NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2019/20

NHS Somerset CCG Annual Report 2019/20

Contents

PERFORMANCE REPORT

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
18 June 2020

1. INTRODUCTION

I am delighted to be writing the introduction to our 2019/20 annual report which highlights both the successes and the challenges we have faced over the past 12 months. Whilst I only joined NHS Somerset CCG in September 2019 part way through 2019/20, I was aware of Somerset CCG and the challenges it has faced. I have also seen much of the transformational work that NHS Somerset CCG and the wider system had undertaken, having previously been the Chief Executive of Weston Area Health NHS Trust.

NHS Somerset CCG is not unique in the challenges that it has faced, the NHS as a whole has been facing an unprecedented period of change and transformation over the past few years. This has been particularly exasperated recently due to the COVID-19 pandemic.

Somerset's vision still remains focused on working together to improve the health and wellbeing of everyone who lives and works in Somerset. We can only do this if we work together with our partners in the health and care system and with our patients and the public. We know that bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services is a priority and we will to do this to build stronger communities with services which support people to live happy, healthy lives.

During 2019/20 we worked with our system partners to develop and implement the Somerset Long Term Plan and develop our 2020/21 System Operational Plan. During 2019/20 we agreed a set of principles to support 2019/20 delivery and into the future. This system working has been paramount to deliver the transformation changes that we need to make in Somerset. One area of system delivery of particular note was our investment in core mental health services; we recognised the current level of investment and service gaps, and began implementing universal support for children and adults aimed at mitigating specialist demand. We have gone a long way in terms of implementing 'neighbourhoods' across the system having implemented 13 Primary Care Networks across the county. We have also improved access to elective care in the Somerset and are making good progress towards more equitable access across the county.

As a county we are now working towards becoming an Integrated Care System and we hope to be formally authorised as such during the coming year; this may, however, need to be reconsidered due to COVID-19 pandemic. That said, we are still committed to working with our partners in an integrated way.

Our Health and Care Strategy for Somerset 'Fit for My Future' aims to transform out of hospital care beyond the traditional primary and secondary care boundaries and across mental and physical health, we want to work on the principle of 'your bed is the best bed' so care is delivered closer to home as possible. During 2019/20 through Fit for My Future we carried out a detailed review of mental health services which has resulted in a co-production of a new model for the delivery of mental health services in the community. We have consulted on this during 2019/20, and are now analysing the results. With regard our community health and care settings, again through Fit for My Future we have developed an emerging model for the potential configuration of community based health and care services. During 2019/20 we have been engaging with the public and wider stakeholders to gather views to help shape and improve the emerging model; this will ultimately lead to a public consultation during 2020/21.

In 2019/20 the CCG supported the financial position of the system which resulted in a deficit of £16.025m and across the county we have found delivery of our key constitutional standards challenging. Our local providers have not consistently met the Accident and Emergency 95% constitutional standard so have recovery plans in place to improve on performance. At year end we had 50 patients waiting in excess of 52 weeks, with a high proportion of these due to patients choosing to delay their treatment prior to COVID-19 impact. We also did not achieve two of the nine cancer standards in 2019/20 as well as the agreed 18 week improvement standard of 83.1% having achieved an average year to date performance of 82.3%.

It should be noted that NHS Somerset CCG has come a long way since it was put into special measures in 2017; we have been recognised by NHS England and NHS Improvement for the progress we have made. These positive achievements are testament to the hard work of our staff and system partners. I would therefore, like to take this opportunity to thank our staff, volunteers, partners, providers and Governing Body for their hard work and dedication over the past year. Their continued commitment helps us to make sure that we are all working together to improve the health and wellbeing of everyone in Somerset.

As I write this, we are in the midst of addressing the COVID-19 pandemic. We have a two-fold aim in addressing this; first to protect and keep the people of Somerset as safe as we can; and secondly, to protect and keep safe health and care colleagues across Somerset. I have been heartened by the way both the people of Somerset have supported these aims through their social distancing and how health and care colleagues have faced the challenges with bravery and resilience. The Thursday evening #ClapforCarers #ClapforourNHS has given me great encouragement; we appreciate your support and will endeavour to continue to improve our services to meet your needs.

James Rimmer
Chief Executive
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1.1 Somerset Sustainability and Transformation Partnership (STP)

Our ambition for modern health and care services in Somerset is that we want:

People to live health and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and efficient public services when they need them

During 2019/20 we knew that changes would be more effective if we focussed on a small number of areas and that concentrating our efforts on actions that will have the greatest impact. So we agreed five priority areas of focus for health and care that we began work on to change how we would deliver by April 2020. We focussed on: prevention; development of local services; strengthening more specialist and acute services; developing an Integrated Care system and improving our sustainable financial position.

To this end we agreed a set of principles to support 2019/20 and into the future:

- we will pursue equity of service provision for the whole Somerset population
- we will ensure parity of esteem for mental and physical health
- we will make decisions in the interests of the Somerset population and work together to handle adverse impacts at an organisational level
- we will have an open book approach in respect of quality, operational, workforce and financial information to support system wide assurance, transformation and delivery
- we will ensure that acute services meet the needs of the population in a clinically and financially sustainable way, recognising that we need to have tow vibrant district general hospitals, each with a 24/7 emergency department
- we will have a single programme of work and approach that is aligned with the movement to an Integrated Care System Structure
- we will transform clinical services towards a neighbourhood model, enabling a shift of activity and cost of acute services

As a system our key deliverables during 2019/20 were:

- we improved access to elective care in the county and made good progress towards more equitable access across the county
- we invested in core mental health services, recognising the current level of investment and service gaps, and began implementing universal support for children and adults aimed at mitigating specialist demand
- we began work on implementing Neighbourhoods across the system to work to support the longer term mitigation of demand growth:
    - we have implemented 13 Primary Care Networks across the system
    - we are taking a prevention focussed approach to stop of reduce escalation
    - as a result of this we want to ensure that we are prepared to support the move away from a (excess) reliance on bed based care
- Acute Services:
    - we implemented a number of quick wins from our external review of paediatrics
    - we have begun work on the future of acute stroke services
    - we have begun work on changes to acute pathways
    - and began developing proposals for longer term changes to elective referral patterns on the back of in-year work aimed at improving waiting times

As a result of the impact of Covid-19 we have had to put on hold a number of our areas of focus.

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

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

Fit for my Future: a Healthier Somerset is the Somerset system's strategy for delivering this ambition, supporting the health and wellbeing of the people of Somerset by changing the way services are commissioned and delivered.

We have developed four workstreams, focussing on mental health services, community health and care services, acute services provision and prevention.

Mental Health

We have carried out a detailed review of our mental health services, coproducing a new model for the delivery of mental health services within the community. This has led to national recognition of our model of care and success in gaining trailblazer status from NHS England and additional funding of £17m over the next two years. This means we are going to be able to invest additional funds into our community based services.

We have reviewed our acute inpatient services for people of working age, developing three options for the future configuration of our inpatient acute adult wards, and are consulting on a single preferred option to relocate the ward currently sited in Wells to be adjacent to the ward based within Yeovil. For more information see

www.fitformyfuture.org.uk

Community Health and Care Services

We have developed an emerging model for the potential configuration of community based health and care services, to support people to live independent, healthier lives by having the right services in the right place for their needs, available at the right time and delivered by the right people. We are now engaging with the public and wider stakeholders to gather views to help shape and improve the emerging model, ultimately leading to a public consultation later this year on options for the future.

Acute Settings of Care

We are currently reviewing the acute services provided to the population of the 580,000 people currently registered with a Somerset GP. This is looking to understand how we can provide sustainable, safe, effective hospital based services that meet the needs of our population both now and in the future.

Prevention

Having recognised the importance of population health and prevention as a way to not only benefit the health of our population but reduce the demand on and improve the sustainability of (from both a finance and workforce perspective) our services, we are now reviewing the potential for high impact actions, provided on a system wide basis, to improve the health and wellbeing of our population. Our initial focus is on the prevention, both primary and secondary, of cardiovascular disease in all its forms.

Consultation and Engagement

During the autumn of 2018 we carried out an extensive engagement exercise to ask people to share their views about health and care services in Somerset and tell us how we could improve these services. We did this as part of Fit for My Future - our programme to transform health and care services across Somerset.

In the twelve months since then we have moved implementation of our new mental health model and consultation on the potential future location of our adults of working age acute mental health inpatient beds. In summer 2019 we held a one day workshop with a group of staff, service users, carers, voluntary sector organisations and other stakeholders to work through and appraise three options. Following this, we launched a public consultation on our preferred option, to relocate the beds currently in Wells to Yeovil, on Thursday 16 January 2020 following approval from our Governing Body. The consultation will run until 12 April 2020.

On 30 January 2020, we launched an engagement programme on our early thinking about how we could improve community health and care services with the aim of gathering feedback from local people about providing care closer to home. We invited everyone who lives and works in Somerset, to join us in thinking about and shaping a new way of providing services which is, where practical, closer to where they live, supports independence and maintains health. The engagement programme runs until 12 April 2020.

For our consultation and engagement programmes we are using a mixed method approach including public meetings, listening events, social media, pop-ups at colleges, libraries and other community venues. We are also piloting a community asset based approach working with our voluntary, community and social enterprise partners to hear directly from vulnerable and seldom heard groups and individuals in Somerset.

Public health guidance associated with Covid-19 meant that we had to stand down remaining face to face events on 17 March 2020. We made a decision to continue with both the consultation and engagement by utilising an alternative approach though use of digital and telephone. We supported this switch through the following mechanisms:

- emailing all identified stakeholders, informing them of the cancellations and how they can still have their say
- a dedicated phone line and email address
- increased social media
- Freepost address
- promoting our online questionnaire
- advertising the mental health consultation in the press covering the Wells area

- additional copies of questionnaires and documentation sent to GP surgeries and Pharmacies across Somerset

1.3 Development of the Somerset Integrated Health and Care System (ICS)

Somerset has held the ambition to create an Integrated Health and Care System (ICS) since the establishment of the Somerset System Transformation Partnership (STP). During this time there have been multiple changes to both the local leadership and to national policy, however the vision for an ICS has remained consistent. Now is both the right time for the system to change as there is an established system way of working, and the changes required strategically to deliver transformation are wider than existing organisational boundaries.

It has been agreed that an ICS in Somerset will consist of the following:

- a single Strategic Commissioner (being progressed by SCC and NHS Somerset CCG, and supported by NHSE)
- a single Integrated Care Partnership (ICP) (a wide reaching network of providers)

The small Integrated Strategic Commissioning (SC) function will bring together the health and care commissioning organisations for Somerset to establish the needs of the population, set the strategic commissioning vision and identify the commissioning priorities for the system.

An ICP is the collection of local providers and commissioners which work together to take collective responsibility for the effectiveness of the overall provision system.

More commonly, it might be helpful to think of the strategic commissioners' role as describing "What" needs to happen and the integrated care partnership's role as delivering "How" things will happen.

As we progress the development of our ICS, we will need iteratively to refine our thinking as to the optimal 'end state' as we learn what works best to support the delivery of integrated care within Somerset. Over the last year (through 2018/19 and into 2019/20) the Somerset system has collectively used the NHS ICS maturity framework as a guide for the development of system working. This in line with lessons learnt from other systems and is informing the steady evolution of the ICS and its parts.

Somerset has a planned timeline of moving into "Shadow ICS" from the 1st April, allowing the six months through to September 2020 to embedded and formalised arrangements before operating as an ICS formally. The impacts and benefits will then be delivered throughout the period of the existing Long Term Plan and past this. However, the impact of COVID-19 may delay our plans as indicated.

2. PROFILE OF SOMERSET

Somerset is the 12th largest county in England. The county is markedly rural and dispersed, 48% live in the countryside, with border-to-border travel times east to west of two hours, and north to south of one hour. We have no large urban areas, or universities.

Our population is relatively older than the national average, and over the next 25 years while the overall population will rise by 15% we expect those over the age of 75 to double, resulting in a significant rise in demand for health and care services.

While Somerset is relatively less deprived than other parts of England there are areas with high levels of deprivation. People living in deprived areas in Somerset do not live as long as people from other areas; they are more likely to experience both physical and mental health issues. Deprivation not only impacts on the length of life but its quality. In many cases the differences with people from less deprived areas are linked to lifestyle and environmental factors, including smoking, obesity, housing, income, education and disability. Vulnerability is also often linked to deprivation.

People in Somerset are living longer than they used to, but there is an increasing gap between life expectancy and healthy life expectancy; typically, fifteen years of life can be spent with a long-term condition or conditions.

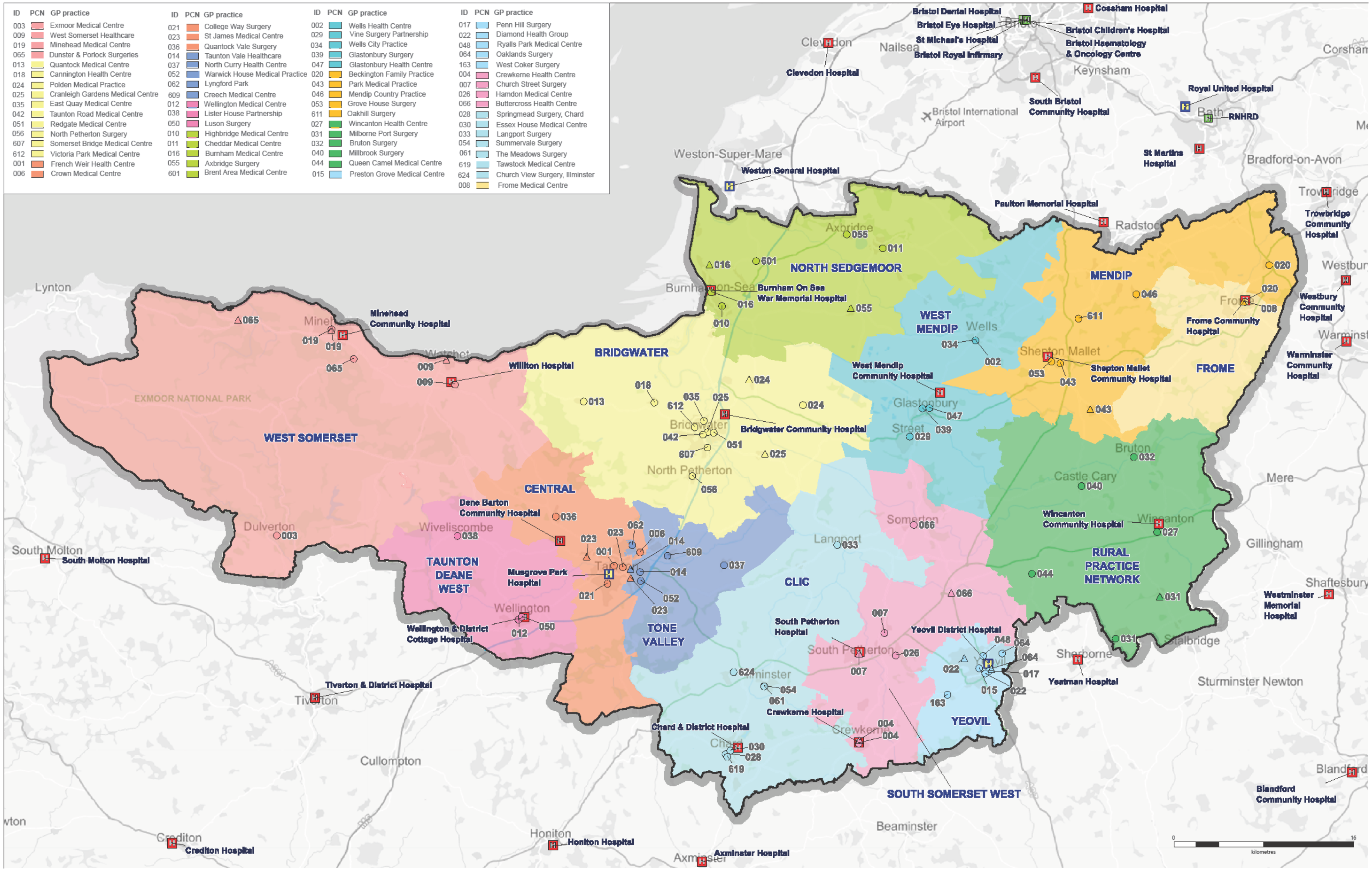
The ageing population brings new challenges:

- the older we get the more likely we are to have more than one long term condition affecting our health. Support for people with multiple conditions is more complex and needs to be much better integrated
- dementia is becoming an increasing problem and we could see a doubling of the number of people with dementia by 2035; however, lifestyle choices have a significant impact on the risk of dementia and so this could be partially mitigated

Mental health is a major issue for Somerset and affects around 70,000 people at any one time. This often influences and is influenced by multiple factors including low educational attainment, social isolation, unemployment and financial and relationship problems. People with a mental health issue often also have poor physical heath.

Lifestyle end environmental factors have a huge part to play in maintaining health and wellbeing. These include areas such as smoking, diet, exercise, social isolation, and alcohol abuse. It is estimated that lifestyle factors, environmental and societal factors together account for 60% of health issues (compared to genetic inheritance at 30% and healthcare provision at 10%).

The most important reason we need to do more to support health and wellbeing and address inequalities is the impact this will have on the quality of longevity of life for individuals. However, doing so will also help address our financial position. It costs far less to help someone stay healthy than it is does to treat and support them when they have become ill.



WEST SOMERSET
CENTRAL
BRIDGWATER
NORTH SEDGEMOOR
WEST MENDIP
MENDIP
FROME
RURAL PRACTICE NETWORK
TAUNTON DEANE WEST
TONE VALLEY
CLIC
YEOVIL
SOUTH SOMERSET WEST
EXMOOR NATIONAL PARK
Minehead Community Hospital
Williton Hospital
Burnham On Sea War Memorial Hospital
Bridgwater Community Hospital
West Mendip Community Hospital
Shepton Mallet Community Hospital
Frome Community Hospital
Wincanton Community Hospital
Dene Barton Community Hospital
Musgrove Park Hospital
Wellington & District Cottage Hospital
South Petherton Hospital
Yeovil District Hospital
Crewkerne Hospital
Chard & District Hospital
Weston General Hospital
Clevedon Hospital
Bristol Dental Hospital
Bristol Eye Hospital
St Michael's Hospital
Bristol Royal Infirmary
Cossham Hospital
Bristol Children's Hospital
Bristol Haematology & Oncology Centre
South Bristol Community Hospital
Royal United Hospital
RNHRD
St Martins Hospital
Paulton Memorial Hospital
Trowbridge Community Hospital
Westbury Community Hospital
Warminster Community Hospital
Westminster Memorial Hospital
Yeatman Hospital
Blandford Community Hospital
South Molton Hospital
Tiverton & District Hospital
Crediton Hospital
Honiton Hospital
Axminster Hospital
kilometres

ID	PCN	GP practice
003		Exmoor Medical Centre
009		West Somerset Healthcare
019		Minehead Medical Centre
065		Dunster & Porlock Surgeries
013		Quantock Medical Centre
018		Cannington Health Centre
024		Polden Medical Practice
025		Cranleigh Gardens Medical Centre
035		East Quay Medical Centre
042		Taunton Road Medical Centre
051		Redgate Medical Centre
056		North Petherton Surgery
607		Somerset Bridge Medical Centre
612		Victoria Park Medical Centre
001		French Weir Health Centre
006		Crown Medical Centre
021		College Way Surgery
023		St James Medical Centre
036		Quantock Vale Surgery
014		Taunton Vale Healthcare
037		North Curry Health Centre
052		Warwick House Medical Practice
062		Lyngford Park
609		Creech Medical Centre
012		Wellington Medical Centre
038		Lister House Partnership
050		Luson Surgery
010		Highbridge Medical Centre
011		Cheddar Medical Centre
016		Burnham Medical Centre
055		Axbridge Surgery
601		Brent Area Medical Centre
002		Wells Health Centre
029		Vine Surgery Partnership
034		Wells City Practice
039		Glastonbury Surgery
047		Glastonbury Health Centre
020		Beckington Family Practice
043		Park Medical Practice
046		Mendip Country Practice
053		Grove House Surgery
611		Oakhill Surgery
027		Wincanton Health Centre
031		Milborne Port Surgery
032		Bruton Surgery
040		Millbrook Surgery
044		Queen Camel Medical Centre
015		Preston Grove Medical Centre
017		Penn Hill Surgery
022		Diamond Health Group
048		Ryalls Park Medical Centre
064		Oaklands Surgery
163		West Coker Surgery
004		Crewkerne Health Centre
007		Church Street Surgery
026		Hamdon Medical Centre
066		Buttercross Health Centre
028		Springmead Surgery, Chard
030		Essex House Medical Centre
033		Langport Surgery
054		Summervale Surgery
061		The Meadows Surgery
619		Tawstock Medical Centre
624		Church View Surgery, Illminster
008		Frome Medical Centre

NHS Somerset Clinical Commissioning Group

Overview Map: GP Surgeries, Hospitals & Primary Care Networks

Specialist Hospital
Community Hospital
Acute Hospital

Somerset CCG Boundary

Main Surgery (65)
Branch Surgery (within Somerset) (18)

Primary Care Network
West Somerset
Bridgwater
Central
Tone Valley
Taunton Deane West
North Sedgemoor
West Mendip
Mendip
Rural Practice Network
Yeovil
South Somerset West
CLIC
Frome

South, Central and West Commissioning Support Unit
scwcsu.healthGIS@nhs.net - 31/07/2019
Created By: CS, Checked By: WJ

3. PERFORMANCE REPORT OVERVIEW

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

The sections include how the organisation has delivered its key workstreams, statutory responsibilities and the overall performance during 2019/20.

3.1 Quality and Safety

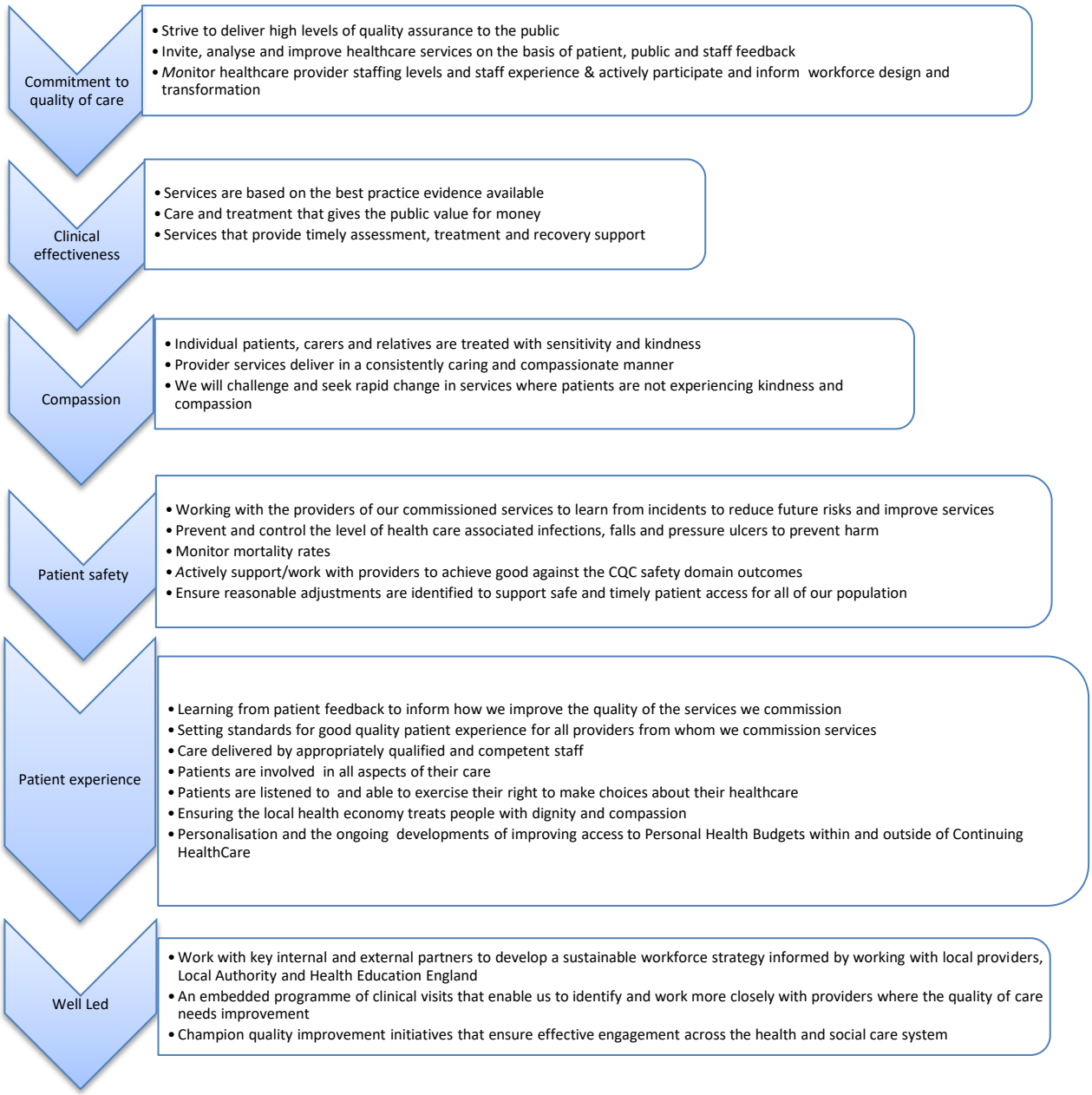
We see the improvement of quality and patient safety to be the organising principle of our health and care services. It is what matters most to people who use the services and it is what motivates and unites everyone working in health and care. Our key focus is to ensure that quality and patient safety is built into commissioning structures, values, practices and business processes through the annual cycle of clinical quality activity.

Health providers and commissioners in Somerset are working together more closely reducing organisational and professional silos. Over the past 2 years or so, we have reviewed the ways in which we monitor the quality, effectiveness and safety of services and have an agreed system wide process that aims to reduce the burden of assurance whilst encouraging more transparent ways of working together to improve the services and the experience for people in Somerset. In addition, we are working collaboratively with Somerset County Council to monitor the quality of our health and social care services.

