NHS
Barnsley
Clinical Commissioning Group

Annual Report and Accounts 2021/22

Putting Barnsley People First

Welcome to the annual report and accounts for NHS Barnsley Clinical Commissioning Group (CCG) for the financial year 2021/22.

This has been our second year operating in the middle of a worldwide pandemic. It was another year of great sadness but also one of hope.

We saw the introduction of new treatments for those with severe coronavirus infections to relieve symptoms and reduce the effects of the virus. We also welcomed the introduction of the biggest vaccine programme we have ever seen, which has gone extremely well in Barnsley. This went on to make a huge impact by reducing the number of people dying or needing hospital care because of the virus.

We have continued to see an incredible response, both personally and collectively, from our own teams and those teams working in the services we commission. They worked seamlessly as one focusing on those most vulnerable - providing safe care under extreme pressure.

> "We have seen an incredible response to the pandemic, both personally and collectively, from our own teams and those working in the services we commission."

Against the backdrop of the pandemic, we have continued to pull out all the stops to treat thousands of people with other conditions and restore services and tackle the backlog. We have invested in a new diagnostic centre which will be based in the new shopping centre in Barnsley town centre, providing more appointments for things like screening and blood tests and in a convenient location.

We know there is still much to do. The new Barnsley mental health and wellbeing strategy highlights the work we'll be doing as a health and care community across the borough this year. We will also be moving into a new way of working as part of the proposals to introduce Integrated Care Boards (ICB). This will see the end of clinical commissioning groups in their current format, transferring the statutory responsibilities to the ICB, which for us will cover South Yorkshire. Our work will continue, building on the strong foundations of our partnerships in Barnsley.

On behalf of our membership council, governing body and our chair, Dr Nick Balac, I want to record our thanks to our dedicated staff in the CCG and in our member GP practices and to those in our partner organisations for the continued overwhelming effort and dedication they have shown to the people of Barnsley this year. Our thanks also go to colleagues who have been part of the CCG family over previous years, all contributing to our commitment to local people and communities.

Chris Edwards
Accountable Officer, NHS Barnsley Clinical Commissioning Group

Making a difference

Responding to the pandemic

Health and care partners have spent 2021/22 responding to the demands of the COVID-19 pandemic.

There have clearly been a number issues and challenges this year. Barnsley has seen high rates of COVID-19 cases and sadly just over 200 more people have died this year bringing the total to 1045 of people whose death certificate mentioned COVID-19 during the pandemic.

We have worked with our local communities to provide support for those who are most vulnerable. Like in many other areas and similar to the previous year, we have seen fewer people accessing health services during the pandemic. Our teams have worked hard and used a variety of techniques to encourage and motivate people to come forward. Whilst health services have been, and continue to be, required to ensure robust infection prevention measure controls are in place, they have clinically prioritised those in most need.

Throughout the pandemic, health and care organisations have continued to work within local, regional and national command and control structures to coordinate contingency planning and ensure rapid escalation and resolution of any operational challenges.

There has been a tremendous effort from staff at the CCG and across all sectors during this pandemic. The personal impact that working through this pandemic has had has been great and the dedication and commitment of our colleagues in all areas across Barnsley and the region can never be underestimated.

Despite the focus on COVID-19, there has been a significant amount of effort to maintain core services and to focus on some of those areas of transformation that were planned before the pandemic. The Barnsley health and care plan, developed by the Barnsley Integrated Health and Care Partnership.

Supporting people to return home from hospital

During the pandemic we have also seen the need to ensure that anyone needing hospital care, for whatever reason, was able to be discharged in a timely way.

We know that longer stays in hospital, for older people in particular, can lead to worse health outcomes and can increase their long-term care needs.

Where people are medically fit for discharge and do not require an acute hospital bed, but may still require care, services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

Assessment for their longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: ‘discharge to assess’, ‘home first’, ‘safely home’, ‘step down’.

In Barnsley, health and social care teams have been leading the way in implementing a way of discharging people where their assessment is at home.
This has included:

- Redeployment of therapists to work in people's homes to complete assessments
- Social services undertaking assessments in people's homes
- 24-hour telephone follow-up after discharge from a registered nurse
- Implementation of a discharge hub 7 days a week to allocate and co-ordinate discharges

We have seen more people being discharged and the time they have stayed in hospital has reduced. People have told us that this has been a positive experience. We have also seen a reduction in duplication of some services.

COVID-19 vaccination programme

Over half a million COVID vaccines have now been given to Barnsley residents. The booster vaccine was introduced in September. As it was rolled-out we saw a big push in December as the vaccine service set up home in Barnsley Metrodome for a pop-up clinic. Thousands of people took the chance to get boosted ahead of the Christmas and New Year.

The Barnsley NHS GP Vaccination Service, along with some local pharmacies, has safely and successfully delivered the Barnsley element of what has been the biggest vaccination programme the country has seen.

Together with the support of partners, the primary care network of GP practices, hosted by Barnsley Healthcare Federation, has continued to run the community vaccination hub service across Barnsley. They have been joined by hundreds of volunteers organised by Barnsley CVS.

Community diagnostic centres

During this year people in South Yorkshire will benefit from improved diagnostic facilities following confirmation of £3million of capital funding to develop two new community diagnostic centres.

The first year of funding has been successfully secured by South Yorkshire and Bassetlaw Integrated Care System (SYBICS) for diagnostic centres, which it is hoped will enable people to take tests faster, receive a diagnosis earlier and get onto their treatment journeys sooner.

Two initial sites have been identified for the first year of funding, The Glassworks in Barnsley town centre and Montagu Hospital in Mexborough, with bidding plans already underway for future funding to develop further centres across South Yorkshire.

The Glassworks site is set to include Ultrasound, X-ray, breast screening, phlebotomy, echocardiography and DEXA scanning, while the Montagu Hospital site will include CT and MRI services to complement the diagnostics already delivered at the site along with phlebotomy, point of care testing and physiological measurement.

The funding has been secured as part of a national programme to help the NHS further accelerate diagnostic activity and recover services from the impact of the COVID-19 pandemic as quickly as possible.

The Community Diagnostic Centre represents a significant advance in how we will deliver diagnostic services for the people of Barnsley. We have worked very closely with our health and care partners to develop a service model that aims to both improve the experience of our patients and reduce wait times and we are really looking forward to delivering diagnostic services in this fantastic new venue in Barnsley town centre.

Improving early cancer diagnosis

Throughout the pandemic we have been working to better understand the hidden harms that people may have experienced. This has been supported by the work of our teams focusing on cancer diagnosis and care.

We have been using behavioural science approaches to increasing early diagnosis**.** They have used detailed data to understand where we can make the biggest impact in increasing screening attendance amongst key target populations which then uses detailed community insights to design behavioural science based “nudges” towards behaviour change.

This has been used to adapt the invitation method and wording which is sent to people dure for their breast screening appointment for example.

Children and young people’s mental health and wellbeing

We have seen several positive programmes put into place this for children and young people to support their mental and emotional wellbeing. This has been a priority for the CCG and the Barnsley Health and Wellbeing Board.

Providing seamless care

We know that having a range of services, provided by a range of teams or organisations, can sometimes make it difficult to navigate. Children and young people (CYP) and their families looking for help for mental health and wellbeing issues in Barnsley now have an easy, new way of finding the right support. This year teams have been working to launch a single point of contact for young people and families.

Both the Barnsley Mental Health Support Team (MHST) and the CAMHS team have a central contact point to handle all requests for support, including those from professionals and partner agencies. They will work with children, young people and families to get the right support at the right time, whilst providing more seamless care.

The MHST works with children, young people, and families in education settings in Barnsley.

They provide free, confidential support, help and advice for pupils, students and schools for issues related to mental health and emotional wellbeing. Barnsley MHST works directly across all Barnsley secondary schools providing group and one to one support for young people.

CAMHS stands for child and adolescent mental health services. They are the NHS service that offers support and treatment for children and young people, aged up to 18 years old,

who are experiencing difficulties with their mental health and wellbeing. They also support parents, carers and families of these children and young people

Mental health support team working in schools

Alongside being open for referrals to all Barnsley CYP with mild-to-moderate mental health needs, the Barnsley Mental Health Support Teams have:

- Provided school-based support in 36 schools (11 secondary and 25 primary) with link sessions offered to all. The aim is to empower staff and build confidence to work with young people on mental health and emotional wellbeing issues.
- Recruited a second temporary specialist bereavement counsellor to provide support to young people who have experienced bereavement.

H.O.M.E Help with Our Mental 'Ealth! – a place for children and young people

After listening to young people through consultation and work with our young commissioners over the last five years, Chilypep have opened H.O.M.E – a hub for them in Barnsley.

During 21/22 services and drop-in sessions began to be delivered from H.O.M.E including the BRV Project (Belonging, Resilience, and Vocabulary) which aims to improve emotional literacy within boys and young men and give them a better understanding of themselves.

Also there is a peer mentoring programme which trains young people to be able to support their peers with their emotional wellbeing and issues they may be facing. Peer mentors have access to training through Chilypep and have the opportunity to develop their own communication and social skills.

The vision for H.O.M.E is to have a coordinated, integrated mental health and wellbeing space dedicated to young people. They will be able to access interventions at an early stage and all partners across Barnsley can work together to provide a range of high quality, easily accessible and supportive services which will benefit young people creating a positive and welcoming H.O.M.E – this work will continue into 22/23.

Performance Report

Signature of the Performance Report by the Accountable Officer

Chris Edwards, Accountable Officer,
16 June 2022

Performance overview

Our role

As a clinically led statutory NHS body, NHS Barnsley CCG is responsible for planning and commissioning health care services for our local area to achieve the best possible health outcomes for our local registered population of around 264,000 and in doing so acting effectively, efficiently and economically. We do this by assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

NHS Barnsley CCG is led by local doctors and elected primary care members; a specialist consultant; and a nurse, all of whom are close to patients and their needs. The CCG also has lay members on its governing body, sharing responsibility as part of the team to ensure that the CCG exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of the CCG's constitution as agreed by its members. We believe that this enables us to improve the quality of care provided to all the people of Barnsley. We are supported by a very experienced team of NHS professionals.

Vision and values: We have set out our vision for Barnsley which is underpinned by our values and principles. This vision will guide and inform our work, along with the local population's health needs and experience of health care.

Our vision

"We are a clinically led commissioning organisation that is accountable to the people of Barnsley. We are committed to ensuring high quality and sustainable health care by putting the people of Barnsley first."

Our values

These underpin everything we do as commissioners and an employing organisation. They are:

- Equity and fairness
- Services are designed to put people first
- They are needs led and resources are targeted according to needs
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital
- Excellent communication with patients.

Our strategy

As medicine advances, health needs change and society develops, the NHS has to continually move forward so that in 10 years' time we have a service fit for the future. The NHS Long Term Plan was drawn up by frontline staff, patient groups, and national experts to be ambitious but realistic.

South Yorkshire and Bassetlaw Integrated Care System (ICS) published plans to significantly invest and improve healthcare for local people – including aims to significantly reduce the number of preventable deaths and illness that are caused by smoking obesity and mental illness.

Healthy life expectancy is lower in South Yorkshire and Bassetlaw compared to the national average, and there are high levels of the common causes of disability and death including smoking, obesity, physical inactivity and hospital admissions due to alcohol. The plan aims to address these issues by tackling the 'burden of illness' where it can be prevented from occurring in the first place.

Highlights from the plan included improved community-based services to prevent unnecessary hospital admissions; investment in digital systems to enhance patient accessibility to online appointments and working more closely with community-based institutions like schools to teach children about good mental health.

We have also been a partner in the development of Barnsley 2030 strategy.

Barnsley 2030 is a fantastic opportunity to work together to tell the story of our borough - so we can visualise a future for everyone.

A lot can change in a short amount of time, so we need to start thinking about how the Barnsley borough might be different in 2030.

Barnsley 2030 focuses on what every one of us does across the borough that makes Barnsley the place that it is.

The Barnsley 2030 board, of which the CCG is a member, is a group of key place stakeholders, from different businesses and organisations across all sectors, that will provide oversight for the delivery of the Barnsley 2030 strategy and making sure that we all play a part in achieving our borough's vision and ambitions.

Our objectives

- To have the highest quality of governance and processes to support our business
- To commission high quality health care that meets the needs of individuals and groups
- Wherever it makes safe clinical sense to bring care closer to home
- To support safe and sustainable local hospital services, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley
- To develop services through real partnerships with mutual accountability and strong governance that improves health and health care and effectively use the Barnsley pound.

Our constitution

Through our constitution, our 32 member GP practices delegate responsibility for running the organisation to our Governing Body, which in turn is supported by a range of strategic committees. Our Governing Body's role is to set the strategic direction of the organisation, seek assurance that the strategy is being delivered, and to set the culture of the organisation.

Our partnerships

We believe that we can achieve more when we work in partnership. This year it has continued to be more important than ever to come together and work as one team.

A swift and effective emergency response was put into place across the whole of Barnsley and across South Yorkshire and Bassetlaw, as every statutory organisation and health and care providing organisation responded to the unprecedented needs emerging from the pandemic.

Throughout the year we also continued to meet as part of the Barnsley integrated care partnership, with updates from this group reported regularly at out Governing Body meetings.

We also continued to be a member of the Barnsley Health and Wellbeing board and the South Yorkshire and Bassetlaw Local Resilience Forum.

Future plans for South Yorkshire and Bassetlaw Integrated Care System

With the February 2021 publication of the government's white paper, 'Integration and innovation: working together to improve health and social care for all', the South Yorkshire Integrated Care Board (ICB) is set to evolve into a statutory body in July 2022. Barnsley CCG, along with all other CCGs in England, will be abolished and the functions and staff from the CCGs in South Yorkshire will transfer into the new NHS body. Bassetlaw CCG will move to the Nottingham area.

There will still remain a strong Barnsley place-based commissioning presence and we continue to work in collaboration with the other health and social care organisations to ensure that we take advantage of these system changes to further integrate care and improve the health outcomes for our local populations.

Performance summary

CCG Oversight Framework

The NHS Oversight Framework informs the assessment of CCGs in 2020/21. It is intended as a focal point for joint work, support and dialogue between NHS England, NHS Improvement, CCGs, providers and integrated care systems.

In recent years it has become increasingly clear that the best way to manage NHS resource to deliver high quality, sustainable care is to focus on organising health at both system and organisational level.

This approach to oversight set out how regional teams review performance and identify support needs across integrated care systems (ICSs). As the NHS moved into a national emergency response, the meetings between local and system leaders were paused.

The final rating for the CCG’s assessment was Outstanding. This has been the rating for the last four years.

Financial Performance

NHS Barnsley CCG achieved all its financial duties in 2021/22. This is demonstrated in the table on page 16 and within the Annual Accounts. In addition, the CCG ended the year with a surplus of £1.6m.

The Annual Accounts have been prepared under International Financial Reporting Standards (IFRS) and in accordance with the Group Accounting Manual issued by NHS England and the Department of Health and Social Care.

The financial landscape for 2022/23 remains challenging as we continue to recover from the impact of the Covid-19 pandemic. Financial planning processes for 2022/23 are expected to be completed by the end of April 2022. There is significant financial challenge within Barnsley and across the South Yorkshire Integrated Care System (ICS), but the CCG and the ICS continue to ensure that services are delivered making the best use of funding received and are focused on recovery in line with planning guidance requirements.

Performance analysis

How we measure performance

NHS Constitution Rights and Pledges and NHS England's Oversight Framework	We monitor our performance against the NHS constitution measures domains within the NHS England and NHS Improvement Oversight Framework on an ongoing basis, and we meet with NHS England to formally take stock of our performance against the domains. The outcomes from these meetings are formally reported to our Governing Body via our Chief Officer Report.
Financial performance	Our finance and contracting team monitor our financial performance on an ongoing basis. Our financial performance is overseen at the monthly Finance and Performance Committee and is reported to our Governing Body in the integrated performance report.
Provider performance including NHS Constitution standards	We measure the performance of providers using contractually agreed schedules of key performance indicators and quality indicators. The quality and completeness of the data received is continually assessed by our business intelligence team. Where performance is below the required standard for a single, or for multiple measures, the provider is asked for an explanation including actions and timeframes to bring the performance or quality of care back up to the required standard. Performance is reported and monitored to the Finance and Performance Committee and to the Governing Body via the Integrated Performance report.
Better Care Fund	The Better Care Fund (BCF) is intended to transform local health and social care services so that they work together to provide improved and joined up care and support. It is a government initiative, bringing existing resources from the NHS and local authorities into a single pooled budget. Performance against the pooled budget is monitored with local authority colleagues, through a sub-committee of the Health and Wellbeing Board. The CCG's Finance and Performance Committee receives reports on operational and financial performance of the BCF as part of the Integrated Performance Report. The schemes supported by the BCF are an inherent part of the overall integrated performance report to Governing Body.

Progress on NHS Constitution Targets

The NHS constitution targets listed below are standards which are reported at each of the CCG's Governing Body meeting in public. They relate to any person registered with a Barnsley GP, wherever they are treated.

We have a history of good performance for our registered population and in previous years have reported these targets have been met or nearly met. The NHS has seen another incredibly challenging year however, impacted on by the pandemic. We have seen some targets met with the number people receiving anti-cancer drugs, or radiotherapy, within 31 days of a diagnosis being above target.

The reasons some targets were met, and some were not, are many and have varied throughout the year as each wave has emerged, peaked and passed. It is important to note that the NHS operated under the highest level of emergency control for much of the year. This dictated that many of the services needed to be prioritised, such as treatment for COVID-19 along with tests for cancer and any subsequent treatment, with many non-urgent and routine health care needs assessed and in some cases treatments deferred.

Where the targets have not been met and people may have waited longer for treatment, everything possible has been done to make sure ensure patient safety. Those with the most urgent need have continued to receive the treatment and care that they need.

The CCG and the local health and care system had a comprehensive recovery and reset plan for 2021/22, which was guided by NHS planning guidance and locally determined priorities. The priorities included progressing treatments and diagnostics for those with or suspected of having cancer as well as reducing the wait for those people who need a planned operation/procedure.

Further information on the targets is detailed below.

These are the NHS Constitution targets:

Referral to treatment waiting times for non-urgent consultant-led treatment

- Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – the target was 92% and the figure for Barnsley was 84.5%

Diagnostic test waiting times

- Patients waiting for a diagnostic test should have been waiting less than six weeks from referral – target 99%. At March '22 15.02% (against the 1%) waited more than six weeks.

A&E waits

- Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department – target 95%. The figure for Barnsley registered patients was 71.23%.

Cancer waits – Two-week wait

- Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – target 93%. Barnsley's figure was under target at 90.74%
- Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – target 93%. Barnsley's figure was under target at 78.81%.

Cancer waits – 31 days

- Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – target 96%. Barnsley's figure was under target at 94.95%.
- Maximum 31-day wait for subsequent treatment where that treatment is surgery – target 94%. Barnsley's figure was under the target at 76.92%.
- Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – target 98%. Barnsley's figure was above target at 98.72.
- Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – target 94%. Barnsley's figure was above target at 97.19%.

Cancer waits – 62 days

- Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer – target 85%. Barnsley's figure was under the target at 83.64%.
- Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – target 90%. Barnsley's figure was under target at 81.76%.

Ambulance response times

- This information is only measured across Yorkshire and the Humber. Category 1 incidents (the most urgent) should be responded to within 7 minutes (mean response time). There was a reduction on figures in March 2022 with the 21/22 time at 9 minutes 42 seconds. Category 2 incidents should be responded to within 18 minutes (mean response time) but remains over the target at 46 minutes 41 seconds average for March 2022.

Mental health waiting times - Improving Access to Psychological Therapies (IAPT):

- People who complete treatment, moving to recovery – target 50%.
- People entering treatment against level of need – target 2.08%.
- Proportion of people waiting 18 weeks or less from referral to first IAPT treatment appointment – target 95%.
- Proportion of people waiting 6 weeks or less from referral to first IAPT treatment appointment – target 75%.

People entering treatment did not meet the 2.08% per month target in March 2022 however, we did see an improvement on last year's results. The other IAPT measures did meet planned targets as at March 2022 and these were mostly consistent throughout the year.

Development and performance in-year

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended). Full details of the CCG's financial performance are available in the Annual Accounts section. The CCG's performance against those duties in 2021/22 was as follows:

Duty	Target £'000s	Actual Performance £'000s	Achievement
Expenditure not to exceed income	531,055	529,458	Yes
Capital resource use does not exceed the amount specified in NHS Directions	0	0	Yes
Revenue resource use does not exceed the amount specified in NHS Directions	530,985	529,388	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in NHS Directions	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in NHS Directions	0	0	Yes
Revenue administration resource use does not exceed the amount specified in NHS Directions– running costs	5,236	3,985	Yes

Better Care Fund Performance

The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions.

The aim of the BCF is to support transformation and integration of health and social care in line with the Health and Wellbeing Strategy for Barnsley.

The total value of the fund in 2021/22 is £39million. £3.4million of this is provided from grants made directly to the local authority for disabilities facilities and social care adaptations and £13.1million from the Improved Better Care Fund and Winter Pressures Grant. The remaining £22.8million is provided from the CCG baseline allocation.

Note 15, page 23 of the financial statements details the contributions and services commissioned as per the pooled budget arrangement.

Quality, engagement, health inequality and health and wellbeing strategy

We work to ensure that we comply with the statutory duties laid down in the *National Health Service Act 2006 (as amended).* In this section, we have reflected on our duties under:

- Duty as to improvement in quality of services
- Patient and public involvement and consultation
- Duties as to reducing inequalities
- Contribution to the delivery of joint health and wellbeing strategies

Improvement in quality of services

The NHS Constitution places a requirement on all providers of healthcare to strive to deliver high quality and safe care to patients. Commissioners of healthcare have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations that they commission services from.

Clinical Quality Boards

Clinical Quality Boards (CQB) are in place with each main NHS provider. The Clinical Quality Boards focus on the three domains of quality: patient experience, patient safety and clinical effectiveness. During 2020/21 the CQBs have continued their work to provide assurance to the CCG on the quality and safety of locally commissioned services.

Quality Assurance Visits

The purpose of the clinically led visits is to assist in gaining assurance about the quality and safety of healthcare services the CCG commissions. It provides an opportunity for commissioners to engage directly with patients, clinicians and management to hear what they feel works well, their ideas for improvement and for the CCG to recommend any areas for further development. The visits are developmental in nature with a supportive and enabling focus.

Feedback will be aimed at highlighting good practice and identifying ways in which safety, experience and effectiveness can be improved. This can be through actions by the provider and through collaboration with other partners.

Care Quality Commission (CQC) inspections

The CQC adapted the way they monitor services due to the coronavirus (COVID-19) pandemic. Their transitional monitoring approach helped them target their regulatory activity most effectively. Throughout 2020/21 the CCG's Quality and Patient Safety Committee

received updates on the outcome of these inspections. No new inspections were due or made for Barnsley Hospital or for South West Yorkshire Partnership NHS Foundation Trust. Three GP practices received their rating.

