.50 Demand for urgent and emergency care services has increased in 2022/23 (April-June) with approximately 400 attendances per day to Somerset's main Accident and Emergency Departments (ED) in comparison to 380 per day in 2021/22 (April-March). The increased demand alongside other factors including increased patient acuity (whereby the patient complexity and severity of presentations has significantly increased) and delays for patients requiring beds compromised due to the high level of patients residing in hospital with no criteria to reside has resulted in patients staying longer in the ED. Therefore, the performance against the Accident and Emergency 4-hour operational standard (whereby 95% of patients should be seen, diagnosed, discharged, or admitted within four hours of arrival) was 64.4% in Q1 2022/23 in comparison to 73.44% in 2021/22 (April-March). Overall, ED and MIU performance combined across Somerset during Q1 2022/23 was 76.5% in comparison to 81.7% during 2021/22 (April-March).

6.51 Whilst ambulance handover performance is better in comparison to other Providers in the South-West Region there has been a decline in recent months with 48.8%of ambulances not being handed over within 15 minutes of arrival to hospital (in comparison to 37.5% during 2021/22). In addition, there has also been 274 12-hour trolley breaches in the first quarter of 2022/23 which is an increase from 466 that occurred throughout 2021/22.

6.52 Whilst the overall level of emergency admissions during Q1 2022/23 has reduced by 1.8% when compared to the same period of 2021/22 (and 11.2% when compared to the pre-covid period 2019/20) the requirement

for beds has increased, leading to an increase in the reliance upon escalation capacity. Patients continue to experience a longer length of stay than the pre-pandemic due to a combination of patient acuity and high levels of patients residing in hospital with no criteria to reside.

Ambulance Response Times

Percentage of Category A calls receiving a response from South Western Ambulance Service NHS Foundation Trust for the period 1 April 2022 to 30 June 2022

Standard	Target (mins)	2021/22		Q1 2022/23		Variance +/(-) to Standard		Variance +/(-) to 2021/22	
		Provider Performance	Performance in Somerset	Provider Performance	Performance in Somerset	Provider Performance	Performance in Somerset	Provider Performance	Performance in Somerset
Category 1 response - mean	7	10.3	11.3	11.3	12.2	4.3	5.2	1.0	0.9
Category 1 response - 90th percentile	15	19.3	21.2	20.8	22.7	5.8	7.7	1.5	1.5
Category 2 response - mean	18	61.9	56.5	68.9	50.2	50.9	32.2	7.0	-6.3
Category 2 response - 90th percentile	40	139.1	120.1	155.4	104.1	115.4	64.1	16.3	-16.0

6.53 During the period April 2022 to June 2022 on the quarterly basis the mean Category 1 (life threatening calls) performance was 12.2 minutes against the 7-minute national standard compared against Trust-wide performance of 11.3 minutes, and Category 2 performance was 50.2 minutes against the 18-minute standard (compared to the Trust-wide performance of 68.9 minutes).

Waiting Times for Cancer Treatment

6.54 The performance scorecard in respect of the cancer waiting times standards achieved for services and Somerset patients, for the period 1 April 2022 to 30 June 2022 is shown below:

Waiting Times Standard	Standard	YTD 2021/22	2022/23 Q1	Variance +/- to Standard	Variance +/- to 2021/22
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	79.6%	63.7%	-29.26%	-15.86%
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	69.7%	57.2%	-35.80%	-12.50%
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	93.3%	92.1%	-3.92%	-1.22%
31-Day Standard for Subsequent Cancer Treatments-Surgery	94%	84.7%	75.6%	-18.43%	-9.13%
31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	98%	99.4%	99.6%	1.58%	0.18%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94%	97.3%	97.7%	3.65%	0.35%
62 day wait - % treated in 62 days from GP referral	85%	73.4%	66.3%	-18.72%	-7.12%
62 day wait - % treated in 62 days from screening programme	90%	78.1%	71.6%	-18.41%	-6.51%
62 day wait - % treated in 62 days from consultant upgrade	90%	86.1%	86.6%	-3.40%	0.50%
28-Day Faster Diagnosis Standard for patients on the 2 week wait referral route	75%	74.8%	70.5%	-4.52%	-4.32%

6.55 The NHS Constitution includes a number of targets relating to treatment for cancer patients. These include the right to be seen within two weeks when referred for a suspected cancer; the right to be treated within 62 days from the date of GP referral to treatment, the right to be treated within 31 days from the day of decision to treat to the day of treatment and 75% of patients should be told whether or not they have cancer within 28 days of an urgent referral from their GP or a cancer screening programme.

6.56 During the period April 2022 to June 2022 only two of the ten operational cancer standards were delivered for Somerset patients. As elective services have continued to recover a number of the cancer sites have experienced either significant increases in demand or operational pressures leading long waiting times and a breach to the waiting times standards. The waiting times have been further compounded by an increase in the number of complex cases with patients often requiring multiple diagnostic tests prior to diagnosis and at times requiring treatment outside of Somerset. Wider Somerset System partners are working closely together to develop and implement improvement plans to address identified performance shortfall which lead to an improvement in waiting times.

Elective Pathways

NHS Somerset CCG Key Performance Scorecard (Somerset Relevant Population) between 1 April 2022 and 30 June 2022

6.57 The performance scorecard in respect of elective access standards achieved for services delivered to Somerset patients, for the period 1 April 2022 to 30 June 2022 is set out below.

Indicator		Standard	YTD 21/22	Q1 2022/23	Variance to Standard	Variance to 2019/20
					+/-	+/-
Referral to Treatment waiting times	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting less than 18 weeks from Referral	92%	64.5%	62.5%	-29.50%	-1.97%
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 52 weeks	0 by Mar-25	2638	2892	2892	254
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 78 weeks	0 by Mar-23	599	500	500	-99
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 104 weeks	0 by Jun-23	159	49	49	-110
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99%	66.2%	71.0%	-28.00%	4.81%

Referral to Treatment (RTT) Waiting Times

6.58 The pressures being seen across primary care and all emergency services continue to be unprecedented with the demand for both elective and non-elective in-patient beds remaining high. The challenges in discharging patients due to the availability of further packages care or external bed availability has led to an increase in the length of stay and higher bed occupancy and with it an increased of risk of the cancellation of elective operations. Despite these pressures the Trusts in Somerset have been working hard to restore elective services to pre pandemic levels whilst with a focus upon treating the priority patients first and reducing those waiting the longest.

6.59 All RTT performance measures were impacted by the Covid-19 pandemic and during 2022/23 as a result of referral demand restoring but activity levels not yet reaching pre-pandemic levels the overall number of patients awaiting their first definitive treatment has increased. This is due to service capacity challenges meeting the levels of current and backlog demand, the change in casemix, workforce constraints and the focus on treating the longest waiting patients. The emphasis continues to be to keep patients safe whilst ensuring that those patients with urgent conditions continue to be prioritised. Performance against the 18-Week Referral to Treatment (RTT) Incomplete Pathway in the first Quarter of 2022/23 was 62.5% (in comparison to 64.5% 2021/22) although the number of patients waiting in excess of 78 and 104 weeks for treatment

has significantly reduced: >104 Week Waits as at 31 March 2022 was 159 to 49 as at 30 June 2022 and >78 Week Waits as at 31 March 2022 was 599 to 500 as at 30 June 2022.

Diagnostic Waiting Times

6.60 The NHS Constitution standard for diagnostics is that 99% of patients should wait less than six weeks for a diagnostic test or procedure. During the first quarter of 2022/23 the proportion of patients waiting six weeks or less improved to 71.0% compared to 65.4%. NHS England and Improvement have introduced a recovery ambition of 75% by March 2023 and plans are in place to reduce the level of backlog for the most challenged modalities, namely echocardiography, Non-Obstetric Ultrasound and Endoscopy which take up around 65% of the overall backlog.

Mental Health and Learning Disabilities

Somerset CCG Key Performance Scorecard (Somerset Relevant Population) between 1 April 2022 and 30 June 2022

Adult Mental Health

IAPT Mental Health	Standard	2021/22 Performance	Q1 22/23	Variance to standard +/-	Variance to 2021/22 +/-
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period	14003	8155	2,336	-11667	-5819
The proportion of people who wait 6 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period (rolling 12 month to June 2022)	75%	62.30%	46.9%	-28%	-15%
The proportion of people who wait 18 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period (rolling 12 month to June 2022)	95%	97.90%	98.2%	3%	0%
The proportion of people who are moving to revcovery (June 2022)	50%	55.90%	62.0%	12%	6%

IAPT

6.61 The number of people accessing Improving Access to Psychological Therapies (IAPT) treatment for the first quarter 2022/23 is 2,336 (local un-validated data) against a local indicative target for 2022/23 of 14,003 (16.7% delivered). Performance for the period currently performing behind plan due to high rates of maternity leave and long-term sickness absence, alongside a spike in referrals in Quarter 4, particularly for high intensity therapies, which has affected the overall capacity of the service. Growing the IAPT service workforce by taking additional trainees in 2022/23, taking advantage of the Health Education England offer of one-off funding for additional trainees. The additional trainees will commence in post in the later part of 2022/23 and therefore more activity will take place in the latter part of the year.

6.62 The IAPT recovery rate for June 2022 is 62%. The national ambition of 50% continues to be met and exceeded. Somerset has consistently been one of the top performing systems nationally.

6.63 Since January 2022, there has been a deterioration of the 6-week national standard, in that performance dropped to 46.9% in June 2022, against the target of 75% of people being seen within 6 weeks of referral. The deterioration relates to a sudden surge in the number of referrals/people entering treatment in the latter part of 2021/22 alongside capacity issues within the service. We anticipate the access standard will improve as the new trainees commence in post as well as increasing capacity of the service across all areas. Positively, the 18-week standard continues to be met, with 98.2% of patients seen and received treatment within 18 weeks from referral against the 95% national ambition.

Dementia

Dementia	Standard	2021/22 Performance	Q1 22/23	Variance to standard +/(-)	Variance to 2021/22 +/(-)
Estimated Diagnosis Rate for people with Dementia	66.70%	53.60%	53.3%	**-13.40%**	**-0.30%**

6.64 The Dementia Diagnosis Rate (DDR) for Somerset is 53.3% in June 2022 against the national ambition of 66.7%. Somerset, like many other areas across the country and in the South West, has not achieved the national target in a number of years, though performance has deteriorated further over the COVID period. This is partly because of the lack of post-diagnostic support available, and during the COVID period, diagnoses have decreased because of the vulnerability of this cohort and the resulting reduction in face-to-face contacts. The reduction of direct contacts during this period particularly affected the previously proposed approach to improve dementia diagnosis rates in Somerset, which was based upon physically visiting care homes and other sites as well the lack of post-diagnostic support available.

6.65 In 2022/23, the Dementia Operational Oversight Group (a cross-organisational strategic group led by NHS Somerset) created a new model of community dementia support for Somerset and authored a successful business case to apply for funding from the system. Resultant funding is being used to implement the new service based upon the model and work is taking place with voluntary and social enterprise (VCSE) partners to develop an alliance model for support as part of this initiative. Services are being coproduced with people with dementia and their carers and a localised dementia support line has already been implemented as set out in the NHS Long Term Plan.

6.66 Funding has also been used to enhance capacity within the Memory Assessment Service (MAS), including new care home liaison posts and to double the number of Dementia Support Workers employed by the Alzheimer's Society across the county.

Community Mental health Services	Standard	2021/22 Perfomance	Q1 22/23
Mindline Calls Received	-	32,110	9,526
Open Mental Health Contacts	-	1,948	659

Mindline

6.67 The Mindline 24/7 Crisis Line offers a supported conversation to callers and has access to a range of Mental Health Services within Somerset, depending on the level of need. In line with the national expectation, offers a 24/7 all age mental health crisis line, with good links into statutory services.

6.68 In the first quarter (April to June) of 2022/23, Mindline received 9,526 calls, with approximately 2% of these calls from Children and Young People. Fewer than 1% of total calls were directed towards the ambulance service or the police, and fewer than 1% were directed towards the Home Treatment Team or equivalent for child and adolescent mental health services (CAMHS). Patient stories demonstrate that the service can effectively de-escalate patients in crisis. The most common presenting call themes are for emotional support, anxiety, family, and relationships.

Open Mental Health

6.69 The Community Mental Health Services transformation programme is a collaboration between Somerset NHS Foundation Trust and a range of VCSE partners, and is operating under 'Open Mental Health'. In the first quarter of 2022/23, there were 659 service introductions to Open Mental Health. More than 95% of people accessing Open Mental Health wait less than 4 weeks to be seen.

Children and Young People's (CYP) and Perinatal Mental Health

CYP Mental Health and Perinatal Mental Health	Standard	2021/22 Performance	Q1 22/23	Variance to standard	Variance to 2021/22
				+/-	+/-
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 month period to June 2022)	**95%**	75%	80.2%	**-14.8%**	**5.0%**
The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 month period to June 2022)	**95%**	84%	80.0%	**-15.0%**	**-3.9%**
The number of women accessing specialist community PMH services in the reporting period (rolling 12 month period to June 2022)	**547**	558	430	**-117**	**-128**

Perinatal Mental Health

6.70 430 women accessed the Perinatal and Maternal Mental Health Services in the 12-month period to June against an ambition of 547. Somerset was awarded 'Fast Follower' status to develop and implement a Maternal Mental Health Service (MMHS). The MMHS aligns with the established Perinatal Mental Health Service, focusing on women with issues surrounding bereavement, Tokophobia and birth trauma. Progress has been made in delivering the Perinatal Mental Health Long Term Plan ambitions which includes offering partner assessments, increasing access to evidence-based psychological therapies and extending how long care can be provided by the specialist service from pre-conception to 24 months after birth. National data is understated due to MHSDS reporting issues which have now been resolved and the 'true' Somerset position will not be reflected until October 2022 due to limitations in refreshing historic MHSDS data.

Children and Young Persons (CYP) Eating Disorder Services

6.71 On a rolling 12 month basis to June 2022, performance for the Community Eating Disorder Services (CEDs) for routine patients was 79.4%, whilst for urgent patients performance was 83.3%, against the national standards of 95% (using local unvalidated data).

6.72 Performance for urgent patients has regularly achieved 100% since May 2021. The routine waiting time standard has been more difficult to achieve consistently partly as a result of COVID-19 restrictions as well as patient choice. Referral numbers to the service are low therefore percentage variance is significantly influenced by small breach numbers. However, a new pathway is being piloted in which Somerset & Wessex Eating Disorders Association (SWEDA) and CEDs will work in partnership which will generate additional capacity and is also anticipated to reduce the length of time a patient stays on the CEDs caseload.

Learning Disabilities

Learning Disabilities	Standard	2021/22 Perfomance	Q1 22/23
Learning Disability registers and annual health checks delivered by GPs	**75% (cumulative annual)**	77%	9.7% (Quarterly actual)
The number of adults aged 18 and over from the ICS who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder and whose bed is commissioned by an ICB	**8 (plan)**	8	7
The number of adults aged 18 or over from the ICS who are autistic, have a learning disability or both and who are inpatient care for a mental disorder and whose bed is commissioned by NHSE or via a provider collaborative	**6 (plan)**	6	6
The number of children under 18 from the ICS who are autistic, have a learning disability or both and who are inpatient care for a mental disorder and whose bed is commissioned by NHSE or via a provider collaborative	**1 (plan)**	0	0

Learning Disabilities Annual Health Checks (LD AHCs)

6.73 283 (9.7% of total LD Register List) of Learning Disability Annual Health Checks were completed in the first quarter of 2022/23. Most health checks are completed in the last quarter of the financial year, and we are confident that similar level of performance will be achieved by the end of 2022/23. A programme of work has been undertaken to increase the uptake and quality of Annual Health Checks (AHCs) for people with a learning disability, supporting primary care to achieve the national target in line with recent guidance. Going forward, a Learning Disability AHC Data project is being established, working with public health to gain more understanding of the group who do not attend AHCs. There will be continued representation at NHSE annual health check meetings to share good practice and learn from other areas.