In accordance with the Somerset Long Term Plan and STP governance arrangements the quality and safety of commissioned health services is monitored through system partners governance arrangements, with an assurance and exception reporting route to the Somerset Quality Surveillance Group (QSG), which is a sub-committee of the Somerset System Assurance Forum. This ensures that quality and safety issues are taken into account in strategic decision-making within the Integrated Care System (ICS). Membership of the Somerset QSG comprises representation of system senior clinical leaders including medical and nursing directors from the CCG, secondary care NHS services, local authority social care leaders, NHS England and the Care Quality Commission (CQC).

Somerset has strong foundations to support local implementation of the National Patient Safety Strategy. In the last year this has been built upon with ICS partners by increasingly collaborating and sharing our patient safety work programmes, covering the safety areas set out in the national strategy.

3.2 Our Quality and Safety Framework



3.3 Prevention

In 2019/20 we achieved the following**:**

- through the Somerset Health and Wellbeing Board, an outcomes framework has been agreed and work on this is continuing
- the Mums2Be stop smoking service continues to provide community based support for pregnant women
- by December 2019, a total of 1,077 staff from a range of health and care organisations in Somerset had undergone Make Every Contact Count (MECC) training
- individuals can be signposted to a range of tier 1 and 2 community led physical activity and healthy eating services including Zing, and commercial providers such

as Slimming World. These are services commissioned by Local Authority colleagues
- 1,437 people were offered a diabetes prevention programme. 1,320 people in Somerset attended a diabetes prevention programme which gave them the opportunity of making lifestyle changes to prevent the onset of diabetes
- in 2019/20 the Somerset Cardiovascular Disease Board was established. We developed a baseline on the Somerset position with cardiovascular disease which has given the programme a foundation on which to develop
- the NHS Health Checks Programme was re-procured
- a hypertension detection project is being piloted with Public Health colleagues

We are now reviewing the potential for high impact actions, provided on a system wide basis, to improve the health and wellbeing of our population. Our initial focus is on the prevention, both primary and secondary, of cardiovascular disease in all its forms.

3.4 **Integrated Care**

Summary for Integrated Care for 2019/20:

Essentially, integrated care means changing how we commission and provide some services so that people, groups and functions are able to work more closely together where this will provide higher quality care and support to patients. Considering some of the highest performing health systems in the world, together with national and local evidence, Integrated Care Systems will need to:

- adopt a truly *person-centred approach* where what matters to patients, the people, their aspirations and goals, their strengths, motivations, circumstances and life situations form the basis of care and treatment plans and the tailoring of support. A key feature of person-centredness is in ensuring people recognise and make use of their own resources and those often available in their local community
- *Population health management:* A more proactive, systematic approach to identifying healthcare risks, at a local population level and an individual level, and actively engaging people in education, advice, support and behaviour change in order to ensure people remain healthy and well. Given some of the unprecedented health risks observed within the population of Somerset, this approach needs to develop at a significantly greater scale than in the past
- develop a *neighbourhood approach* over the next two years. This will provide a modern effective way of delivering health and care that strengthens individual and community resilience and wellbeing. The neighbourhood approach is made up of local partnerships where all agencies and communities collaborate to support people to deliver fulfilled happy and healthy lives.

In 2019/20 we achieved the following:

- we fully established 13 Primary Care Networks across the county by June 2019
- we continued to develop wider Neighbourhood Teams to include social care, local voluntary sector organisation and community groups
- we progressed the Integrated Model of Care for Diabetes (see Diabetes section below) which is based on four key principles:
    - stopping diabetes
    - promoting self-care and people's knowledge, skills and confidence to self-manage

- shared decision making between patients and professionals
- seamless pathways of care.

3.5 **Diabetes**

In 2019/20 we achieved the following**:**

- Diabetes prevention - In 2019/20 1,437 people were offered a diabetes prevention programme. 1,320 people in Somerset attended a diabetes prevention programme which gave them the opportunity of making lifestyle changes to prevent the onset of diabetes
- Diabetes structured education - In 2019 NHS Somerset CCG worked with Oviva to test a remote access structured education programme for diabetes. 233 people were able to access the programme which proved popular with people of working age and men. 80% of those referred attended and 81% went onto complete the programme. Clinical outcomes showed significant benefits with average weight loss of 2.6kg and HbA1c reductions of 6.3mmol/mol. An economic evaluation calculated a saving of £946 per patient
- 3,600 people have registered for My Diabetes My Way which enables people to access their records and manage their care digitally
- The Somerset Diabetes team have progressed their integrated model of care with developments including peer support groups, virtual clinics, advice, guidance and triage, and group insulin initiation. The team have also benefited from organisational development to enable them to function in a more integrated way.

3.6 **Primary Medical Care**

Summary for Primary Medical Care for 2019/20**:**

- we would ensure that Somerset CCG establishes itself as a capable commissioner of GP services from 1 April 2019
- we would establish contiguous Primary Care Networks covering the whole population by June 2019
- invest £2 million in improving GP services, going beyond the minimum £1.50 per head requirement
- deliver the recommendations of the Fit For My Future strategy GP workstream, particularly improving continuity of care
- ensure that the GP provider sector is fully engaged in our data analytics and business intelligence strategy and digital agenda more fully
- deliver 7 day access to GP Improved Access
- undertake a review of GP Premises as part of the STP estates workstream programme
- lead change in the primary care provider landscape
- continue to invest in improvements in access, resilience and workforce development

In 2019/20 we achieved the following**:**

- we achieved an overall increase in GP workforce numbers
- we supported practices to redesign their appointment systems so that patients could benefit from online consultations
- Primary Care Networks – 13 were fully established by June 2019, with all milestones completed according to the national timetable

- successful return to the new Quality and Outcomes Framework (QOF) with support for providers to improve primary care data quality – support plan to improve primary care data quality was put in place in April 2019
- supported general practice to ensure that they have a strong presence as we move towards an Integrated Care System in Somerset

3.7 **Urgent and Emergency Care**

In 2019/20 we achieved the following:

- completed Urgent Treatment Centre (UTC) test and learn at Bridgwater hospital. This showed evidence of reducing attendances at nearby Acute hospital and has informed our plans for including UTC within our LTP. This has been extended for a further year
- compiled and submitted our Somerset LTP stating our ambition to work towards a talk before you walk model realising a shift towards prevention and more Integrated Urgent Care. We have experienced positive engagement with all stakeholders with this vision for the future
- worked closely with our Integrated Urgent Care service (IUCS) provider to achieve progress in IUC ADC (Aggregated Data Collection) reporting and the National specification. We supported engagement with local Primary Care leaders to understand how In hours and Out of Hours clinicians might work differently and achieve more integration in the future
- worked with system partners to develop strategy in Urgent Care and Stroke to explore our direction of travel in terms of configuration and workforce. These have been taken forward within the Fit For my Future strategy and engagement.
- extended the previously successful schemes from Winter 2018 to ensure that we were able to offer improved flow and capacity within the system throughout Winter 19/20 period. These include the expansion of Rapid Response and was further extended to falls support and MDT workforce. Home First capacity was extended and more recently an independent evaluation was completed to inform future provision. Care Home Support was also extended to increase the support to care homes and therefore reduce the risk of inappropriate admission
- there were also a range of additional schemes implemented including Mental Health Crisis Cafes across the County, improved specialist support within inpatient settings to prevent admission and signpost to appropriate services. Additional Emergency Department (ED) provision also extended the Multi-Discipline MDT to include Social Care workers, housing advice and Frailty support at the front door
- saw an improved Flu Vaccination campaign improving on uptake from last year and look forward to a system wide approach in the year ahead
- our Acute Trusts and South Western Ambulance Service NHS Foundation Trust (SWASFT) worked together closely to support improved handover performance and introduced recommended Hospital Ambulance Liaison Officer (HALO) role in Musgrove Park Hospital ED
- we have implemented digital initiatives including Community Pharmacy Consultation Service and made good progress with progressing GP Connect which will offer the function of direct booking into Primary Care from Integrated Urgent Care Service which includes 111
- we have worked with a Multi-Organisational group to map and understand the support for High Intensity Users across Somerset and aim to co-produce a single approach for Somerset to achieve an equitable offer of these excellent services across Somerset

- most recently there have been a number of rapidly implemented COVID response services to reconfigure provision to offer remote consultations, Urgent Care hubs across the County for individuals needing a face to face consultation as well as creation of a Health and Care hub and discharge hub model in both trusts and urgent community response services to ensure prevention of admission and facilitation of discharge. There has also been the extension of the Mental Health helpline to 24/7 and this brings us a step closer to realising the planned Crisis Response service which is intended to be available via NHS 111 within the year to come

3.8 **Planned Care**

Summary for Planned Care for 2019/20:

- we would begin to address inequity in waiting times between our two main acute provider trusts
- we would reduce long waits for patients
- we would stabilise the waiting list for Somerset
- we would work towards a sustainable dermatology service
- and begin to deliver the long term plan requirement for a 30% reduction in face to face outpatient attendances

In 2019/20 we achieved the following:

- implemented an enhanced choice conversation with patients to enable them to choose the shortest waiting time for their outpatient appointment or surgery
- almost eradicated over 52 week waits that are not due to patient choice for in Somerset providers (9 in January). However, due to COVID-19 this increased
- waiting list growth in November and December showed signs of slowing. Again, as above due to COVID-19
- began to implement new and innovative ways of delivery outpatient attendances that do not require a face to face attendance
- agreed a future vision for dermatology services for Somerset

3.9 **Cancer Treatment**

Summary for Cancer Care for 2019/20:

- pilot the development of rapid diagnostic centres in preparation for the new cancer standard
- deliver an improvement in cancer diagnosed at stage 1 or 2
- improve performance against cancer waiting time targets and focus on specific pathway improvements

In 2019/20 we achieved the following:

- implemented FIT (Faecal Immunochemical Test) testing in the bowel screening programme
- worked with Public Health England to focus on increasing screening uptake in low performing areas
- transformed the colorectal referral pathway to include symptomatic FIT testing, triage hubs, and straight to test

- designed and commenced a rapid diagnostic service for non -specific symptoms based in Mendip Primary Care Network
- began systematically reviewing and implementing new cancer pathways that transform routes to diagnosis with a view to achieving earlier diagnosis. This includes reviewing innovative ways to manage system demand
- urology clinicians were trained in local template biopsy techniques to provide a safer service in the system
- endobronchial ultrasound (EBUS) was implemented in Somerset for lung cancer patients
- swimming programme piloted which reduced counselling sessions and improved physical movement and self confidence

3.10 **End of Life Care**

The themes in the National End of Life (EOL) Care Strategy, recent policy and research documents, has enabled Somerset to identify local priority areas. Overall movement is towards fulfilling the wish of many who would want to die at home if they feel safe and well cared for there. Many of the initiatives, including Advanced Care Planning (ACP), Somerset Treatment Escalation Plan (STEP) forms, Dying matters and the Compassionate Communities project are all working towards this aim. The development of new community non clinical and clinical roles should support this. This is with the recognition that care needs and wishes may change rapidly towards the end of life and admission to an acute hospital, community hospital, nursing home or hospice may be in the best interest of the patient and carers. There are areas such as bereavement support where there is scope for improvement and will need to be revisited as the planning to take this forward develops.

In 2019/20 we achieved the following:

- supported end of life choices through the timely provision of fast track funded care in a variety of settings
- embedded guidance and the introduction of Somerset Treatment Escalation Plans (STEP) for individuals in the end of life
- we put in place proactive and personalised care planning for everyone identified as being in their last year of life and a 5% reduction in acute care admissions for End of Life care
- End of Life Care Plans completed on Somerset Integrated Digital electronic Record (SIDeR) programme by primary care

In October 2019 as part of its Fit for Future review St Margaret's Hospice took the decision to close the inpatient unit in Yeovil. Since this time the CCG has been working closely with St Margaret's Hospice to put in place strengthened arrangements for hospice care within the community. These include the following:

- new community nursing posts have been created
- St Margaret's now works closely with Somerset Partnership NHS Foundation Trust to provide targeted specialist palliative inpatient support to the community hospital bases
- additional medical staff support outside of the hospice, allowing them to see more patients than was previously the case. This means they now see complex patients outside of the hospice setting, having direct conversations with GPs, carers and families and also get involved in home visits

- a new GP training placement has been created in South Somerset to work alongside the palliative consultant team
- the hospice team has also been working directly with a number of nursing homes in the Yeovil area to provide targeted end of life support and training - not only does it improve the knowledge and skill base across a range of smaller providers, but also avoids the need for patients to travel unnecessarily
- a county-wide EOL rapid response service is also in the process of developed. This provision will enable more people to remain in their own homes where they wish to.

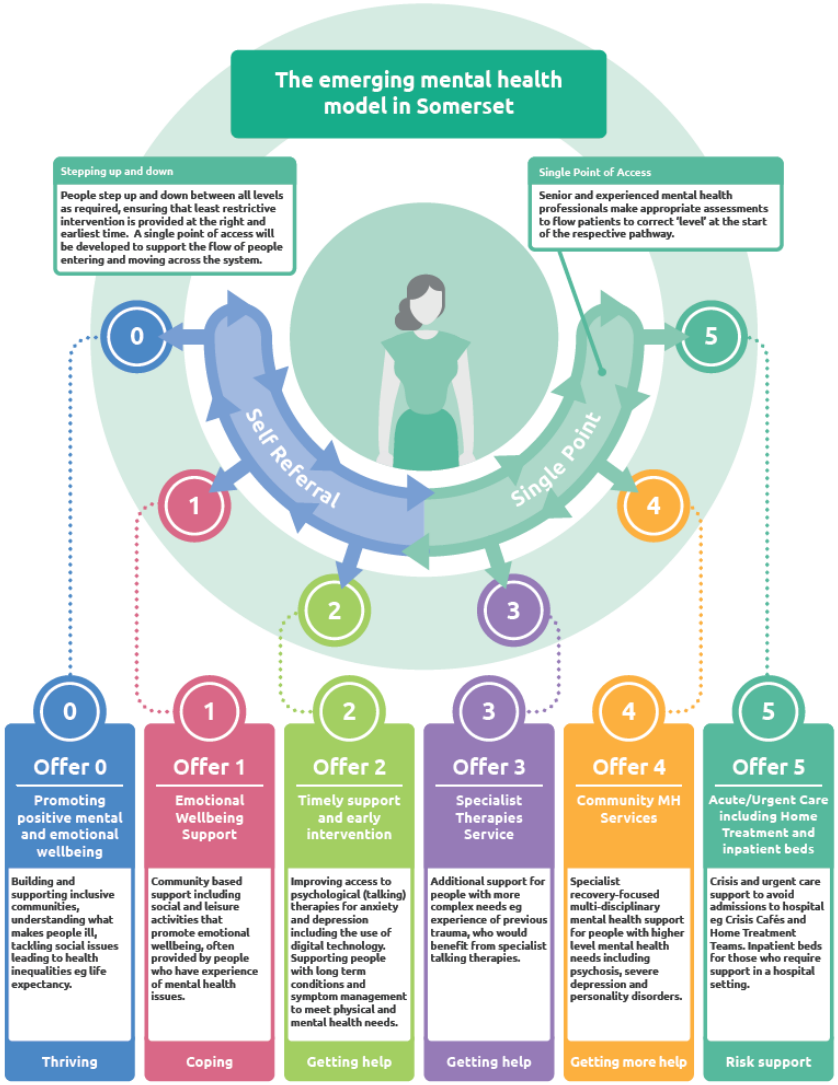
Published in January 2019 the NHS Long Term Plan supports giving more people more say about the care they receive and where they receive it, the Long term Plan implementation framework (June 2019) has a focus on supporting individuals and their families to support delivery of coordinated care and an offered holistic support before and after death.

3.11 **Mental Health**

Mental Health has, over recent years, had an increasingly higher profile in society as a whole and this is being reflected in Government policy and initiatives. There is a national aspiration to enhance the parity of esteem between physical and mental health and investment is beginning to reflect this. Somerset has, historically, been underfunded for Mental Health.

There has been a strong emphasis on prevention; earlier intervention; better integration of services, (health and social care, primary and secondary care, mental health and physical health care); shifting the balance towards community based support; avoiding crises but managing them better when they do occur; and increasing the investment in mental health to improve the provision and outcomes of those who access support.

Our aim in Somerset has been to address these themes within our work programme and we are committed to working towards delivering the outcomes required to improve mental health outcomes for the population of Somerset. To that end, we developed the model below:



Please note that planning for the COVID-19 post-pandemic state will affect our key priorities and projects for the next financial year and will need to be taken into account in next year's annual report. We will continue to work towards the goals of the NHS Long Term Plan and in accordance with guidance from NHS England.

Summary for Mental Health for 2019/20:

- enhancing the Somerset population's mental and emotional wellbeing and resilience
- improving access to mental health support and intervening earlier
- improving the quality of services delivered – Getting It Right First Time
- improving the provision of all age support to people in crisis
- the Fit for My Future (FFMF) public consultation, in relation to the location of adult acute mental health beds, has commenced. The findings will be reviewed independently and presented and reviewed by the governing body in the summer of 2020. For further information: https://www.fitformyfuture.org.uk/mental-health/
- enhancing sustainable recovery and resilience for those who access mental health support
- working as a partnership as a whole health and care system to deliver better outcomes for our patients
- development of the Mental Health and Learning Disabilities board structure to oversee all matters pertaining to all age Mental Health and Learning Disabilities

- developing a new and targeted approach in the transition from child to adult mental health services
- enhancing the digital mental health and wellbeing approach across all ages of provision; giving easier access to services for people, their families and carers

In 2019/20 we achieved the following:

- recruitment of Mental Health clinical leads which will be crucial for liaison with, and development of, work at PCN level:
    - two clinical leads for Mental Health in Somerset now appointed: Dr. Peter Bagshaw is the clinical lead for Adults and Older Adults mental health and Dr. Theresa Foxton is the clinical lead for Children and Young People's Mental Health
- enhancedthe Somerset population's mental and emotional wellbeing and resilience including individuals, families and communities:
    - we enhanced tier 1 and 2 provision across both child and adult pathways using voluntary and third sector organisations closely linked to primary care
    - we bid for, and obtained, Trailblazer funding and status from NHS England (NHSE) and worked with partner agencies across the NHS and the Voluntary, Community and Social Enterprises (VCSE) in the development of neighbourhood provision of preventative support and emotional wellbeing for all in our new Expanded Community Mental Health Service. This extra funding means an extra £1 million per year for the VCSE which should make a real difference to people in the county
    - this new service builds upon the work that we explored during the Emotional Wellbeing Service pilot scheme conducted in association with the Community Council for Somerset and Somerset Partnership. This will improve emotional wellbeing for all people across the county as well as people with an eating disorder through close working with the Somerset and Wessex Eating Disorders Association (SWEDA), people with cognitive disorders like depression and anxiety, older people with mental health problems and young adults
    - we worked in collaboration with local authority and other providers to enhance the social care support offered in line with recommendations from the prevention concordat
- improved access to mental health support and intervene earlier:
    - we have developed a wider menu of interventions in primary care alongside the Improving Access to Psychological Therapies (IAPT) offer by creating the new Specialist Therapies service, supporting and enhancing the Mindline open phone support service and piloting digital solutions to more effectively intervene at an earlier point in a person's care. This should help to reduce demand on specialist secondary care services
- Improved the quality of services delivered – Getting It Right First Time:
    - we have worked hard to ensure that our commissioned services are evidence based, person-centred, recovery focussed and linked to clear outcome based pathways of care by revising service specifications and developing a suite of qualitative metrics in association with the Academic Health Science Network (AHSN)
    - we work to ensure that physical health and mental health have parity of esteem to increase the life expectancy of all, especially those with enduring severe and enduring mental illness by placing the patient's needs at the heart of service development. Where possible, we co-produce our services with

service users and make use of social media and other methods of communication to raise awareness

- improved the provision of support to people in crisis:
  - alongside our partner providers across the system, we've developed an all age 24/7 Crisis Resolution and Home Treatment Team (CRHTT) support function including children, adults and older adults (including Dementia). This includes the delivery of appropriate Psychiatric Liaison Services at Musgrove Park Hospital (full core 24 model) and Yeovil District Hospital (modified – and agreed model)
- enhanced sustainable recovery and resilience for those who have accessed mental health support:
  - we have worked in tandem with our partner providers to develop, and deliver, a system-wide culture of individual personalised outcome based care planning that sets the objectives for each individual with a clear recovery focus. Our goals continue to be getting people well and keeping people well across the county
- enhanced'Tier 1 and 2' provision for child and young people pathways using the voluntary and third sector organisations, linking with Primary Care:
  - although this transformation programme is still in its infancy, the Big Tent concept has been piloted in two areas- Yeovil (South Somerset) and North Sedgemoor
  - steering groups for both localities have been formed, aligning with their Terms of Reference
  - the Big Tent is an alliance of VCSE organisations coming together to improve the mental health and emotional wellbeing of children and young people in Somerset. Attendance at both steering groups has been strong and consistent. The group consists of representatives of Young Somerset, MIND, GP Clinical Leads, SPARK, SASP and other organisations who provide mental health and emotional wellbeing services in both localities
  - Young Somerset has also set up their Wellbeing Service which contains IAPT-trained Children's Wellbeing Practitioners (CWPs) who are able to provide Cognitive Behavioural Therapy (CBT) for low level mental health, emotional wellbeing and behavioural difficulties. The development of Wellbeing Hubs to hold the CWP's is currently in progression. They will be able to broker the best deal for Children and Young People (CYP) if necessary criteria for CBT have not been met
  - expanding the Children and Adolescent Mental Health Service (CAMHS) Enhanced Outreach and Psychiatric Liaison Service to become a seven day service
  - supporting Somerset CAMHS to maintain waiting time standards (typically below the regional and national average)
  - further investment in the Community Eating Disorder Service to sustain high levels of access
  - further investment in the CAMHS Single Point of Access to improve timely access to specialist CAMHS or ensure that people are sign-posted to other targeted support services
- Dementia Improvement:
  - the dementia pathway has been reviewed in 19/20; the specific areas of focus in the review were the dementia diagnosis rate and post-diagnostic dementia care. To support this and actions required, there was a commitment of funding agreed. Work continues with reviewing and ensuring appropriate diagnosis

codes are captured to accurately reflect diagnosis rates and continued improvements to the post diagnostic support offer

- Suicide Prevention:
  - the CCG are active members of the countrywide Suicide Prevention Partnership Board (SuPPa) and aspires to move towards a zero suicide position in the county by working with all partners through proactive outreach to support people and prevent them from entering in to crisis and supporting families through post suicide bereavement processes. The CCG continues to work to raise awareness that suicide prevention is everybody's business as two thirds of people that take their own lives are not known to mental health services
- Implement CYP Mental Health Support Teams in Schools Trailblazer Bid:
  - Somerset was nominated to become a Trailblazer site to implement the proposals that were set out in the Green Paper 'Transforming Children and Young People's Mental Health Provision'
  - two Mental Health Support Teams were established (in Taunton Deane and The TOR School) which are led by a multi-disciplinary team and cover a mixed group of schools. This work builds upon the Somerset Wellbeing Framework and support already offered to schools by Somerset Partnership, Public Health and Health Education England (HEE)
  - the multi-disciplinary team consists of:
    - a Somerset Foundation Trust Operational Manager; a Clinical Team Leader, an Education Psychologist, Education Mental Health Supervisors, Education Mental Health Practitioners (employed by Young Somerset) and a team administrators. A referral process and panel has been put in place

3.12 **Learning Disabilities and Autism**

Summary for Learning Disabilities (LD) for 2019/20:

- we would develop the market to provide a choice of local housing, care and support Somerset
- develop a whole system culture which supports a progression-based model of care which is aspirational and supports positive risk taking
- we would remodel our services
- develop a single pathway
- Care and Treatment Reviews (CTR) / Care, Education and Treatment Reviews (CETR) / Blue Light meetings, training of chairs and closer partnership working between NHSE Specialised Commissioning (SC), the CCG, CAMHS and Somerset County Council's (SCC) children's services
- co-design progression-based care and support plans
- developi personalisation
- develop both the paid and unpaid workforce

In 2019/20 we achieved the following**:**

- Somerset Transforming Care Partnership (TCP) has discharged another five Transforming Care patients from specialist inpatients beds (with two out of area) into the community. A further four patients will be ready for discharge in the next year, with one patient requiring a step down placement in the first instance

- Somerset TCP has started work to improve the process around the Care Education and Treatment Review/Care Treatment Review CETRs/CTRs and Assuring Transformation (AT) database. Further work is planned in 2020/21 with the Local Authority (LA) / Somerset NHS Foundation Trust (SFT) / NHSE SC and CAMHS to ensure that we are notified of new admissions in a more timely way. An adult Admission Avoidance Register (AAR) is in place and monthly conversations are held to ensure that it works as efficiently as possible. A children's AAR is also being developed. This will need further focus during the course of the next year
- the adult AAR has been very successful in avoiding unnecessary or inappropriate admissions of people with Learning Disabilities (LD) and / or Autism into hospital through close working with the Rapid Intervention Team and the Rapid Emergency Action Crisis Team (REACT) in Somerset (as well as multi-agency Blue Light meetings)
- REACT has now been running for a year (from formation in March 2019) and has been very successful. It works in close partnership with the Somerset Partnership Foundation Trust's Rapid Intervention Team (RIT) and Adult Social Care to provide Positive Behavioural Support (PBS) focused intensive community support. It works alongside the provider to stabilise any placements in crisis and to prevent avoidable or unnecessary hospital admissions
- Somerset TCP is also working towards developing a community place of safety which is now near completion
- NHS Somerset CCG is working closely with the Registered Care Providers Association (RCPA) and Primary Care to run two projects to improve the uptake and quality of Annual Health Checks (AHC) in Somerset. This is to support the promotion of AHCs in addressing health inequalities and leading a healthy lifestyle; improving care provider support to people with LD and Autism during AHCs; and provide training and resources to GP practices. The two projects were started in early 2020 and will be co-produced working with the Somerset 'Our Voice' peer support group. (These peer support groups were set up as part of a network to inform the Somerset LD Partnership Board in early 2019)
- one of the proposed outputs of this work is a quality mark for Learning Disability Friendly GP practices. This will include a range of measures including reasonable adjustments, having LD and Autism champions in place, Annual Health Check guidance etc. as well as involving people with a LD and Autism in accrediting practices and training
- the first Learning Disabilities Mortality Review (LeDeR) Annual Report was produced highlighting the findings and actions being implemented by the programme in Somerset including:
    - the November 2019 event in Glastonbury which promoted healthy lifestyle choices across Somerset and was attended by many practitioners from across the health and social care system
    - the promotion of the use of hospital passports and easy read resources (distribution across service providers and volunteer organisations)
    - LeDeR newsletters published quarterly, including easy read versions; the newsletters have specifically focused on reasonable adjustments for people with LD and Autism and how this needs to be used to provide better access to mainstream services. Reasonable adjustments have also been incorporated into relevant staff training sessions
    - Dysphagia work with Speech and Language Therapists and care providers to improve understanding
    - involving people with LD and Autism in 'mystery shopping' the Sunflower Lanyard scheme with local shops, with videos produced

- At the end of February 2020, plans for a Stopping Over Medication of People with a Learning Disability, Autism or Both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) STOMP / STAMP working group by NHS Somerset CCG were discussed with system partners which will be developed in 2020.