Serious Incidents

The CCG has a responsibility to hold providers to account for their responses to serious incidents. The CCG is informed of all serious incidents and near misses within any of its commissioned services, the key providers are BHNFT and SWYPFT. The CCG receives regular updates from these providers regarding serious incidents and provider assurance documents to demonstrate there is a continued focus on lessons learned which are shared with the Quality and Patient Safety Committee.

The Clinical Quality Boards provide high level communication at a senior level between provider and commissioner and we work together to identify and action potential or actual serious quality failures in the interests of patients.

The CCG is also informed about serious incidents within other NHS providers that involve Barnsley residents.

Patient Experience

Friends and Family Test (FFT) scores and patient opinions from the NHS website are assessed alongside local information in order to understand health services from a patient experience. Themes and trends are analysed and taken into account alongside regional and national comparisons.

Data submission and publication for the Friends and Family Test (FFT) restarted for acute and community providers from December 2020, following the pause during the response to COVID-19.

Data from December 2020 onwards reflects feedback collected during the COVID-19 pandemic, while, also, implementing the new guidance after a long period of suspension of FFT data submission. The number of responses collected is, therefore, likely to have been affected. Some services may have collected fewer FFT responses, or been unable to collect responses at all, because of arrangements in place to care for COVID-19 patients.

Comments, Complaints, Compliments

The CCG welcomes all comments and feedback about the CCG and its role in commissioning services on behalf of the people of Barnsley. The CCG aims to provide a clear, simple and easy to understand process for managing patient experience feedback which is fair and impartial, widely publicised and accessible to all.

The CCG also has a role in signposting people to the appropriate providers of NHS care regarding complaints and ensuring people are aware of both the provider's patient feedback systems and the local independent advocacy service.

The majority of contacts made to the CCG are signposted to other organisations, with only a minority referring specifically to the CCG. This year, the contacts are mainly focused on children's continuing healthcare packages of care.

In addition to using complaints and comments to support its role in commissioning services, the CCG is delighted to receive compliments and positive feedback that help to demonstrate where things have gone well and where lessons about good practice can be shared.

There has been an incredible amount of support and positive messages toward the NHS during this year which has been received on our social media sites and direct to services. This has been linked to the work the NHS has been doing to respond to the pandemic and then through the successful roll out of the COVID-19 vaccination programme in Barnsley.

Never Events

NHS Improvement describes a never event as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

There have been four never events which were recorded at Barnsley Hospital NHS Foundation Trust in 2020/21.

Safeguarding – Adults

As commissioners of care and partners in the Barnsley Safeguarding Adults Board the CCG has a key role in the safeguarding of adults including the prevention of abuse and neglect. To do this the CCG works in partnership with other agencies and is an active partner in the Barnsley Safeguarding Adults Board and its subgroups. This work has continued through the pandemic and safeguarding has remained a priority for the CCG and the services it commissions.

Cases of self-neglect and hoarding continue to be a concern and partners continue to work collectively to address this. This last year has also seen a focus on getting things right for those young people transitioning into adulthood.

We continue to explore quality issues within the care home setting. The CCG works in partnership with the local authority and provides professional advice to support contractual actions they may need to take in relation to the standards of care provided by care home services. In addition, safe and well checks are undertaken for any patients funded through continuing health care and in a home where there are concerns about standards. We have structured and proportionate approaches to identify and address concerns within care homes, and where appropriate the CCG will provide support in planning and implementing changes.

Safeguarding – Children

As with adult safeguarding, the CCG is a key partner in the multi-agency arrangements to safeguard children and promote their welfare and is a committed and active member of the Barnsley Safeguarding Children Partnership (BSCP) and its subgroups.

As a CCG we work in partnership, with other relevant agencies and partners, to ensure that good governance arrangements are in place to safeguard children. Ensuring that staff in all agencies understand their role and responsibilities and are well supported by robust policies,

training, supervision, and support. The CCG supports the BSCP in delivering a comprehensive training and audit programme to ensure these objectives are being achieved.

The CCG is involved in both the safeguarding review and the child death process and in prioritising the learning from these tragic events. Sadly, in the previous year we reported a high number of deaths from sudden infant death syndrome relating to unsafe sleep arrangements, five in total.

The CCG has taken a lead role in addressing this including developing multi-agency guidance, training and an awareness raising campaign. It is therefore pleasing to report that this figure dropped to zero.

Engaging people and communities

In order to effectively commission the right services on behalf of our local community, we need to find out the views and experiences of members of the public, patients, and their carers, especially those people who are less likely to speak up for themselves.

As the people who use and pay for the local NHS, it is important for us to hear comments, experiences, ideas and suggestions from local people from across Barnsley about the ways in which we can develop and improve services to benefit our local communities.

Our duty to involve

NHS England published the most recent statutory guidance for CCGs and NHS England commissioners on Patient and Public Participation in Commissioning Health and Care.

It sets out ten key actions and links to the Guide to annual reporting on the legal duty to involve patients and the public in commissioning.

Our approach to involvement

Our engagement and involvement strategy is available on our website here. It outlines how we are committed to engaging, involving and consulting with a wide range of audiences, using the most appropriate tools and techniques.

At the heart of our strategy is a set of guiding involvement principles which were developed in collaboration with the Barnsley Patient Council.

How we involve the public in our governance

Public, community and patient engagement activity is formally reported through to our Governing Body meetings in public. These have taken place virtually during the pandemic and people have been able to submit questions beforehand.

At the start of each governing body meeting in public we hear a patient story to ensure that the service user voice is at the heart of every meeting. We also film these patient stories and publish them on our website so anyone can view them. We also use the films in staff training and development.

Our Equality and Engagement Committee is a sub-committee of our governing body. This committee oversees our engagement and equality work and is responsible for assuring the governing body that we are carrying out our statutory duties in relation to these two areas.

A Healthwatch Barnsley representative sits on the group which is chaired by our CCG Lay Member with the remit for patient and public involvement. Minutes and key actions feed into the governing body through a standing item on the agenda presented by the lay member.

There is also an involvement and engagement report at every governing body meeting which is presented by the head of communications and engagement.

Where appropriate engagement and/or consultation proposals are also submitted to the local Overview and Scrutiny Committee. Where matters span more than one CCG area, such as in the case of work across the South Yorkshire and Bassetlaw Integrated Care System, a joint overview and scrutiny committee will receive proposals.

Meetings of both our Governing Body and Primary Care Commissioning Committee have taken place virtually during the pandemic and people have been able to submit questions beforehand.

Equality impact assessments (EIA) are an integral part of our commissioning processes. This involves looking at what steps could be taken to advance equality, eliminate discrimination and promote good relations.

To meet our statutory duties as a CCG, all policies, procedures, strategies, organisational change and services should be equality impact assessed. This is alongside being assessed in terms of their appropriate patient and public involvement requirements.

Our equality objectives are published on our website as well as our Public Sector Equality Duty report.

Engagement activities in partnership

Engagement with local communities is key to shaping both our local and the wider regional developments relating to integrated care. It is of upmost importance to involve key community-based organisations and partners, and local people at the earliest stage possible as an integral part of discussions taking place to influence local decision making to shape the effective planning, development and provision of local health and care services.

The CCG provides some dedicated funding to Barnsley Council to undertake a range of engagement and involvement activities. This is aligned to the core work of the council, linking with the wider role of community engagement.

The pandemic led to the development of an Engagement, Experience and Equality Leads Group (EEELG) across the Barnsley system as part of the COVID response and the role of the group continues to expand and develop as we have started to look to the future and beyond the pandemic.

Understanding the issues, challenges and barriers faced by local people during lockdown and at the height of the pandemic, helped to shape the ongoing response to try and ensure that people were supported appropriately.

Some of the specific examples of work that involved engagement with local people, community groups/forums and stakeholders from over the past year includes but is not limited to the following; The COVID-19 Emergency Contact Centre (including a wide ranging offer for food, shopping, prescription & befriending support for the most vulnerable residents) the development of COVID community champions (targeting migrant and disabled communities), community listening events led by Area Council teams, seeking feedback to aid the development of a new All Age Mental Health Strategy, developing a new Carers Strategy and targeted engagement to assist with the ongoing roll out of the COVID-19 Vaccination programme.

All of the above created opportunities to discuss and involve local people to understand the real issues they faced as a result of lockdown and other COVID restrictions.

Throughout much of our collective engagement work, several key themes have again come to the forefront including:

- Having access to different types of support and information
- The importance of clear consistent and regular communication in a range of appropriate and accessible formats
- The importance of joined up thinking and the effective integration of services beyond organisational boundaries and systems
- Ensuring that health and care services can be flexible and tailored to different people's needs and circumstances and that they/ their carer and or family members are involved as equal partners in any planning and decision making that takes place about their own lives.

The wider focus on engagement and involvement work continues to evolve and develop. This work needs to be further strengthened on a system-wide footing. Some of the work focusing on inequalities has also been reviewed alongside this work with plans to develop a more proactive approach to engaging with local people moving forward, and to strengthen the service user voice through a variety of different ways including but not limited to via forums/groups, individual feedback through champions/connector schemes and links with local partner & community organisations.

Our involvement highlights

During 2021/22 people have talked to us about the following issues and service areas.

Patient and public involvement in the re-procurement of primary care services at Brierley Medical Centre

As a CCG we are responsible for planning and buying NHS GP services across Barnsley. All GP practices have a contract to provide NHS services that last for a number of years. The contract for NHS GP services at Brierley Medical Centre was scheduled to come to an end, as planned, on 30 November 2021.

As a CCG, we took the decision to maintain and continue with GP services at Brierley Medical Centre after this date, meaning that registered patients would continue to have all the same NHS GP services available to them from 1 December 2021. However, to enable us to do this, we needed to carry out an open competitive selection process where any qualified providers of health services could bid for and to carry out the contract from 1 December 2021.

Back in August 2021, we wrote out individually to and invited views and feedback from all registered patients of Brierley Medical Centre via a brief survey. This could be completed online, via paper freepost copy or at an in person drop- in session held at Brierley Methodist Church about anything that they would like to share with us about their personal experiences of the GP services that they receive at the practice.

We received 215 responses which was 9% of the total amount of people that were sent the survey and we had a good coverage of responses across all age groups and post codes within the catchment area that the practice serves.

We collated all the feedback into a report and then used the feedback to help develop some of the questions we asked all the bidders as part of the selection process.
A copy of the summary engagement report can be accessed **here**

An open competitive selection process took place between September and November 2021, and we were pleased to confirm that the current provider Barnsley Healthcare Federation were the successful bidder for the new contract to provide NHS services at Brierley Medical Centre from December 2021.

Developing a new all age Mental Health and Wellbeing Commissioning Strategy for Barnsley

Between 17 December 2021 and 26 January 2022, we asked people from across Barnsley to share their thoughts and feelings about the vision and priorities for mental health and wellbeing set out in the draft all-age Mental Health and Wellbeing Commissioning Strategy document. People fed back on the format and content of the strategy document; provided direct feedback on their own experiences and/ or posed questions and suggestions for further consideration.

Over the course of this specific engagement phase, we received comments and feedback from over 50 people, either as individuals or on behalf of groups, either in person, via the feedback survey that we have hosted online and provided paper copies of (upon request) or via email or telephone call directly to the CCG.

The emerging themes from the conversations and feedback that we have received as part of this engagement phase have helped in most areas to reinforce our direction of travel in relation to the aims and objectives set out within the draft strategy.

The feedback captured will also be used to help the next stage which is to shape the development of the delivery plan that will sit alongside the strategy.

Our aim is to continue to develop and strengthen the dialogue that we have established with the range of partners and stakeholders highlighted below and build upon the established local networks we have in place as well as developing new ones in areas where we know there are currently gaps.

A copy of the engagement summary report can be accessed here. This provides details of who responded, what people told us, and what we need to consider and emphasize in relation to the principles set out and sections included with the final version of our draft strategy and future ways of working.

Developing local Children and Adolescent Mental Health Services (CAMHS)

CAMHS is provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) who have been delivering specialised services for children and young people experiencing mental ill health for many years in Barnsley. SWYPFT have been mobilising the new CAMHS specification since early 2020. A key aim of the new specification is to integrate the low-level and specialised support for children, young people, their families, and the agencies that support them. The aim was to remove barriers, reduce waiting times, and create seamless care.

At the time of writing the new specification, it was acknowledged that although multiple community and voluntary organisations are working in Barnsley to deliver lower-level support for children and young people with mental health and emotional wellbeing needs, this resource needed to be enhanced to meet the need and demand for services. An engagement exercise was completed at the time (September 2019). Since February 2021, with support from the CCG, CAMHS and the mental health teams have worked closely together to develop strong working relationships. A major milestone in the continued development of both services is developing a Single Point of Contact, or SPoC.

The CCG are working with local Children and Young People's (CYP) groups to help re-name the SPoC ready for public launch in spring 2022. Two joint engagement sessions took place in January 2022.

CYP representatives from the following groups were invited to both sessions:

- Young Commissioners
- Barnsley Youth Council
- Care4Us Youth Council
- SEND Youth Forum
- EXODUS
- YMCA
- Ad Astra
- Youth Association

The aim is that by having two joint consultation session dates could enable reps from across groups to have choice/options of which focus group session they'd like to/be able to attend.

23 children and young people attended over the two weeks. The sessions involved an ice breaker exercise and input into the service including ideas for a new name and logo. The sessions were written up and this work will be taken forward and we will look to go to a vote for the final name ahead of the spring 2022 launch.

Developing more opportunities for engagement and participation in shaping local SEND (Special Educational Needs and Disabilities) for children and young people across the borough

Our collective vision for Barnsley is to create a local area where local education and health services and parents feel they play an active part in all SEND services. This means everyone; children, young people, parents, carers, services, and senior leaders from across education, health and care working together to play their part.

We have a dedicated SEND Participation Officer, whose role is to support and encourage service improvement around co-production and make sure that children and young people and parent/carer voice is embedded across the local area.

The ways that parents, carers children and young people can have their voice heard are:

- Completing online surveys
- Being involved in developing strategies through involvement with the SEND Youth Forum and the Parent and Carer Forum.
- Coming along to face to face discussions.
- Joining workshops looking at how they want services to work.
- Drop-in sessions where they can meet with representatives from local SEND services

Barnsley's local area SEND inspection took place during September 2021. The inspection was led by one of Her Majesty's Inspectors from Ofsted, with a team of people including an Ofsted inspector and a children's services inspector from the Care Quality Commission (CQC).

During the week the inspection team spoke with children, young people parents and carers, partners and stakeholders including managers and leaders from the Barnsley's education, health and social care services. The purpose was to review how well Barnsley meets its responsibilities for children and young people (aged 0-25) who have SEND.

During the week before the inspection and throughout the week-long inspection period, the inspectors were provided with information about Barnsley's children and young people with SEND, as well as the available services on offer to support them and their families.

Over 30 focus groups and meetings were held with a wide range of participants and the inspectors also visited several settings, including primary and secondary schools, special schools, our further educations college and early years settings. This equated to up to two hundred people being involved during the inspection.

A letter outlining the findings from the inspectors has now been provided and this has been published on the Ofsted and CQC website as well as on the Barnsley's local offer website This site also highlights how people can get involved in shaping and developing local SEND services and what local developments have taken place following the local inspection on the dedicated we said, we did page. One of the areas to come out of the inspection was the need for greater involvement of parents and carers. A parent and carer led group has now been established.

Work with our partners across the South Yorkshire and Bassetlaw Integrated Care System

The CCG is a partner in the South Yorkshire and Bassetlaw Integrated Care System (ICS). The ICS is a group of partners involved in health and social care that have agreed to work in closer partnership to improve health and care. The ICS has made a commitment to involving patients and the public in health service developments.

During the COVID-19 Pandemic the ICS has continued to host the Citizen's Panel for virtual meetings, recruited over 1000 people to a new engagement membership online database 'Let's Talk Health and Care' and conducted a number of bespoke engagement exercises.

The 'Get Involved' page of the ICS website directs members of the public to opportunities to become involved in work being carried out by the partnership. Members of the public can keep abreast of ways in which they can contribute their thoughts, views and time via the ICS's social

media channels as well as by signing up to the 'Let's Talk Health and Care' engagement membership database.

Details about feedback received and how we put it to use is available on our 'Using your feedback' page.

Recruitment to the Let's Talk Health and Care Membership

In July 2020 recruitment was launched to a new online health and care membership scheme across South Yorkshire and Bassetlaw. As a member, people are invited to be involved as little or as much as they like in helping to shape health and care services. The aim is to create a community of over 1000 people who all want to make their health and care services better.

They are connected through regular newsletters and sharing of opportunities to get involved. Recruitment was delayed due to the pandemic, however face to face recruitment took place in Autumn 2021 following social distancing and other safety guidance. The first newsletter to the newly recruited 1000+ people was issued in February 2022.

Accelerator Programme Review

NHS partners across SYB are working together to ensure routine NHS care can get back to where it was before the pandemic as quickly and efficiently as possible, whilst continuing to provide high quality patient care.

We commissioned an independent report to look at what patients and the public had already told us about their views on a number of solutions being pursued by partners of the South Yorkshire & Bassetlaw (SYB) Integrated Care System (ICS) to aid the current Accelerator Programme and speed up access to secondary care for patients. Read the report here.

Community Diagnostic Hubs/ Centres

South Yorkshire and Bassetlaw Integrated Care System are in the process of establishing South Yorkshire's first community diagnostic Centres. We commissioned independent engagement with local service users to understand their recent experiences of diagnostic services in the area and how they would like to see community diagnostic hubs delivered.

The main body of this research took the form of an online survey and a survey and focus groups with seldom-heard groups undertaken by South Yorkshire's Community Foundation. Read the report here.

Explaining Data Flow in the Yorkshire and Humber Care Record

The Yorkshire and Humber Care Record (YHCR) is a partnership to provide health and care staff with better and faster access to vital information about the person in their care. All partners in the SYB ICS are part of the YHCR. It will also provide citizens with access to their information and encourage them to be more involved in looking after their health. This report describes research with the public to explore acceptability and to co-design explanations of how data flows in the Yorkshire and Humber Care Record (YHCR) and Population Health Management (PHM) platform. The research took place to ensure that the public accept that their data must flow from NHS systems in order for the PHM platform to operate, and that the public understand at what point their data is de-identified, how they can be re-identified, and how they can opt out. Read the report

Establishing the Respiratory Clinical Network

South Yorkshire and Bassetlaw ICS is in the process of establishing a new Respiratory Clinical Network across the area of the partnership. This new clinical network will bring together clinicians and multi-disciplinary expertise to help design and promote optimal respiratory care pathways.

As part of the process of setting up the clinical network, the ICS commissioned a report to review past engagement around issues relating to respiratory services to help provide the new network insight to help develop its areas of focus as it seeks to understand service users' priorities for respiratory care. The report can be read here.

Integrating NHS Pharmacy and Medicines Optimisation Programme Plan for South Yorkshire and Bassetlaw

The national Integrating NHS Pharmacy and Medicines Optimisation (IPMO) programme aims to develop a framework which will set out how to tackle the prescribing priorities for the local population across the ICS footprint. We shared the draft IPMO Plan for SYB for feedback/comments. The feedback and how this was used to adapt the plan can be found here.

Supporting Children, Young People and Families following a bereavement by suicide

SYB ICS have commissioned CHILYPEP (Children and Young People's Empowerment Project) to identify what support Children, Young People and Families would like to see following a bereavement by suicide, and work with them to develop a toolkit for professionals to use with them focusing on how best to offer this support.

A range of stakeholders have been consulted with, including organisations working with Children and Young People and their Families affected and bereaved by suicide, commissioners and others. The output of this work will be a number of proposed deliverable solutions to the issues identified, which will then be co-produced into a toolkit for use across the ICS. These are expected to be finalised in 2022.

Birth Trauma Service – Engagement with vulnerable women and women from a Black, Asian or Ethnic Minority background

SYB ICS secured funding for a maternal mental health service around birth trauma and loss, and we wished to build the service provision based on the experiences of local people. We commissioned South Yorkshire Community Foundation to ensure the views of hard-to-reach groups such as: women from a Black, Asian or Ethnic Minority background and marginalised women could be better understood and fed into the service provision review.

The report of this work can be found here. Further work is now underway, following the recommendations in the original report, to better understand the experiences of the seldom heard communities throughout the whole maternity journey.

Children and Young People's Mental Health Strategic Plan

SYB ICS was tasked with producing a Children and Young people's Mental Health Strategic Plan by October 21. In order to do this, each place liaised with local residents and users of

services to pull together a template shared centrally. From there, an overall strategy was created to highlight achievements so far, gaps in provision and where we could address these gaps at a system level.

We commissioned Chilypep to run a number of sessions with young people from across SYB to create the final strategy by highlighting areas they were most interested in and creating a format that would appeal to young people. Final document is now available to view on SYB ICS website here.

Integrated Stroke Delivery Network Patient Panel

The Long Term Plan for the NHS recognises the importance of tackling the growing impact of stroke in England. The South Yorkshire and Bassetlaw ISDN is committed to ensuring that public and patient voices are at the centre of shaping our stroke services. The ISDN want to make sure that services are developed and improved by those with lived experience of stroke and so reached out to the public about becoming part of a panel of people with experience of living with stroke or caring for someone with stroke.

We were overwhelmed by the support we received and have recruited 12 panel members from across the region. Our members represent a diverse mix of stroke survivors and carers, all with lived experience of stroke. Members come from each place across our region and are already making a real difference.

Digital

In 2021 the digital team undertook discovery work around what a good ‘digital offer’ would look like for the population in SYB. We supported them to ensure they heard from a number of SYB communities about their needs. The report can be found here.

School Engagement

The school engagement team offer a large range of activities and sessions as part of their outreach work, which engage children and young people in their work. Their work over 2021-22 has included the following: A series of insights sessions that are live streamed into schools where pupils learn about a range of jobs in health and social care that are a good match for the course they are on and the subjects they are studying.

These are hosted, interactive sessions using real job holders, pre-recorded footage and live presentations to showcase roles. The team also offers a range of employer led projects with schools covering topics such as the mental health workforce, health promotion and digital skills in health. They also attend careers events, provide 1-2-1 information, advice and guidance to students, up-skill teachers and careers leaders through CPD sessions, support mock interviews and offer internship placements to ‘A’ level students.

Involvement to help shape the Integrated Care Board People & Communities Strategy

In March 2022 we have launched an engagement exercise to involve people in the development of the People & Communities Engagement Strategy for the emerging ICB. Opportunities to get involved include telling us how people would like to be engaged, engagement on the principles for engagement and a chance to review the draft Strategy. The draft strategy will be submitted to NHS England/ Improvement in May 2022.

South Yorkshire and Bassetlaw ICS Cancer Alliance engagement activity 2021/22

Over the last twelve months we have continued to strengthen the involvement of our Patient Advisory Board – an advisory group made up of people affected by and living with and beyond cancer. The group helped us to shape the role and specification of new Pathway Navigators who are now in place supporting the development of Rapid Diagnostics across the region.