Learning Disability Reliance on Inpatient Care

6.74 Performance for quarter one (April to June) of 2022/23 in Somerset for inpatient children whose bed was commissioned by NHSE or a provider collaborative achieved the local trajectory (zero children against a plan of

one). Somerset met the local plan for adults whose bed was commissioned by an ICB or by NHSE (ICB: seven adults against a plan of eight; NHSE: six adults against a plan of six). Somerset have consistently low numbers of adult and child inpatients and compare favourably both regionally and nationally.

Self-Certification by the Accountable Officer

6.75 I certify that NHS Somerset Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

6.76 We certify that Somerset Clinical Commissioning Group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Jonathan Higman
Chief Executive
NHS Somerset Integrated Care Board
29 June 2023

ACCOUNTABILITY REPORT

Jonathan Higman
Chief Executive
NHS Somerset Integrated Care Board
29 June 2023

7 CORPORATE GOVERNANCE REPORT

Members Report

7.1 The membership of NHS Somerset CCG Governing Body and Leadership Team up to 30 June 2022 is set out in Table 1 below detailing names, roles and membership of the key committees within the CCG. A detailed breakdown of attendance at each of the committees plus a full list of member practices is provided in Annex 1 to the Annual Governance Statement.

7.2 The key roles undertaken by the Governing Body Non-Executive leadership (as at 30 June 2022) are set out in the table below:

Name	Governing Body Appointment	Governing Body Lead Roles
Lou Evans	Lay Member Non-Executive Director (Governance and Audit)	Vice Lay Chair Conflict of Interest Guardian Cyber Security Non Executive Lead Audit Committee Chair Remuneration Committee Chair
David Heath	Lay Member Non-Executive Director (Patient and Public Involvement)	Primary Care Commissioning Committee Chair Remuneration Committee Member Patient and Public involvement Non-Executive lead
Grahame Paine	Lay Member Non-Executive Director (Finance and Performance)	Finance and Performance Committee Chair Remuneration Committee Member
Dr Basil Fozard	Secondary Care Specialist Doctor Non-Executive Director	Remuneration Committee Member Quality and Safety Committee Member Primary Care Commissioning Committee
Dr Ed Ford	CCG Chair Member Practice Representative, Non-Executive Director	Emergency Planning Resilience and Response (EPRR) Non Executive Lead Clinical Executive Committee Finance and Performance Committee Health and Well Being Board
Wendy Grey	Member Practice Representative, Non-Executive Director	Quality and Safety Committee (Chair from January 2022) Equality Steering Group Chair
Trudi Mann	Member Practice Representative, Non-Executive Director	Vice Chair Finance and Performance Committee
Dr Helen Thomas	Co-opted Member Practice Representative Non-Executive Director	Audit Committee Member

7.3 The CCG register of interests up to the end of 30 June 2022, which includes details of company directorships and other significant interests held by senior CCG leaders, is available on request and the current version available on the ICB website at: Lists and Registers - NHS Somerset.

7.4 There have been no incidents regarding the loss of personal data that have required reporting to the Information Commissioner's Office.

Statement of Disclosure to Auditors

7.5 Each individual who is a member of the Members' Report, confirmed at the Governing Body of 10 June 2022, the following:

- So far as the member is aware, there is no relevant audit information of which NHS Somerset'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 NHS Somerset's auditor is aware of it.

Modern Slavery Act

7.6 NHS Somerset CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 30 June 2022 is published on our website at: https://www.somersetccg.nhs.uk/publications/modern-day-slavery-and-human-trafficking-statement/.

7.7 Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. When we hear the term modern slavery, most people think this only exists overseas, but the Home Office estimates there are 13,000 victims and survivors of modern slavery in the UK. Modern slavery victims are among the most vulnerable people in our society and can be hesitant to seek help due to fear of their traffickers. Although modern slavery is considered a 'hidden' crime, many victims can be working or otherwise visible in the community, in a range of places such as nail bars, food outlets, car washes, factories, and the fishing industry.

7.8 With more than one million people accessing NHS funded services every 36 hours, the 1.5million staff that work in our NHS, not just in hospitals but in places where people live their lives, will come into contact with victims or survivors of modern slavery.

7.9 NHS Somerset CCG, along with partner agencies, is working towards a world without slavery by supporting, influencing and raising awareness:

- by supporting survivors and vulnerable people through the specialist services that we commission, we can enable them to recover safely and develop resilient, independent lives

- by influencing the development of the NHS workforce through access to national training, advice and resources we can better identify and support actual and potential victims of slavery

- by raising awareness of modern slavery through the NHS Somerset website and the safeguarding newsletter, we can support NHS staff to recognise the signs of modern slavery and understand the role they have to play.

Breakdown of NHS Somerset CCG Senior Leaders and their roles in the CCG governance structure as at 30 June 2022

		Committee Membership (voting and non-voting membership)							
		Governing Body	**Clinical Executive Committee**	**Audit Committee**	**Remuneration Committee**	**Quality and Safety Committee**	**Primary Care Comm'g Committee**	**Finance & Performance Committee**	**Health and Well Being Board**
CCG Executive Leadership									
Chief Executive	James Rimmer	✓	✓		✓				✓
Director of Finance, Performance, Contracting and Digital	Alison Henly	✓	✓	✓		✓	✓	✓	
Acting Director of Quality and Nursing	Kathy French	✓	✓			✓		✓	
Acting Director of Commissioning	Alison Rowswell	✓	✓				✓	✓	
Programme Director, Fit For My Future	Maria Heard	✓	✓						
GP Clinical Leadership									
Associate Clinical Director, Mental Health	Dr Peter Bagshaw		✓						
Associate Clinical Director, Planned Care	Dr Will Chandler		✓						
Consultant in Public Health, SCC	Dr Orla Dunn		✓						
CCG Chair	Dr Ed Ford	✓	✓					✓	✓
Associate Clinical Director: Digital Strategy	Dr Justin Harrington		✓						
Local Medical Committee	Dr Tim Horlock		✓						
Associate Clinical Director, Primary Care	Dr Emma Keane		✓				✓		
Associate Clinical Director, Integrated Care	Dr Tom MacConnell		✓						
Associate Director, Women's and Children's Health	Dr Kate Staveley		✓			✓	✓		
Clinical Lead: Evidence Based Interventions/Medicines Management	Dr Andrew Tressider		✓						
Clinical Lead, Cancer	Dr Angela Beattie		Devt Session						

		Committee Membership (voting and non-voting membership)							
		Governing Body	**Clinical Executive Committee**	**Audit Committee**	**Remuneration Committee**	**Quality and Safety Committee**	**Primary Care Comm'g Committee**	**Finance & Performance Committee**	**Health and Well Being Board**
Clinical Lead, Diabetes and Integrated Care	Dr Henk Bruggers		Devt Session						
Clinical Lead, Emotional Wellbeing (Children and Young People)	Dr Theresa Foxton		Devt Session						
Clinical Lead, Respiratory, and Integrated and Planned Care	Dr Steve Holmes		Devt Session						
Clinical Lead, Named GP for Safeguarding Children and Adults	Dr Jo Nicholl		Devt Session						
Clinical Lead, Primary Care	Dr Jill Wilson		Devt Session						
Non-Executive Leadership									
Vice Chair and Non-Executive Director, Lay Member, Governance and Audit	Lou Evans	✓		✓	✓		✓	✓	
Non-Executive Director, Secondary Care Specialist Doctor	Dr Basil Fozard	✓			✓	✓	✓		
Director of Public Health, Somerset County Council	Dr Trudi Grant	✓							✓
Non-Executive Director, Member Practice Representative	Wendy Grey	✓				✓			
Non-Executive Director Lay Member, Patient and Public Involvement and Chair of the Joint Committee (Primary Care)	David Heath	✓		✓	✓		✓		
Non-Executive Director, Member Practice Representative	Trudi Mann	✓						✓	
Non-Executive Director, Finance and Performance	Grahame Paine	✓			✓			✓	
Non-Executive Director Member Practice Representative	Dr Helen Thomas	✓		✓					

8 STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

8.1 The Health and Social Care Act 2012[29] states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). I have been appointed by NHS England as the Chief Executive, to be the Accountable Officer of NHS Somerset Integrated Care Board.

8.2 The responsibilities of an Accountable Officer are set out under the Health and Social Care Act 2012, 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 Health and Social Care Act 2012 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the Health and Social Care Act
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the Health and Social Care Act 2012.

8.3 Under the Health and Social Care Act 2012 NHS England has directed each CCG to prepare, for each financial year, financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accrual basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

8.4 In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

[29] replaced on 1 July 2022 by The Health and Social Care Act 2022

- 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 Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements

- prepare the financial statements on a going concern basis.

8.5 To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the Health and Social Care Act 2012, Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

8.6 I also confirm that:

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

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

Jonathan Higman
Chief Executive
NHS Somerset Integrated Care Board
29 June 2023

9 GOVERNANCE STATEMENT

Introduction and Context

9.1 NHS Somerset CCG is a body corporate established by NHS England on 1 April 2013 under the Health and Social Care Act 2012.

9.2 The CCG's statutory functions are set out under the Health and Social Care Act 2012. 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 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.

9.3 Between 1 April 2022 and 30 June 2022, the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of Responsibility

9.4 As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

9.6 The main function of the Governing Body of the CCG 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.

9.7 NHS Somerset CCG is a membership body comprising 64 practices. Each practice has a delegate who represents that practice and practices are able to align themselves to a Primary Care Network (PCN) Locality. A full list of Member Practices is attached as Annex 1 to the Governance Statement. Each PCN works with the CCG and a range of GP clinical leads are engaged to work on specific workstreams.

9.8 The CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: GPs, a secondary care specialist doctor, a registered nurse, a Director of Public Health, three independent lay members, the Accountable Officer and Chief Finance Officer. Three Member Practice representatives have been appointed to the Governing Body, although one vacancy remains unfilled as at the end of June 2022 Dr Helen Thomas was appointed as a co-opted member to fulfil the role until the transition to the Integrated Care Board is complete. The Registered Nurse post was vacated when Dr Jayne Chidgey-Clark left the CCG in December 2021. Due to the forthcoming closedown of the CCG it was not possible to appoint a replacement but the key roles have been covered by existing Board members. Details of the membership and the attendance of those members are set out in Annex 2 to the Governance Statement.

9.9 Organisational structure and accountabilities are clear and well defined. Where capacity and/or capability gaps have been identified, actions are put in place with expected outcomes and timescales. NHS Somerset CCG clearly articulates its values to stakeholders through its Commissioning Plan and associated strategies. The Organisational Development plan includes undertaking a Staff Survey, implementing the High Performing Organisation (HPO) Programme and developing actions to address issues for development.

9.10 The following committees have been established by the Governing Body:

- Clinical Executive Committee (CEC)
- Audit Committee
- Remuneration Committee
- Primary Care Commissioning Committee
- Quality and Safety Committee
- Finance and Performance Committee

9.11 The remit of each committee is as follows:

Committee	**Key roles and responsibilities**
Clinical Executive Committee	GP Clinical Lead: Dr Ed Ford Executive Lead: James Rimmer Non-Executive Lead: n/a The Clinical Executive Committee (CEC) is the primary executive decision-making body of the CCG, authorised to make decisions within the powers delegated to it by the CCG Governing Body and is accountable to the CCG Governing Body. Its main functions are: • responsible for developing the CCG strategy, clinical and other policies, and operational plans for consideration and approval by the Governing Body • within the strategic and operational planning framework agreed by the Governing Body, the Clinical Executive

Committee	Key roles and responsibilities
	Committee is the primary decision making body responsible for delivery of these plans. It is held to account for progress against these plans • to oversee and performance manage clinical commissioning teams and to receive updates on key areas of responsibility • to oversee and performance manage all operational, financial, clinical and risk management issues • to oversee and performance manage the quality of commissioned services, quality being defined as clinically effective, personal and safe care • to ensure that the patient's view has been effectively considered in commissioning decisions made by the group • to receive reports on statutory corporate responsibilities including Information Governance, Emergency Preparedness, Health and Safety and workforce and inform the Governing Body on recommendations or areas of concern
Audit Committee	GP Clinical Lead: Dr Helen Thomas Executive Lead: Alison Henly Non-Executive Lead: Lou Evans The Audit Committee provides assurance to the Governing Body by reviewing the CCG's systems of financial reporting and internal control and ensuring that an effective programme of audit and counter fraud is in place. In particular: • the committee shall critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with internal and external auditors, and counter fraud is maintained • the Committee shall review the work and findings of the external auditor and consider the implications and management's responses to their work • the Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Governing Body • the Committee shall ensure that there is specialist counter-fraud information, guidance and service provision within the CCG and that policies and procedures for all work related to fraud and corruption are in place, as required by the Secretary of State's Directions and by the Counter Fraud Authority

Committee	Key roles and responsibilities
	• the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities (both clinical and non-clinical), that supports the achievement of the CCG's objectives • the Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation • the Committee shall request and review reports and positive assurances from officers and managers on the overall arrangements for governance, risk management and internal control and ensure robust action plans are in place, and delivered, to address any areas of weakness • the Audit Committee shall review the Annual Report and Financial Statements before submission to the Governing Body • the Committee should also ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board • where the Committee considers that there is evidence of ultra vires or improper actions, it shall report them to the Governing Body through its Chair
Remuneration Committee	Non-Executive Lead: Lou Evans [Executive and Clinical Leads only attend upon invitation] • The Committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG (Accountable Officer, other officer members and senior employees) and people who provide services to the CCG (including salary, any performance-related elements/bonuses, other benefits including pensions and cars, and contractual terms and termination of employment). • The Remuneration Committee shall make recommendations to the Governing Body on any proposed remuneration for individual CEC Members for specific work in addition to their CEC role. • The Remuneration Committee is authorised by the Governing Body to obtain legal, remuneration or other professional

Committee	Key roles and responsibilities
	advice as and when required, at the CCG's expense, and to appoint and secure the attendance of external consultants and advisors if it considers this beneficial. • The Remuneration Committee is authorised to decide on the most appropriate action needed by the Governing Body in the achievement of its Terms of Reference.
Primary Care Commissioning Committee	GP Clinical Lead: Dr Emma Keane Executive Lead: Alison Henly Non-Executive Lead: David Heath The Primary Care Commissioning Committee has delegated powers of responsibility from the Governing Body to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract) • Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services") • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF) • Decision making on whether to establish new GP practices in an area • Approving practice mergers; and • Making decisions on 'discretionary' payment (e.g. returner/retainer schemes). The committee also carries out the following activities: • Plan, commission and deliver primary medical services for the population of Somerset • Make primary care commissioning decisions; contribute to the development of the primary care strategy, ensuring recommendations are in line with the CCG Governing Body's Health and Care Strategy • Oversee the implementation and delivery of the primary care strategy and work plan

Committee	Key roles and responsibilities
	• To secure the provision of comprehensive and high quality primary medical service in Somerset • To co-ordinate a common approach to the commissioning of primary care services generally • To make decisions on investment on the infrastructure of primary medical services, to ensure adequate and high quality provision as well as value for money for the public • Undertake reviews of primary medical services in Somerset • To manage the commissioning budget for primary medical services in Somerset • Provide oversight across a number of functions, including but not limited to: primary cre workforce; primary care premises; primary care information management and technology (IM&T); Primary Care Networks (PCNs)
Finance and Performance Committee	GP Clinical Lead: Dr Ed Ford Executive Lead: Alison Rowswell Non-Executive Lead: Grahame Paine The purpose of this Committee is to provide assurance to the CCG Governing Body on the CCG's finance and performance. The Committee will look at the overall Somerset system position in terms of finance and performance. As an assurance Committee of the Governing Body, it will hold to account the CCG Executive team for delivery of the financial and performance plan, and recommend further areas for turnaround and performance improvement. This will be done through: • reviewing the financial and service performance of the CCG against statutory financial targets, financial control targets and the annual commissioning plan • reviewing the CCG's financial, performance and improving value schemes (QIPP) agenda and provide assurance to the Board in the delivery against annual plans • reviewing performance improvement plans, identifying areas for further improvement or commissioner actions and monitors trajectories towards improvement • monitoring the overall process of financial planning across the system and reviewing through the 5 year financial plan • where finance and performance issues are raised then these will be highlighted to the Clinical Executive Committee, A&E

