NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2021/22

21 June 2022

Contents

PERFORMANCE REPORT

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
21 June 2022

1 INTRODUCTION

Welcome to the NHS Somerset Clinical Commissioning Group (CCG) Annual Report for 2021/22. The report highlights our progress and performance over the past year and where we have worked as a wider Integrated Care System (ICS) for Somerset and with our people of Somerset.

When I wrote the introduction to our 2020/21 Annual Report, which was dominated by ours and the wider NHS response to the COVID-19 pandemic, I did not envisage that I would be saying similar for this past year. I am particularly proud of how Somerset has delivered the vaccination programme. Since the start of the programme we have delivered 1,406,012 vaccinations up to 31 March 2022. This included a period where the programme delivered over 63,000 in just one week! This is all thanks to the staff and volunteers that helped make this happen.

Due to the pandemic we have of course suffered significant operational pressures across health and social care services, particularly in the second half of the year. We have strived to return activity levels to pre-COVID-19 levels and bring down long waiting times for the people of Somerset. This has been hampered however by ongoing operational pressures and rising levels of COVID-19 in patients and staff. That said, we have achieved almost 75% of inpatient elective operating (requiring an overnight say) returned to pre-COVID19 levels and day cases are at 115% of pre-COVID-19 levels. The pandemic has accelerated a move towards virtual outpatient clinics and 20% of outpatients are now offered as face-to-face interactions.

In addition, access for our patients to extra scanning capacity with mobile vans along with the opening of the Rutherford Diagnostic centre in Taunton have enabled us to deliver over 150% of pre-COVID-19 levels of scanning in MRI and CT.

Our urgent and emergency care services have suffered as a result of the pandemic and the continued development with system partners on initiatives such as Think 111 first and SAVES (Immediate Care and First Responder Enhanced Service) has supported our services and improved access for our patients.

Access to primary care was also improved by the successful implementation of the Community Pharmacy Consultation Scheme (CPCS).

Mental health is just as important as physical health and this has become more evident due to the pandemic. In Somerset we have introduced several initiatives to support our staff and people. This includes a clinically led telephone support line for health and care staff, the Somerset Emotional Wellbeing (SEW) podcasts (we were shortlisted by the Health Service Journal for a Mental Health Innovation of the Year Award) and our 24/7 mental health crisis line (Mindline) offer, which is available to all ages, and accepts calls from Somerset residents of all ages.

I would like to thank everyone for their continued patience and support whilst we endeavour to improve access and bring the longer waits down, caused by the pandemic. We continue to work well as a system to ensure the quality and safety of our services remains a priority.

As in previous years, the CCG annual assessment for 2020/21 provides a headline assessment against the indicators in the NHS System Oversight Framework. I am delighted to report that following our move out of 'special measures' in 2020/21 and a 'requires improvement rating' we achieved the equivalent of a 'good' rating for 2021/22. I would like to thank everyone that made this possible.

Within this report we describe the changes that the Government are making to the NHS Act. A Health and Health and Care Bill went through Parliament which set 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**.

On 28 April 2022 Royal Assent was given and this now 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. As I write this we are carrying out the work required to get us to this point. Although these legislative changes are welcome to establish ICS's on a statutory footing, I am pleased that in Somerset we have been working in an integrated and collaborative way for many years now.

Our Annual Report for 2021/22 highlights many areas of achievement for NHS Somerset CCG and I hope you enjoy reading it. I want to end by thanking our CCG staff, Governing Body members, our GP practices, wider system partners, and our voluntary sector as none of this would have been possible without them.

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
21 June 2022

2. Profile of Somerset

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 be able to live healthy and independent lives, within thriving communities, with timely, easy access to high quality and efficient public services when they need them.

This vision is currently 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. No matter where people in Somerset live, we will:

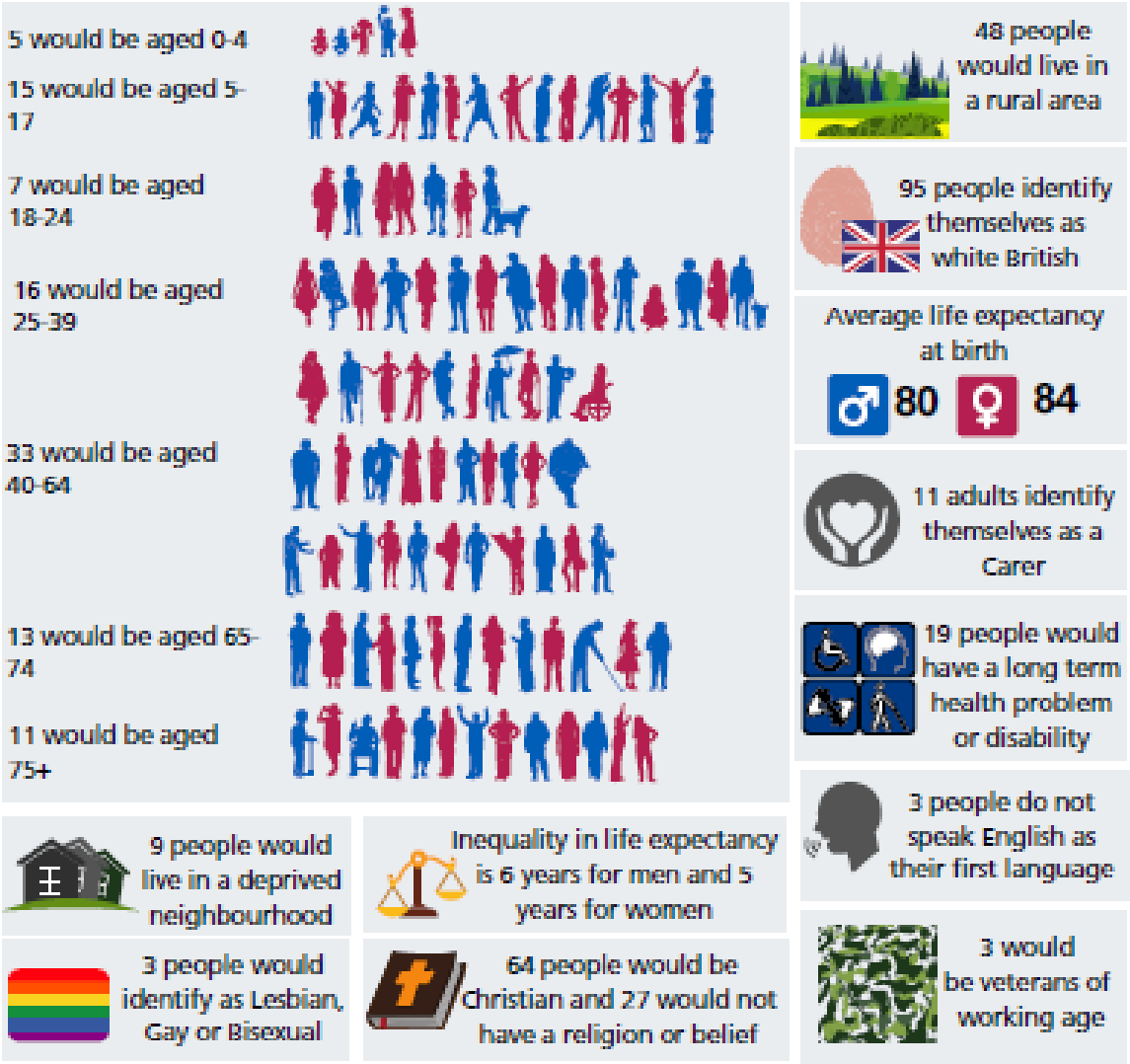
- Enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management.
- Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.
- Provide support in neighbourhood areas with an emphasis on self-management and prevention.
- Value all people alike, addressing inequalities and giving equal priority to physical and mental health.
- Improve outcomes for people through personalised, co-ordinated support.

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.

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

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.

If Somerset was a village of 100 people:

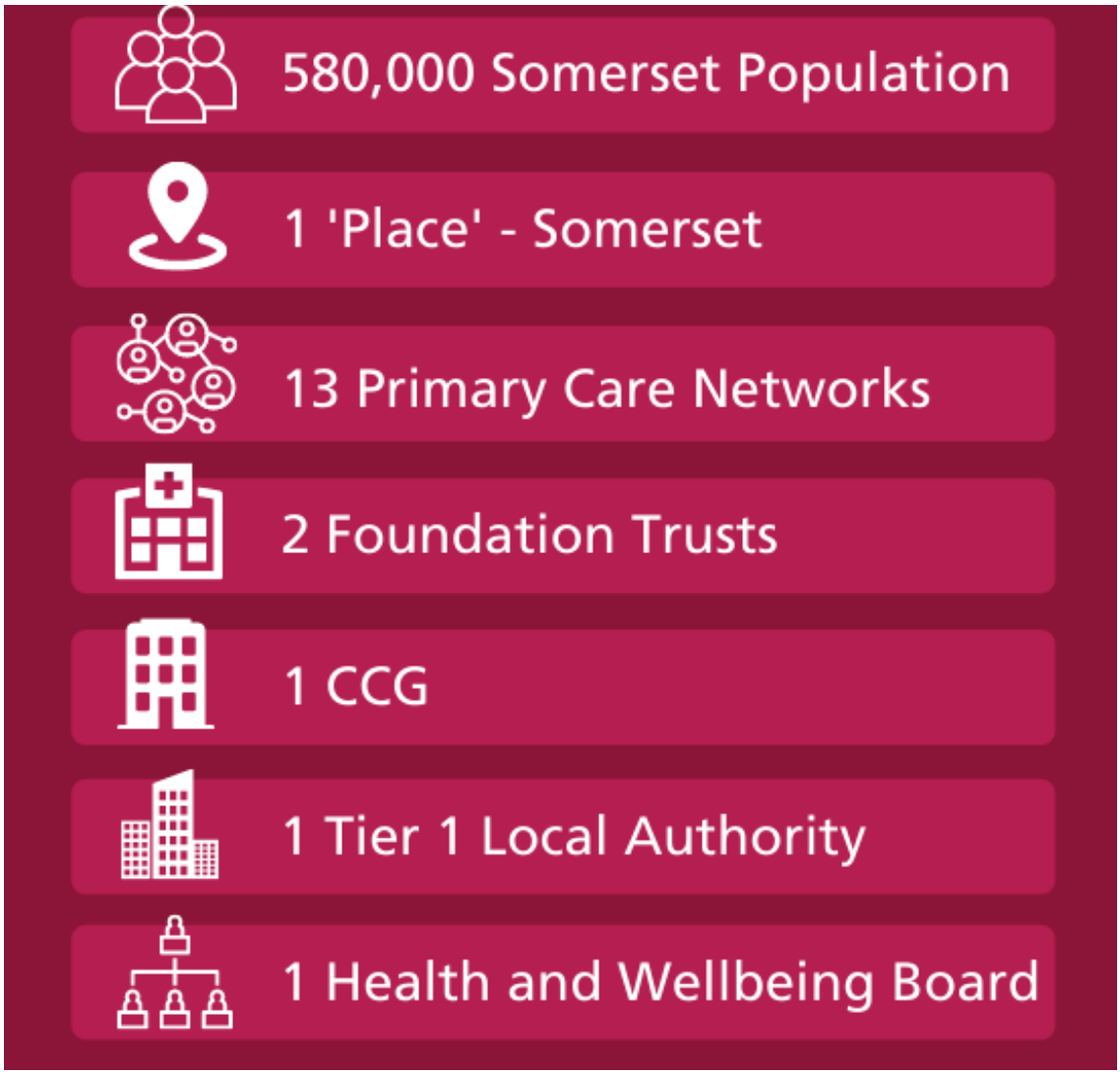


As an ICS we can go further and faster together to front-end resources and support into prevention and health promotion, tackling health inequalities head on and supporting our communities to thrive. No individual organisation in Somerset has what it takes to respond to these challenges alone.

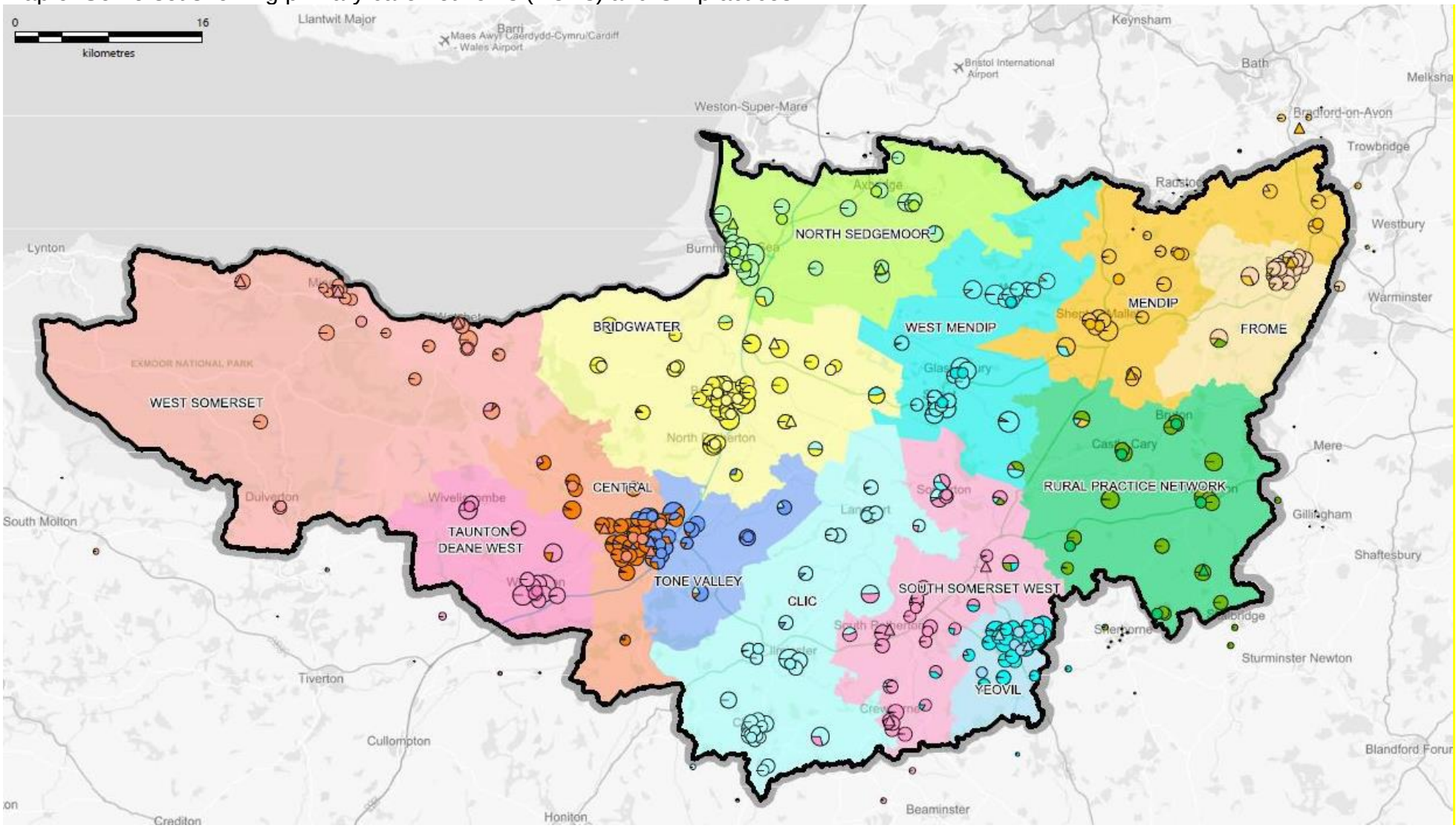
We need to bring our skills, knowledge and resources in health together with those of our colleagues in social care, education, housing and the voluntary sector, if we are to tackle health inequalities and enable our communities to thrive, in line with our strategy.

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.

We have 13 primary care networks (PCNs) 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 both health, care, the voluntary, community and social enterprise sector (VCSE) and our communities. This underpins the strong and well-established partnership arrangements within Somerset.



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



2.1 Transition to an Integrated Care Board (ICB)

Our 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 (ICS) 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. At present ICSs aren't legal entities, but the Government is progressing legislation to change this.

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 prevents systems from being truly integrated.

The Health and Care Bill, currently going through Parliament, 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**.

The proposals mean 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, CCGs will be abolished.

It was originally expected that these changes would come in to effect in April 2022. However, this target date has now been 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.

As part of the changes, a commitment has been made to support our 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.

In Somerset, we are well prepared for these changes.

2.2 Health and Wellbeing Board

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.

NHS Somerset CCG is an active member of the Health and Wellbeing Board which was comprised of the following membership at 31 March 2022:

Member	**Organisation**
Cllr Clare Paul (Chair)	Somerset County Council (SCC)
Cllr Frances Nicholson (Vice Chair)	SCC
Cllr David Huxtable	SCC
Cllr Mike Best	SCC
Cllr Brian Hamilton	South Somerset District Council
Cllr Janet Keen	Sedgemoor District Council
Cllr Chris Booth	Somerset West and Taunton Council
Cllr Ros Wyke	Mendip District Council
Dr Ed Ford (Vice Chair)	NHS Somerset CCG
Alex Murray	NHS Somerset CCG
James Rimmer	NHS Somerset CCG
Richard Schofield	NHS England
Judith Goodchild	Healthwatch
Trudi Grant	Director of Public Health, SCC
Julian Wooster	Director of Children's Services, SCC
Mel Lock	Director of Adult Services, SCC
Supt Dickon Turner	Avon and Somerset Police Chair, Safer Somerset Partnership

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 in 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.

2.3 Health and Care Strategy for Somerset – 'Fit for my Future'

To deliver our vision, we are creating an Integrated Care System for Somerset where all the agencies collaborate to meet the health and wellbeing needs of adults and children within our population. This means that no matter where people in Somerset live, we will:

1. Enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management
2. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting
3. Provide support in neighbourhood areas with an emphasis on self-management and prevention
4. Value all people alike, addressing inequalities and giving equal priority to physical and mental health
5. Improve outcomes for people through personalised, co-ordinated support

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

As part of the ICS, we plan to transform out of hospital care beyond the traditional primary and secondary care division. 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'. Enabling 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.

Fit for my Future: a Healthier Somerset is the Somerset system's strategy for delivering this ambition, supporting the health and wellbeing of the people of Somerset by changing the way services are commissioned and delivered. The strategy is the health element of the broader county Improving Lives Strategy and the Health and Well Being Board have been an integral part in developing the Fit for my Future strategy to ensure both strategies are fully aligned.

We have developed four workstreams, focussing on:

- Mental health services

- Community health and care services
- Acute services
- Provision and prevention.

Although the pandemic paused much of our work, while we refocussed our efforts and redeployed our staff to respond, our workstreams resumed, taking any of the learning and benefits we have gained during this period.

2.4 Mental Health

We have carried out a detailed review of our mental health services, coproducing 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.

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.

2.5 Community Health and Care Services

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.

The learning from the pandemic will be incorporated into the work we do in 2021/22 and 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.

2.6 Acute Settings of Care

Our acute service currently serve 594,000 people (those registered with a GP) across Somerset. During 2021/22 we will be reviewing our services and considering how best to provide sustainable, safe, effective hospital based services that meet the needs of our population both now and in the future

2.7 Prevention

It is recognised that population health and prevention as a way to benefit the health of our population is an important factor in helping us to reducing 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.

A major focus for the Somerset 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 cardio vascular disease (including diabetes and high blood pressure).

2.8 Inequalities

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.

3 PERFORMANCE REPORT OVERVIEW

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

The sections include how the organisation has delivered its key workstreams, statutory responsibilities and the overall performance during 2021/22.

3.1 COVID-19 Vaccination Programme - Somerset

Since the start of the COVID-19 vaccination programme in December 2020, the Somerset Integrated Care System (ICS) has delivered 1,397,033 vaccinations up to 24 March 2022. This includes a period before Christmas 2021 where, as part of a national surge to get as many people vaccinated as possible, the programme delivered over 63,000 in just one week. The programme has been well supported through a combination of main vaccination centres, primary care network sites and community pharmacies.

The Somerset ICS has performed well in comparison to other areas of the country and is above average in all cohorts for first doses, and a total of 6% above the national average combined. The system is 2% above the national average for the booster programme and is the best performing in the country for boosters for immunosuppressed people. 100% of self-declared carers have been vaccinated, and we are the best performing system in the South West for the delivery of vaccinations to housebound people with 97% having received at least one dose, and 94.3% having received a booster. In addition, 95.8% of care home residents have received at least one dose, and 94.9% received a booster. We are the third best system in the country for 1st dose uptake in people aged 12-15 at 71.2% compared to a national average of 60.7%

We have worked closely with Public Health colleagues to ensure that any areas of low uptake are identified, and targeted communications and specific approaches are taken to support these individuals to reduce areas of inequality. This work will continue as we move forward with the programme, and people will be able to continue to come forward for vaccination that haven't yet.

The vaccination programme has been made possible through the dedication of staff and volunteers who have worked tirelessly, particularly in the December 2021 surge which was also supported by partner organisations.

We look forward to building on our successes as we commence with vaccinating healthy 5-11 year olds and the Spring booster programme, and if instructed to do so by the Joint Committee on Vaccination and Immunisation (JCVI), the Autumn 2022 booster programmes.

3.2 Oximetry at Home/Covid Virtual Wards

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. Since mid-October, when the new service was launched, over 2,800 people have been supported.

COVID virtual wards continued to be available, with capacity expanded to respond to Omicron.

Building on the success and learning from these services a programme of work has been started to expand the virtual ward and hospital at home models in line with the national ambitions.

3.3 Elective Care and Elective Care Recovery

This has undoubtably been a challenging year for delivering elective care. We have strived to return activity levels to pre-COVID19 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.

The Somerset Integrated Care System (ICS) identified the following key deliverables/outcomes for its transformation of outpatient and referral pathways work for 2021/22:

- More timely outcomes for patients referred for secondary care opinion
- Outpatient consultations only where these add value
- Straight to test / direct access tests as the default
- Hospital attendances minimised (virtual attendances where appropriate)
- Acute provider capacity freed-up to undertake more complex work
- Market research to inform basis of patient choice decisions
- Transport links / infrastructure to support use of independent sector

During 2021/22, our Elective Care Plan aimed to maximise elective activity across Somerset. This achieved the following (approaching the end of the financial year):

- Almost 75% of inpatient elective operating (requiring an overnight stay) returned to pre COVID-19 levels
- Day cases at 115% of pre COVID-19 levels
- We have delivered 120% of pre-COVID-19 outpatient attendances
- Up to 20% of all outpatient attendances now being offered as non-face-to-face interactions
- We have greatly reduced the numbers of patients waiting in excess of 104 weeks for treatment and expect this to be only 100 patients by the end of the year

3.4 Diagnostics and Diagnostics recovery

Diagnostic waiting times grew during 2020/21, but in 2021/22 we have made significant inroads to bring down waiting times. 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 150% of pre-COVID levels of scanning in MRI and CT. Endoscopy levels are also at 130% of pre pandemic levels.

This work has helped to bring down the numbers of patients waiting more than six weeks for diagnostics in 2021/22.

. 3.5 Cancer Treatment and restoration

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.

During 2021/22 we achieved the following:

- 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.

- Returned cancer referrals to over 110% of pre-COVID levels.

3.6 Urgent and Emergency Care

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 experienced and ensure safe services were in place.

3.7 Think 111 First

The Think 111 First service is a nationally led campaign, which was successfully implemented within Somerset with ongoing system-wide work to embed and develop further. Social distancing and infection prevention precautions continue in the waiting areas in emergency departments (A&E). It is even more important to support our public 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.

Around 70% of emergency department attendances (nationally) are made up of walk-in patients. The NHS seeks to keep patients safe despite the reduced space in emergency department waiting rooms. Evidence also indicates that a significant proportion of those attending emergency departments could be seen elsewhere, for example in a primary care facility or at a minor injury unit (MIU).

Think 111 First is about offering people a different way of accessing and receiving healthcare, including a new way to access emergency departments. This means:

- That NHS 111 or a GP practice are the first places a patient should contact when they experience a health issue that is not life-threatening.

- Reducing the need for a patient to go to a physical location when accessing healthcare, embracing remote assessment and the technology that supports it.

- Avoiding risk of nosocomial (hospital-acquired) infection by ensuring fewer urgent patients attend emergency department waiting rooms.

- Ensuring patients get clear direction on what they need to do and where they need to go to resolve their health issue.

- Protecting those most at risk (e.g., people who are extremely clinically vulnerable from COVID-19) by giving them an enhanced service.

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 (e.g., 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.

The Somerset integrated urgent care service (IUCS) is now able to book a timed arrival slot for patients needing to be seen in an emergency department, ensuring patients are seen safely and conveniently. This allows departments to better plan their day-to-day running of services and patients benefit from a better experience as they are seen close to their booked timed arrival slot.

The IUCS has also implemented clinician call-back (validation) for those who may need to attend an emergency department following contacting NHS 111 (be it via telephone or online). This enhancement to the existing service is key to ensuring patients are directed to the most appropriate service. Over time this, coupled with Think 111 First, may have a positive impact on improving emergency department waiting times for patients. Since clinical validation of calls coming into NHS 111 in November 2020 we have consistently helped to direct patients to a more appropriate service, rather than despatch a 999 ambulance. For example, for calls categorised as category 3 (those conditions that are serious but stable such as abdominal pain) our out-of-hours provider validates up to 1000 calls a month and avoids more than 95% of ambulances that would otherwise have been despatched.

In Somerset, we implemented the Think 111 First service in November 2020, ahead of the winter period and in advance of the national deadline for implementation which was 1 December 2020.

3.8 High Intensity Users

High Intensity Users (HIU), while a relatively small percentage of patients, are known to generate a disproportionately high percentage of emergency department (ED) attendances and hospital admissions. High intensity use is

defined as attending ED more than five times in a year, and that less than 1% of England population attends ED at this frequency or more.

In Somerset, the top 75 frequent attenders at A&E alone accounted for 2,190 A&E attendances and 141 associated admissions at a cost of £647,000 in 18/19. For each of these 75 patients, this equates to an average of 30 attendances in a year. In addition, there are another 3,774 patients who meet the NHS England definition as a cost in the same period of almost £14.5M.

Understanding what contributes to high intensity use is not just about the number of attendances or their associated costs. Outcomes for people who attend ED frequently are worse than the general population, with higher mortality and greater dissatisfaction due to unmet needs. This inequality requires more local investigation; the demographic profile of those frequently attending ED include those with inadequate housing, loneliness and social isolation, alongside higher prevalence of physical and mental health problems.

Emergency services are often unable to address the root cause of behaviours and many have exhibited this behaviour for several years, in addition to countless contacts with the police, GP's and council services.

The teams delivering the services have been building a trusted relationship with HIUs to help understand the reasons for why they attend ED so often and to work with them to implement person-centred solutions; developing strategies that address their needs and hopefully lead to behaviour changes that can be sustained. A HIU Network Group is also in place 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.

3.9 **Models of Urgent Care**

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. Work during the early part of 2022/23 will include 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.

3.10 **GP 999 Car**

NHS Somerset CCG commissions the GP 999 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.

The overall operating model for this service compromises of a rapid response vehicle (RRV), staffed by an experienced and autonomous ambulance GP and a clinical support colleague. This resource provides community treatment for the full range of urgent cases entering the '999' workflows in Somerset. The service provides 81 hours of doctor availability each week, evenly spread across the full 7-day week, with an extended service at weekends. The RRVs will operate a mixed, dynamic workstream, including:

- Emergency response and treatment of suitable cases.
- Remote support to front-line paramedics.
- Enhanced triage and 'hear and treat' management of patients in the Somerset 999 incident stack.

The objectives are to provide complete community treatment without emergency department attendance or hospital admission, where possible, improving the experience of service users by supporting NHS Somerset CCG's aim to deliver care closer to home. The service works with other key health and social care stakeholders in Somerset to provide a flexible and responsive offering to urgent and emergency situations. Through direct access to the '999' incident stack, potentially suitable cases can be identified in real time, enabling early intervention and mitigation of impact on our hospitals.

3.11 **SAVES (Immediate Care and First Responder Enhanced Service)**

The 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.

SAVES is a registered charity which provides the network of doctors who support the ambulance service in Somerset. SAVES co-ordinates the immediate and first response service, with the South Western Ambulance Service NHS Foundation Trust (SWASFT) requesting the call outs.

Most of the provision through SAVES is responding to road traffic collisions, but they do also provide immediate and urgent medical care to those who have become ill or suffered trauma within the community.

The types of incidents that the service are called out to include the following Category 1 and 2 calls below:

- Road traffic collisions
- Falls
- Acute heart failure
- Sepsis

- Cardiac arrest
- Cellulitis/sepsis
- Acute asthma attacks
- Stabbing
- Head injuries

Currently there are significant pressures on SWASFT in their delivery of Category 1 and 2 calls. These calls are the most serious and therefore need to be responded to quickly.

In Q3 21/22 SAVES were allocated to 35 emergency incidents by South Western Ambulance Service NHS Foundation Trust (SWAST), and were first on the scene for 28 of those, and travelled around 379 miles to attend patients across Somerset in which the doctors volunteered 40.5 hours treating patients.

The additional benefits that SAVES provided to SWASFT were that 9 ambulance resources were stood down, SAVES accompanied 13 patients to hospital and 13 patients were treated / discharged on scene (otherwise normally conveyed by ambulance).

3.12 **Intermediate Care**

The Somerset hub for coordinating 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 coordinate all care from the hub, building on existing arrangements. The main components to the new service model have been drawn from the lessons learnt 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.

3.13 Primary Care including restoring and increasing access

Primary care forms an integral part of our integrated care model for Somerset and in 2021/22 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.

In addition to delivering these priorities, during 2021/22 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.

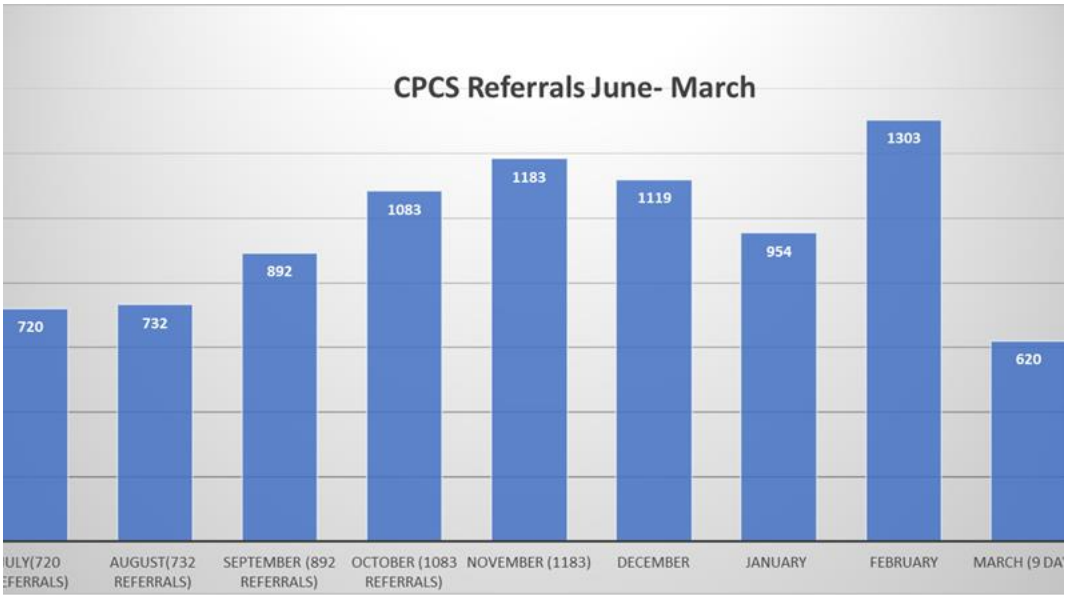
- Primary care also delivered the majority of our COVID-19 vaccinations.

Increasing GP workforce was challenging in Somerset, as elsewhere in the country, however we 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 (PCN) and staff including pharmacists, physiotherapists and health coaches increased from 110 whole-time equivalents in April 2021 to 222 in March 2022.

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.

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 the end of the year we saw an 11.8% growth in appointment numbers.

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. 89% of surgeries in Somerset are offering this service to their patients, compared with 30% nationally. The graph below shows the increase in patients benefiting from the new service. Please note that March 2022 data only includes the first 9 days of the month.



Throughout the 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%. 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.

Demand, particularly over the winter period was 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 a digital first approach remained a priority, which included optimisation of triage services with face-to-face appointments where clinically necessary.

To ensure any health inequalities demonstrated during the COVID-19 pandemic were addressed, (particularly within our learning disabilities (LD) and black, Asian and minority ethic population), we prioritised health checks and ensured equitable access to primary care health services, considering individual needs. All our primary care network clinical directors are champions of health equality and general practice is committed to achieving (at least) the 67% target of health checks for people with LD by 31 March 2022.

3.14 The Better Care Fund

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.

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.

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

- Disabled facilities grant – managed via district councils.
- Mandated NHS (CCG) contributions.
- Improved better care fund (contributions via Somerset County Council).

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. BCF plans are overseen and signed-off by health and wellbeing boards and this is the case for Somerset.

During 2021/22 the Somerset BCF continued to help drive forward our person-centred integration agenda and our plan secured and stabilised investment in:

- Social prescribing and community-based support.
- Major and minor home adaptations and equipment.
- Carers support services.
- Core health and social care services.
- Intermediate care services (including rapid response and ‘home first’).
- COVID-specific hospital discharge schemes.
- Additional social care support for people able to leave hospital at weekends.

3.15 Neighbourhoods and Communities

The Somerset Integrated Care Service (ICS) together with key voluntary sectors 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.

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 £1m and distributed funds to support local action.

- Worked to support homeless people into safe accommodation.

- Agreed countywide 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.