As part of this work, the group also helped us to shape and define the ten nationally identified Quality Markers and how we can implement them to improve local cancer services.

Helping to shape and inform the future of oncology services in South Yorkshire and Bassetlaw

During the last two years of the pandemic, receiving cancer care has been different for many.

People may have received care in a different hospital to normal, either closer to where they live or they may have had more appointments at our specialist cancer centre, Weston Park in Sheffield. Most people will undoubtedly have had some appointments in a non-face to face way (e.g. on the phone or via online).

We now have the opportunity to look at what has been working well and what hasn't so we can better plan our future services. We also have an imperative to do this now. There continues to be a national Oncology Consultant shortage and we have an increased number of patients waiting to see us. We need to make sure the quality of care across South Yorkshire, Bassetlaw and Chesterfield remains high for everyone during these challenging times.

We are therefore currently actively seeking the feedback of anyone receiving care and treatment for cancer across Barnsley, Bassetlaw, Chesterfield, Doncaster, Rotherham and Sheffield.

Further work shaped by patients and the public:

- Improving skin cancer pathways – surveys of skin cancer patients to support the development of the "optimum" skin patient pathway
- Quality of Life Survey **–** we support the rollout of the national survey to people 18 months post treatment to understand what more support we can offer to people locally once they have completed their treatment journey.
- Cancer Patient Experience Survey – we support the rollout of the national Cancer Patient Experience Survey, pulling together local responses to highlight any opportunities for improvement.
- Breast Pain Service **–** "Breast pain only is not a symptom of cancer" – we have been gathering views of people across South Yorkshire and Bassetlaw to gauge understanding of the signs and symptoms of breast cancer, self-checks and when further investigation may be needed. We are now actively seeking involvement from members of the public to help us design and develop a breast pain service for our region.
- Recovering cancer services post Covid-19 **–** We are working with our colleagues at the South Yorkshire Community Foundation in four postcode areas across the region where recovery of two week wait (suspicious of cancer) referrals are the slowest since the Covid-19 pandemic. We will use all feedback to co-design a campaign to encourage early presentation and early diagnosis.
- Nudge the Odds, adopting behavioural science approaches to increasing early diagnosis **–** Through the Inequalities and Early Diagnosis workstream, detailed Business Intelligence

and data insights have been used to understand where we can make the biggest impact in increasing screening attendance amongst key target populations. This includes a pilot to increase cervical screening amongst Roma and South Asian communities, using detailed community insights to design behavioural science based “nudges” towards behaviour change.

Reducing health inequalities

COVID-19 has shone a light on health inequalities, and further increased the inequality gap both nationally and across the borough. The coronavirus pandemic is affecting social, economic, and family lives dramatically and in widely varying ways, and its potential for impacts on inequalities not only now but in the longer term is huge.

The renewed focus and emphasis on tackling health inequalities is welcomed by partners across Barnsley. In line with the NHS planning guidance 2021/22 partners committed to restoring services inclusively, prioritising those people and communities experience inequalities and implementing population health management and personalised care approaches to improve health outcomes.

This is also reflected on the CCG’s Public Sector Equality Duties. The CCG Governing Board has approved our equality objectives that have been developed and supported by underpinning actions that are linked to the Equality Delivery System (EDS) goal 2 of improved patient access and experience:

- Ensuring equality and inclusion are at the core of the commissioning process.
- Broaden the scope and content of information that we hold on protected groups and ensure maximum use from analysis.
- Build upon our understanding of patient experience of services, re equality, diversity and inclusion, and act upon instances of potential discrimination to continually improve service delivery.
- Developing strong and consistent leadership on equality, diversity and inclusion issues.
- Evidencing an informed, empowered, engaged and well-supported staff team.
- Improving access to services through informed commissioning.

All NHS partners now have executive director leads within their organisation for tackling health inequalities and all six of the neighbourhood clinical directors within the local primary care network are also leads for inequalities.

The Barnsley Health Inequalities Action Group (HIAG) is helping organisations to create action plans and align ambitions across partners. We have been working to the Core20PLUS5 which is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level.

The approach defines a target population cohort – the ‘Core20PLUS’ – and identifies ‘5’ focus clinical areas requiring accelerated improvement.

In April 2022 we will be starting the national population health management development programme delivered by Optum. Health inequalities will be a theme of this work as we will target underserved communities.

HIAG is working with the Barnsley health intelligence cell to improve data quality and reporting of health inequalities through routine reporting to transformation boards and the integrated care partnership group (ICPG) through the ICPG dashboard.

Through 2021/22 we have worked to create a health index for residents by identifying flags of vulnerability from across 27 different datasets and weighting these to create an index score. In 2022/23 we will build on this to create a mapping tool that shows the picture of need and inequalities across the Barnsley population using deprivation, protected characteristics and the applying the vulnerabilities index.

HIAG is working with the engagement, equality and experience leads to prioritise engagement with groups who experience health inequalities. The health index is being used to target winter wellbeing calls, affordable warmth. The insights we have gathered are informing our prioritisation of proactive care for frailty.

In response to the eight urgent actions on health inequalities set out by NHS England, the CCG, as part of the wider Barnsley integrated health and care partnership, has:

- Implemented a recovery plan for cancer, including understanding hidden harm and variations in referral patterns. This work is being done in conjunction with the Cancer Alliance. In Barnsley the rate of two-week referrals for suspected cancer recovered quickly after the initial wave of the pandemic, faster than in other parts of the region.
- Undertaken a detailed analysis of urgent and planned care pathways using indices of multiple deprivation.
- Seen ongoing work between Barnsley Hospital and primary care to support and prioritise patients waiting the longest for planned procedures. This includes consideration of quality of life and social circumstances to prioritise existing services for those in the greatest need.
- Expanded the Barnsley Hospital Healthy Lives team (secondary care prevention offer). Recruitment to new alcohol care teams and expansion of tobacco control advice service.
- Developed a local mental health projection model to understand the likely impact of COVID on population need and demand over the coming months and years.
- Worked continuously to improve data quality, including the recording of ethnicity and other protected characteristics. This leads to better intelligence and insights.
- Developed surveillance reporting of health inequalities through the health intelligence cell. This includes COVID 19 vaccine uptake and coverage.
- Used a Barnsley Hospital population health analyst to provided tailored health inequalities intelligence to hospital business units to aid strategic planning.
- NHS leaders present on place-based economic development boards.
- A team of community engagement officers, established by BMBC, to support recovery.
- Established an engagement and experience leads group to bring together collective insight, intelligence and experience gathered to help to shape future patient and public involvement.

Health and wellbeing strategy

Barnsley's Health and Wellbeing Board aims to improve health and wellbeing for the residents of Barnsley and reduce inequalities in health outcomes.

The Board agreed the Health and Wellbeing Strategy for 2021 to 2030 at its meeting in October 2021 and you can view it here.

Back in 2020/21 the Health and Wellbeing Board prioritised two areas of work: mental health and wellbeing and children and young people. In doing so it has set up a Barnsley mental health partnership, recognising the need to come together to tackle the growing mental health needs coming through the pandemic.

Whilst these are our key current priorities, our strategy sets our vision for a Healthy Barnsley and is underpinned by a series of ambitions across the life course, that we hope to achieve from pre-birth through to end of life. The strategy strengthens the Board's commitment to reducing health inequalities within the borough by focussing on the wider determinants of health (such as housing, employment and education) to give everybody in Barnsley a fair opportunity to live a healthy life.

In order to achieve our vision, and reduce health inequalities, we'll need the commitment of everybody within Barnsley. From our partners, that sit on the Health and Wellbeing Board, to our businesses and our communities – we all have a role to play in delivering a Healthy Barnsley.

The Health and Wellbeing Board brings together local anchor institutions, who will work together to improve outcomes for our Barnsley residents. Our strategy for a 'Healthy Barnsley' is both long-term and ambitious, taking action across the life course to improve the health and wellbeing of everyone in Barnsley.

We will focus on reducing health and social inequalities to enable everyone in Barnsley to have the opportunity to live a healthy and satisfying life. Our immediate focus is on improving mental health in Barnsley and ensuring Barnsley is a great place for a child to be born. We know we can't do this alone, and it will require support and commitment from our communities and change at societal level – by harnessing the Barnsley spirit that has been evident throughout the COVID-19 pandemic, we're confident we can continue to deliver a Healthy Barnsley.

Sustainable Development

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. At Barnsley CCG we acknowledge our responsibility to our patients, local communities and the environment and are committed to work hard to minimise our carbon footprint.

Governance

The CCG has a sustainability lead (the Head of Governance & Assurance) and has put in place a Green Plan (previously called our Sustainable Development Strategy and Management Plan). This was refreshed in 2021 with the support of our staff engagement group, the Radiators, and our health and safety lead. The Green Plan is available on our website. It describes our commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner.

Some of the key actions and achievements are described below:

Commissioning	
Using our influence as a commissioner	• We work with our providers to ensure they are delivering their own stretching carbon reduction targets. • As described in this report, our commissioning priorities include a reduction in secondary care admissions, with more services being delivered closer to home in primary or community settings, which should reduce costly journeys for local people. • During 2021/22 we continued an ambitious medicines ordering – safety and waste programme which is successfully reducing medicines waste associated with third party ordering.
Corporate	
Travel & mobile working	We: • Encourage CCG staff to car share or engage in active travel. • Have supported all CCG staff to work from home during the covid-19 pandemic through the provision of phones and laptops, and will continue to offer home working as a flexible working option once restrictions are lifted. • Offer both a 'bikes to work' and 'bike shop' salary sacrifice option to our staff. • Provide a car lease option for our staff which offers preferential terms for electric vehicles. • Have installed a charging point for electric vehicles at our premises.
Improving the efficiency of our facilities	• We encourage recycling and provide facilities for recycling paper and batteries at Hillder House. • We encourage black & white rather than colour printing wherever possible and have upgraded our printers to more efficient models.

	• We have made significantly less use of printing throughout the covid-19 pandemic as staff have adapted to remote working. • Where appropriate staff are provided with mobile devices and are expected to use these rather than paper in meetings. • We encourage staff to conserve energy eg by switching off lights when rooms are not in use, and have seen a significant reduction in our energy consumption during the pandemic.
Our workforce	• We are passionate about supporting and developing the health & wellbeing of our staff. • We run regular 'health and wellbeing weeks' during which staff are encouraged to participate in a wide range of activities aimed at improving their physical and mental health.
Buildings	• We work with NHS Property Services on all aspects of estates sustainability as a tenant, for example, the boiler at Hillder House has been replaced and we have put thermostats on our radiators. • Working with the Barnsley Strategic Estates Forum (SEF) we will seek to maximise the use of NHS Estate. • We will work with our member GP practices to review primary care estate as part of the primary care development programme.

NHS Property Services (NHSPS) owns Hillder House on Gawber Road, which is the head office for Barnsley CCG. We work closely with NHS Property Services to improve our building. For example modern electronic fittings have been renewed throughout the building, the boiler has been replaced, and low energy lighting installed to reduce consumption. We will continue to work with NHSPS to better understand our energy usage and seek ways to utilise our facilities more efficiently.

Usage figures for 2021/22 are provided below, along with comparators from the previous three years:

Total NIA (m^2)	**Electricity kWh**	**Electricity Cost**	**Gas kWh**	**Gas Cost**	**Water m^3**	**Water Cost**
2021/22	51,150	£6,145	133,082	£4,300	607	£1,788
2020/21	38,333	£6,780	153,514	£4,299	607	£1,788
2019/20	64,150	£12,205	128,868	£4,796	*Not available*	£1,039
2018/19	58,913	£10,356	107,011	£4,035	816	£4,547

Emergency Planning, Resilience & Response (EPRR) and Business Continuity

We have worked collaboratively with other South Yorkshire and Bassetlaw CCGs to ensure that we have robust EPRR and business continuity arrangements in place.

We participated in the annual EPRR assurance process with NHS England, completing a self-assessment against applicable NHS England core standards and identifying actions to ensure full compliance. The Local Health Resilience Partnership (LHRP) has confirmed the CCG's self-assessment of 'fully compliant.'

Throughout this year the CCG has continued to have strong processes in place for managing the impact of Covid-19 and supporting partners and providers to maintain essential services for patients. We operated our own emergency response for the CCG, and for the ongoing delivery of primary care in Barnsley, ensuring that the Governing Body and all employees were up to date or the arrangements. As partners in the Barnsley and South Yorkshire wide response, we have also played an active role, taking on a coordination role on behalf of the Barnsley Integrated Care Partnership and representing the health sector on the Barnsley Tactical Coordination Group.

Accountability Report

Signature of the Accountability Report by the Accountable Officer

Chris Edwards, Accountable Officer,
16 June 2022

Corporate Governance Report

Members' Report

Member Profiles

Profiles of the Governing Body members and other relevant information can be found on the CCG's website www.barnsleyccg.nhs.uk/about-us/governing-body.htm

Member Practices

Clinical commissioning groups are member organisations and representatives from the 32 Barnsley GP practices form the NHS Barnsley CCG Membership Council. Details of all our practices are on our website http://www.barnsleyccg.nhs.uk/about-us/membership.htm

Composition of the Governing Body

As set out in the Health and Social Care Act 2012, each CCG must have a Governing Body. The Governing Body of the CCG provides oversight and assurance as well as giving strategic direction to the CCG's activities.

During 2021/22 the Governing Body was made up of 13 people including seven members elected by the Membership Council; two Lay Members; a Secondary Care Clinician; a Chief Nurse; and two other senior executive officers.

The members of our Governing Body during 2021-22 are shown below:

Name	Position on the Governing Body	Appointment dates	Attendance record*
Dr Nick Balac	Elected Member & Chair of the CCG	1 April 2013, reappointed 1 April 2017, 1 April 2020 and to 30 June 2022	11/11
Dr John Harban	Elected Member	1 April 2013, reappointed 1 April 2015, 1 April 2018, 1 April 2020 and to 30 June 2022	8/11
Dr Mark Smith	Elected Member	1 April 2015, reappointed 1 April 2018 and to 30 June 2022	9/11
Dr Adebowale Adekunle	Elected Member	18 July 2016, reappointed 18 July 2019, 1 April 2020	10/11
Dr Jamie MacInnes	Elected Member	10 December 2018, reappointed 9 December 2021	9/11
Dr Mohammed Hussain Kadarsha	Elected Member	1 April 2017, reappointed 1 April 2020	8/11
Dr Madhavi Guntamukkala	Elected Members & Medical Director	1 September 2020 as elected GP and 1	10/11

Name	Position on the Governing Body	Appointment dates	Attendance record*
		December 2020 as Medical Director	
Nigel Bell	Lay Member for Governance (Conflicts of Interest Guardian)	20 July 2017, reappointed 20 July 2020	10/11
Chris Millington	Lay Member Representative for Patient and Public Engagement and Primary Care Commissioning	1 April 2015, reappointed 1 April 2018 and to 30 June 2022	11/11
Mike Simms	Secondary Care Clinician	1 September 2013, reappointed 1 April 2017, 1 April 2020 and to 30 June 2022	10/11
Jayne Sivakumar	Chief Nurse	1 December 2019	6/11
Chris Edwards	Chief Officer (and Accountable Officer)	Appointed 1 September 2020	10/11
Roxanna Naylor	Chief Finance Officer	19 June 2017	10/11

[During 2021/22 Governing Body has met 11 times. This includes extra ordinary meetings].

Committees, including Audit Committee

During 2021/22 the following members of the Governing Body were members of the CCG's Audit Committee: Nigel Bell, Chris Millington, and Dr Adebowale Adekunle. There was a vacancy for a Member of the Membership Council to serve as a Member of the Audit Committee throughout 2021/22.

All CCGs are required by statute to have an Audit Committee and a Remuneration Committee (for details see Remuneration Report). In addition, although not stipulated in legislation, we have established a:

- Primary Care Commissioning Committee
- Quality & Patient Safety Committee
- Finance and Performance Committee
- Equality and Engagement Committee, and an
- Integrated Care Organisation Procurement Committee.

Details of the functions, membership, and attendance records of each of these Committees can be found in the Governance Statement.

Register of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship.

We require interests to be declared on appointment in writing, at meetings, on changing roles or responsibilities, on any other change of circumstances, and at specific points during the procurement process.

Our Registers of Interests are available on our website Registers of Interest (barnsleyccg.nhs.uk)

Personal data related incidents

We have had no Information Governance Serious Incidents Requiring Investigation (IG SIRI) reportable to the Information Commissioner in the past year.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

NHS Barnsley 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 http://www.barnsleyccg.nhs.uk/about-us/modern-slavery.htm

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Barnsley CCG.

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), 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.

Chris Edwards, Accountable Officer
16 June 2022

Governance Statement

Introduction and context

NHS Barnsley Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

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

During 2021/22 NHS England has continued to oversee the performance and development of the CCG through its Oversight Framework (formerly known as the Improvement and Assessment Framework). The 2021/22 year-end assessment will be published by the CCG when it has been received from NHS England.

The Governing Body continues to oversee the CCG's performance through the engagement of its members in the work of the CCG and the performance & risk management arrangements described in this Statement.

CCG Closedown & Transition

The proposed Health & Care Bill will allow for the establishment of Integrated Care Boards (ICBs) and Integrated Care Partnerships across England. This will be done at the same time as abolishing Clinical Commissioning Groups (CCGs). It is currently expected that NHS Barnsley CCG will cease to exist on 30 June 2022, and that NHS South Yorkshire ICB will take on the NHS commissioning functions of the four South Yorkshire CCGs from 1 July 2022.

Nationally, several documents have been published to support the establishment of the Integrated Care Board and abolishment of CCGs, with further documents expected in the coming weeks. CCG Accountable Officers will be required to provide the Integrated Care Board (ICB) Chief Executive with assurance on the due diligence undertaken to allow the safe legal transfer of people, property and liabilities on 30 June 2022. This due diligence will also act as important evidence to support the Readiness to Operate Statement (ROS) to be signed off by the ICB Chief Executive during June 2022.

To support this assurance process the CCG has established a Change and Transition Group. The focus of this group is to work through the requirements of the national closedown checklist and ensure safe transition. Each task within the national closedown checklist has been assigned to a lead officer and RAG rated. The Group has also established a Closedown Risk register to highlight potential issues or barriers to achieving a safe transition.

The group reports progress into special meetings of the Governing Body convened for this purpose each month. In addition, the Audit Committee has undertaken periodic 'confirm and challenge' sessions with the Group, and internal audit is using some of its audit days to provide oversight and assurance around this process across the four CCGs.

Whilst there are some elements of this checklist linked to the creation of the ICB, this Group does not maintain oversight of the design or set up of the ICB as this will be part of the governance within the Integrated Care System with design working groups being established and reporting through the Joint Committee of CCGs. The ICS has also established a Transition Executive Group to oversee the transition process.

Scope of responsibility

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

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

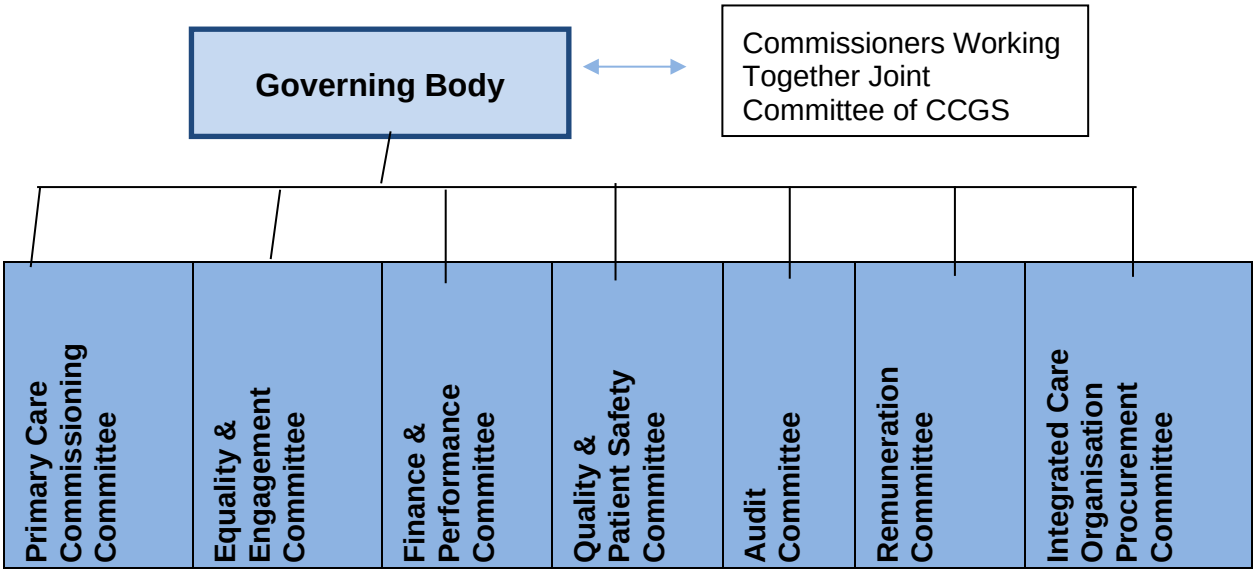
Governance Arrangements and Effectiveness

The main function of the Governing Body is to ensure that the Group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently, and economically and complies with such generally accepted principles of good governance as are relevant to it. This section provides details of how this has been achieved.

Key features of the CCG's Constitution

CCGs are member organisations. The 32 Barnsley General Practitioner (GP) Practices each nominate one representative to the Membership Council, which in 2021/22 elected 7 Members to the Governing Body. The Membership Council has met three times during 2021/22. The functions reserved to the Membership Council are to agree the vision, values and overall strategic direction of the CCG; approval of the CCG's Annual Commissioning Plan and supporting Financial Plan; and approval of changes to the Constitution. Details of the CCG's member practices can be found on the CCG's website http://www.barnsleyccg.nhs.uk/about-us/membership.htm .

The Membership Council has delegated the responsibility for carrying out the remaining functions of the CCG to the Governing Body and its Committees. These are shown in the next table.



Information about the Governing Body

The Governing Body has responsibility for leading the development of the vision and strategy, and for agreeing the Annual Commissioning Plan in collaboration with the Membership Council. It also retains overall responsibility for financial management, quality improvement, and monitoring and reporting performance against the plan. The 2021/22 Annual Report provides highlights of the Governing Body's work over the year (see Performance Report), details of the Governing Body members including their attendance records and declared interests (see Members' Report), and the remuneration paid to senior managers (see the Remuneration Report).

Information about the Committees of the Governing Body

Some of the Governing Body's functions are exercised on its behalf by its Committees. Terms of Reference for all Committees are available via the CCG's Governance Handbook on our website (https://www.barnsleyccg.nhs.uk/about-us/governance-handbook.htm). Minutes of all Committees are reported to the Governing Body, significant matters are escalated through the Risk Management Framework, and Governing Body Members sit on the Committees.