Committee	Key roles and responsibilities
	Delivery Board and Elective Care Delivery Board to agree actions and mitigations (via the CCG's Chief Officer) to rectify the issue • ensure that the Committee agenda and papers take into account the risks on the Board Assurance Framework (BAF) and risk registers. The Committee will wish to be assured that matters of risk are being effectively managed
Patient Safety and Quality Assurance Committee	GP Clinical Lead: Dr Kate Staveley Executive Lead: Kathy French Non-Executive Lead: Wendy Grey The purpose of the Committee is to: • promote a culture within Somerset CCG that focuses on Patient Safety and Quality Improvement • provide assurance on all NHS Provider services governance arrangements and patient safety performance, through receiving exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services. The Committee will report areas of concerns and quality improvement to the Somerset CCG Governing Body • monitor serious incidents, incidents and action plans linked to key areas of responsibility where Somerset CCG: - are Lead Commissioners - have statutory responsibility - or where responsibility falls directly to Somerset CCG for improving the quality of services • to ensure that key themes and lessons learned from serious incidents, safeguarding, domestic homicide reviews and significant event audits are identified and shared across all NHS providers for continuous quality improvement of service provision and to prevent re-occurrence • to monitor mortality data and review findings, including Learning Disability Mortality Reviews (LeDeR) and the implementation of improvement actions • monitor progress in promoting harm free care across all NHS providers to include a focus on organisational actions to reduce pressure ulcer incidence, falls, health care acquired infection and medication incidents

Committee	Key roles and responsibilities
	• receive assurance from the Clinical Executive Committee that service strategy and redesign have prioritised quality and safety alongside service delivery efficiency • review service and pathway redesign proposals and make recommendations about patient safety concerns and outcome of quality impact assessments to the Clinical Executive Committee • receive focussed subject matter reports from the Clinical Executive Committee as required, with evidence that quality and patient safety issues and safeguarding alerts in respect of health services are fully considered, risks identified and reduced or mitigated • have oversight of the CCGs providers integrated quality dashboard and request attendance of providers, as required • provide a forum for representatives from the CCG's directorates to work collaboratively with members of the Committee to provide assurance around patient safety/quality improvement aspects of the Health and Care Strategy • receive reports on the CCGs duty to promote quality improvement in primary care. Assurance for quality and safety in primary care is currently discharged through the Joint Committee for Primary Care • receive reports on patient experience of NHS services from patient surveys, real time feedback, Friends and Family test and complaints and PALS enquiries and Health Watch to identify lessons learned and inform commissioning • ensure engagement with GP Localities and practices, and establish feedback mechanisms so that lessons learnt from complaints and incidents are shared in order to improve and inform services • to receive reports on the quality and safety of services jointly commissioned with Somerset County Council

9.12 The CCG's performance of effectiveness and capability is subject to continuous assessment including regular checkpoint assessments with NHS England.

9.13 The Internal Audit work programme has been reviewed via the Audit Committee and this work supports our review of internal control processes such as the Assurance Framework, risk management procedures, conflicts of interest and hospitality reporting procedures, data security and

business continuity. The audit programme, together with the subsequent work to improve systems where appropriate and scrutiny by our committees, supports my assurance that we have a sound system of governance and internal control in place.

UK Corporate Governance Code

9.14 NHS Somerset CCG is not required to comply with the UK Code of Corporate Governance. However, the CCG has reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG. For the financial period ended 30 June 2022, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

Discharge of Statutory Functions

9.15 In the light of recommendations of the 1983 Harris Review, NHS Somerset 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.

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

Risk Management Arrangements and Effectiveness

The CCG Risk Management Strategy

9.17 There is a clear commitment to corporate governance across NHS Somerset CCG and that risk management is applied throughout the organisation.

9.18 During 2022 the CCG has continued to develop its Risk Management Strategy to ensure it is embedded across the CCG and ensure that risk management whilst having to balance the delivery against the operational pressures of responding to the COVID-19 pandemic.

9.19 The NHS Somerset CCG Risk Management Strategy policy sets out both the arrangements for risk management across the CCG and the Governing Body Assurance Framework (GBAF). This policy supports the adoption of a positive risk management culture where individuals are encouraged to manage risk to ensure the CCG and the services it commissions are protected against risk (possible events that may have an adverse impact on the organisation's objectives). The policy also defines:

- responsibilities for forums within the CCG governance structure and roles within the CCG
- definitions and terminology
- the risk management process
- monitoring
- compliance.

9.20 During 2022 work has commenced with system partners to develop a risk management framework to support the transition into a Somerset Integrated Care System (ICS).

Capacity to Handle Risk

9.21 NHS Somerset CCG utilises risk capability and risk capacity to determine capacity to handle risk.

9.22 The CCG is committed to maintaining high risk capability (the knowledge and leadership competencies of individuals or a collective group in maximise their ability to comply with and deliver the CCG Risk Management Strategy policy). It is also committed to support the successful achievement of high-risk capability: anyone who has contractual employment within the CCG undertakes risk management training relevant to their role in addition to an overview of the CCG risk management as part of the CCG induction training programme. The CCG's Corporate Business team provides overall risk management support within the CCG and has continued to work in collaboration with CCG Risk Champions during 2022. This has supported the upskilling of teams so that their ability to manage risk and add value to their team within the function of risk management could be maximised.

9.23 CCG risk capacity is calculated through the resources (financial, human, equipment and estate) required (the risk exposure the CCG "must" take in order to reach an aim/objective) and resources available to manage materialised and non-materialised risk. Through adherence to the CCG Risk Management Strategy policy and using the risk monitoring activities through the assurance flow within the CCG governance structure, CCG risk capacity is reported, managed and monitored by the CCG statutory and non-statutory forums. The CCG's Governing Body sets the tolerance for risk capacity against CCG strategic aims in alignment for its ability to handle risk.

Risk Appetite

9.24 The CCG has established risk appetite within its risk management strategy to support the CCG to achieve its strategic aims and increase its rewards through optimising risk taking. The CCG's approach to risk appetite is defined within the CCG Risk Management Strategy policy.

9.25 The CCG Governing Body is responsible for:

- the definition of risk appetite

- the risk appetite review
- ensuring that the risk management process operates successfully to deliver and the risk appetite
- setting the tolerance for risk appetite against CCG strategic aims.

9.26 The CCG will use risk appetite to continually improve risk management to:

- assess its effectiveness for risk owners and decision makers in clearly and effectively defining the degree in which they can operate in to deliver CCG strategic and corporate aims/objectives
  Provide assurance that the aggregate and/or interlinked risk position is deliverable within risk appetite
- identify changes to conditions which may affect the risk appetite
- assess its effectiveness in enabling value added outcomes in proactive risk management
- maximise opportunity from evidence that the CCG has implemented risk appetite effectively.

Risk Assessment

9.27 NHS Somerset CCG has statutory obligations to ensure that risks arising from its undertaking are assessed through a standard risk assessment process as detailed within the CCG Risk Management Strategy.

9.28 The CCG performs assessment of risk to evidence the controls attributed to the risk, the control ownership and the measure of the control performance. The risk assessment also evidences the rationale for uncontrolled, target or current risk rating scores in addition to the risk proximity, risk appetite, treatment option and rationale to substantiate acceptable/non acceptable decisions. As part of the risk assessment process, risk plans are created to address any gaps in controls or assurance in addition to any tasks required to continue to deliver the controls and/or assurance to an effective level. The CCG has also encompassed an approval of the risk assessment by the Risk Owner as part of this process.

Other Sources of Assurance

Internal Control Framework

9.29 A system of internal control is the set of processes and procedures in place in the CCG 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.

9.30 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.

9.31 To strengthen internal control and to ensure the effectiveness of risk management, the CCG has encompassed the 'Three Lines of Defence' model within its risk management strategy, being:

- First Line of Defence: The CCG implemented a Risk Management Group, being the CCG Chief Executive and CCG Directors internal risk scrutiny forum

- Second Line of Defence: CCG statutory and non- statutory committees that specialise in risk management for clinical and/non-clinical functions in the overseeing and monitoring of risk and/or compliance

- Third Line of Defence: The CCG Audit committee, internal and external audit providers, and external assurance providers.

9.32 The CCG Governing Body assesses the organisational compliance and delivery of the strategic objectives against the GBAF.

9.33 All reports presented to the Governing Body include identified risks. All strategic documents are reviewed by the Clinical Executive Committee and clinical risks to delivery considered. The effectiveness of the Committee Structure is continually reviewed internally via the Governing Body review programme and against best practice where available. During 2022 the CCG committee structure was subject to annual review, and the membership and terms of reference updated, to ensure it was relevant and providing a sound system of internal governance for the organisation.

9.34 During 2022, the CCG Governing Body has continued to oversee and monitor the implementation of the Health and Care Strategy work programme, Fit for My Future. The CCG Governing Body and Clinical Executive Committee review the organisational compliance and delivery of the strategic objectives against the Assurance Framework and Corporate Risk register. The frequency of reporting has been impacted by the response to the pandemic and the cycle has been adjusted accordingly.

9.35 Attendance at the Governing Body is recorded in the minutes and full membership of the Governing Body has been present at the majority of the Governing Body meetings and seminars during 2022.

9.36 Regular reports are presented to the Governing Body to provide assurance on all CCG business and include:

- strategic planning
- financial management

- patient safety and quality of clinical care
- Care Quality Commission inspection reports
- organisational development
- performance management and the achievement of national and local NHS targets
- patient engagement
- stakeholder engagement
- emergency planning
- compliance with the NHS constitution
- identified risks and actions to address or mitigate the risks
- development of clinical commissioning.

9.37 The Governing Body's performance, effectiveness and capability is subject to continuous assessment. The CCG meets regularly with NHS England to provide assurance and the Chief Executive has had regular meetings with the NHS England Regional Director and Director of Strategy and Transformation in order to provide assurance of the continued effective delivery of local services. In addition, there was also full programme of regional assurance and oversight of the transition period to ensure ICBs were full prepared for establishment on 1 July 2022.

Annual Audit of Conflicts of Interest Management

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

9.39 An annual audit was carried out by the CCG's Internal Auditors which provided a moderate level of assurance of both the design and operational effectiveness of the CCG's systems for managing conflicts of interest.

9.40 The audit found that, overall, the CCG has controls in place to manage conflicts of interests through the administration processes undertaken by the Executive Assistant, Committee meetings discussion, decision-making, contract procurement and commissioning process. The audit raised three medium rated findings in relation to the declaration of interests, training and new starters, leading to a final assessment of moderate assurance relating to control design, and moderate assurance relating to control effectiveness.

Data Security

9.41 The UK is subject to the UK General Data Protection Regulation and UK Data Protection Act 2018 following the completion of the exit from the EU on 1 January 2021. Any information breaches are assessed and, where appropriate, reported through the Data Security and Protection (DSP) Toolkit, as set out in the NHS Digital guidance document - 'Guide to the Notification of Data Security and Protection Incidents'. The Security of

Network and Information Systems (NIS) Directive also requires reporting of relevant incidents to the Department of Health and Social Care. As there is no link between the DSP toolkit and the Strategic Executive Information System (STEIS), DSP Toolkit reportable incidents also need to be reported on STEIS. NHS Somerset CCG had one incident which met the DSP Toolkit reporting threshold during April to June 2022.

Data Quality

9.42 NHS Somerset CCG recognises the fundamental importance of reliable information and meets its responsibility in ensuring that good quality data is collated and appropriately used. All decisions, whether clinical, managerial or financial need to be based on information which is of the highest quality. During financial year up to 30 June 2022 we have continued to focus upon data quality in conjunction with our principal business analytics partner, South Central and West CSU. The data used by the Governing Body and delegated Committees/Groups is obtained through various sources, the majority of which are national systems and official NHS data sets. The provider data is quality assured through contract and performance monitoring and against the Secondary Uses Service (SUS).

9.43 There is collaborative agreement across the Somerset system that the data collected is appropriately sought and recorded, complete, accurate, timely and accessible, and that appropriate mechanisms are in place to support service delivery and continuity. Any identified data quality issues are addressed and resolved through the operational or contractual routes to ensure the accuracy of the Performance Reports provided to the CCG Governing Body and its delegated Committees, the System Performance Group and the System Assurance Board.

9.44 In addition, within the CCG, our Continuing Healthcare (CHC) team has developed local operating processes and continues to focus on data quality to provide a strong foundation for effective delivery of the CHC service.

Information Governance

9.45 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 the Data Security and Protection (DSP) toolkit, and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

9.46 All organisations that have access to NHS patient information are required to provide assurances that they are practising good information governance and use the DSP Toolkit to evidence this through publication of annual assessments. The DSP Toolkit is part of a framework for

assuring that organisations are implementing the ten National Data Guardian data security standards as well as their statutory obligations for data protection and data security. The annual assessment and submission process completed by commissioned organisations provides assurance to the CCG, as the commissioner of health services for the population of Somerset, that commissioned services meet the required standards for information governance.

9.47 We place high importance on ensuring that robust information governance systems and processes are in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the DSP Toolkit and good information governance practice. All staff are required to undertake annual information governance training and we have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

9.48 At the end of June 2022, of the whole workforce, 88% had completed their training in year since 1 July 2021. Due to the transition to ICB, it had not been possible to achieve 100% of the CCG Governing Body completing their training. As the CCG was closed at 30 June 2022, it was agreed with NHS

9.49 Digital that the improvement plan action against assertion 3.4.2 would focus on the ICB Board members in post at 30 June 2022.

9.50 Although the CCG was unable to publish a compliant DSPT at the end of June 2022, on completion of the improvement plan, the overall percentage of assertions met (mandatory (100%) and non-mandatory (84%) for 2021/22 was 94%.

9.51 Processes are in place for incident reporting and investigation of serious incidents. We have been developing information risk assessment and management procedures and a programme is being rolled out to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

9.52 The CCG uses a number of models to support operational management; however, none of these models are business critical.

Third Party Assurances

9.53 NHS Somerset CCG contracts with a range of third party providers in order to deliver both healthcare services to the population of Somerset and to support the corporate functions of the CCG, for example through the commissioning support service (CSU) and external payroll services: further details can be found under Delegation of Functions (pages 144 to146 refer)

Control Issues

9.54 An assessment of control issues associated with third party providers is detailed in sections 9.72 to 9.80 of this report. No further control weaknesses have been identified.

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

9.55 The CCG has a Scheme of Delegation which ensures that financial controls are in place across the organisation.

9.56 The Audit Committee is responsible for seeking assurance and overseeing Internal and External Audit and Counter Fraud services, reviewing financial and information systems and monitoring the integrity of the financial statements, and reviewing significant financial reporting judgements. The Committee reviews the system of governance, risk management and internal control, across the whole of the CCG's activities.

9.57 The Audit Committee receives regular reports from Internal and External Audit and Counter Fraud.

9.58 The Audit Committee supports the view that fraud against the NHS will not be tolerated. All genuine suspicions of fraud are investigated and if proven the strongest sanctions are sought against the perpetrators.

9.59 As well as overseeing the anti-fraud, bribery and corruption arrangements in place at providers, the CCG must also ensure that its own counter fraud measures remain robust. Somerset CCG has well-established counter fraud arrangements in order to help us achieve the standards set out by the NHS Counter Fraud Authority. The CCG engages an Accredited Counter Fraud Specialist to implement an ongoing programme of anti-fraud, bribery and corruption work across the whole organisation. During 2022 work has involved the delivery of an annual work plan which follows the NHS Counter Fraud Authority standards to ensure our resources are protected from fraud, bribery and corruption, as well as addressing all four key areas of the national counter fraud strategy: namely, strategic governance; inform and involve; prevent and deter; and hold to account.

9.60 NHS Somerset CCG has historically taken a very robust approach to counter fraud work. The Local Counter Fraud Specialist (LCFS) is well resourced in terms of work plan days and the Audit Committee and senior management throughout the CCG understand the importance of counter fraud work and fully support the LCFS and the Director of Finance, Performance and Contracting in conducting that work.

9.61 The LCFS has developed key relationships with the following teams/directorates: Human Resources, Recruitment, Payroll, Risk Management and Communications. These relationships, coupled with the significant work done by the LCFS to develop an anti-fraud culture, have

resulted in good quality referrals being made to the LCFS. This in turn has resulted in a good proportion of cases concluding in civil, criminal and/or disciplinary sanctions. Where possible these sanctions are publicised within the CCG to give staff confidence that robust action is taken when allegations of fraud are made; this also has a significant deterrent effect on other employees and prevents other incidents of fraud.