3.13 **Children and Young People**

Summary for Children and Young People:

The priority for the Women's and Children's Health team this year has been to look at how we can work together with our partners to improve health, education and care outcomes for Somerset's most vulnerable children and young people to increase their life chances, acknowledging system pressures and how these might be overcome.
For some time it has been recognised that the Somerset Local Area is not yet fully effective in meeting the needs and aspirations of our children and young people in line with the Special Educational Needs and Disabilities (SEND) Code of Practice (Children and Families Act 2015). With agreement on the importance of putting the individual and their family at the centre of all we do and working towards a position where all women, children, young people and their families in Somerset can access the support they need and that is right for them, no matter where they live or what their circumstance over the last year, the CCG, Local Authority commissioning and provider teams and representatives of parents, carers, children and young people have increasingly worked together towards finding solutions. Of note is that Somerset has recently had a Care Quality Commission (CQC) and Office for Standards in Education, Children's Services and Skills (OFSTED) review of SEND services in March 2019 and we are awaiting the outcome.

Within this, children and young people's emotional wellbeing and mental health, with a particularly focus on Autistic Spectrum, Neuro-behavioural and Attention Deficit Disorder pathways for support have been identified key area for improvement and significant work is underway with our key stakeholders and colleagues from the Mental Health Team to develop.

In 2019/20 we achieved the following:

Significantly, we began to work with our partners and stakeholders on a shared vision to underpin our strategic direction for the delivery of services for women and children going forward. More work is still to be finalised, but emerging principles include:

- a holistic approach that considers the whole person, physically, psychologically and emotionally, and takes into account everything that affects them from the start
- the same offer for all family members and their families, no matter where they live in Somerset
- person centred planning – asset and strength based and according to their individual needs; finding a way forward through understanding the persons wishes and circumstances
- continuity of relationship - particularly for our most vulnerable families
- prevention and early intervention – getting in early and helping people to help themselves
- care wrapping around the need; building a cumulative approach to how we work (proportionate universalism)

- care in the right setting at the right time - making access easier within geographies and through pathways

Working with our partners, we strengthened governance arrangements with refreshed terms of reference and membership for Special Educational Needs and Disability (SEND). This included:

- developing a detailed Improvement Action Plan that has improved partnership working arrangements, given focus and drive to priority work streams and where activity is monitored and steered by a jointly Chaired Local Area SEND Improvement Programme Board
- implemented tracking and reporting systems to support developing joint working arrangements
- instigated a Task and Finish Group for reviewing cost of Children Missing from Education (CME) with Children's Scrutiny oversight
- established a Joint Commissioning Executive Group to increase understanding of our different perspectives and offer high level leadership commitment to enable joint working
- jointly commissioned the Somerset SEND Information Advice and Support Service (SENDIASS); The Local Offer (Somerset Choices) and Somerset Parent Carer Forum
- overseen the roll out of training development linked with Electronic Health Assessment and the parent/carer toolkit

Regarding the specific focus on improving support to parents and children when children have behaviours which challenge, we have been working hard to understand what families need and how these needs can be addressed. Although we have a robust pathway and offer to infants and children under 5 years old, presenting with severe autism, we are currently looking at how we can overcome the systemic difficulties we have experienced which has left many of our school aged children and their families without the support they need. Our work has included:

- establishing a cross system focus to look at the system wide approach to children with a wide range of behavioural presentations
- calling a multi-disciplinary meeting to review those children who have been referred but that have not met the criteria for Autism Spectrum Disorder (ASD) assessment (approx. 40 cases) to examine what else can be done to support them within existing resource and elicit any emerging clusters or trends to inform immediate management and service development
- holding co-production sessions focussed on neurological conditions (eg. Autism, Attention Deficit Disorder) to support future pathway redesign

In line with our commitment to implement identified early help projects, multi-agency and multi-disciplinary workshops identified 'behaviours that challenge' as a key focus area across the system. This led to:

- work to increase earlier interventions through whole school training in how to support children and young people with autism
- work towards design and implementation of a single system point of telephone contact for children, young people, parents/carers and professionals to receive signposting advice

- securing of funding to support a short term multiagency project to test out the impact of Adverse Childhood Experiences (ACEs) on life outcomes for children and young people (aligned to ongoing work on ACEs led by Somerset Public Health)

Other work that has been undertaken during 2019/20 includes:

- co-production, stakeholder meetings and formulation of initial plans and business case to develop and improve to the obesity pathway access for children, young people and their families
- piloting an admission avoidance project through developing a Paediatric Assessment Unit at Musgrove Park hospital to inform a system wide proposal for a standardised model
- working with our partners in Public Health to improve children in need of respiratory support. Somerset is the only Bristol Community Health facing CCG to offer our children specialist paediatric physiotherapy, allowing better supported discharges and condition management. This includes partnership working to reduce unplanned admissions with this group of children with high needs
- co-producing a multidisciplinary workshop that included women's and children's health clinicians from MPH, YDH and SomPar to focus on potential options for system wide single leadership and governance modelling. This included looking at the interface between acute and community settings
- assessed 1040 new requests and finalised 692 education, health and care plans to make sure that our vulnerable children can access the services that they need (SENPERF01a report)
- reconfiguration of leadership capacity, bringing the strategic and commissioning elements together and to support the women and children's commissioning team to drive essential quality improvements leading to improved outcomes for children and young people

3.14 **Maternity**

Summary for maternity 2019/20:

Somerset Local Maternity System (LMS) was set up to implement the requirements of the 'Better Births' guidance (2016). The LMS is made up of representatives from a range of stakeholders including maternity professionals, public health, commissioners and service users working closely together to develop services that meet the need of Somerset families.

In January 2019, the NHS launched the Long Term Plan which includes actions for Maternity Services which build on the Better Births requirements, including a personalised digital offer and targeted Continuity of Carer for our most vulnerable women. These requirements have been integrated into our LMS plans.

What we achieved in 2019/20:

- 27% of Somerset women were booked onto a Continuity of Carer pathway, against a target of 20%
- formed the Somerset Maternity Voices Partnership, to ensure the voice of Somerset women is heard as we develop our maternity services. The MVP chair sits on our LMS Board and is fully involved in our workstreams

- both trusts have taken part in the Maternity and Neonatal Safety Collaborative, working on programmes to improve safety in our maternity services
- started to implement the requirements of the Saving Babies Lives Care Bundle (SBLCB) v2, building on the improvements achieved by the implementation of the original SBLCB in 2015
- developed a robust Postnatal Improvement Plan, bringing together Midwifery, Public Health nursing, Neonatal and Primary Care. The plan includes breastfeeding support, communication with families and professionals, emotional health and wellbeing and physical health following birth
- the Perinatal Mental Health Team began offering specialist support to women at the end of Quarter 4 2019:
    - the service in its first year of operation has seen 5% of women who are pregnant or have a baby under the age of 1 with a Perinatal Mental Health condition which met the National expectation

3.15 **Medicines Optimisation**

The medicines spend in Somerset accounts for a significant proportion of the overall NHS budget. Somerset continues to promote both getting value for money from that spend and at the same time identifying unmet need and getting the best outcomes for patients from their prescribed medication.

Ensuring patients are regularly monitored and reviewed helps ensure any potential side effects are identified and medicine related risks reduced.

During 2019/20 the medicines optimisation team has continued to support clinicians in Somerset to improve medicines optimisation.

Safety has been a particular focus and by supporting practices to use the eclipse live IT tool the team has helped identify and prevent many medicines related side effects. This work has been led by the CCG Medicines Safety Officer. During 2019/20 NHS Somerset CCG won an award for the best monitoring of Disease modifying anti-rheumatic drugs (DMARDs).

Large numbers of patients in Care Homes continued to have a structured medication review delivered by the CCG commissioned care home pharmacist team. This team has recommended De-prescribing of medicines no longer required which again has reduced the risk of side effects for this group of patients and delivered considerable cost savings.

Cardiovascular disease and Respiratory disease have both been clinical areas of focus during 2019/20.

Over 3,000 Somerset respiratory patients have been reviewed and had their inhalers rationalised to a single type. This has improved their inhaler technique and contributed to reduced respiratory admissions in Somerset. Because patients generally have better inhaler technique with Drug Powder Inhalers (DPIs) this rationalisation work has also contributed to a reduced carbon footprint from prescribed inhalers in Somerset.
Within Cardiovascular disease the medicines optimisation team has facilitated better monitoring of anti-coagulants as well as switches to more cost effective and evidence based medicines.

3.16 **Improving Quality**

In 2019/20 we achieved the following:

System wide new approach to Clinical Quality Review meetings

NHS Somerset CCG has begun a movement towards a more collaborative approach to clinical quality review with our lead commissioned NHS Trusts. The quality schedule requirements are still central to the quality monitoring process, but replaces formal meetings with a review process based on an ongoing 'open book' communication process. The aim is to iteratively improve this process (through Quality Improvement Test and Change methodology) to build a quality monitoring process that supports transition to an Integrated Care System (ICS).

Quality, Safety and Improvement Strategy

The CCG has begun work on developing a Quality and Safety strategy with our service providers, during this last year focussing on the building blocks of the strategy, such as developing a County wide Learning From Deaths Group and a revised approach to investigating serious incidents. The development of these various elements covered in the national strategy will come together to inform the overall strategy. Some of this work has been delayed in waiting for implementation of the new national arrangements for the various elements and going into 2020/21 the COVID-19 pandemic.

Quality Improvement (QI) Training

The Quality Team has been working with stakeholders across Somerset to continue building on the development of Quality Improvement Capability across all providers in the county.

Key to the development of this capability has been the ongoing work of the Somerset Quality improvement faculty (SQIF). From this the Somerset health and Social care systems have agreed a single approach to the development of QI training, based around three levels: Bronze, Silver and Gold.

During 2019/20 the Quality Team and partners concentrated on ensuring access to Bronze level training across the System. NHS Somerset CCG has focused on providing Bronze level training across the county for Primary Care staff, with a specific focus on supporting Primary Care nurses to be involved in improvement projects.

The total number of Primary Care staff trained in Quality Improvement during 2019/2020 was 167. This included Nurses, General Practitioners, Pharmacists, Paramedics and Practice Managers.

The Quality Team has also developed a Quality improvement training programme focused on how commissioners can support system wide QI. This started in January 2020 with 19 staff trained.

Work has been undertaken by the SQIF to develop programmes of more advanced QI training at Silver (practitioner) and Gold (System leader) levels. NHS Somerset CCG has supported the development of these programmes and will be providing trainers and resources to support these programmes.

Improvement Projects

During 2019/20 the CCG has been supporting a number of improvement projects, these have been informed from learning from incidents with elements related to sepsis and communication between clinical teams. This includes the Testing and roll out of RESTORE 2 documents and assessment process into Nursing Homes and GP practices. The RESTORE 2 document incorporates soft signs, NEWS2 and SBARD. This is utilised within the community to acute care pathway, it has been piloted in the east of the county with three GP practices and the nursing homes they work with.

The initial feedback demonstrates an improvement in the referrals that are being provided by Nursing homes, improving the communication and relationship with GP practices and homes. Most importantly it is supporting the clinicians to prioritise patient care and need and supporting the homes to articulate their concerns and receive instruction on the deemed appropriate actions.

Feedback from the homes suggest that the tool supports their decision making process, identifying individuals deterioration earlier and improving clinician responses.

Patient Safety

During 2019/20 the Quality Team has monitored and supported improvement in preventing known patient safety risks such as pressure ulcers, falls, infections and venous thrombo-embolism. There has been specific work on supporting the identification and early treatment of sepsis, including Introducing the wide scale use of NEWS 2 and trained sepsis leads in each GP practice.

Complaints

NHS Somerset CCG values complaints, which act as a barometer for the quality and safety of our local health services and a measure of how services interact across the whole patient pathway. Formal complaints are captured, investigated, analysed and categorised.

During 2019/20, NHS Somerset CCG closed 48 formal complaints. The main themes arising from these were:

- access to services - 18
- NHS Continuing Healthcare (CHC) - 9
- quality of care - 11

In access to services, the highest number of complaints related to the urgent and emergency care services and tended to be about delays. A number of complaints were received about the CHC process. There were also a number of complaints about the quality of care provided in a range of different settings.

Learning from complaints has been used to inform the CCG commissioning decisions and improve processes. Examples include:

- from 1 April 2019 a new Electronic Palliative Care Co-ordination System was introduced in Somerset. This system has been designed to address issues with

sharing information between different agencies around end of life care plans and medication

- the Continuing Health Care (CHC) team continually use the intelligence gained from complaints to refine their processes and communication to improve applicants experience and manage their expectations

- an independent complaint review commissioned by the CCG made a number of recommendations to improve the way in which the health service and children's social care adoption/fostering service work together. These are being taken forward jointly by the CCG and local authority

Further details on complaints will be available in the Annual Complaints Report 2019/20, which will be published on the NHS Somerset CCG website later in the year.

3.17 **Children Looked After and Care Leavers**

The NHS has a major role in ensuring the timely and effective delivery of health services to children who are looked after, (CLA). The Mandate to NHS England, (HMGov), Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, (DoH, 2013), and The NHS Constitution for England, (HMGov, 2015) make clear the responsibilities of CCGs and NHS England to CLA and by extension Care Leavers. The NHS fulfils these responsibilities by contributing to meeting the health needs of CLA in the following ways:

- Commissioning effective services
- Delivering through:
    - provider organisations
    - individual professionals providing coordinated care for each child.

Furthermore under the Children Act 1989 *and Promoting the health and well-being of looked-after childr*en Statutory Guidance, (DfE,DoH, 2015), CCGs and NHS England have a duty to comply with requests from Local Authorities to help them provide support and services to children who are looked after.

Somerset Context

In 2018 the CCG Designated Nurse for Safeguarding Children raised concerns in respect of her joint responsibilities for both Safeguarding and Children Looked After (CLA). She produced a comprehensive business case which clearly evidenced the CCG's duties and responsibilities in respect of CLA, the commissioning gaps and that the Intercollegiate Role Framework, (RCPCH, 2015), cited in the Statutory Guidance was clear that each CCG should employ a minimum of one Designated Nurse for CLA per 70,000 child population. Somerset had a child population of 110.000 at that time. The business case was approved by the CCG and a stand-alone Designated Nurse for Children Looked After was recruited in November 2018, commencing in the post in February 2019. Her first role was to implement a Whole Service Review of Health Services for Children Looked After and Care Leavers in Somerset.

Whole Service Review

The Whole Service Review identified commissioning gaps which had resulted in major breaches in the provider services ability to effectively meet the health needs of the population Children Looked After and Care Leavers in Somerset in line with Statutory Guidance, the Intercollegiate Role Framework and the Care Planning, Placement and Case Review (England) Regulations (2010). As a result NHS Somerset CCG was not meeting its statutory responsibilities to ensure the timely and effective delivery of health services to CLA and Care Leavers. Subsequently the Designated Nurse requested additional urgent investment to ease specific and high risk pressures in respect of the statutory Medical Advisor for Fostering and Adoption role, the re-implementation of a medical practitioner led Initial Health Assessment model to comply with Statutory Guidance and investment in an additional Clinical Coordinator post based within the CLA Nursing Team.

In addition to addressing specific and urgent commissioning gaps the Designated Nurse developed a comprehensive business case recommending an investment and transformation plan phased over three years to address the issues identified and ensure the CCGs statutory responsibilities are met. The whole business case was successfully approved in March 2020.

Safeguarding Children

We are responsible for ensuring that statutory responsibilities in relation to safeguarding and promoting the welfare of children are embedded in the services we plan, buy and monitor (commission) in Somerset.

We make sure that we and the services we commission work within legislation and national, regional and local guidance in relation to safeguarding and promoting the welfare of children. For example the Children and Social Work Act 2017 and the NHS England Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework.

One of our key aims is to ensure that safeguarding and promoting the welfare of children is built into commissioning structures, values, practices and business processes through the annual cycle of clinical quality activity.

The quality and safety of safeguarding children practice in commissioned health services will be monitored through a range of mechanisms including the Somerset Quality Surveillance Group (QSG) a sub-committee of the Somerset System Assurance Forum.

Oversight and assurance of safeguarding children practice in commissioned health services are monitored through a range of mechanisms including the provider's own safeguarding committee meetings, commissioner and provider liaison meetings and through work undertaken within the Somerset safeguarding children partnership.

In addition to analysis of the safeguarding children dashboard indicators, safeguarding children assurance activities are undertaken on a regular basis to gain intelligence on the quality of safeguarding children service provision, to identify any areas the commissioned providers may need support with and to work with providers and partner agencies towards sustainable improvements in safeguarding children practice across the health system.

In 2019/20 we achieved the following:

- in response to the Children and Social Work Act 2017 and the statutory guidance Working Together to Safeguard Children 2018 the CCG along with key safeguarding children partners –Somerset County Council and Avon and Somerset Police– the new safeguarding children arrangements (known as the Somerset Safeguarding Children Partnership) in Somerset was launched on 26 June 2019
- the Somerset Safeguarding Children Partnership (SSCP) was implemented as planned on in October 2019
- the CCG worked with Child Death review partner agencies in Dorset and Somerset to develop the new joint Pan Dorset and Somerset Child Death Review arrangements –the new arrangements in Somerset was launched on 26 June 2019
- the new joint Pan Dorset and Somerset Child Death Review arrangements were implemented in July 2019
- both arrangements support the first joint NHS England and NHS Improvement Safeguarding Accountability and Assurance Framework (SAAF) published in September 2019, by strengthening the NHS commitment to promoting the safety, protection and welfare of children, young people and adults
- the CCG has worked with statutory partners across the South West region, through the Avon and Somerset Safeguarding Strategic Partnership (ASSSP). Added value will be brought to local and regional multi-agency safeguarding arrangements by collaborating with core partners – councils, NHS and police - across Avon and Somerset
- through the ASSSP shared priorities for the 5 multi-agency safeguarding arrangements will be explored

3.18 **Safeguarding Adults**

Everyone has the right to live their lives free from abuse and neglect.

Some adults are unable to protect themselves from abuse or neglect because they have needs for care and support. Our key aim is to ensure that both Somerset CCG and its commissioned providers protect the rights of those adults to live free from abuse and neglect; in a way that supports them in making choices and having control about how they want to live.

The CCG has a Designated Nurse for Safeguarding Adults. The Designated Nurse provides expert advice and guidance to the CCG in order that it fulfils its duties in a number of areas.

This includes:

- Safeguarding Adults as described in the Care Act (2014)
- Domestic Abuse and Violence
- The Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards
- Prevent

In addition, the Designated Nurse works with our NHS Hospitals and Community Services to monitor how all its commissioned services support adults who need safeguarding. We also monitor who they work with other agencies. We do this by requiring our Trusts to provide monthly information on a safeguarding dashboard. Our smaller providers are required to complete and annual safeguarding report. We also attend the Trusts

safeguarding committee meetings. Performance and risk is reported to the CCG's Patient Safety and Quality Assurance Committee.

Somerset CCG is a member of the Somerset Safeguarding Adults Board (SSAB). It is made up of senior individuals from organisations that have a role in preventing the neglect and abuse from adults. The Board ensures agencies all work together to minimise the risk of abuse to adults at risk of harm. The Board also monitors who effectively agencies work together.

In 2019/20, the Designated Nurse for Safeguarding Adults:

- provided CCG attendance at the Somerset Safeguarding Adults Board meetings including all five sub groups. The Designated Nurse chaired the policy and procedures group which developed new guidance and refreshed all existing guidance in 2019 to 20
- participated in five safeguarding adults reviews
- completed the SSAB annual self-audit and represented the CCG at the annual peer review

Domestic Abuse

The CCG was successful in a bid for funding from the Pathfinder Consortium to support improvements in how the NHS Hospitals and Community services respond to and support people who use our services and are experiencing Domestic Abuse. The following outcomes were achieved:

- completion of a Somerset Health Wide domestic Abuse Policy
- a Domestic Abuse Link (DAL) Worker network across our hospitals and community services has been developed. The link workers receive additional training in Domestic Abuse and can provide advice and support to colleagues who are responding to Domestic Abuse
- a resource pack for DAL workers
- a CCG policy to enable us to support colleagues in our workforce who are experiencing Domestic Abuse
- two training packages.

We also supported the Domestic Abuse Board, and the Designated Nurse has participated and eight ongoing Domestic Homicide Reviews.

Prevent

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

This year, the Designated Nurse for Safeguarding Adults has:

- joined the Channel Panels. Channel panels are the way that support is offered to people at risk of being radicalised. This has provided additional health support and strengthened links with primary care
- refreshed how we monitor our providers compliance with their Prevent Duties.

The Mental Capacity Act

The Designated nurse has undertaken a number of briefing sessions within the CCG in order to prepare us for the changes that will happen as a result of the Mental Capacity Amendment Act (MCAA) (2019). This includes a briefing session to the CCG Governing Body.

We have also undertaken an audit across our hospitals to understand the impact of the MCAA and to enable us to understand how to prepare effectively.

3.19 Infection Prevention and Control

Infection Prevention and Control remains a key quality imperative for health and social care commissioners and providers. Good progress has been made in reducing some Health Care Associated Infections (HCAIs) but there is still more progress and constant vigilance needed to address infection risks from improvements and changes in healthcare provision and emerging infection threats. Such as:

Gram Negative Bloodstream infections (GNBSIs) including Escherichia coli (E.coli)
Rates of blood stream infections due to gram negative bacteria have been rising since national reporting of these infections began in 2011 and 2017. There is a national ambition to reduce these infections by 50% by 2023/24. Approximately 80% of these infections arise in the community, making prevention of infection as much of a community problem as a hospital one. The majority of all GNBSIs are found to have started from a urinary source and much work is being carried out to tackle this matter. No official trajectory was received for 2019-20. There were a total of 519 cases at year end, which is a 1.8% increase on the previous year, and overall a 6.1% increase over the benchmark figure of 489.

At the same time many of the existing antimicrobial treatments that we have for bacteria, viruses and fungi are becoming less effective. When this is combined with very limited development of new antibiotics there is a real risk that everyday infections or diseases will become untreatable, making prevention of spread of infection even more critical.

Tackling Antimicrobial Resistance (AMR)

The UK's national action plan sets out to tackle AMR within and beyond our own borders and focuses on three key ways to tackling AMR:

- reducing need for, and unintentional exposure to, antimicrobials
- optimising use of antimicrobials
- investing in innovation, supply and access

Clostridium difficile (C.diff)

We are on trajectory for C diff cases with a total of 124 cases in 2019/20 to date against a target of no more than 124 cases.

MRSA

Zero tolerance approach. There have been a total of 2 MRSA BSIs in 2019/20 to date, of which none were acute trust onset. There was also a case in January 2020 involving a

Somerset patient which was an acute trust onset attributable to Bristol Royal Hospital for Children as the patient had been with them since September 2019. A post infection review took place on each case to identify why the infection occurred and how future cases can be avoided.

Our healthcare providers have well developed structures and processes in place and this provides a good basis from which to develop a county-wide approach that is fully inclusive of primary, community, social and home care settings. The challenge is to ensure investigation and rapid learning from an increased number of infection incidents, ensuring this is translated into consistent knowledge and practice in care homes, social care and further community settings.

COVID-19

NHS Somerset CCG Infection Prevention and Control Team resources were diverted to this area of work in February 2020 in order to support the incident response.

A pneumonia of unknown cause detected in Wuhan, China was first reported to the WHO Country Office in China on 31 December 2019. The outbreak was declared a Public Health Emergency of International Concern on 30 January 2020. On 11 February 2020, WHO announced a name for the new coronavirus disease: COVID-19.

The Department of Health and Social Care (DHSC) and Public Health England leading the UK government response to coronavirus (COVID-19) outbreak.

3.20 **Continuing Health Care (CHC)**

NHS Somerset CCG holds the statutory responsibility to deliver the Continuing Health Care (CHC) process aligned to the principles laid of the National Framework for Continuing Healthcare and NHS-funded Nursing Care 2018 (revised). Following significant transformational change the CHC Team has established firm partnership processes with Somerset County Council, with a focus on embedding quality and efficiency in practice.

In 2019/20 we achieved the following:

- resolved the historic backlog of over 450 outstanding eligibility assessments
- achieved both quality premiums of no more than 15% of all eligibility assessments to be completed within acute settings as well as at least 80% of all eligibility decisions being made within 28 days of notification to the CCG
- completed audit on our Personal Health Budget (PHB) offer
- completed audit on the maturity of the team's processes against the national tool developed by NHS England's strategic improvement programme and developed associated action plans
- explored the quality and processes supporting of our practice through shared events with Dorset, Devon and are planning a further event with Buckinghamshire
- complied fully with NHS England's requirements to offer a PHB to all newly eligible patients from April 2019 who live in their own homes
- completed an appraisal of our local independent review offer against recognised best practice and shared this with NHS England
- developed and delivered training content to our providers jointly with Somerset County Council (SCC)

- revised our fast track documentation and supported greater application of essential criteria in practice
- supported NHS England in their role of Independent Review
- developed jointly with Somerset County Council (SCC) a framework for micro-providers that supports greater quality and safety of care provided to our patients
- implemented a new quality framework for our providers, working jointly with SCC to reduce the burden of returns
- worked collaboratively with SCC to undertake share outcomes of contract reviews This has reduced the burden in frequent reviews on both commissioners and providers
- improved the timeliness of care reviews, ensuring that we understand the needs of our patients and what care provision is needed
- delivered on the Quality, Innovation, Productivity and Prevention plans of over £2 million
- set out a proposal to work on a joint arrangement with SCC to manage the market and cost of care for CHC funded patients from 2021 onwards as part of an integrated care system
- scoped the demand for those who will need provision under the new upcoming Liberty Protection Safeguards within CHC
- fully implemented the new version of the NHS England's assurance framework "CHAT"
- developed a new patient feedback form from the national tools so that we can better understand patient and family perspective and shape our services accordingly.