3.16 Ageing Well Programme

NHS Somerset CCG has an established programme team to oversee the Ageing Well Programme which comprises of urgent community response (UCR), anticipatory care and enhanced health in care homes (EHCH). Within Somerset there has been an increase in patient falls in the community, and several patients with chronic and complex health conditions.

Over the next 12 months to 2 years, the Ageing Well Programme will look at a falls response model offering full geographic coverage, with an expectation of reducing demand on South Western Ambulance Service NHS Foundation Trust (SWASFT) services and conveyance to acute emergency facilities. In addition to this, additional falls equipment will be available across all UCR services to support patients to remain at home where appropriate. In addition, the UCR model will develop whole system integrated pathways to support patients, families and carers to remain in the place they call home.

We have some exemplary complex care services in place across Somerset and plan to develop these further in line with the anticipatory care model. By working at primary care network population level, the aim is that people identified with greatest risks and needs will be offered targeted support for

physical and mental health needs which include musculoskeletal conditions, cardiovascular disease, dementia and frailty.

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.

3.17 Prevention

- Developing more detailed proposals for the use of the £1m 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 CEC recently.
- Smoking cessation and tobacco control
- Healthy Weight and the Healthy Weight Alliance
- Somerset Moves – our countywide physical activity strategy
- Hypertension strategy

This work programme also links closely to the Improving Lives and Fir for my Future Strategies outlined in sections 2.2 and 2.3.

3.18 Diabetes Prevention Programme

Somerset has a nationally commissioned diabetes prevention programme which continued to operate successfully during 2021/22 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. Practice participation reached 98% with only one non-referring practice at the end of 2021/22.

The direct to consumer pathway which was brought in to support practices during the pandemic has continued 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.

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 in these areas are due to start in early 2022/23.

Diabetes Low Calorie Diet Programme

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.

Diabetes Management

My Diabetes My Way is a self-management platform that allows patients to set goals, monitor their results and access education. On the 31 March 2022 we had 4,820 users, which is around 14% 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.

In 2022 we were awarded funding from NHS England to double the number of people registered with My Way Diabetes. In addition, funding was awarded to Somerset from NHS England and NHSX to deliver a risk stratification programme using remote monitoring to support primary care with those people with diabetes who are at high risk of developing complications.

An open online course was held for people with diabetes during 2021/22 and was tailored to the needs of people during Ramadan and to Type 1 diabetes.

An innovative joint clinic between Yeovil Primary Care Network (PCN) and Yeovil District Hospital NHS Foundation Trust for young people with type 1 diabetes was piloted. It has improved engagement for those who find it challenging to engage with mainstream NHS services.

The impact of the pandemic meant that all face-to-face structured education ceased during 2020/21 and has been delivered remotely. Although the numbers accessing structured education have decreased, people have accessed innovative online programmes for both type 1 and type 2 diabetes. Face to face programmes have started to take place once more.

3.19 Respiratory Management

During 2021, we developed another business case to request funding for a community based integrated respiratory team. The funding outcome is awaited, however we do recognise that Somerset is a national and regional outlier by not having this resource in place.

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.

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.

Three respiratory clinical champions were recruited to PCNs and funded from the South West Respiratory Network. We now aim to increase our champions in Somerset during 2022/3.

Work 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.

3.20 Cardiovascular Disease

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

Somerset participated in the national blood pressure (BP) at home project, where Symphony Healthcare 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.

3.21 Somerset COVID-19 Recovery service

NHS Somerset CCG has 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 then personalised management plans are agreed. Management plans will include advice and support, guided self-help resources and referral to specialist services for support/rehabilitation as required.

In 2021, the multi-disciplinary team were trained to operate video group sessions which has improved the capacity of the clinics. They have also implemented singing groups and peer support for people with post COVID-19 syndrome. Since the launch of the Somerset service, over 800 people have been assessed and supported.

A paediatric clinic has also been established which connects to the regional specialist MDT in Bristol.

3.22 End of Life Care

Sadly, for many people and their families both across the UK and the world, the COVID-19 pandemic ended people's lives early. It brought into sharp focus our deeply human need to express and fulfil certain wishes at the end of our lives. It also highlighted how important it is to be around the people who matter most to us at the end. The pandemic, particularly in the early phases brought many challenges around this, to people, families and communities, to health and care teams, hospices, chaplaincy as well as spiritual and funeral services and bereavement support. Some people, for example were not able to be by their loved one's side during the last days of life or even attend their funeral. These sorts of situations were incredibly distressing for people, families and professionals alike. As the pandemic eases and life can return to normal there is bound to be a need of ongoing support, reflection and kindness as we all come to terms with what has happened.

Despite the urgent and challenging pressures brought by the pandemic, local organisations, professionals and communities remained committed to supporting people at the end of their lives; able to die with dignity, without pain and with as much contact as possible with those who mattered to them.

The 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 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.

The Programme Board also managed to make progress on important strategic developments, including:

- ‘Talk About project’, which has recently launched in Somerset to help families have important end of life conversations with their loved ones. These are enabled through trained Marie Curie champions.

- In support of spiritual care in care homes we partnered with the Diocese of Bath and Wells and healthcare Chaplains in sending a card to every home signposting to avenues of advice and provision.

- Progress in improving and promoting the use of digital technology and the sharing of people’s end of life wishes across various teams involved in supporting them. This was achieved through the Somerset integrated digital electronic record (SIDeR) programme.

- Improving our recording of people’s end of life care clinical needs using the Somerset treatment escalation plan (STEP).

- Developing an End of Life Care Education and Training Strategy, which will help improve knowledge, confidence and expertise across generic and specialised end of life care services across Somerset.

- Clinical audits and improvement plans. This included an audit of the number of families who were trained to safely provide subcutaneous injections to their loved ones at the end of their life.

- Learning from national publications and local patient and family and professional experience.

- Oversight of an end of life component to the rapid response team.

The Somerset end of life care and bereavement support website was launched on 1 March 2022. The website has been developed to enable patient’s families and carers access services within Somerset.

3.23 Mental Health – Adults and Children

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.

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, focused on improving the overall mental wellbeing of the population, avoiding crises, and managing them better when they do occur.

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. Our priorities for the year were as follows:

- Enhancing the Somerset population's mental and emotional wellbeing and resilience, including staff health and wellbeing.

- Improving access to mental health support and intervening earlier.

- Improving the provision of all age support to people in crisis.

- Concluding the Fit for My Future (FFMF) public consultation; the Governing Body of Somerset Clinical Commissioning Group approved a proposal to relocate adult mental health beds from Wells to Yeovil and implementing any decision made through that process.

- Enhancing sustainable recovery and resilience for those who access mental health support.

- Further embedding and developing our Open Mental Health model of community mental health care across the county.

- Working towards improvement in dementia services

In 2021/22 we achieved the following against each of these priorities:

- **Enhancing the Somerset population's mental and emotional wellbeing and resilience, with dedicated focus on staff health and wellbeing in light of the COVID-19 pandemic**

  We launched an inequalities initiative, in partnership with our experts by experience and voluntary, community and social enterprise sector partners, which will continue into 2022/23.

The multi-disciplinary, pan-Somerset, organisationally agnostic pastoral care cell that we developed to provide specific support for health and care staff (including VCSE employees and volunteers), informed by staff feedback, has transformed into the Somerset Emotional Wellbeing (SEW) Resilience Hub Steering Group. NHSE have confirmed substantial funding again for 2022/23 and reiterated the importance of this initiative in supporting our overall health and care workforce. The SEW Hub Steering Group have been leading on the commissioning, implementation, and oversight of a range of initiatives, including:

- A clinically led telephone support line for health and care staff, including volunteers and those working within Somerset's VCSE organisations, across the county, operational six days a week. The line offers immediate support as well as fast, seamless referrals into other services such as Talking Therapies.

- The Health Service Journal Award shortlisted (for Mental Health Innovation of the Year) Somerset Emotional Wellbeing (SEW) podcast which is a library of free, on demand mental health and wellbeing conversations. It has surpassed 21,000 total downloads for the 67 episodes released to date.

  Developed our Somerset Emotional Wellbeing Resilience Hub website. We have added support for South Western Ambulance Service NHS Foundation Trust (SWASFT), care staff who work with the homeless, teachers, NHS 111/Devon Doctors and Dorothy House Hospice. The SEW website has been visited by 5,029 users so far this financial year.

- Virtual Somerset Emotional Wellbeing Conference in October 2021.

Improving access to mental health support and intervening earlier

Our Talking Therapies Service has seen even more people than last year (and is progressing towards delivery of the national ambition). We grew our service with additional trainees and recruiting qualified practitioners. We continued to offer face to face and virtual appointments.

Somerset developed its maternal mental health service (MMHS) following selection as a fast follower site by NHS England and NHS Improvement. This service combines maternity, reproductive health and psychological therapy for women experiencing moderate-severe mental health difficulties arising from or relating to the maternity experience, including birth trauma, perinatal loss, or severe fear of childbirth (tokophobia). We have appointed to all vacancies and staff training has commenced. The service is accepting referrals and the formal service launch is planned in April 2022. In addition to this, our perinatal mental health service continued to deliver interventions and we are on track to exceed the 2021/22 target set out nationally.

We have improved our adult attention deficit hyperactivity disorder (ADHD) offer. We now meet regularly with staff from Somerset NHS Foundation Trust

that are involved in delivering adult ADHD care to work together on overcoming barriers to service delivery. A growing number of people in Somerset are choosing to use the virtual services offered by independent and / or digital providers during the pandemic and we are keen to adopt elements of these offers within our developing model of care.

We have continued our work to ensure that physical health and mental health have parity of esteem, noting the significant premature mortality for people with serious mental illness. Specifically, we have recruited additional practitioners to support the programme, as well as a peer support offer. We have made significant progress in resolving the data flow issues, to ensure that in 2022/23 data will flow nationally to reflect the activity taking place in Somerset.

Specifically for children and young people, we have expanded our mental health support teams (MHSTs) in schools, which now covers 60% of Somerset's grant-maintained schools, well ahead of the national ambition. Our innovative model is managed through a lead provider partnership between Somerset NHS Foundation Trust (SFT) and Young Somerset, working in collaboration with the four hosting pupil referral unit (PRU) schools, Somerset County Council education (educational psychologists and inclusion) and NHS Somerset CCG. These new teams consist of operational and clinical leadership via children and adolescent mental health service (CAMHS), mental health clinicians and education mental health practitioners via Young Somerset. Our current focus is to align other school-focused support (such as educational psychology, neuro-developmental and mental health training inputs etc) to deliver a whole school approach. We look forward to closer working with our schools and their leadership teams to ensure a shared understanding of our offer – this will support our aim to deliver an early and preventative offer of support.

We have also expanded our young Somerset wellbeing service, which offers low intensity cognitive behavioural therapy to young people aged 5 – 18 with mild to moderate mental health difficulties such as low – mood, anxiety, stress, phobias, sleep problems and obsessive compulsive disorder (OCD). We also partnered with MeeToo, to pilot a project to support young people in Somerset by creating a unique portal which sits inside the MeeToo app. MeeToo is a multi-award winning, fully moderated, peer support app for young people aged 11 – 18. This enables young people to talk about difficult things and to help themselves by helping each other. We have evaluated the service this year, which will inform our commissioning plans for 2022/23.

We made progress in recruiting to mental health additional reimbursable roles (adult and CYP), roles which are based in primary care, although not to the levels anticipated due to challenges with workforce.

Improving the provision of all age support to people in crisis

Our 24/7 mental health crisis line (Mindline) offer, available to all ages, accepts calls from Somerset residents of all ages and provides initial active listening support from trained call handlers, dedicated support from clinicians where

appropriate, and transfers to other services where appropriate is being well utilised. We have also implemented an instant messenger support offer as part of this service this year.

Working alongside our partner providers, we have developed close working relationships between our Mindline, our 24/7 crisis resolution and home treatment team (CRHTT) and our four crisis safe spaces. These provide effective alternatives to emergency departments, as we know that A&E settings can be distressing to people experiencing mental health crisis. We have also expanded psychiatric liaison services at Yeovil Hospital, which complement the existing services at Musgrove Park Hospital.

This year we also launched a joint initiative between mental health partners and the ambulance service, whereby the ambulance control room has dedicated mental health professionals. These mental health professionals help people who contact the ambulance service to access the most appropriate intervention for their needs.

We continue to be an active member of the Suicide Prevention Partnership Board (SuPPa) and aspire to move towards a zero-suicide position in the county. We are working with all partners to deliver proactive outreach to support people and prevent them from entering crisis, as well as supporting families through post suicide bereavement processes. We continue to work to raise awareness, to ensure that suicide prevention becomes everybody's business, as we know that two thirds of people that take their own lives are not previously known to mental health services.

Implementing the outcome of the Fit for My Future (FFMF) public consultation to relocate adult mental health beds from Wells to Yeovil

We successfully concluded the public consultation and the NHS Somerset CCG Governing Body made the decision to relocate the beds from Wells to Yeovil (with no reduction in bed numbers). Work is now underway to complete the refurbishment of the Yeovil site to enable the relocation to be realised during 2023.

Enhancing sustainable recovery and resilience for those who access mental health support

Our Talking Therapies service is one of the top performing services nationally for recovery.

We also implemented a "next steps" service for patients admitted to mental health inpatient beds to support their sustainable recovery in community settings. We are looking to expand and develop this service in 2022/23.

Working in tandem with our provider partners we have made good progress in implementing a system-wide culture of individual personalised outcome-based care planning (via DIALOG+) that sets the objectives for each individual with a

clear recovery focus. Our key goals continue to be getting, and keeping, people well across our county.

Specifically for children and young people (CYP), in 2021/22 we launched the Jigsaw Project. This service was commissioned to reduce the re-admissions CYP experiencing emotional distress and mental health needs, (self-harm, suicidal ideation, or attempted suicide). It has delivered a more proportionate response to need and has made an impressive contribution to enabling CYP to engage with services, focused upon their desired outcomes.

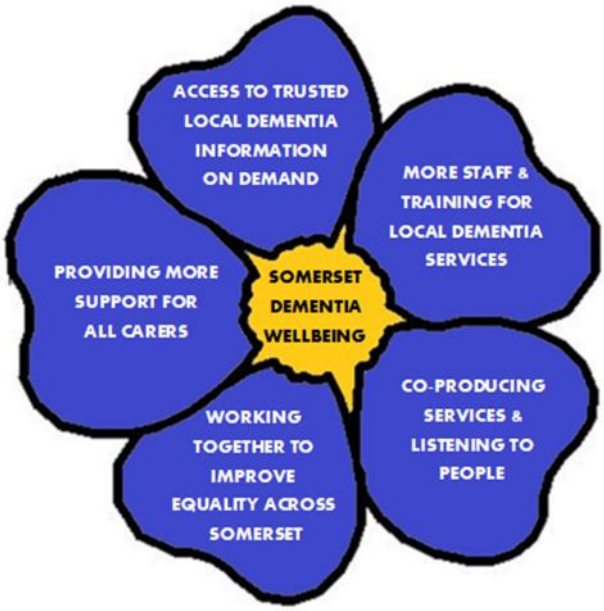
Further embedding and developing our Open Mental Health model of community mental health care across the county

Our transformed and expanded community mental health service, Open Mental Health, is now established and maturing well. We have a holistic offer around mental health supported by both NHS and voluntary, community and social enterprise (VCSE) partners. An evaluation of these services, in partnership with Plymouth University is underway and nearly complete. The Open Mental Health website has also now launched (http://www.openmentalhealth.org/) and is at the vanguard of a wide-ranging communications and engagement campaign to drive awareness of the service more widely across the county, to ensure underserved populations are given equality of provision as part of our programme of continuous service improvement.

Worked towards Dementia Improvement

We established the multi-organisational Dementia Operational Oversight Group and an associated Dementia Task and Finish Group and Sounding Board Focus Group to look at the entire dementia pathway (including diagnosis) to ensure that dementia services offered in Somerset are fit for purpose. We are proactively working together as a system to develop a new model of care for dementia, the Somerset dementia wellbeing model (SDWM), using an Integrated Care System (ICS) approach that is similar to our trailblazing, nationally recognised Somerset Open Mental Health service.

The key elements of the Somerset dementia wellbeing model are detailed in the visual version we have developed below which is based upon the forget-me-not, recognised nationally as the flower of dementia:



In the short term we have expanded our workforce within the memory assessment service to assess and diagnose dementia, improve confidence in diagnosis and to provide post-diagnostic support in the community, including support to carers. We also increased the number of dementia support workers in Somerset and implemented a dementia connect phoneline, as mandated by the NHS Long Term Plan, and delivered by the Alzheimer's Society in collaboration with Somerset NHS Foundation Trust.

Autism and Learning Disabilities

Our overarching principles are as follows:

- 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.
- Do things with people, not for them or to them.
- Promote rights, respect, choice, and control.
- Improve equity of access and provision in mainstream services.
- Reduce health inequalities for people with a learning disability, autism, or both.
- Reduce premature mortality in people with a learning disability, autism, or both.

In 2021/22 we achieved the following**:**

- Recruitment of an assistant commissioning manager for learning disability and autism, allowing us greater focus on commissioning for individuals and carrying out 6–8-week commissioner oversight visits for people cared for in hospital settings.

- Agreement of a 3-year delivery 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.

- For all those in hospital on 31 October 2021, we carried out safe and wellbeing reviews (a requirement following a Norfolk Safeguarding Adults Review). The findings of these reviews were considered at multi-disciplinary safe and wellbeing review panels in March 2022 to ensure necessary and appropriate learning and action.

- Improvement in processes around care education and treatment review/care treatment review (CETRs/CTRs) and the assuring transformation (AT) database. This work will continue in 2022/23.

- Ensured that dynamic support registers (DSR) are in place for adults, children and young people, and monthly conversations are held to ensure that these work as efficiently as possible. The adult DSR has been successful in avoiding unnecessary or inappropriate admissions of people with learning disabilities and autism into hospital through close working with the rapid intervention team and the rapid emergency action crisis team (REACT) in Somerset (as well as multi-agency Blue Light meetings). There is a very low admission rate for children and young people with autism and/or a learning disability.

- Improvement to the autism pathway for children and young people.

- Improving access and waiting times for assessment.

- Strong performance against national ambition for annual health checks (AHCs) for GP learning disability registers, delivering 82% at the end of 2020/21. We have worked closely with partners to continue encouraging uptake and improve processes and we have developed a wide ranging set of resources to support this. All this work is supporting the promotion of AHCs in addressing health inequalities and leading a healthy lifestyle, as well as improving care provider support to people with learning disabilities and autism and training, and resources to system partners.

- Commenced work on treatment escalation plans and advance care planning to ensure these services are accessible and appropriate for people with a learning disability.

- Continuation of our work on the learning disabilities mortality review (LeDeR) programme, including:

- Implementation of the new LeDeR policy in Somerset, with a dedicated LeDeR review team now in place.
- Creation of a three-year LeDeR strategy
- Learning into action from the reviews has focussed on three themes:

    - Improving the quality and uptake of annual health checks
    - The application of the Mental Capacity Act
    - Holistic commissioning

- Established a multi-organisational stopping over-medication of people with a learning disability, autism or both (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP) STOMP / STAMP working group. Its work programme will continue to be progressed into 2022/23.

- Implemented the host commissioning recommendations as set out in May 2019 by the Minister of State for Care. A host CCG model has been implemented taking responsibility for the oversight of any issues relating to quality and safety from a commissioning perspective for CCG-commissioned inpatient care.

3.24 Women and Children's and Families Services

Introduction
As well as a portfolio for maternity, special educational needs and disability (SEND), women's and pediatric service commissioning, an additional large transformation work programme relating to children and young people has also been required as the result of renewed focus following the publication of the NHS Long Term Plan.

The main priority areas for 2021/22 have been:

- Maternity, where, following the publication of 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.

- Continuing progress against the nine priority areas identified by Inspectors that need improvement 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 COVID-19 pandemic recovery.

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.

Background

Influences on good health are different for children and young people than adults. because they are subject to a rapid period in physical and mental development, timeliness is essential to support children's growth, and as they are dependent on their care givers, their health development and requirements are inextricably influenced and linked to how they are being looked after and the context, circumstance and environment they live in. This means there has to be a real focus on the effect on health disparities and inequalities, particularly in relation to providing children with the best start in life as the first 1001 days of development has a critical impact on an individual's health burden throughout their life-course.

To be able to meet the needs of mothers, babies, children and young people, the way that the delivery of services integrate is critical. Care needs to be seamless within care pathways: across transition points such as between paediatric and adult services, in transfer between services where there are co-dependent or related conditions such as maternity and perinatal and infant mental health and wherever needs are best served through multi-disciplinary and/or multi-agency approaches.

This different way of doing things aligns to a key ambition for the NHS over the past few years, that is to deliver more joined up care for patients. The goal is to improve people's outcomes and experiences of care by bringing services together around people and communities. The aim is that ICSs will remove barriers between organisations, addressing the fragmentation of services and lack of co-ordination that people often experience by providing person-centred, joined-up care. (King's Fund, 2021) to deliver better, more joined up care for local communities.

Working from a population base means that integration is a key dynamic for the team, which is unique in the level of direct experience it holds working within and with stakeholder organisations. Women's, children's and family work is often at the forefront of the integration journey, with co-design and coproduction at the heart to ensure that services meet the needs of our population and ensuring that we have the insight to continually improve the quality of those services.

COVID-19 Recovery for Children and Young People

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. Childhood development patterns exacerbate the impact from delays in accessing planned care, and some diagnostic processes were compromised by the inability to undertake face to face assessments to comply with social distancing. Schools were closed, expected health care appointments did not take place, children's

mental health deteriorated and, although full monitoring has not yet been restored, the impact on other conditions that affect health are beginning to be evidenced. Much of the restorative heath care needed to address these factors are included throughout the rest of the work being undertaken, for instance between Long COVID-19, and other associated or similarly presenting conditions, and within the asthma pathway where other respiratory conditions are included.

In terms of direct care, modelling predicted a surge in paediatric respiratory syncytial virus (RSV) which could potentially overwhelm paediatric care in acute settings. Ahead of the rest of the South West, a successful funding bid was made for paediatric oximeters to enable primary care to effectively triage respiratory virus in the community thus easing pressure on acutes. The resulting procurement and distribution of paediatric oximeters to every GP Practice in Somerset, including a training package and support contract for three years meant that the potential impact of the surge was mitigated.

Local Maternity and Neonatal System Transformation

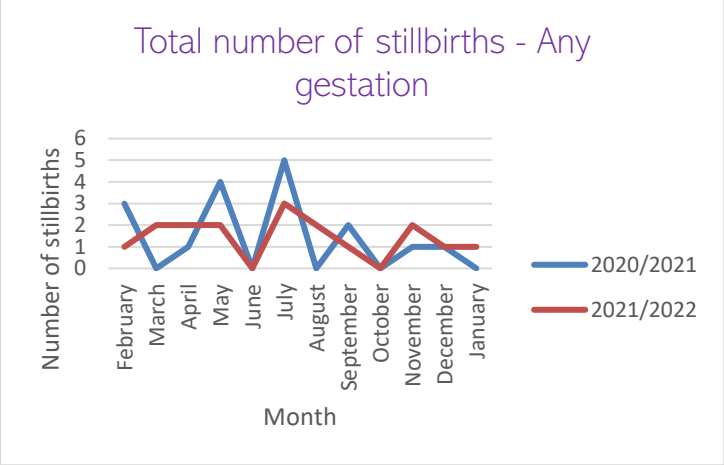
Maternity services have been challenged over the last year with high levels of COVID-19 in staff and the people they care for. The higher than usual levels of staff absence has increased pressure on a tired workforce, alongside increasing demands from the Donna Ockenden report which was published in December 2020. The second part of this report is due this Spring 2022, and the Kirkup enquiry which will add additional insight and recommendations will publish its findings in the autumn of 2022, so further safety recommendations are likely to follow.

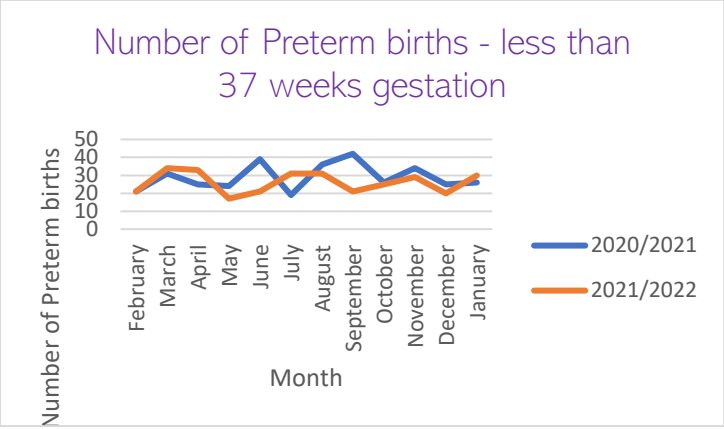
To meet these new requirements, additional funding towards the extra staff needed to fulfil these obligations has been made available. However, with a national shortage of midwifery and obstetric staff we are needing to search for new ways of attracting professionals to Somerset.

Despite these additional pressures, and the effect of COVID-19 on both staff capacity and increasing complexity in the health status for more women, Somerset remains a safe place to receive maternity care. The recent CQC maternity survey gives good patient feedback for both Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust (YDH).

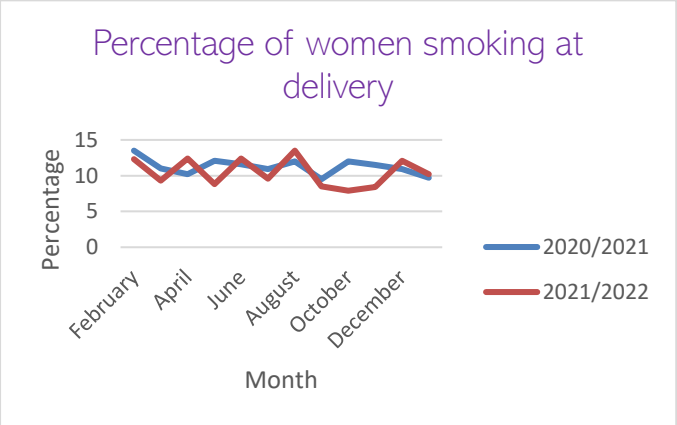
We continue to constantly search for ways to improve safety for Somerset women. Alongside the implementation of the Ockenden essential actions, both foundation trusts are fully compliant with the saving babies lives care bundle v2 and have implemented the PeriPrem care bundle, designed to improve outcomes relating to potential brain injury and mortality rates amongst babies born prematurely.

The graphs below demonstrate this, though it must be noted that variation is enhanced when looking at such small numbers.





Smoking in pregnancy remains a major risk factor, and reducing smoking continues to be high on the agenda. Because of risks of COVID-19 transmission, carbon monoxide (CO) monitoring was stopped during the pandemic and only restarted before Christmas. Disposable mouthpieces for the monitors have now been purchased to allow this to happen, but despite any anomalies that may be caused by self-reporting, progress continues to be made although there is still much to do.



Alongside the safety workstream, we continue to develop maternity transformation projects with the support of our excellent and dedicated Maternity Voices Partnership (MVP) who offer support and challenge as an independent advocate, broker and critical friend to ensure that developments properly reflect and address the experience of women and their families. Developments this year include:

- the ongoing implementation of the national bereavement care pathway to ensure all women who suffer baby loss get a gold standard level of bereavement support regardless of where they have received their care.

- Development of a joint 'ICON' / safer sleep training package to reduce non accidental injury in infants

- The roll out of a cultural awareness training package developed by midwives in YDH with the Academic Health Science Network (AHSN) which is receiving national recognition

- Joint working with the MVP to develop personalised care and support plans that adapt to the woman's care, including bereavement and mental health support if needed.

- Commissioning a maternal mental health service to sit alongside our perinatal mental health service. This additional service will provide psychological support to women after the loss of a baby or birth trauma as well as women with tokophobia (fear of giving birth).

Special Educational Needs Disabilities (SEND)

Much progress has been made since March 2020 when the Ofsted/CQC Inspectorate team identified significant weakness within the Somerset system in their delivery of services to support some of our most vulnerable children and young people. Implementation of the written statement of action has showed how the Somerset Integrated Care System would work together to address and rectify the nine priority areas identified to ensure that we got things right for these children and their families.

Over the last year the SEND Improvement Board, which includes key representatives from the Somerset system, has overseen and assured the journey towards becoming 'good'. Certainly, there is real evidence across agencies and organisations that stronger partnership and more joined up working has happened, supporting service improvement together, and the Inspectorate agreed that in terms of:

- Culture of inclusion and collaboration:

    - more families are attending listening events. Across organisations families are starting to feel a culture change around a willingness to involve families in service design and move away from 'should we' to 'how can we', though it is recognised that more work needed to include children and young people in designing services. Feedback from

listening events in December 2021 showed a positive move towards people feeling listened to and their views being valued.

- "Green shoots" of culture change are showing across all areas. Initial feedback shows more confidence in joint working and the ability to challenge our inclusive practice.

- Joint commissioning:

  - 'Tell it once' user research is providing insight into the issues parents, carers, children and young people have in accessing services. Children, young people and their families have also engaged in the early help review - their thoughts and experiences have heavily influenced the design contained within the recommendation, which has formed the basis for the 'family hubs' bid to government.

  - There has been a marked increase in the number of referrals that result in an assessment for autism and ADHD from an average of 11.2% in April 2020 to an average of 65.3% (April 2021 to October 2021). Average waiting times have reduced from over 26 weeks at April 2020 to approximately 16 weeks (on average) between referral and first clinical appointment.

  - Feedback collection across the Somerset ICS will link into the feedback collection/ sharing cycle and continue to inform joint commissioning strategies and joint ways of working.

- Inclusive education:
  - Feedback from 'test and learn' of area-based structures indicates that practitioners are already reporting an improvement in timeliness and confidence in getting the right support in place for families. 45% of respondents reported more timely provision of interventions for vulnerable young people. 85% reported increased understanding of other agencies.

  - A wide range of health pathways made accessible to families and published in the Local Offer. Identification of a gap in funding for equipment for augmentative and alternative communication (AAC) a jointly funded budget has been identified to purchase equipment needed. Families are experiencing easier and quicker referrals for children and young people from therapists to paediatricians

- Better assessment & planning

  - Feedback from families on collaborative outcomes meetings has been extremely positive with families reporting they feel much more involved and better supported. Citizens Portal means families can now submit their views and receive live updates on the progress of an assessment.

- There is growing confidence within the special educational needs and disability (SEND) statutory team to carry out quality assurance activity and challenge quality of contributions. There has been an increase in education, health and social care plans (EHCPs) graded as 'good' and 'outstanding' which is an indication that the quality of plans is improving.

Two areas NHS Somerset CCG has been specifically leading relate to priorities concerning the development of the neurodevelopmental pathway and for improving the consistency of practice, particularly in relation to education, health and social care plans (EHCP). Significant progress has been made in both these areas

- Neurodevelopmental pathway, specifically autism and attention deficit hyperactivity disorder (ADHD).
  - Following co-design and co-production, feedback indicates that the changes are having a positive impact on children, young people and their families as well as staff. All referrals have the benefit of being considered by a multi-disciplinary team and as part of this process alternative support recommendations are also explored for referrals that are identified as not needing an autism/ ADHD assessment at this time. Referrals are now accepted via a single point of access through use of the 'next steps form' which collates and includes the voices of children, young people, parents carers and professionals.

  - An increase in the number of referrals that result in an assessment for autism and ADHD from an average of 11.2% in April 20 to an average of 65.3% (Apr 21 to Oct 21). Waiting times are expected to continue to reduce as the pre-assessment pathway becomes further embedded and incoming referrals become more comprehensive. Average waiting times have reduced from over 26 weeks April 20 to approximately on average 16 weeks between referral and first clinical appointment.

- Improving the consistency of our practice

  Systems are now coming into place across several areas which will improve consistency of support for children and young people and their families. There has been some demonstrable progress in this area, including:

  - Direct referrals from therapists to paediatricians in place across the county

  - Effective handovers from maternity services to health visitors

  - The dynamic risk register to support very vulnerable children is now established and in use

  - Area leaders do now have an overview of the young people with a learning disability aged 14+ who are eligible for an annual health check

There are other issues that have been addressed but where we need more time over the coming months to identify and assess evidence data to give confidence that sufficient progress has been made. These include:

- Services under pressure due to vacant posts, funding challenges and rising demand which impacts on joint working e.g., capacity to attend meetings and complete joint projects.

- Young people and families are feeling unsupported in certain areas e.g., some emotional and mental health conditions where they are finding that lower level services do not have the skills for their condition and they do not meet thresholds for specialist services.

- Data flows are still being established for some areas of this improvement priority so would not be easy to evidence.

- Schools are variable in their attitude to inclusion and implementing the graduated response, a tool for early identification of health needs.

Over the next year, it is expected that the Somerset ICS will be re-inspected against its commitments within the SEND written statement of action, so the focus for the next year will be on readiness for this, and how the learning achieved as a result of the work can be thoroughly embedded, including the monitoring arrangements, into 'business as usual' to ensure the quality improvement journey is sustained and enhanced to continue to meet the needs of our SEND population into the future.

Children and Young People's Transformation Plan

The NHS Long Term Plan (LTP) set out a vision for the future of the NHS. The plan highlighted the importance of a strong start in life for children and young people. The Children and Young People's (CYP) Transformation Programme was established to oversee commitments relating to children and young people in the NHS Long Term Plan. To deliver these commitments key partners will need to work together across health, care and education. The vision is to deliver innovative, high quality, holistic health and care, with a focus on addressing gaps in health and well-being outcomes for our CYP, with the voice of the child/young person informing all that we do.

We need to design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services. These models will support health development by providing holistic care across local authority and NHS services, including primary care, community services, speech and language therapy, community and school nursing, oral health, acute and specialised services. This includes the pathways between tertiary, acute and community, and the development of specialist hubs to offer support, advice and expertise from tertiary to local systems.