9.62 The LCFS shares briefings with all staff through the CCG 60 seconds bulletin, which covers key areas of learning from within the sector.

9.63 The CCG has a Whistleblowing Policy and reporting processes which are well publicised to staff, alongside two Freedom to Speak Up Champions. The CCG is confident these processes are effective. No cases have been reported during 2022.

9.64 In 2022 a level of efficiency savings were delivered in-year in relation to Continuing Healthcare services, GP Prescribing and CCG running costs. Through ICS meetings, local leaders continue to discuss QIPP/CIP assumptions to inform future planning decisions and ensure that a robust peer challenge is in place across Somerset, but to also confirm that clear assumptions and monitoring are in place to ensure no double-counting across organisations.

9.65 The CCG looks at all opportunities for cost savings through demand management schemes and agree these with system partners.

9.66 To support this, the CCG has a Finance and Performance Committee, chaired by a Non-Executive Director of the CCG Governing Body, which looks at the financial position and QIPP opportunities across the range of services commissioned. This group meets monthly to review the position and has an active work programme which is actioned through the CCGs Leadership Team.

9.67 As part of the developing and continued working towards a single system of finance, activity and workforce, the individual operational and financial plans of the Somerset Health Partners are developed, cross-checked and triangulated as one, through established joint working and strengthened governance, as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery. The Somerset approach to managing the system as a single health and care system, supported by a long term strategy, continues to be developed to ensure alignment and delivery of the aims for the system as a whole. This forward strategy will build on and refresh the already approved estates programme, capital plans, and digital plans. Future plans will continue to focus on managing demand and reducing cost across the system. This includes a focus on clinical variation (using Rightcare[30], Getting It Right First Time, Model Hospital, Reference Costs and more benchmarks), and looking at elective and non-elective pathways, medication, continuing healthcare, and optimisation in

[30] RightCare aims to support health and care systems to improve care quality, population health and system sustainability

both the short and longer term through changes to the models of care. We also have a system-wide planning approach to the efficient and cost effective use of bed capacity across all ICS Partners.

Delegation of Functions

9.68 It is implicit through the work of the Governing Body and delegated Committees that members have clear responsibility for ensuring appropriate use of resources. Where there are concerns in relation to budgetary management, these are clearly documented in the Corporate Risk Register.

9.69 Through the committee structure within NHS Somerset CCG, regular reports are received on the performance of contracted Providers. Areas of under and over performance are addressed through contract meetings and reported though finance, performance and quality papers presented to CCG groups and committees.

9.70 The Audit Committee, under the scheme of delegation, monitors the financial stewardship of the organisation and is responsible for scrutinising and signing off the end of year financial accounts.

9.71 The Governing Body, delegated Committees and Risk Management Group retain oversight of all risks, including those deemed to be systematic, and are responsible for ensuring that relevant mitigating actions are undertaken. There have been no significant internal control failures identified throughout the period from 1 April 2021 to 30 June 2022 and Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken during this period.

9.72 The CCG commissions support services from the South, Central and West Commissioning Support Unit for the provision of functions such as Business Intelligence support, Information Technology and Information Governance support, Procurement Services support, Care Navigation Services, GP IT Services and additional consultancy and project support. The contract form provides the framework under which assurance on performance can be monitored and managed. In addition, in order to deliver assurance over the internal controls and control procedures operated by all Commissioning Support Units (CSUs), NHS England engage a reporting accountant to prepare a report on internal controls. The objective of this is to provide assurance in a cost-effective manner for the NHS through reducing the duplication which would likely arise from multiple CCG internal and external auditors separately assessing CSU controls. The scope of the Service Auditor Report (SAR) covers Payroll, Financial Ledger, Accounts Payable, Accounts Receivable, Financial reporting, Treasury and Cash Management and Non-Clinical Procurement. Of these services, Somerset CCG only commissions the Non-Clinical Procurement service through the South Central and West CSU (SCW CSU). There were no exceptions identified within the SAR for the Non-Clinical Procurement service for the 2021/22 financial year. In addition to the report provided for the 2021/22 financial year, further

written assurance has been provided by the SCW CSU confirming that, for the period 1 April to 30 June 2022:

- there have been no significant changes to the Description within the latest report
- there have been no changes to the risks within the In-scope control environment that would give rise to changes to any of the control objectives listed in the last report
- there has been no reduction in the coverage of risk provided by the control objectives for the services covered per the last report
- there have been no changes to the control activities within the control environment, significant enough to cause one or more of the existing control objectives not to be met
- control activities listed within the report have been operationally effective.

9.73 Type II ISAE 3402 Service Auditor reports assessing the state of the control environment, for the most recently available period of 1 April 2021 to 31 March 2022, have also been received and reviewed for the following services provided to the CCG:

9.74 **NHS Digital** provides IT services to support processing of NHS payments and deductions to providers of general practice (GP) services in England. The 2021/22 SAR presented a qualified opinion with exceptions reported for two control areas. The CCG considers that these exceptions had no significant impact on the control environment of the CCG.

9.75 **NHS Shared Business Services Limited** provide finance and accounting services to the CCG. The 2021/22 SAR presented a qualified opinion with one exception reported. This exception related to the controls in place to provide reasonable assurance that equipment and facilities are protected from damage by fire, flood and other similar environmental hazards and that physical security is adequate. The CCG considers that this exception had no significant impact on the service provided to the CCG.

9.76 **NHS Business Services Authority** provide and maintain the Electronic Staff Record system (ESR system) and the prescriptions payment process on behalf of the CCG.

9.77 The 2021/22 SAR covering the prescriptions payment system presented a qualified opinion with one exception identified. This exception related to the controls in place to provide reasonable assurance that access to systems is appropriately restricted. The CCG considers that this exception had no significant impact on the service provided to the CCG.

9.78 The 2021/22 SAR covering the Electronic Staff Record system (ESR system) presented a qualified opinion with one exception identified. This

exception related to the controls in place to achieve Control Objective 2 “Controls provide reasonable assurance that security configurations are created, implemented and maintained to prevent inappropriate access”. The controls necessary to ensure that access to the development and production areas of the NHS hub was controlled and appropriately restricted, were not designed effectively from 1 April 2021 to 6 June 2021 but updated controls were implemented on 7 June 2021. The CCG considers that this exception had no significant impact on the service provided to the CCG.

9.79 **Capita Primary Care Support England (PCSE)** provide administrative and support services as part of the delegated commissioning function for Primary Care Medical services. The 2021/22 SAR presented a qualified opinion for the payments and pensions administration services provided by Capita PCSE, with exceptions identified relating to 6 out of 17 control objectives during the year. The report provided a qualified opinion as the exceptions were deemed to be minor and no significant impacts have been identified in respect of the service provided to the CCG.

9.80 Further written assurance has been provided by NHS Shared Business Services, NHS Business Services Authority and Capita PCSE, covering the period 1 April 2022 to 30 June 2022, to confirm that there have been no significant changes to the control environments of the services provided since the issue of 2021/22 SARs. These letters also provide details of updates and actions taken in relation to any exceptions raised in the 2021/22 SARs.

The Better Care Fund

9.81 The Better Care Fund (BCF) was established by the Government to encourage the integration of health and social care and to achieve specific national conditions and local objectives. These relate to supporting people to live as independently as possible in their own homes and avoid unnecessary admissions to hospital, long term care placements or avoidably long stays in a treatment or care setting.

9.82 It was a requirement of the BCF that NHS Somerset CCG and Somerset County Council establish a pooled fund for this purpose. This is in place and the management of the fund is covered by a signed agreement under Section 75 of the National Health Service Act 2006.

9.83 The BCF has evolved since its inception and now incorporates three budgetary components:

- the Disabled Facilities Grant – managed via District Councils
- mandated NHS (CCG) Contributions
- the Improved Better Care Fund (contributions via Somerset County Council).

9.84 Each year, local systems are required to provide a plan and progress reports on the use of the BCF. Better Care Fund plans are required to

have oversight and sign off by Health and Wellbeing Boards and this is the case for Somerset.

9.85 During 2022 the Somerset BCF continued to help drive forward our person-centred integration agenda and the 2022 plan secured and stabilised investment in:

- Social prescribing and community-based support
- Major and minor home adaptations and equipment
- Carers support services
- Core social care services
- Intermediate care services (including Rapid Response and Home First)
- COVID-19 specific Hospital Discharge Schemes
- Additional social care support for people able to leave hospital at weekends.

Review of the Effectiveness of Governance, Risk Management and Internal Control

Counter Fraud Arrangements

9.86 The 2022/23 Counter Fraud Strategy and Annual Plan has been developed to support the CCG and the new Integrated Care Board (ICB) in implementing appropriate measures to counter fraud, bribery and corruption. Having appropriate measures in place helps to protect NHS resources against fraud and ensures they are used for their intended purpose, the delivery of patient care.

9.87 The Counter Fraud Strategy and Annual Plan for 2022/23 aligns with the Government Functional Standards for Counter Fraud. These have been introduced to ensure a consistent approach across the public sector to protecting services against the risk of fraud, bribery and corruption. The 2022/23 strategy and work plan was produced taking into account:

- discussions with the Director of Finance, Performance, Contracting and Digital and members of the Audit Committee

- local proactive work, risk measurement exercises and evaluation of previous work conducted at the CCG by the Local Counter Fraud Specialist (LCFS) and CCG staff

- risks identified from referrals received and investigations conducted at the CCG by the LCFS

- risks identified at other clients either locally or nationally by the NHS Counter Fraud Authority (NHSCFA)

- any national programme of proactive work by the NHSCFA

- the NHSCFA's strategic aims, including implementation of the new Functional Standards and increasing engagement with NHS organisations.

9.88 The Counter Fraud service is provided by BDO LLP, which includes a local accredited Counter Fraud Specialist who ensures that the annual work plan is delivered. Regular progress reports are provided at each Audit Committee meeting detailing progress against the work plan and highlighting any emerging fraud risks or allegations as they arise. In addition, an annual report is produced showing an assessment against the functional standards, including any actions which need to be taken in order to ensure the standards are achieved.

9.89 The overall executive lead for counter fraud is Alison Henly, Director of Finance, Performance, Contracting and Digital, who is responsible for proactively tackling fraud, bribery and corruption.

Head of Internal Audit Opinion

9.90 Following completion of planned audit work for the fifteen-month period from 1 April 2021 to 30 June 2022 for the clinical commissioning group, the Head of Internal Audit has 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:

9.91 The role of internal audit is to provide an opinion to the Governing Body, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period. The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Governing Body and Assurance Framework and supporting processes

- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses

- Any reliance that is being placed upon third party assurances

9.92 Overall, we are able to provide moderate assurance that there is a sound system of internal control designed to meet the CCG's objectives and that

controls are being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

9.93 In forming our view we have taken into account that:

- the CCG has delivered a breakeven position for the 2021/22 financial year and for the three-month period to 30 June 2022. As a result, the CCG's cumulative financial deficit will remain at £19.581m

  the CCG has displayed strong controls in relation to the key financial systems

- despite the impact on the staff due to the Covid-19 pandemic, we have been able to complete sufficient audit work to provide an overall opinion. There have been no limitations in scope due to the homeworking restrictions

- the Covid-19 pandemic has resulted in aspects of the NHS Constitutions Standards not being met, however, from the work we have undertaken and the reports provided, it was evident that the Governing Body, Audit Committee and other Committees have been kept informed on the issues on a timely basis

- the CCG has embedded its risk management processes, however, the new format of the Governing Body Assurance Framework has not been finalised. The strategic objectives, which are aligned to the Somerset Integrated Care System priorities, are embedded

- good progress has been made during the year with the implementation of the actions arising from the audit work.

9.94 Internal Audit services are provided to the CCG by BDO LLP. A risk-based approach is taken to the development of internal audit planning, using the CCG's own risk management processes and risk register. The internal audit work programme for 2022/23 has been divided between the CCG and the ICB.

9.95 During the period 1 April to 30 June 2022, Internal Audit carried out its planned audit programme for the CCG and the table below sets out a summary of the audit reports completed and the level of assurance provided:

Area of Audit: CCG Closedown and ICB Establishment Due Diligence (Part 2)
Director: James Rimmer, Somerset CCG Chief Executive

Design: N/A **Effectiveness**: N/A **Recommendations**: Advisory observations only

Summary of report:

This audit is an advisory piece which follows on from previous work undertaken on the CCG closedown and ICB Establishment arrangements.

Areas that had not been covered during the initial review, including the Workforce transfer and ICB governance arrangements, are covered in this audit.

The purpose of the audit is in two parts:

- to provide assurance that there is a robust plan in place to ensure complete and accurate transfer of staff from the CCG to the ICB; and
- to provide assurance on the progress being made to set up the governance and structure arrangements for the Integrated Care Board

Key Findings:

HUMAN RESOURCES DUE DILIGENCE

ICS Implementation guidance has been issued to support CCGs transferring to ICBs. One tool that has been developed is the due diligence checklist which details the requirements to ensure transfer of people and property.

We tested a number of Human Resources areas identified in the due diligence checklist in order to ascertain the plans in place to transfer the staff to the ICB, including;

- People impact assessment
- Policies
- Management of change business case
- Colleague Consultation
- Employee contracts
- HR due diligence checklist

Observations: Somerset CCG should ensure that all HR Due Diligence checklist and People Impact Assessment actions are completed as practically as possible, prior to the Audit Committee meeting scheduled for 25 May 2022. The CCG has taken the ‘lift and shift’ approach to all contracts and policies which will ensure that there will be minimal disruption to the organisation when the closedown occurs.

PAYROLL

Observations: We would recommend the CCG creates a payroll plan outlining everything that needs to be completed up until April 2023 and that regular meetings are scheduled with the payroll provider in the run up to the transition to ensure everything is ready for 1 July 2022.

CONSTITUTION, GOVERNANCE HANDBOOK AND TERMS OF REFERENCE FOR ICB COMMITTEES

Observations: Somerset is up-to-date and have met all deadlines for submission of documents to NHS E/I for review. No areas of concern identified.

PROGRESS WITH BOARD APPOINTMENTS & ICB STRUCTURE
Observations: Somerset should ensure that there is a mitigation plan in place to address the risk of Board members not being in post on 1 July 2022.

STATUS OF THE PREPARATION OF KEY ORGANISATIONAL DOCUMENTATION EG RISK FRAMEWORK, SORD, SFI, SYSTEM DEVELOPMENT PLAN
Observations: The CCG should consider including further risks that may occur before, during and after the transition to the ICB. We have found Somerset to be making good progress with regards to the SoRDs, SFIs and Readiness to Operate.

FUNCTIONS AND DELEGATION MAPPING
Guidance states that the CCG should prepare an ICB functions and decision map ready to be adopted on 1st July 2022 - including (where applicable) place boundaries, place-based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements.

Observations: Progress is being made with regards to the functions and delegation mapping, but the CCG could improve this. To further improve on the information available, the CCG could create a functions and decisions map spreadsheet which lays out each function, the category, delivery route and the new ICB lead for 2022.

Overall Conclusion:
Based on the work undertaken between April and 16th May 2022, it is evident that the CCG is making good progress with regards to the transfer of staff and governance arrangements for the establishment of the ICB. Somerset CCG has evidence of good practice when compared to peer CCG organisations in areas of these ICB arrangements. However, we have identified a few actions that should be addressed in order for the CCG to be ready for the ICB transition date of 1 July 2022.

Management Response:
We have taken the recommendations within this report and have indicated in a separate appendix the actions we will take regarding these recommendations.