Each Committee produces and presents to the Governing Body an Annual Assurance Report setting out how it has discharged its responsibilities as set out in its Terms of Reference, its key achievements in the year, how it has assessed its own effectiveness, and the key risks it has been responsible for managing. In this way the Governing Body remains fully sighted on all key risks and activities across the CCG, as described in the tables on the next pages.

Audit Committee

Function Provides assurance and advice to the Governing Body on the entirety of the CCG's control and integrated governance arrangements. This includes the proper stewardship of resources and assets, including value for money; financial reporting; the effectiveness of audit arrangements (internal and external); and risk management arrangements.		
Assurance provided to the Governing Body The Committee receives and reviews the Risk Register and Assurance Framework on a regular basis. It considers reports and opinions from internal audit, external audit, and the Local Counter Fraud Service. Reports on tender waivers, declarations of interest, gifts & hospitality are considered at every meeting. It reviews the annual accounts and annual governance statement and recommends these for approval to the Governing Body. This enables the Audit Committee to assure the Governing Body that the system of internal control set out in the constitution and corporate manual is being implemented effectively.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Lay Member for Governance	Nigel Bell	6/6
Lay Member for PPE & Primary Care Commissioning	Chris Millington	6/6
Elected Governing Body Member	Dr Adebowale Adekunle	4/6
Membership Council Representative	Vacant	

Finance and Performance Committee

Function Advises and supports the Governing Body in scrutinising and tracking of key financial and service priorities, outcomes and targets.		
Assurance provided to the Governing Body An Integrated Performance Report is taken to every Governing Body meeting, providing assurance that the CCG is delivering its key performance targets and statutory financial duties and providing early warning where this is not the case.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Chair of the Governing Body (Chair)	Dr Nick Balac	8/10
Governance Lay Member	Nigel Bell	8/10
Elected Governing Body Member	Dr John Harban	10/10
Elected Governing Body Member	Dr Jamie MacInnes	9/10
Elected Governing Body Member	Dr Adebowale Adekunle	8/10
Member of the Membership Council – left as a member from September 2021	Dr Andy Mills	4/5
Chief Officer (September onwards)	Chris Edwards	9/10
Chief Finance Officer	Roxanna Naylor	10/10
Chief Operating Officer	Jamie Wike	9/10

Quality & Patient Safety Committee

Function Advises the Governing Body with a view to ensuring that effective quality arrangements underpin all services commissioned on behalf of the CCG, regulatory requirements are met and safety is continually improved to deliver a better patient experience.		
Assurance provided to the Governing Body The Committee receives monthly Quality Metrics reports covering quality, patient safety, serious incident reviews, safeguarding, infection control, mortality rates, and other relevant issues. Quality Highlights reports are provided to the Governing Body after every meeting.		
Membership and attendance		
Role	**Name**	**Meetings attended**
Medical Director (Chair)	Dr Madhavi Guntamukkala	4/6
Chief Nurse (Deputy Chair)	Jayne Sivakumar	6/6
Governing Body Secondary Care Clinician	Mike Simms	6/6
Governing Body Member	Dr Mark Smith	6/6
Governing Body Member	Dr Adebowale Adekunle	5/6
Lay Member for Public and Patient Engagement	Chris Millington	5/6
Head of Medicines Optimisation	Chris Lawson	5/6
Membership Council Rep (resigned 28 July 2021)	Dr Shahriar Sepehri	0/2
Specialist Clinical Portfolio Manager	Jo Harrison	4/6

Equality & Engagement Committee

Function
Advises the Governing Body to ensure that effective systems are in place to manage and oversee the implementation of a strategic vision for equality, diversity and human rights across all services commissioned on behalf of the CCG. It also provides advice to the Governing Body on communication and patient, carers and public engagement, ensuring that Patient and Public Engagement is central to the business of the CCG.

Assurance provided to the Governing Body
This group establishes and monitors the CCG's action plan related to its equality duties. The group has ensured a process for equality impact assessments is in place, supported staff briefings, and leads on the approval and review of human resources policies. In addition the Committee develops and reviews the Patient & Public Engagement Strategy and Plan, and receives regular updates on all PPE related activities across the CCG to ensure these are aligned to the commissioning priorities.

Membership and attendance

Role	*Name*	*Meetings attended*
Lay Member for Public and Patient Engagement (Chair)	Chris Millington	3/4
Chief Nurse (Vice Chair)	Jayne Sivakumar	2/4
Deputy Chief Nurse	Martine Tune (left 31.10.2021)	2/2
Member of the Membership Council	Vacant	N/A
Head of Communications and Engagement	Kirsty Waknell	4/4
Senior Primary Care Commissioning Manager	Julie Frampton	1/4
Elected Governing Body Member	Dr A Adekunle	3/4
Healthwatch Barnsley	Lesley Cooper (joined 18.11.21)	2/2
Equality, Diversity & Inclusion Lead	Colin Brotherston-Barnett (left 31.08.2021	2/2
Equality, Diversity & Inclusion Lead	Roya Pourali (joined 01.09.21)	2/2
Head of Governance & Assurance	Richard Walker	4/4

Remuneration Committee

Function Advises the Governing Body on determinations about the appropriate remuneration, fees and other allowances; terms of service for employees and for people who provide services to the CCG; and provisions for other benefits and allowances under any pension scheme.		
Assurance provided to the Governing Body Drawing on benchmarking and expert HR advice, the Remuneration Committee has advised the Governing Body on appropriate remuneration and contractual arrangements for Governing Body members and others not covered by Agenda For Change terms and conditions.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Lay Member for PPE and Primary Care Commissioning (Chair)	Chris Millington	2/2
Chair of the Governing Body	Dr Nick Balac	2/2
Lay Member for Governance	Nigel Bell	2/2
Elected Governing Body Member	Dr John Harban	2/2
Elected Governing Body Member	Dr Jamie MacInnes	2/2
Governing Body Secondary Care Clinician	Mike Simms	2/2

Primary Care Commissioning Committee

Function Makes collective decisions on the review, planning and procurement of primary care services in Barnsley, including functions under delegated authority from NHS England. The Committee manages the delegated allocation for commissioning of primary care services in Barnsley. In addition, where the Governing Body is unable to take a decision due to conflicts of interest, the matter will be delegated to the Primary Care Commissioning Committee for approval or consideration.		
Assurance provided to the Governing Body Provides assurance to the Governing Body that the functions delegated to the CCG have been appropriately discharged, with regard to outcomes for patients, the management of any conflicts of interest, primary care procurement and contract management, and the availability of services.		
Membership and attendance		
Voting Members	*Name*	*Meetings attended*
Chris Millington (Chair)	Lay Member for PPE & Primary Care Commissioning	8/9
Nigel Bell	Lay Member for Governance	9/9
Mike Simms	Governing Body Secondary Care Clinician	9/9
Richard Walker	Head of Governance and Assurance	8/9
Chris Edwards	Chief Officer	8/9
Non- Voting Members	*Name*	*Meetings attended*
Dr Nick Balac	Chair of the Governing Body	7/9
Dr Madhavi Guntamukkala	Medical Director	5/9
Dr Mark Smith	Elected Governing Body Member	7/9

Integrated Care Organisation (ICO) Procurement Committee

Function The ICO Procurement Committee is responsible for oversight of the procurement process, providing assurance that appropriate governance is in place, and managing conflicts of interest related to the procurement.
Assurance provided to the Governing Body Subsequent to the issue of the contract notice it will have delegated authority to take procurement decisions on behalf of the Governing Body, including: • Approval of the preferred bidder as recommended by the evaluation panel, and • Giving authority to award the contract.

**Whilst this Committee is established and now forms part of the CCG Constitution it has never formally met as the procurement of an ICO in Barnsley is currently on hold.*

Information about the Health and Wellbeing Board

The CCG's Chair and Chief Officer are also members of the Barnsley Health & Wellbeing Board, a Committee of Barnsley Metropolitan Borough Council which was set up in April 2013 as a requirement of section 194 of the Health and Social Care Act 2012. The objective of the Health & Wellbeing Board is to promote integrated working across health and care services and to redesign health and wellbeing services across organisational boundaries so that services are joined up and health outcomes are improved for local people.

The Health and Wellbeing Board also has very senior representatives from a range of other stakeholders including Barnsley Metropolitan Borough Council, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership Foundation Trust, NHS England, Barnsley Healthwatch, and South Yorkshire Police. The Board produces and regularly updates a Joint Strategic Needs Assessment, which underpins the Health and Wellbeing Strategy and other partnership plans to improve health outcomes and address health inequalities.

Better Care Fund

The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions. The aim of the BCF is to support transformation and integration of Health and Social Care in line with the Health and Wellbeing Strategy for Barnsley.

A governance structure and pooled budget arrangements for the BCF has been agreed with Barnsley MBC and formalised in a Section 75 agreement which provides for reporting on BCF indicators through the CCG's Committee structure to the Governing Body.

The Health & Wellbeing Board is responsible for oversight of the Better Care Fund. There is clear CCG senior management ownership and leadership of the BCF and clinical involvement through GP membership of the Governing Body and as Vice Chair of the Health and Wellbeing Board.

Joint Committee of Clinical Commissioning Groups

In 2015 the CCG became a member of the Joint Committee of CCGs (JCCCG). Initially the Committee had delegated authority to only make decisions on two service areas (Hyper Acute Stroke Services and some out of hours Children's Surgery and Anaesthesia services). In June 2019 CCGs agreed revised delegated authority for decision making for a new set of priorities, which can be found here: https://www.healthandcaretogethersyb.co.uk/application/files/5915/6096/1736/JCCCG_-_26_June_2019_Agenda_and_Papers.pdf

These were accompanied by a revised Manual Agreement, Terms of Reference and Workplan for the JCCCG. These documents were updated last year to reflect the future transition of CCGs to an Integrated Care Board (ICB) and to ensure the joint committee could support CCGs to work collectively together on some aspects of transition.

Due to no joint decisions needing to be made, largely due to the impact of the COVID-19 pandemic, none of the scheduled public meetings for 2021-22 proceeded as planned. The most recent meeting papers can be found here: https://sybics.co.uk/about/meetings-and-minutes

As a result of the revised timetable for implementation of statutory ICBs the Joint Committee has also considered changes to ensure it can continue to work jointly and with the emerging ICB Board and delegates from April 2022.

South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)

The CCG is also a partner in the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS). ICSs are systems in which NHS commissioners and providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

The SYB ICS has evolved from the establishment of a Sustainability and Transformation Partnership in January 2016, an Accountable Care System in April 2017, to then becoming one of the first and most advanced ICS systems in England.

During 2021-22 the ICS did not replace any legal, or statutory, responsibilities of any of the partner organisations and the ICS governance remained the same as 2020-21. Noting that some changes were made to enable organisations and leaders to come together to support the response and manage issues relating to the pandemic. This includes pausing or adapting some of our meetings.

In February 2021, NHS England & Improvement made five recommendations to Government on the question of how to legislate Integrated Care Systems on a statutory footing, having gathered the views of the NHS, local government and wider stakeholders. Following this, the Government published the White Paper *'Integration and Innovation: Working Together to Improve Health and Social Care For All'* (February 2021):

https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

These proposals will shape the future of the SYB ICS which, legislation pending, will become an Integrated Care Authority in 2022.

Following the implementation of the proposed legislation during 2022 there will be an NHS Integrated Care Board (ICB) which will take on CCG's functions and broader strategic responsibility for setting health care strategies for the system. The ICB will work with an Integrated Care Partnership (ICP) formed jointly with Local Authority partners. Together the ICP and ICB will become the Integrated Care System (ICS).

In 2021-22 the governance of the ICS included the following:

The ICS System Health and Care Management Team

During the pandemic the health and care management team, which is a collaborative forum of SYB statutory bodies and regional bodies, has come together on a weekly basis to ensure they are able to respond well to the pandemic. This forum has also acted as the Local Resilience Forum's (LRF) Health Cell when the LRF has declare a critical incident.

In addition, the following have continued to meet:

The System Health Executive Group

The System Health Executive Group (HEG) is the primary executive group comprising Chief Executive and Accountable Officer members from each health statutory organisations across the ICS and other partner organisations across Yorkshire and the Humber, to plan and deliver strategic health priorities which require collaborative working across the SYB ICS footprint.

The Integrated Assurance Committee

The Integrated Assurance Committee has non-executive and lay member representatives as well as executive membership. The purpose of the Integrated Assurance Committee is to provide assurance to the partners and to regulators on the performance, quality and financial delivery of health and care services within the five places and across the system in South Yorkshire & Bassetlaw.

Workstream Programme Boards

There are also a range of programme boards responsible for delivering the workstreams. These are led by a chief executive and senior responsible officer (an accountable officer from a clinical commissioning group) and supported by a director of finance and a project manager/workstream lead.

Effectiveness of the Governing Body

The Governing Body has been proactive in improving its effectiveness during the year. For example:

- The Governing Body has continued to implement and adapt new ways of working in response to the restrictions during the covid-19 pandemic, including virtual meetings and innovative ways of involving and engaging the public eg enabling written questions and making recordings of meetings available via our website and social media platforms
- Development sessions have been held at regular intervals through the year covering issues such as future commissioning arrangements at system and place, Continuing Health Care arrangements in Barnsley, Child & Adolescent Mental Health Services, suicide prevention and bereavement, and liberty protection safeguards
- Statutory and Mandatory training has been provided for Governing Body members in conflicts of interest management, data security awareness, counter fraud, equality and diversity, infection control, fire safety, health & safety, and safeguarding
- Individual personal development reviews (PDRs) have been undertaken with Governing Body members by the CCG Chair
- The Governing Body and its Committees all include a reflection on the conduct of the meeting at the end of every agenda
- Governing Body has established monthly Transition and Closedown Oversight sessions to gain assurance over the safe closedown of the CCG and the process for setting up new commissioning arrangements at system and place
- All Governing Body members agreed to extend their terms to 30 June 2022 to enable CCG to continue to function following a three-month extension to transition deadline.

Compliance with the UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have 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 and best practice.

We have self-assessed our arrangements against the UK Corporate Governance Code and are satisfied we are compliant with those aspects relevant to the CCG.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and documented in the Constitution, Corporate Manual, and Prime Financial Policies were developed with extensive expert external input, to ensure compliance with all relevant legislation. That expert advice also informed the matters reserved for Membership Council and Governing Body decision and the Scheme of Delegation.

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with

each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Compliance with statutory functions is delivered through the CCG's management structure and monitored through the CCG's committee structure and work plans. These arrangements have been subject to external scrutiny through a range of processes, including the NHS England CCG Improvement and Assessment Framework.

Since 1 April 2015 the CCG has had delegated responsibility from NHS England for commissioning primary medical services under a signed Delegation Agreement. In 2018/19 NHS England introduced a mandatory requirement for CCGs to have internal audit review of the CCG's arrangements for discharging its delegated responsibilities. The internal audit focus for 2021/22 was on primary care finance, and the report received in November 2021 provided full assurance and made no recommendations.

Risk management arrangements and effectiveness

Overall risk and control arrangements

In accordance with its intention of achieving the highest standards of governance and accountability, since its authorisation on 1 April 2013 the CCG has worked hard to implement, embed, and enhance its risk and control arrangements.

Identifying, rating, and managing risks

The Integrated Risk Management Framework sets out the CCG's approach to scoring risks and the risk appetite. Any risks identified in the course of the CCG's business are scored using the National Patient Safety Agency's 5 by 5 matrix, which takes account of both the likelihood and consequence of a risk occurring. This results in an overall risk rating of between 1 and 25. Risks are then included on the risk register and prioritised as follows:

RAG	Score	Risk description	Managerial Action
	1 - 3	Low risk	Can be managed locally by routine controls.
	4 - 6	Moderate risk	Managed locally with individual risk treatment plans
	8 - 12	High risk	Senior Management attention required. Detailed planning and controls
	15 - 25	Extreme risk	Immediate action Chief Officer or nominated Deputy level management

A Lead Officer (Risk Owner) for each risk is identified, and the Risk Register is shared with risk owners monthly for review and revision.

The Governing Body's risk tolerance is a score of 12 or below. These risks are managed by the appropriate Chief Officer or Manager and monitored at the CCG's Committees. Extreme

risks (scores of 15 or higher) are considered to represent a threat to the delivery of the CCG's strategic objectives. These risks are:

- Subject to immediate Chief Officer action
- Considered and reviewed at every meeting of the Governing Body, and are
- Escalated to the Assurance Framework as gaps in control against the relevant corporate objective(s).

In addition, Committees receive and consider extracts of both the Assurance Framework and Risk Register, and escalate significant matters to the Governing Body. Red and amber risks are considered at every meeting, yellow and green risks twice a year.
The Governing Body receives reports summarising the current position with respect to extreme risks on the Assurance Framework at every meeting, and reviews the entire document on a quarterly basis.

These arrangements have continued to evolve and become further embedded in 2021/22:

- In response to the Covid-19 pandemic a number of covid-specific risks were identified and added to the corporate risk register in the summer of 2020 – these have continued to be monitored and reported along with other corporate risks during 2021/22
- In May 2021 Senior Management Team undertook a review of the GBAF in the light of the 2021/22 Planning Guidance, to ensure that it remained relevant and fit for purpose - in most cases the refresh process entailed updating the existing priority areas on the GBAF to take account of any new deliverables or threats to delivery, however, three new priority areas have been added to the GBAF related to: Maximising elective activity (3.2), Implementing Population Health Management and Personalised Care (5.3), and Delivering the covid vaccination programme & meeting needs of patients with covid-19.
- The GBAF maps each of these priority areas onto the CCG's corporate objectives (highest quality governance, high quality health care, care closer to home, safe & sustainable local services, strong partnerships, effective use of £) in order to provide assurance that, in delivering the Priority Areas, we will also be delivering the CCG's corporate objectives
- The CCG's strategic risk management arrangements were reviewed by internal audit as part of the Head of Internal Audit Opinion Stage 1 work with just one low risk recommendation made, and the Stage 2 work completed in December 2021 likewise made just one low risk recommendation.

How risk management is embedded in the activity of the CCG

A range of systems and processes are in place to embed risk management more broadly in the CCG's activities. These arrangements are described briefly below.

- There is a well-established system of **incident reporting** which ensures that incidents are managed appropriately and that learning takes place and is shared across the organisation.

- The CCG is fully committed to **complying with the public sector equality duty set out in the Equality Act 2010**, both as an employer and a commissioner of health services for the people of Barnsley. Details of how the CCG complies are available on its website Equality, diversity and inclusion (barnsleyccg.nhs.uk).

- The CCG has robust arrangements to ensure its **Health and Safety** responsibilities are effectively discharged. A Health and Safety and Business Continuity Group, reporting to the Audit Committee, is supported by experts from a local shared service hosted by Rotherham CCG. This group is also attended by staff side, and a GP Member of the Governing Body, as well as CCG employees, and meets four times a year. The Group reviews the annual fire and health and safety risk assessments, as well as any incidents reported, and ensures appropriate actions are being taken. It also maintains oversight of the CCG's corporate business continuity arrangements and the annual EPRR self-assessment process. The CCG's risk assessments indicated a low risk in respect of fire and health and safety. All CCG staff receive mandatory training in fire safety, health and safety, infection control and manual handling.

Involvement of public stakeholders

The CCG has well-established arrangements by which **public stakeholders** can influence the work of the CCG and therefore be involved in managing the risks which impact on them. For example:

- The CCG has a Governing Body Lay Member for Patient and Public Engagement and Primary Care Commissioning, and an Equality and Engagement Committee responsible for overseeing the CCG's arrangements in this area
- Members of the public are able to attend meetings of the Governing Body and Primary Care Commissioning Committee (alternatives have been put in place during the pandemic)
- During the Covid-19 pandemic, when public attendance has not been possible due to meetings being held virtually to comply with social distancing rules, the CCG has made alternative arrangements to ensure full transparency in the conduct of its business. Video recordings of Governing Body and Primary Care Commissioning Committee meetings have been published on the website and via social media channels, and provision has been made for the public to submit written questions in advance of meetings which are then answered and incorporated into the minutes.
- Similarly due to covid-19 the Annual General Meeting in September 2021 was held virtually, with a video presentation of the year's highlights along with answers to the public's questions submitted in advance – see this link https://www.barnsleyccg.nhs.uk/annualreport
- The CCG works closely with Healthwatch Barnsley, which has a standing invitation to attend the Equality & Engagement Committee and the Primary Care Commissioning Committee
- Barnsley Patient Council has been established to act as an independent advisory panel. It is made up of Barnsley residents and PRG representatives who offer the views and expectations of members of the public and local communities served toward improving, delivering and maintaining health care services for Barnsley people.

Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Officer as Accountable Officer. The Governing Body collectively ensures that robust systems of internal control and management are in place. These arrangements, and the enhancements that have been made to them during 2021/22, are described in detail in this Statement.

The Integrated Risk Management Framework was originally approved by the Governing Body in October 2012, and subjected to regular review and revision thereafter. The framework sets out the CCG's commitment to the management of all risk using an integrated approach covering clinical, non-clinical and financial risk. Accountability arrangements for risk management are clearly set out and roles and responsibilities in terms of key committees and individuals are identified, as follows:

- The *Governing Body* on behalf of the Membership Council ensures that the organisation consistently follows the principles of good governance applicable to the NHS organisation.
- The *Audit Committee* oversees the risk management function and ensures that systems of internal control exist and are functioning correctly.
- The *Committees of the Governing Body* are responsible for identifying risks to the delivery of corporate objectives, and ensuring appropriate actions are in place to mitigate them (see Risk Register and Governing Body Assurance Framework below).
- The specific responsibilities of the *Chief Officer*, *Lay Members, other senior officers, and all other staff of the CCG* are clearly articulated.
- The *Risk Register* provides an ongoing identification and monitoring process for operational risks, as well as strategic risks that may adversely impact on the delivery of the Annual Commissioning Plan, and the CCG's strategic objectives.
- The *Governing Body Assurance Framework* is a high level report which enables the Governing Body to demonstrate how it has identified and met its assurance needs focused on the delivery of its objectives through the annual Commissioning Plan. The Assurance Framework identifies the key risks to the delivery of corporate objectives, and sets out the controls in place to mitigate those risks and the assurances (both internal and external) available to give the Governing Body confidence that the risks are being managed.

Risk management capacity has been developed across the CCG in a number of ways. The statutory and mandatory training programme includes numerous elements relevant to risk management, including data security awareness, health and safety, fire safety, safeguarding adults and children, infection control, and counter fraud.

A word and excel-based incident reporting system is now well established. Governing Body and Committee reporting arrangements prompt authors to confirm that all aspects of potential risk – financial, contractual, quality, equality and diversity, information governance, human resources, and sustainability – have been appropriately considered in the preparation of committee reports and business cases.

How do the control mechanisms work?