3.21 **Enablers – Workforce**

Summary for workforce for 2019/20:

Workforce is an important area for the NHS to focus on in 2020 and beyond. The number and complexity of the patients our workforce care for continues to increase and there is much to be done in terms of all staff, nurses, therapists, doctors, support staff, midwives, health visitors to name but a few. Going forward we need more training, more recruitment, better retention and greater return to practice numbers.

In 2019/20 we achieved the following:

The response to these pressures is being looked at by the Somerset Local Workforce Action Board (LWAB) who has been active in supporting system developments. There have been a number of successful work programmes in support of the Long Term Plan and the Interim People Plan around the following areas:

- making the NHS the best place to work
- improving the leadership culture
- tackling the nursing challenge
- delivering 21st century care
- a new operating model for workforce.

We ran a programme across the system called My Shared Endeavour which has resulted in work groups being set up in support of making the NHS a better place to work. Talent Management, Careers, Coaching, training and learning and development are some of the areas being taken forward.

The system also commissioned a leadership development programme for the Chief Executives focussed on the Integrated Care System Maturity Matrix.

We are currently looking at educational routes for our nurses and upskilling and multiskilling our workforce to meet an NHS service that befits the 21st Century.

The Somerset system has been looking at:

- stable leadership, membership and alignment for system Workforce Board, Training Hub and priority subgroups including Nursing Workforce development and Skills/Education
- system wide ownership of the Long Term Plan (LTP) workforce plans, appointment of SROs for each workstream area
- establishment of Primary Care strategic workforce group for strategic coherence to workforce development in primary care
- establishment of Somerset Extended and Advanced Practice group to steer development and implementation of advanced clinical roles
- awarded Health Education England (HEE) pilot status for developing a Place-Based approach to clinical placement management

The CCG has provided a lot of focus internally on cultural developments and organisational development activities in recognition of the evidence cited many times that a more engaged workforce results in greater productivity.

We are starting to see early signs of changes with staff reporting that they have noticed a difference in the ways of working and openness of the culture. We will continue to monitor progress against our staff survey results. This will be particularly important as we move into 2020/21 in light of the COVID-19 pandemic.

3.22 **Enablers - Digitally Enabled Transformation**

Summary for Digital Enabled transformation for 2019/20:

The NHS Somerset CCG Digital Team has worked on an expanding portfolio of work during 2019/20, collaborating with local organisations within Somerset, as well as neighbouring communities across the South West. The need for matrix working is an approach the Digital Team continue to be ambassadors for, with continued and expanding engagement opportunities with clinical, executive, operational and patient led groups. The Somerset Digital footprint includes the following core organisations:

- NHS Somerset CCG
- Somerset GP Practices
- Somerset County Council
- Yeovil District Hospital NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Taunton and Somerset NHS Foundation Trust
- St Margaret's Hospice
- Devon Doctors 111 and Out Of Hours

Other organisations vital to delivering effective care the team has engaged with include:

- Dorothy House Hospice
- Weston Hospicecare
- Children's Hospice South West
- Somerset Care Homes
- Care UK
- Governing Bodies including Somerset Local Medical Committee (LMC), Local Dental Committee (LDC), Local Optical Committee (LOC) and Local Pharmacy Committee (LPC)

In 2019/20 we achieved the following:

- we continued to deliver Somerset Integrated Digital Electronic Record (SIDeR) Programme, joining up specific records identified in plan:

    - End of Life Care Plans being completed on SIDeR by primary, secondary and hospice care staff
    - special patient notes being created through Black Pear integration with EMIS
    - shared care record tested and safety case validated for use
    - primary care information is available across all clinical settings through EMIS web viewer – community pharmacies rollout also ongoing
    - social care viewer technical capability put in place, to be deployed in early summer
    - mapping NHS numbers to children's social care record
    - learning difficulties cross organisational care co-ordination project, acute records have been amended to make clinicians aware of the people's LD status when presenting for treatment.

- Primary Care Online Consultations rolled out the NHS App and digitally enabling Neighbourhood Teams. Primary care providers are receiving active promotional and communications support to encourage a significant and informative on-line presence.
- promoted the NHS App and digital access to primary care through online consultations and GP online services.
- engaged and worked with the Digital People's Champion's Group
- improved social media platforms and communications to the public (via "Your Somerset" SCC newsletter, Facebook, Twitter and Instagram)
- ensured that local residents and groups were more engaged in digital access to services, health records and information
- digitally enabled Village Agents, providing equipment and NHS email addresses
- employed Digital Outreach Team Communicators as a pilot project to promote digital tools to the public and educate practice staff on enabling and encouraging usage of the same
- employed a Digital Apprentice, to support the team with all projects as well as to help improve engagement with the younger generation through relevant social media, supporting fresher's fairs and digital promotion events across a number of academic settings in Somerset
- confirmed role of Associate Clinical Director – Digital Strategy, and development of Clinical Lead role
- Data Security and Protection:

  - provided care homes with NHS mail
  - promoted the Data Security and Protection (DSP) toolkit across core and new organisations to support information flow
  - renewed focus on cyber security and protective measures planned
  - carried out penetration testing
  - carried out a phishing project with CCG and General Practices
  - provided education and communications for staff

- secured funding via NHS England to support Estates and Technology Transformation Fund projects, emerging Digital First Primary Care approach and Clinical Leads
- continued investment in GP and CCG IT, including laptops for mobile working and software to improve information sharing for direct care
- at pace deployed MS Teams for video conferencing across CCG corporate teams and into General Practices, to support COVID19 response for virtual working
- improved digital maturity and connectivity of provider systems across health and care community:

  - Gov WiFi
  - HSCN migration from N3
  - public access WiFi
  - Axe the Fax project
  - resolved DocMan messaging issues and replaced with MESH (National data standard)
  - Electronic Referral Service, 98% of referrals now sent this way, with increased use of electronic Advice & Guidance
  - Electronic Prescription Service, majority of practices using, encouraged use of Electronic Repeat Dispensing

- Community and Mental Health inpatient settings are now paper light across the Somerset system
- acute clinical digital implementation continues on plan with core prescribing, vital signs monitoring and assessments being implemented.
- contributed to regional discussions for 'One South West' Local Health and Care Record Programme
- provided Business Intelligence analyst support to clinical strategy delivery
- explored development of Somerset Integrated Dataset through Somerset Business Intelligence Strategy (drafted and Working Group established)
- continued to explore use of artificial intelligence to improve direct care and care planning through BRAVE AI tool
- enabled development of digital skills/capabilities in the workforce through range of projects
- connected digital systems for system wide bed state and availability dashboard

3.23 **Enablers – Estates**

Summary for Estates for 2019/20:

The overarching aim of the estates strategy is to develop a modern estate that can support the delivery of new service models that can meet the constant increases in demand for urgent and emergency care. The work programme has focussed on:

- supporting the Fit For My Future health and care services strategy review
- working with partners across Somerset through the STP and One Public Estate Programme

In 2019/20 we achieved the following:

- the projects to implement the re-provision of new theatre and critical care facilities and an acute assessment and ambulatory care centre on the Musgrove Park Hospital site have continued. The existing facilities are provided from outdated buildings that require investment in order to provide compliant premises. Taunton and Somerset Trust were successful in obtaining funding of £79.5 million through the Wave 3 STP capital bidding process and the Outline Business Case has been approved by NHSI/DHSC. In addition Musgrove Park were successful in the wave 4 STP capital bidding with a proposal to centralise acute assessment and ambulatory care services on the Musgrove Park Hospital Site (£11.5 million). This scheme has been prioritised as it is not subject to the Health and Care Strategy outcome and consultation. Furthermore, the scheme supports delivery of recurrent savings across the STP

- the STP put in place a capital programme which has been prioritised against assessment criteria focused on enabling service transformation and tackling backlog maintenance. Moving forwards the programme will be aligned to a funding strategy and implementation plan. Utilisation of core estate is a core workstream of the estates group and a workstream has been developed to utilise key estate, delivery is underway

- a baseline assessment of the primary care estate has been undertaken, in order to inform investment priorities. This has resulted in a good local knowledge of where the existing and future risks and vulnerabilities are and where priority actions are needed. Locally works to define future plans are underway in priority areas such as Taunton

- the clinical strategy is developing steadily but has not been concluded. The STP Estates Group continue to work with STP colleagues to ensure that support is offered to core STP workstreams and the estates work programme is aligned to and enables service change. The revised capital programme articulates key priorities for future capital waves and a short list of projects for future bidding is in place

- the Somerset OPE group is actively pursuing opportunities and working on projects across Somerset. OPE links are strong and the group is active with Local Authority and NHS being the key participants. The STP Estates Group has continued to work with partners on priority project delivery and identify new opportunities within the OPE programme and outside of it

- the Primary Care Estates Group actively meets bi monthly to progress the development of a primary care estates strategy and to resolve operational issues that affect the primary care estate. All key parties are represented at primary care estates group, including NHS England, CCG and Local Medical Council

- one of the key objectives of the STP Primary Care Estates Group is to develop and deliver a primary care estates strategy and associated capital programme. Work is underway to do this, taking into account the link with national efforts to develop a

primary care estates strategy toolkit. Locality based planning is underway and future solutions being investigated through options appraisals in priority areas.

3.24 **Sustainable Development**

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

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

- supported the cycle to work scheme which also helps to improve the health and well-being of staff
- helped the national NHS target of reducing carbon emissions through employee travel
- worked with the waste management service provider to increase the amount of recycled materials and promote these opportunities with our staff
- reduced the use of printers and consumables and promote a paperless environment and ensure recycling of the printer consumables through the service provider
- continued to integrate the principles of sustainability across the organisation, including reducing use of single use plastics where possible.

3.25 **Engaging people and communities**

We know that in the past we haven't been as good as we could be at listening to the people who live or work in Somerset. To help us change this, we have brought our communications and engagement teams together to develop new ways of working to improve how we listen and use the information we gather to help shape and change services.

We want to put the patient and public voice at the heart of everything we do. We aim to be system leaders who support our providers to improve and innovate. Participation helps us to understand people's needs, improve access to services and reduce health inequalities in health. This is part of our duty to involve the public under section 14Z2 of the Health and Social Care Act 2012.

Our key priorities for 2019/20 were:

- developing our new communications and engagement strategy
- developing our new consultation strategy
- building the team

Our new communications and engagement strategy was developed with the input and support of key stakeholders including our staff, our NHS and social care providers, our People Champions, our Patient Participation Group (PPG) Chairs, our Somerset Engagement and Advisory Group (SEAG), primary care colleagues and the public.

Together we identified four objectives:

Our PPG Chairs and SEAG members have supported us to identify the actions required to deliver the chosen objectives and these form the basis of our three year action plan. The new strategy and action plan were approved by the Governing Body in September 2019.

We developed our new consultation strategy based on best practice and the legal requirements. This was considered by the Somerset County Council Health Overview and Scrutiny Committee and approved by our Governing Body in January 2020. All future consultations will be delivered in line with this strategy.

This year we have merged the communications and engagement teams and combined these with the Fit for My Future communications and engagement team. We now have one single cohesive team leading on system communications and engagement. Appraisals have been completed for all team members and a training plan is in development.

In 2019/20 we achieved the following:

- produced and ratified new policies including: media policy, social media policy and volunteer (People Champion) policy
- established regular reporting and assurance processes for communications and engagement
- introduced 10 steps to better engagement training and delivering a regular programme of training to identified staff (and provider colleagues)
- developed our processes to record and feedback patient stories and making these visible internally and externally
- improved connections with Voluntary Community and Social Enterprise (VCSE) partners and seldom heard/listened to communities and groups including people with learning disabilities, Black and Minority ethnic (BAME) communities, gypsy and traveller communities and young people
- established a Somerset Engagement Leads network to share best practice
- developed and launched an induction and training programme for our volunteers (People Champions)
- developed and introduced a tone of voice guidelines for the CCG
- we are growing our social media presence and starting to produce creative, original content
- delivered and will continue to deliver regular social media workshops for staff
- content reviewed, design refreshed and relaunched of established communications and engagement channels including internal staff newsletter, Engagement Bulletin and development of new channels including Our Somerset News stakeholder newsletter
- quarterly Pulse Check sent out regularly to staff to assess and adapt our CCG internal communications
- devised and successfully launched internal monthly CCG Somerset Star staff awards

3.26 **Health and Wellbeing Strategy**

Health and Wellbeing Board

NHS Somerset CCG is an active member of the Health and Wellbeing Board which was comprised of the following membership at 31 March 2020:

Member	**Organisation**
Cllr Clare Paul (Chair)	Somerset County Council (SCC)
Cllr Frances Nicholson (Vice Chair)	SCC
Cllr David Huxtable	SCC
Cllr Linda Vijeh	SCC
Cllr Amanda Broom	SCC
Cllr Brian Hamilton	South Somerset District Council
Cllr Janet Keen	Sedgemoor District Council
Cllr Chris Booth	Somerset West and Taunton Council
Cllr Ros Wyke	Mendip District Council
Dr Ed Ford (Vice Chair)	NHS Somerset CCG
Alex Murray	NHS Somerset CCG
James Rimmer	NHS Somerset CCG

Member	Organisation
Mark Cooke	NHS England
Judith Goodchild	Healthwatch
Trudi Grant	Director of Public Health, SCC
Julian Wooster	Director of Children's Services, SCC
Supt Mike Prior	Avon and Somerset Police Chair, Safer Somerset Partnership

The overall aim of the Health and Wellbeing Board is that it will provide strategic leadership to improve the health and wellbeing of the residents of Somerset through the development of improved and integrated health, public health and adults and children's social care services.

In particular, the Board:

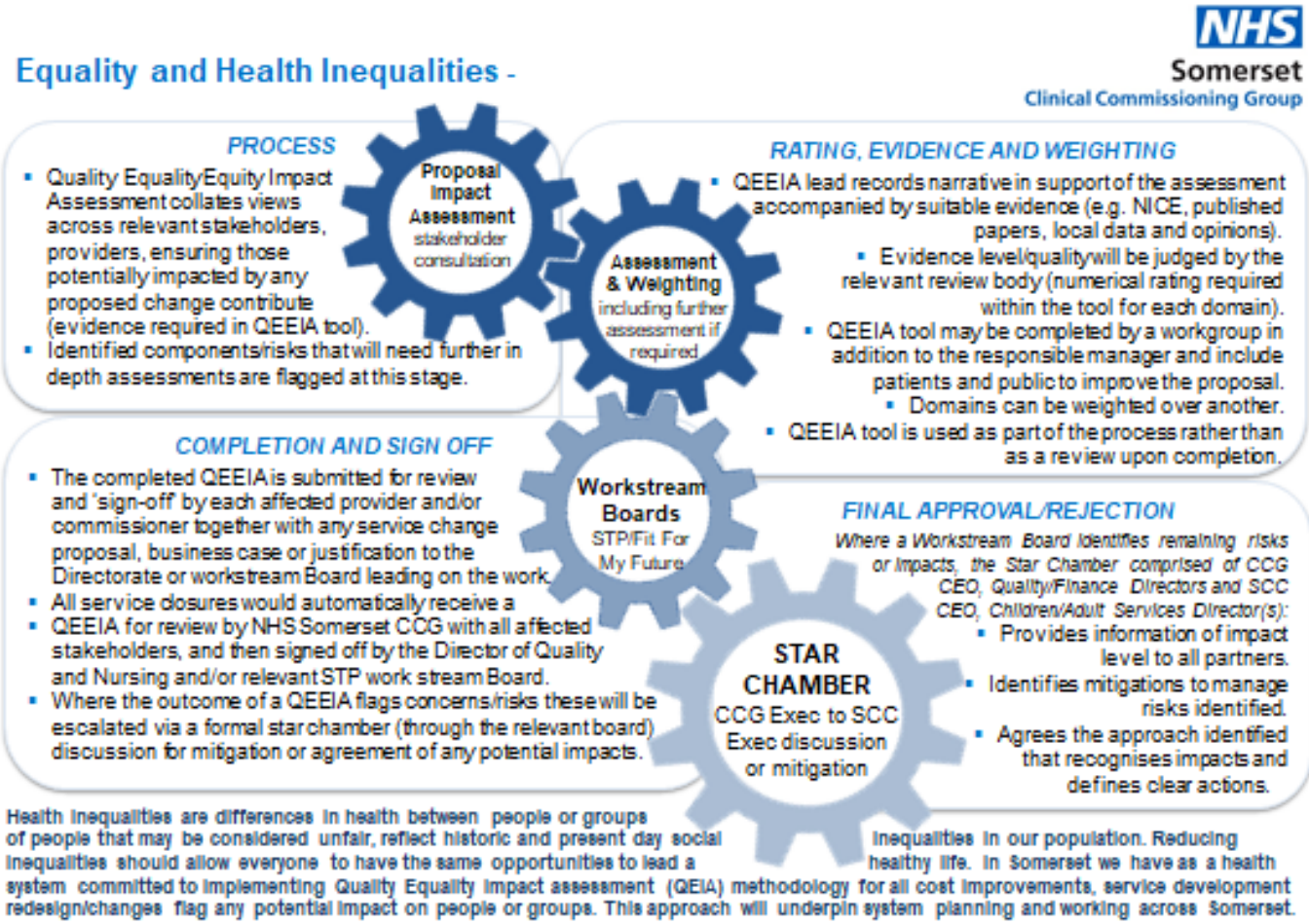
- oversee, where appropriate, the use of resources across a wide spectrum of services and interventions, to ensure that the SHWBS and priority outcomes are achieved and, to drive a genuinely collaborative approach to commissioning, including the co-ordination of agreed joint strategies
- support the inclusion of the public, patients and communities in the setting of strategic priorities, including (but not solely) through the involvement of local Healthwatch
- communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their own health and wellbeing and that of the people living around them

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

The Health and Wellbeing Board is the partnership which has oversight responsibility for the Somerset Sustainability and Transformation Partnership (STP), and the Board have received regular reports, and have been consulted on developments.

3.27 **Equality and Health Inequalities**

We are committed to ensuring that we reduce health inequalities and that we have the needs of our communities at the heart of our commissioning. We know that people access services and need support in a range of different ways. We endeavour to understand our communities, individuals and representative groups to gather experiences and barriers of our services. This information is used to influence the commissioning of services to meet their needs. We look beyond the Protected Characteristics defined by the Equality Act 2010 to ensure that all vulnerable groups, for example military families, homeless, and people living in rural areas have equitable access to NHS commissioned services. We have representation on a number of multi-agency equality networks which consider a variety of communities. We use these networks to attempt to make movement between NHS services and other services, such as Social Care, sensitive to the needs of different groups. Our quality, equality, equity impact assessment process is outlined below, this is in line with our duty to reduce inequalities under section 14T of the Health and Social Care Act 2012.



3.28 **Emergency Planning**

All NHS organisations work together with the emergency services and local authorities to overcome potential disruption to civil life caused by major incidents, outbreaks of infection, severe weather or acts of terrorism. The responsibilities for emergency

planning are set out in the Civil Contingencies Act 2004, Section 46 of the Health and Social Care Act 2012 and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

NHS Somerset CCG is part of the Avon and Somerset Local Resilience Forum and the Local Health Resilience Partnership (LHRP) that covers Bristol, North Somerset, Somerset and South Gloucestershire. Planning is coordinated through the LHRP and we have been an active member of both the executive and tactical steering groups. We have worked in partnership with NHS England during 2019/20 to ensure there was a coordinated response to escalation pressures and emergency planning by health services in Somerset. In addition, organisations across Somerset work closely together to ensure that plans are as integrated and effective as possible.

Our CCG has emergency response plans in place, which are fully compliant with the NHS England Emergency Preparedness, Resilience and Response Framework 2015. We regularly reviews and makes improvements to our incident response and business continuity plans and there is a programme in place for regularly testing these plans, the results of which are reported to the Clinical Executive Committee and Governing Body. We carried out our annual self-assessment assurance process with NHS England to assess our plans and procedures and together we and NHS England met with our three key providers to review their plans. We were assessed as being fully compliant with the standards and Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust were both assessed as being fully compliant and Somerset Partnership NHS Foundation Trust were assessed as being substantially compliant.

Somerset's Emergency Planning capacity during the first half of 2019/20, as was true for the rest of the UK, concentrated heavily on the planning and preparation for a no-deal exit from the European Union (EU). The CCG and Trusts teams worked closely with the Regional Teams to develop preparation plans and provide assurance that local health services were well prepared.

The latter half of the year was initially focussed on work to support plans to prepare for winter and severe weather but the national COVID-19 major incident has led to the activation and implementation of the pandemic flu plans. The CCG activated its business continuity plans and established its incident coordination centre from 11 February 2020. The CCG has been working closely with all system partners to ensure there has been an effective response to the incident.

The CCG has an Incident Response and Business Continuity and Service Recovery Plan which it has put into practice to respond to the incident. Teams within the CCG have used their plans to identify and prioritise the critical services that need to be maintained and release capacity where appropriate to support the incident response command and control framework. The CCG Incident Coordination Centre (ICC) and supporting team was established early during the incident on site at NHS Somerset CCG Offices at Wynford House in Yeovil, Somerset. Wynford House is a resilient building with systems designed to protect the integrity of the Incident Coordination Centre (ICC) and the building is accessible at all times. The ICC has independent telephony, paper based systems and generator backed power supply in order to withstand any problems with continuity of utilities. Once the national social distancing policies were put in place, the CCG reverted to remote working. Staff have been provided with remote access and equipment that enables them to work away from the office base and theses systems were well tested prior to the incident. The virtual ICC processes have independence as they work from national systems (ie. NHSMail, Resilience Direct, Future NHS website) that are

accessible from home broadband and systems as well as by remote login to CCG networks. The CCG has been utilising MS Teams extensively to enable business to be maintained effectively. The IT services provider has its own disaster recovery and network business continuity planning which provides additional network security with its ability to mitigate supply disruption in one area from the wider network.

The Incident Management Team is led by the Incident Director, Maria Heard, and supported out of hours by the 24/7 on call director rota. All communication is managed through telephone and email single points of contact and all action and decisions are logged through a team of operational managers and supporting administrative staff. The Incident Director and On Call director are supported by a loggist. The ICC process and action cards have been refined to reflect the current incident and the need to manage it virtually. A common Future NHS workspace is being used by the CCG and system partners to log and share important information. There is Covid-19 Incident risk and issues log which has been designed to align to the CCG Corporate Risk Register. A framework of specialist support cells has also been established to lead key workstreams and these have multi agency representation and link into the LRF cell structure and NHSE Regional command and control as appropriate.

3.29 **Risk Management**

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

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

Overview of NHS Somerset CCG Risks

In 2020 we saw the outbreak of the COVID-19 pandemic and to ensure that the CCG's risk management process integrated to incident control management and was resilient to the subsequent health system challenges, the CCG undertook a review of how risk management could be affected during times of crisis or major incident.

The review identified opportunities to improve risk management which were specifically related to crisis or major incidents. The improvements maintained compliance to the CCG's Risk Management Strategy policy and further strengthened CCG governance, in addition to reducing negative and unquantified impact arising from risk, to the CCG and the health system. Additionally, risks themes that arise from a pandemic crisis, CCG responsibilities during the crisis and post crisis learning for risk management were also identified in the review.

Although not in 2019/20 it is worth noting that a proposal to implement the recommendation from the review, together with key tasks associated with the themes identified in the review was given final approval by the CCG in early April 2020. The proposal highlighted that the current CCG risk management process must continue during the COVID19 crisis. However, where capacity to manage risk was affected by competing priorities during the crisis, the CCG would focus on existing or new risks that

are sensitive to the crisis, and in a timely manner which represented frequency of risk change.

During April 2020, the recommendations were implemented so that the CCG risk management process integrated with the incident control centre risk management process. This ensured that all risks, or concerns leading to risk, were identified, monitored and reported, removing duplication and reducing possibility of unaccounted risk. Risks generated from the crisis were reviewed weekly to ensure that where their exposure affected the aims or objectives of the CCG, they entered into the CCG risk management process. The risk monitoring activities, specified with the CCG Risk Management Strategy policy, were then used to enable timely reporting of risk within the CCG governance structure.

Key risks managed by us during this financial year have included:

- COVID-19 pandemic business continuity
- COVID-19 Personal Protection
- ambulance service response times
- workforce sustainability
- financial budget overspends due to under delivery of the Quality, Innovation, Productivity and Prevention (QIPP) savings targets, overspends against activity related contracts and national increases in drug tariffs
- financial stability within the CCG and the STP
- access to services waiting times, including waits in A&E and from referral to treatment
- increased demand on urgent care reducing performance and causing delays in health and social care services (ambulance, A&E, GP primary care, 111, Out of Hours)
- NHS Somerset CCG's arrangements for looked after care leavers, nurse led Initial Health Assessment service
- provision of patient transport
- delivery of the STP Health and Care Services Review 'Fit for My Future'.

There is also more detailed analysis of the key risks set out in the Governance Statement later in this report.

4. FINANCIAL AND PERFORMANCE ANALYSIS

4.1 Finances

NHS England has directed, under the National Health Service Act 2006 (as amended), that CCGs prepare financial statements in accordance with the 'Group Accounting Manual 2019/20 issued by the Department of Health. The financial information included in this section of the Annual Report is taken from the 2019/20 financial statements.

Operating and Financial Performance

4.2 Financial Duties

During 2019/20, our performance against our financial duties is demonstrated in the table below:

2019/20 Target Performance	Achieved
Expenditure not to exceed income	X
Capital resource use does not exceed the amount specified in Directions	✓
Revenue resource use does not exceed the amount specified in Directions	X
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	✓
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	X
Revenue administration resource use does not exceed the amount specified in Directions	✓

Specific details of each of these duties are provided below.