Area of Audit: Data Security & Protection Toolkit Follow Up
Director: Alison Henly, Director of Finance, Performance, Contracting and Digital

Design: N/A **Effectiveness**: N/A **Recommendations**: Advisory observations only

Summary of report:
The purpose of this follow-up review was to assess whether the recommendations raised as part of the 2021/22 audit have been implemented and whether any further action is required ahead of the year-end submission

Key Findings:
During our review we found sufficient evidence to demonstrate that the following areas of good practice are currently in place in line with the requirements of the DSP Toolkit:

- The CCG is in the process of conducting a data quality audit, which is expected to be concluded by the time of the final toolkit submission (sub-assertion 1.1.7).
- The CCG's incident response procedure was updated in May 2022 and quarterly reporting of high severity alerts is provided to the Information Governance, Records Management and Caldicott Committee (sub-assertion 6.3.1).
- The CCG has appropriate arrangements in place for acknowledging all cyber security incidents within 48 hours (sub-assertion 6.3.2).
- Arrangements are in place for regular reporting to be provided to the CCG by the CSU with regards to the CCG's vulnerability profile (sub-assertion 6.3.3).
- The CCG's digital procurement policy has been reviewed in June 2022 and links with the CCG's Data Protection Impact Assessment template. A review of existing digital services is in the process of being conducted and it is expected that this will conclude by the time of the final toolkit submission(sub-assertion 6.3.4) .
- A hard copy of emergency contacts is maintained and distributed to those who would be involved in the recovery of the CCG's operations in the event of an incident (sub-assertion 7.3.2).
- The CCG's backups are replicated to both a secondary data centre and a cloud environment, which are separate from the CCG's IT network (sub-assertion 7.3.6).

Following the provision of further audit evidence, we conclude that there are no further actions to be completed or additional findings to be reported as part of this review.

Summary Review of the effectiveness of Governance, Risk Management and Internal Control

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

9.97 Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed. I have been advised on the implication of the result of this review by:

- the work of the internal auditors
- Executive Directors, Senior Managers and Clinical Leads within the CCG who have responsibility for the development and maintenance of the internal control framework
- available performance information
- comments made by the external auditors in their annual audit letter and other reports.

9.98 The Governing Body Assurance Framework and Corporate Risk Register have been designed to provide me, as Accountable Officer, with sources of assurance which are evidence that the effectiveness of controls that manage risks to the CCG are achieving their principal objectives and are reviewed on an on-going basis as described earlier in this chapter.

9.99 The Executive Directors within the CCG who have responsibility for the development and maintenance of the system of internal control provide me, as Accountable Officer, with assurance.

9.100 As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described above.

9.101 We have also described the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including the role and outputs of the:

- Governing Body
- Audit Committee
- Finance and Performance Committee
- Patient Safety and Quality Committee
- Clinical Executive Committee
- Remuneration Committee
- Primary Care Commissioning Committee

Conclusion

9.102 I can confirm that no significant internal control issues have been identified.

Jonathan Higman
Chief Executive
NHS Somerset Integrated Care Board
29 June 2023

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 30 June 2022 are listed below grouped within their Primary Care Network.

Practice Name	Address
West Somerset PCN	
West Somerset Healthcare	West Somerset Healthcare, Williton Surgery, Robert Street, Williton, Taunton, Somerset, TA4 4QE
Minehead Medical Centre	Minehead Medical Centre 2 Irnham Road, Minehead, Somerset, TA24 5DL
Exmoor Medical Centre	Exmoor Medical Centre, Oldberry House, Fishers Mead, Dulverton, Exmoor, TA22 9EN
Dunster & Porlock Surgeries	Dunster & Porlock Surgeries, West Street, Dunster, Somerset, TA24 6SN
Bridgwater PCN	
Quantock Medical Centre	Quantock Medical Centre, Banneson Road, Nether Stowey, Bridgwater, Somerset, TA5 1NW
Cannington Health Centre	Cannington Health Centre, Mill Lane, Cannington, Bridgwater, Somerset, TA5 2HB
East Quay Medical Centre	East Quay Medical Centre, Symons Way, East Quay, Bridgwater, Somerset, TA6 4GP
Taunton Road Medical Centre	Taunton Road Medical Centre, 12-16 Taunton Road, Bridgwater, Somerset, TA6 3LS
Cranleigh Gardens Medical Centre	Cranleigh Gardens Medical Centre, Cranleigh Gardens, Bridgwater, Somerset, TA6 5JS
Redgate Medical Centre	Redgate Medical Centre, Westonzoyland Road, Bridgwater, Somerset, TA6 5BF
Somerset Bridge Medical Centre	Somerset Bridge Medical Centre, Stockmoor Park, Taunton Road, Bridgwater, Somerset, TA6 6LD
North Petherton Surgery	North Petherton Surgery, Mill Street, North Petherton, Somerset, TA6 6LX
Polden Medical Practice	Polden Medical Practice, Quarry Ground, Edington, Bridgwater, Somerset, TA7 9HA and

Practice Name	Address
	Woolavington Surgery, 9 Bitham Walk, Woolavington, Somerset, TA7 8ED
North Sedgemoor PCN	
Burnham and Berrow Medical Centre	Burnham Medical Centre, Love Lane, Burnham on Sea, Somerset, TA8 1EU
Brent Area Medical Centre	Brent Area Medical Centre, Anvil House, East Brent, Highbridge, Somerset, TA9 4JD
Cheddar Medical Centre	Cheddar Medical Centre, Roynon Way, Cheddar, Somerset, BS27 3NZ
Axbridge & Wedmore Medical Practice	Axbridge Surgery, Houlgate Way, Axbridge, Somerset, BS26 2BJ
Highbridge Medical Centre	Highbridge Medical Centre, Pepperall Road, Highbridge, Somerset, TA9 3YA
West Mendip PCN	
Wells City Practice	Wells City Practice, Priory Medical Centre, Priory Health Park, Glastonbury Road, Wells, Somerset, BA5 1XJ
Wells Health Centre	Wells Health Centre, Priory Medical Centre, Priory Health Park, Glastonbury Road, Wells, Somerset, BA5 1XJ
Glastonbury Surgery	Glastonbury Surgery, Feversham Lane, Glastonbury, Somerset, BA6 9LP
Glastonbury Health Centre	Glastonbury Health Centre, 1 Wells Road, Glastonbury, Somerset, BA6 9DD
Vine Surgery Partnership	Vine Surgery, Hindhayes Lane, Street, Somerset, BA16 0ET
Mendip PCN	
Oakhill Surgery	Oakhill Surgery, Shepton Road, Oakhill, Radstock, Somerset, BA3 5HT
Grove House Surgery	Grove House Surgery, West Shepton, Shepton Mallet, Somerset, BA4 5UH
Park Medical Practice	Park Medical Practice, Cannards Grave Road, Shepton Mallet, Somerset, BA4 5RT

Practice Name	Address
Mendip Country Practice	Mendip Country Practice, Church Street, Coleford, Radstock, Somerset, BA3 5NQ
Beckington Family Practice	The Beckington Family Practice, St Luke's Surgery, St Luke's Road, Beckington, Frome, Somerset, BA11 6SE
Frome PCN	
Frome Medical Practice	Frome Medical Practice, Enos Way, Frome, Somerset, BA11 2FH
South Somerset East – Rural Practice Network PCN	
Bruton Surgery	Bruton Surgery, Patwell Lane, Bruton, Somerset, BA10 0EG
Millbrook Surgery	Millbrook Surgery, Millbrook Gardens, Castle Cary, Somerset, BA7 7EE
Wincanton Health Centre	Wincanton Health Centre, Dykes Way, Wincanton, Somerset, BA9 9FQ
Milborne Port Surgery	Milborne Port Surgery, Gainsborough, Milborne Port, Sherborne, Dorset, DT9 5FH
Queen Camel Medical Centre	Queen Camel Medical Centre, West Camel Road, Queen Camel, Yeovil, Somerset, BA22 7LT
South Somerset West PCN	
Buttercross Health Centre	Buttercross Health Centre, Behind Berry, Somerton, Somerset, TA11 7PB and The Ilchester Surgery, 17 Church Street, Ilchester, Somerset, BA22 8LN
Martock Surgery & South Petherton Medical Centre	Martock Surgery & South Petheron Medical Centre, Church Street Surgery, Church Street, Martock, Somerset, TA12 6JL
Crewkerne Health Centre	Crewkerne Health Centre, Middle Path, Crewkerne, Somerset, TA18 8BX
Hamdon Medical Centre	Hamdon Medical Centre, Matts Lane, Stoke Sub Hamdon, Somerset, TA14 6QE
Yeovil PCN	
Ryalls Park Medical Centre	Ryalls Park Medical Centre, Marsh Lane, Yeovil, Somerset, BA21 3BA

Practice Name	Address
Oaklands Surgery	Oaklands Surgery, Birchfield Road, Yeovil, Somerset, BA21 5RL
Penn Hill Surgery	Penn Hill Surgery, St Nicholas Close, Yeovil, Somerset, BA20 1SB
Diamond Health group	74 Hendford, Yeovil, Somerset, BA20 1UJ and Abbey Manor Medical Practice, Abbey Manor Park, Yeovil, Somerset, BA21 3TL
Preston Grove Medical Centre	Preston Grove Medical Centre, Preston Grove, Yeovil, Somerset, BA20 2BQ
Chard, Crewkerne and Ilminster	
Summervale Surgery	Summervale Surgery, Ilminster Medical Centre, Canal Way, Ilminster, Somerset, TA19 0DT
Essex House Medical Centre	Essex House Medical Centre, 59 Fore Street, Chard, Somerset, TA20 1QA
The Meadows Surgery (Ilminster)	The Meadows Surgery, Ilminster Medical Centre, Canal Way Ilminster, Somerset, TA19 9FE
Springmead Surgery	Springmead Surgery, Summerfields Road, Chard, Somerset, TA20 2EW
Tawstock Medical Centre	Tawstock Medical Centre, St Mary's Crescent, Chard, Somerset, TA20 2DZ
Church View Medical Centre	Church View Medical Centre, Broadway Road, Broadway, Ilminster, Somerset, TA19 9RX
Langport Surgery	Langport Surgery, North Street, Langport, Somerset, TA10 9RH
Tone Valley	
North Curry Health Centre	North Curry Health Centre, Greenway, North Curry, Taunton, Somerset, TA3 6NQ
Creech Medical Centre	Creech Medical Centre, Hyde Lane, Creech St Michael, Taunton, Somerset, TA3 5FA
Taunton Vale Healthcare	Taunton Vale Healthcare, Lisieux Way, Taunton, Somerset, TA1 2LB
Lyngford Park Surgery	Lyngford Park Surgery, Fletcher Close, Taunton, Somerset, TA2 8SQ

Practice Name	Address
Warwick House Medical Practice	Warwick House Medical Practice, Upper Holway Road, Taunton, Somerset, TA1 2QA
Taunton Deane West	
Lister House Surgery	Lister House Surgery, Croft Way, Wiveliscombe, Somerset, TA4 2BH
Luson Surgery	Luson Surgery, 41 Fore Street, Wellington, Somerset, TA21 8AG
Wellington Medical Centre	Wellington Medical Centre, Mantle Street, Wellington, Somerset, TA21 8BD
Taunton Central	
College Way Surgery	College Way Surgery, Comeytrowe Centre, Taunton, Somerset, TA1 4TY
St James Medical Centre	St James Medical Centre, St James Street, Taunton, Somerset, TA1 1JP
French Weir Health Centre	French Weir Health Centre, French Weir Avenue, Taunton, Somerset, TA1 1NW
Crown Medical Centre	Crown Medical Centre, Venture Way, Taunton, Somerset, TA2 8QY
Quantock Vale Surgery	Quantock Vale Surgery, Mount Street, Bishops Lydeard, Taunton, Somerset, TA4 3LH
No PCN	
West Coker Surgery (Patients are covered by the Yeovil PCN)	Westlake Surgery, High Street, West Coker, Somerset, BA2 9AH

Annex 2 (Governance Statement)

NHS Somerset CCG Governing Body Meetings Apr-June 2022 Attendance Record			
(V) = voting Member (NV) = non-voting Member	26.05.22	16.06.22	30.06.22
Dr Ed Ford (V) Chair	✓	✓	✓
James Rimmer (V) Chief Executive	✓	✓	X
Lou Evans (V) Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	X
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	X	X	X
Kathy French Acting Director of Quality and Nursing	✓	X	✓
Judith Goodchild (NV) Chair, Healthwatch	✓	✓	X
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓
Wendy Grey (V) Non-Executive Director, Member Practice Representative	X	X	X
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	X	✓
Maria Heard (NV) SRO COVID-19 Programme Director Fit for my Future	✓	✓	✓
Alison Henly (V) Director of Finance, Performance , Contracting and Digital	✓	✓	✓
Trudi Mann (V) Non-Executive Director, Member Practice Representative	✓	✓	X
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	✓	✓
Alison Rowswell Acting Director of Commissioning	✓	✓	✓
Dr Helen Thomas (NV) Non-Executive Director, Member Practice Rep	✓	X	✓
Sandra Wilson (NV) PPG Lay Observer	✓	✓	✓
Paul von der Heyde ICB Chair Designate	✓	✓	✓
Jonathan Higman ICB Chief Executive Designate	✓	X	✓
Christopher Foster ICB Non-Executive Director Designate		✓	X

NHS Somerset Clinical Executive Committee (CEC) Meeting Attendance: 1 April 2021 to 31 March 2022					Present = ✓ Apologies = X
First Name	**Surname**	**Position**	**06-Apr**	**04-May**	**15-Jun**
Peter	Bagshaw	Associate Clinical Director: Mental Health and Learning Disabilities	Y	Y	Y
Will	Chandler	Associate Clinical Director: Planned Care	Y	Y	Y
Iain	Chorlton	Associate Clinical Director: Urgent and Emergency Care	Y	Y	Y
Ed	Ford	CCG Chair	Y	Y	Y
Kathy	French	Acting Director of Quality and Nursing	Y	N	Y
Justin	Harrington	Associate Clinical Director: Digital Strategy	N	Y	Y
Maria	Heard	Programme Director: Fit For My Future	N	Y	Y
Alison	Henly	Director of Finance, Performance and Contracting	Y	Y	Y
Jonathan	Higman	CEC Chair; and, Chief Executive (ICB)		Y	N
Jeremy	Imms	Acting Associate Clinical Director: Primary Care	N	Y	Y
Tom	MacConnell	Associate Clinical Director: Integrated Care	Y	Y	Y
Shelagh	Meldrum	Chief Nursing Officer, Somerset ICB			Y
James	Rimmer	Chief Executive and CEC Chair	Y	Y	N
Alison	Rowswell	Acting Director of Commissioning	Y	N	Y

NHS Somerset Clinical Executive Committee (CEC) Meeting Attendance: 1 April 2021 to 31 March 2022					Present = ✓ Apologies = X
First Name	**Surname**	**Position**	**06-Apr**	**04-May**	**15-Jun**
Kate	Staveley	Associate Clinical Director: Women's and Children's Services	Y	Y	Y
Attendees (Not Members)					
Orla	Dunn	Consultant in Public Health, Somerset County Council	Y	Y	Y
Shaun	Green	Deputy Director of Clinical Effectiveness and Medicines Management	N	Y	N
Tim	Horlock	GP and LMC Representative	Y	N	N
Nick	Kennedy	Secondary Care Clinical Lead: FFMF	N	N	N
Andrew	Tresidder	Clinical Lead: EBI/Medicines Optimisation	Y	Y	N

NHS Somerset CCG Audit Committee Meetings April to June 2022 Attendance Record		✓ = Present X = Apologies Given	
Name	**Member (M)/ In Attendance (A)**	**25.5.22**	**14.6.22**
Lou Evans Audit Committee Chair and Non-Executive Director, Lay Member (Governance and Audit)	M	✓	✓
Alison Henly Director of Finance, Performance, Contracting and Digital	A	✓	✓
Dr Helen Thomas Non-Executive Director	M	✓	✓

Notes:

Representatives from External and Audit Internal and Counter Fraud were present at meetings throughout the year, with other representatives attending as required.