The national priorities and deliverables for 2021/22 for children and young people (CYP) covered the key overarching themes of:

- CYP system Integration
- Addressing health inequalities in CYP

as well as condition-based focus on:

- Severe obesity
- Tackling asthma
- Management of bowel and bladder health
- Paediatric palliative care
- Epilepsy

and system improvements in:

- Paediatric NHS 111
- SPOT (system-wide paediatric observations tracking), including early warning systems
- CYP urgent and emergency care pathways

Within Somerset, work has begun against all these priorities, but energy has been primarily focused this year on:

- Obesity:
    - Immediate priority has been given to begin to rectify the missing pathway for severely obese children. Although there are 'gold standard' obesity services, these are restricted for adults and did not have a paediatric element. A gap was identified between the tertiary services offered for those children morbidly obese and a support pathway.

    - During the year, a test and learn pilot for tier 3 paediatric weight management services for severely obese children (BMI >99th centile) has been commissioned, and development of a Somerset partnership approach to a family pathway for healthy weight management has been initiated.

- Asthma
    - Work has begun looking at what more can be done in preventing asthmatic episodes, acknowledging there is a link to the condition to both health inequalities and other conditions, for example obesity. Links have also been made to COVID-19 recovery in children.

    - Early insight suggests quality improvement needs to be undertaken in the prescribing, dispensing and use of inhalers as a first step. An asthma/respiratory clinical lead has been recruited to support primary care skills development and liaison with system partners. Additional nurse specialist role recruited, to undertake discrete training project.

    - Review of Somerset wide asthma pathway commenced in March and a work plan is in place, to monitor progress on key deliverables, including identifying appropriate governance routes for reporting.

- End of Life and Palliative Care

- Somerset CYP Palliative Care Strategy is being collaboratively created to drive forward work and vision.

- There is an established Palliative Care Working Group and a project manager has been recruited to map current service provision with a focus on psychology and staffing.

- Children and Young People in Urgent Care
  - Both hospitals are operating a paediatric assessment unit to manage flow which will be reviewed, and learning shared over the next year.
  - A monthly Steering Group has been established with excellent clinical engagement. Currently, opportunities with HandiApp are being scoped to support alignment of pathways.

- Integration
  - As part of the Integration Programme, Somerset was successful in securing additional funding to support the development of integration. The aim is that by improving knowledge, understanding and synergy within early years' services, we will improve children and families outcomes and better manage health needs within local communities.

  - Knowing the importance of maternity and early years in determining outcomes for long term health, a test and learn Integration project focused on expectant families and those with children under school age.

  - The Chard, Ilminster and Langport area was chosen because it has wards with high levels of deprivation and rural challenge, is equidistant from the two existing provider trusts (Somerset NHS Foundation Trust and Yeovil District Hospital Foundation Trust) within the County and sits close to the Devon/Dorset boundary so has cross border challenges.
  - The project brings together a wide range of partners including primary care, acute and community health providers, Public Health nursing, maternity and not for profit organisations to work in partnership to improve system working. A Multi-Agency Steering Group has been established with two active working groups that are focussing on:

    - Best start in life
    - Early help – aligning with the development of 'family hubs'
    - Alignment with the Emotional Mental Health Transformation Plan and trauma informed care.

  - Four key focus areas have been identified:
    - Joint pathways
    - Parenting support
    - Tackling inequalities
    - Improving communication

3.25 Women's Health Services

We continue to commission women's health services and are in the process of reviewing gynaecology and its relationship with maternity. Within 2021/22 two further commissioning pieces of work were undertaken relating to menopause services and termination of pregnancy Services

- Menopause services:

  A critical gap in services was identified, and as a result, a pilot 12 month service is about to go live. This will be led by a specialist menopause GP based in Glastonbury Surgery who will be delivering advice and information to GPs and offering patient consultations as appropriate. The new service will also offer patient and GP education as well as taking referrals for Somerset patients needing specialist menopause support. For further information, including referral process and criteria, this can be accessed through the menopause page on the Glastonbury Surgery website: https://www.glastonburysurgery.co.uk/somerset-nhs-menopause-clinic/

- Termination of pregnancy services:

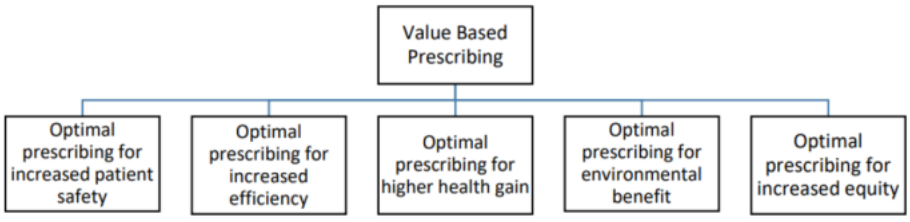
  During 2021, contracting arrangements gave an opportunity to recommission services to provide better access and equity and to work with a single provider to improve quality. A rigorous engagement and co-production exercise was undertaken to ensure that the design of the commissioned service took into account all available evidence and insight in specifying the service to be delivered, and a rigorous procurement process undertaken to ensure the best provider was selected.

  A national Women's Health Transformation Strategy is expected in the summer of 2022, which will support development of these and other crucial women's services.

3.26 Medicines Optimisation

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 and at the same time identifying unmet need and getting the best outcomes for patients from their prescribed medication.

During 2021/22 NHS Somerset CCG continued to implement its medicines optimisation strategy for high quality value-based prescribing.



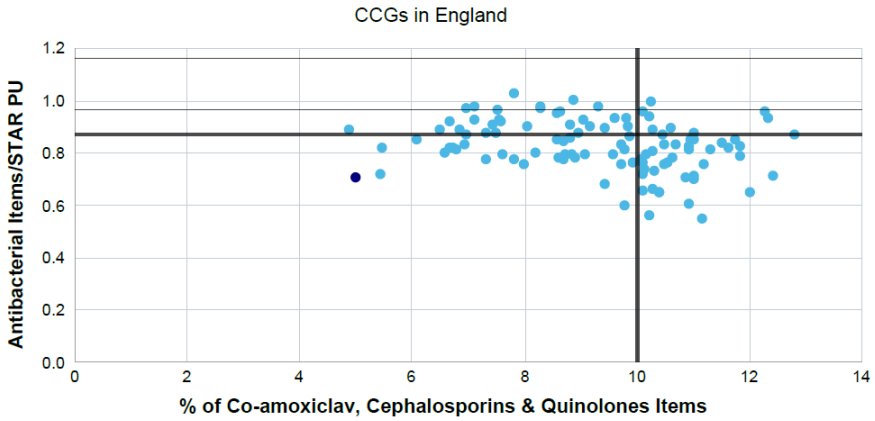
Numerous workstreams were continued despite COVID-19 to ensure where medicines were prescribed they were an integral part of safe and effective care. This included ensuring where possible patients were regularly monitored and reviewed so any potential side effects were identified and medicine related risks reduced.

The COVID-19 pandemic meant that fewer patients were seen face to face so our medicines optimisation team provided guidance on the high risk medicines requiring monitoring and helped practices maintain a focus on non-COVID-19 related safety issues via the use of our eclipse live IT safety tool. Somerset continued to improve on national safety and quality benchmarking during the pandemic, being one of the best performing CCGs in many clinical areas.

These included improvements during 2021/22 in:

- Reducing inappropriate prescribing of high dose inhaled corticosteroids.
- Ensuring three-day courses for uncomplicated urinary tract infections.
- Reducing inappropriate prescribing of short acting beta agonist inhalers.
- Reducing inappropriate prescribing of the following antibiotics: co-amoxiclav, cephalosporins and quinolones.

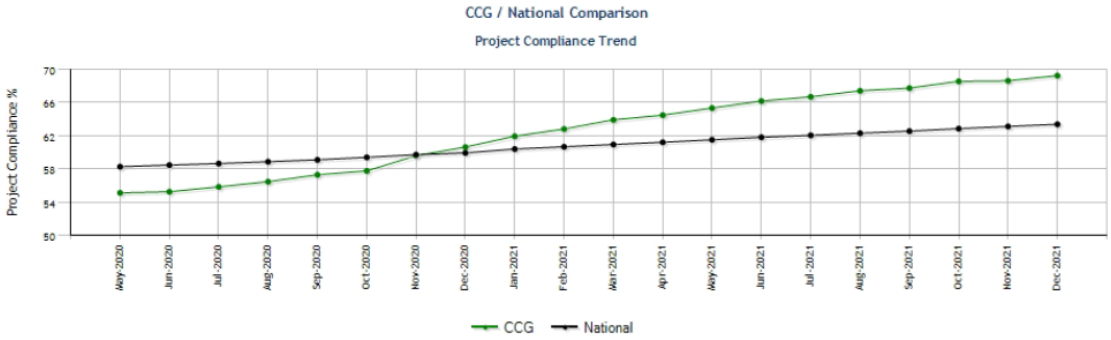
Antibacterial BNF 5.1 Items/STAR PU versus % of Co-amoxiclav,Cephalosporins & Quinolones Items
12 months to 202110



- Reducing inappropriate prescribing of trimethoprim antibiotic vs nitrofurantoin.
- Reducing inappropriate prescribing of excess quantities of semaglutide.
- Reducing inappropriate prescribing of seven day prescribing for long term conditions.
- Reducing inappropriate prescribing of soluble/effervescent forms of paracetamol and co-codamol.
- Reducing inappropriate prescribing of high-cost tramadol preparations.
- Reducing inappropriate prescribing of vitamin B complex per 1000 patients.
- Reducing inappropriate prescribing of topical treatment of fungal nail infections.
- Reducing inappropriate prescribing of high carbon footprint inhalers so helping the environment.
- Increasing appropriate prescribing of medicines to treat unmet need and help reduce inequalities.

  This was particularly important around cardiovascular disease and Somerset's improvement in prescribing higher intensity statins to help reduce heart attacks and strokes.

NHS Somerset CCG percentage of high potency statins prescribed compared to national average



3.27 Quality and Patient Safety

Quality and patient safety is a key strategic and operational priority for NHS Somerset CCG to ensure 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.

Quality improvement is also a key priority for NHS England/NHS Improvement (NHSE/I) and the National Quality Board and is also a key strategic priority for the formation of the Integrated Care Board (ICB) and Integrated Care System (ICS). To support the move to an ICS, NHSE/I have 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)
6. **Safeguarding** – Safeguarding assurance and accountability, including children in care / looked-after children; child death responsibilities

A significant amount of work has been undertaken by the quality and nursing directorate within the CCG during the year to prepare us for the move to an ICB next year 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 an ICS Quality Improvement and Accountability Framework which has been developed collaboratively with system providers during this year.

Equally we have undertaken a significant amount of work on the national Patient Safety Strategy implementation which was published in 2019 and set out a new approach by recognising the influence human behaviour and systems can have upon patient safety.

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:

- 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)**

Responsibilities of the CCG and developing ICS in delivering the national patient safety strategy are below:

- **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** - there are currently contract and quality review meetings (CQRM) 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) within 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 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 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 PALS, complaints, 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 22/23 to review at least 10 discharge summaries each month for both NHS trusts.

Our Quality Improvement and Accountability Framework

As we prepare for Somerset to become a statutory ICS, we have been developing 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.

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.

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 delivering the best outcomes for patients.

Experience – we will provide services based on insights from our populations' preferences and strengths. Ensuring our services are inclusive and equitable.

Our Quality Improvement and Accountability Framework will be published at the end of June 2022.

Monitoring Quality

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)

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.

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.

In addition to QSG, three key system wide forums have been set up this year 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 coordinated efforts to implement and deliver the national patient safety strategy and will 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 aim to coordinate and have oversight of medical devices equipment issued to community services during COVID alongside creating a governance and assurance process for issuing of equipment into community. Other key areas of focus surround horizon scanning for new products and digital opportunities and training and competency considerations for end users.*

In addition, in September 2021 the 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

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.

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 QI training programme, and presenting the Somerset QI journey to the Somerset People Board. During the year we continued our support of our capacity and capability for continuous quality improvement (QI) through training and coaching our local workforce. To comply with social distancing, SQIF continued to provide quality improvement training through video conferencing.

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. We recognise this is not an exhaustive list of the fantastic quality improvement work being undertaken by various teams within the CCG, as described in other sections of our report, and a key priority for 2022/23 is to create a repository of

quality improvement work within Somerset to both showcase the great work being undertaken but also to enable spread of QI initiatives across providers.

Examples of existing and planned QI initiatives can be found below:

Patient Safety & Risk Management Quality Improvement	
Existing	**Planned / Opportunities**
1. Review and revision of the Q&N risk register **2.** Introduction of the patient safety specialists	**1.** Implemention of PSIRF **2.** Implemention of LFPSE **3.** Implemention of the national patient safety training syllabus **4.** Development of the Review, Learn, Improve meeting across the system **5.** Creation and implementation of the the Patient Safety Strategy

Infection Prevention and Control Quality Improvement	
Existing	**Planned / Opportunities**
1. Discharge risk assessment 2. Resource materials for care homes in response to Omicrom 3. Top tip posters for care homes 4. PPE/hand hygiene and environment audits 5. Looking at trialling new fluid charts in care homes 6. Development of the IPC champions	1. Development of the E-coli audit which will identifiy QI improvements 2. MRSA seminar to address the high rates within drug users 3. C-Diff collaborative 4. IPC collaboration 5. Hydration project

Equality and Diversity Quality Improvement	
Existing	**Planned / Opportunities**
1. Advancing Mental Health Equality (GRT, next group rural & agriculture and LGBT to follow - tbc) **2.** Trans pathway in primary care	**1.** LGBT action plan (CCG Chair but multi-agency) **2.** Primary Care training aligned with the Doctors of the World - Safe surgeries which looks at recording access needs, offering appointments to those not registered & the homeless. Doctors of World are keen to review the training to see how this can be incorporated nationally **3.** Implementation of the training ward at Strode college. The intention is for there to be multi-disciplinary and system wide participation in the training

Primary Care Quality Improvement	
Existing	**Existing**
1. Bronze training for primary care, PCN and CCG staff **2.** Delivery of Silver training in liaison with Somerset Quality Improvement Faculty (SQIF) **3**. Leading the QI Lead Nurse project support to include; digital proxy access; home monitoring of hypertension; LD annual health checks; development of MDT's Care Home Home rounds	**1.** Delivery of Silver training for the PCN QI Lead Nurses **2.** Establishment of an audit tool to measure clinical effectiveness with Diamond contracted provider and the CCG contracting team **3.** Develop improved audits of contracted services

During the last year it has still been important to ensure 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™ official westhampshireccg.nhs.uk)* and RESTORE mini

tools, which supports 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

3.28 Complaints

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 coordinated across the patient pathway. Formal complaints are captured, investigated, analysed and categorised.

The following figures reflect the number of formal complaints which have been managed by the CCG during the year. 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.

During 2021/2022 we closed a total of 44 formal complaints. The four main themes arising from these complaints were:

- Access to medication or medical devices (nine formal complaints)
    - four complaints were received about access to Continuous Glucose Monitoring devices
    - the remainder of complaints related to access to specialist medication or the management of medication or their side effects

- Dissatisfaction with the NHS Continuing Healthcare assessment process; the priority assigned to domains and applications being declined (seven formal complaints)

- Dissatisfaction with acute in-patient admission/treatment (four formal complaints)
    - two patients were dissatisfied with their surgical procedure
    - two concerns about the general quality of care

- Delays and dissatisfaction with the urgent and emergency care services (four formal complaints)

Learning from complaints has resulted in a number of Quality Improvement projects for the CCG:

- *Personal Wheelchair Budgets* - a complaint about the Somerset Wheelchair Service identified learning for the CCG about access to and the promotion of Personal Wheelchair Budgets

- *Home Oxygen Service* - a complaint relating to the Home Oxygen Service (HOS) highlighted an opportunity to improve accessing to oxygen for sleep apnoea patients in the future. It was identified that nurses in the Sleep Apnoea Clinic

should be trained to prescribe oxygen as this would allow patients to access home oxygen immediately following diagnosis by the clinic. The CCG facilitated discussions between the HOS provider and the Sleep Apnoea Clinic to improve collaboration and training across both services and to ensure there are no gaps in service

- *End of Life Care in the community* – complaints received continue to highlight the difficulties families/carers face with having to deal with different providers and the continued challenge of those providers communicating with families in an effectively and in a timely way, so they know who is responsible for each aspect of care.

  They also demonstrate the challenge families/carers face of accessing appropriate help and support quickly when their loved one rapidly/unexpectedly deteriorates.

  Learning from complaints is shared with the Somerset End of Life Improvement Board and taken forward through their annual work programme.

- *Treatment Escalation Plans (TEPS)* – a complaint highlighted the challenge clinicians have in making decisions about patients who have a treatable condition, but do not wish to be admitted to hospital. The Somerset multi-agency professional group who oversee the TEP, continuously review and consider if further improvements can be made to the process.

- *Mental Capacity Act: Assessing capacity* – a complaint involving an individual with a frontal lobe injury highlighted the challenges with assessing capacity in individuals who may perform well in interviews and tests but have impairments in daily life. The CCG agreed to lead a small project group, linking Adult Safeguarding Leads across the Somerset system and the ambulance service to devise appropriate guidance for the application of the Mental Capacity Act.

Further analysis about the closed formal complaints is available in the NHS Somerset CCG Annual Complaints Report 2021/2022.

3.29 Safeguarding – Children and Children Looked After (CLA)

Overview

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.

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.

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.

We work with Somerset County Council to ensure that there are effective plans 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.

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

Two multi-agency governance groups, both led by the CCG, met regularly during 2021/2022. 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.

The Health and Wellbeing Subgroup of the Corporate Parenting Board, of which the CCG is a member, met virtually on a quarterly basis in 2021/2022. 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 Subgroup is to develop and monitor actions that deliver the health and wellbeing elements of the Corporate Parenting Board Strategy.

Progress 2021/2022

Significant work has taken place in 2021/22 to better understand the operational and strategic complexities of the statutory health assessment service. This has led to 90% of assessments being offered and 60%-90% attended within the 20 day statutory timeframe. Reasons for non-attendance include carer and social worker availability, refusal by the child to attend, short notice placement moves, and COVID-19 infections and quarantines. A clear pathway is in place to manage non-attendance, including refusal.

The CCG has again jointly commissioned with Somerset County Council a bespoke care leaver counselling service. Placement quality assurance work has been completed to ensure therapeutic placements meet CLA needs and support their recovery. Work has been completed to ensure up-to-date strengths and difficulties questionnaires are available for statutory health assessments.
Work has also been completed to develop a partly digital solution to the collation of obstetric and neonatal information for all CLA to better inform statutory health assessments and adoption health reviews. A clear pathway to deliver health summaries to CLA prior to their 18th birthday has also been developed and will be implemented in 2022/23.

Risks and challenges

Adoption health services

In April 2021 Taunton Families Court identified an issue which suggested Somerset County Council had not relied on the correct health information, provided by CCG commissioned agency medical advisors for adoption service, constituting a breach of statutory adoption regulations. Somerset County Council also raised concerns with the CCG that the agency medical advisors had not been correctly appointed to their roles, also a breach of regulations.

The issue was reviewed by the High Court and a subsequent judgement ruled that the Somerset agency medical advisors had been properly appointed and a solution in law was found to ensure Somerset adoptions could be resumed.
Significant investment has been made by the CCG into the adoption medical advisor service in 2021/22 with more planned for 2022/2023, ensuring the service is compliant with statute, is timely, safe and high quality and that no further commissioning gaps exist.

Therapeutic placement access

The CCG has been involved in several cases in 2021/22 where suitable placements for complex CLA have not been available leading to delayed discharges from acute paediatric wards and emergency departments. This is a national issue and in Somerset the 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 service access

Access to NHS dental services has been a significant issue for CLA and care leavers during the COVID-19 pandemic and as services recover. NHS dentists in Somerset have not been taking on new patients which disadvantages CLA and care leavers who are often more mobile than the general population. The CCG is working with Public Health and specialist commissioners to better understand this issue and increase local capacity, whilst supporting professional networks to improve oral hygiene knowledge and skills and better support CLA and care leavers. However dental assessment performance has continued to recover in the wake of the COVID-19 pandemic.

3.30 Safeguarding Adults

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. Other adults 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 the 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 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

The Named GP for Safeguarding Adults post became vacant in October 2021 when the current post holder was successfully appointed into the Designated Doctor for Safeguarding Children role. The Named GP post has remained vacant since then despite recruitment . Therefore, alternative ways of fulfilling some of this role has been explored. The Designated Nurse for Safeguarding Adults post was vacant between July - October 2021 due to a gap between the existing post holder leaving and the replacement starting. The gap in Designate role was backfilled by the Deputy Designated Nurse for Safeguarding Adults alongside support from the Designated Nurse for Safeguarding Children.

Prior to the Named GP moving role they supported primary care through the provision of a number of training 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 the GP practices and enabled them to work with other agencies to take preventative steps to either prevent or stop abuse or neglect occurring, including through provision of regular updates shared via the CCG Safeguard newsletter and though regular contributions to the LMC weekly newsletter.

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 the CCG 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 our Patient Safety and Quality Assurance Committee.

Despite the additional pressures on our provider trusts during the pandemic, they have been able to continue to send us the monthly information on the safeguarding dashboard, 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 pandemic, most staff have been able to stay up to date with their basic safeguarding adults training.

During the pandemic, 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 adult who need safeguarding.

The CCG are members of the Somerset Safeguarding Adults Board (SSAB). The Board 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 Board ensures agencies all work together to minimise the risk of abuse to adults at risk of harm. The Board also monitors how effectively agencies work together. Board functions returned to business as usual in 2021/22 despite ongoing pressures and restrictions related to the pandemic

This year, the safeguarding adult team contributed to the work of the Safeguarding Adults Board through its attendance at meetings including all five sub groups. The CCG has completed the bi-annual SSAB safeguarding adults self audit this year. Further information about the activity of the board over the past year can be found here.

The CCG safeguarding adults team have continued through 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.

The Liberty Protection Safeguards (LPS), which were originally planned to be implemented in April 2022, has been delayed. The consultation on the changes to the MCA Code of Practice and implementation of the LPS commenced on 17th March 2022 and will run for 16 weeks. LPS implementation is now anticipated to take place in 2023 but the Government will not be announcing an implementation date until after the consultation ends. The implementation of LPS (to replace the Deprivation of Liberties Safeguards currently in place) 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 the NHS providers / continuing healthcare (CHC) team about plans for implementation and the wider health and social system in Somerset to agree areas of shared working. A CCG LPS business case

for additional funding for LPS specific roles in the CCG CHC team was submitted to the CCG Board and approved in 2022.

Domestic Abuse

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 guidance recognises that the NHS spends more time dealing with the impact of violence that any other agency and states there is a strong need to improve health commissioning of universal and specialist services in interrupt perpetrators and support victims of domestic abuse. The Domestic Abuse Act introduces 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 where people from every background can be reached.

The COVID-19 pandemic has highlighted domestic abuse as a national issue. We have worked closely with our Local Authority and other partners to monitor and respond to the effects of lockdown on domestic abuse. Our safeguarding adults team continue to support the work of the Domestic Abuse Board, and have participated and ten 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.

In 2020, the CCG were successful in a second bid for funding from the Pathfinder Consortium to support improvements in how NHS hospitals and community services respond to and support people who use our services and are experiencing domestic abuse. This money from the bid has been used to fund two posts (Health Independent Domestic Violence Advocates) between April 2021 and March 2022 to help drive improvements. Their role is to educate and support staff working in our trusts and GP practices about how to support people who are experiencing domestic abuse. They have specialist knowledge and are employed by the Somerset Integrated Domestic Abuse Service. The advocates have responded to enquiries from GP practices and Trust staff and when necessary have provided direct interventions to individuals experiencing abuse and violence.

Our trusts have also invested in this area by each employing a Domestic Abuse Coordinator who have work 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 in Q1 2022/2022.

Prevent

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.

This year, the CCG safeguarding adults team has:

- Attended all Channel panels within the Somerset areas and provided health advice and support to panel.
- Provided a link between the GP practices and the Channel panel.
- Monitored the progress of compliance with Prevent training within the provider trusts and the CCG.

Compliance with Prevent training has improved significantly over the course of the year, despite the ongoing pandemic, but has still not, as an average, reached the target of 85%.The provider trusts have ongoing action plans in place and the ongoing pressures experienced across the system are widely acknowledged as a significant factor in the delay in reaching this target.

Violence Reduction Unit

The 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 ensure representation at NHS England and Improvement's South West Serious Violence and Contextualised Safeguarding Group and have contributed to the 2021 review of the Avon and Somerset Serious Violence Strategic Needs Assessment.

Support to the wider system during COVID-19 pandemic

The safeguarding adults team have undertaken a number of activities to support the wider system during the ongoing pandemic and recovery phase. This has included the following:

- Providing specialist advice about safeguarding adults, domestic abuse, Mental Capacity Act, depravation of liberty / Liberty Protection Safeguards and Prevent agenda to colleagues across the system.

- Supporting primary care with completion of statutory s42 enquiries.

- Providing content to and oversight of several guidance documents and pathways to enable staff to provide care for people in a way that supports their human rights and ensures decisions are made appropriately for those people who cannot make the decisions themselves. Examples include end of life care, professional curiosity webinar development.

- Provided written guidance to GP practices about treatment escalation plans to enable them to comply with the Mental Capacity Act and ensure human rights are upheld.

- Supported the health system programme to treatment escalation plans, giving advice in relation to the Mental Capacity Act.

- The safeguarding team have supported the ongoing COVID-19 vaccination programme across Somerset and responded to vaccination queries and quality/safeguarding issues around consent and best interest decisions

- Supported the ongoing work programme of the Domestic Abuse COVID-19 Task Group

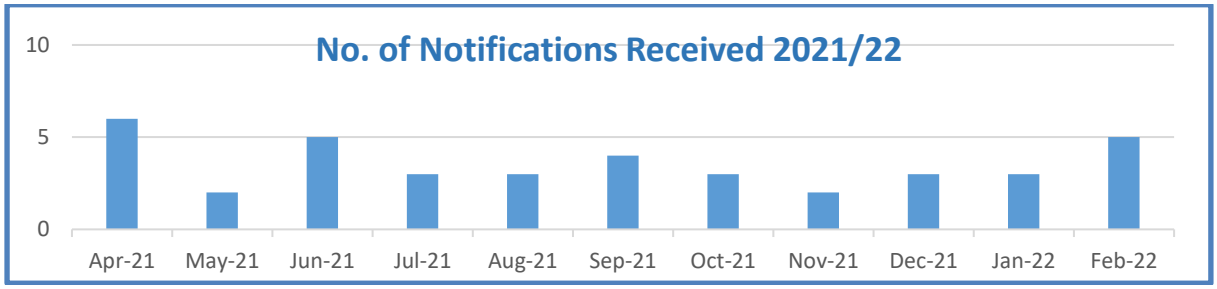
Our priorities for next year will be to prepare for the implementation of the Liberty Protection Safeguards anticipated for 2023, to continue our improvement work relating to domestic abuse and to progress specific workstreams in relation to the integrated care system and safeguarding across the lifespan.

3.31 LeDeR – Learning from Lives and Deaths

The Learning from Lives and Deaths of People with Learning Disabilities and Autism Programme (LeDeR) was set up as a service improvement progamme which aims to improve care, reduce health inequalities and prevent premature mortality of people with learning disabilities and autism.

LeDeR reviews deaths of people with learning disabilities and autistic people to identify areas of good practice and highlight areas of improvement. A LeDeR review looks at a person's death as well as significant episodes of health and social care relevant to the persons overall health and wellbeing. The information from reviews is then used to improve services both locally and nationally.
NHS Somerset CCG is responsible for the implementation of LeDeR reviews in Somerset. The substantive LeDeR team was fully recruited to in 2021/22.

LeDeR Reviews
In 2021/2022 the LeDeR team in Somerset completed 47 reviews.



In line with what was seen nationally due to the COVID-19 pandemic we saw a peak in death notifications in April 2021, reducing to a more typical level of notification following that. The pandemic has further highlighted the health inequalities people with learning disabilities and autistic people experience and

the LeDeR review process and in particular action into learning will be an integral part of addressing that going forward.

Key Performance Indicators

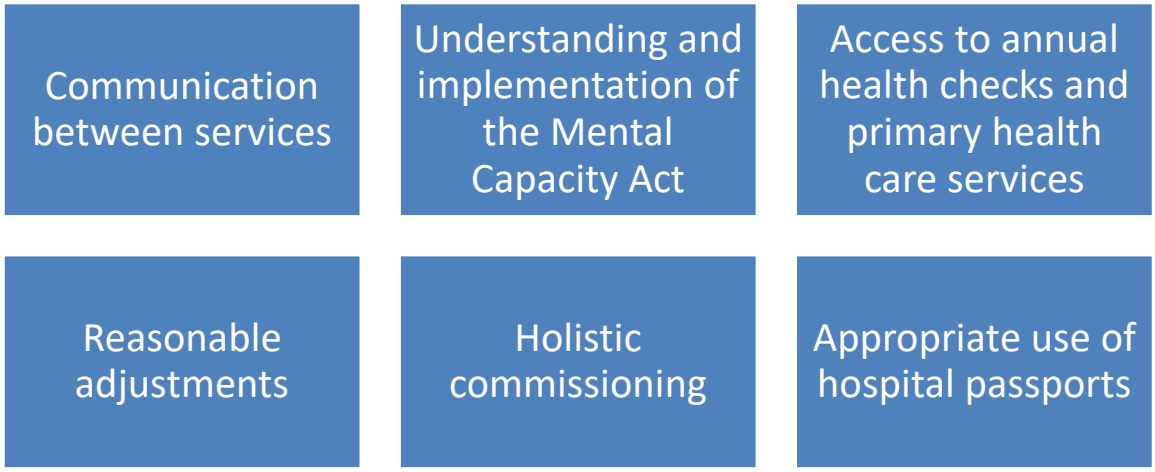
NHS England have set two targets which we are measured against:

- Requiring all LeDeR notifications to have been allocated to a reviewer within 3 months of receipt.

- Requiring all LeDeR reviews to be complete within 6 months of the notification date.

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

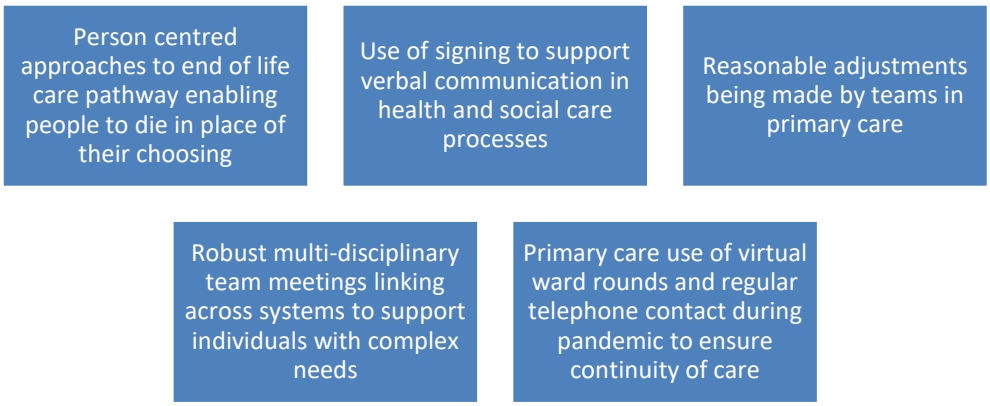
Learning from Reviews
The following themes have emerged from the actions generated by the LeDeR reviews completed in 2021/2022:



These themes have informed our key action into learning areas and are further detailed in our 3 year strategy:

- Improving access to and quality of annual health checks.
- To assess current levels of understanding of the Mental Capacity Act and its application to health and health care and to promote positive practice and its application to health and health care.
- Developing a joint health and social care approach to commissioning and quality contract management that supports holistic care.

Good Practice Examples
The following good practice themes were identified from reviews in 2021/22:



Achievements 2021/2022
During 2021/22 our achievements have very much been guided by the LeDeR policy, learning from the COVID-19 pandemic and actions generated from our reviews.

LeDeR achievements include the following:

- Recruitment of substantive LeDeR team, which now consists of: Local Area Contact, Senior Reviewer, two reviewers, an administrator and one fixed term contract reviewer has been supporting us on a temporary basis.
- Completion of 47 reviews in line with key performance indicators.
- Significant improvement in compliance with key performance indicators following completion of recruitment to the LeDeR team.
- Adjustment to the new LeDeR reporting system after the University Of Bristol contract ended.
- Establishing of quality assurance and governance processes with the inaugural meeting of LeDeR Governance Group being held in March 2022.
- Significant amount of work to support the annual health check process.
- Work to understand the current knowledge base around the application of the Mental Capacity Act in health and health care and to identify future work.

3.32 Continuing Health Care (CHC) and Children and Young People's Continuing Care

Continuing healthcare (CHC) and children and young people's (CYP) continuing care continues to exceed the national service delivery requirements,

with good practice noted in providing people with decisions about their eligibility for health funding within 28 days.

Our aim is to ensure 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.

The service has also continued to support the NHS response to the COVID-19 pandemic, with clinical staff being redeployed on a number of occasions to support the wider system in Somerset. In addition, supporting enhanced discharge arrangements through the intermediate care pathway, which ends on 31 March 2022.

During the year, internal audit (BDO) carried out a planned audit of the CHC fast track service, to provide assurance over the governance arrangements, performance management, risk escalation and the quality and financial monitoring mechanisms in place. Upon conclusion, the level of assurance provided regarding the 'service design' and 'operational effectiveness' were both recorded as being 'substantial'.

Our programme of transformation has continued this year, with the particular focus being on new digital technology available to support the service moving to using an end-to-end patient management solution, as well as the planning the impact of the new and national data collection system. The positive working relationships with our Local Authority colleagues has also ensured good quality delivery, financial proportionate spend and our interventions in patients' lives continues to be legally robust, with the CHC safeguarding team continuing to drive quality improvements.