The CCG has a robust internal control mechanism to allow it to prevent, manage and mitigate risks, including the governance structure of the CCG, the approach to risk management, and the key components of the internal control structure described elsewhere in this statement. Taken together these arrangements underpin the CCG's ability to control risk through a combination of:

- *Prevention* – the CCG's structures, governance arrangements, policies, procedures, and training minimise the likelihood of risks crystallising.
- *Deterrence* – staff are made aware that failure to comply with key policies and procedures, such as the Standards of Business Conduct Policy or the Fraud, Bribery and Corruption Policy, will be taken seriously by the CCG and could lead to disciplinary action, or dismissal.
- *Management of risk* – once risks are identified the arrangements for ongoing monitoring and reporting of progress through the Committee structure to the Governing Body ensure appropriate action is taken to manage risks.

Risk Assessment

The CCG's process for identifying, rating, and responding to risks was described in the sections above. The number and severity of the risks on the Corporate Risk Register during the year is summarised in the table below:

Date	Extreme (red)	High (Amber)	Moderate (Yellow)	Low (Green)
April 2021	9	20	6	3
Sept 2021	9	20	6	3
March 2022	13	20	6	3

In accordance with the CCG's Integrated Risk Management Framework any risk rated as extreme (red) is deemed to exceed the Governing Body's risk tolerance, since they are considered to threaten the delivery of the CCG's strategic objectives.

Such risks are escalated to the Governing Body as gaps in control against relevant objectives in the assurance framework. The table below sets out how the CCG's extreme risks have been (and where relevant continue to be) managed or mitigated:

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
COVID 1 demand surge The new Omicron variant appears to be more transmissible than previous variants and the two-dose vaccine programme is less effective at preventing illness. There is a risk	COVID booster programme Surge planning, Operational Pressure and Escalation Framework Close monitoring of staff absence through the Local Resilience Forum	Director of Commissioning CCG Gold Command F&PC	**4x4=16**	**4x4=16**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
that a surge in COVID cases could have a very significant impact on urgent and emergency care with high levels of staff absence due to COVID infection at the same time as increased COVID admissions.	Coordination of local response from the multi-agency bronze, Tactical Coordination Group and Integrated Care Delivery Group Business Continuity Plans Local communications and engagement strategy			
COVID 2 planned care backlog During the earlier part of the pandemic there was a significant drop off in people being referred to secondary care for treatment which enabled providers to create capacity to prepare to treat high numbers of COVID patients. Throughout the pandemic there have been social distancing/infection prevention and control measures that mean some services have had less capacity to treat patients. This has resulted in a backlog of patients waiting for treatment. Some known to services (on a waiting list) and others that have not presented. There is a risk that the backlog results in harm to patients and services.	Elective Recovery Framework Planned care and outpatients work programme SYB Cancer Alliance “hidden harms” work including behavioural insights Recovery plans for screening services PCN specifications for early cancer detection and hypertension case finding Communications and engagement strategy	Director of Commissioning CCG Gold Command F&PC	**4x4=16**	**4x4=16**
21/02 - If the Barnsley and South Yorkshire and Bassetlaw System are unable to commission care that demonstrates value for money for complex patients, there is a risk that the market of private provision will create significant financial risk to the CCG. This is a national issue with provision for this cohort of patients being limited and therefore costly. The CCG needs to shape and develop the home care and residential care	Chief Nurse to work across South Yorkshire and Bassetlaw to determine level of risk and action plan to be developed to develop the market within NHS providers and within the private sector. The Chief Nurse to work with the LA/JCU to develop the Framework of providers.	Chief Nurse Finance and Performance Committee and QPSC	**Not on the RR in April 2021**	**5x4=20**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
provider market working with the Local Authority and across the ICS where complex case provision needs development. If this does not happen and the provider framework is not reviewed the quality of care may be jeopardised, patients may need to be placed outside of area and it is likely the costs will continue to rise.	The Chief Nurse to work with the SY&B Chief Nurses to explore options for a wider ICB solution.			
18/04 - If the health and care system in Barnsley is not able to commission and deliver out of hospital urgent care services which have sufficient capacity and are effective in supporting patients in the community to avoid the need for hospital attendance or non-elective admission there is a risk that non-elective activity will exceed planned levels potentially leading to (a) failure to achieve NHS Constitution targets (with associated reputational damage, and (b) contractual over performance resulting in financial pressure for the CCG	Regular review of activity data as part of contract and performance management and monitoring arrangements. Other data reviewed and analysed to identify new opportunities to reduce non elective activity e.g. NHS Rightcare Packs, Dr Foster data etc. A&E Delivery Board is established (Barnsley Urgent and Emergency Care Delivery Board) with responsibility for delivering improvements to urgent care services and achieving related targets. The Board is overseeing work to develop appropriate services to ensure that patients are able to access appropriate care and support outside of hospital, or in a different way in hospital utilising SDEC pathways and implementing a new model at the front of A&E. Engagement with regional and SYB programme to implement 'Think 111' (Talk before you walk) model in partnership with Integrated Urgent Care providers Work ongoing with NHSE Emergency Care Improvement and Support Team (ECIST) and iUEC	Chief Operating Officer (Finance & Performance Committee)	**5x4=20**	**5x4=20**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
	programme to review pathways Additional Primary Care Capacity is in place for same day appointments through IHEART and Home Visiting Services Community 2 Hour rapid response in place accessed through the Rightcare Barnsley SPA Priority areas of work identified to support ICP vision and principles for proactive care and care out of hospital.			
21/03 - If issues in the timely reporting of data continue in relation to Continuing Health Care (Adult and Children) and complex case management (Including S117), this is likely to result in the financial forecast for this area to be misstated and lead to variation in the forecast position, creating financial risk.	Chief Nurse and CHC/complex case team to work on systems and processes within the team to ensure data is recorded and reported in a timely manner. The Chief Nurse, CHC/complex case and Finance team will also work with BMBC to ensure reporting issues relating to the brokerage of care are improved with a clear process in place from within BMBC brokerage/PHB and finance team.	Chief Nurse Finance and Performance Committee QPSC	**Not on the RR in April 2021**	**5x4=20**
18/02 - If the CCG and BMBC do not develop a collaborative commissioning approach underpinned by shared values there is a risk that BMBC commissioned services will not meet the requirements and aspirations of the CCG for the people of Barnsley leading to increased health inequalities and poorer health outcomes	Escalation of CCG concerns to BMBC senior management Escalation via SSDG and health & wellbeing board To be raised and discussed at H&W Board development Session (August 2018)	Jeremy Budd (SSDG)	**4x4=16**	**4x4=16**
21/06 b - There is a risk that if the CCG is unable to reprocure at the end of March 2022 for the Medical Oversight of the Acorn Unit, that potentially medical oversight at the Unit will not exist.	•BHNFT and the CCG agreed that BH would take oversight until the end of March 2022 and work on a plan this financial year to finalise in Q4 and implement in April 2022. •Workshops taking place to go through options to reprocure. •Emergency Team supporting the group of looking at model now and what is needed going forward.	Q&PSC Chief Nurse	**Not on the RR in April 2021**	**4x4=16**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
	Right care Barnsley pulling together data to be reviewed by the CCG.			
21/05 - There is a risk that Barnsley patients will not have the option to have face to face oncology appointments at BHNFT due a shortage of consultant capacity for oncology across SY&B. This will impact on patients choice and access to the service.	•Awareness of the issues via Cancer Alliance. •Conversations are ongoing about an interim solution to ensure there is efficient capacity in the service. •Providing transport for patients to travel who are unable to or may struggle to get where the oncologists are based. •Greater use of visual virtual appointments. •Continue face to face appointments where necessary. •Cancer Alliance working on longer term solution after short term solution is in place •Working with HEE about having additional roles to upskill existing staff in oncology service. Weston Park are tracking patients attending or not attending for appointments to monitor and reduce the impact on patient care	Jamie Wike (SL) Q&PSC	**Not on the RR in April 2021**	**4x5=20**
14/10 - If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce e.g. due to delays in recruiting into the Additional Role Reimbursement Scheme (ARRS) roles there is a risk that: (a)Primary Medical Services for patients are inconsistent (b)The people of Barnsley will receive a poorer quality of healthcare services (c)Patients services could be further away from their home.	The NHS Long Term Plan includes a section on workforce planning and Network Contract DES includes provision for a number of Primary Care specific roles that will support the delivery of services. The Network Contract DES has several deliverables that will support existing service delivery, utilise roles under the Additional Roles Scheme, support reduction in healthcare inequalities, and that will work towards achieving sustainable service delivery in Barnsley. The Primary Care Strategy Group has a workforce element included within its transformation plans and will support the Barnsley “Place” Workforce Plan. The Primary Care Strategy Group will incorporate the SYB ICS Primary Care Strategy to support consistent service delivery across the ICS reflecting the needs of Barnsley as a “place”.	Head of Primary Care. (Primary Care Commissioning Committee)	**4x4=16**	**4x4=16**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
	NHS England has published an Interim People Plan to support the workforce challenge. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students.			
20/03 - If the Barnsley and South Yorkshire and Bassetlaw System are unable to commission care that demonstrates value for money for complex patients, there is a risk that the market of private provision will create significant financial risk to the CCG. This is a national issue with provision for this cohort of patients being limited and therefore costly.	Adverts currently out to fill 3 vacant posts Extension of contracts of 2 agency nurses to 26.2.21 will support clearance of covid backlog Seeking to recruit a further 2 agency nurses to support with both backlog and new cases although it is currently difficult to find available suitably qualified individuals Discussion of risks and issues to take place at Governing Body in January 2021 Development of training plan for the CHC team on case management and handling difficult conversations with patients, families and carers. Ensure protocols are developed to provide appropriate guidance and consistency to staff and patients in relation to the cost of care packages and rationale for the level of care provided.	Chief Nurse Finance & Performance Committee And Quality & Patient Safety Committee	**4x4=16**	**5x4=20**
14/15 - There are two main risks: 1. Scant or absent information relating to why medication changes have been made. Poor communication of medication changes, even if changes are appropriately made for therapeutic/safety reasons, creates a patient safety risk when post discharge medicines reconciliation is being undertaken by the GP practice. The risk being that the GP practice may	Ongoing discharge medication risks escalated to BCCG Chief Officer and Chief Executive of BHNFT resulted in 2 quality risk meetings (August and November 2016). Area Prescribing Committee (APC) monitor concerns and will report 2017 audit to the Quality & Patient Safety Committee. A working Group (with reps from Practice managers Group & BHNFT) looking at D1 Discharge Summary Letters.	Head of Medicines Optimisation (Quality & Patient Safety Committee)	**4x5=20**	**4x5=20**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
either accept inappropriate changes when all the patients' risk factors have not been accounted for by the hospital clinicians or an error has been made or not accept clinically important changes as not confident about the reasons for the change. 2. Clinically significant safety alerts, such as contraindicated combinations of medication, are being frequently triggered by primary care prescribing systems during post discharge medicines reconciliation when adding medicines to the Patients Primary Care Record. This indicates that either the hospital is not reconciling medicines using the GP Practice Summary Care Record or that the reconciliation is not sufficiently robust.				
13/13 - If improvement in Yorkshire Ambulance Service (YAS) performance against the ARP response time targets is not secured and sustained, there is a risk that the quality and safety of care for some patients could be adversely affected.	Regular consideration of YAS incident reporting by QPSC and GB to understand the frequency and severity of incidents associated with ambulance response.	Chief Nurse (Quality & Patient Safety Committee)	**2x5=10**	**4x5=20**
19/05 - If the health and care system in Barnsley is not able to commission and deliver end of life care services of sufficient quality and capacity to support end of life patients in the community, there are risks for the CCG across a number of areas, as follows:	1) Chief Nurse has raised issue with BMBC Joint Commissioning Team. BMBC is due to hold meetings with both their in house provider and contracted providers to try and get more detail around current capacity as well as longer term issues and look at any possible options to address those. A wider meeting with home care providers is planned for November 2019.	Chief Nurse QPSC	**5x3=15**	**5x3=15**

Risk	How managed / mitigated	How assessed	Status at April 2021	Status at March 2022
a) Quality and Patient Safety Risks Delayed discharges due to staff not being able to obtain care packages leading to patients not being able to be in preferred place of care at end of life. b) Patients at home without a care package or a care package that is not being delivered as required. b)Financial Risks Increased costs to CCG due to having to obtain care from specialist providers Delayed discharges will affect CCG's efficiency plans c) Performance Risks Delayed discharges impact upon patient flow which could affect delivery of 4 hour A&E standard and elective waiting times. Increase in non-elective admissions to hospital because of patients being left without care in the community.	2) CHC EOL team to: a) email all providers each morning requesting what care package vacancies they have b) liaise with Rightcare Barnsley to provide updates on care packages c) offer 24 hour placement in residential/NH to all patient awaiting a care package in hospital to prevent delayed discharge and then to continue to try and procure a care package to transfer patient to their own home. d) explore additional support from neighbourhood nursing service/ palliative care services in Barnsley e)Care packages to be spot purchased from any provider f) CHC EOL team to contact care providers on Barnsley borders to identify if they could pick up packages just over the borders.			

As well as being escalated to the Governing Body as gaps in control against relevant objectives in the assurance framework these risks have been allocated to the appropriate Committee and Chief Officer within the governance structure, with mitigating actions being monitored by the Committee on an ongoing basis. Risk and Assurance reports to the Governing Body will enable it to monitor the effectiveness of the mitigating actions in 2022/23 for those risks which remain open.

Other sources of assurance

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.

The governance and risk management sections have already explained how important elements of the system of internal control work. Other key components of the internal control framework include:

- An overarching governance structure set out in the *Constitution, Standing Orders, Scheme of Reservation and Delegation, and Prime Financial Policies*
- Beneath the Constitution and Corporate Manual, the CCG has a range of *Corporate Policies* in place to support the delivery of its statutory and other functions which have been communicated to staff, made easily available via the website, and supported by training and briefings as appropriate
- The *Standards of Business Conduct Policy*, setting out the CCG's policies and procedures for managing Conflicts of Interest, including maintaining and publishing registers of interests, gifts and hospitality
- The *Governing Body & Committee Structure*, underpinned by clear Terms of Reference and work plans
- The CCG's *management structure*, with responsibilities clearly allocated to teams and individuals
- The *Risk Management Framework*
- Robust arrangements to ensure *effective financial control* including budgetary control and contract monitoring
- Ongoing *monitoring of the delivery of key performance targets* and commissioning priorities by the Finance & Performance Committee and the Governing Body
- The Equality & Diversity Working Group, reporting to the Equality & Engagement Committee, oversees the CCG's *compliance with the requirements of the Equality Act 2010*
- The Equality & Engagement Committee also ensures appropriate *consultation and engagement* takes place with stakeholders including users of health services in Barnsley
- The CCG seeks continually to develop the *skills and competencies* of its employees through regular performance and development reviews, the statutory and mandatory training programme, organisational development activities including regular development sessions for the Governing Body and the 'Investment In Excellence' programme which has been provided to all CCG staff
- Objective *oversight of the internal control framework* by the Audit Committee, drawing on reports from internal and external auditors

- External *scrutiny by NHS England* through the Improvement & Assessment Framework.

Annual audit of conflicts of interest management

The CCG has robust arrangements for managing Conflicts of Interest. The CCG maintains a Register of Interests covering Membership Council, Governing Body Members, and all CCG staff. The Register is publicly available on the CCG's website http://www.barnsleyccg.nhs.uk/about-us/). It is also considered at the public session of the Governing Body twice a year. The Audit Committee receives and reviews the Register twice a year and updates on new or changed declarations are taken to every meeting.

The CCG's Conflicts of Interest Policy requires interests to be declared within 28 days. Declarations are recorded on a form which is returned to the Head of Governance & Assurance who enters the interest on the Register. Declarations of Interest are requested at the commencement of all meetings of the Governing Body and its Committees. On at least an annual basis all staff are requested to review and update their entries in the Register.

The CCG's Conflicts of Interest Policy, which sets out the approach to managing conflicts, is incorporated within the Standards of Business Conduct Policy which was reviewed, clarified and strengthened in January 2015 to address the requirements of new statutory guidance issued by NHS England in December 2014. Key enhancements included:

- The establishment of a Primary Care Commissioning Committee with a Lay and Executive majority to enable effective management of Conflicts of Interest arising in respect of the CCG's delegated responsibility for commissioning primary medical services
- The creation of a publicly available Register of Procurement Decisions setting out how any conflicts arising in the course of the CCG's procurement activity had been managed
- The use of a primary care procurement checklist provided by NHS England giving detail of how conflicts have been managed, and
- The extension of the CCG's Register of Interests to cover senior staff working in member Practices.

In June 2016 NHS England issued updated statutory guidance for CCGs on the management of conflicts of interest. In response to this guidance further enhancements were made to the CCG's arrangements, including:

- Adding the role of Lay Member for Accountable Care to the membership of the Governing Body, to provide additional capacity to manage conflicts of interest both at Governing Body and Primary Care Commissioning Committee
- Designating the Chair of the Audit Committee as the CCG's 'Conflicts of Interest Guardian'
- GP Members of the Primary Care Commissioning Committee remain as clinical advisers to the Committee but do not have the right to vote
- The format of the Registers and other documentation was reviewed and updated to comply with the guidance
- Training was provided to Committee Chairs and minute takers.

In June 2017 NHS England published further revised statutory guidance. The CCG again reviewed its *Standards of Business Conduct, Managing Conflicts of Interest, and the Acceptance of Gifts & Hospitality Policy* and made a number of further changes to ensure the Policy remained consistent with the revised guidance, most notably the rules around accepting gifts and hospitality were clarified. The *Standards of Business Conduct, Managing Conflicts of Interest, and the Acceptance of Gifts & Hospitality Policy* was also 'de-coupled' from the CCG's Constitution in order that the process for future updates is more streamlined.

The statutory guidance on managing conflicts of interest 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.

The CCG's annual audit of conflicts of interest concluded in August 2021. The review provided significant assurance over the CCG's arrangements, and concluded that the CCG has a well-defined process in place for managing conflicts of interest. The report raised one medium and two low risk recommendations, all of which were accepted and are either complete or being actioned, as follows:

Recommendation	Risk	Status
The CCG will review [a number of minor inconsistencies between declaration forms and the details on the published registers] and ensure they are corrected. Going forward, the Corporate Affairs team will continue to review all completed declaration of interest forms received and ensure they are complete and accurate.	Low	Complete
The CCG will update the register of procurement decisions to include recent contracts issued via single tender actions. The CCG will also ensure the latest version of the single tender action reporting form is used for reporting to the CCG Audit Committee.	Medium	Complete
The Corporate Affairs team will refresh and reissue guidance to Committee chairs and minute takers re ensuring full details re the management of any declared conflicts of interest are recorded in the minutes. The CCG will also review the recording of interests when approving meeting minutes to ensure all details are recorded.	Low	Complete

In accordance with NHS England requirements the CCG requires all Governing Body members, Committee members, senior managers and staff engaged in procurement activity are required to complete online training in the management of conflicts of interest. As at November 2021, 91% of relevant staff had completed the mandatory module one.

Data Quality

Quality data is essential for commissioning effective, relevant and timely care, efficient administrative processes, management and strategic planning, establishing acceptable service agreements/contracts for healthcare provision, identification of local priorities and health needs assessments, ensuring that the organisation's expenditure is accurately

calculated, providing reliable intelligence regarding local providers, and delivery of local and national priorities. Data therefore needs to be accurate, credible, reliable and secure.

The majority of the data used by the CCG for these purposes is derived from external sources, such as providers' systems and national IT systems, and much is processed by third parties. There are a wide range of sources of assurance available to the CCG to monitor the quality of this data – national datasets, local audits, data quality targets, contractual requirements etc.

The CCG has a data quality policy which clarifies roles and responsibilities and makes provision for an annual data validation exercise to be undertaken on key data flows. The key findings will be reported through Finance & Performance Committee in accordance with the policy.

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 a Data Security & 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.

Barnsley CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and supporting processes and procedures in line with the Data Security & Protection (DSP) Toolkit. We require all staff to undertake annual data security awareness training to ensure they are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation. Based on these arrangements the CCG was able to report full compliance across all standards in its Information Governance Toolkit submissions in each year of its existence.

Internal Audit has now completed its annual review of the CCG's arrangements for ensuring compliance with a sample of the requirements of the Data Security & Protection (DSP) Toolkit which seeks to provide assurance over our data security and data protection control environment across a sample of areas within the scope of the Toolkit, and over the veracity of our Toolkit self-assessment. The report provided a 'significant assurance opinion and raised no formal findings or actions. The CCG anticipates being able once again to declare full compliance with Toolkit requirements in our final submission, which must be completed on or before 30 June 2022.

Business Critical Models

The CCG has no business-critical models which meet the required threshold for reporting to the Department of Health (via NHS England) in line with the recommendations from the MacPherson report.

Commissioning Support

During 2021/22 the CCG has obtained commissioning support functions from a variety of sources:

Scope of Service	Provider	Sources of Assurance
Business Intelligence GPIT / Corporate IT / IG	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Review of KPIs • Regular meetings with team at both strategic and operational levels
Financial Services	Rotherham CCG provides accounting processes (overall control and decision making remains within Barnsley CCG)	• 360 Assurance provides internal audit services for both CCGs • KPMG provides external audit services for both CCGs • It has been agreed to utilise the joint audit scope to allow Barnsley CCG transactions to be tested and assured across the boundary between the two organisations
Human Resources	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Regular meetings with HR Service Lead • Annual assurance report • Internal Audit reviews on a cyclical basis
Health and Safety	Joint service hosted by Rotherham CCG	• Memorandum of Understanding • Regular meetings with H&S Lead • Oversight by CCG Health & Safety & Business Continuity Group and SY&B Governance Leads • Annual assurance report
IFR	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Oversight by host organisation and by IFR Leads at each CCG • Internal Audit reviews on a cyclical basis
Procurement	Joint service hosted by Sheffield CCG	• Memorandum of Understanding • Regular meetings between CCG procurement lead and shared service manager • Oversight of all procurement activity by Finance & Performance Committee • Internal Audit reviews on a cyclical basis
Equality & Diversity	Shared resource with BHNFT	• Memorandum of Understanding • Oversight by the Equality & Diversity Working Group and the Equality & Engagement Committee

Third party assurances

Service Organisations (including CSUs) do not generally allow access to client auditors, as this is an inefficient approach to providing assurance, costly for clients commissioning the work and disruptive to the Service Organisation. Service Auditor Reports (SARs) are an internationally recognised method for Service Organisations to provide details of controls and their operation in a specified period to their clients.

A SAR typically includes a high-level description of the governance and assurance arrangements in place at the Service Organisation, a high level description of the Service control environment, an assertion by the Service Organisation management regarding the design of internal controls over the process, and a low level description of the Service's control objectives and supporting key controls.