NHS Somerset CCG Patient Safety and Quality Assurance Committee Meetings 2021/22 Attendance Record*	✓ = Present X = Apologies Given		
	April 2022	May 2022	June 2022
Wendy Grey (Chair) Non-Executive Director	✓	✓	✓
Basil Fozard, Non-Executive Director, Secondary Care Specialist Doctor		✓	✓
Kathy French, Acting Director of Quality and Nursing	✓	✓	✓
Shaun Green, Associate Director, Head of Medicines Management and Clinical Effectiveness	✓		✓
Emma Savage, Deputy Director of Quality and Nursing		✓	✓

NHS Somerset CCG Remuneration Committee Meetings Apr-June 2022 **Attendance Record**	✓ = Present X = Apologies Given		
(V) = voting Member (NV) = non-voting Member	12 May 2022	26 May 2022	14 June 2022
Lou Evans (V) – Committee Chair Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	X	X	X
David Heath (V) Non-Executive Director, Patient and Public Engagement	X	✓	X
Marianne King (NV) Associate Director of Organisational Development and Workforce	✓	X	✓
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	X	✓
James Rimmer (NV) Chief Executive	✓	✓	✓

NHS Somerset CCG Primary Care Commissioning Committee April to June 2022 Attendance Record		✓ = Present X = Apologies
(M) Committee member (A) In attendance (P) Presenting (O) Observer	Committee Role (eg. Executive, Lay, GP, etc)	8.6.22
David Heath (M)	Chair, Non-Executive Director	✓
Dr Basil Fozard (M)	Vice Chair, Non-Executive Director	x
Michael Bainbridge (M)	Associate Director of Primary Care	✓
Dr Chris Campbell (M)	External GP	✓
Kathy French	Acting Director of Quality and Nursing	✓
Judith Goodchild (M)	Chair of the Board, Healthwatch	✓
Alison Henly (M)	Director of Finance, Performance ,Contracting and Digital	✓
Dr Jeremy Imms (M)	Associate Clinical Director – Covid Vaccinations & Primary Care and GP Clinical Lead – Rapid Diagnostic Service, CCG	x
Dr Emma Keane (M)	Associate Clinical Director of Primary Care	x
Laila Pennington (M)	Head of Primary Care, NHS E	x
Dr Karen Sylvester (M)	LMC Representative	✓
Tanya Whittle (M)	Deputy Director of Contracting	✓
Sandra Wilson (M)	Chair, Somerset PPG Chairs Network	✓
Louise Woolway (M)	Deputy Director of Public Health, SCC	✓
Jacqui Damant (A)	Associate Director of Finance	✓
Alison Rowswell (O)	Acting Director of Commissioning	✓

NHS Somerset CCG Finance and Performance Committee Meetings
April to June 2022
Attendance Record

✓ = Present
X = Apologies Given

Name	27 April	17 May	16 June (Planning Submission)	28 June
Voting				
Kathy French, Acting Director of Quality and Nursing	X	✓	X	✓
Neil Hales, Director of Commissioning	✓			
Alison Henly, Director of Finance, Performance, Contracting and Digital	X	X	✓	✓
Trudi Mann, Non-Executive Director, Member Practice Representative	✓	X	✓	✓
Grahame Paine, Non-Executive Director (Finance and Performance)	✓	✓	✓	✓
In attendance				
Carmen Chadwick-Cox	✓	✓	X	Y
Jacqui Damant	✓	✓	✓	✓
Simon Edwards	X	Y	X	X
Alison Rowswell	✓	X	✓	✓
Michelle Skillings	✓	✓	✓	✓
Tanya Whittle	✓	X	✓	X*
Observing				
Christopher Foster	✓	✓	✓	✓
Paul von der Heyde		✓	✓	✓
Jonathan Higman				✓

*Michael Bainbridge attended on behalf of Tanya Whittle

10 REMUNERATION REPORT

10.1 This section of the report contains details of remuneration and pension entitlements for senior managers of the CCG in line with Chapter 5 of Part 15 of the Companies Act 2006.

10.2 Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members. In defining this, the scope the ICB has used is to include members of the decision-making groups within the ICB, which the ICB has defined as the ICB Board, excluding those members not directly employed by the ICB. Senior managers (excluding Lay Members) are generally employed on permanent contracts with a six month period of notice.

10.3 The CCG's Remuneration Committee was chaired by a Non-Executive Director, the Deputy Chair of the Governing Body. It is the Remuneration Committee that determines the reward packages of Executive Directors, whilst taking account of the Pay Framework for Very Senior Managers (VSM) published by the Department of Health.

10.4 The table below details the remuneration levels for all senior managers in the CCG:

Senior manager remuneration (including salary and pension entitlements) – (subject to audit)

		Total 1 April to 30 June 2022						Total 2021/22					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Perform. Pay and Bonuses	Long Term Perf. Pay and Bonuses	All Pension Related Benefits	Total
Name	Title	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
James Rimmer	Chief Executive	40-45	0	0	0	0	40-45	160-165	0	0	0	117.5-120	280-285
Alison Rowswell	Acting Director of Commissioning	20-25	0	0	0	25-27.5	45-50	0	0	0	0	0	0
Alison Henly	Director of Finance, Performance, Contracting and Digital	25-30	1,800	0	0	0-2.5	30-35	110-115	7,500	0	0	40-42.5	160-165
Maria Heard	Programme Director of 'Fit for My Future'	25-30	0	0	0	0	25-30	110-115	0	0	0	30-32.5	140-145
Kathy French	Interim Director of Quality and Nursing	25-30	0	0	0	0	25-30	0	0	0	0	0	0
Edward Ford	Chair	20-25	0	0	0	0	20-25	90-95	0	0	0	0	90-95
Lou Evans	Vice-Chair and Non- Executive Director Governance and Audit	10-15	0	0	0	0	10-15	25-30	0	0	0	0	25-30
David Heath	Non-Executive Director, Patient and Public Engagement	0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15

		Total 1 April to 30 June 2022						Total 2021/22					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Perform. Pay and Bonuses	Long Term Perf. Pay and Bonuses	All Pension Related Benefits	Total
Name	Title	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
Basil Fozard	Non-Executive Director, Secondary Care Doctor	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Wendy Grey	Non-Executive Director, Member Practice Representative	5-10	0	0	0	0	5-10	25-30	0	0	0	0	25-30
Trudi Mann	Non-Executive Director, Member Practice Representative	5-10	0	0	0	0	5-10	25-30	0	0	0	0	25-30
Grahame Paine	Non-Executive Director, Finance and Performance	0-5	0	0	0	0	0-5	15-20	0	0	0	0	15-20
Helen Thomas	Non-Executive Director, Audit Committee (from 01/08/2021)	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10

Officer Full Year Equivalent Salaries (bands of £5,000):

James Rimmer	165-170
Alison Rowswell	95-100
Alison Henly	115-120
Maria Heard	105-110
Kathy French	100-105
Edward Ford	90 - 95

Lou Evans	25 - 30
David Heath	10 - 15
Basil Fozard	5 - 10
Wendy Grey	25 - 30
Trudi Mann	25 - 30
Grahame Paine	15 - 20
Helen Thomas	10 – 15

Officer Holder Changes:
Alison Rowswell was appointed as Acting Director of Commissioning on 1 April 2022.

Kathy French was appointed as Interim Director of Quality and Nursing on 1 April 2022. This appointment is an off-payroll engagement paid via a recruitment agency and therefore incurs no pension related benefits. The full cost of this appointment for the period 1 April to 30June 2022 was £48,360, comprising of pay costs of £29,264, employers NI of £4,536, agency fees of £6,500 and VAT of £8,060.

Other Notes:

Expense payments relate to Lease Cars
No senior manager waived his/her remuneration.
No annual or long-term performance related bonus payments were made to any senior managers during the period 1 April to 30 June 2022.

10.5 The next table details the pension entitlements for each of the senior managers who received pensionable remuneration through the NHS pension scheme.

10.6 Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

Pension benefits as at 30 June 2022 (subject to audit)

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at Pension age at 30 June 2022	Lump sum at pension age related to accrued pension at 30 June 2022	Cash equivalent transfer value at 1 April 2022	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 30 June 2022	Employer's contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
James Rimmer	Chief Executive	0-2.5	0-2.5	75-80	170-175	1,564	16	1,599	0
Alison Henly	Director of Finance, Performance, Contracting and Digital	0-2.5	0-2.5	45-50	100-105	860	26	896	0
Maria Heard	Programme Director of Fit for My Future	0-2.5	0-2.5	15-20	0-5	213	3	222	0
Alison Rowswell	Acting Director of Commissioning (from 01/04/2022)	0-2.5	2.5-5	35-40	80-85	682	43	733	0

Notes:

1. Non-Executive Directors do not receive pensionable remuneration.

2. Pensionable contributions may include more than just those from CCG employment. Where a GP is under a contract of service with the CCG and pays pension contributions then they are classed as 'NHS staff (Officer)' for pension purposes. The figures provided by NHS Pensions cover only the 'Officer' element of the GP's pension entitlement.

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

Cash equivalent transfer values

10.7 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.

10.8 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.

10.9 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

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

Compensation on early retirement of for loss of office (subject to audit)

10.11 NHS England has set restrictions on the payment of any compensation within the CCG. There have been no compensation terms agreed by NHS England.

Payments to past directors (subject to audit)

10.12 The CCG has made no payments to past directors during the period 1 April to 30 June 2022.

Fair Pay Disclosure (subject to audit)

10.13 Reporting bodies are required to disclose separately, for salary and allowances, and performance pay and bonuses:

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

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

Percentage changes in remuneration of the highest paid director

Disclosure	Increase / (Decrease) %	2021/22 Increase / (Decrease) %
The percentage change in salary and allowances from the previous financial year in respect of the highest paid director	3.0%	5.1%
The percentage change in performance pay and bonuses from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change in salary and allowances from the previous financial year in respect of all employees (excluding the highest paid director)	0.5%	3.4%
The average percentage change in performance pay and bonuses from the previous financial year in respect of all employees (excluding the highest paid director)	0%	0%

10.14 The highest paid Director was awarded a 3% inflationary increase effective from 1 April 2022.

10.15 Staff remuneration increases since 2021/22 include an annual pay increase awarded to NHS Agenda for Change staff for 2022/23. This has been offset by a decrease in the average salary value due to a number of factors including:

- a decrease in the appointment of higher cost agency staff.
- a decrease in the number of higher pay banded staff.

Pay ratio information (subject to audit)

10.16 The Clinical Commissioning Group is required to disclose:

- the 25th percentile, median and 75th percentile of remuneration of the CCG's staff (based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date)

- the 25th percentile, median and 75th percentile of the salary component of remuneration of the CCG's staff (based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date)

- the range of staff remuneration

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

10.17 The table below illustrates:

- remuneration of NHS Somerset CCG staff
- the ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director
- the ratios of the salary component of staff remuneration against the mid-point of the banded remuneration of the highest paid director

Disclosure	1 April to 30 June 2022			2021/22		
	25th percentile	Median	75th percentile	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£27,055	£40,588	£48,526	£27,780	£39,027	£47,126
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£27,055	£40,588	£48,526	£27,780	£39,027	£47,126
Ratio of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	6.19 : 1	4.13 : 1	3.45 : 1	5.85 : 1	4.16 : 1	3.45 : 1
Ratio of the salary component of remuneration of all staff to the mid-point of the banded salary of the highest paid director	6.19 : 1	4.13 : 1	3.45 : 1	5.85 : 1	4.16 : 1	3.45 : 1

10.18 The banded remuneration of the highest paid director / member in NHS Somerset CCG in the reporting period 1 April to 30 June 2022 was £165,000 to £170,000 (2021/22: £160,000 to £165,000).

10.19 During the reporting period from 1 April to 30 June 2022, no employees (2021/22, one) received remuneration in excess of the highest-paid director/member. Remuneration ranged from £8,440 to £163,468

(2021/22: £8,440 to £180,400) based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

10.20 The remuneration report and other disclosures referenced as 'subject to audit' in the Accountability Report will be audited by Grant Thornton UK LLP, Somerset CCG's external auditors:

- Single total figure of remuneration for each director
- CETV disclosures for each director
- Payments to past directors
- Payments for loss of office
- Fair pay disclosures
- Pay ratio information
- Exit packages
- Analysis of staff numbers and costs

Explanation of Key Terms used in Remuneration and Pension Reports

Term	Definition
Annual Performance Related Bonuses	Money or other assets received or receivable for the financial year as a result of achieving performance measures and targets for the period.
Cash Equivalent Transfer Value (CETV)	A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations.
Employer's contribution to stakeholder pension	The amount that the CCG has contributed to individual's stakeholder pension schemes.
Lump sum at pension age related to real increase in pension	The amount by which the lump sum to which an individual will be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 30 June 2022	The amount of lump sum pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 30 June 2022
Real increase in CETV	This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Real increase in pensions at pension age	The amount by which the pension to which an individual will be entitled at pension age has increased during the year
Total accrued pension at pension age at 31 March 2022	The amount of annual pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2022

Remuneration of the Accountable Officer and Directors

10.21 The remuneration of the Chief Executive and Directors within the CCG is the responsibility of the Remuneration Committee. The committee comprises five voting members and two non-voting members, although one of the voting member positions was vacant for the period.

10.22 The membership and attendance at the Somerset CCG Remuneration Committee during the period 1 April to 30 June 2022 is set out below:

Somerset CCG Remuneration Committee Meetings 1 April to 30 June 2022 Attendance Record	✓ = Present X = Apologies Given		
(V) = voting Member (NV) = non-voting Member	12 May 2022	26 May 2022	14 June 2022
Lou Evans (V) Remuneration Committee Chair, CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	x	x	x
David Heath (V) Non-Executive Director, Patient and Public Engagement, and Chair of the Primary Care Commissioning Committee.	x	✓	x
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	x	✓
Marianne King (NV) Associate Director of Organisational Development and Workforce	✓	x	✓
James Rimmer (NV) Chief Executive	✓	✓	✓

The following people were in attendance, at the invitation of the Committee Chair:

12 May 2022:	26 May 2022:	14 June 2022:
Dr Ed Ford, Somerset CCG Chair Jonathan Higman, ICB Chief Executive Designate Madeleine McPeak, Head of HR, NHS South, Central and West CSU Paul von der Heyde, ICB Chair Designate	Dr Ed Ford, Somerset CCG Chair Jonathan Higman, ICB Chief Executive Designate Paul von der Heyde, ICB Chair Designate	Dr Ed Ford, Somerset CCG Chair Jonathan Higman, ICB Chief Executive Designate Christopher Foster, ICB Remuneration Committee Chair Designate

10.23 The CCG also has an established committee to oversee the appointments and remuneration for Non-Executive Directors. This Committee makes determinations about the appointment, pay and remuneration for Non-Executive Directors of the CCG Governing Body.

Policy on Remuneration of Senior Managers

10.24 A benchmarking exercise was carried out across the South West to determine Senior Manager pay scales when the CCG became fully authorised in April 2013. The recommendations were implemented in determining Senior Manager terms and conditions of employment. Further benchmarking exercises continue to take place with CCG's in the South West to ensure that pay scales remain competitive and in line with the NHS current financial position.

10.25 Agenda for Change guidelines are taken into consideration when assessing whether to award an inflationary increase to Directors.

Remuneration of Very Senior Managers (VSMs)

10.26 The CCG had a senior manager in post with a salary that exceeded £150,000 per annum. Guidance was sought from the Director of Workforce and Organisational Development at NHS England and NHS Improvement to determine a suitable remuneration banding to recognise the responsibilities and complexities of this position. This was subsequently reviewed and approved by the CCG's Remuneration Committee and received final approval from NHS England and NHS Improvement.

Policy on Contracts

10.27 All Senior Managers are on permanent contracts with a six month notice period in place.

11 STAFF REPORT

Number of senior managers

11.1 The number of senior managers is set out below in paragraph 11.5.

Staff numbers and costs (subject to audit)

11.2 The NHS Somerset CCG's total staff costs for the period 1 April to 30 June 2022 are summarised in the following table. These figures are consistent with information provided within the financial statements:

	Total		
	Permanent Employees £'000	Other £'000	Total £'000
	N4G	N4H	N4I
Salaries and wages	2,940	337	3,277
Social security costs	342	14	356
Employer contributions to the NHS Pension Scheme	564	13	577
Other pension costs	-	-	-
Apprenticeship levy	11	0	11
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross Employee Benefits Expenditure	**3,857**	**364**	**4,221**
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure incl. capitalised costs	**3,857**	**364**	**4,221**
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excl. capitalised costs	**3,857**	**364**	**4,221**

Average Number of Persons Employed (subject to audit)

11.3 The average number of CCG staff employed by staff grouping is as follows:

	1 April – 30 June 2022			2021/22
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	5	0	5	6
Administration and estates	201	22	223	192
Healthcare assistants and other support staff	0	0	0	0
Nursing, midwifery and health visiting staff	54	0	54	58
Social Care Staff	1	0	1	1
Total	**261**	**22**	**283**	**257**
Of the above: Number of whole-time equivalent people engaged on capital projects	-	-	-	-

11.4 The majority of employees are members of the NHS defined benefit pension scheme. Details of the scheme and its accounting treatment may be found within the accounting policies disclosed in the full audited annual accounts.