4.3 Overview

For the financial year 2019/20 (1 April 2019 to 31 March 2020), NHS Somerset Clinical Commissioning Group had a planned in year deficit position of £4.5m and was eligible to receive Commissioner Sustainability Funding (CSF) of £4.5m to enable delivery of a break even position for the financial year. The Clinical Commissioning Group did not deliver to plan for the financial year with a deterioration of £13.1m from the planned position. This resulted in the loss of the final two quarters of CSF for 2019/20, equating to £2.925m. This results in a total deficit of £16.025m for the 2019/20 financial year. The required protocol for a deterioration from financial plans was adhered to and this position was discussed and approved with NHSE/I prior to the financial year end.

As a result of the Clinical Commissioning Group's breach of its duty to breakeven against revenue resource limit for the year ending 31 March 2020 a referral will be made under section 30 of the Local Audit and Accountability Act 2014, by the CCG's appointed auditors, to the Secretary of State and NHS England, to notify them of this breach.

4.4 Analysis of Revenue Performance

	2019/20 £'000
In Year Revenue resource limit	877,026
Overspend variance against revenue resource limit	(16,025)
Percentage variance against revenue resource limit	(1.83)%

The CCG's Finance and Performance Committee and Governing Body receive regular reports on the financial performance of the CCG which gives considerable assurance and documentary evidence of financial performance. Other documentation provided includes risk register reviews, draft Financial Plans, final Financial Plans, monthly Quality, Innovation, Productivity and Prevention (QIPP) savings reports and ad-hoc reports and information as required. We also submit monthly and quarterly information to NHS England as part of the CCG assurance process.

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

The CCG has an established Audit Committee whose role is centred on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee is appointed by the Governing Body and comprises of three Lay Members. The Audit Committee is chaired by Lou Evans, a Non-Executive Director who is also the Vice Chairman of the Governing Body, and held four meetings during the year and considered:

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

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

A full set of the NHS Somerset CCG's Annual Accounts for 2019/20 are included at Section 10 of this report and describe how we have used our resources to deliver health services to residents of Somerset during 2019/20. An explanation of the key financial terms can be found as an Appendix at the end of the Annual Accounts.

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

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

E-mail: alison.henly@nhs.net
Alternatively, the full document can be viewed on the CCG's website at:
www.somersetccg.nhs.uk/

4.5 Going Concern

Introduction

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

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

The Department of Health Group Accounting Manual for 2019/20 has the following recommendation as the standard accounting policy:

The CCG's accounts have been prepared on a going concern basis. The Government Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 of International Accounting Standard (IAS) 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context:

- for non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. Department of Health and Social Care (DHSC) group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up

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

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

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

- should a DHSC group body have concerns about its "going concern" status (and this will only be the case if there is a prospect of services ceasing altogether) it must raise the issue with its sponsor division or relevant national body as soon as possible.

4.6 **Criteria**

IAS 1 requires management to make an assessment of the entity's ability to continue as a going concern when preparing the financial statements. The standard stipulates that in assessing if the going concern assumption is appropriate the management should take into account all available information about the future.

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

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

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

The Financial Reporting Council, in their publication 'Going Concern and Liquidity Risk: Guidance for Directors of UK Companies 2009,' has set out a number of areas Boards, or in CCGs, Governing Bodies, may wish to consider. Those relevant to CCGs in the NHS are as follows:

- forecast and budgets
- timing of cash flows
- contingent liabilities
- products, services and markets
- financial and operational risk management
- financial adaptability
- documentation

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

Financial Assumptions for 2019/20

4.7 **Outturn**

For the financial year 2019/20 (1 April 2019 to 31 March 2020), NHS Somerset CCG had a planned in year deficit position of £4.5m and was eligible to receive Commissioner Sustainability Funding (CSF) of £4.5m to enable delivery of a break even position for the financial year. The Clinical Commissioning Group did not deliver to plan for the financial year with a deterioration of £13.1m from the planned position. This resulted in the loss of the final two quarters of CSF for 2019/20, equating to £2.925m. This results in a total deficit of £16.025m for 2019/20. The required protocol for a deterioration from financial plans was adhered to and this position was discussed and approved with NHSE/I prior to the financial year end.

As a result of the Clinical Commissioning Group's breach of its duty to breakeven against revenue resource limit for the year ending 31 March 2020 a referral will be made under section 30 of the Local Audit and Accountability Act 2014, by the CCG's appointed auditors, to the Secretary of State and NHS England, to notify them of this breach.

Within the reported year-end financial position, where there is no agreed year-end position with providers, the CCG has used provider forecast positions in line with their accruals statements and best estimates where this is not available.

4.8 **Cash Flow**

The cash position is reported on a monthly basis to the Finance and Performance Committee and to the Governing Body at each public meeting. In addition, detailed cash flow monitoring and forecasting is in place with NHS England on a monthly basis. The CCG met its cash requirements for 2019/20 and is planning to do so on an ongoing basis.

4.9 **Contingent Liabilities**

The CCG has contingent liabilities in 2019/20 relating to:

- Continuing Healthcare cases – to reflect a risk associated with the provisions estimate made for pending continuing healthcare eligibility assessments
- pending employment legal claims

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

4.10 **Services**

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

4.11 **Interim Operational Financial Plan 2020/21**

In collaboration with health partners across the Somerset system, NHS Somerset CCG submitted an interim operating plan for 2020/21 to NHS England on 5 March 2020. Due to current circumstances relating to the COVID-19 pandemic, operational planning for 2020/21 has since been suspended until further notice.

The interim CCG plan for 2020/21 does not fully comply with the CCG business rules, specifically it will not deliver a 1% cumulative surplus or deliver the financial improvement trajectory of £2.478 deficit to be achieved for 2020/21. Further feedback and guidance on how to close the gap is expected.

The CCG's financial plan assumes a high level of programme savings opportunities for which detailed delivery plans require further development across the Somerset system. This represents a significant system risk at this stage of the planning cycle.

Given that the CCG faces a cumulative deficit, significant financial risks and a challenging in year QIPP target, the CCG is working in partnership with the Somerset system to deliver a joint Financial Recovery Plan including both commissioner QIPP and provider CIP to ensure that the system is focused on real system cost reductions in 2020/21 to support the position.

The CCG has based its interim plan for 2020/21 on a published notified allocation of £903.976m. This allocation includes the following:

- baseline funding including growth - £809.887m
- recurrent funding adjustments from 2019/20 - £(0.149)m

- funding for primary care medical services - £79.895m
- running cost allocation - £10.456m
- Primary Care Improving Access Funding - £3.302m
- tariff inflation adjustments - £0.585m

Although the interim budgets contain a significant unresolved financial challenge to deliver the control total as set by NHS England, the CCG needs to ensure that through actions agreed with partners across the Somerset system, the CCG will not breach its statutory duties as detailed in sections 223H(1) and 223I(3) of the NHS Act 2006 (as amended) which state the clinical commissioning groups have to:

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

Further updates to this plan will be presented to the Governing Body as the operational plan for 2020/21 is agreed and monthly finance reports will specifically highlight the progress against the challenge to achieve overall expenditure in line with the financial improvement trajectory.

The interim draft financial plan for 2020/21 has been based on a number of planning assumptions, which have in turn been taken from national planning guidance and local decisions.

Within the national shared planning guidance, CCGs are required to support the ambition to achieve genuine parity of esteem between mental and physical health services. This includes an expectation that our spending on Mental Health would increase in real terms by 6.4% in 2020/21. For Somerset this requires additional investment of £5.56m into core Mental Health services. The interim draft plan achieves the Mental Health Investment Standard in 2020/21. Discussions are ongoing across the Somerset system as to how mental health investment funding should be most appropriately deployed.

The CCG interim plan submitted to NHS England on 5 March 2020 included a financial gap of £0.674m against its financial improvement trajectory of £2.478m deficit for 2020/21. The coming year is going to be pivotal in making progress against financial turnaround plans. Getting the right plans, delivering in the right ways and at pace is vital and that is why finance and activity plans need to be considered ‘work in progress’ at this stage. The gaps and variances in the interim draft plan submission need to be seen in this context. However the Somerset system is committed to the continued refinement and improvement of these plans to make sure our final plans are the ones that will finally address the shift we need to see in Somerset health and care services.

4.12 **Planning Assumptions**

The 2020/21 interim draft financial plan is based on the application of national tariff prices for 2020/21.

For Somerset provider partners, growth has been included as an investment rather than activity growth. Similarly, growth on mental health and community contracts has also been included as an investment rather than activity growth, along with additional mental health investment required in order to work towards the Mental Health Investment Standard. For other acute sector service providers, such as Out of County and Independent Sector providers, growth has been included at Indicative Hospital Activity

Model rates (IHAM), as per the Long Term Plan assumptions. This includes A&E growth at 2.4%, Non Elective growth at 2.5%, Elective growth at 2.1% and Outpatient growth at 3.9%. QIPP savings have been anticipated against outpatient growth and non-elective activity growth with some providers to reflect the full year effect of the Out of Hospitals business case initiatives introduced during 2019/20.

4.13 **Quality, Innovation, Productivity and Prevention (QIPP) Schemes**

The Clinical Commissioning Group has developed an efficiency programme which focuses on new schemes for 2020/21. The table below shows the anticipated efficiency savings from these programmes.

2020/21 schemes	**Anticipated Efficiency Saving £'000**
GP Prescribing	750
Continuing Healthcare	925
Out of Hospital Business Case	583
Outpatient Growth	311
Consultant Savings	88
Social Care	231
Ambulance Growth Mitigations	735
Falls Pathway (MSK)	1,000
Rightcare Neurology	1,000
Ambulance contract (Pace of Change)	250
Corporate Services	500
Independent Sector	500
Developments Slippage	2,000
Contingency	2,250
Running Cost inflation	131
Other Savings	71
Unidentified Savings	8,492
Total QIPP	**19,817**

4.14 **Financial Governance Arrangements During the Coronavirus COVID-19 Pandemic**

In March 2020 a global pandemic was declared, caused by a novel coronavirus – COVID-19. The impact on healthcare delivery in direct response to this virus, changes in demand and capacity for other healthcare and the impact on wider society (through social distancing and the so-called 'lockdown') and economy has been dramatic. Two specifics items of relevance are firstly, the UK Government publically stating it will fund the NHS 'whatever it takes' to manage the pandemic; and secondly a significant overhaul of the financial architecture of the NHS, for example suspending the current financial performance management regime, moving all NHS providers onto a cost based 'block' payment regime, authorising pre-payments of one month of operating costs to NHS providers, centralising the procurement of Independent Sector Capacity, providing new funding for Hospital Discharge Programmes and NHS Nightingale 'surge' capacity. Taken together this package and Government statements effectively demonstrate how the Clinical Commissioning Group, as a statutory body in the NHS, will have its finances supported by the Government for the period of the pandemic and in the event of any future radical change to demand and funding for healthcare.

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

In response to this, Somerset Clinical Commissioning Group has undertaken a review of financial governance to ensure that decisions to commit resources in response to COVID-19 are robust. The specific processes now in place include the following:

- delegated authority for decision making is given to the clinical and managerial lead of each COVID-19 task and finish cell where spend is anticipated to be less than £10,000. For spend expected to be in excess of £10,000 agreement must be sought from the CCG Directors Group in advance of being committed. Decisions cannot be made on spend above £10,000 until the relevant financial authorisation has been received. Any expenditure commitment anticipated to be in excess of £1m must be approved by the Governing Body

- decision making is to be recorded by the clinical and managerial lead for each COVID-19 task and finish cell and shared with the CCG Executive lead, with copies to be supplied to the Incident Control Centre. Decision making will be reviewed on a weekly basis by the CCG Directors Group and reported monthly to the relevant sub-committee of the Governing Body

- pathway changes – where pathway change is being proposed that impact on more than one system partner, the task and finish cell should involve partners from all organisations / sectors to ensure the impact on other parts of the system is understood. A Quality Impact Assessment must be completed and adverse impacts must be understood and addressed.

The Clinical Commissioning Group has tested the resilience of its finance functions and business continuity plans to ensure that the most important elements can continue throughout the pandemic, and have considered the resilience of its fraud prevention arrangements in conjunction with the Local Counter Fraud service.

As advised by NHS England and NHS Improvement, the Clinical Commissioning Group has a process in place to carefully record any costs incurred in responding to the COVID-19 outbreak and will be reporting actual costs incurred on a monthly basis. It is important that record keeping meets the requirements of external audit, and public and Parliamentary scrutiny.

On the basis of the above the Clinical Commissioning Group considers it remains a going concern.

4.15 **Recommendation**

Having considered the going concern guidelines, the financial reporting and governance arrangements of the CCG, operating plans for 2020/21 as set out above and the continued focus by the CCG and Somerset system partners to drive improvements to the financial position, it is recommended that management prepare the annual accounts for 2019/20 on a going concern basis.

4.16 **2019/20 Revenue Resource Limit**

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

Revenue expenditure covers general day to day running costs and other areas of ongoing expenditure. The CCG has not met its statutory duty to operate within its revenue resource limit for 2019/20.

The CCG's performance for 2019/20 is as follows:

	2019/20 £'000
Total net operating cost for the financial year	893,051
Final in year revenue resource limit for the year	877,026
Under/(over) spend against revenue resource limit	**(16,025)**

This table highlights that in 2019/20 Somerset Clinical Commissioning Group exceeded its revenue resource limit by £16.025m.

4.17 **Better Payment Practice Code**

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

Our performance for the year ended 31 March 2020 is summarised below:

Measure of compliance	2019/20 Number	2019/20 £000	2018/19 Number	2018/19 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,751	134,507	9,794	129,156
Total Non-NHS Trade Invoices paid within target	9,746	134,020	9,754	128,637
Percentage of Non-NHS Trade invoices paid within target	**99.95%**	**99.64%**	**99.59%**	**99.60%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,584	583,307	3,406	538,557
Total NHS Trade Invoices Paid within target	3,570	583,189	3,401	538,171
Percentage of NHS Trade Invoices paid within target	**99.61%**	**99.98%**	**99.85%**	**99.93%**

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

4.18 **Cash Limit**

The CCG is required not to exceed the cash limit set by NHS England, which sets the amount of cash drawings that the CCG can make in the financial year. The CCG drew cash totalling £892.537m (99.9%) against a cash limit of £893.158m, therefore meeting this requirement.

4.19 **Running Costs**

The CCG was funded a total of £12.367 million in 2019/20 to support headquarters and administration costs. This included additional funding of £0.502m released in year to support an increase in employer's pension contributions. To facilitate the effective running of the organisation the CCG continues to review those functions which it provides in house and those which are provided by South, Central and West Commissioning Support Unit. The value of services commissioned via the South, Central and West Commissioning Support Unit is £3,945,605 which covers Business Intelligence support, Information Technology and Information Governance support, Procurement Services support, Care Navigation Services, GP IT Services and additional consultancy support. Expenditure recorded against running costs for 2019/20 totalled £11.923 million.

4.20 **Accounting Policies**

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

4.21 **Governing Body and Clinical Executive Committee Members**

Full details of the remuneration paid to Governing Body and Clinical Executive Committee members and senior employees, which are included within the above management costs, are provided within the Remuneration and Staff Report beginning at page 124 to this report, together with their pension entitlements and declarations of interest.

4.22 **External Audit**

Grant Thornton UK LLP is the appointed external auditor for the CCG. The total fee paid to Grant Thornton UK LLP in 2019/20 was £63,000 including VAT to cover the cost of the statutory audit and associated services.

4.23 **Governance Statement - Summary**

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

A copy of the full Governance Statement is included at page71 of this Annual Report and is also available on request or can be viewed on the CCG's website at: www.somersetccg.nhs.uk

Performance Summary

NHS England and NHS Improvement jointly assess CCG and Provider performance against the Oversight Framework which was brought into effect in 2019/20. This measures the CCG on how it works with others to improve quality and outcomes for patients across Sustainability and Transformation Partnerships and Integrated Care Systems. This new approach to oversight has been worked upon during 2019/20 ready for a new integrated approach from 2020/21.

Performance against the key NHS Constitution requirements continues to be closely monitored through joint review meetings with Providers to ensure that system working is maximised. Constitutional standards and requirements are routinely discussed and monitored within these meetings to ensure that any issues are being shared, and these are then assessed within recovery plans and trajectories.

During 2019/20 Somerset CCG has broadly met the local improvement plans until March when performance declined due to the onset of COVID-19. This has resulted in an increase in the number of patients waiting longer for their diagnostic test, procedure or elective treatment and will see the continued impact of this during 2020/21.

The number of patients on an Referral to Treatment (RTT) Incomplete Pathway awaiting their first definitive treatment in March 2020 is 11.2% lower than planned due to a sustained reduction in referrals. However performance against the agreed 18 week improvement standard of 83.1% was not met in March 2020 with performance of 79.0% (and average year to date performance of 82.3%). The number of patients waiting in excess of 52 weeks in March 2020 significantly increased to 50 (an increase of 30 on the previous month) and prior to the onset of COVID a high proportion of the patients were choosing to delay their elective procedure.

The percentage of patients receiving their diagnostic test or procedure within 6 weeks in March 2020 was 88.2% against the agreed improvement plan of 95.3% which is decline on upon the previous year due to the initial impact of COVID.

The CCG has achieved two of the nine cancer standards in 2019/20, underachieving in two week suspected cancer, two week breast symptoms, 31 day surgery, 31 day radiotherapy, 62 day first definitive, 62 day screening and 62 day consultant treatment pathways. Performance in March 2020 was 85.7% against the 92% standard and 79.2% of patients received their first definitive cancer treatment within 62 days of GP referral against the 85% standard.

During 2019/20 our local Providers have not consistently met the Accident & Emergency (A&E) constitutional standard whereby 95% of patients should be seen, treated and either admitted or discharged within 4 hours of arrival to hospital and therefore have recovery plans in place to improve performance.

4.24 **Self-Certification by the Accountable Officer**

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

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

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
18 June 2020

ACCOUNTABILITY REPORT

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
18 June 2020

CORPORATE GOVERNANCE REPORT

5. MEMBERS REPORT

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

The key roles undertaken by the Governing Body Non-Executive leadership (as at 31 March 2020) are set out in the table below:

Name	Governing Body Appointment	Governing Body Lead Roles
Lou Evans	Lay Member Non-Executive Director (Governance and Audit)	Deputy Lay Chair Conflict of Interest Guardian Cyber Security Non Executive Lead Audit Committee Chair Remuneration Committee Chair
David Heath	Lay Member Non-Executive Director (Patient and Public Involvement)	Primary Care Commissioning Committee Chair Remuneration Committee Member Audit Committee Member Quality and Safety Committee Member Patient public involvement Non-Executive lead
Grahame Paine	Lay Member Non-Executive Director (Finance and Performance)	Finance and Performance Committee Chair Remuneration Committee Member
Dr Basil Fozard	Secondary Care Specialist Doctor Non-Executive Director	Remuneration Committee Member Quality and Safety Committee Member Primary Care Commissioning Committee
Dr Jayne Chidgey-Clarke	Registered Nurse Non-Executive Director	Quality and Safety Committee Chair Workforce Non Executive Lead Remuneration Committee Member Audit Committee Member
Wendy Grey	Member Practice Representative, Non-Executive Director	Quality and Safety Committee Equality Steering Group Chair
Trudi Mann	Member Practice Representative, Non-Executive Director	Vice Chair Finance and Performance Committee
Dr Jo Nicholl	Member Practice Representative, Non-Executive Director	Safeguarding Clinical Lead Audit Committee Member

The CCG register of interests, which includes details of company directorships and other significant interests held by senior CCG leaders, is available on the CCG website at: http://www.somersetccg.nhs.uk/publications/publication-scheme/lists-and-registers/?Lists%20and%20Registers.

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

5.1 Statement of Disclosure to Auditors

Each individual who is a member of the CCG Members' Report, confirmed at the Governing Body of 18 June 2020, the following:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report

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

5.2 Modern Slavery Act

NHS NHS Somerset CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2019 is published on our website at https://www.somersetccg.nhs.uk/about-us/how-we-do-things/modern-slavery-human-trafficking/

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. When we hear the term modern slavery, most people think this only exists overseas, but the Home Office estimates there are 13,000 victims and survivors of modern slavery in the UK. Modern slavery victims are among the most vulnerable people in our society and can be hesitant to seek help due to fear of their traffickers. Although modern slavery is considered a 'hidden' crime, many victims can be working or otherwise visible in the community, in a range of places such as nail bars, food outlets, car washes, factories, and the fishing industry.

With more than one million people accessing NHS funded services every 36 hours, the 1.5million staff that work in our NHS, not just in hospitals but in places where people live their lives, will come into contact with victims or survivors of modern slavery.

The CCG, along with partner agencies, is working towards a world without slavery by supporting, influencing and raising awareness:

- by supporting survivors and vulnerable people through the specialist services that we commission, we can enable them to recover safely and develop resilient, independent lives

- by influencing the development of the NHS workforce through access to national training, advice and resources we can better identify and support actual and potential victims of slavery

- by raising awareness of modern slavery through the CCG website and the safeguarding newsletter, we can support NHS staff to recognise the signs of modern slavery and understand the role they have to play

Table 1: Breakdown of CCG Senior Leaders and their roles in the CCG governance structure as at 31 March 2020

		Committee Membership (voting and non-voting membership)							
		Governing Body	**Clinical Executive Committee**	**Audit Committee**	**Remuneration Committee**	**Quality and Safety Committee**	**Primary Care Comm'g Committee**	**Finance & Performance Committee**	**Health and Well Being Board**
CCG Executive Leadership									
Chief Executive	James Rimmer	✓	✓		✓				✓
Director of Finance, Performance and Contracting	Alison Henly	✓	✓	✓		✓	✓	✓	
Director of Quality and Nursing	Sandra Corry	✓	✓			✓		✓	
Programme Director, Fit For My Future	Maria Heard	✓	✓						
GP Clinical Leadership									
Associate Clinical Director, Mental Health and Learning Disabilities	Dr Peter Bagshaw		✓						
Associate Director, Planned Care	Dr Will Chandler		✓						
Consultant in Public Health, SCC	Dr Orla Dunn		✓						
CEC Vice Chair	Dr Steve Edgar		✓						
CCG Chair	Dr Ed Ford	✓	✓					✓	✓
Associate Clinical Director: Digital Strategy	Dr Justin Harrington		✓						
Associate Clinical Director, Primary Care	Dr Emma Keane		✓				✓		
Clinical Director, Fit For My Future Clinical Director, STP	Dr Alex Murray		✓						✓
Associate Director, Women's and Children's Health	Dr Kate Staveley		✓			✓	✓		
Associate Clinical Director: Same Day and Emergency Care	Dr Helen Thomas		✓						
Associate Clinical Director, Patient Safety	Dr Andrew Tressider		✓						
Clinical Lead, Diabetes	Dr Henk Bruggers		Devt Session						
Clinical Lead, Children and Young People	Dr Theresa Foxton		Devt Session						
Clinical Lead, Safeguarding	Dr Jo Nicholl		Devt Session						
Clinical Lead, Contracts	Dr Geoff Sharp		Devt Session						
Clinical Lead, End of Life	Dr Sally Silsby		Devt Session						

		Committee Membership (voting and non-voting membership)							
		Governing Body	**Clinical Executive Committee**	**Audit Committee**	**Remuneration Committee**	**Quality and Safety Committee**	**Primary Care Comm'g Committee**	**Finance & Performance Committee**	**Health and Well Being Board**
Clinical Lead, Respiratory	Dr Steve Holmes		Devt Session						
Clinical Lead, Primary Care	Dr Jill Wilson		Devt Session						
Clinical Lead, Ad Hoc Integrated Care Projects	Dr Ian Wyer		Devt Session						
Non-Executive Leadership									
Vice Chair and Non-Executive Director, Lay Member, Governance and Audit	Lou Evans	✓		✓	✓		✓	✓	
Non-Executive Director Lay Member, Patient and Public Involvement and Chair of the Joint Committee (Primary Care)	David Heath	✓			✓	✓	✓		
Non-Executive Director, Secondary Care Specialist Doctor	Dr Basil Fozard	✓			✓	✓	✓		
Non-Executive Director, Registered Nurse	Dr Jayne Chidgey-Clarke	✓		✓	✓	✓			
Director of Public Health, Somerset County Council	Dr Trudi Grant	✓							✓
Non-Executive Director, Member Practice Representative	Wendy Grey	✓				✓			
Non-Executive Director, Member Practice Representative	Trudi Mann	✓						✓	
Non-Executive Director, Member Practice Representative	Dr Jo Nicholl	✓		✓					
Non-Executive Director, Finance and Performance	Grahame Paine	✓			✓			✓	

6. STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

The Health and Social Care Act 2012 states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). I have been appointed by NHS England as the Chief Executive, to be the Accountable Officer of NHS Somerset Clinical Commissioning Group.

The responsibilities of an Accountable Officer are set out under the Health and Social Care Act 2012, Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- the relevant responsibilities of accounting officers under Managing Public Money
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the Health and Social Care Act 2012 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the Health and Social Care Act
- ensuring that the CCG complies with its financial duties under Sections 223G to 223K of the Health and Social Care Act 2012

Under the Health and Social Care Act 2012 NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been

followed, and disclose and explain any material departures in the financial statements
- prepare the financial statements on a going concern basis

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the Health and Social Care Act 2012, Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
18 June 2020

7. GOVERNANCE STATEMENT

7.1 Introduction and Context

NHS Somerset Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the Health and Social Care Act 2012.
The CCG's statutory functions are set out under the Health and Social Care Act 2012. The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2019, the CCG is subject to directions from NHS England issued under Section 14Z21 of the Health and Social Care Act 2012as follows:

In July 2017 the CCG was given a performance rating by NHS England as 'inadequate' and was placed in a reframed CCG special measures regime. Further to this the outcome of the NHS England annual CCG assessment in July 2019 identified three key areas requiring further evidence of delivery:

- Financial: To develop a credible plan for 2019/20, incorporating activity, finance and performance balanced with quality
- Leadership: Implement joint strategic commissioning leadership arrangements for NHS Somerset CCG and Somerset County Council
- Performance: Demonstrate improved performance again constitutional standards, particularly cancer, diagnostics and 52 week waits.

Following further evidence provided by the CCG to NHS England we received a letter in November 2019 from Mark Cooke acknowledging the hard work and effort of the CCG but indicating that further areas should be addressed as follows:

- Financial Improvement – Full delivery of the CCGs financial plan for 2019/20
- Performance against key standards – delivery of performance trajectories in accordance with the CCG operational plan 2019/20. Including RTT, 52ww and Cancer (2ww and 62 day)
- Equity – address the inequity of access across providers

The CCG is now awaiting a year-end review with NHSE/I to review our Special Measures status against the progress made and against the operating model for 2020/21. The national level 4 incident around COVID-19 has meant there is no date currently planned for this review.