3.33 Infection Prevention and Control

COVID-19 was declared as a pandemic on 11 March 2020. During 2021/22 NHS Somerset CCG infection prevention and control (IPC) team provided support to primary care and the provider care sector with the continuation of the emergency planning team conducting daily operational and strategic meetings and the diversion of infection prevention and control team resources to support incident response. The 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.

Preventing and controlling the spread of COVID-19 continued to be the CCG infection prevention and control priority throughout 2021/2022, responding to variants of concern, for example Delta and Omicron. The CCG IPC team continued to work collaboratively across all health and social care, communicating and providing training on infection prevention and control measures, in line with national guidance, to apply within their settings to protect the population against transmission of the virus, and providing training on personal and protective equipment (PPE).

The CCG IPC key priorities for 2021/22, carried forward from 2020/21, included deep dive of the methicillin-sensitive staphylococcus aureus (MSSA), blood stream infections (BSIs), monitoring and reviewing GramNegative BSIs (GNBSIs), with a focus of a 10% year-on-year reduction of E Coli bacteraemia as set in previous years which had been put on hold due to the pandemic. This work was commenced in September 2021 with the introduction of MSSA BSI post-infection reviews (PIRs) to the quarterly peer review process.

Due to the resources required to support primary care and the provider care sector through the variants of concern during the ongoing pandemic, the implementation of the antimicrobial stewardship five year plan and improving IPC measures in care homes by creating a Somerset Care Homes Infection Prevention and Control Link Practitioner Group workstreams were not completed, and these have been identified as a priority for 2022/23. Monitoring continued as part of the Somerset Infection Prevention Antimicrobial Assurance Committee (SIPAAC) and has been added to the IPC CCG work plan.

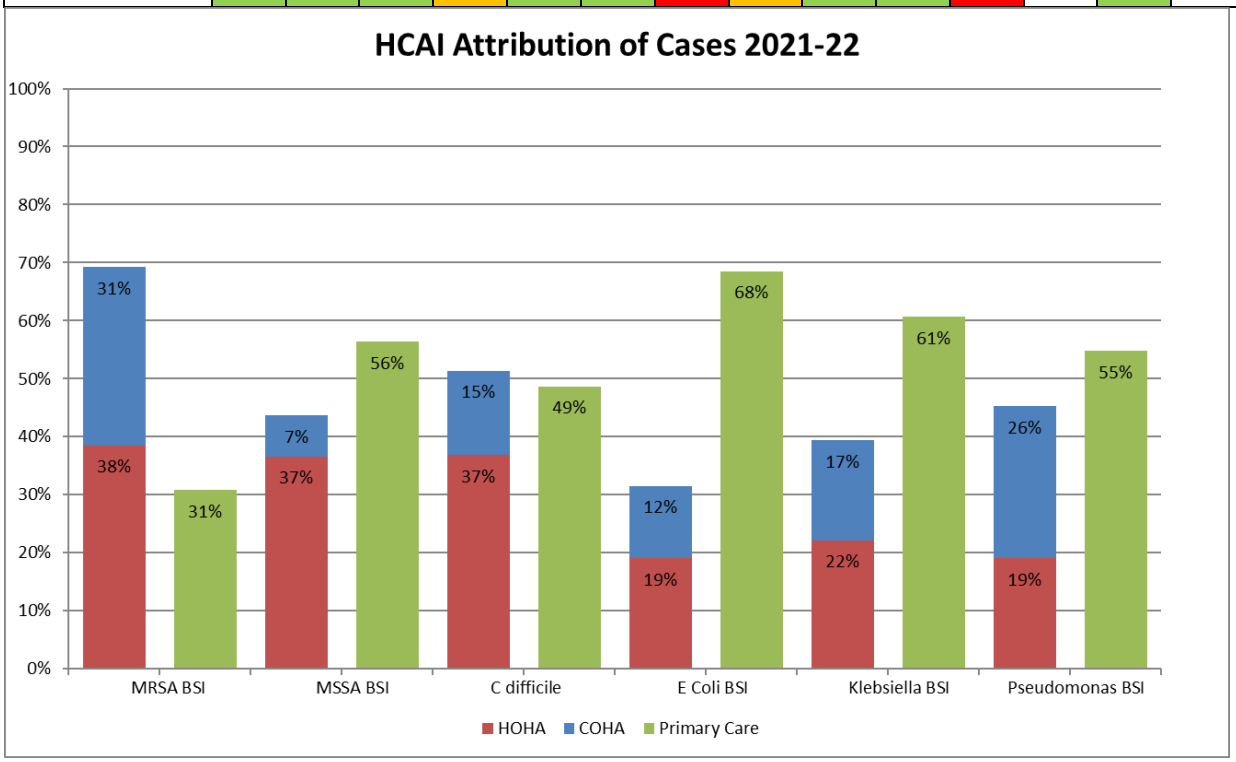
During 2020/21 it was identified that nationally there had been a rise in Clostridiodes difficile (C.diff) cases and the CCG IPC team are part of the regional HCAI CDI Collaborative and the regional IPC Collaborative, the focus of which is to understand the increase in C.diff infections. This includes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

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 has been employed to provide support to the CCG to continue to drive improvement in 2022/2023.

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 with following organisms subject to mandatory surveillance on the UKHSA DCS Portal: MRSA BSIs, MSSA BSIs, C.diff and GNBSIs. The breakdown of case numbers for 2021/22 is shown below (as at 28th February 2022).

Outcome Measures – YTD 2021/22														
OVERALL	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**YTD**	**Threshold**
MRSA BSI	3	1	1	1	2	1	0	1	2	1	0	0	13	0
C Diff	12	15	20	15	10	11	12	8	18	13	10	0	144	104
E. Coli BSI	34	39	32	51	40	48	38	29	39	39	36	0	425	492
MSSA BSI	11	16	9	17	9	15	15	21	10	9	10	0	142	173
Klebsiella BSI	5	7	11	17	10	13	12	10	17	10	10	0	122	127

Pseudomonas BSI	2	4	3	5	3	4	6	5	2	2	6	0	42	45



Significant challenges continue across all health and social care settings through the pandemic and Somerset CCG's focus continues to be ensuring that IPC is maintained and delivered consistently to ensure patient safety wherever care is delivered.

Personal Protective Equipment

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 have been met during 2021/22 via an online Somerset portal. This process was also in place for our other areas of health and social care. During 2021/22, NHS Somerset CCG and Somerset County Council continued to work together through a multi-disciplinary team comprising of health and Government personnel through a PPE Cell. its remit was to:

- Provide a strategic overview of PPE across the whole Somerset system.
- Coordinating mutual aid requests for PPE once all other sourcing routes have failed (applying when necessary a risk based assessment of need approach to inform decision making).

- Management and distribution of the limited stocks received from different sourcing arrangements, which included: donations and mutual aid, Local Resilience Forum and locally sourced/purchase items.
- Signposting to Public Health and SCCG internal resources i.e., infection prevention and control (IPC) for specific advice and guidance on PPE.

- Communications and reporting processes that included internal and external requirements.

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.

3.34 Workforce/Our People

The complexity of service demand, workforce supply overlaid with the pandemic, Brexit and other external factors continues to pose a challenge to Somerset, as it does for other systems. Our system People Plan and our collaborative working across the health and care system provides a robust response to these challenges, identifying priority actions which focuses on eight strategic aims that are aligned to both the NHS and adult social care people plans. These cover:

'Whole system' workforce planning – 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. As we develop our 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 – working in partnership across our system, building on our core purpose as anchor organisations. Our work on developing sector based work academies (SWAPs) has had more than 300 referrals from its inception until January 2022 and these figures are comparably larger than other ICS' with roles deployed in the CCG, trusts and primary care networks, meeting our aims around widening participation and improving social mobility. High vacancies in our social care workforce continues to be a concern. We have significantly developed our Proud to Care brand over recent months through targeted marketing and advertising (led by Somerset County Council). We have also focused on initiatives to improve retention, for example, 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. Youth engagement work is planned in collaboration with Young Somerset and

SPARK with the view to redesigning roles in health and care to make them more attractive to young people. We have emerging partnerships with the Local Enterprise Partnership and Department for Work and Pensions including bootcamps, restart, and employment hubs as new ways to engage and develop the workforce. We are expanding our SWAP programme during 2022 to include social care.

Looking after our people - across Somerset we have a strong reputation for looking after our colleagues. We have an ambitious system-wide Health and Wellbeing Strategy, we continue to develop our Health and Wellbeing programme in addition to our mental health resilience hub and we are extending our offer for primary care colleagues through the Somerset training hub to increase coaching provision and sustainability. This is an important area as we move through various waves of the pandemic, where staff resilience, and emotional and physical wellbeing are central to our health and care system.

Creating clear career pathways and new and more flexible ways of working – 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 are looking at new ways to fund training for continuing professional development or entrants to the workforce including personalised care and clinical skills to support higher acuity patients to remain at home. We have received NHS England funding to develop our Reservists programme, improve retention and increase health care support worker capacity.

Developing system wide learning and development offers - 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.

Work has been commissioned to support the development of the Integrated Care Board (ICB) to ensure a strong leadership team from the point of establishment. This work is based on the outward mindset model. Furthermore, the CCG have put in place an organisational development programme to support the transition from CCG to ICB.

Creating a more inclusive and equitable culture through work on recruitment and retention – including supporting our system goal of achieving Gold Military Covenant status. Following 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.

3.35 Digital

The digital portfolio has continued to see growth in scale and pace with involvement in a widening range of transformation initiatives. The previous year required introduction of new technology and tools, a virtual working environment and a need to keep both workforce and public in safer care delivery. This year has seen the need to sustain those new ways of working, with continued adaptation in response to need for a more hybrid approach.

The NHS Somerset CCG digital team has proudly worked on an extended range of programmes and projects during 2021/22, continuing to collaborate and extend working with local groups and organisations in Somerset, as well as linking with neighbouring communities across the South West. We have continued with a #OneTeam approach of matrix working as a core value. Our ethos of 'clinically led, digitally enabled' has guided us through priority work, whilst maintaining strategic direction.

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

Other organisations we have engaged with vital to delivery of effective care:

- Somerset care homes
- Dorothy House Hospice
- Weston Hospice Care
- Marie Curie
- Children's Hospice South West
- Practice Plus Group
- Bristol Connecting Care
- Governing bodies including Somerset Local Medical Committee (LMC), Local Optical Committee (LOC) and Local Pharmacy Committee (LPC)

We also continue to expand our engagement and involvement with local people, representative groups and 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 extended, alongside stronger links established with the CCG's Equality and Diversity Lead, as well as our communication and engagement team and the associated networks of local contacts.

COVID-19 Response and Elective Care Recovery

The digital team have 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 over the last year. This has been essential to provide a safe virtual environment for both patient care services and system wide planning and operational work.

As we moved into recovery wave planning, digital teams through the #OneTeam approach across Somerset have provided support to shape new services for people needing complex multi-disciplinary team support during their COVID-19 recovery. In late autumn, an opportunity arose for digital funding through the elective care recovery programme, and we are working to establish new shared opportunities for digital and data sharing improvements as an ICS. These projects will continue into implementation stages during 2022.

Since the introduction in summer 2020 of the Care Homes Directed Enhanced Service (DES), the team have continued to expand our links and work with care homes, as we continue to define the connectivity, access, tools and support required for a digital social care programme, working alongside local primary care networks and practices. The initial digital baseline continues to improve and we are supporting good early progress in uptake of NHS Mail and completion of the data, security and protection toolkit. 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.

COVID-19 and recovery activities have continued to incorporate digital aspects of transformation and this collaborative approach will continue to grow as we prepare for ICS development.

Digital Building Blocks

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

- Rollout of MS Teams to the CCG and our 65 general practices and continuing our developmental work with Microsoft on new ways of working, and 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 promote the Think 111 service.

- Engaged with and chaired a Digital Forum of operational leads across partner organisation to share learning and promote good practice

- Engaged and worked with the Digital People's Champion's Group.

- Improved social media platforms and communications to the public (via "Your Somerset" the Somerset County Council newsletter, Facebook, Twitter and Instagram).

- Ensured local residents and groups are supported to engage in digital access to services, health records and information.

- Continued to fund Health Connections Mendip for employing digital connectors.

- Employed three digital outreach team communicators to work countywide following the successful pilot project across the Taunton primary care networks to promote digital tools to the public and educate practice staff on enabling and encouraging a 'digital first' approach.

Further changes to the digital team changes have been made to aid our response to the growing need for digital transformation and support:

- Embedded the digital outreach team (DOT) communicators team by employing the equivalent of three full-time team members.

- Employed a Digital Change Officer to support with technical and project management functions.

- Employed two digital programme officers to increase the communications across the digital portfolio and workstreams.

- Employed a Cyber Security Assistant Officer.

- Employed a Portfolio Assistant Officer to support the development of the digital portfolio, to capture the range of programmes and projects, ensuring highlight reporting, risks, issues and progress are shared as we transition into an Integrated Care System.

- Established a new digital data workstream to support primary care data analytics and the wider strategic approach to population health management (PHM).

- We have appointed another clinical role, a Digital Nurse to support primary care, to champion digital and maximise digital engagement opportunities around the 'digital first' primary care agenda.

- Three administrator roles, recognising the growth in the portfolio, need for operational planning and support, data and population health management programme and corporate and GP IT functions.

- We have agreed to host a digital T Level student in our team as part of digital first/digital inclusion remit.

In recognition of the role of digital in system transformation, and in support of digital workforce development, the CCG digital team are now members of the British Computer Society, The Chartered Institute of IT.

Digital Inclusion and Digital First

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 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 CCG Equality and Diversity Lead and Engagement Lead to ensure links are made to relevant forums and community groups.

We have engaged in several new opportunities for Somerset and been involved with new initiatives in the South West and nationally. We launched the Somerset Apps Library at the end of January 2022 which had over 6500 site visits by members of the public in the first 6 weeks. Working alongside NHS England and Improvement and the Organisation for the Review of Health and Care Apps (ORCHA) we are empowering the people of Somerset to live healthier lives by offering over 3500 health and wellbeing apps assured as safe by clinicians and data security experts. This programme has been funded for the first three years by NHSEI. Next steps include exploring further options with social prescribers and pharmacists. The NHS 111 service have engaged with

us on this tool and shared it on their clinical system, as well as the NHS Directory of Services (DoS). Apps are a key focus including the NHS App and apps which support those to self-manage their conditions and health, e.g., long term conditions and mental health. We have recorded a podcast for the Somerset Emotional Wellbeing Service and are launching a South West social media campaign with Dorset at the end of March 2022. The Frome Primary Care Network is part of a pilot to explore pro-license use which allows a health care professional to recommend an app via text or email directly to a patient.

We have continued to link and work with the South West Local Economic Partnership (SWLEP), the Department for Education and NHSX (Empower the Person Team). We have been working in a partnership approach with Healthwave Hub and the South West Academic Health Science Network. Projects are sponsored by NHS Somerset CCG and promoted across the county, but with a particular focus to support the West Somerset community.

We have embedded and enhanced our digital outreach team (DOT) and 'joining the DOTs' approach. The original DOTs model worked with either primary care networks or care homes but now encompass a collaborative approach, recognising the impacts and a shared approach supporting each team, particularly around proxy access and use of NHS Mail. We are liaising with Healthwatch Somerset around research into access to GP practice websites and are connecting our DOTs with their findings, to support practices in improving accessibility to online tools to support patients.

Through developing collaborative discussions across Somerset, we have been working on closing the gap for digital inclusion. This has involved working with the following community-based organisations and funding specific projects:

- SPARK Somerset
- Heart of the South West LEP
- COSMIC
- Bridgwater and Taunton College
- Strode College
- Healthwave Hub
- Health Connections Mendip
- Care Homes in Somerset
- Healthwatch Somerset

Much of these discussions recognise the need to support our local population and our workforce in improving digital skills and literacy. Digital is a core competency for working in health and care, and we have engaged with workforce leads, the SWLEP and two training providers in developing our workforce (COSMIC and Bridgwater and Taunton College) to focus on:

- Giving people skills and confidence to be able to apply for jobs in the NHS and social care.

- Upskilling the health and social care workforce.

- Advising digital T Level students on digital careers in the NHS.

- Offering a placement for a T Level student in our digital team in academic year 22/23, as well as planning to input to course modules on digital work in the ICS.

A series of 12 week ‘bootcamps’ have been ongoing since January 2021, providing digital skills learning (60 hours) to people in Somerset. These bootcamps have been offered to staff across the health and care system, including care home staff. The aim is to upskill our health and care workforce in order that attendees can either step into a job in the sector, or seek promotion / a digital champion role. There is also potential for engaging with attendees who are living with learning disability, mental health or physical long-term conditions to develop a new expert patient role as part of our digital transformation work. Recognising both the essential need for this initiative and the current operational pressures on our system to release current staff to attend, we extended these schemes to run further bootcamps throughout 2022, linking with other large organisations in the South West.

Other initiatives underway include:

- Loan devices schemes and provision of data to the digitally excluded, linking particularly with Somerset County Council’s Library Loan Service and SPARK IT Somerset.

- Working with the voluntary sector around the ‘digital unite’ platform to share digital tools for volunteers to access.

In 2021, a special educational needs and disability (SEND) focused project ‘Tell It Once’ was undertaken, with two parts – firstly a data and process review of current information flow, and secondly working with Healthwave to undertake some lived experience research. Anonymous research was conducted around how people access SEND services in Somerset, leading to the development of a video and report on their findings. These insights are being used to help improve services for parents, carers and young adults (18-25) with special educational needs and/or disabilities.

Plans are underway to focus on listening and responding to lived experiences of other groups identified in the Core20PLUS5 approach, the aim being to inform strategies and shorter-term action through peer networks we cannot easily reach ourselves. This will help us to identify what is working well and what could be improved from a digital perspective, so that people only need to share their story once when navigating support services.

Digital Transformation

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. Achievements include:

- The SIDeR shared care record (SSCR) is live with Somerset NHS Foundation Trust (SFT), Yeovil District Hospital NHS Foundation Trust (YDH), Somerset County Council Adult Social Care, St Margaret's Hospice and 62/64 GP practices with over 130,000 user requests to the service so far.

- Contextual launch from native clinical system to SIDeR available at YDH, SFT's community and mental health settings, Adult Social Care, St Margaret's Hospice and soon to be available for GP practices via EMIS.

- Over 3,736 end of life care plans have been completed on SIDeR by primary, secondary and hospice care staff.

- Over 9,941 special patient notes have been created and shared through Black Pear integration of EMIS with NHS 111/out-of-hours.

- Approximately 1,900 acute records have been updated to flag people with a learning disability and/or autism, following formal assessment, to give them better support if they present again for treatment in a hospital.

- 9,000 treatment escalation plans digitally shared with GP practices.

- The Advanced Care Plan primarily created by Marie Curie is now live with 28 plans created so far.

- SFT's Open Mental Health Service have three live forms on SIDeR, with over 146 first contact (referral) forms, 1,586 Dialogue+ and there is also an update forms live.

- User acceptance testing community pharmacy access to the GP record via SIDeR with rollout planned for summer 2022.

- Working to provide access to EMIS free text and documents via SIDeR.

- Moving to a Patient Information Portal (PIP) model in 2022/23 that will enable cross population of shared forms where appropriate and developing patient access via NHS login.

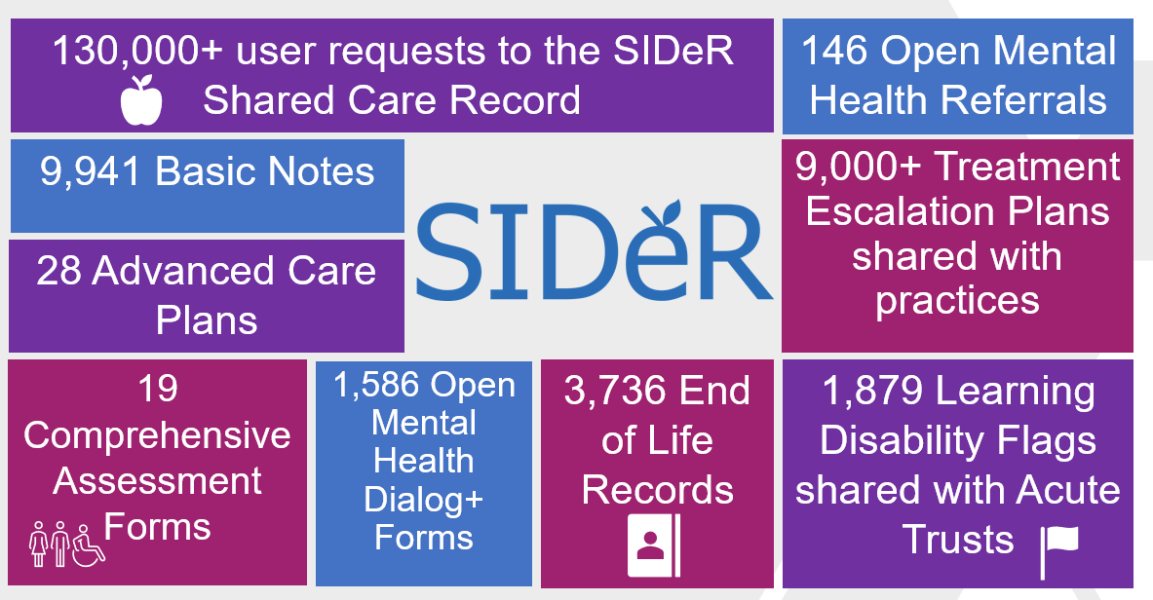
- Working to surface children's education and social care data via the SSCR funded by NHS X and go live due in May 2022.
- Developing a personalised care and support plan (PCSP) and 'about me' first person forms to Professional Record Standards Body (PRSB) standards and funded by NHS X.

- Pilot access to the comprehensive assessment form with a number of Somerset care homes, to support multi-disciplinary team working.

- Creation of a digital Somerset treatment escalation plan (STEP), accessible via SIDeR, but yet to be rolled out due to level of cultural and process change required.

- Creating links to other shared care records and out-of-area GP records to reflect patient flow and access to their records at the point of care.

- Enabling more effective prescribing and medicines reconciliation using open standards and QuickFHIR interoperability between systems and care settings.



Other initiatives include work to reduce the paper flow across care settings to support service improvement and efficiency and fostering a mind-set of challenging convention and improving digital maturity in every care setting.

Data Security and Protection

A key element for digital transformation is to ensure good information governance and safe, secure digital systems are established, such as the following during 2021/22:

- DocuSign as core system for all electronic data and information sharing agreements where CCG and general practices involved.

- Provided care homes with NHS Mail.
- Promotion of the data security and protection (DSP) toolkit across core and new organisations and suppliers to support information flow.

- An established focus on cyber security and improvements through the cyber security action plan, with CCG Governing Body engagement during 2021/22.

- Educating on everyone's role for good data security and protection.

- Ensured new data processing and projects review information governance requirements including national returns under Control of Patient Information Notice (COPI) and new COVID-19 planning activities.

- Supported data and information governance readiness phase for the Optum population health management development programme.

Digital Connectivity

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

- Improved digital maturity and connectivity of provider systems across health and care community.

- N365 has been rolled out across CCG and GP estate and new apps and ways of working are being considered.

- Enabled Health and Social Care Network (HSCN)access to Somerset care homes piloting the comprehensive assessment form.

- 'Axe the fax' work is ongoing.

- Continuing to route electronic messages via MESH (national data standard).

- Assisted with national transfer of care pilot with Dorset County Hospital.

- Looking at implementation of transfer of care using new Fast healthcare Interoperability Resources (FHIR) standards across Somerset organisations by October 2022.

- Worked with the Local Pharmaceutical Committee to embed community pharmacists who will support digital progression between primary care networks and other providers.

- Yeovil District Hospital NHS Foundation Trust is live with the discharge medicines service linked to community pharmacy and Somerset NHS Foundation Trust to go live imminently.

- Rolled out the GP Community Pharmacy Consultation Service (CPCS) with approximately 600 referrals in the last month.

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

- Continued to contribute to regional discussions for ‘One South West’.

- Local health and care record programme.

- Enabled development of digital skills / capabilities in the workforce through range of projects.

Digital Social Care and Care at Home

During 2021/22, there has been 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. This has seen the emergence of a digital social care programme, incorporating care homes initially with expansion to micro-providers and suppliers involved in technology and tools in Somerset. Alongside there is the growth in provision for Care at Home, 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.

The range of specific initiatives in collaboration Somerset County Council, includes:

- Early support for the development of a project to enable proxy access of medications for care homes, working with pharmacists.

- Implementation of home monitoring via MiiCare for patients living with symptoms of mild dementia to enable them to stay in their own homes and provide proactive care before clinical problems or adverse events occur, particularly supporting discharge to assess services.

- Improved digital support for people living with a learning disability, mental health condition or autism to manage their anxiety.

- Implementation of a digital tool to support people with a learning disability (LD) to better manage their wellbeing outcomes and improve the quality of the LD annual health check.

- Provision of digital inclusion support to people most at risk of digital exclusion via a coordinated group of inclusion champions which span Health Connections Mendip, SPARK Somerset, voluntary, community and social enterprise organisations and Yeovil Primary Care Network.

- Implementation of comprehensive assessment form to improve multi-disciplinary team working with care home residents.

Data Analytics and Population Health Management

This year has seen a step forward with establishing a primary care data analytics programme, with an initial focus on GP data, working with and supporting general practices. The digital team has appointed several new roles for data analysts, data facilitators and a Digital Data Administrator. We continue to work with Somerset Local Medical Council (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 in the last six months has been for the COVID-19 vaccination programme, developing and running searches on behalf of all practices to identify relevant cohorts of population to be invited for vaccination. This process continues with some automation and new searches created in response to national and local plans.

To extend this functionality, there are plans underway to replace the historical use of MIQUEST for physical healthchecks for people with severe mental illness searches, which we hope 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.

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.

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). We have been preparing for the Optum PHM development programme, and it has taken time to develop our local delivery model, but final sign up to data sharing agreements is underway and this programme will be implemented during 2022. 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 onwards, in a similar way to 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.

To achieve the ambitions, it is anticipated an overarching 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.

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 PHM approach:

- Maintained Analyst Leads Forum to explore strategic data discussions, priorities and share requests and learning as an ICS.

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

- Growth in use of EMIS search and reports, notably for the COVID-19 vaccination programme.

- Early discussions to identify usage, routine and regular reporting of uptake data across different initiatives, including SIDeR and ORCHA.

- Early exploration of data warehouse options across ICS.

2021/22 has seen further growth of the digital and data functions. With the launch of our SIDeR shared care record as a truly system wide tool to improve information sharing and beginning to establish our PHM and analytics programme, we start to see the transformational efforts for change being utilised in making a difference to care across Somerset.

3.36 Estates

The wider Somerset Integrated Care system (ICS) has in place a mature Strategic Estates Group, which includes representation from Providers, CCG, Somerset County Council, NHSPS and NHSE/I. The group meets regularly to push forward the STP/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.

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.

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.

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 ICS and One Public Estate Programme
- reviewing and updating the ICS Estates Strategy

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 NHSI/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 STP. Construction on both schemes commenced in August 2020 and have continued during 2021/22. The Acute Assessment Hub is due for completion in summer 2022. The surgical centre is due for completion in Autumn 2024.

3.37 Sustainable Development

NHS Somerset CCG adopted the Sustainable Development and Carbon Reduction Strategy and its associated plans that were put in place by Somerset Primary Care Trust and we have continued to meet its obligations through the delivery of this plan. NHS Somerset CCG monitors the plans that Providers have in place through the standard NHS Contract (ref SC18) to demonstrate their progress on sustainable development. We have ensured the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

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

- supported 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
- helped the national NHS target of reducing carbon emissions through employee travel
- worked with the waste management service provider to increase the amount of recycled materials and promote these opportunities with our staff
- reduced the use of printers and consumables and promote a paperless environment and ensure recycling of the printer consumables through the service provider
- continued to integrate the principles of sustainability across the organisation, including reducing use of single use plastics where possible
- recycling our electrical and IT equipment
- promoting greater flexible working from home and use of technology to reduce travel across the county.

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.

During 2021/22 NHS Somerset CCG supported the development of a three-year system Green Plan to set out how the system would work towards delivering the targets of the national strategy ‘Delivering a ‘Net Zero’ NHS’. The Strategy was signed off by the CCG Governing Body on 31 March 2022 and 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.

3.38 Engaging people and communities

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).

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’).

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 and health, 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.

Our Communications and Engagement Strategy 2019/22, outlines four objectives:

Despite the ongoing challenges of the COVID-19 pandemic, in 2021/22 we have still made progress.

We were pleased that we were awarded a green star (outstanding) rating in the NHS England and NHS Improvement Assessment Framework for the patient and community engagement indicator.

With the ongoing COVID-19 pandemic and in light of changing restrictions, we continued to review our engagement activities alongside current guidance and continued to work in line with national COVID-19 good practice for engagement practitioners.

Somerset Engagement Advisory Group (SEAG)
SEAG continued to meet to check and challenge our commissioning decisions, plans and engagement. Members have been asked for their views on a number of programmes of work including:

- Cancer diagnosis
- Promotion of the NHS app and other digital projects
- Somerset educational needs and disabilities (SEND) written statement of action and collaboration framework
- Our 10 principles for working with people and communities in Somerset
- Our Fit for my Future Strategy
- The role of community pharmacies, with a focus on the community pharmacy consultation service
- Musgrove Park Hospital building programme (Musgrove 2030).
- Same day urgent care services in West Somerset

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.

Gillian Keniston-Goble, Manager at Healthwatch Somerset, has also taken on the role of Independent Chair of SEAG.

Somerset Citizens' Panel
Our Citizens' Panel 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.

Throughout 2021/22 we continued to develop and recruit to our Somerset Citizens' Panel. In May 2021, we held a focus group to help develop our Citizens' Panel website. The focus group members provided feedback regarding aspects of the website. They also provided useful feedback about their experiences using the website to share their views and thoughts on a number of project pages and healthcare issues. This feedback was used to make important changes to the engagement website, with the aim of improving accessibility, appeal and use as a key engagement tool.

Our Citizens' Panel have also told us their thoughts on:

- Somerset integrated digital e-record (SIDeR);
- Healthy weight
- Choice in elective care
- Access to healthcare services
- New ways of working in primary care

Feedback from each survey was shared with programme teams to inform their work and we provided feedback to the Panel on the difference their feedback has made.

The Citizens' Panel now has 411 members and continues to grow.

Carers strategic partnership board and the carers' engagement service
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.

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)
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.

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.
In 2021/22 our PALS supported 833 people find the information they needed about NHS services and COVID-19 vaccinations in Somerset. An increase of 41% from 2020/21. The PALS team work 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.

Our weekly engagement bulletin has 510 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
The CCG engagement team supports GP practices and Patient Participation Groups (PPGs) 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.
In Somerset, we have a countywide network of active PPG Chairs who meet on a bimonthly basis. The CCG continued to support and work with our PPG Chairs' Network who continued to meet virtually.

Working together
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.

The 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 our emergency department engagement and 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.

We established 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.

In 2020/21, we facilitated two webinars that explored what we have learnt about the benefits and challenges of volunteering within the health and social care system in Somerset. We used this to consider how we could work better together to create opportunities which grow and support volunteering as we develop our system approach in Somerset.

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 2021/22:
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.

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.

Engagement highlights in 21/22 include:

- We held young people and parent focus groups to support the procurement of a new online counselling service for children and young people by asking what they needed from this service.

- 41 people attended our Mental Health Stakeholder Forum that is run in partnership with Mind Somerset.

- The Somerset NHS Citizens' Panel were given the opportunity to complete the choices in elective care survey. We wanted to know what was important to our patients when choosing where to be seen for treatment and elective care. This feedback was shared with the Elective Care Board to inform their decision-making.

- We supported Somerset Maternity Voices partnership and Somerset Parent Carers Voice with facilitating and documenting engagement workshops.

- Facilitated a community workshop for Yeovil Connect, a partnership of community and health organisations for the Yeovil Primary Care Network.

- 88 Citizens' Panel members shared their views on healthy weight. We asked panel members what healthy weight means to them and what support they would like to see to help them maintain a healthy weight. This feedback was used to inform the healthy weight model for Somerset.

- We asked our Citizen's Panel if they were aware of our Somerset integrated digital e-record (SIDeR) project and checked their understanding of data sharing in the NHS. The findings were presented at the Information Governance Working Group and the Digital Delivery Board.

- We supported the joint engagement work with Somerset County Council on the SEND written statement of action, personalised budgets and community equipment and wheelchair procurement.

- We supported Somerset NHS Foundation Trust (SFT) to hold a series of engagement workshops to help shape the future vision for community hospitals in Somerset.

- Due to the increased pressure on emergency departments across our local hospitals, we worked with Healthwatch Somerset and local hospital trusts to find out from people what had brought them to the emergency department and whether they accessed other services beforehand. The findings from this engagement has been shared with our Urgent Care Operational Group.

- We held an online information session where people could hear the findings from our engagement on the early thinking on the future community health and care services for people in Somerset which took place in early 2020.

- 48 people responded to an autism and ADHD assessment pathway survey.
- Following the closure of Victoria Park Medical Centre in August 2021, we undertook public engagement in the local area to understand the impact of the closure of the GP practice and to begin conversations around what health services could be provided in the future. To start the process of engagement, three drop-in sessions were held in October 2021, along with

an online survey to gather views and feedback from former patients and the local community. All views were gathered and analysed by an independent expert who produced an engagement report, published in December 2021. We then set up a stakeholder group of people who said they would like to stay involved. This group was kept updated throughout the development of the solutions and were provided with opportunities to give feedback at stakeholder meetings held in January, February and March. Feedback from this engagement was used to inform the development of potential solutions.