Service Auditor Reports that are of relevance to CCGS are:

Service Provider	Description of services	Opinion
NHS Business Service Authority	Prescription Services	Qualified
	Dental Services	Qualified
NHS Shared Business Services	Financial Accounting Services	Qualified
NHS Digital	GP Payments Data Processing	Qualified
Capita	Primary Care Payments Services	Qualified
NHS England and NHS Improvement South, Central and West Commissioning Support Unit	Calculating Quality Reporting Service (CQRS) • Type 1 report • Type 2 report	 Unqualified Qualified

The Chief Finance Officer has received and reviewed all relevant SARs. Whilst all except one of them provided a headline qualified opinion, in all cases the SARs concluded that the controls within the systems were suitably designed and operating effectively throughout the period 1 April 2021 to 31 March 2022, with a small number of exceptions, primarily resulting from; the effects of the Covid-19 pandemic, access to core IT systems, authorisation, or lack of evidence to support that the control had been actioned, or was evidenced late. Taken together therefore these reports do not provide the CCG with complete assurance over the controls within these systems.

The Chief Finance officer has considered all these exceptions and is of the view that there is nothing in the findings that would question the presumption of a sound financial system or the validity of the transactions within the CCG's accounts. In forming this view the CCG takes assurance from its own internal control procedures. Expenditure is monitored against budgets on a monthly basis, and is reported to the Primary Care Commissioning Committee, Finance and Performance Committee and Governing Body. Internal audit has provided substantial assurance on Budgetary Controls, Financial Reporting and Key Financial Systems for 2021/22. KPMG undertakes substantive testing and review of the accounts as part of their external audit plan and process. This provides assurance that the figures presented are a true and fair view of the CCG's income and expenditure for the year.

Control Issues

No significant control issues have arisen in 2021/22 which require disclosure in this report.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

Throughout 2021/22 the Governing Body has built upon the experience achieved since its inception in 2013/14 with regard to making investment decisions and identifying efficiency programmes. The Governing Body has exercised control via Management Team for decisions to commit funding below £100k and reserved the right to decide on investments over this level to the Governing Body as a whole.

The Financial Framework for 2021/22 continued to differ from previous years due to the impact of the COVID-19 global pandemic, however the efficient and effective use of the Barnsley pound has remained a key objective for the Governing Body with recurrent investments approved after consideration of alignment with strategic objectives and non-recurrent investment deployed to secure operational imperatives.

Emphasis on the delivery of efficiencies in 2022/23 will continue as the NHS begins its recovery from the pandemic, however, there does remain a risk of further ongoing pressures associated with the pandemic as we begin our recovery. NHS Planning and Contracting guidance has been issued with contracts being reinstated with NHS providers for the first time since the pandemic started in March 2020. Block payment arrangements with NHS providers do continue into 2022/23 with a clear focus on the recovery of elective care and additional funding being provided to reduce waiting lists within hospitals. The CCG will continue to maintain its focus on delivering efficient and effective services across Barnsley with the funding it receives.

As part of budgetary control, the Finance and Performance Committee and Governing Body have received regular Integrated Performance Reports which highlight financial performance in the context of activity, projected year-end position and the identification and proposed management of key risks.

The CCG contained expenditure within allocated resources, both for Programme and Running Costs and has ended the year with a surplus position of £1.6m, in line with NHS England expectations.

Third party assurance is provided by Internal Audit in relation to the effectiveness of the CCG's key financial systems and External Audit provide an opinion in relation to the CCG's use of resources in their Value for Money (VFM) conclusion.

Delegation of functions

The CCG is a member of the Working Together Joint Committee of CCGs (JCCC), with its own Terms of Reference and Scheme of Delegation. In addition to this arrangement the CCG is also a participant in the following arrangement:

- Collaborative commissioning arrangements for **999 and 111 services** across CCGs in the Yorkshire & Humber region. Assurance is provided via a Memorandum of Understanding, and local representation at the Joint Strategic Commissioning Board.

Counter Fraud Arrangements

Overall executive responsibility for counter fraud arrangements rests with the Chief Finance Officer, and the Head of Governance & Assurance is the Counter Fraud Champion.

The **Local Counter Fraud Specialist (LCFS)** supports the CCG in mitigating the risks associated with fraud. Working to a risk-based annual plan approved by the Audit Committee, the LCFS undertakes a wide range of proactive work to promote and embed counter fraud arrangements across the CCG. This has included fraud awareness training for all staff, publicity, fraud alerts, reviews of policies and systems, ad hoc guidance, etc.
The LCFS also undertakes proactive detection exercises, and investigations into potential frauds. The LCFS presents regular reports to the Audit Committee, and also prepares an Annual Report.

The LCFS supports the CCG to complete and submit a self-review of our level of compliance with relevant counter fraud standards. From April 2021 all NHS funded services are required to provide assurance against the Government's Counter Fraud Functional Standard via an annual *Counter Fraud Functional Standard Returns (CFFSR),* which has replaced the previous self-review against the NHS Counter Fraud Authority's *Standards For Commissioners*. In each previous year of submission the SRT has judged the CCG to be at 'green,' which means it has appropriate arrangements in place and that evidence of their effectiveness is in place. In April 2021 the CFFSR was submitted for the first time to establish a baseline against the new requirements. The CCG was rated green against 8 standards, amber against 3, and red against the remaining two.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit has issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control.

The final Head of Internal Audit Opinion received in May 2022 concluded that:

*'I am providing an opinion of s**ignificant assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.*

In accordance with the ICB Establishment and Due Diligence Checklist, we have reviewed the adequacy of the CCG's transition plans. Feedback was provided through the SYB Change and Transition Programme Board on areas where arrangements for governance and risk management, as well as workstream assurances, should be strengthened. The SYB Change and Transition Programme Board responded to this feedback with a refreshed Change and Transition Programme Framework.'

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

Audit Assignment	Status	Assurance Level
Conflicts of Interest	Complete	Significant
Integrity of the General Ledger, Financial Reporting and Accounts Payable System	Complete	Substantial
Primary Medical Care Services – Finance	Complete	Full (NHSE rating)
Data Security Standards	Complete	Significant
Data Quality and Performance Management Framework	Complete	Significant
Client-wide project – Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019	Project ongoing	Outcomes of work completed in 2021/22 is available on this website
Revisit audit of Children's Continuing Care, s117 funding decisions and NHS Continuing Healthcare	Complete	Significant

All audit reports from assurance reviews in the 2021/22 Internal Audit Plan that have been issued to management and the Audit Committee have reported Significant, Full or Substantial Assurance on systems and processes.

Review of the Effectiveness of Governance, Risk Management, and Internal Control

The Accountable Officer's review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework.

The Accountable Officer has drawn on performance information available to him. His review is also informed by comments made by the external auditors in their management letter and other reports.

The Governing Body Assurance Framework provides the Accountable Officer with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed.

The Accountable Officer has been advised on the implications of the result of his review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, and other Committees of the CCG. In carrying out his review the Accountable Officer has relied specifically upon:

- NHSE&I's annual assessment of the CCG's performance under the Improvement & Assessment Framework
- The CCG's overall governance, risk management, and internal control arrangements outlined in this report
- Reviews undertaken by the CCG's internal auditors, 360 Assurance, on a range of significant financial and other systems
- Performance, equality, sustainability, and other information incorporated within the Annual Report and other performance information available to him
- Results of staff and stakeholder surveys

- The statutory external audit undertaken by KPMG, who provide an opinion on the financial statements and form a conclusion on the CCG's arrangements for ensuring economy, efficiency, and effectiveness in its use of resources during 2021/22.

The 'Control Issues' section confirms that no significant control issues were identified in the year.

Conclusion

As Accountable Officer and based on the review process outlined above, the CCG has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Governance Statement above.

My review confirms that NHS Barnsley CCG has a generally sound system of risk management and internal control that supports the achievement of its policies, aims and objectives.

Chris Edwards, Accountable Officer

16 June 2022

Remuneration and staff report

Signature of the Remuneration and Staff Report by the Accountable Officer

Chris Edwards, Accountable Officer
16 June 2022

Remuneration Committee

The details of the remuneration committee can be found on page 49.

Policy on the Remuneration of Senior Managers

The CCG has not developed a specific remuneration policy but used the guidance outlined in the Department of Health July 2012 Pay Framework for Very Senior Managers (VSM) in Health Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts where appropriate in the absence of specific guidance for CCG's for some VSM roles. The CCG has utilised the CCG specific guidance in relation to Chief Officer and Chief Finance Officer remuneration.

The CCG has not implemented any performance related pay.

Remuneration of Very Senior Managers

The CCG's Accountable Officer on a Very Senior Manager contract has been paid more than £150,000 per annum on an annualised basis.

The Accountable Officer is a joint post between NHS Rotherham CCG and NHS Barnsley CCG, with NHS Rotherham CCG being the employer. The remuneration was reviewed and approved by NHS Rotherham CCG's remuneration committee as the employer of the Accountable Officer and subsequently NHS Barnsley CCG's remuneration committee noted the change in remuneration.

Under the pay sector guidance; with the joint role and responsibility the remuneration level was deemed reasonable and appropriate.

GPs and clinicians on the Governing Body are employed on a sessional basis and so their remuneration has not been grossed up on an annualised basis.

Senior manager remuneration (including salary and pension entitlements) [SUBJECT TO AUDIT]

Name and title	(a) Salary (bands of £5,000)		(b) Expense payments (taxable) to nearest £100		(c) Performance pay and bonuses (bands of £5,000)		(d) Long term performance pay and bonuses (bands of £5,000)		(e) All pension-related benefits (bands of £2,500)*		(f) TOTAL (a to e) (bands of £5,000)	
	£000		£000		£000		£000		£000		£000	
Governing Body Members:**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**
Dr N Balac, Chairman	90-95	**90-95**	0	**0**	0	**0**	0	**0**	0	**0**	90-95	**90-95**
L J Smith, Chief Officer (Resigned 31.08.20)***	20-25	**0**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**0**
C Edwards, Chief Officer (Recharged in from 01.09.20)****	35-40	**60-65**	1.1	**1.9**	0	**0**	0	**0**	0	**0**	35-40	**60-65**
R Naylor, Chief Finance Officer	105-110	**110-115**	0	**0**	0	**0**	0	**0**	17.5-20	**15-17.5**	125-130	**125-130**
J Sivakumar, Acting Chief Nurse (from 1.12.19)	90-95	**95-100**	0	**0**	0	**0**	0	**0**	0	**0**	90-95	**95-100**
Dr J Harban, Governing Body Member	30-35	**30-35**	0	**0**	0	**0**	0	**0**	0	**0**	30-35	**30-35**
Dr S Krishnasamy, Governing Body Member & Medical Director (from 01.07.19, resigned 31.08.20)	20-25	**0**	0	**0**	0	**0**	0	**0**	0	**0**	20-25	**0**
Dr M Guntamukkala, Governing Body Member **(**From 01.09.20) and Medical Director (From 01.12.20)	25-30	**60-65**	0	**0**	0	**0**	0	**0**	0	**0**	25-30	**60-65**
Dr M Smith, Governing Body Member	30-35	**30-35**	0	**0**	0	**0**	0	**0**	0	**0**	30-35	**30-35**
Dr M Simms, Secondary Care Clinician, Governing Body Member	30-35	**30-35**	0	**0**	0	**0**	0	**0**	0	**0**	30-35	**30-35**
Dr A Adekunle, Governing Body Member	35-40	**35-40**	0	**0**	0	**0**	0	**0**	0	**0**	35-40	**35-40**
C Millington, Lay Member	10-15	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**10-15**
Dr M H Kadarsha, Governing Body Member	35-40	**30-35**	0	**0**	0	**0**	0	**0**	0	**0**	35-40	**30-35**
N Bell, Lay Member for Governance	10-15	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**10-15**
Dr J MacInnes, Governing Body member	30-35	**30-35**	0	**0**	0	**0**	0	**0**	5-7.5	**7.5-10**	35-40	**35-40**

Name and title	(a) Salary (bands of £5,000)		(b) Expense payments (taxable) to nearest £100		(c) Performance pay and bonuses (bands of £5,000)		(d) Long term performance pay and bonuses (bands of £5,000)		(e) All pension-related benefits (bands of £2,500)*		(f) TOTAL (a to e) (bands of £5,000)	
	£000		£000		£000		£000		£000		£000	
Governing Body Members:**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**	**20/21**	**21/22**
Other Senior Staff:*												
R Walker, Head of Governance & Assurance	55-60	**55-60**	0	**0**	0	**0**	0	**0**	12.5-15	**15-17.5**	70-75	**70-75**
J Wike, Director of Strategic Planning and Performance (to 31.10.20), Chief Operating Officer (from 01.11.20)	95-100	**100-105**	0	**0**	0	**0**	0	**0**	85-87.5	**57.5-60**	180-185	**155-160**
J Budd, Director of Commissioning (to 31.10.20), Director of Strategic Commissioning and Strategic Partnerships (from 01.11.20)	110-115	**115-120**	0	**0**	0	**0**	0	**0**	25-27.5	**27.5-30**	140-145	**145-150**

*All pension related benefits: For defined benefit schemes, the amount included here is the annual increase in pension entitlement determined in accordance with the HMRC method: Increase=((20xpension as at 31.3.22)+pension lump sum as at 31.3.22)-((20xpension as at 31.3.21 adjusted by inflation)+pension lump sum as at 31.3.21 adjusted by inflation). Less the employee pension contributions paid within the year.

**Clinicians on the Governing Body are employed on a sessional basis. The Chair is employed for 2 days per week (applicable from December 2021 to March 2022 (3 days prior to this)); the new medical director is employed for 2 days per week (old 1.5 days per week); the secondary care clinician for 4 days per month; and other Governing Body member GPs for 1 day per week.

***The former Chief Officer's time was partly recharged £60,140 in 2020/21 to the South Yorkshire and Bassetlaw Integrated Care System and £70,969 in 2020/21 to NHS Sheffield CCG as Chief Officer so the salary band disclosed above in the senior management remuneration table for 2020/21 relates only to the duties for the CCG. The total remuneration for all employments in 2020/21 was £155,498.

****The current Chief Officer's time is a joint post and partly recharged from NHS Rotherham CCG £61,830, (plus car benefit £1,888), (£35,361 [Adjusted for the backdated 2020/21 pay award] plus car benefit £1,100 2020/21) so the salary band disclosed above in the senior management remuneration table relates only to the duties for the CCG. The total remuneration for all employments was £154,576 (plus car benefit £4,721), (£146,218 2020/21 plus car benefit £4,721).

Pension benefits as at 31 March 2022 [SUBJECT TO AUDIT]

Name and title	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real Increase in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total Accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age at 31 March 2022 (bands of £5,000)	Cash Equivalent transfer value at 01 April 2021	Real Increase in cash equivalent transfer value	Cash Equivalent transfer value at 31 March 2022	Employers contribution to stakeholder pension
Governing Body Members:	£000	£000	£000	£000	£000	£000	£000	£000
Dr N Balac, Chairman****	0	0	0	0	0	0	0	0
L J Smith, (Resigned 31.8.20) Chief Officer **	0	0	0	0	0	0	0	0
C Edwards, Chief Officer (Recharged in from 01.09.20) **	0	0	0	0	0	0	0	0
R Naylor, Chief Finance Officer	0-2.5	0	30-35	0	402	11	429	0
J Sivakumar, Acting Chief Nurse (from 1.12.19) **	0	0	0	0	0	0	0	0
Dr J Harban, Governing Body Member****	0	0	0	0	0	0	0	1
Dr S Krishnasamy, Governing Body Member & Medical Director (from 01.07.19, resigned 31.08.20)	0	0	0	0	173	0	0	0
Dr M Guntamukkala, Governing Body Member (From 01.09.20) and Medical Director (From 01.12.20) **	0	0	0	0	0	0	0	0
Dr M Smith, Governing Body Member **	0	0	0	0	0	0	0	0
Dr M Simms, Governing Body Member **	0	0	0	0	0	0	0	0
Dr Adebowale Adekunle, Governing Body Member ***	0	0	0	0	0	0	0	0
C Millington, Lay Member *	0	0	0	0	0	0	0	0
Dr M H Kadarsha, Governing Body Member ***	0	0	0	0	0	0	0	0
N Bell, Lay Member for Governance*	0	0	0	0	0	0	0	0

Name and title	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real Increase in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total Accrued pension at pension age at 31 March 2022 (bands of £5,000)	Lump sum at pension age at 31 March 2022 (bands of £5,000)	Cash Equivalent transfer value at 01 April 2021	Real Increase in cash equivalent transfer value	Cash Equivalent transfer value at 31 March 2022	Employers contribution to stakeholder pension
Governing Body Members:	£000	£000	£000	£000	£000	£000	£000	£000
Dr J MacInnes, Governing Body member	0-2.5	0	0-5	0	12	1	18	0
Other Senior Staff:								
R Walker, Head of Governance & Assurance	0-2.5	0	5-10	0	108	11	127	0
J Wike, Director of Strategic Planning and Performance (to 31.10.20), Chief Operating Officer (from 01.11.20)	2.5-5	0	40-45	0	463	39	517	0
J Budd, Director of Commissioning (to 31.10.20), Director of Strategic Commissioning and Strategic Partnerships (from 01.11.20)	0-2.5	0	5-10	0	102	19	136	0

Notes:
*Lay Members do not receive pensionable remuneration from the CCG; there are no entries in respect of pensions for those members.
** Member has opted out of the NHS pension scheme
*** Payment for this individual's work within the CCG is paid directly to them. The amount includes an element for employer's pension contribution and the CCG accounts for all pension contributions with payment made to NHS England
**** Receiving the NHS pension so no figures are provided by NHS pension authority

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office [SUBJECT TO AUDIT]

No payments have been made in compensation for early retirement or for loss of office.

Payments to past members [SUBJECT TO AUDIT]

No payments were made in 2021/22. (2020/21: £30 to S Tyler).

Fair pay disclosures [SUBJECT TO AUDIT]

Pay ratio information

As at 31 March 2022, remuneration ranged from £14,554 to £159,297 (+2% against 2020/21: £14,269 to 156,266*) 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.

The highest paid member used to calculate the 2021/22 and 2020/21 ratio of the median salary to the highest paid member is the current Accountable Officer. The Accountable Officer's time is partly recharged from NHS Rotherham CCG so the salary band disclosed in the senior management remuneration table relates only to the duties for the CCG. The remuneration of the Accountable Officer has been pro-rated to an annualised full-time equivalent for the purposes of the pay multiple disclosures.

*The Accountable Officer comparative remuneration for 2020/21 has been adjusted to include the back dated pay award paid in 2021/22.

Remuneration of NHS Barnsley CCG's CCG staff is shown in the table below:

	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	£39,030	£53,219
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£27,780	£39,030	£53,219

The ratios of staff remuneration against the mid-point of the banded remuneration of the highest paid director, is illustrated in the table below.

Year	**25th percentile pay ratio**	**Median pay ratio**	**75th percentile pay ratio**
2021/22	5.67	4.04	2.96
2020/21	5.50	4.05 *	3.06

*Adjusted from 3.9 as the Accountable Officer comparative remuneration for 2020/21 has been adjusted to include the back dated pay award paid in 2021/22.

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in NHS Barnsley CCG in the financial year 2021/22 was £155,000 to £160,000. The Accountable Officer received a 2% pay award for 2021/22. (There was no change to the banding from 2020/21, £155,000 to £160,000*) and the relationship to the remuneration of the organisation's workforce is disclosed in the below tables.

* The salary band was adjusted to include the back dated 2020/21 pay award actually paid in 2021/22

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	2%	0%

The ratios of staff remuneration and staff salary against the mid-point of the banded remuneration/salary of the highest paid director, is illustrated in the table below.

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
2021/22	5.67	5.67	4.04	4.04	2.96	2.96
2020/21	5.50	5.50	4.05	4.05	3.06	3.06

The movement is due to staff structure changes and the Agenda for Change salary movements between 2020/21 and 2021/22. Barnsley CCG believes the median pay for the relevant financial year is consistent with the pay, reward and progression policies for the entity's employees taken as a whole, as any changes to terms and pay structures are nationally negotiated and reflected through the Agenda for Change bandings. Further information can be found at https://www.nhsemployers.org/. In 2021/22, no (2020/21, Nil) employees received remuneration in excess of the highest-paid director/member.

Staff Report [Subject to Audit]

The table below shows the average number of whole-time equivalent staff permanently employed in the CCG.

	2021/22			2020/21
	Total	Permanently employed	Other	Total
	Number	Number	Number	Number
Total (average Whole Time Equivalent WTE staff)	**122**	119	3	**115**
Of the above: Number of whole-time equivalent people engaged on capital projects	0	0	0	0

Staff numbers and costs 2021/22 [SUBJECT TO AUDIT]

	Total 2021-22			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	**5,252**	4,995	257	**1,943**	1,838	105	**3,309**	3,157	152
Social security costs	**525**	514	11	**204**	196	8	**321**	318	3
Employer contributions to the NHS Pension Scheme	**1,023**	1,020	3	**577**	577	-	**446**	443	3
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Apprenticeship Levy	**16**	16	-	**16**	16	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**-**	-	-	**-**	-	-	**-**	-	-
Gross employee benefits expenditure	**6,816**	**6,545**	**271**	**2,740**	**2,627**	**113**	**4,076**	**3,918**	**158**
Less recoveries in respect of employee benefits (note 3.1.2)	**-**	-	-	**-**	-	-	**-**	-	-
Total - Net admin employee benefits including capitalised costs	**6,816**	**6,545**	**271**	**2,740**	**2,627**	**113**	**4,076**	**3,918**	**158**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**6,816**	**6,545**	**271**	**2,740**	**2,627**	**113**	**4,076**	**3,918**	**158**

Staff numbers and costs 2020/21 [SUBJECT TO AUDIT]

	Total 2020-21			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	**5,023**	4,708	315	**1,777**	1,726	51	**3,246**	2,982	264
Social security costs	**509**	492	17	**187**	181	6	**322**	311	11
Employer contributions to the NHS Pension Scheme	**998**	984	14	**568**	567	1	**430**	417	13
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Apprenticeship Levy	**18**	18	-	**18**	18	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**-**	-	-	**-**	-	-	**-**	-	-
Gross employee benefits expenditure	**6,548**	**6,202**	**346**	**2,550**	**2,492**	**58**	**3,998**	**3,710**	**288**
Less recoveries in respect of employee benefits (note 3.1.2)	**-**	-	-	**-**	-	-	**-**	-	-
Total - Net admin employee benefits including capitalised costs	**6,548**	**6,202**	**346**	**2,550**	**2,492**	**58**	**3,998**	**3,710**	**288**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**6,548**	**6,202**	**346**	**2,550**	**2,492**	**58**	**3,998**	**3,710**	**288**

Staff composition

As at 31 March 2022 the composition of the CCG's workforce was as follows:

The definition of senior managers was agreed at band 8A and above for the purposes of this data.