7.2 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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.

7.3 Governance arrangements and effectiveness

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

NHS Somerset CCG is a membership body comprising of 65 practices. Each practice has a delegate who represents that practice and practices are able to align themselves to a Commissioning Locality. A full list of Member Practices is attached as Annex 1 to the Governance Statement. Each Commissioning Locality works with the CCG and a range of GP clinical leads are engaged to work on specific workstreams.

The CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: GPs, a secondary care specialist doctor, a registered nurse, a Director of Public Health, three independent lay members, the Accountable Officer and Chief Finance Officer. Three new Member Practice representatives were appointed to Governing Body in 2019. Details of the membership and the attendance of those members are set out in Annex 2 to the Governance Statement.

Organisational structure and accountabilities are clear and well defined. Where capacity and/or capability gaps have been identified, actions are put in place with expected outcomes and timescales. NHS Somerset CCG clearly articulates its values to stakeholders through its Commissioning Plan and associated strategies. The Organisational Development plan includes undertaking a Staff Survey, 360 degree stakeholder survey and developing actions to address issues for development.

The following committees have been established by the Governing Body:

- Clinical Executive Committee (CEC)
- Audit Committee
- Remuneration Committee
- Primary Care Commissioning Committee
- Quality and Safety Committee
- Finance and Performance Committee

The remit of each committee is as follows:

Committee	Key roles and responsibilities
Clinical Executive Committee	GP Clinical Lead: Dr Alex Murray (was Dr Steve Edgar) Executive Lead: James Rimmer Non-Executive Lead: n/a The Clinical Executive Committee is the primary executive decision making body of the CCG, authorised to make decisions within the powers delegated to it by the CCG Governing Body and is accountable to the CCG Governing Body. Its main functions are: • responsible for developing the CCG strategy, clinical and other policies, and operational plans for consideration and approval by the Governing Body • within the strategic and operational planning framework agreed by the Governing Body, the Clinical Executive Committee is the primary decision making body responsible for delivery of these plans. It is held to account for progress against these plans • to oversee and performance manage clinical commissioning teams and to receive updates on key areas of responsibility • to oversee and performance manage all operational, financial, clinical and risk management issues • to oversee and performance manage the quality of commissioned services, quality being defined as clinically effective, personal and safe care • to ensure that the patient's view has been effectively considered in commissioning decisions made by the group • to receive reports on statutory corporate responsibilities including Information Governance, Emergency Preparedness, Health and Safety and workforce and inform the Governing Body on recommendations or areas of concern
Audit Committee	GP Clinical Lead: Dr Jo Nicholl Executive Lead: Alison Henly Non-Executive Lead: Lou Evans The Audit Committee provides assurance to the Governing Body by reviewing the CCG's systems of financial reporting and internal control and ensuring that an effective programme of audit and counter fraud is in place. In particular: • the committee shall critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with internal and external auditors, and counter fraud is maintained • the Committee shall review the work and findings of the external auditor and consider the implications and management's responses to their work • the Committee shall ensure that there is an effective internal

Committee	Key roles and responsibilities
	audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Governing Body • the Committee shall ensure that there is specialist counter-fraud information, guidance and service provision within the CCG and that policies and procedures for all work related to fraud and corruption are in place, as required by the Secretary of State's Directions and by the Counter Fraud and Security Management Service • the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities (both clinical and non-clinical), that supports the achievement of the CCG's objectives • the Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation • the Committee shall request and review reports and positive assurances from officers and managers on the overall arrangements for governance, risk management and internal control and ensure robust action plans are in place, and delivered, to address any areas of weakness • the Audit Committee shall review the Annual Report and Financial Statements before submission to the Governing Body • the Committee should also ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board • where the Committee considers that there is evidence of ultra vires or improper actions, it shall report them to the Governing Body through its Chair
Remuneration Committee	Non-Executive Lead: Jayne Chidgey-Clarke [Executive and Clinical Leads only attend upon invitation] The Committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG (Accountable Officer, other officer members and senior employees) and people who provide services to the CCG (including salary, any performance-related elements/bonuses, other benefits including pensions and cars, and contractual terms and termination of employment). The Remuneration Committee shall make recommendations to the Governing Body on any proposed remuneration for individual COG Members for specific work in addition to their COG role. The Remuneration Committee is authorised by the Governing Body to obtain legal, remuneration or other professional advice as and

Committee	Key roles and responsibilities
	when required, at the CCG's expense, and to appoint and secure the attendance of external consultants and advisors if it considers this beneficial. The Remuneration Committee is authorised to decide on the most appropriate action needed by the Governing Body in the achievement of its Terms of Reference.
Primary Care Commissioning Committee	GP Clinical Lead: Dr Emma Keane Executive Lead: Alison Henly Non-Executive Lead: David Heath The Primary Care Commissioning Committee has delegated powers of responsibility from the Governing Body to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract); • Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services"); • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF); • Decision making on whether to establish new GP practices in an area; • Approving practice mergers; and • Making decisions on 'discretionary' payment (e.g. returner/retainer schemes). The committee also carries out the following activities: • Plan, commission and deliver primary medical services for the population of Somerset • Make primary care commissioning decisions; contribute to the development of the primary care strategy, ensuring recommendations are in line with the CCG Governing Body's Health and Care Strategy, • Oversee the implementation and delivery of the primary care strategy and work plan • To secure the provision of comprehensive and high quality primary medical service in Somerset • To co-ordinate a common approach to the commissioning of primary care services generally • To make decisions on investment on the infrastructure of primary medical services, to ensure adequate and high quality provision as well as value for money for the public. • Undertake reviews of primary medical services in Somerset • To manage the commissioning budget for primary medical services in Somerset • Provide oversight across a number of functions, including but not

Committee	Key roles and responsibilities
	limited to: Primary Care Workforce; Primary Care Premises; Primary Care Information Management and Technology (IM&T); Primary Care Networks
Finance and Performance Committee	GP Clinical Lead: Dr Ed Ford Executive Lead: Alison Henly Non-Executive Lead: Grahame Paine The purpose of this Committee is to provide assurance to the Clinical Commissioning Group Governing Body on the Clinical Commissioning Group's finance and performance. The Committee will look at the overall Somerset system position in terms of finance and performance. As an assurance Committee of the Governing Body, it will hold to account the CCG Executive team for delivery of the financial and performance plan, and recommend further areas for turnaround and performance improvement. This will be done through: • reviewing the financial and service performance of the Clinical Commissioning Group against statutory financial targets, financial control targets and the annual commissioning plan • reviewing the Clinical Commissioning Group's financial, performance and improving value schemes (QIPP) agenda and provide assurance to the Board in the delivery against annual plans • reviewing performance improvement plans, identifying areas for further improvement or commissioner actions and monitors trajectories towards improvement • monitoring the overall process of financial planning across the system and reviewing through the 5 year financial plan • where finance and performance issues are raised then these will be highlighted to the Clinical Executive Committee, A&E Delivery Board and Elective Care Delivery Board to agree actions and mitigations (via the Clinical Commissioning Group's Chief Officer) to rectify the issue • ensure that the Committee agenda and papers take into account the risks on the Board Assurance Framework (BAF) and risk registers. The Committee will wish to be assured that matters of risk are being effectively managed.
Patient Safety and Quality Assurance Committee	GP Clinical Lead: Dr Kate Staveley Executive Lead: Sandra Corry Non-Executive Lead: Jayne Chidgey-Clark The purpose of the Committee is to: • promote a culture within Somerset Clinical Commissioning Group that focuses on Patient Safety and Quality Improvement • provide assurance on all NHS Provider services governance arrangements and patient safety performance, through receiving

Committee	Key roles and responsibilities
	exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services. The Committee will report areas of concerns and quality improvement to the Somerset Clinical Commissioning Group Governing Body • monitor serious incidents, incidents and action plans linked to key areas of responsibility where Somerset Clinical Commissioning Group: ➢ are Lead Commissioners ➢ have statutory responsibility ➢ or where responsibility falls directly to Somerset Clinical Commissioning Group for improving the quality of services • to ensure that key themes and lessons learned from serious incidents, safeguarding, domestic homicide reviews and significant event audits are identified and shared across all NHS providers for continuous quality improvement of service provision and to prevent re-occurrence • to monitor mortality data and review findings, including Learning Disability Mortality Reviews (LeDeR) and the implementation of improvement actions • monitor progress in promoting harm free care across all NHS providers to include a focus on organisational actions to reduce pressure ulcer incidence, falls, health care acquired infection and medication incidents • receive assurance from the Clinical Executive Committee that service strategy and redesign have prioritised quality and safety alongside service delivery efficiency • review service and pathway redesign proposals and make recommendations about patient safety concerns and outcome of quality impact assessments to the Clinical Executive Committee • receive focussed subject matter reports from the Clinical Executive Committee as required, with evidence that quality and patient safety issues and safeguarding alerts in respect of health services are fully considered, risks identified and reduced or mitigated • have oversight of the CCGs providers integrated quality dashboard and request attendance of providers, as required • provide a forum for representatives from the CCG's directorates to work collaboratively with members of the Committee to provide assurance around patient safety/quality improvement aspects of the Health and Care Strategy • receive reports on the CCGs duty to promote quality improvement in primary care. Assurance for quality and safety in primary care is currently discharged through the Joint Committee for Primary Care • receive reports on patient experience of NHS services from patient surveys, real time feedback, Friends and Family test and complaints and PALS enquiries and Health Watch to identify lessons learned and inform commissioning • ensure engagement with GP Localities and practices, and

Committee	Key roles and responsibilities
	establish feedback mechanisms so that lessons learnt from complaints and incidents are shared in order to improve and inform services • to receive reports on the quality and safety of services jointly commissioned with Somerset County Council

The CCG's performance of effectiveness and capability is subject to continuous assessment including regular checkpoint assessments with NHS England/NHS Improvement.

The CCG has participated in the NHS England CCG 360 degree Stakeholder Survey which was discontinued in 2019 but the CCG has committed to continue running a local survey and will use this feedback to inform its development plans. The results from the last 360 stakeholder survey held in early 2019 indicated that the CCG had made a number of significant improvements compared to the 2018 survey. There were also a number of areas that required improvement, including:

- the CCG effectiveness as a local system leader i.e. as part of an ICS/STP
- the CCG asks the right questions when commissioning/decommissioning services
- delivering value for money
- reducing health inequalities
- the CCG engaging and considering views of the patients and the public

The results were reported to the Governing Body in July 2019, and an action plan developed and implemented to address areas requiring improvement.

The CCG met the requirements of Community and Patient Involvement Indicator in 2019, having scored an overall green rating, this forms part of the Improvement and Assessment framework (IAF) and we are awaiting review of our submission for 2020.

During 2019/20 the CCG has been formally consulting on mental health service developments and engaging on proposals for changes to community services as part of Fit for My Future, our health and care strategy. This has fulfilled our statutory duties to secure public involvement in the planning, development and consideration of proposals for changes in commissioning.

The Internal Audit work programme has been reviewed via the Audit Committee and this work supports our review of internal control processes such as the Assurance Framework, risk management procedures, conflicts of interest and hospitality reporting procedures, data security and business continuity. The audit programme, together with the subsequent work to improve systems where appropriate and scrutiny by our committees, supports my assurance that we have a sound system of governance and internal control in place.

7.4 UK Corporate Governance Code

NHS Somerset CCG is not required to comply with the UK Code of Corporate Governance. However, the CCG has reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG. For the financial year ended 31 March 2020, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

7.5 Business Continuity for Governance during COVID-19

Summary

Arrangements have been put in place to ensure continued governance during the period of COVID-19. The letter received from NHS England and NHS Improvement 'Reducing the burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic have been adhered to in these arrangements.

The Chair of the CCG continues to hold monthly meetings with the Executives and Non-Executives of the Governing Body. These are and will be conducted by virtually using MS Teams and will be arranged by the Secretariat Support to the meeting. These meetings continue to be minuted.

The Chair of the Committee and the Executive Director (where possible 2x2 executive/NED pairings) will continue to meet regularly virtually. For most committees and meetings this will be on a monthly basis but will be at the discretion of the Committee Chair and lead Executive.

Arrangements

The purpose of these regular meetings of the Governing Body and Committees is to:

- report what key decisions have been taken over the past month / period
- identify any actions and risks that need immediate attention or escalation
- Horizon scan for any significant external requirements that have not been suspended and develop a plan to complete. Consider reducing the work input and output to bare minimum
- identify which items can be carried forward / tolerated and review the suspended/delayed items
- all decisions made in this way should be recorded by the relevant secretary to the committee
- brief notes should be recorded as these will be needed to be recorded in the minutes of the meeting when it resumes in full again

Risk Management

Any risks that cannot be managed through normal channels should be escalated as appropriate. This is particularly important if any risks present

immediate safety concerns or will significantly impact on the provision of services.

If any issue raised can be tolerated then this should be recorded on the risk register including the existing controls and should be for review at a later date.

Policy Decisions

During this period where formally meetings are suspended, it is likely that changes will be needed to respond to the pandemic due to:

- urgent changes in national guidance
- urgent changes in local guidance
- response to a serious incident or significant safety concerns

Any urgent changes will be reported to the Committee Chair on a monthly basis (or more frequently if that is agreed).

Supportive ongoing conversations between Chairs, Non-Executive Directors and Executive Directors will be encouraged to deliver a cohesive response to the pandemic.

Any issues or concerns not dealt with through these channels should be raised with the Chief Executive or Chair.

Escalation

All immediate and safety concerns identified by a Committee Chair or its membership should be escalated to the Chief Executive and the Director of Quality and Nursing.

Actions and Delayed/suspended items

The secretariat support for the committee will record a list of items, actions and issues and those that are being carried forward to ensure no items are lost.

This should be considered regularly by the Committee Chair to identify any issues that may require urgent review.

To include (for example):

- items/papers/Policies carried forward
- risks that have been escalated or managed and tolerated in the short term
- non urgent actions

7.6 **Discharge of Statutory Functions**

In light of recommendations of the 1983 Harris Review, Somerset Clinical Commissioning Group 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.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk Management Arrangements and Effectiveness

7.7 **The Clinical Commissioning Group Risk Management Strategy**

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

In 2019/20 we revised our risk management strategy and implemented the subsequent risk management improvements including a revision of the CCG Risk Management Strategy policy.

The NHS Somerset CCG Risk Management Strategy policy sets out both the arrangements for risks management across the CCG and the Governing Body Assurance Framework (GBAF). This policy supports the adoption of a positive risk management culture where individuals are encouraged to manage risk to ensure the CCG and the services it commissions are protected against risk (possible events that may have an adverse impact on the organisation's objectives). The policy also defines:

- responsibilities for forums within the CCG governance structure and roles within the CCG
- definitions and terminology
- the risk management process
- monitoring
- compliance

Towards the end of 2019/20 NHS Somerset CCG Governing Body commenced a Health and Care Strategy review as part of the ICS development and risk management strategy improvement. As a result, the CCG committed to submitting revised strategic aims and objectives to the Governing Body for approval by end of quarter one 2020/21.

During 2019/20 there has been a substantial change in the manner in which the CCG operates its business planning and governance as part of the Somerset System Transformation Plan (STP) and the transition to an Integrated Care System (ICS). This has necessarily impacted on governance arrangements, assurance flows and the organisational structure within the CCG. This work will carry forward into 2020/21 as the ICS system matures and a Somerset health and care system wide approach to risk management is agreed and implemented.

7.8 **Capacity to Handle Risk**

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

The CCG is committed to maintaining high risk capability (the knowledge and leadership competencies of individuals or a collective group in maximise their ability to comply with and deliver the CCG Risk Management Strategy policy). To support the successful achievement of high risk capability, any person who has contractual employment within the CCG undertakes risk management training in addition to an overview of the CCG risk management within the CCG induction training programme. The CCG's Corporate Business team provide overall risk management support within the CCG and in 2019, CCG Risk Champions were introduced to upskill teams so that their ability to manage risk and add value to their team within the function of risk management could be maximised.

CCG risk capacity is calculated through the resources (financial, human, equipment and estate) required (the risk exposure the CCG "must" take in order to reach an aim/objective) and resources available to manage materialised and non-materialised risk. Through adherence to the CCG Risk Management Strategy policy and using the risk monitoring activities through the assurance flow within the CCG governance structure, CCG risk capacity is reported, managed and monitored by the CCG statutory and non-statutory forums. The CCG's Governing Body set the tolerance for risk capacity against CCG strategic aims in alignment for its ability to handle risk.

The Audit Committee undertakes an annual assessment of the risk management process, risk capacity and risk capability within the CCG against the Healthcare Financial Management Association's Audit Committee Handbook and the CCG Risk management Strategy policy to identify areas on non-compliance and improvement.

7.9 **Risk Appetite**

The CCG has established risk appetite within its risk management strategy to support the CCG to achieve its strategic aims and increase its rewards through optimising risk taking. The CCG's approach to risk appetite is defined within the CCG Risk Management Strategy policy.

The CCG outlines its risk appetite through a risk appetite matrix which provides an objective tool used within the risk assessment process (to identify whether the risk is acceptable to the organisation), an escalation trigger and a GBAF reporting function which demonstrates the number of risks within each risk domain that the CCG is exposed to within a category of appetite.

The CCG Governing Body is responsible for:

- the definition of risk appetite
- the risk appetite review

- ensuring that the risk management process operates successfully to deliver and the risk appetite
- setting the tolerance for risk appetite against CCG strategic aims

The CCG will use risk appetite to continually improve risk management to:

- assess its effectiveness for risk owners and decision makers in clearly and effectively defining the degree in which they can operate in to deliver CCG strategic and corporate aims/objectives
- provide assurance that the aggregate and/or interlinked risk position is deliverable within risk appetite
- identify changes to conditions which may affect the risk appetite
- assess its effectiveness in enabling value added outcomes in proactive risk management
- opportunity from evidence that the CCG has implemented risk appetite effectively

7.10 **Risk Assessment**

The CCG has statutory obligations to ensure that risks arising from its undertaking are assessed through a standard risk assessment process as detailed within the CCG Risk Management Strategy.

The CCG perform assessment of risk to evidence the controls attributed to the risk, the control ownership and the measure of the control performance. The risk assessment also evidences in the rationale for the uncontrolled, target or current risk rating scores in addition to the risk proximity, risk appetite, treatment option and rationale to substantiate acceptable/non acceptable decisions. As part of the risk assessment process, risk plans are created to address any gaps in controls or assurance in addition to any tasks required to continue to deliver the controls and/or assurance to an effective level. The CCG has also encompassed an approval of the risk assessment by the Risk Owner as part of this process.

7.11 **Other sources of assurance**

Internal Control Framework

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

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

To strengthen internal control and to ensure the effectiveness of risk management, the CCG have encompassed the 'Three Lines of Defence' model within their risk management strategy being:

- First Line Defence: The CCG implemented a Risk Management Group, being the CCG Chief Executive and CCG Directors internal risk scrutiny forum.
- Second Line Defence: CCG statutory and non- statutory committees that specialise in risk management for clinical and/non-clinical functions in the overseeing and monitoring of risk and/or compliance.
- Third line of defence: The CCG Audit committee, internal and external audit providers, and external assurance providers.

The CCG Governing Body assesses the organisational compliance and delivery of the strategic objectives against the GBAF. Attendance at the Governing Body is recorded in the minutes and full membership of the Governing Body has been present at the majority of the Governing Body meetings and seminars during 2019/20.

All reports presented to the Governing Body include identified risks. All strategic documents are reviewed by the Clinical Executive Committee and clinical risks to delivery considered. The effectiveness of the Committee Structure is continually reviewed internally via the Governing Body review programme and against best practice where available. During 2019/20 the CCG committee structure was reviewed and the membership and terms of reference updated to ensure it was relevant and providing a sound system of internal governance for the organisation.

During 2019/20, the CCG Governing Body has continued to oversee and monitor the implementation of the Health and Care Strategy work programme, Fit for My Future. The CCG Governing Body reviews the organisational compliance and delivery of the strategic objectives against the Assurance Framework and Corporate Risk register on a quarterly basis.

Attendance at the Governing Body is recorded in the minutes and full membership of the Governing Body has been present at the majority of the Governing Body meetings and seminars during 2019/20.

Regular reports are presented to the Governing Body to provide assurance on all CCG business and include:

- strategic planning
- financial management
- patient safety and quality of clinical care
- Care Quality Commission inspection reports
- organisational development
- performance management and the achievement of national and local NHS targets
- patient engagement
- stakeholder engagement
- emergency planning
- compliance with the NHS constitution
- identified risks and actions to address or mitigate the risks
- development of clinical commissioning

The Governing Body's performance, effectiveness and capability is subject to continuous assessment, including quarterly assurance meetings with NHS England.

Annual Audit of Conflicts of Interest Management

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

An annual audit was carried out by the CCG's Internal Auditors which provided a moderate level of assurance of both the design and operational effectiveness of the CCG's systems for managing conflicts of interest.

Overall, the report raised 2 recommendations designed to strengthen the updating of the CCG's registers and ensuring that conflicts of interest features as a standing item in contract meetings and minutes. The overall audit opinion was that the CCG has good controls in place to manage conflicts of interest with no significant areas of concern, and there were not any major instances of non-compliance with the current controls, leading to a final assessment of moderate assurance over the control design, and moderate assurance over the control effectiveness.

Data Security

Following legislative changes in May 2018 and the introduction of the General Data Protection Regulation and UK Data Protection Act 2018, any information breaches are assessed and where appropriate, reported through the Data Security and Protection (DSP) Toolkit, as set out in the NHS Digital guidance document – 'Guide to the Notification of Data Security and Protection Incidents'. The Security of Network and Information Systems (NIS) Directive also requires reporting of relevant incidents to the Department of Health and Social Care. As there is no link between the DSP toolkit and the Strategic Executive Information System (STEIS), DSP Toolkit reportable incidents also need to be reported on STEIS. NHS Somerset CCG had no incidents which met the DSP Toolkit reporting threshold during 2019/20.

Data Quality

The CCG recognises the fundamental importance of reliable information and meets its responsibility in ensuring good quality data is collated and appropriately used. All decisions, whether clinical, managerial or financial need to be based on information which is of the highest quality; during financial year 2019/20 we have continued to focus upon data quality in conjunction with our principal business analytics partner, South Central and West CSU. The data used by the Governing Body and delegated Committees/Groups is obtained through various sources the majority of which are national systems and official NHS data sets. The provider data is quality assured through contract and performance monitoring and against the Secondary Uses Service (SUS).

There is collaborative agreement across the Somerset System that the data collected is appropriately sought and recorded, complete, accurate, timely and accessible and that there are appropriate mechanisms in place to support service delivery and continuity. Any identified data quality issues are addressed and resolved through the operational or contractual routes to ensure that the accuracy of the Performance Reports provided to the CCG Governing Body and its Delegated Committees, the System Performance Group and the System Assurance Board.

In addition, within the CCG our Continuing Healthcare (CHC) team has developed local operating processes and continues to focus on data quality to provide a strong foundation for effective delivery of the CHC service.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection (DSP) toolkit and the annual submission process provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

All organisations that have access to NHS patient information are required to provide assurances that they are practising good information governance and use the DSP Toolkit to evidence this through publication of annual assessments. The DSP Toolkit is part of a framework for assuring that organisations are implementing the ten National Data Guardian data security standards as well as their statutory obligations on data protection and data security. The annual assessment and submission process completed by commissioned organisations provides assurance to the Clinical Commissioning Group as the commissioner of health services for the population of Somerset that commissioned services meet the required standards for information governance.

We place high importance on ensuring 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 have developed information governance processes and procedures in line with the DSP Toolkit and good information governance practise. All staff are required to undertake annual information governance training and we have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

95% of all staff had completed their information governance training by 31 March 2020.

NHS Somerset CCG has submitted a Data Security and Protection (DSP) Toolkit for 2019/20 with a rating designation of ‘exceeds expectations’.

There are processes in place for incident reporting and investigation of serious incidents. We have been developing information risk assessment and management procedures and a programme is being rolled out to fully embed an information risk culture throughout the organisation against identified risks.

Business Critical Models

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

Third Party Assurances

NHS Somerset CCG contracts with a range of third party providers in order to deliver both healthcare services to the population of Somerset and to support the corporate functions of the CCG, for example through the commissioning support service (CSU) and external payroll services.

7.13 **Review of economy, efficiency and effectiveness of the use of resources**

The Clinical Commissioning Group has a scheme of delegation which ensures that financial controls are in place across the organisation.

The Audit Committee is responsible for seeking assurance and overseeing Internal and External Audit and Counter Fraud services, reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements. The Committee reviews the system of governance, risk management and internal control, across the whole of the organisation's activities.

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

The Audit Committee supports the view that fraud against the NHS will not be tolerated. All genuine suspicions of fraud are investigated and if proven the strongest sanctions are sought against the perpetrators.

As well as overseeing the anti-fraud, bribery and corruption arrangements in place within its providers, the CCG also needs to ensure its own counter fraud measures remain robust. NHS Somerset CCG has well established counter fraud arrangements in order to help the organisation achieve the standards set out by the NHS Counter Fraud Authority. The CCG engages an Accredited Counter Fraud Specialist to implement an ongoing programme of anti-fraud, bribery and corruption work across the whole organisation. During 2019/20 work has involved the delivery of an annual work plan which follows the NHS Counter Fraud Authority standards to ensure the organisation's resources are protected from fraud, bribery and corruption, as well as addressing all four key areas of the national counter fraud strategy, namely strategic governance, inform and involve prevent and deter and hold to account.

Somerset has historically taken a very robust approach to counter fraud work, the Local Counter Fraud Specialist (LCFS) is well resourced in terms of work plan days and the Audit Committee and senior management throughout the

organisation understand the importance of counter fraud work and fully support the LCFS and the Director of Finance, Performance and Contracting in conducting that work.

The LCFS has developed key relationships with the following teams/directorates, Human Resources, Recruitment, Payroll, Risk Management and Communications. These relationships coupled with the significant work done by the LCFS to develop an anti-fraud culture have resulted in good quality referrals being made to the LCFS. This in turn has resulted in a good proportion of cases concluding in civil, criminal and/or disciplinary sanctions. Where possible these sanctions are publicised within the organisation to give staff confidence that robust action is taken when allegations of fraud are made, this also has a significant deterrent effect on other employees and prevents other incidents of fraud.