- We commissioned Healthwatch Somerset to carry out engagement with people in West Somerset to gather feedback and better understand the local populations needs in relation to same day urgent care services. This included a public survey, focus groups and conversations with local people. We will use this feedback to inform the development of services and to develop communications to ensure the community is supported on accessing same day urgent care services.

- We supported our stroke programme to ensure the patient voice is embedded in the review of hyper acute stroke services in Somerset. A key part of this work programme is listening to the views of people with lived experience of stroke to ensure the programme responds to what matters most service users. The Stroke Transformation Group, which has been leading on the development of the proposals, includes membership from clinicians, managerial staff, the Stoke Association and people with lived experience. We also set up a wider stakeholder group to hear from a wider range of communities and gain insight and feedback on our plans. This work will continue in 2022/23, our aim is to create meaningful engagement with local people and stakeholders to involve them in deliberations about the future configuration of hyper acute stroke services in Somerset.

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.

The 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.

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.

3.39 Equality and Health Inequalities

The following is a summary of engagement events and work to address health inequalities we have undertaken during 2021/22:

Equality and Diversity Networks
Wednesday 12 May 2021 was the national say for staff networks. Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust joined forces to showcase their networks throughout the day. Invitations to join these staff networks were extended to colleagues at the CCG.

As a result of CCG colleagues attending these, several staff have taken up the offer to join the trusts' networks and we now have representatives on:

- Women's Network (Somerset NHS Foundation Trust (SFT) and Yeovil District Hospital NHS Foundation Trust (YDH))
- Multi-cultural Network (YDH)
- Lesbian, Gay, Bisexual & Trans (LGBT) Network (YDH &SFT)

The CCG has been invited to co-chair Yeovil District Hospital's Diversity Network. The Diversity Network is tasked with looking at inequalities that can be faced due to different combinations of characteristics, often referred to as "intersectionality". This network brings together all staff networks at the Trusts.

Awareness months, weeks and days
Throughout the year, we have acknowledged and promoted many awareness events across the CCG. We shared various pieces of information with our colleagues to provide some awareness to people across the organisation. The campaigns we linked with over the year were:

- LGBT awareness month – June 2021
- Gypsy, Roma and Traveller (GRT) history month – June 2021
- International Day Against Homophobia, Transphobia and Biphobia (IDAHO) – 17 May 2021
- Anniversary of George Floyd's murder – 25 May 2021
- Deaf Awareness Week – 3-9 May 2021
- NHS Pride Week – 6-10 September 2021
- National Inclusion Week #UnitedForInclusion – 27 September 2021 – 3 October 2021
- Black History Month – 1-31 October 2021
- Transgender Day of Remembrance – 20 November 2021

Refugees and Asylum Seekers
Somerset County Council formed a working group looking specifically at the needs of Somerset's refugee and asylum-seeking communities.
This focusses 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.

The formation of 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
The Afghan Relocations and Assistance Policy (ARAP) is the scheme run by the Home Office to enable the resettlement of people from Afghanistan to the UK. Somerset's ARAP scheme is being led by Somerset County Council with guidance from the Home Office. We are working closely with Somerset County Council to ensure that we respond quickly to the health needs of potential arrivals. We have undertaken preparatory work to ensure that health needs can be met should any people be resettled in Somerset. This includes provision of interpreters, cultural awareness and access to community support.

Ukrainian Refugee Resettlement
More recently, work has been undertaken, led by Somerset County Council, on how best to meet the needs of people resettling in Somerset from Ukraine. This has been fast paced but we have been able to build on the work undertaken as part of the Afghan resettlement activities. Numbers are already appearing to be higher than those arriving from Afghanistan and we are continuing to review the health needs and providing support to meet these.

Training and "Lunch & Learn" sessions
Training
We have continued to provide training on equality impact assessments (EIA) 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
Earlier in the year we launched our monthly "lunch & learn" sessions. These are designed as taster sessions for colleagues across a range of topics. We have held the following throughout the year:

- Gypsy, Roma and Traveller health
- Barriers to health for asylum seekers, refugees and migrant populations
- Mental health in agriculture
- Beta-blockers for bias

Equality in Nursing Training
In October 2021 we joined forces with Yeovil District Hospital NHS Foundation Trust (YDH) to deliver a module at Bridgwater and Taunton College to those enrolled on the local University nurses training programme. This two-hour module looked at different characteristics in different settings across primary and secondary care. Some of the topics included were:

- Ethnic minorities in maternity care
- Mental health crises in emergency departments

- Transgender access to primary care

Each area focussed on the specific challenges in each of these settings for the different groups. The overarching theme of all topics aimed to reinforce the importance of a person's identity in delivering patient-centred care. Feedback from the students was overwhelmingly positive.

Gypsy, Roma and Traveller (GRT) Communities
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 CCG, all District Councils, Somerset County Council, the Gypsy Liaison Service, Avon & 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.

Also, during GRT History Month, we worked with Somerset's Gypsy Liaison Officers to pull together commonly asked health questions when visiting sites. This resulted in the creation and publication of a GRT health page on the CCG website: Gypsy, Roma and Traveller Health - Somerset CCG

Equality Impact Assessments
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. This is of particular importance as we begin to restore services and stand-down activities in response to the COVID-19 response.

GP Access Cards
GP access cards is a national initiative to improve people's experiences of registering with a GP where they don't':

- Have an address
- Have proof of ID
- Have evidence of their immigration status

These cards are being delivered to local Healthwatch organisations to be distributed. Healthwatch Somerset has provided a supply of these to the CCG and Somerset County Council for distribution. These are currently being given our homeless population, 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
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

The 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 gets 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.

BSL/English Interpreting Review

NHE England and Improvement (NHSEI) commissioned the North of England Commissioning Support Unit (NECS) to undertake a national review of how BSL (British Sign Language)/English Interpreting is offered to d/Deaf patients across all services. This national review aims to provide organisations with best practice guidance and recommendations. CCGs and ICSs are responsible for commissioning all interpreting services (both verbal and non-verbal) for primary care and Somerset has changed its provider to Word360. Word360 has provided interpreting services for both of Somerset's trusts for some years. The working group were keen to have representation from a CCG/ICS in their group and NHS Somerset CCG was recommended to them by NHS England and Improvement.

Yeovil Pride 2021
On 21 August 2021, we teamed up with Yeovil District Hospital to attend the second Yeovil Pride event, which included a march through the town centre.

We had short notice of this event due to COVID-19 restrictions but plan to have a bigger presence in 2022. We have already commenced conversations with South Somerset District Council, Somerset Wide Integrated Sexual Health Services and others around joining up public services at the event.

Eastern European Wellbeing Event
We have been working with a large group of Eastern European people living in the Sedgemoor area. It became clear that there were a number of cultural, language and other barriers to accessing healthcare and other services being experienced by these families.

With support from Somerset County Council's Public Health team, and other services, we ran a "wellbeing afternoon" where they are living which included:

- Sexual health information and self-testing kits
- Primary care signposting
- COVID-19 testing
- Mental health information and signposting
- Information around accessing education

We met with approximately 50 people during the afternoon and provided appropriate information and support. We continue to work with the group to encourage increased access to mainstream services available in Somerset.

Advancing Mental Health Equality
Somerset NHS Foundation Trust (SFT) 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.

The group has reviewed each group and collectively decided that 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.

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.

Subsequently, the project group has agreed another focus area is LGBT+ and a sub-group has now been formed to take this work forward.

The third area of focus is rural communities which should be launching its working group in early 2022/2023.

"Get Your Queer Cheer Here!"
On 17 December 2021 we joined with YDH and SFT to host the second virtual LGBT Christmas event. This year we had people joining from NHS Somerset CCG, both trusts, NHS England and people from neighbouring trusts and CCGs. There were approximately 20 people that joined the event which consisted of an informal virtual gathering along with a quiz. The event was open to anyone who identifies as LGBTQIA+ and those who are allies. We plan to run our third event again next year.

3.40 Health Inequalities

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 though the equality, populational health management and health inequalities workstreams.

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

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

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.

SWAPS consists of two weeks training with Weston College (virtually) and then week 3 is 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)

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

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

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.

During 2021/22 we developed our Maternity Equity Strategy (to be published in September 2022) that sets 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 access care.

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.

Yeovil District Hospital'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

Across Somerset, we have approximately 1,750 people waiting over 52 weeks for planned surgery or treatment. From the analysis we have undertaken to better understand the needs of our population against those waiting for planned surgery/treatment we plan to do the following:

<u>Peri-Operative Care</u>
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.

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

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.

We in the process of 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.

The 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.

3.41 Emergency Planning

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.

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 coordinated 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 2021/22 to ensure there was a coordinated 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.

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.

Somerset's Emergency Planning capacity during 2021/22, has continued to concentrate heavily on the COVID-19 pandemic response whilst also having to manage a number of concurrent incidents such as fuel supply disruption, severe weather disruption from Storm Eunice, returning Afghan and Ukrainian refugees, isolation hotels and disruption to supplies of blood bottles and lateral flow test kits on top of severe system pressures. EU Exit transition has not presented any significant specific issues in Somerset to date; the first phase of increased border checks came into effect on 1/1/22 with full implementation due by 1/7/22. There have recently been cases of avian flu detected in the SW in wild birds – the health system works closely with public health colleagues to ensure each case is followed up with testing and appropriate treatment.

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. There is COVID-19 Incident risk and issues log which has been designed to align to the CCG Corporate Risk Register. A framework of specialist support cells has also been established to lead key workstreams and these have multi agency representation and link into the LRF cell structure and NHSE Regional command and control as appropriate.

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-coordinated and effective.

3.42 Risk Management

NHS Somerset CCG's policy and approach to risk management is set out in detail in section 5 of the Governance Statement. The risk management process underpins the successful delivery of our strategy, achievement of our objectives and the management of our relationships with key partners.

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

2021/22 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, specified within the CCG Risk Management Strategy policy, were then used to enable timely reporting of risk within the CCG governance structure.

The main areas of risk managed by us during 2021/22 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

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:

- Establishing additional capacity via community mental health services transformation workstream.
- Completed demand and capacity modelling work.
- 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 and Improvement.
- 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 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.
- Meetings of Suicide Prevention Strategic Partnership Board (quarterly).
- Delivery of crisis home treatment services.

COVID-19 pandemic – Nosocomial transmission

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

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 IPC Committee meetings.
- 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

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 within the CCG.
- Continued roll out of the COVID-19 vaccination programme.

Sustainability of and Access to Health Care Services

We have managed 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 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
- 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

In 2021/22 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.
- 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 (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

We have managed 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:

- 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 People Board and local providers with recommendations
- Early adopter site for Maternity Care Assistants and working with Universities to Assist.
- 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 plan workforce plan.
- Degree pathway.
- Career pathways for critical roles.
- One year system workforce / NHS People Plan.

Financial management and achievement of efficiency savings

National guidance from NHS England and Improvement for 2021/22 financial planning round was an alternative framework for both H1 and H2 2021/22 due to the COVID-19 pandemic. The Somerset Integrated Care System (ICS) submitted a balanced plan for H1 (the first six months of 2021/22) which was delivered and a balanced plan for H2 (the second six months of 2021/22).

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.

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

- Strategic financial issues are identified and reported.
- Arrangements are in place to ensure sound financial control.
- Monthly finance reports are produced to inform the 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

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.

ICS Transition

Now that Royal Assent has 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 (ICB). During 2021/22 preparation work for the transition has been 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 has been taking place:

- Development of ICB Constitution - structure and decision-making processes.
- Completion of required due diligence through specified worksteams.
- 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.

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

4 FINANCIAL AND PERFORMANCE ANALYSIS

4.1 Finances

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) 2021/22' 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 2021/22 financial statements.

4.2 Financial Duties

During 2021/22, our performance against our financial duties is outlined in the table below:

2021/22 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	✓

Specific details regarding these duties are provided below.

4.3 Overview

The NHS financial framework arrangements for 2021/22 continued to support a system-based approach to funding and planning. The Government agreed an overall financial settlement for the NHS for 2021/22 which was broadly consistent with a continuation of funding envelopes as allocated for the latter half of 2020/21. This included a continuation of system top-up and COVID-19 fixed allocation arrangements and introduced increased efficiency requirements for the second half of the 2021/22 financial year.

Throughout 2021/22 there was a continued focus on restoration and recovery of services, with additional funding made available to support this, and recovering finances back to a sustainable footing.

Some services continued to be funded outside of system funding envelopes for 2021/22, including;

- specialised high-cost drugs and devices.

- some specific COVID-19 related services (i.e. testing, vaccination, Hospital Discharge Programme (HDP)).
- non-clinical services contracted by NHS England and NHS Improvement
- allocations of national system development funding (SDF).
- elective recovery funding

The Somerset system submitted balanced financial plans for 2021/22 and NHS Somerset CCG has delivered a balanced year-end financial position according to plan and within its allocated financial resource.

4.4 Analysis of Revenue Performance

	2021/22 £'000
In year revenue resource limit	1,134,671
Variance against revenue resource limit	0
Percentage variance against revenue resource limit	0%

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, monthly Quality, Innovation, Productivity and Prevention (QIPP) savings, 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.

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

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 (Vice Chair of the Governing Body) chairs the Audit Committee. Six meetings were held during the year, and the committee members considered:

- governance, risk management and internal control
- internal audit
- external audit
- counter fraud
- other assurance functions

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

A full set of Somerset CCG's Annual Accounts for 2021/22 are included in this report and describe how we have used our resources to deliver health services

to residents of Somerset during 2021/22. An explanation of the key financial terms can be found as an Appendix at the end of the Annual Accounts.

A full copy of the set of audited accounts is available upon request, without charge, from:

Alison Henly
Director of Finance, Performance, Contracting and Digital
Wynford House
Lufton Way
Yeovil
Somerset
BA22 8HR

E-mail: alison.henly@nhs.net

Alternatively, the full document can be viewed on the Trust's website at: www.somersetccg.nhs.uk/

Going Concern

4.5 Introduction

The annual accounts of the 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.

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.

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.

4.6 Criteria

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 the management should consider all available information about the future.

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.

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.

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

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

Financial Assumptions for 2021/22

4.7 Budgets and Outturn

The NHS financial framework arrangements for 2021/22 continued to support a system-based approach to funding and planning. The Government agreed an overall financial settlement for the NHS for 2021/22 which was broadly consistent with a continuation of funding envelopes as allocated for the latter half of 2020/21. This included a continuation of system top-up and COVID-19

fixed allocation arrangements and introduced increased efficiency requirements for the second half of the 2021/22 financial year.

Throughout 2021/22 there was a continued focus on restoration and recovery of services, with additional funding made available to support this, and recovering finances back to a sustainable footing.

Some services continued to be funded outside of system funding envelopes for 2021/22, including;

- specialised high-cost drugs and devices.
- some specific COVID-19 related services (i.e. testing, vaccination, Hospital Discharge Programme (HDP)).
- non-clinical services contracted by NHS England and NHS Improvement
- allocations of national system development funding (SDF).
- elective recovery funding

The Somerset system submitted balanced financial plans for 2021/22 and NHS Somerset CCG has delivered a balanced year-end financial position according to plan and within its allocated financial resource.

4.8 Cash Flow

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. The CCG met its cash requirements for 2021/22 and is planning to do so on an ongoing basis.

4.9 Contingent Liabilities

The CCG has contingent liabilities in 2021/22 relating to:

- continuing healthcare (CHC) cases - to reflect a risk associated with the provisions estimate made for pending CHC eligibility assessments and appeals

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.

4.10 Services

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.

4.11 Operational Financial Planning 2022/23

The NHS's financial arrangements for 2022/23 will continue to support a system based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. ICS' 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 in the first half of 2022/23. 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.

The 2022/23 financial framework signalled a change from those in operation in 2020/21 and 2021/22, with a move back towards population-based funding in the context of system collaboration, key points being:

- maintaining system funding allocations and collaborative planning with the ICB and its partner trusts having a financial objective to deliver a breakeven position.

- reintroducing population-based funding based on fair share allocations. Funding on a glidepath from current system revenue envelopes to a fair share of the affordable recurrent NHS settlement (known as the convergence adjustment).

- system envelopes now include sustainability funding previously allocated through the Financial Recovery Fund.

- return 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. Expectation that elective activity flows will have a variable component.

- funding to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding to support elective recovery, with access to further additional revenue where systems exceed target levels.

- continue to be required to deliver the Mental Health Investment Standard (MHIS).

- final year of separate Covid-19 allocation, based on assumption that Covid-19 levels return to early summer 2021 levels. This assumption is being kept under review locally.

All systems are expected to report a balanced financial position within their submitted plans.

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

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

4.12 Financial Arrangements During the Coronavirus Pandemic

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.

NHS England and NHS Improvement 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.

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.

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.

As advised by NHS England and NHS Improvement, 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.

4.13 Establishment of Integrated Care Boards (ICBs)

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 will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). Subject to the issue of an establishment order by NHS England, ICBs will take on the commissioning functions of CCGs from 1 July 2022 and all CCG functions, assets and liabilities will transfer to an ICB. On this date NHS Somerset CCG's functions, assets and liabilities will transfer to NHS Somerset ICB.

This transition will not affect the going concern status of the CCG given that its services will continue to be provided (using the same assets), by the ensuing ICB.

4.14 Recommendation

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

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 annual accounts for 2021/22 on a going concern basis.

4.15 2021/22 Revenue Resource Limit

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

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 2021/22.

The CCG's performance for 2021/22 is as follows:

	2021/22 £'000
Total net operating cost for the financial year	1,134,671
Final in year revenue resource limit for the year	1,134,671
Under/(over) spend against revenue resource limit	**0**

This table highlights that in 2021/22 Somerset CCG operated within its revenue resource limit.

4.16 Better Payment Practice Code

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.

Our performance for the year ended 31 March 2022 is summarised below:

Measure of compliance	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,723	£210,244	9,513	159,468
Total Non-NHS Trade Invoices paid within target	9,723	£210,244	9,513	159,468
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	672	731,378	1,203	619,369
Total NHS Trade Invoices Paid within target	672	721,378	1,202	619,369
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	**99.92%**	**100.00%**

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

4.17 Cash Limit

The CCG is required not to exceed the cash limit set by NHS England, which sets the amount of cash drawings that the CCG can make in the financial year. The CCG drew cash totalling £1,142.839 million (99.94%) against a cash limit of £1,143.473million, therefore meeting this requirement.

4.18 Running Costs

The CCG was funded a total of £11.09 million in 2021/22 to support headquarters and administration costs. This included additional funding of £0.634 million released in-year to support an increase in employers' pension contributions. 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 value of services commissioned via the SCW CSU in 2021/22 was £3.62 million, which covered Business Intelligence support, Information Technology and Information Governance support, Procurement Services support, Care Navigation Services, GP IT Services, and additional consultancy and project support. Of this £3.62 million, £2.17 million was charged against the CCG's running cost allocation and £1.45 million was reported as programme expenditure. Total expenditure recorded against running costs for 2021/22 was £11.033 million.

4.19 Accounting Policies

Full details of the accounting policies used to prepare the accounts and summary financial statements can be found within Note 1 of the CCG's audited accounts.

4.20 Governing Body and Clinical Executive Committee Members

Full details of the remuneration paid to Governing Body and Clinical Executive Committee members and senior employees, which are included within the above management costs, are provided within the Remuneration and Staff Report at sections 8 and 9 of this report, together with their pension entitlements and declarations of interest.

4.21 External Audit

Grant Thornton UK LLP is the appointed external auditor for the CCG. The total fee paid to Grant Thornton UK LLP in 2021/22 was £79,334 including VAT to cover the cost of the statutory audit, Value for Money audit requirements and associated services.

4.22 Governance Statement

The Chief Executive, as Accountable Officer, publishes an Annual Governance Statement, confirming the systems for managing risk within the CCG. This statement is supported by the Head of Internal Audit who provides an opinion on the overall arrangement for gaining assurance through the Assurance Framework and on the effectiveness of the controls in place to mitigate risks.

A copy of the full Governance Statement is included in section 7 of this Annual Report and is also available on request or can be viewed on the CCG's website at: www.somersetccg.nhs.uk

4.23 Performance Summary

NHS England and Improvement (NHSEI) assesses NHS performance against the Single Oversight Framework resulting in an overall performance rating at the end of the year. NHSEI consulted on the new NHS System Oversight Framework (SOF) in 2021/22, which introduced a new approach to provide focused assistance to organisations and systems.

Following consideration by NHS England and Improvement, the Somerset ICS was placed into SOF segment 2. Trusts also received individual SOF ratings with Somerset NHS Foundation Trust receiving a rating of 2 and Yeovil District Hospital NHS Foundation Trust a rating of 3. This represents significant improvement across the system, and by the CCG in particular with the move from special measures to a SOF rating of 2 in a two-year period (equivalent to 'good' under the previous rating system).

Performance against the key NHS Constitution requirements has continued to be closely monitored during 2021/22. However, because of the ongoing effect of the COVID-19 pandemic it has been a challenging year leading to changes in the patterns of emergency demand, patients staying longer in hospital or waiting longer for elective treatment. Where performance has not met the required level remedial actions have been developed across the Somerset system and improvement plans agreed.

Due to halting elective services and lower levels of demand during 2020/21 (due to COVID-19) the performance analysis below assesses Somerset Clinical Commissioning Group against the pre-pandemic period of 2019/20.

4.24 Performance Analysis

Emergency and Urgent Care Performance Scorecard between 1 April 2021 and 31 March 2022

Emergency Care	Standard	19/20	YTD 21/22	Variance to Standard +/(-)
Cumulative percentage of Trustwide MPH & YDH patients spending no more than four hours in A&E from arrival to admission, transfer or discharge	95%	85.7%	73.4%	(21.56%)
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%	91.3%	81.7%	(13.32%)
Cumulative number of MPH & YDH patients spending greater than twelve hours in A&E from decision to admit to admission	0	0	466	466
Percentage of ambulance handovers to A&E department that exceed 15 minutes	35%	20.9%	37.5%	2.45%
Percentage of ambulance handovers to A&E department that exceed 30 minutes	5%	3.8%	12.0%	7.03%
Percentage of ambulance handovers to A&E department that exceed 60 minutes	0%	0.4%	4.0%	4.00%
Percentage of emergency admissions who stay less than 1 day	-	33.1%	33.2%	-
Number of patients with "No Right To Reside" in an Acute Hospital	-	n/a	242	-

Demand for urgent and emergency care services has increased in 2021/22 with approximately 381 attendances per day to Accident and Emergency Departments (ED) in Somerset in comparison to 365 per day in 2019/20. However, due to a number of factors including increased patient acuity (whereby the patient complexity and severity of presentations has significantly increased) has resulted in patients staying longer in the ED. As a consequence, the annual 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 73.4% in comparison to 85.7% in 2019/20.

Whilst ambulance handover performance remains strong in comparison to other Providers in the South-West Region there has been a decline in recent months with 37.5% of ambulances not being handed over within 15 minutes of arrival to hospital (in comparison to 20.9% during 2019/20). In addition, there has also been a deterioration in the level of 12-hour trolley breaches (from 0 in 2019/20 to 466 in 2021/22).

Whilst the overall level of emergency admissions during 2021/22 has reduced by 11.1% when compared to 2019/20 the bed occupancy has significantly increased demonstrating that patients are staying longer in hospital and a

higher proportion are requiring further out of hospital care leading to a significant increase in the number of patients in an Acute 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 to 31 March 2022

Standard	Target	2021/22		Variance +/(-) to Standard		Variance +/(-) to 2019/20	
		Provider Performance	Performance in Somerset	Provider Performance	Performance in Somerset	Provider Performance	Performance in Somerset
Category 1 response - mean	7 mins	10.3	11.3	3.3	4.3	3.2	3.5
Category 1 response - 90th percentile	15 mins	19.3	21.2	4.3	6.2	6.3	6.4
Category 2 response - mean	18 mins	61.9	56.5	43.9	38.5	33.3	22.7
Category 2 response - 90th percentile	40 mins	139.1	120.1	99.1	80.1	79.2	51.1

During the period April 2021 to March 2022 on a cumulative basis the mean Category 1 (life threatening calls) performance was 11.3 minutes against the 7-minute national standard compared against Trust-wide performance of 10.3 minutes, and Category 2 performance was 56.5 minutes against the 18 minute standard (compared to the Trust-wide performance of 61.9 minutes).

Waiting Times for Cancer Treatment

The operational standards require the following standards to be attained:

- 93% of patients to be seen within two weeks of referral
- 96% of patients' first treatments to be within 31 days or less from the decision to treat
- 98% of patients second or subsequent treatments by anti-cancer drug treatments, within 31 days or less from decision to treat
- 94% of patients second or subsequent treatments by surgery, within 31 days or less from decision to treat
- 94% of patients second or subsequent treatments by radiotherapy, within 31 days or less from decision to treat
- 85% of patients' first definitive treatment will be within 62 days from urgent GP referral to their first definitive treatment
- 90% of patients' first definitive treatment will be within 62 days from cancer screening programme or consultant upgrade to their first definitive treatment
- 75% of patients 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.

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

Waiting Times Standard	Standard	2019/20	YTD 2021/22	Variance +/(-) to Standard	Variance +/(-) to 2019/20
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	86.6%	79.6%	(13.40%)	(6.99%)
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	91.2%	69.6%	(23.40%)	(21.56%)
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	95.8%	93.3%	(2.70%)	(2.54%)
31-Day Standard for Subsequent Cancer Treatments-Surgery	94%	91.4%	84.7%	(9.30%)	(6.66%)
31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	98%	99.5%	99.5%	1.50%	0.04%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94%	93.1%	97.3%	3.30%	4.17%
62 day wait - % treated in 62 days from GP referral	85%	79.8%	73.4%	(11.60%)	(6.44%)
62 day wait - % treated in 62 days from screening programme	90%	83.7%	78.0%	(12.00%)	(5.68%)
62 day wait - % treated in 62 days from consultant upgrade	90%	84.0%	86.1%	(3.90%)	2.07%
28-Day Faster Diagnosis Standard for patients on the 2 week wait referral route	75%	-	74.8%	(0.20%)	-

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

During the period April 2021 to March 2022 two of the operational cancer standards were delivered for Somerset patients with the cancer standards continuing to be impacted by the Covid-19 pandemic during 2021/22. As elective services recovered a number of the cancer sites experienced either 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. 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

Somerset Clinical Commissioning Group Key Performance Scorecard (Somerset Relevant Population) between 1 April 2021 and 31 March 2022

The performance scorecard in respect of elective access standards achieved for services delivered to Somerset patients, for the period 1 April 2021 to 31 March 2022 is set out below.

Indicator		Standard	2019/20	YTD 21/22	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%	82.3%	64.5%	(27.5%)	(17.8%)
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 52 weeks	0 by Mar-25	50	2627	2627	2577
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 78 weeks	0 by Mar-23	-	591	631	-
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 104 weeks	0 by Jun-23	-	156	195	-
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99%	90.4%	65.4%	(33.6%)	

Referral to Treatment Waiting Times

The pressures being seen across primary care and all emergency services is unprecedented resulting in an increased volume of patients arriving at A&E and being admitted, against a backlog of challenges in discharging patients from hospital due to the availability of further packages care or bed availability. This has led to an increase in the length of stay and higher bed occupancy and unfortunately an increase in the cancellation of elective operations. Despite these pressures the Trusts in Somerset have worked 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.

All RTT performance measures have been impacted by the Covid-19 pandemic during 2021/22 due to services working at reduced capacity due to impact of social distancing, enhanced infection control measures, workforce constraints and patients choosing not to attend (for both Covid-19 and non-Covid-19 reasons). The emphasis has continued to be to keep patients safe whilst ensuring that those patients with urgent conditions continue to be prioritised. The size and shape of the waiting list has changed since the onset of the Covid-19 pandemic due to the change in referral patterns and the wait for first definitive out-patient and in-patient treatments; performance against the Referral to Treatment (RTT) Incomplete Pathway in 2021/22 was 64.5% (in comparison to 82.3% in 2019/20).

New waiting times reporting was introduced from April 2021 enabling Clinical Commissioning Groups to monitor waiting times up to and exceed 104 weeks. In March there were 156 patients in Somerset experiencing a wait in excess of 104 weeks and Somerset System have developed plans to ensure that these very long waits are eliminated by June 2022.

Diagnostic Waiting Times

The NHS Constitution standard for diagnostics is that 99% of patients should wait less than six weeks for a diagnostic test or procedure; however all diagnostic services have been impacted during 2021/22 by the Covid-19 pandemic due to services working at reduced capacity as a result of the ongoing impact of social distancing in waiting rooms, enhanced infection control measures (PPE and cleaning measures between patients), staff sickness, recruitment challenges and increased emergency (in-patient) demand. This has led to a significant increase in the number of patients waiting in excess of 6 weeks for their diagnostic test or procedure when comparing 2021/22 to 2019/20. During 2021/22 65.4% of patients on the waiting list waited six weeks or less compared to 90.4% during 2019/20; however, across the 2 most challenged diagnostic modalities as a result of additional capacity the MRI backlog has reduced during the latter part of the year and the successful recruitment to vacant Echocardiography posts is starting to lead to an improvement in waiting times.

Mental Health and Learning Disabilities

Somerset Clinical Commissioning Group Key Performance Scorecard (Somerset Relevant Population) between 1 April 2021 and 31 March 2022

Adult Mental Health

IAPT Mental Health	Standard	2021/22 Performance	Variance +/(-)
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period (YTD to March 2022)	10307	8155	(2152)
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 (March 2022)	75%	62.3%	(12.7%)
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 (March 2022)	95%	97.9%	2.9%
The proportion of people who are moving to recovery (March 2022)	50%	55.9%	5.9%

IAPT (Improving Access to Psychological Therapies) Programme

The number of people accessing IAPT treatment for 2021/22 is 8,155 (local un-validated data) against a local indicative target of 10,307 (79% delivered). Performance for the period is lower than plan. This is due to workforce issues and the impact of COVID within the service: a number of vacancies and unplanned absences (long term sickness and maternity). Recruitment to vacant positions continues to be challenging as there is a national shortage of appropriately qualified therapists. Somerset continues to take trainees to grow its own workforce.

The IAPT recovery rate for March 2022 is 55.9%. The national ambition of 50% continues to be met and exceeded, and during 2021/22 Somerset has consistently been one of the top performing systems nationally.

In March, the 6-week national standard, that 75% of patients referred for treatment were seen by the service within 6 weeks was not achieved, with performance of 62.3%. The service has expressed concern about ongoing delivery of the 6 weeks wait standard on the basis of a sudden surge in the number of referrals/people entering treatment. We continue to monitor this but anticipate it will naturally resolve as the new trainees commence in post. Positively the 18-week standard was met, with 97.9% of patients seen and received treatment within 18 weeks from referral against the 95% national ambition.

Dementia	**Standard**	**2021/22 Performance**	**Variance +/(-)**
Estimated Diagnosis Rate for people with Dementia (March 2022)	66.7%	53.6%	(13.1%)

Dementia

The dementia diagnosis rate for Somerset is 53.6% in March 2022 against the national ambition of 66.7%. Dementia diagnosis delivery in Somerset during 2021/22 has been impacted by the pandemic, due to a reduction in face-to-face contacts, which has particularly affected the previously proposed approach to improve dementia diagnosis rates in Somerset, which was based upon physically visiting care homes and other sites.

The multi-organisational Dementia Operational Oversight Group (DOOG) and associated Dementia Task and Finish Group have been established to look at the entire Dementia pathway. They are working together to design the Somerset Dementia Wellbeing model (SDWM), which is nearing completion, to better support people and their carers in the community, throughout their entire pathways from pre-diagnosis onwards to prevent need for admission wherever possible. There has been workforce expansion within the Memory Assessment Service (MAS) to improve rates of dementia diagnosis in patients.

Community Mental Health Services	**Standard**	**2021/22 Performance**	**Variance +/(-)**
Mindline Calls Received (March 2022)	-	3450	-
Open Mental Health Contacts (March 2022)	-	1948	-

Mindline

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. The service was expanded in April 2020, and in line with the national expectation, offers a 24/7 all age mental health crisis line, with good links into statutory services.

In March 2022, Mindline received 3,450 calls, with approximately 3% 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 CAMHS, and patient stories demonstrate that the service is able to effectively de-escalate patients in crisis. The most common presenting call themes are for emotional support, anxiety, family and relationships.

Open Mental Health

The Community Mental Health Services transformation programme is a collaboration between Somerset FT and a range of VCSE (Voluntary, Community and Social Enterprise) partners, and is operating under 'Open Mental Health'. In March 2022, there were 1,948 contacts across both NHS and VCSE partners. More than 90% of people accessing Open Mental Health wait less than 4 weeks to be seen.

Children and Young People's (CYP) Mental Health

CYP Mental Health	Standard	2021/22 Performance	Variance +/(-)
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months to March 2022)	95%	75.2%	19.8%
The proportion of CYP with ED (urgent cases) that wait one week or less from referral to start of NICE-approved treatment (rolling 12 months to March 2022)	95%	83.9%	11.1%
The number of women accessing specialist community PMH services in the reporting period (YTD to March 2022)	471	558	87

Perinatal Mental Health

In 2021/22 558 people have accessed perinatal mental health services in Somerset, against a plan of 471 (87 people). 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. These services have started developing plans for the Perinatal Mental Health Long Term Plan ambitions which includes offering partner assessments, increasing access into the service and extending how long care can be provided by the specialist service from pre-conception to 24 months after birth.

CYP Eating Disorder Services

On a rolling 12 month basis to March 2022, performance for the Community Eating Disorder Services (CEDs) for routine patients was 75.2%, whilst for urgent patients performance was 83.9%, against the national standards of 95% (using local unvalidated data).