Staff composition

11.5 The breakdown of the gender profile for the CCG as at 30 June 2022 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	60.0%	40.0%	10
Membership Body Clinical Executive Committee Voting Members	61.5%	38.5%	13
Very Senior Managers	33.3%	66.7%	6
All substantive CCG Staff	18.7%	81.3%	305

Sickness absence data and ill health retirements

11.6 The absence FTE % for NHS Somerset CCG during the period 1 April to 30 June 2022 was 1.9%.

11.7 The CCG has a clear and robust Management of Sickness Absence Policy.

11.8 Sickness absence data for Somerset CCG is available via the following link: NHS Sickness Absence Rates - NHS Digital

11.9 No ill health retirements were supported during the period 1 April to 30 June 2022.

Staff Turnover

11.10 Staff turnover for NHS Somerset CCG during the period 1 April to 30 June 2022 was 5.46%.

11.11 Staff turnover information for NHS Somerset CCG is captured as part of NHS Digital's NHS workforce statistics and is available via the following link: NHS workforce statistics - NHS Digital

11.12 This data series is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

Staff engagement percentages

11.13 In the NHS National Staff Survey, staff engagement is measured across three themes:

Theme	NHS Somerset CCG Staff Engagement Scores *
Advocacy	7.3
Motivation	7.3
Involvement	7.5
Overall staff engagement	**7.4**

*These scores are taken from the 2021 NHS National Staff Survey, which was the last survey undertaken by NHS Somerset CCG.

11.14 The themes are summary scores for groups of questions, which taken together give more information about each area of interest. They are worked out by assigning values to responses (on a scale from 0 to 10) and calculating their average. All values reported relate to an average (mean) score, where a higher score indicates a more favourable outcome for the given indicator.

11.15 Staff engagement levels demonstrate the health of the workforce within the CCG. Compared to other organisation in the benchmarking sector, Somerset CCG has scored above average in eight key themes, and average for one key theme. There are no themes within the 2021 survey for which Somerset CCG scored below average. In addition, the overage engagement score improved from 7.25 in 2020 to 7.4 in 2021.

11.16 Somerset CCG continued to develop a High Performing Organisation Programme of work and this involved numerous engagement activities and events with all CCG colleagues to ensure that focus is given to speaking up, our culture of compassion, and learning.

Staff Policies

11.17 The CCG applied the following new or updated staff policies in the period 1 April to 30 June 2022:

- the Maternity Leave Policy

Staff Diversity and Inclusion Policy, initiatives and longer term ambitions

11.18 Whilst Somerset CCG does not hold a staff facing Diversity and Inclusion Policy, there are a number of programmes within the organisation which support our aims.

11.19 These include:

Measure	Detail
Equality Steering Group	The CCG has an equality steering group under which matters of both internal (staff facing) and external (patient facing) matters of diversity and inclusion (D&I) are discussed. Whilst D&I is a core consideration for all staff, this group seeks to respond to more complex matters regarding D&I and to contribute towards ethical decision making within the organisation.
Black Lives Matter Group	The CCG has a black lives matter group to support BAME staff within the organisation.
Inclusion High Performing Organisation Champion	Alongside our core role of Equality and Diversity officer, the organisation has appointed an Inclusion champion as part of the High Performing Organisation group to promote inclusion and diversity across the organisation.
Disability Confident Scheme	The CCG is a member of the Disability Confident scheme, which supports employers to make the most of the talents disabled people bring to the workplace.
Recruitment practices	The CCG operates a blind recruitment practice, to ensure that details such as gender, age, race etc. are not provided to recruiting managers for shortlisting purposes.
Equality training	The CCG has a mandatory training requirement for all members of staff, which must be renewed annually.

Trade Union Facility Time

11.20 The trade union (facility time publication requirements) regulations 2017 came into force on 1 April 2017.

11.21 In line with these regulations, all organisations employing more than 49 staff, must publish information on facility time, which is agreed time off from an individual's job to carry out a trade union role.

Our organisation

11.22 Somerset CCG
1 April 2022 to 30 June 2022

Employees in our organisation

11.23 50 to 1,500 employees

Trade union representatives and full-time equivalents

11.24 Trade union representatives: 1
FTE trade union representatives: 0.80

Percentage of working hours spent on facility time

11.25 0% of working hours: 0 representatives
1 to 50% of working hours: 1 representative

51 to 99% of working hours: 0 representatives
100% of working hours: 0 representatives

Total pay bill and facility time costs

11.26 Total pay bill: £4,221,399
Total cost of facility time: £383
Percentage of pay spent on facility time: 0.01%

Paid trade union activities

11.27 Hours spent on paid facility time: 12.4
Hours spent on paid trade union activities: 2.4
Percentage of total paid facility time hours spent on paid TU activities: 19.35%

Expenditure on consultancy

11.28 The CCG did not incur any consultancy expenditure in the period 1 April to 30 June 2022 (2021/22 £75,000), as per note 5 in the annual accounts.

Off-payroll engagements

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

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

	Number
Number of existing engagements as of 30 June 2022	4
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 the time of reporting	3
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

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

11.30 All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

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

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

	Number
Number of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	4
Of which:	
No. not subject to off-payroll legislation(2)	0
No. subject to off-payroll legislation and determined as in-scope of IR35(2)	0
No. subject to off-payroll legislation and determined as out of scope of IR35(2)	4
Number of engagements reassessed for compliance / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following review	0

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

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

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

Table 3: Off-payroll engagements / senior official engagements

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial reporting period	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial reporting period. This figure should include both on payroll and off-payroll engagements.	9

11.33 During the period there have been no incidences where a senior officer position has been held by an off-payroll member of staff.

Exit packages, including special (non-contractual) payments – (subject to audit)

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	-	-	-	-	-	-	-	-
£10,000 - £25,000	-	-	-	-	-	-	-	-
£25,001 - £50,000	-	-	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 – £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	-	-	-	-	-	-	-	-

There were no exit packages paid by the CCG in the period 1 April to 30 June 2022.

Exit costs in this note are accounted for in full in the year of departure. Where NHS Somerset CCG has agreed early retirements, the additional costs are met by NHS Somerset CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
TOTAL	-	-

There were no other departures paid by the CCG during the period 1 April to 30 June 2022.

As a 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 Table 1, which will be the number of individuals.

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

12 Parliamentary Accountability and Audit Report

12.1 NHS Somerset 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 **Appendix 1**.

Appendix One

NHS Somerset Clinical Commissioning Group
Accounts for the three month period ended 30 June 2022

NHS Somerset CCG - Accounts for the three month period ended 30 June 2022

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the period ending 30 June 2022

	Note	Apr-Jun 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(692)	(2,259)
Other operating income	2	(468)	(753)
Total operating income		**(1,160)**	(3,012)
Staff costs	4	4,221	15,441
Purchase of goods and services	5	271,822	1,121,327
Depreciation and impairment charges	5	129	76
Provision expense	5	8	14
Other operating expenditure	5	72	824
Total operating expenditure		**276,252**	1,137,682
Net Operating Expenditure		**275,092**	1,134,670
Finance expense		4	1
Comprehensive Expenditure for the year		**275,096**	1,134,671

The notes on pages 5 to 27 form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	Apr-Jun 2022 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	9	193	213
Right-of-use assets	10	1,585	0
Intangible assets	11	0	0
Total non-current assets		**1,778**	213
Current assets:			
Inventories	12	2	2
Trade and other receivables	13	3,379	3,392
Cash and cash equivalents	14	0	46
Total current assets		**3,381**	3,440
Total assets		**5,159**	3,653
Current liabilities			
Trade and other payables	15	(41,531)	(51,888)
Lease liabilities	10	(4)	0
Borrowings	16	(1,593)	0
Provisions	17	(359)	(440)
Total current liabilities		**(43,487)**	(52,328)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(38,328)**	(48,675)
Non-current liabilities			
Lease liabilities	10	(1,694)	0
Total non-current liabilities		**(1,694)**	0
Assets less Liabilities		**(40,022)**	(48,675)
Financed by Taxpayers' Equity			
General fund		(40,022)	(48,675)
Total taxpayers' equity:		**(40,022)**	(48,675)

The notes on pages 5 to 27 form part of this statement

The financial statements on pages 1 to 4 were approved by the NHS Somerset ICB Board on 29 June 2023 and signed on its behalf by:

Jonathan Higman
Chief Executive
NHS Somerset ICB

Statement of Changes In Taxpayers Equity for the period ending 30 June 2022

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Apr-Jun 2022		
Balance at 01 April 2022	(48,675)	(48,675)
Net operating expenditure for the financial year	(275,096)	(275,096)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Period	**(275,096)**	**(275,096)**
Net funding	283,749	283,749
Balance at 30 June 2022	**(40,022)**	**(40,022)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(57,477)	(57,477)
Net operating costs for the financial year	(1,134,671)	(1,134,671)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(1,134,671)	(1,134,671)
Net funding	1,143,473	1,143,473
Balance at 31 March 2022	(48,675)	(48,675)

The notes on pages 5 to 27 form part of this statement

Statement of Cash Flows for the period ending 30 June 2022

	Note	**Apr-Jun 2022 £'000**	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(275,096)	(1,134,671)
Depreciation and amortisation	5	129	76
Interest paid	10	4	0
Other Gains & Losses		0	1
(Increase)/decrease in trade & other receivables	13	13	3,018
Increase/(decrease) in trade & other payables	15	(10,357)	(11,625)
Provisions utilised	17	(89)	(144)
Increase/(decrease) in provisions	17	8	14
Net Cash Inflow (Outflow) from Operating Activities		**(285,388)**	(1,143,331)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(140)
Net Cash Inflow (Outflow) from Investing Activities		**0**	(140)
Net Cash Inflow (Outflow) before Financing		**(285,388)**	(1,143,471)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		283,749	1,143,473
Net Cash Inflow (Outflow) from Financing Activities		**283,749**	1,143,473
Net Increase (Decrease) in Cash & Cash Equivalents	14	**(1,639)**	2
Cash & Cash Equivalents at the Beginning of the Financial Year		**46**	44
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(1,593)**	46

The notes on pages 5 to 27 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis**.**

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished clinical commissioning groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

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.

When clinical commissioning groups ceased to exist on 1 July 2022, the services continued to be provided (using the same assets, by another public sector entity) by ICBs. Accordingly, the financial statements for CCGs for the 3 months ending 30 June 2022 have been prepared on a Going Concern basis.

1.2 **Reporting Period**

These accounts are for the three month period from 1 April 2022 to 30 June 2022. This shorter reporting period is due to the abolition of Somerset Clinical Commissioning Group on 30 June 2022, with the establishment of Somerset Integrated Care Board from 1 July 2022.

It should be noted that prior year comparators provided in these financial statements are for a full financial year.

1.3 **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.

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 **Joint arrangements**

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

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator, it recognises its share of, assets, liabilities, income and expenses in its own accounts. The pooled budget agreements that NHS Somerset CCG holds with Somerset County Council (as mentioned in Note 1.6) are joint operations, with the exception of the Better Care Fund.

1.6 **Pooled Budgets**

The clinical commissioning group has entered into a pooled budget arrangement with Somerset County Council (in accordance with section 75 of the NHS Act 2006). Under the arrangement, funds are pooled for learning disability services, community equipment provision, carers services and the Better Care Fund, and a memorandum note to the accounts provides details of the income and expenditure.

The pool is hosted by Somerset County Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.7 **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.

1.8 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is
Payment terms are standard reflecting cross government principles. Payment terms are within fourteen days of invoice date.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.9 **Employee Benefits**

1.9.1 **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.

1.9.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pensions 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. These schemes 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. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, 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 is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.10 **Other Expenses**

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

1.11 **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.

1.12 **Property, Plant & Equipment**

1.12.1 **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.

1.12.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

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

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

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

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive net expenditure in the Statement of Comprehensive Net Expenditure.

1.12.3 **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.

1.13 **Intangible Assets**

1.13.1 **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.

1.13.2 **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

1.13.3 **Depreciation, Amortisation & Impairments**

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

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

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation

1.14 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Leases**

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

1.15.1 **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 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise

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

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases, a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.16 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.17 **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.

1.18 **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

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

A nominal short-term rate of 3.27% (2021/22: 0.47%) is applied for inflation adjusted expected cash flows up to and including 5 years from 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.

1.19 **Clinical Negligence Costs**

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

1.20 **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.

1.21 **Contingent liabilities and contingent assets**

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

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

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

1.22 **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.

1.22.1 **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.

1.22.2 **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.

1.22.3 **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.

1.22.4 **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 month expected credit losses (stage 1).
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.23 **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.

1.24 **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.

1.25 **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. NHS Somerset Clinical Commissioning Group does not have any exposure to foreign currencies.

1.26 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed. No key sources of estimation uncertainty have been

1.26.1 **Critical accounting judgements in applying accounting policies**
No critical judgments with a significant effect on the amounts recognised in the financial statements were required.

1.27 **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.

1.28 **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 Under IFRS 16 the CCG will recognise a right-of-use asset representing the CCG’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 CCG will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the CCG will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

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

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

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

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

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

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

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

As of 1 April 2022, the CCG recognised £1.694m of right-of-use assets and lease liabilities of £1.694m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a zero impact to tax payers' equity.

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

The following table reconciles the CCG's operating lease obligations at 31 March 2022, disclosed in the CCG's 2021/22 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	(1,707)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	16
Operating lease commitments discounted used weighted average IBR	**(1,691)**
Less: Short term leases (including those with <12 months at application date)	(3)
Lease liability at 1 April 2022	**(1,694)**

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

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.

2 Other Operating Revenue

	Apr-Jun 2022 Total	2021-22 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**312**	604
Non-patient care services to other bodies	**357**	1,564
Other Contract income	**23**	91
Total Income from sale of goods and services	**692**	2,259
Other operating income		
Non cash apprenticeship training grants revenue	**13**	44
Other non contract revenue	**455**	709
Total Other operating income	**468**	753
Total Operating Income	**1,160**	3,012

3 Disaggregation of Revenue

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Total
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	0	72	0	72
Non NHS	312	285	23	620
Total	**312**	**357**	**23**	**692**

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Total
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	312	357	23	692
Over time	0	0	0	0
Total	**312**	**357**	**23**	**692**

4 Employee benefits and staff numbers

4.1 Employee benefits

	Total		Apr-Jun 2022
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	2,940	337	**3,277**
Social security costs	342	14	**356**
Employer Contributions to NHS Pension scheme	564	13	**577**
Other pension costs	0	0	**0**
Apprenticeship Levy	11	0	**11**
Gross employee benefits expenditure	**3,857**	**364**	**4,221**
Less recoveries in respect of employee benefits	0	0	**0**
Total - Net admin employee benefits including capitalised costs	**3,857**	**364**	**4,221**
Less: Employee costs capitalised	0	0	**0**
Net employee benefits excluding capitalised costs	**3,857**	**364**	**4,221**

4.1 Employee benefits

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	10,862	1,148	12,010
Social security costs	1,188	23	1,211
Employer Contributions to NHS Pension scheme	2,149	26	2,175
Other pension costs	3	0	3
Apprenticeship Levy	42	0	42
Gross employee benefits expenditure	14,244	1,197	15,441
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	14,244	1,197	15,441
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	14,244	1,197	15,441

4.2 Average number of people employed

	Apr-Jun 2022			2021-22		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**261**	**22**	**283**	247	10	257
Of the above:						
Number of whole time equivalent people engaged on capital projects	0	0	0	0	0	0

4.3 Pension costs

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

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

4.3.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 30 June 2022, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.3.2 Full actuarial (funding) valuation

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

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

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

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

5 Operating expenses

	Apr-Jun 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	990	3,769
Services from foundation trusts	188,055	711,067
Services from other NHS trusts	2,442	8,105
Services from Other WGA bodies	6	17
Purchase of healthcare from non-NHS bodies	22,785	159,615
Purchase of social care	10,432	38,486
Prescribing costs	20,844	91,684
General Ophthalmic services	132	496
GPMS/APMS and PCTMS	24,741	99,786
Supplies and services – clinical	9	29
Supplies and services – general	19	796
Consultancy services	(0)	75
Establishment	105	1,195
Transport	639	3,905
Premises	199	923
Audit fees	0	79
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services	0	0
Other professional fees	38	146
Legal fees	54	284
Education, training and conferences	319	826
Non cash apprenticeship training grants	13	44
Total Purchase of goods and services	**271,822**	1,121,327
Depreciation and impairment charges		
Depreciation	129	76
Amortisation	0	0
Total Depreciation and impairment charges	**129**	76
Provision expense		
Provisions	8	14
Total Provision expense	**8**	14
Other Operating Expenditure		
Chair and Non Executive Members	70	263
Grants to Other bodies	0	513
Clinical negligence	2	10
Other expenditure	0	38
Total Other Operating Expenditure	**72**	824
Total operating expenditure, excluding staff costs	**272,031**	1,122,241

Notes

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

2. Internal Audit - As Internal Audit is carried out by a different organisation to our Statutory Audit, the Department of Health guidance is to show Internal Audit costs in 'Other professional fees'.