During 2019/20 the LCFS shared briefings with all staff through the CCG's 60 seconds bulletin, which covered key areas of learning from within the sector.

The CCG continued to set a challenging Quality, Improvement, Productivity, Prevention (QIPP) programme, with QIPP savings of £22.8m planned to be delivered in 2019/20, which included a Somerset system savings stretch target of £8.4m. Such schemes are monitored to ensure key risks and issues are identified and decisions taken by the Leadership Team where required. Through the Sustainability and Transformational Planning meetings local leaders continue to discuss QIPP/CIP assumptions to ensure a robust peer challenge is in place across Somerset, but to also confirm clear assumptions and monitoring are in place to ensure no double counting across organisations.

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

To support this, the CCG has a Finance and Performance Committee, chaired by a Non-Executive Director of the CCG Governing Body, which looks at the financial position and QIPP opportunities across the range of services commissioned. This group meets monthly to review the position and has an active work programme which is actioned through the CCGs Leadership Team.

As part of the developing and continued working towards a single system of finance, activity and workforce, the individual operational and financial plans of the Somerset Health Partners have been worked up, cross checked and triangulated as one through established joint working and strengthened governance as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery. The Somerset approach to managing the system as a single health and care system, supported by a long term strategy is being developed, with the more immediate development of a financial recovery plan, to ensure alignment and delivery of the aims for the system as a whole. This forward strategy will build on and refresh the already STP approved estates programme, capital plans, and digital plans. The recovery plan continues to focus on managing demand and reducing cost across the system. This includes a focus on clinical variation (using Rightcare, Getting It Right First Time, Model Hospital, Reference Costs and more benchmarks), and is looking at elective

and non-elective pathways, medication, continuing health care, and optimisation in both the short term and longer term through changes to the models of care. We also have a system-wide planning approach to the efficient and cost effective use of bed capacity across all STP Partners.

7.14 Delegation of Functions

It is implicit through the work of the Governing Body and delegated Committees that members have clear responsibility for ensuring appropriate use of resources. Where there are concerns in relation to budgetary management, these are clearly documented in the Corporate Risk Register.

Through the committee structure within NHS Somerset CCG, regular reports are received on the performance of contracted Providers. Areas of under and over performance are addressed through contract meetings and reported though finance, performance and quality papers presented to CCG groups and committees.

The Audit Committee, under the scheme of delegation, monitors the financial stewardship of the organisation and is responsible for scrutinising and signing off the end of year financial accounts.

The Governing Body, delegated Committees and Risk Management Group retain oversight of all risks, including those deemed to be systematic, and are responsible for ensuring that relevant mitigating actions are undertaken. There have been no significant internal control failures identified throughout the financial year 2019/20 and Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken in this financial year.

The CCG commissions support services from the South, Central and West Commissioning Support Unit for the provision of functions such as Business Intelligence support, Information Technology and Information Governance support, Procurement Services support, Care Navigation Services, GP IT Services and additional consultancy support. The contract form provides the framework under which assurance on performance can be monitored and managed. In addition, in order to deliver assurance over the internal controls and control procedures operated by all Commissioning Support Units (CSUs), NHS England engage a reporting accountant to prepare a report on internal controls. The objective of this is to provide assurance in a cost effective manner for the NHS through reducing the duplication which would likely arise from multiple CCG internal and external auditors separately assessing CSU controls. The scope of the Service Auditor Report (SAR) covers Payroll, Financial Ledger, Accounts Payable, Accounts Receivable, Financial reporting, Treasury and Cash Management and Non-Clinical Procurement. Of these services, Somerset CCG only commissions the Non-Clinical Procurement service through the South Central and West CSU. There were no exceptions identified within the SAR for the Non-Clinical Procurement service for 2019/20.

Capita Primary Care Support England (PCSE) provide administrative and support services as part of the delegated commissioning function for Primary Care Medical services. The 2019/20 Service Auditor Report for Capita PCSE is not currently available.

A number of services are provided to the CCG by other service organisations. The ISAE 3402 Service Auditor Type II reports have been received which assess the state of the control environment for the period 1 April 2019 to 31 March 2020 for the following services used by the CCG:

NHS Shared Business Service Limited: Finance and Accounting Services

A qualified opinion was given in respect of this SAR due to access to the service organisation's Indian sites being restricted as a result of Covid-19 and the Indian Government's lockdown arrangements during the period 16 March 2020 to 31 March 2020. Restricted access prevented the auditor being able to obtain evidence in respect of a number of controls for the months of February 2020 and March 2020.

NHS Digital GP Payments

A qualified opinion was given in respect of this SAR in relation to the following control objective:

"Controls are in place to provide reasonable assurance that system change cannot be undertaken unless valid, authorised and tested".

The qualification issue arose as for two out of nine samples reviewed by the service auditor there was no evidence that approval had been sought and/or received from the Technical Architecture Team prior to implementation of a system change.

The CCG does not consider that these outcomes will impact on the CCG.

7.15 **The Better Care Fund**

The Better Care Fund (BCF) was established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It was a requirement of the BCF that NHS Somerset CCG and Somerset County Council established a pooled fund for this purpose, this was achieved in 2019/20 through a signed agreement under Section 75 of the National Health Service Act 2006. Somerset County Council received additional funding in 2019/20 through the improved Better Care Fund (iBCF), which has been pooled as part of the Section 75 agreement.

The Somerset BCF reflects key intentions and strategic plans of key partners, it aligns with our other local strategy plans for example the Somerset 5 Year Plan, the Somerset Winter Plan, the countywide Improving Lives Strategy, The Somerset STP. It was signed off by the Somerset Health and Wellbeing Board

(HWBB) on 26 September 2019, whose members include the CCG and Local Authority. The governance of the Somerset BCF is principally through the Health and Wellbeing Board and this is key and influential partnership Board. The Somerset BCF and its delivery plans are specifically designed in relation to Somerset's unique context, its geography, demography and service provider landscape.

Somerset plans will ensure the Disabled Facilities Grant continues to be managed by District Councils to support their ongoing statutory duties. The District Planning representatives are members of the HWBB and this helps to ensure that the oversight of these funds are weaved into the entire BCF governance process.

Our plans have been progressed at:

- the level of the person and their relationship with professionals
- the neighbourhood level and our integration agenda which includes the development of Primary Care Networks (PCNs) and our wider integrated health and care teams and
- a strategic county level through various strategic multi-agency working groups and the HWBB

The Somerset Plan incorporates the full use of the Winter monies allocations and this together with the other funding streams provides a significant opportunity to progress joint working, integrated, personalised care and helping to both stabilise the local system and address key system pressures. Importantly, the Somerset BCF for 2019/20 has built on the significant successes of last year.

The Somerset BCF will continue to help drive forward our person-centred integration agenda and examples from this year's plan include:

- building on successful schemes last year e.g. Home First, the use of additional community support during Winter to help meet our stretched targets (High Impact Change)
- extending access to Social Workers Physiotherapists and Occupational Therapists across 7 days (High Impact Change) to ensure the people who are ready to go home from hospital can do so without delay
- continuing support for people to make more significant adaptations in their own home through the use of the DFG, including shared housing OT posts across district and county council boundaries. In conjunction with this, continue our joint funding arrangements in respect of our community equipment service.
- continuing our Care Home Intensive Support schemes (High Impact Change)
- introducing a wide range of schemes which will promote prevention including the promotion of exercise and movement, the take up of health checks, new out of hospital specialist diabetes clinics, new campaigns to help reduce the incidence of high blood pressure (hypertension)
- meeting the NHS contributions toward Social Care and in doing so support the Local Authority to meet requirements of the Care Act.

Including for example more support for people who self-fund their residential placement and the sustainability of a vibrant and quality care market whilst dealing with staffing shortages and increasing costs

- increasing our focus and support for carers including reviewing the current service model, maintaining and protecting financial contributions and ensuring carers issues have a higher profile within the HWB and CCG

The BCF specifically helps to drive the agenda for service integration. In particular:

- we have established 13 Neighbourhood areas as the basis for future joint working between health and social care teams. Each serves a population of 30-50,000 people based on the registered list of a group of GP practices. These neighbourhoods align with 12 Primary Care Networks. (In one locality a large PCN will cover 2 Neighbourhood areas). In accordance with the national requirements, each PCN has a nominated Clinical Director. Each of our neighbourhoods includes representation from health, social care teams and local voluntary and community organisations. The BCF 2019/20 has continued the development of neighbourhood working and ensuring that the development of Primary Care Networks takes a broader and inclusive approach in relation to other local health, care and community sector partners.

- as part of the development of neighbourhood working and to promote the community-oriented approach, NHS Somerset CCG and Somerset County Council have agreed to commission social prescribing support on a long term and sustainable basis as a core part of the local system offer. This development is based on the success of a number of local schemes previously supported by the BCF.

- during 2019/20 have continued to commission joined up multi-disciplinary (MDT) team approach to reducing Delayed Transfers of Care through our very successful Home First scheme. (High Impact Change). We have also continued to support the development of MDT working as part of our integrated health and social care teams, which are key components of our neighbourhood working. This will build on areas which already have regular MDT meetings, information sharing arrangements and joint working in place.

The BCF includes NHS contributions to what is now a Joint Community Equipment Service and Somerset County Council and the CCG are undertaking a re-procurement for a new, more innovative and person-centred service which will come on stream in the summer of 2020. This will introduce new technologies which allow local people to view a range of products on line, a range of local centres to allow easier access for people to come and try out equipment and purchase additional items.

The BCF has helped and will continue to help build relationships and engagement between health and care commissioners and a wider range of partners. At a strategic level this includes:

- our continued support for the Somerset Voluntary and Community Sector Forum
- our improved joint working with Police, District Councils, the Fire Service and other partners through the Somerset Safer Somerset Partnership
- through our new Improving Lives In Neighbourhoods Group which includes representation from Police, District Councils, Hospice and care homes, Public Health teams, Sports and Activities partners and community health services.

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

7.16 Control Issues

In January 2020, a month 9 Governance Statement Report was submitted to NHS England. This return highlighted a number of areas of control where significant performance issues have been experienced during 2019/20. These areas, along with the mitigating actions, are shown in the table below.

Control Issue	Mitigating Actions in Place
For all areas	The CCG has controls in place for managing Provider performance, including monthly Finance and Performance Committee meetings and a Somerset System Assurance Forum and System Performance Group where all local system partners are in attendance (and includes representation from NHSE/I). The Somerset System Assurance Forum provides assurance to system partners (including providers, commissioners and regulators) on the performance of the Somerset system. The Forum performs the following functions, ensuring that it works closely with each partner organisation and that it considers audit and assurance information provided or otherwise made available by each statutory organisation and national regulatory bodies (including NHS England, NHS Improvement and the CQC, among others): - Oversee the development and implementation of the Single Assurance Framework and establish the SAF as the forum for oversight and assurance of the system by commissioners and regulators - Tasks the quality surveillance group to review and provide assurance on the quality and safety of health and care across the Somerset ICS - Tasks the finance group with reviewing and providing assurance on in-year financial performance and the delivery of the ICS control total - Tasks delivery groups (A&E / Urgent Care, Elective Care and Mental Health) with reviewing and providing assurance on in-year delivery of national targets - Review risks to performance, quality and finance across the ICS, and seek assurance that risks are mitigated - Co-ordinate the production of the system operational plans and agree the use of non-recurrent resources including improvement capacity to support quality, delivery and financial performance The System Performance Group's core task is to take collective responsibility for delivering (or maintaining) improvements in performance against agreed targets & delivery plans and to take responsibility for the development of / alignment to the new performance metrics set out in the NHS Oversight Framework. The SPG is accountable and reports by exception into the System Assurance Forum. To support these meetings a single dashboard is in place which clearly identifies any areas of under performance or emerging issues for discussion; it includes Regional and National benchmarking alongside the national or agreed improvement standard. Recovery focus is specifically focused upon RTT Long Waits (>40 and >52-week waits), cancer and diagnostic waiting times where recovery actions and improvement trajectories are in place.

Control Issue	Mitigating Actions in Place
	A monthly performance meeting is in place with Taunton and Somerset NHS Foundation Trust to review performance at a more granular level in order to understand the improvement actions / mitigation in place to address the performance shortfall. This information feeds into the CCG's Integrated Quality and Performance Report and into the System Performance Dashboard. NHS Somerset CCG continues to work with System Partners to implement schemes for demand management, which include Emergency Demand Mitigation Schemes (stranded patients, rapid response, single point of access, 7 day working, care homes and home first) and review of other referral demand (urgent and elective care) using external benchmarking such as Rightcare as well as internal data to identify areas of unwarranted variation with improvement schemes agreed via the Delivery Boards as required.
Quality and Performance - Accident and Emergency	A&E: Taunton & Somerset NHS Foundation Trust has an A&E improvement plan in place, but is behind the improvement trajectory. A key driver of lower than expected performance is high patient acuity and workforce challenges. Recruitment to vacancies continues across a range of staff groups and review of staffing against the daily profile of demand. The newly reformed A&E Delivery Board continues to work to understand the changes in demand, and to agree schemes to mitigate emergency demand.
Quality and Performance - RTT/52 week wait	Long Waits: The main concentration of very long waits is at Taunton and Somerset NHS Foundation Trust; the Trust plan is for there to be zero by December 2019. However, due to patients choosing to delay treatment over the Christmas period and challenges in Clinical Immunology and Maxillofacial, the position on a Trust-wide basis is expected to be significantly higher than this. The Trust has detailed pathway tracking in place, which is shared with NHS Somerset CCG on a fortnightly basis, and has an Expert Panel which meets weekly to trouble shoot pathways. Ongoing discussions take place with the CCG and via the formal System Performance Group and System Assurance Forum. Central funding has been awarded to the Trust to reduce >40 week waits, and weekly monitoring will be put in place to track performance against the agreed specialty level improvement trajectory
Quality and Performance - Ambulance Services	The Clinical Commissioning Group has strengthened the monitoring and oversight of the national Clinical Commissioning Group assurance framework (CCG Improvement and Assessment Framework) introducing monthly oversight wherever possible and with many of these objectives incorporated into the Integrated Quality and Performance Report (and Governing Body Exception Report). Ambulance: A South Western Ambulance Service Joint Improvement Plan is in development, being led by Dorset CCG (Lead commissioner). Additional ambulance resources are in place in Somerset to improve response times and both T&S and YDH ambulance handover performance has improved and are one of SWASTs top performers in respect of ambulance handovers. Oversight of demand and ambulance performance is managed via the System Dashboard, which is presented to SPG and SAF, as well as a detailed update included in the Integrated Quality and Performance Report. Regular meetings between the Trust and SWAST representatives take place to address any issues and to implement actions as required.
Quality and Performance - Mental Health and Dementia	Mental Health: IAPT - ongoing recruitment is underway to ensure the IAPT service and the Specialist Therapies Services can meet local demand. IAPT recruitment has progressed but there are challenges within the Specialist Therapies Service due to the vacancy rate. The IAPT Service Lead and Trust HR department are actively trying to recruit to these posts and have been successful in securing trainees to take up opportunities for the High Intensity and Low Intensity places at Exeter University and it is anticipated that this will positively impact the

Control Issue	Mitigating Actions in Place
	access rate for both teams. Development of Mental Health Support Teams in Schools trailblazer programme will positively contribute to the Children & Young People MH access rate target. Education Wellbeing Practitioners employed by Young Somerset will be starting interventions with CYP in January 2020. Discussions taking place with Kooth (commissioned online counselling), who also undertake outreach work with local schools, to start a publicity programme across PCNs and Community settings to increase. The Big Tent programme is being piloted within Yeovil locality and work is underway for Children's and Wellbeing Practitioners (CWPs) to see CYP in community settings. North Sedgemoor locality meetings have commenced and referrals are being received to see a CWP. Young Somerset and Somerset CAMHS have established a joint triage meeting/process to begin to address the gaps between targeted and specialist provision. Dementia - there has been a commitment of funding agreed within the CCG's planned mental health investment for 2019/20 to support the dementia pathways and this is being worked through.
Quality and Performance - Access to Service/Capacity	The Clinical Commissioning Group has strengthened the monitoring and oversight of the national Clinical Commissioning Group assurance framework (CCG Improvement and Assessment Framework) introducing monthly oversight wherever possible and with many of these objectives incorporated into the Integrated Quality and Performance Report (and Governing Body Exception Report).

7.17 **Counter Fraud Arrangements**

The 2019/20 Annual Counter Fraud Work Plan was developed to support the CCG in implementing appropriate measures to counter fraud, bribery and corruption. Having appropriate measures in place helps to protect NHS resources against fraud and ensures they are used for their intended purpose, the delivery of patient care.

The Counter Fraud work plan for 2019/20 was risk-based and has been aligned to counter fraud objectives as per the NHS Counter Fraud Authority (NHSCFA) Standards for Commissioners 2019/20. The work plan was produced taking into account:

- discussions with the Director of Finance, Performance and Contracting and members of the Audit Committee
- local proactive work, risk measurement exercises and evaluation of previous work conducted at the CCG by the LCFS and CCG staff
- risks identified from referrals received and investigations conducted at the CCG by the LCFS
- risks identified at other clients either locally or nationally by the NHS Counter Fraud Authority
- any national programme of proactive work by the NHS Counter Fraud Authority.

The Counter Fraud service is provided by BDO LLP, which includes a local accredited Counter Fraud Specialist (LCFS) who ensures that the annual work plan is delivered. Regular progress reports are provided at each Audit Committee meeting detailing the progress against each element of the work plan. In addition, an annual report is produced showing the assessment against each of the commissioner standards, including any actions which need to be taken in order to ensure the standard is achieved.

The overall executive lead for counter fraud is Alison Henly, Director of Finance, Performance and Contracting, who is responsible for proactively tackling fraud, bribery and corruption.

7.18 **Head of Internal Audit Opinion**

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

The role of internal audit is to provide an opinion to the Governing Body, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It

also summarises the activities of internal audit for period. The basis for forming my opinion is as follows:

- an assessment of the design and operation of the underpinning Governing Body and Assurance Framework and supporting processes

- an assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses

- any reliance that is being placed upon third party assurances

Overall, we are able to provide moderate assurance that there is a sound system of internal control designed to meet the CCG's objectives and that controls are being applied consistently. In forming our view we have taken into account that:

- the CCG has a planned in year deficit position of £4.5 million for 2019/20. The financial forecast for 2019/20 anticipates that the CCG will not deliver to plan for the financial year. A deterioration of £13.1m from the planned position is forecast, which will result in the CCG not achieving the required conditions to enable release of the final two quarters of Commissioner Sustainability Funding, equating to £2.925m. This results in a total forecast deficit of £16.025m for 2019/20 and a cumulative anticipated deficit of £19.581m

- the CCG has displayed strong controls in relation to the key financial system, continuing healthcare – children and primary care commissioning processes

- the CCG has developed and is in the process of embedding more robust risk management processes, together with a new format of the Governing Body Assurance Framework which will better reflect the assurances and controls that are in place for delivering the strategic objectives which will be aligned to the Somerset System priorities

- good progress has been made during the year with the implementation of the actions arising from the audit work

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

Area of Audit: Key Financial Controls; **Director:** Alison Henly, Director of Finance, Performance and Contracting

Design: substantial **Effectiveness**: substantial **Recommendations**: none

Summary of report:

The purpose of the audit was to provide assurance over the CCG's internal financial controls in order to support effective management of resources. The review focussed on general ledger access controls, control account reconciliations, journal preparation and out of area contract payment processes.

Overall, no key findings were identified. There are robust financial controls being demonstrated by the CCG. Risks and challenges are clearly identified in financial reporting, with a realistic recurring underlying financial position forecast..

A number of areas of good practice were identified:

- Comprehensive and detailed policies and procedures for financial reporting and accounting are available for staff to follow. Following a staffing restructure in the CCG, clear roles and responsibilities have been set out in the policies and procedures for all aspects of financial systems.
- Robust controls have been evidenced over user access management to Oracle. Sample testing confirmed that all current users have had an application form completed and authorised appropriately. Delegated levels of authority have been set commensurate with an individual's role within the CCG. Moreover, leavers have also been removed from Oracle properly.
- A Finance Report is produced monthly and presented to the Governing Body (GB) bi-monthly. We confirmed all key areas have been reported to the GB to inform strategic decision making. Testing highlighted that financial information included can be accurately traced back to supporting documentation.
- The CCG reviews actions agreed with NHSE/I and the system to mitigate risks to the 2019/20 financial position. A Grip and Control checklist is monitored and results reported to the Audit Committee on a quarterly basis.
- All journals entered by the Finance Team have been approved properly, and sample testing confirmed that journals tested were supported with valid evidence. Assurances are in place where no journals had been self-authorised for the year to date and monthly controls are in place to identify any instances where this may occur. Control account reconciliation packs are received from Shared Business Services (SBS) and reviewed by the financial accounts team in a timely manner.
- Control Accounts Reconciliation is prepared by SBS and reviewed by the Senior Financial Accountant. Internal balance sheet reconciliation is also prepared monthly by the Finance Team and reviewed by the senior Financial Accountant. Following our audit in 2019, the CCG stopped the process of keeping paper files for control account reconciliation records, as recommended.
- For all Out of Area and Community Contracts, the relevant contract managers review invoices received to confirm they are valid and accurate. The Management Accountants for Acute contracts and Community contracts reconcile activities planned/paid against provider activity reports and monitor budgets on a monthly basis to identify variances. Sample testing confirmed that payments have been authorised properly with a clear audit trail maintained in Oracle.

No recommendations were raised

Area of Audit: Conflicts of Interest; **Director:** James Rimmer, Chief Executive

Design: moderate **Effectiveness**: moderate **Recommendations**: 2 medium significance.

Summary of report:

The audit was undertaken to provide assurance that the CCG is complying with the Revised statutory guidance on managing conflicts of interest for CCGs (June 2017) and that it had implemented the eight key areas highlighted by NHS England in the 'Best Practice Update on Conflicts of Interest Management: Call to Action for CCGs' issued February 2019.

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

- The CCG's Standards of Business Conduct and Managing Conflicts of Interest Policy (the Policy) sets out how the CCG will manage conflicts of interests arising from the operation of its business to ensure that public service values remain at the heart of the decisions it makes and that the organisation inspires confidence and trust amongst the public.
- The Policy was updated in December 2019 in accordance with recommendations raised in the BDO 2018/19 Conflicts of Interest audit, and is now largely compliant with the Revised Statutory Guidance for CCGs – NHS England 2017 (the National Guidance).
- The CCG maintains and publishes the Registers on the CCG's website, in line with the National Guidance (although not all registers are kept updated). The registers include:
  - Declarations of Interest for Governing Body Members (properly updated)
  - Declaration of Interest of All Staff (Band 7 and above, less Nil Returns, including Governing Body members)
  - Declarations of Interest for Principal Member Practices Staff Working with the CCG
  - Gifts, Hospitality and Sponsorship
  - Procurement decisions
- A review was undertaken of a sample of three sets of minutes of the Clinical Executive Committee, Governing Body, Prescribing and Medicines Management Group, Patient Safety and Quality Assurance Committee and Primary Care Commissioning Committee. It was found that conflicts of interest were a standing agenda item at each of these meetings. Moreover, the 'current' Members Interests and the Gifts and Hospitality Reports were enclosed and reviewed during the meetings. Members were reminded of the necessity to review their entries on a regular basis.
- The COI Policy clearly provides the process for recognising and managing breaches, which will be published on the CCGs register of breaches. The register of breaches is available from the CCG internet page, with none recorded for 2019/20.
- The CCG makes use of the online training module produced by NHS England, requiring all staff to complete this mandatory online training on an annual basis, which is in line with NHS England's requirement. The training system is linked to the Payroll system so automatic reminders are sent to staff when training is due to be completed. As at 09/01/2020, 222/278 (80%) staff have completed the annual online training, and the HR manager will continue to send out reminders to ensure all staff complete the training before the annual deadline 31 January 2020.
- Declarations of interest are consistently completed during the recruitment process. Sample testing did not identify any exceptions.
- Conflicts of interest have been properly managed during the Procurement and Contract awarding process. Only one contract has been awarded within the year - Home Oxygen Services and Review plus Pulmonary Rehabilitation Service awarded to BOC Healthcare. We confirmed that Declaration of Interest (DOI) forms have been completed by the bidders, evaluation panel meetings and members at the decision making meeting. Actions have been taken to address the conflicts declared.

- Each year in May/June, the Association of the British Pharmaceutical Industry (ABPI) write to the CEO of the CCG to share payments being registered against the CCG, ie where a pharmaceutical company has funded the CCG for either a healthcare professional or an organisation for an event/speaking arrangement/lunch etc. A process has been implemented at the CCG that all items recorded against the CCG are investigated to ensure declarations are made appropriately. It was confirmed that all payment recorded against the CCG in 2018/19 have been reported to the Audit Committee with explanations of the receipt of sponsorships/donations.

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

Maintenance and Publishing of Registers
- The Conflicts of Interest Register should be updated to ensure that data fields recommended by National Guidance for declarations of gifts and hospitalities (for staff and GPs) are included in the electronic forms for completion by staff.
- The Register of Procurement Decisions should be updated to capture essential decisions only.
- Regular reviews should be carried out to ensure that all staff and GPs have made their declarations fully and in a timely manner (within 28 days from the date that the interest arises). A direct reminder should be sent from the Corporate Governance team to all staff.

Ensure Robust Mechanisms for the Management of Conflicts within Procurement Decision Making or Contract Meetings
- A standard meeting agenda that includes Declarations of Interest and Interest Register reviews should be used by all contract monitoring meetings. Annual spot checks should be carried out to ensure that Declarations of Interest is a standing agenda item at all contract meetings and that Conflicts of Interest are properly documented in meeting minutes.

Area of Audit: Evidence Based Interventions; **Director:** Sandra Corry, Director of Quality, Patient Safety & Governance

Design: moderate **Effectiveness**: moderate **Recommendations**: 2 medium significance, 2 low significance

Summary of report:
The purpose of this review was to ensure that evidence based intervention (EBI) requests are treated consistently and that the assessment and governance infrastructures in place are robust.