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 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 Performance	Variance +/(-)
Learning Disability registers and annual health checks delivered by GPs (YTD to March 2022)	70%	76.8%	6.8%
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 (Q4 2021/22)	3	8	5
The number of adults aged 18 or 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 NHS England or via a provider collaborative (Q4 2021/22)	5	6	1
The number of children under 18 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 NHS England or via a provider collaborative (Q4 2021/22)	1	0	(1)

Learning Disabilities Annual Health Checks (LD AHCs)

In 2021/22 Somerset achieved the 70% national standard (2,174 health checks) with performance of 76.8% (2,385 health checks – using local unvalidated data). 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, an LD 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

Performance for Q4 2021/22 in Somerset for inpatient children whose bed was commissioned by NHSE or a provider collaborative achieved the local trajectory for the quarter (zero children against a plan of 1). Unfortunately, Somerset has not meet the local plan for adults whose bed was commissioned by an ICB or by NHSEI (ICB: 8 adults against a plan of 3; NHSEI: 6 adults against a plan of 5), this is attributable to COVID impacting on the onward transfer of these patients into appropriate settings. Somerset have consistently low numbers of adult and child inpatients, and compare favourably both regionally and nationally.

Self-Certification by the Accountable Officer

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

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

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
21 June 2022

ACCOUNTABILITY REPORT

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
21 June 2022

5 CORPORATE GOVERNANCE REPORT

5.1 Members Report

The membership of NHS Somerset CCG Governing Body and Leadership Team 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.

The key roles undertaken by the Governing Body Non-Executive leadership (as at 31 March 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

The CCG register of interests, which includes details of company directorships and other significant interests held by senior CCG leaders, is

available on the CCG website at: https://www.somersetccg.nhs.uk/publications/lists-and-registers/.

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

5.2 Statement of Disclosure to Auditors

Each individual who is a member of the CCG 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 the CCG's auditor is unaware that would be relevant for the purposes of their audit report

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it

5.3 Modern Slavery Act

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 31 March 2022 is published on our website at https://www.somersetccg.nhs.uk/publications/modern-day-slavery-and-human-trafficking-statement/.

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.

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.

The 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 CCG 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 CCG Senior Leaders and their roles in the CCG governance structure as at 31 March 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	✓	✓	✓		✓	✓	✓	
Director of Quality and Nursing	Val Janson	✓	✓			✓		✓	
Interim Director of Commissioning	Neil Hales	✓	✓				✓	✓	
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		✓						
Clinical Director, Fit For My Future Clinical Director, STP CEC Vice Chair	Dr Alex Murray		✓						✓
Associate Director, Women's and Children's Health	Dr Kate Staveley		✓			✓	✓		
Clinical Lead: Evidence Based Interventions/Medicines Management	Dr Andrew Tressider		✓						

		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, Cancer	Dr Angela Beattie		Devt Session						
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	✓		✓					

6 STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

The Health and Social Care Act 2012 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 Clinical Commissioning Group.

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

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.

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:

- 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

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.

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

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
21 June 2022

7 GOVERNANCE STATEMENT

7.1 Introduction and Context

NHS Somerset CCG (CCG) is a body corporate established by NHS England on 1 April 2013 under the Health and Social Care Act 2012.

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, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

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

7.2 Scope of Responsibility

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 CCG Accountable Officer Appointment Letter.

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.

7.3 Governance arrangements and effectiveness

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.

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.

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 March 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.

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.

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

The remit of each committee is as follows:

Committee	**Key roles and responsibilities**
Clinical Executive Committee	GP Clinical Lead: Dr Alex Murray (to end of March 2022) 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 is the primary decision making body responsible for delivery of these plans. It is held to account for progress against these plans

Committee	Key roles and responsibilities
	• 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 advice as and when required, at the CCG's expense, and to appoint and secure the attendance of

Committee	Key roles and responsibilities
	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 • To secure the provision of comprehensive and high quality primary medical service in Somerset

Committee	Key roles and responsibilities
	• 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: Neil Hales (to end of March 2022) 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 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)

Committee	Key roles and responsibilities
	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: Val Janson Non-Executive Lead: Wendy Grey (Jayne Chidgey-Clark to December 2021) 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 • 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

Committee	Key roles and responsibilities
	• 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

The CCG's performance of effectiveness and capability is subject to continuous assessment including regular checkpoint assessments with NHS England/NHS Improvement. The regularity during 2021/22 has been affected by the ongoing COVID-19 pandemic.

The CCG met the requirements of the Community and Patient Involvement Indicator in 2020, having scored an overall green star rating. The results for 2021/22 are not yet available.

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.

7.4 UK Corporate Governance Code

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 year ended 31 March 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.

7.5 Discharge of Statutory Functions

In the light of recommendations of the 1983 Harris Review, 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.

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

7.6 The CCG Risk Management Strategy

There is a clear commitment to corporate governance across NHS Somerset CCG and that risk management is applied throughout the organisation.

During 2021/22 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.

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

During 2021/22, following the CCG's designation as an ICS, work has commenced with system partners to develop a risk management framework to support the transition into a Somerset ICS.

7.7 Capacity to Handle Risk

The CCG utilises risk capability and risk capacity to determine capacity to handle risk.

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 2021/22. 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.

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.

7.8 Risk Appetite

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.

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

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

7.9 Risk Assessment

The 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.

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

7.10 Internal Control Framework

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.

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.

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

The CCG Governing Body assesses the organisational compliance and delivery of the strategic objectives against the GBAF.

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 2021/22 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.

During 2021/22, 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.

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 2021/22.

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

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.

7.11 Annual Audit of Conflicts of Interest Management

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

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.

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.

7.12 Data Security

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 no incidents which met the DSP Toolkit reporting threshold during 2021/22.

7.13 Data Quality

The 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 2021/22 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).

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.

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.

7.14 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular, personal identifiable information. The NHS Information Governance Framework is supported by 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.
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.

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.

68% of all staff had completed their information governance training by 31 March 2022. The Data Security and Protection (DSP) Toolkit requires at least 95% of staff to have undertaken training in year.

NHS Somerset CCG submitted a Data Security and Protection (DSP) Toolkit for 2020/21 with a rating designation of ‘exceeds expectations’. Following

the change in target date for establishment of Integrated Care Boards to 1 July 2022, the CCG has retained responsibility for completion of the Data Security and Protection (DSP) Toolkit for 2021/22. Publication for 2021/22 is required by 30 June 2022.

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.

7.15 Business Critical Models

The CCG uses a number of models to support operational management; however, none of these models are business critical.

7.16 Third Party Assurances

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 in 7.25 Delegation of Functions.

7.17 Review of economy, efficiency and effectiveness of the use of resources

The CCG has a Scheme of Delegation which ensures that financial controls are in place across the organisation.

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.

The Audit Committee receives regular reports from Internal and External Audit and Counter Fraud.

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.

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 2021/22 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.

Somerset 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.

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.

The LCFS shares briefings with all staff through the CCG 60 seconds bulletin, which covers key areas of learning from within the sector.

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 2021/22.

In 2021/22 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.

The CCG looks at all opportunities for cost savings through demand management schemes and agree these with system partners.

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.

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, 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 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.

7.18 Delegation of Functions

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.

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.

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.

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 financial year 2021/22 and Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken in this financial year.

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 2021/22.

Type II ISAE 3402 Service Auditor reports, which assess the state of the control environment for the period 1 April 2021 to 31 March 2022, have also been received and reviewed for the following services provided to the CCG:

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.

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.

NHS Business Services Authority provide and maintain the Electronic Staff Record system (ESR system) and the prescriptions payment process on behalf of the CCG.

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.

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.

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 with regard to the service provided to the CCG.

7.19 The Better Care Fund

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.

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.

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)

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.

During 2021/22 the Somerset BCF continued to help drive forward our person-centred integration agenda and the 2021/22 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-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

7.20 Control Issues

In January 2022, a month 9 Governance Statement Report was submitted to NHS England. This return highlighted a number of areas of control where significant performance issues have been experienced during 2021/22. These areas, along with the mitigating actions, are shown in the table below.

Control Issue	Mitigating Actions in Place
Quality and Performance - Access to Service/Capacity	Access performance has continued to be significantly impacted as a result of the Covid-19 pandemic, with patients waiting longer for their diagnostic tests, procedure or first definitive treatment (routine and cancer). In November 2021 performance against the key access standards is as follows: * Diagnostic 6 week performance was 66.9% against the 99% target * RTT 18 week performance was 64.6% against the 92% standard** * 62 Day First Definitive Treatment for Cancer was 75.8% against the 85% standard ** In respect of RTT in November 2021 there were 2,726 patients waiting in excess of 52 weeks, 772 patients waiting in excess of 78 weeks and 145 patients waiting in excess of 104 weeks) During the winter of 21/22 the Omicron strain of Covid-19 and the unprecedented levels of non-covid demand upon the hospitals elective capacity has been significantly compromised. Plans are being developed to secure additional non-NHS capacity in order to support the delivery of elective care for the remainder of the year. The H2 plan required for there to be zero >104 week waits (with the exception of patient choice) and plans are currently being developed to work through this. Whilst performance has remained challenged across a number of Adapt and Adopt Programme areas (particularly overnight in-patients and selected diagnostic modalities (Echo, CT and MRI)) due to emergency pressures and Covid related factors, endoscopy performance has been better than planned. In respect of MRI, as a result of securing additional capacity the 6-week diagnostic backlog has significantly reduced over the summer months and is expected to further reduce throughout the remainder for 21/22 with workforce improvements expected to reduce the Echo backlog. The CCG has controls in place for managing provider performance, including monthly Finance and Performance Committee meetings, Patient Safety and Quality meetings and the System Performance and Activity Group where all local system partners are in attendance. Deep dives on areas of challenge supplement dashboards to enable the identification of areas of under performance or emerging issues for discussion; this includes Regional and National benchmarking alongside the national or agreed improvement standard.
Quality and Performance - Mental Health and Dementia	We have continued to deliver services in spite of the significant workforce challenges presented by COVID and our ongoing expansion and transformation of services in line with the NHS Long Term Plan. In terms of our performance and quality monitoring, we continue to hold weekly multi-agency strategic cell meetings where we collectively consider performance and quality issues, set strategic direction, and review/manage operational challenges. We develop, review and update recovery action plans where delivery falls behind national standard, underpinned by dedicated system-wide steering groups or equivalent services. This includes physical health checks, dementia, CYP access, access to psychological therapies.
Quality and Performance -	A&E 4-hour (to admission, transfer or discharge) performance has been impacted as a result of the Covid-19 pandemic, with testing and IPC protocols reducing the speed of flow in the Emergency Department. There have not only been delays at the front door (seen by an increase

Control Issue	Mitigating Actions in Place
Accident and Emergency	in the volume of ambulance handover delays) but there has also been delays in admitting patients from A&E due to operational bed pressures. Patients are currently staying longer in hospital as a result of increased acuity and challenges with discharge capacity. The impact of the latter is seen in the increase of patients in hospital beds with 'No Right To Reside'. A winter plan incorporating a bed model (which forecasted the potential bed deficits for winter 21/22) and the UEC 10 Point Plan was agreed by Somerset System Partners in the Autumn and factored in mitigations to prevent avoidable admissions to hospital and to facilitate earlier discharge of patients from hospital (intermediate care, rapid response discharge schemes, Care Homes and the IUCS/CAS). Further discharge capacity has been secured over recent weeks to improve the out of hospital flow to support delivery of the 30% reduction in patients with No Right to Reside (by 31/1/22). The A&E Delivery Board and Urgent Care Operational Group has continued to meet throughout 2021/22 to ensure Urgent Care plans continue to be implemented and progressed.
Quality and Performance - RTT/52 week wait	There has been a significant impact on Elective Waiting Times due to the Covid-19 pandemic and in November 2020 18 week performance was 64.6% (Somerset FT 64.9%, YDH 67.1% and Other Providers 66.8%). There has been a significant increase in the number of 52 week waits increasing from 21 in February 2020 (pre-Covid) to 2,726 in November 2021. New long waits RTT reporting was introduced from April 2021: * >78 weeks: April 578 to 772 in November * >104 weeks: April 32 to 145 in November The number of patients waiting in excess of 78 weeks peaked to 1036 in September 2021 and due to the focus on very long waits this has reduced to 772 in November. The longest waits across the Somerset System are within Ophthalmology, T&O, ENT and Colorectal and improvement plans have been developed for these specialities. Actions include the securing of additional internal and external capacity and pathway improvements. However as a consequence of the increase in Covid-19 cases in recent weeks (Omicron) and the unprecedented levels of non-covid emergency demand there has been a significant impact upon the delivery of elective services (and these improvement plans). A weekly System Performance Group was established in 2021/22 to review current system performance and to put in place remedial actions (and monitor the delivery thereafter) as required and the Elective Care Delivery Board is in place to improve service delivery and to deliver transformational change in elective care. See (1) Quality & Performance - Access to Service Capacity
Quality and Performance - Other	Due to the continued impact of the Covid-19 pandemic the CCG will not achieve a range of required access and waiting time performance targets throughout this financial year. National operational priorities over the past year have been focussed on the NHS response to the Covid-19 pandemic, with most recent priority being given to ensuring we make maximum use of our available capacity whilst we remain in a level 4 incident.

7.21 Counter Fraud Arrangements

The 2021/22 Annual Counter Fraud Work Plan was developed to support the CCG 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.

The Counter Fraud work plan for 2021/22 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. On the 1 April 2021 the 12 NHS Functional Standards replaced the NHS Counter Fraud Authority (NHSCFA) Standards for Commissioners, which previously organised counter fraud activity around four key pillars: Strategic Governance; Inform and Involve; Prevent and Deter; and Hold to Account. The 2021/22 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
- any national programme of proactive work by the NHS Counter Fraud Authority

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.

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.

7.22 Head of Internal Audit Opinion

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

The 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

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.

In forming our view we have taken into account that:

- The CCG has delivered a break-even position for the financial year against a balanced financial plan, based on the unaudited accounts. As a result, the CCG's brought forward cumulative financial deficit will remain at £19.581m. Fully triangulated financial plans were developed separately for the H1 and H2 period of 2021/22, with financial settlements being agreed for the two halves of the financial year. These financial settlements were based on funding envelopes for the H2 period of 2021/21 and included the continuation of system top-up and Covid-19 funding arrangements.

- 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.

During the year, Internal Audit carried out its planned audit programme and the table below sets out a summary of the audit reports completed and the level of assurance provided:

Area of Audit: Key Financial Controls **Director:** Alison Henly, Director of Finance, Performance, Contracting and Digital
Design: substantial **Effectiveness**: substantial **Recommendations**: 1 low significance
Summary of report: The purpose of the audit was to provide assurance over the CCG's internal financial controls in order to support effective management of resources. The review focussed on general ledger access controls, control account reconciliations, journal preparation and entry and the accuracy of financial reports. Overall the CCG has sound controls in place to ensure the financial performance and activities can be managed and reported effectively. As a result, we have provided substantial assurance on both the design and operational effectiveness. **A number of areas of good practice were identified:** • We tested a sample of 10 Oracle users and noted that all have the relevant forms completed and their authority levels are set commensurate with their roles • Control account reconciliations completed by the CCG and NHS SBS reconciled with the trial balance to nil • We tested a sample of 10 code combinations from control account reconciliations prepared by SBS for June, Sept and Oct 21 and confirmed that all agree to the trial balance and to the CCG reconciliations • We reviewed the financial information in the Finance reports used in the bi-monthly Governing Body meetings for June, September and October 2021 and confirmed that they were consistent with the general ledger data • There are clear processes in place to clear/resolve older accounts receivable balances and for a sample of debtors, there was clear evidence of compliance with these debt recovery policies • We reviewed the Balance Sheet Update presented in the December 2021 Audit Committee and confirmed that the accounts receivable data used matched the underlying aged debtors report • Creditors were generally paid within a timely manner of the invoice being received by the CCG. In some instances, where invoices were disputed/investigated and this caused a delay in payment, details were documented in Oracle • We tested a sample of two leavers between April and November 2021 and all were found to have the required forms authorised in line with the CCG's procedures. They were found to have had their Oracle access removed in a timely manner

- We tested a sample of three new starters between April and November 2021 all were found to have the required forms authorised in line with the CCG's procedures. They were found to have been correctly added to Oracle user access.

One low priority recommendation was raised regarding the need for enhanced narratives for journal entries to ensure evidence is easier to obtain.

Area of Audit: Conflicts of Interest
Director: Alison Henly, Director of Finance, Performance, Contracting and Digital

Design: moderate **Effectiveness**: moderate **Recommendations**: 3 medium significance.

Summary of report:

The purpose of this audit was to provide assurance that the CCG's controls are in place to ensure conflicts of interest are identified and managed appropriately.

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. We raised three medium rated findings in relation to the declaration of interests, training and new starters. As a result, we have provided moderate assurance over the design effectiveness and moderate assurance over the operational effectiveness.

The following aspects of the CCG's management of conflicts of interest were considered to be good practice:

- The CCG has designed robust policies for declarations of interest and managing conflicts of interest. The policies clearly outline the registers of interest that must be maintained and published, in line with the statutory requirements of the CCG's Constitution.
- We reviewed a sample of two sets of minutes of the Governing Body, Audit Committee, Patient Safety & Quality Assurance Committee, Clinical Executive Committee and Primary Care Commissioning Committee. Conflicts of interest were a standing agenda item at each of these meetings and we confirm that they have been recorded in the meeting minutes with appropriate actions taken.
- The CCG maintains accurate registers, which are reviewed and published on the CCG's website, in line with the National Guidance and Best Practice (published by NHS England in 2019). The registers include:
    - Declarations of Interest for Governing Body Members
    - Declarations of Interest for GP Member Practices
    - Gifts, Hospitality and Sponsorship
    - Procurement decisions/contracts
    - Register of Interest of All Staff (Band 8C and above + GP Clinical Leads)
- The ESR system has been updated to ensure fields recommended by the National Guidance for declaration of gifts and hospitalities (for staff and GPs) are included in the electronic forms that staff need to complete. We can confirm that the relevant sections have been added to the gifts & hospitalities register. The sections added are reviewing Officer, reason and date of declaration.
- On a half-yearly basis, a '60 Second Briefing' email covering conflicts of interest is distributed to all staff. The Brief outlines the recent programme updates, deadlines, and reminders for the declarations of interest, gifts and hospitality and the conflict-of-interest mandatory training. The '60 Second Briefing' emails have been sent in September 2021 and in January 2022. Automated emails from ESR are sent to members of staff three months prior to the expiry date, to complete their training and their Line Managers are also notified.
- A report is produced from ESR monthly by HR to monitor the completion of Conflicts of Interest training. The monthly compliance reports generated by the Human Resources team feed into the quarterly Workforce Reports which are delivered to the Internal Group

Forum and the Leadership Team, who comprise the Executive Directors. The CCG monitors completion of mandatory training as part of their key performance indicators. Where the completion rate of training is below target, these are identified in the Workforce Reports with a corresponding action plan. We have reviewed the Workforce Reports for quarter 1 and 2 and confirm that there was an action in place in one instance where underperformance in relation to Conflicts of Interest training was identified

Opportunities for enhancement

Recommendations have been raised against areas of the assessment as summarised below:

- We have found three instances out of the five sampled where the Declaration of Interest (DoI) forms of new starters had not been signed and dated by Human Resources and the DoI form in one instance was incomplete. Where DoI forms are not completed and signed by an appropriate member of staff, there is a risk of the CCG being unaware of these interests and the individuals could be included in the decisions in which they have an interest. Overall, this could have an impact on the integrity of the decision-making process and as a result bring reputational damage to the organisation. The staff member checking the form should ensure that all sections of the form are completed before sending them to the Executive Assistant. The Executive Assistant should check that all sections of the form are completed before allocating access permissions to new starters.
- We have identified that the CCG's Registers for Governing Body, GP Practices and All Staff indicate that not all staff have updated their declaration of interests or made nil return in the past 12 months. We identified that the 'last updated' section of the GP Practices register had 16 blank entries. If the Registers are not updated in line with the National Guidance, it gives rise to the risk that conflicts of interest may not be identified and managed properly by the CCG and the confidence in the probity of commissioning decisions and the integrity of clinicians involved could be undermined. A reminder email should be sent by the Executive Assistant to all staff and Governing Body Members that have not updated their declarations to ensure that declarations are up to date.
- We have reviewed the Conflicts of Interest Training Compliance Reports and have found that the completion rate across levels 1, 2 and 3 were 80.89% (237/293), 66.67% (38/57) and 60.71% (17/28). Through an inspection of the Workforce Reports, we have identified that the Clinical Leadership, Governing Body and Accountable Officers had the least training completion rates. Where the adequate level of training is not being allocated, there is a potential risk of staff members not being aware of their declaration requirements and this could ultimately lead to non-compliance with the Standards of Business Conduct Policy. If staff members do not complete mandatory training, there is a potential risk of non- compliance with the CCG's Standards of Business Conduct Policy and legislation. An email should be sent out to the Clinical Leadership Team, Accountable Officers and the Governing Body to ensure that all mandatory training is completed with immediate action.

Area of Audit: Primary Care Commissioning
Director: Alison Henly, Director of Finance, Performance, Contracting and Digital

Design: Substantial **Effectiveness:** Moderate **Recommendations:** 1 medium significance

Summary of report:

The purpose of this audit is to provide assurance that;

- The processes undertaken for administering the locum reimbursement scheme and rent reviews are robust
- The processes for appointing to the Additional Roles to ensure the changes to structures are robust and correct payments are made.

Overall, sound controls have been evidenced at the CCG with comprehensive local operating procedures and monitoring arrangements embedded within the dedicated Primary Care team to ensure national regulation and guidance are complied with for SFE claims, Rent Reviews and ARRS applications. However, we noted a number of the Practice properties were overdue for Rent Review, with inconsistent methods for recording rental costs on the Premises Database.
It was acknowledged that the environment for rent review processes has been challenging. It was also recognised that a pause on performing rent reviews for 6 months and the prioritisation of recovery delayed the completion of the rent reviews and development of the wider process. We are therefore providing substantial control over control design and moderate assurance over operating effectiveness in this area.

The following areas of good practice were identified:

Locum Reimbursement Scheme

- The CCG has developed a SFE (Statement of Financial Entitlement) Process Card, outlining steps and processes that the Primary Care team should follow when processing reimbursement claims on GP and Locum's sickness, parental and study leaves. The procedures have been designed in line with the national guidance
- A central database is maintained by the Contract Officer and an individual tab is created for each GP with all payment claims registered to date
- The details of the SFE requirements are emailed to the Practice every time an application is made to ensure processes and requirements are followed
- The Contract Manager identified conflicts between the Primary Medical Care Policy and Guidance Manual (PGM) and the SFE guidance, and the different approaches adopted by the neighbour CCGs, ie whether to pay beyond 26 weeks for parental leave reimbursement. Confirmation has been sought from the NHSE/I officer that SFE (no time limit) should be followed
- There were 13 reimbursement claims made on sickness leaves and 10 claims on parental leaves during 2021. Our sample testing confirmed that sufficient evidence can be traced for each claim, including the application form, medical note, finance calculation, and management's authorisation emails, etc. Payment has been calculated correctly within the maximum allowance limit
- On a monthly basis, SFE transactions are provided by the Primary Care Finance Officer to the Contract Manager and Deputy Director of Contracts for approval.

Rent Review

- A Current Market Rent (CMR) Review Process Card is in place, providing a step by step guide on how CMR Review should be carried out for each type of Practice premises (ie owned, leased, mortgaged, rented). It is in line with the NHS General Medical Services (GMS) Premises Cost Directions 2013
- A CMR master spreadsheet which was inherited from NHSE is maintained by the Primary Care Contracts Officer, who monitors it monthly. All Practices are registered in the spreadsheet with the details of the property and the next CMR due date listed.

Additional Roles Reimbursement Scheme (ARRS)

- A Process Card for ARRS claims has been developed for the Primary Care team to follow when reviewing and approving applications and payment. The processes have been designed in line with the latest national guidance – 'Network Contract Directed Enhanced Service - Contract specification 2021/22 – PCN Requirements and Entitlements'
- The workforce baseline for each PCN has been agreed with the CCG as part of the Network Contract Directed Enhanced Services registration process at the start of the year. A budget is allocated to each PCN based on their weighted population
- ARRS utilisation is monitored on a monthly basis for each PCN and they are encouraged to utilise the budget in full. The underspent amount is open for bidding from other PCNs
- A library of job descriptions has been developed to align with the national specification, to ensure the roles offered meet the eligibility criteria. The CCG uses TeamNet to share the NHSE job resources, and those that have been adapted and approved by the CCG (eg a Care Coordinator with a Cancer focus)
- All claims are made and approved through the NHS Mandated Portal. Roles maximum salaries are capped by the Portal automatically – including NI and Pension. The team also register the claims on a spreadsheet as there have been issues with the Portal. The Primary Care team attend the monthly Portal user group for the South West region, to feedback issues with the portal
- We tested a sample of five ARRS claims made during 2021 and can confirm that they have been reviewed and approved properly in line with the national guidance.

General

- Clear roles and responsibilities have been defined in the Primary Care team with regular management meetings taking place within the team to ensure concerns and issues can be identified and escalated effectively to the Primary Care Operational Group (PCOG) and Primary Care Commissioning Committee (PCCC)
- A Primary Care Update Report is produced monthly and presented to PCOG. The report has been re-designed to include a section of SFE and Rent Review progress update.

Opportunities for enhancement

The following areas have been identified where controls can be strengthened:

Rent Review

We noted 58 (67%) of the 87 premises that are subject for regular Rent Reviews were overdue for the review as of 10 January 2022. We understand that the majority are in the process of being reviewed and the main issues were with the Practices being unresponsive.

Area of Audit: Continuing Healthcare (CHC) – Fast track
Director: Val Janson, Director of Quality and Nursing

Design: Substantial **Effectiveness:** Substantial **Recommendations:** 1 low significance

Summary of report:

The purpose of this audit was to provide assurance over the governance arrangements in place for the process of approval for applications and arrangements in place to support CHC packages of care for fast-track patients.

COVID-19 had a disruptive effect on Fast Track processes at the CCG, with staff being redeployed and key processes put on hold. Following the response to COVID-19, the Fast Track team has undergone significant structural change with appointment of a new team leader and recruitment of two new members of staff and key processes have been resumed.

Issues are managed by the CCG which include implementing procedures to check if payments are correct and correspond to care provided, review dates are monitored and wellbeing of staff is prioritised.

We have reported one low priority finding relating to documentation not always being fully updated on Caretrack. Therefore, we have assessed the systems in place are of substantial design and substantial operational effectiveness.

The following areas of good practice were identified:

- Documented procedures – The CCG has documented procedures, which outline how Fast Track cases should be processed within the team. The latest version was reviewed in September 2021
- Staff Support – In our discussion with CHC Assessors, we identified that:
    - Staff felt as though they had sufficient wellbeing support in their role
    - The daily meetings with district nurses and hospices were helping to improve any potential miscommunications
    - The major challenge highlighted around high workload has been addressed now they have a larger team.
- Performance metrics – The CCG monitors a Fast Track performance dashboard, which analyses data held regarding Fast Track. This includes but is not limited to:
    - number of Fast Track reviews completed
    - number of discounted applications
    - number of unique individuals found eligible later
    - origin of referrals

  These performance metrics enable the CCG to evaluate their position with regards to overdue reviews as well as identify the number of applications completed incorrectly thus helping them focus Fast Track training in the necessary areas.
- Review dates - When a Fast Track review has taken place, the average number of weeks for cases to be reviewed is 11.8 (within tolerance of the CCG) and 19 of 54 reviews (36%) took over 12 weeks to complete. It is important to note that this would include:
    - cases where it is identified that a formal review would be inappropriate to carry out, for example, if patients were in hospital for treatment, or if their condition indicated that were clearly still eligible for Fast Track
    - cases where the first formal review had taken place within eight weeks but a follow-up review (four weeks from the eight-week review) had not.

  The CCG are aware of every patient's review status through use of a weekly case load tracker.
- New oversight mechanisms – As noted above, the CCG has implemented a weekly case load tracker which lists all patients currently on the caseload and monitors their review status. At the monthly performance meeting, each line is discussed to understand the rationale behind any overdue reviews

As at October 2021, 29 of 71 patients outstanding a review (41%) were classified as 'amber' using the traffic light system indicator, meaning a review had not been booked and the scheduled review date was within 42 days. The CCG made us aware that this has been affected by staff availability to undertake reviews as CHC staff have been redeployed to support the mass vaccination programme

- Pathway Tool - In our sample of 15, we found that the Fast Track Pathway tool was completed in line with the CCG's Fast Track process for all cases
- Changes to care plan / payments – In our sample of 15 we found that 14 of 15 had authorisation for all changes to care plans clearly documented in Caretrack. There were nine in our sample where eligibility ceased. We found that for all nine cases, payments were discontinued correctly in line with processes
- Patient preference – In our sample of 15, we found that the patients' first choice on the Fast Track Pathway Tool matched the first placement of care for all cases. The CCG identifies any patients that did not pass away in their preferred location and analyses the root causes behind this in the monthly performance dashboard
- Financial monitoring – The finance team monitors spend and carries out national benchmarking monthly, discussing any trends in monthly meetings with senior management. As at September 2021 (reported in the Month 6 CHC Budget Meeting), Fast Track has a favourable variance of £131k against budget YTD. The CCG does not expect an overspend on budget this year
- Contract management procedures – The CCG has processes in place to manage contracts and monitor performance of care providers relating to Fast Track. Weekly callsare carried out with all providers to discuss every patient's package of care and confirm payments. In August 2021, the CCG identified a large underpayment across June and July 2021 (approximately £12k) due to one of the larger providers returning a Commission Care Report in an untimely manner, resulting in errors being overlooked. Following this, in September 2021 the CCG implemented additional meetings every six weeks for its two larger providers, Butterfields and New Cross, to facilitate communication and prevent similar errors occurring in the future
- Unmet need – Unmet need refers to the number of Fast Track cases that could not be met on the same day as approved. Every day, an email from the End of Life centre provides an overview of the number of unmet need cases and details of any filed referrals. Each month, the number of Fast Track unmet need cases and number of patients that died whilst awaiting their package of care are monitored in the CCG's monthly performance dashboard. Between April and August 2021, there were only four unmet need cases in total with a maximum of two a month and no patients died whilst awaiting their package of care.

Opportunities for enhancement

We did not identify any key findings. However, we have raised one low finding where documentation on Caretrack did not fully reflect all changes that took place for cases reviewed in our sample. There is a risk that if changes are not clearly documented on Caretrack, it may become unclear whether changes to care plans are correct. This could lead to inappropriate care being given to patients and/or incorrect payments being made to providers. The CCG should send a reminder to all staff to promote awareness of the importance and purpose of documenting sufficient notes on Caretrack.

Area of Audit: Data Security and Protection Toolkit (Report currently in draft)
Director: Alison Henly, Director of Finance, Performance, Contracting and Digital

Design: N/A **Effectiveness:** N/A **Recommendations: 7**

Summary of report:

The purpose of this audit is to provide an independent high-level review of the assertions and evidence items in the Data Security and Protection (DSP) Toolkit self-assessment return in February 2022 and to identify how compliance could be improved for the 2021/22 year-end return.

The following areas of good practice were identified:

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 maintains a current record of staff as well as their roles and has implemented the principle of least privilege to minimise the amount of data that individuals have access to (assertion 4.1)
- Regular user reviews, for both standard and administrator level access, are performed and there is an effective log management framework in place that allows the monitoring of user actions for potentially malicious or suspicious activities (assertion 4.2)
- The CCG has a password policy in place that is in line with industry good practice and has implemented additional technical controls to protect brute force attacks and password guessing (assertion 4.5)
- There are procedures in place for identifying the root causes of data security and protection incidents and designing and implementing mitigating controls to either prevent similar incidents from occurring in the future or to be in a position to better manage them if they do occur (assertion 5.1)
- Hardware and software has been surveyed to understand if it is supported and up to date (assertion 8.1)
- Systems that handle sensitive information or key operational services are identified and there are operational controls in place to protect them from the exploitation of known vulnerabilities (assertion 9.3)
- The CCG can name its suppliers, the products and services they deliver and the contract durations (assertion 10.1).

Opportunities for enhancement:

We found that there was insufficient evidence to completely support, at the time of the audit, seven of the 32 mandatory sub-assertions included in our sample. We found that the evidence provided for these sub-assertions does not currently meet the requirements of the DSP Toolkit. The key exceptions relate to the absence of sufficient evidence to support the following:

- A data quality audit has been performed during the current reporting period and there are arrangements in place for reporting on the effectiveness of the CCG's data quality controls on a regular basis (sub-assertion 1.1.7)
- Known vulnerabilities are acted upon based on advice from CareCERT and NHS Digital and lessons are learned from previous incidents and near misses (sub-assertions 6.3.1 and 6.3.2), there are proportionate monitoring solutions in place to detect cyber events on systems and services (sub-assertion 6.3.3) and transactional monitoring techniques are implemented for all new digital services that are attractive to fraud (sub-assertion 6.3.4)
- There is a hard copy record of the emergency contacts and their contact details for use during a data security incident where the CCG's systems may not be available (sub-assertion 7.3.2) and there is a defined requirement and arrangements in place for at least one backup to be held offline to ensure that incidents cannot affect all backups simultaneously (sub-assertion 7.3.6)

Recommendations:

- ***Data quality audit procedures and arrangements (sub-assertion 1.1.7)***

Management should ensure that, in line with the current arrangements and the CCG's data quality policies and procedures, a formally documented data quality audit is performed before the end of the current reporting period as required by the DSP Toolkit.
Arrangements should be put in place for data quality audits to be repeated on at least an annual basis.