6 Better Payment Practice Code

Measure of compliance	**Apr-Jun 2022 Number**	**Apr-Jun 2022 £'000**	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,652	39,856	9,723	210,244
Total Non-NHS Trade Invoices paid within target	2,652	39,856	9,723	210,244
Percentage of Non-NHS Trade invoices paid within target	**100.00%**	**100.00%**	100.00%	100.00%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	195	189,629	672	731,378
Total NHS Trade Invoices Paid within target	195	189,629	672	731,378
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	100.00%	100.00%

7 Other gains and losses

	Apr-Jun 2022 £'000	2021-22 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	0	1
Total	**0**	1

The loss in 2021/22 related to the disposal of IT equipment due to damage.

8 Finance costs

	Apr-Jun 2022 £'000	2021-22 £'000
Interest		
Interest on lease liabilities	4	0
Total interest	**4**	0
Total finance costs	**4**	0

9 Property, plant and equipment

Apr-Jun 2022	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	650	119	**769**
Additions purchased	0	0	**0**
Disposals other than by sale	(107)	0	**(107)**
Cost/Valuation at 30 June 2022	**543**	**119**	**662**
Depreciation 01 April 2022	462	94	**556**
Disposals other than by sale	(107)	0	**(107)**
Charged during the year	16	4	**20**
Depreciation at 30 June 2022	**371**	**98**	**469**
Net Book Value at 30 June 2022	**172**	**21**	**193**
Purchased	172	21	**193**
Total at 30 June 2022	**172**	**21**	**193**
Asset financing:			
Owned	172	21	**193**
Total at 30 June 2022	**172**	**21**	**193**

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	5	7
Furniture & fittings	7	10

10 Leases

NHS Somerset CCG has one lease which meets the definition of a lease under IFRS 16. This lease is in relation to Wynford House which is leased from NHS Property Services Limited. The lease is a 25 year lease, which ends December 2026.

10a.1 Right-of-use assets

Apr-Jun 2022	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	0	**0**
IFRS 16 Transition Adjustment	1,694	**1,694**
Cost/Valuation at 30 June 2022	**1,694**	**1,694**
Depreciation 01 April 2022	0	**0**
Charged during the year	109	**109**
Depreciation at 30 June 2022	**109**	**109**
Net Book Value at 30 June 2022	**1,585**	**1,585**

10a.2 Lease liabilities

Apr-Jun 2022	Apr-Jun 2022 £'000	2021-22 £'000
Lease liabilities at 01 April 2022	0	0
IFRS 16 Transition Adjustment	1,694	0
Interest expense relating to lease liabilities	4	0
Lease liabilities at 30 June 2022	**1,698**	0

10a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Apr-Jun 2022 £'000	2021-22 £'000
Within one year	(4)	0
Between one and five years	(1,694)	0
Balance at 30 June 2022	**(1,698)**	0
Included in:		
Current lease liabilities	(4)	0
Non-current lease liabilities	(1,694)	0
Balance at 30 June 2022	**(1,698)**	0

10a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

Apr-Jun 2022	Apr-Jun 2022 £'000	2021-22 £'000
Depreciation expense on right-of-use assets	109	0
Interest expense on lease liabilities	4	0

11 Intangible non-current assets

Apr-Jun 2022	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2022	16	**16**
Cost / Valuation at 30 June 2022	**16**	**16**
Amortisation at 01 April 2022	16	**16**
Amortisation at 30 June 2022	**16**	**16**
Net Book Value at 30 June 2022	**-**	**-**
Purchased	-	**-**
Total at 30 June 2022	**-**	**-**

11.1 Economic lives

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

12 Inventories

	Energy £'000	Total £'000
Balance at 01 April 2022	2	**2**
Balance at 30 June 2022	**2**	**2**

13.1 Trade and other receivables	Current Apr-Jun 2022 £'000	Non-current Apr-Jun 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	538	0	1,796	0
NHS prepayments	67	0	75	0
NHS accrued income	17	0	117	0
Non-NHS and Other WGA receivables: Revenue	735	0	141	0
Non-NHS and Other WGA prepayments	1,544	0	456	0
Non-NHS and Other WGA accrued income	453	0	470	0
VAT	25	0	337	0
Total Trade & other receivables	**3,379**	**0**	3,392	**0**
Total current and non current	**3,379**		3,392	

13.2 Receivables past their due date but not impaired

	Apr-Jun 2022 DHSC Group Bodies £'000	Apr-Jun 2022 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	557	454	928	86
By three to six months	0	0	0	2
By more than six months	0	0	0	0
Total	**557**	**454**	928	88

14 Cash and cash equivalents

	Apr-Jun 2022 £'000	2021-22 £'000
Balance at 01 April 2022	46	44
Net change in year	(1,639)	2
Balance at 30 June 2022	**(1,593)**	46
Made up of:		
Cash with the Government Banking Service	0	46
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**0**	46
Bank overdraft: Government Banking Service	(1,593)	0
Total bank overdrafts	**(1,593)**	0
Balance at 30 June 2022	**(1,593)**	46

15 Trade and other payables	Current Apr-Jun 2022 £'000	Non-current Apr-Jun 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS payables: Revenue	226	0	698	0
NHS accruals	6,328	0	2,152	0
Non-NHS and Other WGA payables: Revenue	726	0	7,121	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	28,288	0	34,211	0
Non-NHS and Other WGA deferred income	75	0	23	0
Social security costs	199	0	182	0
Tax	157	0	157	0
Other payables and accruals	5,532	0	7,344	0
Total Trade & Other Payables	**41,531**	**0**	51,888	0
Total current and non-current	**41,531**		51,888	

Other payables include £798,326 outstanding CCG pension contributions at 30 June 2022.

16 Borrowings	Current Apr-Jun 2022 £'000	Non-current Apr-Jun 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Bank overdrafts:				
· Government banking service	1,593	0	0	0
Total overdrafts	**1,593**	**0**	0	0
Total Borrowings	**1,593**	**0**	0	0
Total current and non-current	**1,593**		0	

This balance above represents a technical overdraft only, due to payments made by BACS on 30th June 2022 which did not clear the bank until 2nd July 2022.

17 Provisions

	Current Apr-Jun 2022 £'000	Non-current Apr-Jun 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Redundancy	208	0	320	0
Continuing care	151	0	120	0
Total	**359**	**0**	**440**	0
Total current and non-current	**359**		**440**	

	Redundancy £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2022	**320**	**120**	**440**
Arising during the year	48	151	**199**
Utilised during the year	0	(89)	**(89)**
Reversed unused	(160)	(31)	**(191)**
Balance at 30 June 2022	**208**	**151**	**359**
Expected timing of cash flows:			
Within one year	208	151	**359**
Balance at 30 June 2022	**208**	**151**	**359**

The above is based on information currently held by NHS Somerset Clinical Commissioning Group
The redundancy provision included above is an assessment of potential cost commitments for Executive staff at risk due to the impending establishment of Integrated Care Boards and abolition of Clinical Commissioning Groups.
The 'Continuing Care' provision is an assessment of continuing care cases which are currently being reviewed by the Clinical Commissioning Group's assessment panel. This has been based on the best professional judgement in line with IAS37. All of the cases awaiting panel have been provided for and the calculation has been based on estimated cost and the probability of success. The probability factor applied is based on success rates in the current financial year. A contingent liability in respect of this provision is shown in note 18.

18 Contingencies

	Apr-Jun 2022 £'000	2021-22 £'000
Contingent liabilities		
Continuing Healthcare	32	26
Net value of contingent liabilities	**32**	26

There are no contingent assets.

19 Financial instruments

19.1 Financial risk management

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

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

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

19.1.1 Currency risk

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

19.1.2 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.

19.1.3 Credit risk

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

19.1.4 Liquidity risk

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

19.1.5 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.

19 Financial instruments cont'd

19.2 Financial assets

	Financial Assets measured at amortised cost Apr-Jun 2022 £'000	**Total Apr-Jun 2022 £'000**
Trade and other receivables with NHSE bodies	530	**530**
Trade and other receivables with other DHSC group bodies	596	**596**
Trade and other receivables with external bodies	617	**617**
Cash and cash equivalents	0	**0**
Total at 30 June 2022	**1,743**	**1,743**

	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	1,773	1,773
Trade and other receivables with other DHSC group bodies	645	645
Trade and other receivables with external bodies	105	105
Cash and cash equivalents	46	46
Total at 31 March 2022	2,569	2,569

19.3 Financial liabilities

	Financial Liabilities measured at amortised cost Apr-Jun 2022 £'000	**Total Apr-Jun 2022 £'000**
Loans with external bodies	1,593	**1,593**
Trade and other payables with NHSE bodies	281	**281**
Trade and other payables with other DHSC group bodies	6,330	**6,330**
Trade and other payables with external bodies	36,189	**36,189**
Total at 30 June 2022	**44,393**	**44,393**

	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Loans with external bodies	0	0
Trade and other payables with NHSE bodies	731	731
Trade and other payables with other DHSC group bodies	2,176	2,176
Trade and other payables with external bodies	48,620	48,620
Total at 31 March 2022	51,527	51,527

20 Operating segments

	Gross £'000	**Income £'000**	**Net expenditure £'000**	**Total assets £'000**	**Total liabilities £'000**	**Net assets £'000**
NHS Somerset Clinical Commissioning Group	276,256	(1,160)	**275,096**	5,159	(45,181)	**(40,022)**
Total	**276,256**	**(1,160)**	**275,096**	**5,159**	**(45,181)**	**(40,022)**

21 Joint arrangements - interests in joint operations

NHS Somerset Clinical Commissioning Group is party to a number of pooled budget agreements with Somerset County Council. Under these arrangements funds are pooled under S75 of the Health Act 2006 for the provision of the following services;

Community Equipment Services
Carers Services
Learning Disability Services
The Better Care Fund (not treated as a Joint Operation)

The pool is hosted by Somerset County Council and, as a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pool. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

			Amounts recognised in Entities books ONLY	
			Apr-Jun 2022	2021-22
Name of arrangement	Parties to the arrangement	Description of principal activities	Expenditure	Expenditure
			£'000	£'000
Integrated Comminity Equipment Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase healthcare equipment services	271	1,318
Carers Services Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Carers services	54	223
Learning Disability Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Learning Disability services	6,898	23,915
Better Care Fund (not treated as a Joint Operation)	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase health and social care services	11,357*	42,984**

* Excludes £50,875 included within Carers Pooled Budget figure
** Excludes £203,500 included within Carers Pooled Budget figure

22 Related party transactions

2022/2023 M1-3

Details of related party transactions with individuals are as follows:

2022/23 M1 - M3	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
Ed Ford, Chair, is a GP Partner at Minehead Medical Centre (transactions disclosed for Minehead Medical Centre)	554	0	0	0
Grahame Paine, Non-Executive Director, is Chair of Trustee Board, SPARK Somerset (transactions disclosed for SPARK Somerset)	29	0	0	0

Note

In formulating this note the Clinical Commissioning Group has considered all declarations of interest for Governing Body Members.

Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:

(i) have control or joint control over the reporting entity;

(ii) have significant influence over the reporting entity; or

(iii) are a member of the key management personnel

The Register of Interests can be found on our website www.somersetccg.nhs.uk/publications/lists-and-registers/

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

NHS England

South, Central and West Commissioning Support Unit

NHS FOUNDATION TRUSTS

Dorset County Hospital NHS Foundation Trust

Royal Devon University Healthcare NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Salisbury NHS Foundation Trust

Somerset NHS Foundation Trust

South Western Ambulance Service NHS Foundation Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Yeovil District Hospital NHS Foundation Trust

NHS TRUSTS

North Bristol NHS Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Somerset County Council, NHS Property Services Limited, National Insurance Fund, NHS Pension Scheme and Her Majesty's Revenue and Customs.

2021/2022 Comparatives

Details of related party transactions with individuals are as follows:

2021/2022	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ed Ford, Chair, is a GP Partner at Minehead Medical Centre (transactions disclosed for Minehead Medical Centre)	1,989	0	3	0
Wendy Grey, Non-Executive Director (Practice Representative), is a Director of Gemini Healthcare Consultancy Ltd (transactions disclosed for Gemini Healthcare Consultancy Ltd)	5	0	5	0
Maria Heard, Programme Director of Fit for my Future, is a Non-Executive Director of South West Academic Health Science Network (transactions disclosed for South West Academic Health Science Network)	28	0	2	0

Note

In formulating this note the Clinical Commissioning Group has considered all declarations of interest for Governing Body Members.

Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:

(i) have control or joint control over the reporting entity;

(ii) have significant influence over the reporting entity; or

(iii) are a member of the key management personnel

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The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

NHS England
South, Central and West Commissioning Support Unit
NHS FOUNDATION TRUSTS
Dorset County Hospital NHS Foundation Trust
Royal Devon and Exeter NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
Somerset NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
NHS TRUSTS
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Somerset County Council, NHS Property Services Limited, National Insurance Fund, NHS Pension Scheme and Her Majesty's Revenue and Customs.

23 Events after the end of the reporting period

The Health and Care Act was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and the abolition of clinical commissioning groups (CCGs). An establishment order was issued by NHS England at the end of June 2022 confirming that the CCG will be dissolved on 30 June 2022. On 1 July 2022 the assets, liabilities and operations of NHS Somerset CCG will transfer to NHS Somerset ICB.

24 Financial performance targets

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

	Apr-Jun 2022 Target	**Apr-Jun 2022 Performance**	**Duty Achieved**	2021-22 Target	2021-22 Performance	Duty Achieved
Expenditure not to exceed income	276,256	276,256	**Yes**	1,137,753	1,137,753	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	**Yes**	70	70	Yes
Revenue resource use does not exceed the amount specified in Directions	275,096	275,096	**Yes**	1,134,671	1,134,671	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	**Yes**	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	**Yes**	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2,778	2,778	**Yes**	11,090	11,033	Yes

Independent auditor's report to the members of the Board of NHS Somerset Integrated Care Board in respect of NHS Somerset Cinical Commissioning Group

Report on the audit of the financial statements

Opinion on financial statements

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

In our opinion, the financial statements:

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

Basis for opinion

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

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to Note 1.1 to the financial statements, which indicates that the Health and Care Act was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Act Allows for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs from 1 July 2022 and all CCG functions, assets and liabilities will therefore transfer to an 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 the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraudulent income and expenditure recognition We determined that the principal risks were in relation to:
  - unusual journals (including journals posted by senior management and material post year end journals).
- 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 journals as defined above;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of expenditure accruals; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to year-end manual expenditure accruals, including 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 is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources 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 plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we 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 Somerset 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 Somerset 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 Somerset 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 Somerset ICB and the CCG and the members of the Boards of the both entities, as bodies, for our audit work, for this report, or for the opinions we have formed.

Jackson Murray

Jackson Murray, Key Audit Partner

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

Bristol

29 June 2023