	Permanently employed			Other			**Total**		
	Female	Male	Total	Female	Male	Total	**Female**	**Male**	**Total**
Governing Body	3	9	**12**	0	1	**1**	3	10	**13**
Very Senior Manager	0	0	**0**	0	0	**0**	0	0	**0**
Director	0	2	**2**	0	0	**0**	0	2	**2**
GP	0	1	**1**	0	0	**0**	0	1	**1**
Band 8D	0	0	**0**	0	0	**0**	0	0	**0**
Band 8C	3	1	**4**	0	0	**0**	3	1	**4**
Band 8B	5	2	**7**	0	0	**0**	5	2	**7**
Band 8A	23	13	**36**	1	0	**0**	24	13	**37**
Other staff	72	7	**79**	5	0	**5**	77	7	**84**
Total	**106**	**35**	**141**	**6**	**1**	**7**	**112**	**36**	**148**

Sickness absence and ill health retirements data

NHS Digital publishes NHS sickness absence rates at the following link
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

The average working days lost per Full Time Equivalent for 2021/22 is 3.6.

	2021-2022	2020-2021
Number of persons retired early on ill health grounds	0	0
	£'000	£'000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme.

Staff turnover percentage

The staff turnover rate can be found at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics. The series is an official statistics publications complying with the UK statistics code of practice.

Staff survey and engagement

The CCG carried out a bespoke staff survey in 2020/21. This was a comprehensive all staff survey looking at the culture of the organisation and the values and views of staff.

CCG employees were found to be generally positive when considering their overall experiences of working at the organisation. Employees gave an average score of 8.10 out of 10 (1 being very dissatisfied and 10 being very satisfied) with how satisfied they were working at the CCG. This average increased slightly to 8.11 out of 10 when employees were asked to consider satisfaction within the last 12 months.

Over nine-tenths (93%) said they would be likely to recommend NHS Barnsley CCG as a place to work for friends and family. Over two-thirds (69%) felt that the CCG provides equal opportunities for career progression and promotion with a tenth that did not feel this was the case. A third found Barnsley CCG to be a better place to work than this time last year with only 7% that felt it was worse when compared to last year

Nearly all employees (98%) had worked from home for at least part of their contracted hours of the past year. Employees were asked to rate aspects of their working arrangements during that period from 1-10 with 1 being not at all satisfied and 10 being completely satisfied. Virtual meetings were rated highest (8.85 out of 10) closely followed by IT access (8.76) and the equipment and resources needed to do their job (8.68). All aspects of home working scored well with work station set-up (8.03) the lowest scoring aspect.

On average, colleagues rated the ability to maintain a work/life balance 7.88 out of 10 (1 being not at all and 10 perfectly). In context, on average, employees rated the ability to maintain work/life balance as 9.62 out of 10 (1 being not at all important and 10 being extremely important). Colleagues felt they were able to work flexibly both in terms of how they do their job (91% a lot / some flexibility) and when they do their work (88% a lot / some flexibility).

Over three-fifths of employees (62%) revealed they either often or always look forward to attending work whilst less than a tenth (5%) said seldom or never. Employees were positive that they were able to do their job to a standard that is expected of them with this scoring 8.25 out 10, with 1 being not at all and 10 being completely. They also indicated that they were clear about what of expected of them in their role (8.10 out of 10).

A third of employees mentioned they had experienced musculoskeletal problems as a results of work activities in the last 12 months; with less than a fifth (18%) that revealed they had felt unwell as a result of work-related stress in the last 12 months. Over half (55%) said they had attended work while feeling unwell in the last 12 months.

Less than a tenth (6%) revealed they had experienced bullying and/or harassment at work in the last 12 months. Around nine-tenths (89%) knew what steps to take if they experienced bullying or harassment in the future.

The survey collected Workforce Race Equality Standards data. This WRES report is available to view on the CCG website here. The report highlights that 11.5% of our workforce is from a Black, Asian or Ethnic Minority background. At Governing Body level, this jumps to 33%.

In addition to the focus of inequalities brought about by the pandemic, work continued in the CCG to meet our Equality Delivery Standard 2 (EDS2) objectives. A number of training and awareness sessions were put on for staff for example. Whilst there were initial discussions around a South Yorkshire and Bassetlaw CCG-wide forum for colleagues from a Black, Asian or ethnic minority background in 20/21, these didn't progress further. The CCG picked this up with a wider discussion with staff about the appetite for bespoke or wider inclusion forums. This work will be taken forward as we move to a single organisation.

The CCG is also a member of the wider work taking place at the ICS. SYB is progressing well with a number of EDI commitments first proposed towards the end of 2020. Aligned to NHS England and NHS Improvement's (NHSE/I) Workforce Race Equality Standards (WRES), SYB identified five key areas for action. One of the key aims was to set-up a system-wide EDI Steering Group which is up-and-running with energy and commitment from all members.

Our CCG has been part of the new reciprocal mentoring programme called Inclusive Cultures. This programme matches aspiring leaders from who are from an ethnic minority background with leaders from across a range of NHS organisations in our area. The successes and learnings from this programme will be reviewed and built upon in 2022/23. Throughout 2021/22 a series of regular staff pulse surveys were carried out to understand the impact of the pandemic on staff's own health and wellbeing, their working environment and their ability to operate effectively throughout the various periods during the year. These survey results were fed back to staff at regular points and actions set across the organisation.

Staff policies

Consultation and engagement with employees is a fundamental principle of good employment practice. The CCG holds regular staff briefings open to all staff and heads of service hold individual team meetings. Staff are engaged through their meetings and open staff briefings on the strategic direction, delivery and performance of the CCG. In addition, there is a CCG-wide staff volunteer group, the Radiators, who meet on a monthly basis and where policies are discussed. Members of the Radiators then encourage colleagues in their teams to feedback any comments they may have.

The CCG actively welcomes suggestions and ideas from all staff on the ways the CCG can improve the overall performance of the organisation.

This year a range of HR policies were reviewed and refreshed. These included the:

- Re-location policy
- long service award policy
- Working Time regulations

- Alcohol and Substance Misuse
- Induction, Mandatory and Statutory Training

The CCG policies can be found at http://www.barnsleyccg.nhs.uk/strategies-policies-and-plans.htm

Disabled Employees

The CCG always strives to be an inclusive organisation, which is fully committed to a culture and environment which actively promotes equality of access and treatment for all employees, visitors, contractors and members of the general public. The CCG has published its policies covering Equality, Diversity and Human rights. The policies are monitored and updated to ensure that best practice is incorporated with regards to all aspects of recruitment and selection including the fair treatment of disabled people.

The CCG is a Disability Confident employer which means the organisation has agreed to take action to meet the five commitments regarding the employment, retention, training and career development of disabled employees.

The CCG is fully committed to ensuring that all employees with a disability have equal access to opportunities to develop to their full potential. All career promotion opportunities are made widely available to all employees in line with best practice, whilst ensuring that any unfair bias and discrimination is eliminated. Monitoring is undertaken to ensure that the CCG remains compliant.

All employees are assessed for the training needs to ensure they are compliant with the job designation, these assessments will incorporate any reasonable adjustments required to ensure that learning and development is fully accessible for all employees.

Other employee matters

This year our staff volunteer group, the Radiators, has introduced a range of improvements and activities focused on staff wellbeing as part of the work to support staff during the ongoing pandemic.

Traditional office-based working patterns have been replaced with the majority of staff continued to work from home during 2021/22. Risk assessments and health and wellbeing 1 to 1s were put in place and reviewed over the year. This looked at a range of factors linked to the individual and their as further data came out about the higher risks of the coronavirus to certain characteristics including ethnicity, gender, and pregnancy for example.

Regular pulse surveys were also put in place to assess people's personal resilience, the pressure, their access to the relevant equipment to be able to do their job. It also focused on capturing things that were working well for staff and encouraging people to share the things that worked well for them.

Trade Union (Facility Time Publication Requirements) regulations 2017

Under the Trade Union (Facility Time Publication Requirements) regulations 2017, the CCG has to disclose the relationship of Trade Union official's employment costs and time to the whole CCG.

The CCG does not employ any Trade Union officials. We do however have union representatives representing CCG staff from a shared service and the disclosure below reflects that arrangement. The relationship with them this year has continued to be positive. They have provided regular support to members via video call, email or telephone and attendance at staff briefings.

Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent number
1	0.196

Percentage of time spent on facility time
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99%, d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1%-50%	1
51%-99%	0
100%	0

Percentage of pay bill spent on facility time
Provide the figures requested in the first column of the table below to determine the percentage of your total paybill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£7,649
Provide the total pay bill	£4,995,000
Provide the percentage of the total paybill spent on facility time, calculated as: (total cost of facility time ÷total pay bill) × 100	0.15%

Paid Trade Union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) × 100	80%

Expenditure on consultancy

Consultancy expenditure is the provision to management of objective advice and assistance relating to the CCG's strategy, structure, management or operations. Such assistance will be provided outside the "business as usual" environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions.

No payments were made for consultancy in 2021/22 (2020/2021 £0k).

Off-payroll engagements

It is the Treasury requirements for public sector bodies to report arrangements whereby individuals are paid through their own companies and so are responsible for their own tax and national insurance arrangements. Payments to GP practices for the services of employees and GPs are deemed to be 'off payroll' engagements and are therefore subject to these disclosure requirements.

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

For all off-payroll engagements as at 31 March 2022, for more than £245* per day:

	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	4
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

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.

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

For all off-payroll engagements between 1 April 2021 and 31 March 2022 for more than £245 per day.

	Number
Number of temporary workers engaged between 1st April 2021 and 31st March 2022	5
Of which…	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	5
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements where the status was disputed under provisions in the off-payroll legislation	0
Of which: Number of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll engagements / senior official engagements

Off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022 are as follows:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	3

The Clinical Chair, Chief Officer (as Accountable Officer) and the Chief Finance Officer are the three members of the Governing Body deemed to have significant financial responsibility for the purposes of the table above.

The Accountable Officer is currently recharged in from NHS Rotherham CCG and the remaining two were paid through the payroll during 2021/22.

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	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 –£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of NHS terms and conditions of service (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where NHS Barnsley CCG has agreed early retirements, the additional costs are met by NHS Barnsley 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**	0	0
TOTAL	0	0

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 Note 3.3 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and amounts relating to non-contractual payments in lieu of notice.

No non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

The remuneration report includes disclosure of exit packages payable to individuals named in that report.

Parliamentary Accountability and Audit Report

NHS Barnsley 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 notes 2, 11 and 19.

An audit certificate and report is also included in this Annual Report at the end of the Annual Report and Financial Statements.

Financial Statements & Notes

Foreword to the accounts

The Clinical Commissioning Group was licenced from the 1 April 2013 under provisions enacted in the Health and Social Act 2012, which amended the National Health Service Act 2006.

These accounts for the year ended 31 March 2022 have been prepared by NHS Barnsley Clinical Commissioning Group under c. 7, Schedule 2, S. 17 CCG Annual Report Directions (chapter A1 of part 2 of the National Health Service Act 2006 as amended by 14Z15 of the Health and Social Act 2012 Reports by Clinical Commissioning Groups) in the form which the Department of Health and Social Care has directed.

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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	(67)	(59)
Other operating income	2	(3)	0
Total operating income		**(70)**	**(59)**
Staff costs	3	6,816	6,548
Purchase of goods and services	4	522,250	483,391
Depreciation and impairment charges	4	10	16
Provision expense	4	0	0
Other Operating Expenditure	4	372	395
Total operating expenditure		**529,448**	**490,350**
Net Operating Expenditure		**529,378**	**490,291**
Finance expense		10	-
Total Net Expenditure for the Financial Year		**529,388**	**490,291**
Other Comprehensive Expenditure		**0**	**0**
Comprehensive Expenditure for the year		**529,388**	**490,291**

The notes on pages 6 to 25 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	7	0	20
Trade and other receivables	8	9	79
Total non-current assets		**9**	**99**
Current assets:			
Trade and other receivables	8	777	915
Cash and cash equivalents	9	35	17
Total current assets		**812**	**932**
Total assets		**821**	**1,031**
Current liabilities			
Trade and other payables	10	(29,022)	(32,656)
Total current liabilities		**(29,022)**	**(32,656)**
Assets less Liabilities		**(28,201)**	**(31,625)**
Financed by Taxpayers' Equity			
General fund		(28,201)	(31,625)
Total taxpayers' equity:		**(28,201)**	**(31,625)**

The notes on pages 6 to 25 form part of this statement

The financial statements on pages 2 to 5 were approved by the Governing Body on 16 June 2022 and signed on its behalf by:

Christopher Edwards
Chief Accountable Officer
16 June 2022

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	**(31,625)**	**(31,625)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22		
Net operating expenditure for the financial year	(529,388)	(529,388)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(529,388)**	**(529,388)**
Net funding	**532,812**	**532,812**
Balance at 31 March 2022	**(28,201)**	**(28,201)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	**(31,515)**	**(31,515)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating costs for the financial year	(490,291)	(490,291)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(490,291)**	**(490,291)**
Net funding	**490,181**	**490,181**
Balance at 31 March 2021	**(31,625)**	**(31,625)**

The notes on pages 6 to 25 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		(529,388)	(490,291)
Depreciation and amortisation	4	10	16
Disposal of property, plant & equipment other than by sale		10	0
(Increase)/decrease in trade & other receivables	8	208	1,359
Increase/(decrease) in trade & other payables	10	(3,634)	(1,278)
Net Cash Inflow (Outflow) from Operating Activities		**(532,794)**	**(490,194)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	**0**
Net Cash Inflow (Outflow) before Financing		**(532,794)**	**(490,194)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		532,812	490,181
Net Cash Inflow (Outflow) from Financing Activities		**532,812**	**490,181**
Net Increase (Decrease) in Cash & Cash Equivalents	9	**18**	**(13)**
Cash & Cash Equivalents at the Beginning of the Financial Year	9	**17**	**30**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	**0**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	9	**35**	**17**

The notes on pages 6 to 25 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 Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC 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 the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC 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 are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

The Health and Care Act received royal assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and will abolish CCGs. ICBs will take on the commissioning functions of CCGs. As a result the functions, assets and liabilities of the CCG will therefore transfer to NHS South Yorkshire Integrated Care Board.

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 CCG 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. If services will continue to be provided the financial statements are prepared on the going concern basis. As the CCG's functions will continue to be delivered by the ICB the CCG has therefore assessed that it remains a going concern as at 31 March 2022.

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 Pooled Budgets

Barnsley Clinical Commissioning Group has entered into pooled budget arrangements under Section 75 of the National Health Service Act 2006 for activities relating to Children's Services and the Better Care Fund. A memorandum note to the accounts provides details of the joint income and expenditure (note 15, Page 23).

The Children's Services pool is hosted by Barnsley Metropolitan Borough Council; the Better Care Fund operates on an aligned budget basis. The Clinical Commissioning Group makes contributions to the pools, which are then used to purchase healthcare services. The Clinical Commissioning Group accounts for its share of assets, liabilities, income and expenditure of the pools as determined by the pooled budget agreement.

1.4 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.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.5.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Operating lease commitments - The Clinical Commissioning Group has in substance a property lease arrangement with NHS Property Services Ltd relating to the headquarters site. NHS England determined that the Clinical Commissioning Group has not obtained substantially all the risks and rewards of ownership of this property; the lease has been classified as an operating lease and accounted for accordingly.

Legacy balances in respect of assets and liabilities arising for transactions or delivery of care prior to 31st March 2013 are accounted for by NHS England. The Clinical Commissioning Group's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in Notes to these financial statements

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

The Clinical Commissioning Group has included certain accruals within the financial statements which are estimates. The key accruals being healthcare contracts, continuing healthcare and prescribing for which the basis of the estimation of the accruals was approved by the Chief Finance Officer.

1.6 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 standard reflecting cross government principles.

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.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

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

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements on the basis of 2.5 days per whole time equivalent employee.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that covers 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 to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. 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 any such 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.

Where employees cannot be members of the NHS pension scheme they are enrolled into The National Savings Scheme (NEST). The scheme is accounted for a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

1.8 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.

Expenses and liabilities in respect of grants are recognised when the Clinical Commissioning Group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.9 Property, Plant & Equipment

1.9.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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 individual useful economic lives.

1.9.2 Measurement

All property, plant and equipment are 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.

Property revaluations are performed with sufficient regularity to ensure that the carrying amounts are not materially different from those that would be determined at the end of the reporting period. Land and non-specialised buildings are held at market value for existing use.

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

1.9.3 Depreciation, Amortisation & Impairments

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight-line basis over their estimated useful lives. 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.

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.

1.10 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.

1.10.1 The Clinical Commissioning Group as Lessee

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.

1.11 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. Cash, bank and overdraft balances are recorded at current value.

1.12 Clinical Negligence Costs

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

1.13 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.

1.14 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Group previously contributed to a pooled fund, which is used to settle the claims.

1.15 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 when the asset has been transferred and the Clinical Commissioning Group has transferred substantially all of the risk and rewards or ownership or has not retained control of the asset.

The only category of Financial asset applicable to the Clinical Commissioning Group is Loans and receivables, which are measured at amortised cost.

1.15.1 Financial Assets at Amortised Cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and where cash flows are solely payments of principal and interest. This includes most trade receivables, loan 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.

1.15.2 Impairment

For all financial assets measured at amortised cost, lease receivables and contact assets, the Clinical Commissioning Group recognises a loss allowance representing expected credit losses on the financial instrument.

The Clinical Commissioning Group adopts a simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables 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. Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and Clinical Commissioning Group does not recognise loss 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.

1.16 Financial Liabilities

Financial liabilities are recognised when 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 extinguished – that is, the obligation has been discharged or cancelled or has expired.

1.16.1 Financial Liabilities at Amortised Cost

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

1.17 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.

1.18 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).

1.19 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.20 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.

1.21 Contingent liabilities

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

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

The DHSC 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.

· IFRS 16: Leases - The Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The effective date for adoption of the standard as adapted and interpreted by the FReM was originally 1 April 2020 but this has been deferred until 1 April 2022.

· IFRS 17: Insurance Contracts -Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 16 Impact on the accounts from 1st April 2022.

IFRS 16 Leases is now applicable from 1 April 2022, superseding IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease, SIC 15 Operating lease incentives and SIC 27 Evaluating the substances of transactions involving the legal form of a lease. The standard introduces new or amended requirements with respect to lease accounting by removing the distinction between operating and finance leases. From 1 April 2022 the Clinical Commissioning Group will recognise a right-of-use (ROU) asset and a lease liability for all leases, except for short-term leases and leases of low value assets on the Statement of Financial Position (SoFP).

Impact of the new definition of a lease.

The Clinical Commissioning Group following the mandated guidance from NSHE will adopt the practical expedients available on transition to IFRS 16 by not reassessing whether a contract is or contains a lease. Accordingly, the definition of a lease in accordance with IAS 17 and IFRIC 4 will continue to be applied to lease entered or modified before 1 April 2022.

The change in definition of a lease mainly relates to the concept of control. IFRS 16 determines whether a contract contains a lease on the basis of whether the user has the right to control the use of an identified asset for a period of time in exchange for consideration.

The Clinical Commissioning Group has developed and executed an adoption plan which consists of;

1. a qualitative review and analysis of leases to determine the impact of the new standard
2. an assessment of the impact of the standard on systems and controls
3. a financial assessment of the impact of application of the standard.

As part of the assessment the Clinical Commissioning Group has applied the definition of a lease and the related guidance detailed in IFRS 16 to all lease contracts entered into or modified on or after 1 April 2020 to ascertain the accounting classification for each lease post 1 April 2022.

Financial impact of IFRS 16 Adoption

IFRS 16 changes how the Clinical Commissioning Group accounts for leases under IAS 17, with the operating cost solely have been recognised with the Statement of Comprehensive Net Expenditure (SoCNE). From 1 April 2022 on the adoption of IFRS 16 the Clinical Commissioning Group will:

· recognise a right-of-use assets and lease liabilities in the SoFP, initially measured at the present value of future lease payments based on the rate of interest implicit in the lease or the DHSC average borrowing rate (0.95%);

· recognise associated depreciation on the right-of-use assets and interest on lease liabilities in the SoCNE; and

· Separate the total amount of cash paid into the principal portion (presented within financing activities) and interest (presented with operating activities) in the Consolidated statement of Cash-flows.

For short-term (lease term of less than 12 months) and leases of low-value assets (such as personal computers, office furniture and photocopiers), the Clinical Commissioning Group under the permitted expedients within IFRS 16 will continue to recognise the expense on a straight line basis within the SoCNE.

The Clinical Commissioning Group as mandated by NHSE will adopt the modified retrospective basis. This method will result in a cumulative adjustment to retained earnings as of 1 April 2022, as if IFRS 16 has always been in effect, and whereby comparative periods will not be restated. The cumulative effect on adoption of the standard is expected to be £Nil adjustment to reserves.

On the adoption of IFRS 16 the leases previously classified as operating lease under IAS 17 will result in the recognition of a ROU asset £401K and corresponding finance liability of £401K. The lease liability been the present value of lease payments over a 4 year period, and discounted at the DHSC average borrowing rate (0.95%)

The application of the other Standards that have been issued but have not been adopted would not have a material impact on the accounts for 2021-22, were they applied in that year.

2 Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	67	59
Other Contract income	0	0
Total Income from sale of goods and services	**67**	**59**
Other operating income		
Non cash apprenticeship training grants revenue	**3**	0
Total Other operating income	**3**	**0**
Total Operating Income	**70**	**59**

Revenue in this note does not include cash received from NHS England for Healthcare and other service contracts, this is drawn down directly into the bank account of the CCG and credited to the General fund.

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

	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue		
NHS	8	0
Non NHS	59	0
Total	**67**	**0**

	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue		
Point in time	0	0
Over time	67	0
Total	**67**	**0**

2.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date

	2021-22 Total £000s	Revenue expected from NHSE Bodies £000s	Revenue expected from Other DHSC Group Bodies £000s	Revenue expected from Non-DHSC Group Bodies £000s
Not later than 1 year	0	0	0	0
Later than 1 year, not later than 5 years	0	0	0	0
Later than 5 Years	0	0	0	0
Total	**0**	**0**	**0**	**0**

	2020-21 Total £000s	Revenue expected from NHSE Bodies £000s	Revenue expected from Other DHSC Group Bodies £000s	Revenue expected from Non-DHSC Group Bodies £000s
Not later than 1 year	0	0	0	0
Later than 1 year, not later than 5 years	0	0	0	0
Later than 5 Years	0	0	0	0
Total	**0**	**0**	**0**	**0**

3. Employee benefits and staff numbers

3.1.1 Employee benefits	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,995	257	5,252
Social security costs	514	11	525
Employer Contributions to NHS Pension scheme	1,020	3	1,023
Other pension costs	0	0	0
Apprenticeship Levy	16	0	16
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**6,545**	**271**	**6,816**
Less recoveries in respect of employee benefits (note 3.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,545**	**271**	**6,816**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,545**	**271**	**6,816**

3.1.1 Employee benefits	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,708	315	5,023
Social security costs	492	17	509
Employer Contributions to NHS Pension scheme	984	14	998
Other pension costs	0	0	0
Apprenticeship Levy	18	0	18
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**6,202**	**346**	**6,548**
Less recoveries in respect of employee benefits (note 3.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,202**	**346**	**6,548**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,202**	**346**	**6,548**

3.1.2 Recoveries in respect of employee benefits			2021-22	2020-21
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	0	0	0	0
Social security costs	0	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**0**	**0**	**0**	**0**

3.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	119	3	122	111	4	115
Of the above:						
Number of whole time equivalent people engaged on capital projects	0	0	0	0	0	0

3.3 Exit packages agreed in the financial year

The Clinical Commissioning Group has not paid any exit packages in 2021-22 (2020-21: Nil)

There has not been any non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that report, where applicable.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change terms and conditions (Section 16) and the Clinical Commissioning Group's Organisational Change Policy

Exit costs are accounted for in accordance with relevant accounting standards and at the latest cost in full, in the year of departure.