- ***Acting upon advice from CareCERT for preventing data security incidents (sub-assertion 6.3.1)***
  Management should review and, where necessary, update the CCG's data security incident response procedures so that they include a requirement for reviewing the root cause of the incidents to determine if they are caused by known security vulnerabilities.
  Arrangements should be in place for becoming aware of and assessing known vulnerabilities in relation to the technology deployed in the CCG's IT estate.
- ***Acknowledgement of high severity cyber alerts within 48 hours (sub-assertion 6.3.2)***
  Management should put arrangements in place for ensuring that all high severity CareCERT alerts are responded to within 48 hours as required by the DSP Toolkit to prevent the vulnerabilities from being exploited and resulting in data security incidents.
- ***Implementation of appropriate technology solutions and processes for detecting cyber security events (sub-assertion 6.3.3)***
  Management should formally document the CCG's current security monitoring control environment controls, including controls in place at both the network and end-point levels. This should follow a risk-based approach, ensuring that the CCG's most critical services and assets are prioritised in the scope of its monitoring solutions.
  Gaps in the CCG's security monitoring control environment should be documented and mitigations should be put in place and there should be a strategy or plan for how the CCG will develop its security monitoring technology and processes over future years.
- ***Transactional monitoring techniques for new digital services (sub assertion 6.3.4)***
  Management should assess which of the CCG's digital services are susceptible to fraud, based on the nature of the service and the amount and type of data that it processes.
  A requirement should be put in place for transaction-level monitoring to be included in the system or service requirements documentation for any new digital services that could be susceptible to fraud.
  Where such systems are identified, transaction-level monitoring should be implemented, regularly performed and formally documented.
- ***Hard copy record of emergency contacts (sub-assertion 7.3.2)***
  Management should develop and maintain a central record of emergency contacts, including members of staff as well as third parties, which should be kept up to date and reviewed on at least an annual basis.
  Key members of staff involved in the CCG's business continuity and IT disaster recovery procedures should maintain hard copies of the record for use where the CCG's systems may not be available.
- ***Maintaining at least one backup outside of the CCG's IT network (sub-assertion 7.3.6)***
  Management should review and, where necessary, update the CCG's backup policies and procedures so that they include the requirement for keeping at least one separate backup offline at any given time, which could be in a cloud service designed for this purpose.
  Arrangements should be put in place for keeping these backup copies up to date and securely stored and they should only be connected to live systems when absolutely necessary.
  Standard good practice for creating resilient data backups is to follow the '3-2-1 rule'; at least 3 copies, on 2 devices and 1 offsite.

Conclusion:

The CCG has been consistently completing the DSP Toolkit self-assessment return throughout the reporting period and we noted that where assertions have been completed, the work done has, to a large extent, been in line with the requirements of the Toolkit.
However, in order to comply with the DSP Toolkit, the CCG is required to meet all mandatory sub-assertions, therefore further work will be required ahead of the year-end submission to address the areas of non-compliance identified as part of this audit.

Management Response:

Data quality audit procedures and arrangements (sub-assertion 1.1.7)

As part of our CCG audit activity a data quality review is planned to be undertaken before the end of June 2022. A data quality audit is part of our annual programme of Information Governance audit work.

Acting upon advice from CareCERT for preventing data security incidents (sub-assertion 6.3.1)

SCW CSU IT services manage the operational response for CCG IT networks and provide regular quarterly reporting of activity to the Information Governance, Records Management and Caldicott Committee. The activity by SCW CSU covers response to CareCERT Threat Notifications, High Severity Alerts and CareCERT Advisories. Relevant CCG colleagues across Digital and Corporate Business teams are actively informed of any potential high impact notifications or alerts at the time they occur. Review of reporting by IGRMCC inform decisions on priorities for addressing any issues relating to vulnerabilities.

Acknowledgement of high severity cyber alerts within 48 hours (sub-assertion 6.3.2)

SCW CSU IT services provide the CCG technical response to high severity cyber alerts. Currently the reporting provided indicates the responses are reviewed and actioned within 14 working days not 48 hours. A check will be made with SCW CSU IT Service to clarify whether the 48 hour acknowledgement of high severity alerts is included as part of the 14 working days.

Implementation of appropriate technology solutions and processes for detecting cyber security events (sub-assertion 6.3.3)

The quarterly Cyber Security reports received by IGRMCC provide details of the controls in place for the CCG IT estate in relation to understanding the vulnerability profile. Microsoft Defender for Endpoint's Exposure and Secure scores are used as metrics for the CCG.

Transactional monitoring techniques for new digital services (sub assertion 6.3.4)

The CCG has established processes for assessing new digital services through its Data Protection Impact Assessment (DPIA) process. We have Information Asset Registers in place which document systems which process personal data. As a commissioning organisation the CCG has a relatively limited range of information assets containing personal data and fewer which are digital services. We will review our DPIA template to ensure assessment of monitoring requirements for any current and future services is captured. Additionally we will review our current digital services to identify current arrangements in place.

Hard copy record of emergency contacts (sub-assertion 7.3.2)

Due to the sensitive nature of the contents of Director on Call emergency contacts card, distribution is limited to a need to know basis (i.e. Director on Call) and marked "Official Sensitive – Hold Securely". The contacts card is kept up to date by the Emergency Planning Officer, with out-of-date details or personal details of staff changes being deleted or amended appropriately. Hard copies of the contacts card, along with other key emergency planning and business continuity policies and plans are held securely in the Incident Coordination Centre cupboard, and in the Major Incident folder, which is held by the Emergency Planning Officer for emergencies in the event of an IT failure. The on-call team are asked to maintain their own hard copy as a contingency for unavailability of electronic copies. There is an agreed process for cascade of business continuity messaging down through the command and control of the Directors, their immediate line reports and then on to individual teams. Teams are responsible for maintaining their own emergency contacts list for their team and maintaining a contingency for contacting if

electronic filing is unavailable. Teams are reminded of the importance of identifying their business critical information, maximum tolerable periods of disruption and having contingencies for accessing priority information as part of the business continuity planning.

Maintaining at least one backup outside of the CCG's IT network (sub-assertion 7.3.6)

CCG IT networks are managed by SCW CSU. SCW CSU data backups are protected and locked/read only which means those backups cannot be deleted, altered, or encrypted etc. These backups are replicated to secondary datacentre and the cloud where the actual workload is not hosted. As such, offline backups are not required. Backups are tested monthly, and assurance is reported to monthly SCW CSU Backup Operations meetings where any exceptions or risk are noted, and plans put in place for improvements. Monthly SCW CSU Backup Operations meeting agenda is available on request.

Area of Audit: Partnership Working – SEND
Director: Neil Hales, Director of Commissioning

Design: Limited **Effectiveness**: Moderate **Recommendations**: 2 High, 1 Medium

Summary of report:

This audit assesses the progress made by the CCG and partners to address the actions required to improve the provision of Special Educations Needs and Disability (SEND), following the Statement of Action and funding in place. This will identify areas of good practice in partnership working, so that learning is incorporated into other joint working arrangements.

The following areas of good practice were identified:

- Despite challenges caused by the Covid pandemic, significant progress has been made since the inception of the SEND Written Statement of Action (WSoA) with regard to implementation of the agreed actions. As of the January 2022 SEND review meeting, nearly 60% of milestones have been reported as delivered. Testing of a sample of nine areas selected for this review, noted that detailed milestones, timescales, risks, expected outcomes and key leads were identified and regularly reported in line with the established governance process.
- There was evidence to demonstrate that governance arrangements for the delivery of WSoA had been reviewed and adjusted to ensure the best possible outcomes at the time. For example, in July 2021, nine improvement priorities (IP) were re-aligned into four new delivery themes to avoid "silo working" and support better planning and management of interrelated activity.
- Each improvement priority had a named lead and dedicated project management support from Somerset County Council and the CCG. External support was also available from the Department for Education (DfE) and NHS programmes.
- Furthermore, the Children's Executive Group had become the SEND Strategic Partnership Board (SPB), with a new Terms of Reference and an extended membership. Comprehensive Terms of Reference (ToR) documents were also in place for the SEND Improvement Board (SIB), which identified the strategic and operational leaders responsible for improvement and set out lines of accountability and the reporting structure.
- In August 2021 the SPB received a joint financial report which set out principles for joint financial reporting between the Council and CCG. The report also outlined a number of next steps to be taken in order to embed these principles. As part of those steps, a series of Show and Tell meetings were held to fully understand the respective budgets for the partner organisations. Ongoing joint financial reporting has since helped to identify opportunities for more joint commissioning and greater efficiency.
- A dedicated SEND Virtual Meeting Room (VMR) platform was established and used as a central database to collate and store evidence of progress with the WSoA actions, minutes of governance meetings and related reports. Our testing confirmed that processes were in place

to assess and report progress against specified targets for success in the WSoA and as more of the tasks were completed, exception-based reporting was introduced.

- Progress reports on work carried out to deliver the WSoA were received from the workstream groups and reported to the SIB and SPB on a monthly basis. In addition, every quarterly SIB meeting was turned into a monitoring meeting with the DfE / NHS, which had a formal report and feedback from the inspectors in relation to further improvements required.
- In addition to the WSoA, in March / April 2021 a local area self-evaluation analysis was conducted to assess the Local Area's (Somerset County Council and Somerset Clinical Commissioning Group) performance against the statutory requirements and duties outlined by the SEND Code of Practice. This analysis has been used to understand the improvement journey and the outstanding areas of focus for the coming months and demonstrates a commitment to continuous improvement for SEND provision. The self-assessment was last updated and at the January SPB meeting.

Key Findings:

- Although the governance, reporting and delivery of actions arising from the WSoA have been established, progress on the overall joint commissioning infrastructure and strategy for Children and Young People is still to be developed.
- Weaknesses in governance meant that partner organisations did not have the ability to raise important issues and ask probing questions. The agenda has been dominated by the WSoA and there was overreliance on a small number of officers from the CCG and SCC to prepare and present papers and provide updates to both Boards.
- There was limited evidence in the recorded minutes, that the SEND performance data was sufficiently understood and queried by all partners and any gaps identified were actioned accordingly. Without adequate and constructive challenge, there is a risk that services may lack adequate and appropriate focus, resulting in poor practices being undetected, missed improvement opportunities and non-compliance with the legislation and SEND Code of Practice, leading to operational, financial and reputational consequences for all partner organisations.
- Processes were in place to assess and report progress against specified actions in the WSoA and data is collected and analysed to demonstrate the impact on improvement areas. However, there was no clear link established between the outcomes of WSoA and wider SEND agenda to ensure that once the WSoA is delivered, the progress can be sustained, evidenced and analysed going forward.

Opportunities for enhancement:

- As part of the ICS structure development plans, the remit of joint commissioning for Children and Young People should be established as part of the programme of work led by the Programme Director – Fit for My Future, in conjunction with partner engagement. This should take into account the recommendations from the IPC report, the need for a strategy, infrastructure and partnership working arrangements across the NHS (community, primary care, acute), Education, Social Care, Voluntary Sector and Public Health.

Management response:

We welcome the recognition of the work that has been undertaken so far as part of the Written Statement of Action in establishing the principles behind joint commissioning and concur that joint commissioning for children with SEND needs to fit within a wider strategic framework in the commissioning of health services for children and young people.

We also acknowledge that in order to do this and to protect the focus on children, young people and their families within a specialist context it is important to ensure that there is dedicated women, children and young people's health leadership identified to retain a holistic approach to meeting their physical and mental health needs and can champion the cohort within competing health care demands.

The ICB and SCC are committed to reviewing the structures, processes and governance arrangements in place to support this moving forward, using the principles outlines in the jointly commissioned Institute of Public Care report which outlined themes of good practice and high performing joint commissioning case studies have been identified. In order to do this, we will:

- Review the identified case studies of best practice in the governance of integrated children's services from elsewhere to inform modelling
- Develop an overarching governance framework for children, young people and their families in which to sit specific focussed work strands including SEND
- Develop a structure for joint commissioning which includes:
- Collaborative arrangements for selected needs
- Lead roles to avoid duplication
- Aligned/pooled budgets associated with a particular population or health issue with needs that span the responsibilities of both organisations
- Co-location of relevant staff
- Hybrid roles for staff who span more than one organisation
- Joint decision-making bodies with clear accountabilities linked to single agency decision making arrangements which consider areas for joint development and can commit to joint investment/ reinvestment through service redesign
- Improve data quality and data collection to enable the system to identify what is important and prioritise through a better understanding of needs, wants and demands and to inform objective and evidence-based planning
- Ensure that at every level within the governance structure, the needs of Somerset's most vulnerable populations, for example Children Looked After are considered, safeguarded and met.
- Establish a system wide children and families risk register to align and share oversight and responsibility for risk and to help identify where there may be potential impact from changes within co-dependent services

- The governance structure should be reviewed to address the weaknesses and inconsistencies identified in this audit including the following:
  1. Frequency
  2. Attendance
  3. Paper distribution list
  4. Papers distribution timeframes
  5. Volume and focus of papers (in conjunction with recommendation 2, the papers should focus on outcome reporting, once those metrics have been agreed, to ensure gaps are identified promptly so timely actions can be agreed to address them).

Management response:
It is acknowledged that the infrastructure to provide the management and reporting of the SEND agenda to meet the requirement of the Written Statement of Action takes up a lot of resource, and could be better utilised through a review and restructure of the current arrangements
Currently, the SEND Improvement Board (SIB) is the key vehicle via which the Written Statement of Action is monitored and assured but sits in isolation from any overarching structure. A review of governance relating to the direction, transformation, commissioning and delivery of a system wide approach to meeting the needs of Children, Young People and Families is being undertaken by the ICB and SCC as the lead accountable bodies for assuring quality and value for money. As part of this, it is has been noted that the SEND

Improvement Board needs to be sited more broadly as services within this joint commissioning remit often extends beyond the SEND population.
To move this forward, discussions are taking place to establish an integrated team across the ICB and SCC who are empowered to take forward joint developments and investment. In doing this we will work jointly with SCC to develop:

- Siting the SEND Improvement Board within a wider Children and Families Partnership Governance Structure of System Senior Executive leaders with Senior Responsible Officer oversight for Children and Families delivery that can embrace SEND through deep dives to ensure an overview whilst directing alignment with other Children and Family strategy work.
- Improve data quality and flow, including qualitative insight and develop our data intelligence and analysis function to monitor progress and identify unwarranted variation to stimulate system solution focussed thinking based on an objective review of the evidence and understanding the barriers to improvement and the support needed
- Review the membership of the SEND Improvement Board and SEND Partnership Board. Each organisation will need to consider its representatives and ensure they have the correct mandate.
- Undertake a demand and capacity review to inform a proper understand of SEND Programme support needs.
- Reconfigure the Programme Management Office Function to reflect a hybrid and co-located support team with dedicated capacity and direct linkage back to the key stakeholder organisations.

- Using the self-evaluation work and any other relevant legal requirements, a comprehensive SEND Local Area Performance Management Framework should be established and monitored including a set of co-produced KPIs / outcome measures needed to deliver successful SEND services.
  These KPIs / metrics should be linked to the WSoA, to continue demonstrating progress against those actions until the programme is completed and / or successfully transitioned into BAU.
- Once the specific measures have been established and reviewed, consideration should be given to commissioning audits of specific areas where gaps in information, data collection, supporting systems, or process weaknesses have been noted to help identify improvements.

Management response:

The audit confirms the level of progress against the Written Statement of Action is appropriate.
This will be especially important as the SEND agenda will migrate from the current intensity of focus and meetings to respond to the Inspectorate findings and meeting the requirements laid out in the WSoA to business as usual. What we work jointly with SCC to:

- Ensure our aspirations move from ambition to implementation by creating a rigorous action plan with key milestones to ensure progress for embedding the infrastructure and enablers to support the development
- Develop a set of co-produced KPIs and outcome measures to demonstrate performance/outcomes for each programme
- Ensure that there is dedicated leadership in place for women, children and young people's health leadership to protect the focus, retain a holistic approach to meeting their physical and mental health needs and champion the cohort within competing health care demands

- Ensure improvements in data and insight analysis to give granularity to highlight good practice to learn from and share and focus on priority areas in need of improvement.

Overall Conclusion:
Whilst significant progress has been made against the WSoA and further work was underway to address the areas for improvement identified, weaknesses in governance meant that partner organisations did not have the ability to raise important issues and ask probing questions, therefore potentially impacting the effectiveness and efficiency of these forums.
The two key recommendations we have raised in this report are very much interlinked. For example, development of the performance framework would help inform the membership of the SEND oversight forum whilst highlighting areas of weaknesses in the SEND processes, which would be easier to address through effective governance.
Management Response:
The recommendation to strengthen joint commissioning for Children and Young People is noted and agreed, though the suggestion this is red RAG rated / High suggests no work has been undertaken in this area further to the IPC report recommendations and extensively developed response to the Written Statement of Action. Somerset does not have a full integrated joint commissioning team for Children and Young People's service which, along with joint Health and Social Care teams covering Children and Mental Health also, is a model that has been adopted elsewhere. Though a Red rated risk would be the same as granted if there was no progress whatsoever and clearly given the progress on the WSoA, and in particularly noting the seniority of officers attending SEND Improvement Board (co-chaired by Somerset County Council and Somerset CCG Chief Executives) this does not seem an appropriate strength recommendation. Developing governance around Childrens services further, including the joint commissioning between Health and Social Care and building in other factors such as Looked After Children (LAC) and Safeguarding will be an aspiration for the Integrated Care System (ICS) to develop from the existing governance processes adopted in the CCG.

Area of Audit: ICS Development – CCG Closedown and ICB Readiness
Director: James Rimmer, Chief Executive

Design: N/A **Effectiveness**: N/A **Recommendations**: Advisory observations only

Summary of report:
This is an advisory piece of work, which aims to support the transition and closedown of the CCG and the establishment of an Integrated Care Board ('ICB').

The purpose of the audit is in two parts:
- to provide assurance over the adequacy of the CCG's transition plans to close down; and
- to provide assurance on the progress being made to establish the Integrated Care Board

The following areas were covered as part of this review:
Overall
- Obtain the overall ICB establishment due diligence plan that supports the transfer of people, property and liabilities. Confirm that this:
  - incorporates all required areas
  - with assigned responsibilities and resource
  - includes deadlines that ensure the completion by the national due dates; and
  - that it has been signed off by the CCG executives, Audit Committee and by internal or external audit, as deemed appropriate.
- Confirm that the risks of transition have been identified as part of the planning process.

CCG Closure

- Using the risk assessment, identify the key areas to test
- Provide representation on transition working groups (in order to keep up to date on progress and provide timely advisory support)
- Detail testing (on a risk basis) on the content of the checklist, in particular the elements under;
    - Core
    - Human Resources
    - Financial Governance, accounts and audit, contracts
    - IT Assets, IT and Records checklist
- Assess the adequacy of the CCG transition plans with regards to the closure of the CCG and provide assurance in January 2022 on progress.

ICB establishment

- Assess progress in the establishment of the Integrated Care Board by review of the relevant areas in the checklist, requirements of the Readiness to Operate Statement (ROS) and draft organisational structures. This will include meetings with key leads.

Key Findings:

OVERALL PROGRAMME CO-ORDINATION

The processes for managing the programme to close down the CCG and establish the ICB follow all aspects of best practice and are being co-ordinated by PMO support.

Overall, we have seen that there has been good programme co-ordination, support processes and reporting output. It has been acknowledged that there are concerns around the staff 'fatigue' with maintaining the intensity on the programme. The current status on the work programme indicates that actions will be completed by 30th June 2022 in order to transfer the CCG functions to the ICB.

There are aspects of the RAG rating of the due diligence checklist that may be overly 'harsh', when compared to other CCG's who are at a similar stage with progress.

FINANCE PROJECT FOR CLOSE-DOWN AND SET UP OF LEDGERS

From attendance at the Finance Project Board meetings and review of the documentation, the CCG is confident that they are on target on the financial ledger. Some points have been highlighted for consideration, including;

- The impact of IFRS 16 Leases, which comes into effect from 1 April 2022, will require a change in accounting policy for the CCG for the three-month period. It is understood that a module within the ledger will be introduced by NHS SBS to support the calculations required. Somerset CCG has registered for the NHS E/I lease training. In addition, consideration on any other changes to accounting policies that may impact on the ICB opening balances should be made, so that relevant information is included as part of the handover
- Business planning for the ICB should pick up on the delivery of cost improvement programmes that were commenced in the CCG. Details should be maintained so that it is clear how work is being transferred and whether working groups are still required and that any benefits achieved are embedded. This is part of the 'business as usual arrangements' that are in place
- To review the financial policies and procedures and compare with HFMA guidance – 'Integrated care boards: finance policies and procedures – Key considerations'

PROGRESS WITH IDENTIFICATION OF POLICIES

Work is underway in a managed way to identify and review policies. No obvious significant gaps were identified.

COMPLETENESS OF CONTRACT LISTS

A few areas of high expenditure were identified from supplier listings where there did not appear to be a contract listed for investigation and some points to consider for incorporation into the contract register. Otherwise, the contract register did appear to be in a good position, with known work required to complete it.

ASSESSMENT OF STATUTORY DUTIES

Somerset CCG is at an early stage of mapping statutory functions to the ICB. However, it was felt that this would be completed by 30th June, as indicated in the due diligence checklist and Readiness to Operate Statement.

RECORDS MANAGEMENT AND RETENTION

The CCG is at an early stage of this work and plans are being established. It is understood that the project is likely to be running for a few months. The CCG does need to be assured of compliance with national record management guidance.

Ultimately, when functions are delegated to other organisations within the ICS, the relevant documents will be transferred. So, the decision on the electronic structure of records will need to consider this requirement as well.

IT ASSETS & SECURITY

The work required in respect of IT is known. Tasks are yet to be completed and action plans to ensure that the resource is allocated are being developed.

The CCG need to ensure that IT changes as a result of the new organisation name and URL are considered for all standalone systems, for example, Caretrack,

WORKFORCE, STAFF TRANSFER & PAYROLL

From meetings attended, it is evident that progress is being made in the following areas:

- Executive and staff consultations
- Communication and Engagement with staff

Internal audit work on the staff transfer and payroll work is recommended to be undertaken early in Quarter 1 2022/23.

GOVERNANCE ARRANGEMENTS

Internal Audit work confirmed that progress is being made on the governance arrangements.

IMPACT ON THE CHANGE IN THE TIMETABLE FOR CCG CLOSEDOWN

The impact of the changes to the timetable, currently set at 30th June 2022 for CCG closedown, have been identified and the level of detail and assessment has been deemed to be best practice. The Audit Committee & Executive Directors are to confirm the inclusion of audit work on workforce processes and ICB governance arrangements in the Internal Audit Plan for Quarter 1 2022/23.

Overall Conclusion:

Based on the work undertaken during November to 14th March 2022, it is evident that the programme in place to co-ordinate the close down arrangements of the CCG and establishment of the ICB, is robust. NHS Somerset CCG has evidence of good practice, good programme oversight and foresight in its planning and approach taken to start to establish its ICB arrangements.

Overall, the CCG has rated the B1: Change and Transition (CCG to ICB) workstream to be 'on plan'. There are risks, but mitigations are in place and there are tasks that are not complete but plans are in place to ensure that these are done.

Limited work has been undertaken by BDO on the ICB establishment aspect, partly due to the stage of the work, at this point in time.

Management Response:

The report is considered a fair reflection of where the CCG are in terms of the progress made on the closedown of the CCG, and where applicable for this report, the establishment of the ICB. At the time of BDO reviewing and writing this report the Due Diligence checklist v3 was reviewed and it is acknowledged that we may have been harsh in our assessment compared to other

CCGs/systems. We have now submitted v4 of the Due Diligence checklist to NHSEI on 31 March 2022, which is an improved position.
We have taken the recommendations within this report and have indicated in a separate appendix the actions we will take regarding these recommendations.

During the year the Internal Audit did not issue any audit reports with a conclusion of no assurance.

7.23 Summary Review of the effectiveness of Governance, Risk Management and Internal Control

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed. I have been advised on the 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.

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.

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.

As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described in pages 139-145.

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

7.24 Conclusion

I can confirm that no significant internal control issues have been identified.

James Rimmer
Chief Executive
NHS Somerset CCG
21 June 2022

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 31 March 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 2021/22 Attendance Record									**Present = ✓ Apologies = x**	
(V) = voting Member (NV) = non-voting Member	27.05.21	10.06.21	22.07.21	23.09.21	25.11.21	16.12.21 (Private)	27.1.22	17.2.22 (Private)	22.3.22 (Private)	31.3.22
Dr Ed Ford (V) Chair	✓	**x**	✓	✓	**x**	✓	✓	✓	✓	✓
James Rimmer (V) Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	**x**	✓	✓	**x**				
Sandra Corry (V) Director of Quality and Nursing	**x**	**x**								
Lou Evans (V) Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	**x**	**x**	✓	**x**	✓	✓	**x**	**x**	✓
Judith Goodchild (NV) Chair, Healthwatch	✓	x	✓	✓	✓		✓			✓
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓	✓	**x**	✓
Wendy Grey (V) Non-Executive Director, Member Practice Representative	✓	✓	✓	✓	✓	**x**	✓	✓	**x**	✓
Neil Hales (V) Interim Director of Commissioning	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

NHS Somerset CCG Governing Body Meetings 2021/22 **Attendance Record**									**Present = ✓** **Apologies = x**	
(V) = voting Member (NV) = non-voting Member	27.05.21	10.06.21	22.07.21	23.09.21	25.11.21	16.12.21 (Private)	27.1.22	17.2.22 (Private)	22.3.22 (Private)	31.3.22
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	✓	✓	✓	✓	✓	✓	✓	**X**	✓
Maria Heard (NV) SRO COVID-19 Programme Director Fit for my Future	✓	✓	**X**	✓	✓	✓	✓	✓	**X**	✓
Alison Henly (V) Director of Finance, Performance , Contracting and Digital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Val Janson Acting Director of Quality and Nursing	✓	**X**[1]	✓	✓	✓	✓	✓	✓	✓	✓
Trudi Mann (V) Non-Executive Director, Member Practice Representative	✓	✓	✓	✓	**X**	✓	✓	✓	✓	✓
Dr Alex Murray (NV) Lead Clinician for Medical/Primary Care input to COVID-19 Clinical Lead, Fit For My Future	**X**	✓	✓	✓	✓	✓	**X**	✓	✓	**X**
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	**X**	✓	✓	✓	✓	**X**	✓	✓	✓
Dr Helen Thomas (NV) Non-Executive Director, Member Practice Rep				✓	✓	✓	**X**	**X**	✓	✓
Sandra Wilson (NV) PPG Lay Observer	✓	✓	✓	✓	✓		✓			✓
Paul von der Heyde ICB Chair Designate								✓	✓	✓
Jonathan Higman ICB Chief Executive Designate								✓	✓	✓

X[1] Represented by Kathy French

NHS Somerset Clinical Executive Committee (CEC) Meeting Attendance: 1 April 2021 to 31 March 2022												Present = ✓ Apologies = X		
	Surname	**Position**	**03-Feb 2021**	**03-Mar 2021**	**05-May 2021**	**02-Jun 2021**	**07-Jul 2021**	**01-Sep 2021**	**06-Oct 2021**	**03-Nov 2021**	**01-Dec 2021**	**02-Feb 2022**	**02-Mar 2022**	**06-Apr 2022**
Peter	Bagshaw	Associate Clinical Director: Mental Health and Learning Disabilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Will	Chandler	Associate Clinical Director: Planned Care	✓	✓	✓	✓	X	✓	✓	✓	X	X	X	✓
Iain	Chorlton	Associate Clinical Director: Urgent and Emergency Care				X	✓	✓	✓	X	✓	✓	✓	✓
Sandra	Corry	Director of Quality, Safety and Governance	X	X	X									
Ed	Ford	CCG Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Kathy	French	Acting Director of Quality and Nursing											✓	✓
Neil	Hales	Director of Commissioning	✓	✓	✓	✓	✓	X	✓	✓	X	✓	✓	
Justin	Harrington	Associate Clinical Director: Digital Strategy	X	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	X

	Surname	Position	03-Feb 2021	03-Mar 2021	05-May 2021	02-Jun 2021	07-Jul 2021	01-Sep 2021	06-Oct 2021	03-Nov 2021	01-Dec 2021	02-Feb 2022	02-Mar 2022	06-Apr 2022
Maria	Heard	Programme Director: Fit For My Future	✓	✓	X	X	✓	X	✓	✓	X	✓	✓	X
Alison	Henly	Director of Finance, Performance, Contracting and Digital	X	✓	✓	X	✓	✓	✓	X	✓	✓	✓	✓
Jeremy	Imms	Interim Associate Clinical Director: Primary Care			✓	✓	✓	✓	✓	✓	✓	X	✓	X
Val	Janson	Acting Director of Quality and Nursing	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	
Emma	Keane	Associate Clinical Director: Primary Care	X	X	X	X	X	X	X	X	X	x		
Tom	MacConnell	Associate Clinical Director: Integrated Care	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Alex	Murray	Clinical Director: FFMF; and, Clinical Director: STP	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	
James	Rimmer	Chief Executive and CEC Chair	✓	X	✓	X	✓	✓	✓	✓	✓	✓	X	✓
Alison	Rowswell	Acting Director of Commissioning												✓

	Surname	Position	03-Feb 2021	03-Mar 2021	05-May 2021	02-Jun 2021	07-Jul 2021	01-Sep 2021	06-Oct 2021	03-Nov 2021	01-Dec 2021	02-Feb 2022	02-Mar 2022	06-Apr 2022
Kate	Staveley	Associate Clinical Director: Women's and Children's Services	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen	Thomas	Associate Clinical Director: Same Day and Emergency Care	✓	✓	X									
Attendees (Not Members)														
Orla	Dunn	Consultant in Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Shaun	Green	Deputy Director of Clinical Effectiveness and Medicines Management	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	X
Tim	Horlock	GP and LMC Representative	✓	✓	✓	X	X	X	✓	✓	✓	✓	✓	✓
Nick	Kennedy	Secondary Care Clinical Lead: FFMF								✓	✓	✓	✓	X
Andrew	Tresidder	Clinical Lead: EBI/Medicines Optimisation	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

NHS Somerset CCG Audit Committee Meetings 2021/22 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	22.4.21	9.6.21	8.9.21	12.10.21	16.12.21	3.3.22
Lou Evans Audit Committee Chair and Non-Executive Director, Lay Member (Governance and Audit)	M	✓	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark Audit Committee Vice Chair, Non-Executive Director, Registered Nurse	M	✓	✓	✓	✓		
Alison Henly Director of Finance, Performance, Contracting and Digital	A	✓	✓	✓	✓	✓	✓
Dr Helen Thomas Non-Executive Director	M				x	✓	✓

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

Name	Member (M)/ In Attendance (A)	April 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Jayne Chidgey-Clark (Chair) Registered Nurse – Governing Body	M		✓	✓	✓	✓	✓		✓				
Basil Fozard, Non-Executive Director, Secondary Care Specialist Doctor	M		✓	x	x	✓	✓		✓	x	✓	✓	x
Wendy Grey, Non-Executive Director	M				✓	✓	✓		✓	✓	✓	✓	✓
Val Janson, Director of Quality and Nursing	M		✓	✓	✓	x	✓		✓	x	✓	✓	✓
Shaun Green, Associate Director, Head of Medicines Management and Clinical Effectiveness	M								✓	✓	x	x	✓
Dr Alex Murray, Clinical Director	M			✓	x	x	x		x	x	x	x	x
Kathy French, Interim Deputy Director of Quality and Nursing	M		✓	✓	✓	✓	✓		✓	✓	✓	✓	x
Neil Hales, Director of Commissioning	M		✓	x	✓	✓	✓		✓	x	x	✓	✓
Emma Savage, Deputy Director of Quality and Nursing	M					✓	x		x	✓	✓	✓	✓

NHS Somerset CCG Remuneration Committee Meetings 2021/22 Attendance Record	✓ = Present X = Apologies Given			
(V) = voting Member (NV) = non-voting Member	21.10.21	30.11.21	16.12.21	17.3.22
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	x		
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	✓	✓	✓	✓
Marianne King (NV) Associate Director of Organisational Development and Workforce	✓	x	✓	✓
Grahame Paine (V) from 1 October 2019 Non-Executive Director (Finance and Performance)	✓	✓	✓	✓
James Rimmer (NV) Chief Executive	✓	✓		✓

Notes:

Dr Ed Ford, Somerset Chair was invited to and attended the Remuneration Committee Meetings held on 30 November 2021, 16 December 2021 and 17 March 2022 (NV capacity)

Sophie Islington, HR, attended the Remuneration Committee meeting held on 30 November 2021 on behalf of Marianne King (Presenter, NV capacity)

Madeleine McPeak, Head of HR, NHS South, Central and West attended the Remuneration Committee meetings held on 16 December 2021 on 17 March 2022 (Presenter, NV capacity)

Jonathan Higman, as ICB Chief Executive Designate, attended (in part) the Remuneration Committee Meeting held on 17 March 2022 (Observer, NV capacity)

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NHS Somerset CCG Primary Care Commissioning Committee 2021/22 Attendance Record	✓ = Present X = Apologies

(M) Committee member (A) In attendance (P) Presenting (O) Observer	Committee Role (eg. Executive, Lay, GP, etc)	4.3.21	9.6.21	29.9.21	8.12.21	10.3.22
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	✓	✓	x	✓	✓
Dr Chris Campbell (M)	External GP	✓	x	✓	x	✓
Kathy French (A, for V Janson)	Interim Deputy Director of Quality and Nursing			✓	✓	
Judith Goodchild (M)	Chair of the Board, Healthwatch	✓	✓	✓	x	✓
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
Val Janson (M)	Director of Quality and Nursing	✓	x	x	✓	✓
Dr Emma Keane (M)	Associate Clinical Director of Primary Care	x	x	x	x	x
Laila Pennington (M)	Head of Primary Care, NHS E	x	x	x	x	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	x	✓	✓	✓	✓
Lou Evans (A)	Non-Executive Director			✓		
Luke Best (P)	Primary Care Contracts Officer				✓	
Ben Casson (O)	Primary Care Commissioning & Clinical Strategy Accountant	✓				
Sam Checkovage (AP)	Assistant Commissioning Manager		✓			
Ed Garvey (P)	Primary Care Commissioning Officer				✓	
Jessica Harrris (O)	Primary Care Devt Manager					✓

(M) Committee member (A) In attendance (P) Presenting (O) Observer	Committee Role (eg. Executive, Lay, GP, etc)	4.3.21	9.6.21	29.9.21	8.12.21	10.3.22
Tracy Green (O)	Primary Care Project Management				✓	x
Wendy Grey (O)	Non- Executive Director, Somerset CCG			✓		
Neil Hales (O)	Director of Commissioning	✓	✓	✓	✓	✓
Dr Alex Murray (O)	Non- Executive Director, Somerset CCG			✓	x	x
Annie Paddock (O)	Primary Care Transformation & Sustainability Manager			✓		
Grahame Paine (O)	Non- Executive Director, Somerset CCG			✓		
Dr Harvey Sampson (O)	Strategic Development Director, Symphony Healthcare Services Ltd		✓			
Dr Andrea Trill (O)	Medical Director – Neighbourhood Integration, Somerset Foundation Trust		✓			
Paul Von De Heyde (O)	Somerset Integrated Care System (ICS) Chair and Chair Designate of the Integrated Care Board (ICB)				✓	✓
Kerry White (O)	Managing Director, Symphony Healthcare Services Ltd		✓			
Christine Young (O)	Primary Care Contracts Officer	✓				

NHS Somerset CCG Finance and Performance Committee Meetings 2021/22 Attendance Record	✓ = Present X = Apologies

Name	20 April 2021	25 May 2021	22 June 2021	20 July 2021	24 Aug 2021	21 Sept 2021	19 Oct 2021	12 Nov 2021 Extraordinary Meeting	23 Nov 2021	18 Jan 2022	1 Mar 2022	22 Mar 2022
Voting												
Sandra Corry	X	X										
Neil Hales	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alison Henly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Trudi Mann	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Grahame Paine	✓	✓	X (1)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Val Janson	✓	✓	✓	X (2)	X	✓	✓	✓	✓	✓	✓	✓
Non-Voting												
Carmen Chadwick-Cox	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Lou Evans	✓	✓	X	X	X	✓	✓	X	X	X	X	✓
Ed Ford	X	X	X	X	X	X	X	X	X	X	X	X
Jacqui Damant	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon Edwards	✓	✓	✓	✓	✓	X	✓	✓	X	✓	✓	X
Michelle Skillings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tanya Whittle	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓

1. Trudi Mann chaired the F&P Committee
2. Kathy French attended on behalf of Val Janson

The December 2021 meeting was postponed; the meeting scheduled for 22 February was re-arranged to take place on 1 March 2022.
An Extraordinary Meeting was held on 12 November 2021 as the GB had delegated approval of the H2 plan to the F&P Committee

REMUNERATION AND STAFF REPORT

8 REMUNERATION REPORT

This section of the report contains details of remuneration and pension entitlements for senior managers of the CCG in line with Chapter 6 of Part 15 of the Companies Act 2006.

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 CCG has used is to include members of the decision-making groups within the CCG, which the CCG has defined as the Governing Body, excluding those members with no voting rights. Senior managers (excluding Lay Members) are generally employed on permanent contracts with a six month period of notice.

The CCG's Remuneration Committee is 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.

The table below details the remuneration levels for all senior managers in the CCG.

8.1 Senior manager remuneration (including salary and pension entitlements) – (subject to audit)

		Total 2021/22						Total 2020/21					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Performance Pay and Bonuses	Long Term Performance 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	160-165	0	0	0	117.5-120	280-285	155-160	0	0	0	67.5-70	225-230
Neil Hales	Interim Director of Commissioning (from 04/01/2021)	130-135	0	0	0	0	130-135	30-35	0	0	0	0	30-35
Alison Henly	Director of Finance, Performance, Contracting and Digital	110-115	7,500	0	0	40-42.5	160-165	110-115	7,500	0	0	15-17.5	135-140
Maria Heard	Programme Director of 'Fit for My Future'	110-115	0	0	0	30-32.5	140-145	105-110	0	0	0	27.5-30	135-140
Sandra Corry	Director of Quality and Nursing (left 30/06/2021)	20-25	0	0	0	0	20-25	90-95	0	0	0	0	90-95
Valerie Janson	Acting Director of Quality and Nursing (from 16/11/2020)	105-110	0	0	0	160-162.5	265-270	35-40	0	0	0	20-22.5	55-60
Edward Ford	Chair	90-95	0	0	0	0	90-95	90-95	0	0	0	0	90-95
Alex Murray	Clinical Director (from 01/04/2021)	155-160	0	0	0	37.5-40	195-200	0	0	0	0	0	0
Lou Evans	Vice-Chair and Non-Executive Director Governance and Audit	25-30	0	0	0	0	25-30	30-35	0	0	0	0	30-35

		Total 2021/22						Total 2020/21					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Performance Pay and Bonuses	Long Term Performance 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
David Heath	Non-Executive Director, Patient and Public Engagement	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Basil Fozard	Non-Executive Director, Secondary Care Doctor	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Jayne Chidgey-Clark	Non-Executive Director and Registered Nurse (left 01/12/2021)	10-15	0	0	0	0	10-15	15-20	0	0	0	0	15-20
Wendy Grey	Non-Executive Director, Member Practice Representative	25-30	0	0	0	0	25-30	25-30	0	0	0	0	25-30
Trudi Mann	Non-Executive Director, Member Practice Representative	25-30	0	0	0	0	25-30	25-30	0	0	0	0	25-30
Grahame Paine	Non-Executive Director, Finance and Performance	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Helen Thomas	Non-Executive Director, Audit Committee (from 01/08/2021)	5-10	0	0	0	0	5-10	0	0	0	0	0	0

Officer Holder Changes:

James Rimmer was appointed to the additional post of Senior Responsible Officer for the Somerset Integrated Care System from October 2020. This resulted in an increase in salary during 2020/21.

Neil Hales was appointed as Interim Director of Commissioning on 04 January 2021. This appointment is an off-payroll engagement paid via a recruitment agency and therefore incurs no pension related benefits.
Valerie Janson was appointed as Acting Director of Quality and Nursing on 16 November 2020.
Alex Murray was appointed as Clinical Director from 01 April 2021.

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 in 2021/22.

The next table details the pension entitlements for each of the senior managers who received pensionable remuneration through the NHS pension scheme.

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.

8.2 Pension benefits as at 31 March 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 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash equivalent transfer value at 1 April 2021	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 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	5-7.5	10-12.5	75-80	170-175	1,399	128	1,564	0
Alison Henly	Director of Finance, Performance, Contracting and Digital	2.5-5	0-2.5	45-50	95-100	799	41	860	0
Maria Heard	Programme Director of Fit for My Future	0-2.5	0	15-20	0-5	183	14	213	0
Sandra Corry	Director of Quality and Nursing	0-2.5	0-2.5	40-45	125-130	0	0	0	0
Valerie Janson	Acting Director of Quality and Nursing (from 16/11/2020)	7.5-10	17.5-20	35-40	90-95	624	171	812	0
Alex Murray	Clinical Director	2.5-5	0	15-20	10-15	206	21	251	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.

8.3 Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

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

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

8.4 Real Increase in CETV

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

8.5 Compensation on early retirement of for loss of office (subject to audit)

NHS England has set restrictions on the payment of any compensation within the CCG. There have been no compensation terms agreed by NHS England.

8.6 Payments to past directors (subject to audit)

The CCG has made no payments to past directors during 2021/22.

8.7 Fair Pay Disclosure (subject to audit)

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) %
Change in salary and allowances in respect of the highest paid director	5.1%
Change in performance pay and bonuses in respect of the highest paid director	0%
Average change in salary and allowances in respect of all employees (excluding the highest paid director)	3.4%
Average change in performance pay and bonuses in respect of all employees (excluding the highest paid director)	0%

The highest paid Director was appointed to the additional post of Senior Responsible Officer for the Somerset Integrated Care System from October 2020, resulting in an increase in salary part way through 2020/21. The percentage increase in remuneration in 2021/22 reflects the full year effect of this salary increase.

8.8 Pay ratio information (subject to audit)

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.

As at 31 March 2022, remuneration ranged from £8,440 to £180,400 (2020/21: £7,626 to £157,000) 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. Values shown for 2020/21 have been restated due to a revision of the calculation methodology.

The banded remuneration of the highest paid director / member in NHS Somerset CCG in the financial year 2021/22 was £160,000 to £165,000 (2020/21: £155,000 to £160,000). Values shown for 2020/21 have been restated due to a revision of the calculation methodology.

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	2021/22			2020/21		
	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)	£27,780	£39,027	£47,126	£27,416	£37,890	£45,753
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£27,780	£39,027	£47,126	£27,416	£37,890	£45,753
Ratio of remuneration of all staff to the mid-point of the banded remuneration of the highest paid director	5.85 : 1	4.16 : 1	3.45 : 1	5.74 : 1	4.16 : 1	3.44 : 1
Ratio of the salary component of remuneration of all staff to the mid-point of the banded salary of the highest paid director	5.85 : 1	4.16 : 1	3.45 : 1	5.74 : 1	4.16 : 1	3.44 : 1

Staff remuneration increases since 2020/21 reflect the 3% pay increase awarded to NHS Agenda for Change staff for 2021/22.

In 2021/22, one (2020/21, zero) employee received remuneration in excess of the highest-paid director/member.

The remuneration report and other disclosures referenced as 'subject to audit' in the Accountability Report have been 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.

8.9 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 31 March 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 31 March 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

8.10 Remuneration of the Accountable Officer and Directors

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 is currently vacant.

The membership and attendance at the Somerset CCG Remuneration Committee during 2021/22 is set out below:

Somerset CCG Remuneration Committee Meetings 2021/22 Attendance Record	✓ = Present X = Apologies Given			
(V) = voting Member (NV) = non-voting Member	21 October 2021	30 November 2021	16 December 2021	17 March 2022
Lou Evans (V) Remuneration Committee Chair, CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse (left 01/12/2021)	✓	X		
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.	✓	✓	✓	✓
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	✓	✓	✓
Marianne King (NV) Associate Director of Organisational Development and Workforce	✓	X	✓	✓
James Rimmer (NV) Chief Executive	✓	✓	X	✓

Notes:

Dr Ed Ford, Somerset Chair was invited to and attended the Remuneration Committee Meetings held on 30 November 2021, 16 December 2021 and 17 March 2022 (NV capacity)

Sophie Islington, HR, attended the Remuneration Committee meeting held on 30 November 2021 on behalf of Marianne King (Presenter, NV capacity)

Madeleine McPeak, Head of HR, NHS South, Central and West attended the Remuneration Committee meetings held on 16 December 2021 on 17 March 2022 (Presenter, NV capacity)

Jonathan Higman, as ICB Chief Executive Designate, attended (in part) the Remuneration Committee Meeting held on 17 March 2022 (Observer, NV capacity)

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.

8.12 Policy on Remuneration of Senior Managers

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's current financial position.

Agenda for Change guidelines are taken into consideration when assessing whether to award an inflationary increase to Directors.

8.13 Remuneration of Very Senior Managers (VSMs)

The CCG has a senior manager in post with a salary that exceeds £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.

8.14 Policy on Contracts

All Senior Managers are on permanent contracts with a six month notice period in place.

9 STAFF REPORT

9.1 Number of senior managers

The number of senior managers is set out below in paragraph 9.4.

9.2 Staff numbers and costs (subject to audit)

The Somerset CCG's total staff costs for the year ended 31 March 2022 are summarised in the following table. These figures are to ensure consistency with information within the financial statements:

	Total		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
	N4G	N4H	N4I
Salaries and wages	10,862	1,148	12,010
Social security costs	1,188	23	1,211
Employer contributions to the NHS Pension Scheme	2,149	26	2,175
Other pension costs	3	-	3
Apprenticeship levy	42	-	42
Other post-employment benefits	-	-	
Other employment benefits	-	-	
Termination benefits	-	-	
Gross Employee Benefits Expenditure	**14,244**	**1,197**	**15,441**
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure incl. capitalised costs	**14,244**	**1,197**	**15,441**
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excl. capitalised costs	**14,244**	**1,197**	**15,441**

9.3 Average Number of Persons Employed (subject to audit)

The average number of CCG staff employed by staff grouping is as follows:

Average number of people employed				
	2021/22			2020/21
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	6	0	6	6
Administration and estates	182	10	192	176
Healthcare assistants and other support staff	0	0	0	0
Nursing, midwifery and health visiting staff	58	0	58	58
Scientific, therapeutic and technical staff	0	0	0	0
Social Care Staff	1	0	1	2
Total	**247**	**10**	**257**	**243**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**-**	-	-	-

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.

9.4 Staff composition

The breakdown of the gender profile for the CCG as at the end of March 2022 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	50%	50%	14
Membership Body Clinical Executive Committee Voting Members	62%	38%	13
Very Senior Managers	33%	67%	6
All substantive CCG Staff	20%	80%	310

9.5 Sickness absence data and ill health retirements

The absence FTE % for NHS Somerset CCG during 2021/22 was 2.80%.

The CCG has a clear and robust Management of Sickness Absence Policy.

Sickness absence data for Somerset CCG is available via the following link:
NHS Digital - nhs-sickness-absence-rates

No ill health retirements were supported through 2021/22.

9.6 Staff Turnover

Staff turnover for NHS Somerset CCG during 2021/22 was 15.23%.

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

This data series is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

9.7 Staff engagement percentages

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**

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.

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 has improved from 7.25 in 2020 to 7.4 in 2021.

Somerset CCG has also continued to develop a High Performing Organisation Programme of work and this has 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.

9.8 Staff Policies

The CCG has applied the following new or updated staff policies in 2021/22:

The Capability Policy
The Disciplinary Policy

The Employment Break Policy
The Fixed Term Contracts Policy
The Job Matching and Evaluation Policy
The Lone Working Policy
The Organisational Change Policy
The Redundancy Policy
The Special Leave policy

9.9 Staff Diversity and Inclusion Policy, initiatives and longer term ambitions

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.

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.

9.10 Trade Union Facility Time

The trade union (facility time publication requirements) regulations 2017 came into force on 1 April 2017.

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
Somerset CCG
1 April 2021 to 31 March 2022

Employees in our organisation
50 to 1,500 employees

Trade union representatives and full-time equivalents
Trade union representatives: 2
FTE trade union representatives: 1.80

Percentage of working hours spent on facility time
0% of working hours: 0 representatives
1 to 50% of working hours: 2 representatives
51 to 99% of working hours: 0 representatives
100% of working hours: 0 representatives

Total pay bill and facility time costs
Total pay bill: £15,440,528
Total cost of facility time: £1,497
Percentage of pay spent on facility time: 0.01%

Paid trade union activities
Hours spent on paid facility time: 60
Hours spent on paid trade union activities: 0
Percentage of total paid facility time hours spent on paid TU activities: 0%

9.11 Expenditure on consultancy

The CCG consultancy expenditure in 2021/22 was £75,000 (2020/21 £196,000), as per note 5 in the annual accounts.

9.12 Off-payroll engagements

For all off-payroll engagements as at 31 March 2022, for more than £245* per day and that last longer than six months.

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

	Number
Number of existing engagements as of 31 March 2022	4
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

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.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245(1) per day and that last for longer than 6 months:

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 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 consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency 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.

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 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 year	1
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	15

Between 1 April 2021 and 31 March 2022, there has been one instance where a senior officer position has been held by an off-payroll member of staff. This relates to the Interim Director of Commissioning post.

It was considered that there was not sufficient capacity or capability within the organisation to provide cover for the previously vacant position of Chief Operating Officer. Instead, an off-payroll member of staff was able to deliver high quality work for a short-term appointment to the post of Interim Director of Commissioning, avoiding significant delays in recruiting traditionally to the vacant post. This post was extended until 31 March 2022, to provide continuity of provision to the date of the transition from a CCG to an ICB, which was originally provided as 1 April 2022.

9.13 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	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	1	32,328	1	32,328	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	1	32,328	1	32,328	0	0

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	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	1	32
TOTAL	**1**	**32**

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.

*includes any non-contractual severance payment made following judicial mediation.

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

9.14 Parliamentary Accountability and Audit Report

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**.

ANNUAL ACCOUNTS **Appendix One**

Entity name:	NHS Somerset CCG
This year	2021-22
Last year	2020-21
This year ended	31-March-2022
Last year ended	31-March-2021
This year commencing:	01-April-2021
Last year commencing:	01-April-2020

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The Primary Statements:

Notes to the Accounts

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

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(2,259)	(1,392)
Other operating income	2	(753)	(596)
Total operating income		**(3,012)**	(1,988)
Staff costs	4	15,441	14,044
Purchase of goods and services	5	1,121,327	980,696
Depreciation and impairment charges	5	76	79
Provision expense	5	14	298
Other Operating Expenditure	5	824	433
Total operating expenditure		**1,137,682**	995,550
Net Operating Expenditure		**1,134,670**	993,562
Finance expense	7	1	0
Comprehensive Expenditure for the year		**1,134,671**	993,562

The notes on pages 5 to 23 form part of this statement

Statement of Financial Position as at 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment	9	213	220
Intangible assets	10	0	0
Total non-current assets		213	220
Current assets:			
Inventories	11	2	2
Trade and other receivables	12	3,392	6,410
Cash and cash equivalents	13	46	44
Total current assets		3,440	6,456
Total assets		**3,653**	6,676
Current liabilities			
Trade and other payables	14	(51,888)	(63,583)
Provisions	15	(440)	(570)
Total current liabilities		**(52,328)**	(64,153)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(48,675)**	(57,477)
Financed by Taxpayers' Equity			
General fund		(48,675)	(57,477)
Total taxpayers' equity:		**(48,675)**	(57,477)

The notes on pages 5 to 23 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 16 June 2022 and signed on its behalf by:

James Rimmer
Accountable Officer
NHS Somerset Clinical Commissioning Group

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(57,477)	(57,477)
Net operating expenditure 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)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	(40,050)	(40,050)
Net operating costs for the financial year	(993,562)	(993,562)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(993,562)	(993,562)
Net funding	976,135	976,135
Balance at 31 March 2021	(57,477)	(57,477)

The notes on pages 5 to 23 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,134,671)	(993,562)
Depreciation and amortisation	5	76	79
Other Gains & Losses	7	1	0
(Increase)/decrease in trade & other receivables	12	3,018	(753)
Increase/(decrease) in trade & other payables	14	(11,625)	17,825
Provisions utilised	15	(144)	(4)
Increase/(decrease) in provisions	15	14	299
Net Cash Inflow (Outflow) from Operating Activities		**(1,143,331)**	(976,116)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(140)	(44)
Net Cash Inflow (Outflow) from Investing Activities		**(140)**	(44)
Net Cash Inflow (Outflow) before Financing		**(1,143,471)**	(976,160)
Cash Flows from Financing Activities			
Net Funding Received		1,143,473	976,135
Net Cash Inflow (Outflow) from Financing Activities		**1,143,473**	976,135
Net Increase (Decrease) in Cash & Cash Equivalents	13	**2**	(25)
Cash & Cash Equivalents at the Beginning of the Financial Year		**44**	69
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**46**	44

The notes on pages 5 to 23 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

The Health and Care Act was introduced into the House of Commons on 6 July 2021 and received Royal Assent on 28 April 2022. The Act will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCGs). Subject to the issue of an establishment order by NHS England, ICBs will take on the commissioning functions of CCGs from 1 July 2022 and all CCG functions, assets and liabilities will transfer to an ICB. On this date NHS Somerset CCG's functions, assets and liabilities will transfer to NHS Somerset ICB

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2022 on a going concern basis.

1.2 **Accounting Convention**

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

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

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

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

1.4 **Joint arrangements**

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

A joint 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 1.5) are joint operations, with the exception of the Better Care Fund.

1.5 **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

1.6 **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.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the 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 obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are 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.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

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

Notes to the financial statements

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.

Notes to the financial statements

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs 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.

1.9 **Other Expenses**

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

1.10 **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.

1.11 **Property, Plant & Equipment**

1.11.1 **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.

1.11.2 **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.

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

1.12 **Intangible Assets**

1.12.1 **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.

1.12.2 **Measurement**

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

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

Notes to the financial statements

1.12.3 **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 reserve.

1.13 **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.

1.14 **Leases**

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

1.14.1 **The Clinical Commissioning Group as Lessee**

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

1.15 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

1.16 **Cash & Cash Equivalents**

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

1.17 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% applies (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

Notes to the financial statements

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

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

1.19 **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.

1.20 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.21 **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.

1.21.1 **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.

1.21.2 **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.

1.21.3 **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.

1.21.4 **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, the 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.

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

Notes to the financial statements

1.23 **Value Added Tax**
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.24 **Foreign Currencies**
The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. NHS Somerset Clinical Commissioning Group does not have any exposure to foreign currencies.

1.25 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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

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

● IFRS 16 Leases – IFRS 16 Leases has been deferred until 1 April 2022.
The clinical commissioning group have conducted an assessment of the impact of IFRS 16 and the financial impact is considered to be immaterial.

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

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

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

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

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. This 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

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	604	538
Non-patient care services to other bodies	1,564	854
Other Contract income	91	0
Total Income from sale of goods and services	**2,259**	1,392
Other operating income		
Non cash apprenticeship training grants revenue	44	27
Other non contract revenue	709	569
Total Other operating income	**753**	596
Total Operating Income	**3,012**	1,988

3. Disaggregation of Revenue

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Total £'000
Source of Revenue				
NHS	-	50	-	**50**
Non NHS	604	1,514	91	**2,209**
Total	**604**	**1,564**	**91**	**2,259**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Total £'000
Timing of Revenue				
Point in time	604	1,564	91	**2,259**
Over time	-	-	-	**-**
Total	**604**	**1,564**	**91**	**2,259**

4. Employee benefits and staff numbers

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**

4.1 Employee benefits	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	10,293	598	10,891
Social security costs	1,095	14	1,109
Employer Contributions to NHS Pension scheme	1,988	16	2,004
Other pension costs	2	0	2
Apprenticeship Levy	38	0	38
Gross employee benefits expenditure	13,416	628	14,044
Less recoveries in respect of employee benefits	0	0	0
Total - Net admin employee benefits including capitalised costs	13,416	628	14,044
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	13,416	628	14,044

4.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**247**	**10**	**257**	236	7	243
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

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:

a) Accounting valuation

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

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

b) 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

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,769	2,966
Services from foundation trusts	711,067	612,700
Services from other NHS trusts	8,105	8,176
Services from Other WGA bodies	17	6
Purchase of healthcare from non-NHS bodies	159,615	128,110
Purchase of social care	38,486	36,384
Prescribing costs	91,684	90,208
General Ophthalmic services	496	479
GPMS/APMS and PCTMS	99,786	91,309
Supplies and services – clinical	29	27
Supplies and services – general	796	2,412
Consultancy services	75	196
Establishment	1,195	1,683
Transport	3,905	3,465
Premises	923	943
Audit fees	79	77
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services	0	12
Other professional fees	146	247
Legal fees	284	159
Education, training and conferences	826	1,110
Non cash apprenticeship training grants	44	27
Total Purchase of goods and services	**1,121,327**	980,696
Depreciation and impairment charges		
Depreciation	76	78
Amortisation	0	1
Total Depreciation and impairment charges	**76**	79
Provision expense		
Provisions	14	298
Total Provision expense	**14**	298
Other Operating Expenditure		
Chair and Non Executive Members	263	273
Grants to Other bodies	513	150
Clinical negligence	10	10
Other expenditure	38	0
Total Other Operating Expenditure	**824**	433
Total operating expenditure, excluding staff costs	**1,122,241**	981,506

Notes

1. External Audit Fees Net of VAT total £66,112.
2. The auditor's liability for external audit work carried out for the financial year 2021/22 is limited to £2,000,000.
3. 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	**2021-22 Number**	**2021-22 £'000**	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,723	210,244	9,513	159,468
Total Non-NHS Trade Invoices paid within target	9,723	210,244	9,513	159,468
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	672	731,378	1,203	619,369
Total NHS Trade Invoices Paid within target	672	731,378	1,202	619,369
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	99.92%	100.00%

7. Other gains and losses	**2021-22 £'000**	2020-21 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	1	0
Total	**1**	0

This relates to the disposal of IT equipment due to damage

8. Operating Leases

8.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Services Ltd. In 2021-22 the charge to the Clinical Commissioning Group included charges for properties that it occupied. This is reflected in Note 8.1.1

The Clinical Commissioning Group also has annual commitments under lease agreements for vehicles and photocopiers. There are no contingent rentals or purchase options built within any of the current lease arrangements

8.1.1 Payments recognised as an Expense			**2021-22**			2020-21
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	867	11	**878**	884	12	896
Total	**867**	**11**	**878**	884	12	896

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for these arrangements only.

8.1.2 Future minimum lease payments			**2021-22**			2020-21
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	0	1	**1**	0	12	12
Total	**0**	**1**	**1**	0	12	12

9. Property, plant and equipment

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	617	119	**736**
Additions purchased	70	0	**70**
Disposals other than by sale	(37)	0	**(37)**
Cost/Valuation at 31 March 2022	**650**	**119**	**769**
Depreciation 01 April 2021	437	79	**516**
Disposals other than by sale	(36)	0	**(36)**
Charged during the year	61	15	**76**
Depreciation at 31 March 2022	**462**	**94**	**556**
Net Book Value at 31 March 2022	**188**	**25**	**213**
Purchased	188	25	**213**
Total at 31 March 2022	**188**	**25**	**213**
Asset financing:			
Owned	188	25	**213**
Total at 31 March 2022	**188**	**25**	**213**

9.1 Economic lives	Minimum Life (years)	Maximum Life (Years)
Information technology	5	7
Furniture & fittings	7	10

10. Intangible non-current assets

2021-22	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2021	16	**16**
Cost / Valuation At 31 March 2022	**16**	**16**
Amortisation 01 April 2021	16	**16**
Amortisation At 31 March 2022	**16**	**16**
Net Book Value at 31 March 2022	**0**	**0**
Purchased	0	**0**
Total at 31 March 2022	**0**	**0**

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

11. Inventories

	Energy £'000	Total £'000
Balance at 01 April 2021	2	**2**
Balance at 31 March 2022	**2**	**2**

12.1 Trade and other receivables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS receivables: Revenue	1,796	-	3,621	-
NHS prepayments	75	-	67	-
NHS accrued income	117	-	724	-
Non-NHS and Other WGA receivables: Revenue	141	-	351	-
Non-NHS and Other WGA prepayments	456	-	1,122	-
Non-NHS and Other WGA accrued income	470	-	327	-
VAT	337	-	198	-
Total Trade & other receivables	**3,392**	**-**	6,410	-
Total current and non current	**3,392**		6,410	

12.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	**2021-22 Non DHSC Group Bodies £'000**	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	928	86	3,039	117
By three to six months	-	2	100	9
By more than six months	-	-	25	-
Total	**928**	**88**	3,164	126

13. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	44	69
Net change in year	2	(25)
Balance at 31 March 2022	**46**	44
Made up of:		
Cash with the Government Banking Service	46	44
Cash and cash equivalents as in statement of financial position	**46**	44
Balance at 31 March 2022	**46**	44

14. Trade and other payables	**Current 2021-22 £'000**	**Non-current 2021-22 £'000**	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	698	-	6,444	-
NHS accruals	2,152	-	263	-
Non-NHS and Other WGA payables: Revenue	7,121	-	7,358	-
Non-NHS and Other WGA payables: Capital	-	-	70	-
Non-NHS and Other WGA accruals	34,211	-	42,805	-
Non-NHS and Other WGA deferred income	23	-	-	-
Social security costs	182	-	167	-
Tax	157	-	131	-
Other payables and accruals	7,344	-	6,345	-
Total Trade & Other Payables	**51,888**	**-**	63,583	-
Total current and non-current	**51,888**		63,583	

Other payables include £216,262 outstanding CCG pension contributions at 31 March 2022.

15. Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Redundancy	320	-	-	-
Legal claims	-	-	353	-
Continuing care	120	-	217	-
Total	**440**	**-**	570	-
Total current and non-current	**440**		570	

	Redundancy £'000	Legal Claims £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2021	**-**	**353**	**217**	**570**
Arising during the year	320	-	120	**440**
Utilised during the year	-	(5)	(139)	**(144)**
Reversed unused	-	(348)	(78)	**(426)**
Balance at 31 March 2022	**320**	**0**	**120**	**440**
Expected timing of cash flows:				
Within one year	320	0	120	**440**
Balance at 31 March 2022	**320**	**0**	**120**	**440**

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

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 16.

16. Contingencies

	2021-22 £'000	2020-21 £'000
Contingent liabilities		
Continuing Healthcare	26	54
Litigation	0	18
Net value of contingent liabilities	**26**	72

There are no contingent assets.

17. Financial instruments

17.1 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.

17.1.1 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.

17.1.2 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.

17.1.3 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.

17.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

17.1.5 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.

17. Financial instruments cont'd

17.2 Financial assets

	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**

	Financial Assets measured at amortised cost 2020/21 £'000	Total 2020/21 £'000
Trade and other receivables with NHSE bodies	1,411	1,411
Trade and other receivables with other DHSC group bodies	3,401	3,401
Trade and other receivables with external bodies	211	211
Cash and cash equivalents	44	44
Total at 31 March 2021	5,067	5,067

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	**Total 2021-22 £'000**
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**

	Financial Liabilities measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other payables with NHSE bodies	426	426
Trade and other payables with other DHSC group bodies	19,682	19,682
Trade and other payables with external bodies	43,177	43,177
Total at 31 March 2021	63,285	63,285

18. Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Somerset Clinical Commissioning Group	1,137,683	(3,012)	**1,134,671**	3,653	(52,328)	**(48,675)**
Total	**1,137,683**	**(3,012)**	**1,134,671**	**3,653**	**(52,328)**	**(48,675)**

The Clinical Commissioning Group has only one operating segment, that of commissioning healthcare services for the population of Somerset. The values above represent those reported internally within NHS Somerset Clinical Commissioning Group.

19. 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	
			2021-22	2020-21
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	1,318	1,412*
Carers Services Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Carers services	223	226
Learning Disability Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Learning Disability services	23,915	22,261

* 20/21 Excludes £167,400 included within Hospital Discharge Programme recharge

Better Care Fund (not treated as a Joint Operation)	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase health and social care services	42,984^	40,619^

^ Excludes £203,500 included within Carers Pooled Budget figure, same value for 20/21 & 21/22

20. Related party transactions

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	28	0	2	0

Note
In formulating this note the Clinical Commissioning Group has considered all declarations of interest for Governing Body
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 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.

2020/2021 31 March 2021	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)	2,129	76	0	0
Maria Heard, Programme Director of Fit for my Future, is a Non-Executive Director of South West Academic Health Science Network (from 04/05/20) (transactions disclosed for South West Academic Health Science Network)	33	2	8	2

Note
In formulating this note the Clinical Commisioning Group has considered all declarations of interest for Governing Body Members.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant
NHS England
South, Central and West Commissioning Support
NHS FOUNDATION TRUSTS
Dorset County Hospital NHS Foundation Trust
Guy's And St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
Royal Brompton & Harefield 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 College London Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust
NHS TRUSTS
Avon And Wiltshire Mental Health Partnership NHS Trust
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust
University Hospitals Plymouth 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.

21. 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 will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCGs). Subject to the issue of an establishment order by NHS England the CCG will be dissolved on 30 June 2022. On 1 July the assets, liabilities and operations of NHS Somerset CCG will transfer to NHS Somerset ICB.

This event does not have an effect upon these financial statements.

22. Financial performance targets

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

	2021-22 Target £'000	**2021-22 Performance £'000**	**Duty Achieved**	2020-21 Target £'000	2020-21 Performance £'000	Duty Achieved
Expenditure not to exceed income	1,137,753	1,137,753	**Yes**	995,620	995,620	Yes
Capital resource use does not exceed the amount specified in Directions	70	70	**Yes**	70	70	Yes
Revenue resource use does not exceed the amount specified in Directions	1,134,671	1,134,671	**Yes**	993,562	993,562	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**Yes**	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**Yes**	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	11,090	11,033	**Yes**	11,142	10,927	Yes

Independent auditor's report to the members of the Governing Body of NHS Somerset CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

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

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

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

Emphasis of matter – Demise of the organisation

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

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have

had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

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

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

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

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

Matters on which we are required to report by exception

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

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

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

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

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

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

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

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

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

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit Committee whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risks 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; and
  - the recognition of year-end manual expenditure accruals and the related payable balances.

  We rebutted the presumed risk of fraudulent revenue recognition.
- 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 the recognition of year-end manual expenditure accruals and the related payable balances; 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
  - 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; and
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure and its services to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

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

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

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

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

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

Use of our report

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

Jackson Murray

Jackson Murray, Key Audit Partner

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

Bristol

20 June 2022

Independent auditor's report to the members of NHS Somerset ICB in respect of NHS Somerset CCG

In our auditor's report issued on 20 June 2022, we explained that we could not formally conclude the audit and issue an audit certificate for NHS Somerset CCG (the 'CCG') for the year ended 31 March 2022, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2022 issued on 20 June 2022 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

In forming our opinion on the financial statements, we drew attention to note 1.1 to the financial statements, which indicates that under the Health and Care Act 2022 the commissioning functions, assets and liabilities of the CCG will transfer to NHS Somerset Integrated Care Board on 1 July 2022.

No matters have come to our attention since 20 June 2022 that would have a material impact on the financial statements on which we gave this opinion.

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 year ended 31 March 2022.

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG 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.

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 December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these

arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

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

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

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of NHS Somerset CCG for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of NHS Somerset ICB, as a body, in respect of NHS Somerset 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 NHS Somerset ICB those matters we are required to state to them in an auditor's report in respect of NHS Somerset 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 members of NHS Somerset ICB as a body and NHS Somerset CCG and the Governing Body of NHS Somerset CCG as a body, 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

27 September 2022