3.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. From 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 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.

The employer contribution rate for NHS Pensions increased from 14.38% to 20.68% (including 0.08% pension levy) from 1st April 2019. For 2021-22, employers’ contributions of £795,985 (£679,144 excluding staffing recharges) (2020-21: £799,540, (excluding staffing recharges £643,703) were payable to the NHS Pensions Scheme by the Clinical Commissioning Group at the former rate of 14.38% of pensionable pay. The balance to the 20.68% actual rate for 2021-22 was paid by NHS England on the Clinical Commissioning Group's behalf. The full cost and related funding of £354K (2020-21: £354K) has been recognised in these accounts.

4. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,750	1,691
Services from foundation trusts	333,106	302,143
Services from other NHS trusts	17,674	16,954
Services from Other WGA bodies	0	0
Purchase of healthcare from non-NHS bodies	53,266	48,332
Purchase of social care	13,381	13,299
Prescribing costs	49,044	49,605
Pharmaceutical services	356	287
General Ophthalmic services	129	147
GPMS/APMS and PCTMS	51,711	46,885
Supplies and services – clinical	3	7
Supplies and services – general	264	590
Consultancy services	0	0
Establishment	(213)	1,269
Transport	634	719
Premises	850	1,041
Audit fees	78	66
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services (1)	0	10
Other professional fees	19	129
Legal fees	(26)	150
Education, training and conferences	221	67
Non cash apprenticeship training grants	3	0
Total Purchase of goods and services	**522,250**	**483,391**
Depreciation and impairment charges		
Depreciation	10	16
Total Depreciation and impairment charges	**10**	**16**
Other Operating Expenditure		
Chair and Non Executive Members	330	371
Grants to Other bodies	0	0
Clinical negligence	0	0
Research and development (excluding staff costs)	23	31
Expected credit loss on receivables	(1)	(7)
Other expenditure	20	0
Total Other Operating Expenditure	**372**	**395**
Total operating expenditure	**522,632**	**483,802**

Auditor Liability

The total aggregate liability of KPMG is limited per the contract to £2 Million for all defaults, claims, losses or damages where arising from breach of contract, misrepresentation, tort, breach of statutory duty or otherwise.

1. Other Audit services represents review costs in relation to the Mental Health Investment standard. The value for 2021-22 includes £12K for the completion of the 2021-22 MHIS review and a (£12K) accrual reversal for 2020-21, as NHS England suspended the requirement for independant review for that year.

5. 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	13,127	121,538	14,672	111,641
Total Non-NHS Trade Invoices paid within target	13,033	121,363	14,669	111,640
Percentage of Non-NHS Trade invoices paid within target	99.28%	99.86%	99.98%	100.00%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	561	353,918	897	325,128
Total NHS Trade Invoices Paid within target	561	353,918	897	325,128
Percentage of NHS Trade Invoices paid within target	100.00%	100.00%	100.00%	100.00%

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.
The target has been set at 95% for all of the above criteria which has been achieved by the Clinical Commissioning Group.

The Clinical Commissioning Group has not made any payments under the Late Payment of Commercial Debts (interest) Act 1998 during 2021-22 (2020-21: Nil)

6. Operating Leases

6.1 As lessee

6.1.1 Payments recognised as an Expense

	2021-22				2020-21			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	102	3	**105**	0	102	3	**105**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**102**	**3**	**105**	**0**	**102**	**3**	**105**

The amount recognised above under Buildings are as follows:
NHS Property Services Ltd £102K (2020-21: £102K).

Of the amount paid to NHS Property Services Ltd, £102K (2020-21: £102K) relates to the occupancy of Hilder House (CCG Headquarters) that was transferred to the lessor on the abolition of the Primary Care Trust in 2013: the amount charged represent market rent. The CCG recharged NHS Sheffield Clinical Commissioning Group 2021/22 £4K (2020/21 £4K) for the IT department's occupancy of the CCG Headquarters.

The costs recognised in Other, in 6.1.1 / 6.1.2 relate to photocopier leases held by the CCG.

6.1.2 Future minimum lease payments

	2021-22				2020-21			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	102	3	**105**	0	0	1	**1**
Between one and five years	0	306	1	**307**	0	0	0	**0**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**408**	**4**	**412**	**0**	**0**	**1**	**1**

Whilst in 2020-21 the Clinical Commissioning Group arrangement with NHS Property Services Limited fell within the definition of an operating lease, the rental charge for future years had not been agreed. Consequently this note does not include future minimum lease payments for those arrangements in 2020-21. In 2021-22 the Clinical Commissioning Group signed a 5 year agreement with NHS Property Services Limited, so the associated commitment is now shown in 2021-22.

7. Property, plant and equipment

2021-22	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2021	691	237	928
Disposals other than by sale	(691)	(237)	(928)
Cost/Valuation at 31 March 2022	**0**	**0**	**0**
Depreciation 01 April 2021	671	237	908
Disposals other than by sale	(681)	(237)	(918)
Charged during the year	10	-	10
Depreciation at 31 March 2022	**0**	**0**	**0**
Net Book Value at 31 March 2021	**20**	**0**	**20**
Net Book Value at 31 March 2022	**0**	**0**	**0**
Purchased	0	0	0
Total at 31 March 2022	**0**	**0**	**0**
Asset financing:			
Owned	0	0	0
Total at 31 March 2022	**0**	**0**	**0**

7.1 Cost or valuation of fully depreciated assets

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

	2021-22 £'000	2020-21 £'000
Information technology	0	642
Furniture & fittings	0	237
Total	**0**	**879**

7.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	2	5
Furniture & fittings	5	10

8. 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	0	0	0	0
NHS prepayments	0	0	0	0
NHS accrued income	0	0	0	0
NHS Contract Receivable not yet invoiced/non-invoice	15	0	101	0
NHS Non Contract trade receivable (i.e pass through funding)	230	0	371	0
Non-NHS and Other WGA receivables: Revenue	0	0	0	0
Non-NHS and Other WGA prepayments	163	9	149	79
Non-NHS and Other WGA accrued income	0	0	0	0
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	302	0	142	0
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	46	0	149	0
Expected credit loss allowance-receivables	(1)	0	(2)	0
VAT	16	0	0	0
Other receivables and accruals	6	0	5	0
Total Trade & other receivables	**777**	**9**	**915**	**79**
Total current and non current	**786**		**994**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS organisations. As NHS organisations are funded by Government, no credit score is necessary.

8.1 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	80	0	3	84
By three to six months	0	0	0	0
By more than six months	0	1	0	1
Total	**80**	**1**	**3**	**85**

£80K of the amount above has subsequently been recovered post the statement of financial position date.
The Clinical Commissioning Group does not hold any collateral against receivable outstanding at 31 March 2022. (2020-21: Nil)

8.2 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2021	(2)	0	**(2)**
Lifetime expected credit loss on credit impaired financial assets	0	0	**0**
Lifetime expected credit losses on trade and other receivables-Stage 2	1	0	**1**
Lifetime expected credit losses on trade and other receivables-Stage 3	0	0	**0**
Credit losses recognised on purchase originated credit impaired financial assets	0	0	**0**
Amounts written off	0	0	**0**
Financial assets that have been derecognised	0	0	**0**
Changes due to modifications that did not result in derecognition	0	0	**0**
Other changes	0	0	**0**
Total	**(1)**	**0**	**(1)**

8.3 Loss matrix on Lifetime expected credit losses on trade and other receivables-Stage 2

Non NHS Debt (excluding other DHSC group bodies)	Lifetime expected credit loss rate %	Gross Carrying Amount £'000	Lifetime expected credit loss £'000
Current	-	44	0
1-30 days	1	0	0
31-60 days	2	0	0
61-90 days	5	0	0
91-120 days	10	0	0
121-180 days	20	0	0
181-360 days	50	0	0
361+ days	100	1	1

9. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	17	30
Net change in year	18	(13)
Balance at 31 March 2022	**35**	**17**
Made up of:		
Cash with the Government Banking Service	35	17
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**35**	**17**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2022	**35**	**17**
Patients' money held by the clinical commissioning group, not included above	0	0

10. 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	226	0	163	0
NHS accruals	129	0	48	0
Non-NHS and Other WGA payables: Revenue	4,756	0	6,090	0
Non-NHS and Other WGA accruals	23,248	0	25,728	0
Social security costs	89	0	101	0
VAT	0	0	4	0
Tax	78	0	85	0
Other payables and accruals	496	0	437	0
Total Trade & Other Payables	**29,022**	**0**	**32,656**	**0**
Total current and non-current	**29,022**		**32,656**	

There are no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2021: Nil).
Other payables include £487K outstanding pension contributions at 31 March 2022 (31 March 2021: £410K)

11. Provisions and Contingencies

The Clinical Commissioning Group had no provisions or contingent liabilities as at 31 March 2022 (31 March 2021:Nil) However, under the Accounts Directions issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group.

The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this Clinical Commissioning Group as at 31 March 2022 is £26K (31 March 2021: £89K).

The total value of legacy NHS Continuing Healthcare contingent liabilities accounted for by NHS England on behalf of this Clinical Commissioning Group as at 31 March 2022 is £1,901K (31 March 2021: £4,441K).

12. Commitments

The Clinical Commissioning Group has no contracted capital commitments not otherwise included in these financial statements as at 31 March 2022 (31 March 2021: Nil)

13. Financial instruments

13.1 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.

13.1.1 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.

13.1.2 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.

13.1.3 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.

13.1.4 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.

13.1.5 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.

13 Financial instruments cont'd

13.2 Financial assets

	Financial Assets measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	218	**218**
Trade and other receivables with other DHSC group bodies	83	**83**
Trade and other receivables with external bodies	298	**298**
Other financial assets	0	**0**
Cash and cash equivalents	35	**35**
Total at 31 March 2022	**634**	**634**

	Financial Assets measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other receivables with NHSE bodies	418	**418**
Trade and other receivables with other DHSC group bodies	53	**53**
Trade and other receivables with external bodies	292	**292**
Other financial assets	5	**5**
Cash and cash equivalents	17	**17**
Total at 31 March 2021	**785**	**785**

13.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	354	**354**
Trade and other payables with other DHSC group bodies	5	**5**
Trade and other payables with external bodies	28,496	**28,496**
Other financial liabilities	0	**0**
Total at 31 March 2022	**28,855**	**28,855**

	Financial Liabilities measured at amortised cost 2020-21 £'000	Total 2020-21 £'000
Trade and other payables with NHSE bodies	82	**82**
Trade and other payables with other DHSC group bodies	138	**138**
Trade and other payables with external bodies	31,809	**31,809**
Other financial liabilities	437	**437**
Total at 31 March 2021	**32,466**	**32,466**

The Clinical Commissioning Group has a financial liability of £28,855K as at the 31 March 2022 (31 March 2021 £32,466K). All of this liability is due to be settled within the financial year ended 31 March 2023.

14. Operating segments

The Clinical Commissioning Group considers that it has only one segment in terms of Operating segments: the commissioning of Healthcare services

	2021-22 £'000
Total Gross Expenditure (as per Statement of Comprehensive Net Expenditure)	529,458
Total Gross Income (as per note 2)	(70)
Total Net Expenditure as at 31 March 2022	529,388
Total Assets (as per Statement of Financial Position)	821
Total Liabilities (as per Statement of Financial Position)	(29,022)
Total Net Assets as at 31 March 2022	(28,201)

During the year the Clinical Commissioning Group spent £525,393K on the commissioning of Healthcare and other services (net programme expenditure), Gross programme Expenditure £525,463K less Gross programme Income £70K . This represents 99.2% of the Clinical Commissioning Group's net expenditure.

55.8% of the Clinical Commissioning Group's net programme expenditure was expensed with the two main local providers £222,007K (42.3%) to Barnsley Hospital NHS Foundation Trust and £71,113K (13.5%) to South West Yorkshire Partnership NHS Foundation Trust.

15. Pooled budgets - interests in joint operations

The Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

Children and Young People's Trust

The Clinical Commissioning Group has entered into a pooled budget arrangement with Barnsley Metropolitan Borough Council (BMBC) under S75 of the Health Care Act 2006.

Both parties contribute funds to a pooled commissioning budget, which is hosted by BMBC. The pooled budget is managed by the Executive Commissioning Group.

This group allocates the funds to the Children and Young People's Trust to commission Childrens services.

Summary of the pooled budget is shown below;

	2021-22 £'000	2020-21 £'000
Contribution to pooled commissioning budget:		
Opening balance as at 1 April	0	0
Barnsley Clinical Commissioning Group	3,120	4,814
Barnsley Metropolitan Borough Council	34,409	34,790
	37,529	**39,604**
Services Commissioned from the pooled budget:		
Barnsley Metropolitan Borough Council	35,422	35,792
South West Yorkshire Partnership NHS Foundation Trust	1,696	1,656
Barnsley Clinical Commissioning Group	411	2,156
Over/ (under) spend	4,006	(1,665)
Transfer / Use of Balances	(4,006)	1,665
Total Commissioned services	**37,529**	**39,604**
Closing balance as at 31 March	**0**	**0**

The £4,006K deficit in the pool has been addressed by the relevant organisation at the year end under IFRS 11 Joint arrangements and is based upon each organisation taking its statutory obligations.

The Clinical Commissioning Group has recognised a surplus of £35K in its financial statements for 2021-22 this relates to the budgets the Clinical Commissioning Group has a statutory obligation for. BMBC has recognised a deficit of £4,041K.

Barnsley Better Care Fund

In line with the national announcement of the creation of a Better Care Fund (BCF) in December 2013, the Clinical Commissioning Group has entered into a pooled budget arrangement with Barnsley Metropolitan Borough Council (BMBC) with effect from 1 April 2015. The aims of the BCF are to improve outcomes for the population of Barnsley by improving integration of health and social care services. This was underpinned by a Section 75 agreement between commissioners. Governance arrangements are in place through the Barnsley Senior Strategic Development Group and the Barnsley Health and Wellbeing Board. The Clinical Commissioning Group hosted the arrangement during 2020-21 and 2021-22 period.

A summary of the pooled budget is shown below;

	2021-22 £'000	2020-21 £'000
Contribution to pooled commissioning budget:		
Opening balance as at 1 April	0	0
Barnsley Clinical Commissioning Group	22,844	20,736
Barnsley Metropolitan Borough Council	16,432	16,432
	39,276	**37,168**
Services commissioned from the pooled budget:		
Barnsley Clinical Commissioning Group	10,068	9,558
Barnsley Metropolitan Borough Council	29,208	27,610
Total Commissioned services	**39,276**	**37,168**
Closing balance as at 31 March	**0**	**0**

16. Related party transactions

Details of related party transactions with individuals are as follows:

				Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
St Georges Medical Centre	Dr Balac	Governing Body Chair	Practice Payments	1,458	4	86	0
Lundwood Medical Practice	Dr Harban	Governing Body Member	Practice Payments	1,005	3	58	0
Kakoty Practice	Dr Harban	Governing Body Member	Practice Payments	964	0	59	0
Victoria Medical Centre	Dr Smith	Governing Body Member	Practice Payments	1,785	4	159	0
Wombwell Chapelfields Medical Centre	Dr Adekunle	Governing Body Member	Practice Payments	1,699	2	144	0
Hollygreen Practice	Dr Kadarsha	Governing Body Member	Practice Payments	2,394	1	124	0
Lakeside Surgery	Dr Kadarsha	Governing Body Member	Practice Payments	379	0	23	0
Grove Medical Centre	Dr Guntamukkala	Governing Body Member	Practice Payments	898	0	70	0
Apollo Court Medical Practice	Dr Guntamukkala	Governing Body Member	Practice Payments	876	0	119	0
Dove Valley practice	Dr MacInnes	Governing Body Member	Practice Payments	1,900	4	134	0

The above payments to practices includes delegated Primary Care Co-commissioning arrangements which are contractual under General/Personal or Alternative Provider Medical service contracts.

Dr Balac, Governing Body Chair for the Clinical Commissioning Group. St Georges Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1. Two of the partners of St Georges Medical Centre are also partners at Kingswell Surgery. Dr Balac until Dec 2021 was also the Clinical lead for primary care for the South Yorkshire and Bassetlaw Integrated Care System.

Dr Harban, Governing Body Member for the Clinical Commissioning Group is a Director for Lundwood Surgical Services Ltd and was a Director of Connect Medical Recruitment: no transactions have been recorded with either of the entities in 2021-22. Dr Harban & Partners is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1. Dr Harban is also a partner at Kakoty Practice which is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1

Dr Smith, Governing Body Member is a Director of Janark Medical Ltd: no transactions have been recorded with the entity in 2021-22. Senior Partner at Victoria Medical Centre. Victoria Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1

Dr Adekunle, Governing Body Member for the Clinical Commissioning Group. Wombwell Chapelfields Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1. He also provides clinical services to Local Care Direct Wakefield, no transactions have been recorded in 2021-22.

Dr Kadarsha, Governing Body Member for the Clinical Commissioning Group is a Director for YAAOZ Ltd and Malkarsha Properties Ltd: no transactions have been recorded with these entities in 2021-22. Dr Kadarsha is a shareholder in Primecare Ltd, which holds the APMS contract for Lakeside Surgery. Hollygreen and Lakeside Surgery are members of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1

Chris Edwards, The Chief Officer for the Barnsley Clinical Commissioning Group and also the South Yorkshire and Bassetlaw Integrated Care System lead for Capital and Estates, and Maternity.

Dr MacInnes, Governing Body Member for the Clinical Commissioning Group is a partner at Dove Valley practice. This practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1

Jayne Sivakumar, The Acting Chief Nurse is a Director for RJS Healthcare Ltd: no transactions have been recorded with this entity in 2021-22.

Dr Guntamukkala, Governing Body Member for the Clinical Commissioning Group. Grove Medical practice and Apollo Court Medical Practice are members of Barnsley Healthcare Federation, a Community Interest Company (CIC) see note 16.1.

The Department of Health and Social Care is regarded as a related party. During the year the Clinical Commissioning Group has had a number of material transactions with entities from which the Department is regarded as the parent department. For example
- NHS England and other Clinical Commissioning Groups
- NHS Foundation Trusts
- NHS Trusts
- NHS Resolution and
- NHS Business Services Authority

In addition the CCG had a number of material transactions with other government departments and other central and local government bodies.
The majority of these transactions have been with Barnsley Metropolitan Borough Council.

In regard to outstanding balances for both payables and receivables the Clinical Commissioning group's terms are 30 days. These values are not secured and no guarantees are given or received but the amounts are settled in cash.
None of the above are classified are bad or doubtful debts in the Clinical Commissioning Group's accounts.

Note 16.1 Barnsley Healthcare Federation (Community Interest Company)
The Barnsley Healthcare Federation was setup in to provide NHS Primary care services to the population of Barnsley.
The organisation is made up of a significant number of Barnsley GP practices. The Governing Body members mentioned above are related to practices that are part of the Barnsley Healthcare Federation.
During 2021-22 the Clinical Commissioning Group recognised an income recharge with the Community Interest Company of £91,702
The Clinical Commissioning Group also made expenditure transactions totalling £7,207,744 predominantly relating to contractual payments for the provision of primary medical services.

17. Events after the end of the reporting period

On 28 April 2022 the Health and Care Act received royal assent. This confirms the establishment of Integrated Care Boards in England. As a result of this the CCG expects to be wound up on 30 June 2022 and NHS South Yorkshire Integrated Care Board to be formed on 1 July 2022. As explained in note 1.1 the CCG's accounts are still prepared on a going concern basis due to the continued provision of the CCG's commissioning functions by the ICB. (2020-21: No events)

18. Financial performance targets

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

		2021-22	2021-22		2020-21	2020-21	
NHS Act Section		Target £'000	Performance £'000	Duty Achieved	Target £'000	Performance £'000	Duty Achieved
223H (1)	Expenditure not to exceed income	531,055	529,458	Yes	490,545	490,350	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	530,985	529,388	Yes	490,486	490,291	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
223J (2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	5,236	3,985	Yes	5,242	3,966	Yes

For the purposes of 223(H); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year and income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis)

Financial performance targets for 2021-22 represent the in year position. The Clinical Commissioning Group's historic surplus brought forward from 2020-21 into 2021-22 was £12,532K (The surplus for 2020-21 of £196K was retained by NHS England). The actual performance for 2021-22 was a surplus of £1,597K, which means that the carried forward surplus into 2022-23 is £14,129K.

19. Losses and special payments

Losses

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases **2021-22 Number**	Total Value of Cases **2021-22 £'000**	Total Number of Cases **2020-21 Number**	Total Value of Cases **2020-21 £'000**
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	2	20	0	0
Claims abandoned	0	0	0	0
Total	**2**	**20**	**0**	**0**

The CCG had no cases individually over £300,000 (31 March 2021: Nil)

Special payments

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	**Total Number of Cases 2020-21 Number**	**Total Value of Cases 2020-21 £'000**
Compensation payments	0	0	0	0
Compensation payments Treasury Approved	0	0	0	0
Extra Contractual Payments	0	0	0	0
Extra Contractual Payments Treasury Approved	0	0	0	0
Ex Gratia Payments	0	0	0	0
Ex Gratia Payments Treasury Approved	0	0	0	0
Extra Statutory Extra Regulatory Payments	0	0	0	0
Extra Statutory Extra Regulatory Payments Treasury Approved	0	0	0	0
Special Severance Payments Treasury Approved	0	0	0	0
Total	**0**	**0**	**0**	**0**

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BARNSLEY CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Barnsley Clinical Commissioning Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 30 June 2022, NHS Barnsley CCG will be dissolved and its services transferred to South Yorkshire Integrated Care Board. Under the continuation of service principle, the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in this respect.

Going concern basis of preparation

The Accountable Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the CCG will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's procedure for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition.

We did not identify any additional fraud risks.

In determining the audit procedures, we took into account the results of our evaluation and testing of the operating effectiveness of some of CCG-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included infrequent user postings.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Review of accruals and expenditure posted around the year end to ensure these transactions have been recognised in the correct period.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and

from inspection of the CCG's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion the other information has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 40-41, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; 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.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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 conform to the authorities which govern them.

Report on 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 if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 40-41, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. 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 the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State and NHS England 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.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Barnsley 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, as a body, 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 Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Barnsley 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.

Rashpal Khangura
for and on behalf of KPMG LLP,
Chartered Accountants
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Sovereign Street,
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20 June 2022