The following areas of good practice were identified:
- The EBI service had efficient processes to review and manage EBI and Prior Approval (PA) applications; there were detailed protocols on the CCG's website which detail the criteria required to be approved for the corresponding procedures. Each protocol is subject to review every three years or before this date if there has been a change in legislation or guidance
- The EBI service had adequate systems in place to process EBI and PA applications, the system was able to store patient information relating to the application, store notes on the system to provide detail on the application process and decision made, send decision letters to notify the corresponding GP/Clinician and patient and subsequently close down the application after two weeks once the application was processed
- 20 EBI applications were sample tested from April 2018 to March 2019. Of the sample of 20 tested it was noted that;
    - Five PA declined applications were appropriately declined within the system and closed off within a timely manner. The reasons for declining a PA application were clearly outlined within the system and within the patient letter. The reason for declining

applications typically ranged from not meeting the PA criteria or using the incorrect pathway to apply for funding and as a result a letter was sent to the GP/ Clinician and declined the application
    - All PA applications were addressed within five working days i.e. from date of receipt of application to sending out the decision letter
    - Five PA approved applications were appropriately approved within the system and were addressed in a timely basis. Each application was reviewed and in line with the PA guidelines; the application was either a Tonsillectomy or Varicose Veins procedure
    - Five EBI applications were appropriately approved in line with the policy and addressed within the prescribed six-week time scale. Each application was subject to a panel review. A letter was sent to the applicants GP notifying of the decision made.
    - Five EBI declined applications were declined in line with the policy and within the six-week timescale. Each application was subject to the panel process and reviewed prior to a decision being made
    - There were detailed meeting minutes in place for each EBI application panel process clearly detailing why the decision for approval or decline of EBI treatment was made. The panel meetings demonstrated whether there was exceptionality demonstrated within the application and whether it was in line with the CCG's protocol. The panel meetings are comprised of members with appropriate clinical expertise to make suitable decisions within the applications process.
- There were effective governance arrangements in place to review EBI applications, whereby each application was subject to a panel review prior to approval.

Opportunities for enhancement

Recommendations have been raised against each of the following areas:

Clinical Audit Methodology

- There should be a clear audit methodology defined which addresses the following areas:
    - percentage of cases to review per provider
    - conduct a risk assessment of the provider i.e. if there were significant issues identified in previous cases the provider should be set as high risk and as a result the sample size increased
    - apportion the number of treatments per provider across the entire sample.
- The EBI service should follow up the acceptance of the audit recommendations. Subsequently, the service should follow up the recommendations to ensure the relevant actions have been undertaken to mitigate the risks identified
- The roles and responsibilities in relation to clinical audit should be discussed and clearly defined between the corresponding provider's contracts manager and the EBI service.

Review of the Administration of Prior Approval Applications

- There should be counter checks completed by the EBI service or Clinician on both PAs declined and approved applications. Conclusions should be formed on whether the decision made on the application was accurate.
- There should be a monthly sample of spot checks completed on PA applications by the EBI's clinical expert to conclude on whether the PA applications were approved or declined appropriately. The results of the spot checks should be presented within the EBI annual report.
- Consideration should be given as to whether administration / documentation processes could be enhanced.

Trends Analysis Reports

- The CCG should consider producing the following trends analysis reports. If the EBI system is unable to produce such reports the Business Intelligence team should be consulted to

understand whether data can be manipulated to produce the following reports:

- The number of cases considered through GP Triage and panel to understand the proportion of cases that go through triage and those that go through panel on a monthly basis
- a percentage of specific treatments approved and declined in the last month/quarter
- a percentage of common treatments requested where a policy/protocol was produced as a result
- the timeliness of referrals i.e. EBI and PA receipted by the EBI service to a decision being made
- a percentage of cases/breakdown of financial recoveries per treatment per provider identified within the quarter
- the number of cases received PA and EBI in the year and the trends of whether it is an increase or decline in the average number of cases received

Area of Audit: Continuing Healthcare (Children); **Director:** Sandra Corry, Director of Quality, Patient Safety & Governance

Design: substantial **Effectiveness**: substantial **Recommendations**: 2 low significance

Summary of report:

The purpose of the audit was to provide assurance over the governance arrangements for continuing care for children and young people (including Personal Health Budgets), performance management, risk escalation and the quality and financial monitoring mechanisms in place.

The following areas of good practice were identified:

- Since June 2019, the CCG has introduced a Continuing Care report to the Patient Safety & Quality Committee, giving the Committee updates as to Continuing Care activity and spend, contracts and commissioning, Personal Health Budgets (PHB), safeguarding, case management and updates on the Team structure
- There is a Continuing Care Policy in place within the CCG which is disseminated to appropriate staff
- There is effective liaison and management processes in place between the Local Authority Social Care Team, Education and the CCG
- There is evidence that there is a decision support tool and a Care Plan in place for those receiving Continuing Care
- There is evidence that verbal consent is received at the continuing care pre-assessment checklist by the Nurse Assessor prior to continuing with the checklist. Whether the child / young person or the parent/ carer is giving consent is recorded within the checklist and saved within CareTrack (the CCGs database for healthcare records)
- Joint liaison with the LA over the LOT 5 framework agreement has meant that providers for health and social care can receive provision from one provider, which has been through an appropriate EU commissioning process
- The Team have arrangements with providers for domiciliary care (paediatrics) through the standard NHS contract. These contracts have been signed and run until the end of March 2021. These contracts relate specifically to the CCG and are not joint with the LA
- The provider contracts under the NHS contracts and LOT 5 had not been in place for a full year at the time of the audit review therefore the first annual contract review has not taken place. However, there are standard agenda and template monitoring returns in place once these reviews fall due
- A review by the Children's Complex Health Needs Panel is completed annually to assess whether the current Continuing Care package is adequate, including completion of an

updated Decision Support Tool
- There is evidence on file that the family is always contacted in writing about the outcome of the review at the Children's Complex Health Needs Panel.

Opportunities for enhancement
Recommendations have been raised against each of the following areas:

Assessment Policy Compliance
- The CHC Framework highlights that the CCG "should aim for a decision to be given to the child or young person and their family within six weeks." This is also reiterated within the CCGs Continuing Care for Children Policy. Whilst this is the target within the CHC Framework and the CCGs own Policy, results are not collected and reported by NHSE (unlike Continuing Healthcare for adults). As a result, this target is not collected or reported, either internally or externally. There is no assessment of the CCGs compliance with the policy in general. In order to ensure the CCG is in compliance with the policy, the targets set within the policy should be assessed. It should then be assessed where this will be reported.

Children's Continuing Care Policy
- The National Framework for Children and Young People's Continuing Care 2016 sets out the framework for dealing with the continuing healthcare needs of children and young people who are under the age of 18. The CCG's Children's Continuing Care Policy should reflect the detail as set out within the framework covering children and young people requiring additional support that is not available through existing universal and specialist healthcare services in Somerset. The CCG policy is not currently aligned with the National Framework in terms of response times for an assessment decision to be communicated to the child or young person and their family. There is a risk that the individual is not informed of the decision in the timescales as recommended under the national framework. The CCG's Policy should be reviewed and updated to ensure it reflects current guidance and also any changes within the Continuing Care Team.

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

Design: substantial **Effectiveness**: N/A **Recommendations**: none

Summary of report:
NHS England's Internal Audit Framework for delegated Clinical Commissioning Groups lays out the requirements for an annual internal audit of the CCG's primary medical commissioning arrangements from 2018/19, with the programme to be delivered over 3 to 4 years. NHS England retains overall responsibility and liability for delegated commissioning arrangements of the primary care medical budget. It is responsible for obtaining assurances that its functions are being discharged effectively. As a result, the internal audit is to provide information that CCGs are discharging NHS England's statutory primary care functions effectively. This information will be used to provide assurance to NHS England and facilitate engagement and improvement.

The audit was performed using the NHS England Internal Audit Framework for delegated CCGs, with the following areas reviewed:
- Contract Oversight and Management Functions
- Governance arrangements
- Primary Care Network Development ('PCN')
- Premises
- Follow up on progress with the implementation of findings raised in the 2018/19 internal audit report

The following areas of good practice were identified:

- All 65 practice visits are almost complete. There has been excellent engagement by the practices which we have not noted in other CCGs we have reviewed. This highlights the way in which the CCG have approached the practice review visits, encouraging them to discuss any quality improvements and supporting where required. This has built a good relationship where honest conversations can be had. Minutes of these meetings are recorded and shared, including agreed actions for both the CCG and the practice. In completing these actions the CCG show their continued support of the practice
- There are detailed procedure cards in place for every process required within Primary Care Commissioning, ensuring staff are following a consistent and correct approach to all work undertaken.

Opportunities for enhancement

No recommendations were raised

Area of Audit: Assurance framework, STP Governance and Risk Follow Up;
Director: Alison Henly, Director of Finance, Performance and Contracting

Design: N/A **Effectiveness**: N/A **Recommendations**: 1 high significance

Summary of report:

The purpose of the audit was to:

- provide advisory support for the development of risk management processes and the Governing Body Assurance Framework for the STP
- provide assurance over the adequate implementation of the actions arising from the STP Governance and support report (2018/19), the Risk Maturity report (2017/18) and the Risk Survey observations (2018/19).

The following areas of good practice were identified:

- Since the appointment of an interim Risk and Assurance Manager, there has been good progress with the development and embedding of a risk management culture in the CCG.
- Processes, procedures, tools, training and communication have been introduced to staff and Governing Body members.
- The Somerset System Project Management Office team has transferred from the consultants, Attain, to an in-house team, comprising mainly of transformation leads from Taunton and Somerset NHS Foundation Trust. Templates, tools and processes for project management and escalation to the System Boards is in place.

Opportunities for enhancement

Recommendations have been raised against the area of the assessment summarised below:

Implementation of the agreed actions from the STP Governance and Support Report which may result in ineffective assurances being provided to the CCG on the work of the STP

- There is no joined up approach between the commissioner and providers within the Somerset System Project Management Office (PMO).
- Currently, the PMO collate the programme risks and issues for discussion and action at the Partnership Executive Group and Somerset System Leadership Board. There are no formal arrangements in place for the dissemination of risks / issues to the providers and commissioners or agreement of the processes to manage and own risks within organisations.
- With effect from 1st February 2020, the management of the PMO is being led by Taunton & Somerset NHS Foundation Trust, so formal arrangements should be easier to embed.
- The Observation in this report on the STP programme risks and Highlight reports provides

some comments on the risk logs that are held in the PMO. A number of the fields were blank (no narrative) and the format does not follow best practice for completion of risk registers in terms of documentation, risk scoring, time-frames, comprehensive actions etc. Also, it is not clear whether any of the risks have been escalated to the organisations who have ownership and who are managing them.

- There is a risk that there is not a clear process of ownership of system, partnership, programme and projects that link to organisations risk management arrangements, where applicable. This could lead to the failure of transformation programmes and unclear prioritisation of the Somerset System Plans.
- It is recommended that the Associate Director of Corporate Business and the Risk Manager work with the System PMO to ensure that system risks which impact on the CCG are escalated to the CCG, and there is ownership of the management of them within the CCG and likewise flow upwards.
- The Director responsible should discuss with the other System Leaders the work required to ensure the Somerset System governance and risk management processes and link with the commissioner and providers. Internal Audit work, during 2020-21 is recommended in this area, on behalf of the NHS providers and commissioner.

Area of Audit: Data Security and Protection Toolkit; **Director:** Alison Henly, Director of Finance, Performance and Contracting

Level of assurance: moderate
Overall confidence level in the DSP Toolkit self-assessment submission: medium
Recommendations: 2 high, 6 medium, 2 low significance

Summary of report:
The purpose of this audit was to provide an independent assessment of the assertions and evidence items in the CCG's Data Security and Protection (DSP) Toolkit self-assessment return in January 2020, using the new assessment guidance published by NHS Digital, and to identify how compliance could be improved for the 2019/20 year-end return.

The following areas of good practice were identified:

- The CCG operates and maintains a risk register and identified the significant risks to the sensitive information it holds and the services it provides
- There is a complete record of all members of staff and their roles
- Procedures are in place for logging and monitoring IT administrator activities
- There are arrangements for reviewing processes that have resulted in data security and protection breaches or near misses
- Known vulnerabilities are acted on based on advice from CareCERT and lessons learned from previous incidents and near misses
- All networking components have had their default passwords changed to a high strength password
- A penetration test has been scoped and undertaken within the reporting period
- There are technical controls in place to prevent all devices managed by the CCG from installing insecure or malicious software.

Opportunities for enhancement
Recommendations have been raised against each of the areas of the assessment and summarised below:

PERSONAL CONFIDENTIAL DATA

- Management should review and, where necessary, update five data security and protection

policies found to be out of date to ensure that they remain relevant to the needs of the CCG and are designed to mitigate the constantly evolving risk and threat landscape.

- Management should review and, where necessary, update the CCG's data flow mapping document so that it identifies for each data flow whether the data is retained and disposed of in line with policies, or if not, why not, and whether a written data sharing agreement or contract is in place and when it ends. Furthermore, management should review and update the CCG's information asset register so that it records for all electronic and software assets what support and maintenance arrangements are in place and the quantity of data held on each system.
- Management should put arrangements in place for carrying out an audit of the CCG's data protection by design and by default arrangements, which should include encryption and computer port controls.
- Management should put arrangements in place for a data quality audit to be performed during the reporting period using the data quality audit template and guidance by NHS Digital.

STAFF RESPONSIBILITIES

- Management should review and, where necessary, update the CCG's information asset register so that it records which systems process or store each information asset.

TRAINING

- Management should request that all members of staff that have not yet completed their annual data security and protection training complete it as soon as possible and before the end of the reporting period (31 March 2020). Training completion should be monitored and followed up and evidence of completion should be maintained.

MANAGING DATA ACCESS

- Management should develop and maintain a list of all systems holding personal and confidential data, which should record who has access to each system. Where information is shared between systems, such as through interfacing, the CCG should identify who has access to both systems. For each system using role based access, such as admin, general user and super user, the CCG should record what rights are assigned to each role and the number of accounts in existence for each role.
- Privileged user accounts should be reviewed on a periodic basis to determine if access is appropriate and action should be taken where elevated rights have not been appropriately revoked. This should include leavers as well as members of staff that have changed roles. Details of the reviews performed within the reporting period, including actions taken, should be provided within the DSP Toolkit as part of sub assertion 4.4.2.

CONTINUITY PLANNING

- Management should conduct a formally documented test of its data security incident response and management plan during the current reporting period to ensure that all parties understand their roles and responsibilities as part of the plan. Testing results should be communicated to all appropriate stakeholders and actions arising from the test should be followed up to implementation.

ACCOUNTABLE SUPPLIERS

- Management should put in place a policy to define the CCG'S IT procurement arrangements, which should include, but not be limited to, a documentation of the accreditations and certifications it requires from suppliers and the requirements to obtain those prior to signing a new contract. The policy should apply to all suppliers of IT systems that could impact the delivery of care or process personal identifiable data. Furthermore, management should put arrangements in place for requesting assurance from the suppliers on an annual basis.

Area of Audit: Risk Management Survey; **Director:** James Rimmer, Chief Executive		
Design: N/A	**Effectiveness**: N/A	**Recommendations**: 4 medium significance

Summary of report:
At the request of the Audit Committee, BDO undertook a survey of the Governing Body members during April / May 2019. This was to ascertain their understanding of CCG processes and to confirm the mechanism for discussion of risks and assurances at committee level.

Twelve people completed the survey, one of whom was a volunteer from the Patient and Participation Group. This individual's responses related to the majority of 'negative' answers. Overall, the responses were positive and demonstrated that there were processes and mechanisms for discussing risks, with acknowledgement that more is required to develop this area, in particular with reference to the Sustainability and Transformation Programme work.

Opportunities for enhancement
Recommendations have been raised against each of the following areas:

- Where volunteers / non-CCG staff sit on committees, their induction should include an overview of the CCG's priorities and risks.
- Regular discussion at the Directors meeting on the risks and progress with the actions to mitigate.
- A joined up approach within the Somerset System so that there is clarity on the priorities, risk ownership and assurance mechanism.

During the year the Internal Audit did not issue any audit reports with a conclusion of no assurance.

7.19 **Summary Review of the effectiveness of Governance, Risk Management and Internal Control**

Review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed. I have been advised on the implication of the result of this review by:

- the work of the internal auditors
- Executive Directors, Senior Managers and Clinical Leads within the CCG who have responsibility for the development and maintenance of the internal control framework
- available performance information

- comments made by the external auditors in their annual audit letter and other reports.

The Governing Body Assurance Framework and Corporate Risk Register have been designed to provide me, as Accountable Officer, with sources of assurance which are evidence that the effectiveness of controls that manage risks to the CCG are achieving their principal objectives and are reviewed on an on-going basis as described earlier in this chapter.

The Executive Directors within the CCG who have responsibility for the development and maintenance of the system of internal control provide me, as Accountable Officer, with assurance.

As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described in page x to x.

We have also described the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including the role and outputs of the:

- Governing Body
- Audit Committee
- Finance and Performance Committee
- Patient Safety and Quality Committee
- Clinical Executive Committee
- Remuneration Committee
- Primary Care Commissioning Committee.

Conclusion

I can confirm that no significant internal control issues have been identified.

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
18 June 2020

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 31 March 2020 are listed below grouped within their Primary Care Network.

Practice Name	Address
West Somerset PCN	
West Somerset Healthcare	West Somerset Healthcare, Williton Surgery, Robert Street, Williton, Taunton, Somerset, TA4 4QE
Minehead Medical Centre	Harley House Surgery, 2 Irnham Road, Minehead, Somerset, TA24 5DL and Irnham Lodge Surgery, Townsend Road, Minehead, Somerset, TA24 5RG
Exmoor Medical Centre	The Exmoor Medical Centre, Oldberry House, Fishers Mead, Dulverton, Exmoor, TA22 9EN
Dunster and Porlock Surgeries	The Surgery Dunster, Knowle Lane, Dunster, Somerset, TA24 6SR and Porlock Medical Centre, Porlock, Somerset, TA24 8PJ
Bridgwater PCN	
Quantock Medical Centre	Quantock Medical Centre, Banneson Road, Nether Stowey, Bridgwater, Somerset, TA5 1NW
Cannington Health Centre	Cannington Health Centre, Mill Lane, Cannington, Bridgwater, Somerset, TA5 2HB
East Quay Medical Centre	New East Quay Medical Centre, East Quay, Bridgwater, Somerset, TA6 4GP
Victoria Park Medical Centre	Victoria Park Medical Centre, Victoria Park Drive, Bridgwater, Somerset, TA6 7AS
Taunton Road Medical Centre	Taunton Road Medical Centre, 12-16 Taunton Road, Bridgwater, Somerset, TA6 3LS
Cranleigh Gardens Medical Centre	Cranleigh Gardens Medical Centre, Cranleigh Gardens, Bridgwater, Somerset, TA6 5JS
Redgate Medical Centre	Redgate Medical Centre, Westonzoyland Road, Bridgwater, Somerset, TA6 5BF
Somerset Bridge Medical Centre	Somerset Bridge Medical Centre, Taunton Road, Bridgwater, Somerset, TA6 6LD

North Petherton Surgery	The Surgery, Mill Street, North Petherton, Somerset, TA6 6LX
Polden Medical Practice	Edington Surgery, Quarry Ground, Edington, Bridgwater, Somerset, TA7 9HA and Woolavington Surgery, Woolavington Road, Woolavington TA7 8ED
North Sedgemoor PCN	
Burnham and Berrow Medical Centre	Burnham Medical Centre, Love Lane, Burnham on Sea, Somerset, TA8 1EU
Brent Area Medical Centre	Brent Area Medical Centre, Anvil House, East Brent, Highbridge, Somerset, TA9 4JD
Axbridge and Wedmore Surgeries	Axbridge Surgery, Houlgate Way, Axbridge, BS26 2BJ
Cheddar Medical Centre	Cheddar Medical Centre, Roynon Way, Cheddar, Somerset, BS27 3NZ
Highbridge Medical Centre	Highbridge Medical Centre, Pepperall Road, Highbridge, Somerset, TA9 3YA
West Mendip PCN	
Wells City Practice	Wells City Practice, Priory Health Park, Glastonbury Road, Wells, Somerset, BA5 1XJ
Wells Health Centre	Wells Health Centre, Priory Health Park, Glastonbury Road, Wells, Somerset, BA5 1XJ
Glastonbury Surgery	The Glastonbury Surgery, Feversham Lane, Glastonbury, Somerset, BA6 9LP
Glastonbury Health Centre	Glastonbury Health Centre, 1 Wells Road, Glastonbury, Somerset, BA6 9DD
Vine Surgery Partnership	Vine Surgery, Hindhayes Lane, Street, Somerset, BA16 0ET
Central Mendip PCN	
Oakhill Surgery	Oakhill Surgery, Shepton Road, Oakhill, Radstock, Somerset, BA3 5HT
Grove House Surgery	Grove House Surgery, West Shepton, Shepton Mallet, Somerset, BA4 5UH
Park Medical Practice	The Park Medical Practice, Cannards Grave Road, Shepton Mallet, Somerset, BA4 5RT
East Mendip PCN	

Mendip Country Practice	The Mendip Country Practice, Church Street, Coleford, Radstock, Somerset, BA3 5NQ
Beckington Family Practice	The Beckington Family Practice, St Luke's Surgery, Beckington, Frome, Somerset, BA11 6SE
Frome PCN	
Frome Medical Practice	Frome Medical Practice, Enos Way, Frome, Somerset, BA11 2FH
South Somerset East PCN	
Bruton Surgery	The Bruton Surgery, Patwell Lane, Bruton, Somerset, BA10 0EG
Millbrook Surgery	Millbrook Surgery, Millbrook Gardens, Castle Cary, Somerset, BA7 7EE
Wincanton Health Centre	Wincanton Health Centre, Dykes Way, Wincanton, Somerset, BA9 9FQ
Milborne Port Surgery	Milborne Port Surgery, Gainsborough, Milborne Port, Sherborne, Dorset, DT9 5FH
Queen Camel Medical Centre	Queen Camel Medical Centre, West Camel Road, Queen Camel, Yeovil, Somerset, BA22 7LT
South Somerset West PCN	
Buttercross Health Centre	Buttercross Health Centre, Behind Berry, Somerton, Somerset, TA11 7PB and The Ilchester Surgery, 17 Church Street, Ilchester, Somerset, BA22 8LN
Martock and South Petherton Surgeries	Church Street Surgery, Church Street, Martock, Somerset, TA12 6JL
Crewkerne Health Centre	Crewkerne Health Centre, Middle Path, Crewkerne, Somerset, TA18 8BX
Hamdon Medical Centre	Hamdon Medical Centre, Matts Lane, Stoke Sub Hamdon, Somerset, TA14 6QE
Yeovil PCN	
Ryalls Park Medical Centre	Ryalls Park Medical Centre, Marsh Lane, Yeovil, Somerset, BA21 3BA
Oaklands Surgery	Oaklands Surgery, Birchfield Road, Yeovil, Somerset, BA21 5RL

Penn Hill Surgery	Penn Hill Surgery, St Nicholas Close, Yeovil, Somerset, BA20 1SB
Diamond Health group	Hendford Lodge Medical Centre, 74 Hendford, Yeovil, Somerset, BA20 1UJ and Abbey Manor Medical Practice, Abbey Manor Park, Yeovil, Somerset, BA21 3TL
Preston Grove Medical Centre	Preston Grove Medical Centre, Preston Grove, Yeovil, Somerset, BA20 2BQ
Chard, Crewkerne and Ilminster	
Summervale Medical Centre	Summervale Medical Centre, 1 Wharf Lane, Ilminster, Somerset, TA19 0DT
Essex House Medical Centre	Essex House Medical Centre, 59 Fore Street, Chard, Somerset, TA20 1QA
The Meadows Surgery (Ilminster)	The Meadows Surgery, Canal Way Ilminster, Somerset, TA19 9FE
Springmead Surgery	Springmead Surgery, Summerfields Road, Chard, Somerset, TA20 2EW
Tawstock Medical Centre	Tawstock Medical Centre, 7 High Street, Chard, Somerset, TA20 1QF
Church View Surgery	Church View Surgery, Broadway Road, Broadway, Ilminster, Somerset, TA19 9RX
Langport Surgery	The Surgery, North Street, Langport, Somerset, TA10 9RH
Tone Valley	
North Curry Health Centre	The Health Centre, North Curry, Taunton, Somerset, TA3 6NQ
Creech Medical Centre	Creech Medical Centre, Creech St Michael, Taunton, Somerset, TA3 5QQ
Taunton Vale Healthcare	The Blackbrook Surgery, Lisieux Way, Taunton, Somerset, TA1 2LB
Lyngford Park Surgery	Lyngford Park Surgery, Fletcher Close, Taunton, Somerset, TA2 8SQ
Warwick House Medical Centre	Warwick House Medical Centre, Upper Holway Road, Taunton, Somerset, TA1 2QA

Taunton Deane West	
Lister House Surgery	Lister House Surgery, Bollams Mead, Wiveliscombe, Somerset, TA4 2PH
Luson Surgery	Luson Surgery, 41 Fore Street, Wellington, Somerset, TA21 8AG
Wellington Medical Centre	Wellington Medical Centre, Mantle Street, Wellington, Somerset, TA21 8BD
Taunton Central	
College Way Surgery	College Way Surgery, Taunton, Somerset, TA1 4TY
St James Medical Centre	St James Medical Centre, St James Street, Taunton, Somerset, TA1 1JP
French Weir Health Centre	French Weir Health Centre, French Weir Avenue, Taunton, Somerset, TA1 1NW
Crown Medical Centre	Crown Medical Centre, Venture Way, Taunton, Somerset, TA2 8QY
Quantock Vale Surgery	Quantock Vale Surgery, Mount Street, Bishops Lydeard, Taunton, Somerset, TA4 3LH
No PCN	
West Coker Surgery (Patients are covered by the Yeovil PCN)	Westlake Surgery, High Street, West Coker, Somerset, BA2 9AH

Annex 2 (Governance Statement)

NHS Somerset CCG Governing Body Meetings 2019/20 **Attendance Record**	✓ = Present X = Apologies Given						
(V) = voting Member (NV) = non-voting Member	23.05.19	25.07.19	19.09.19	28.11.19	16.01.20	30.01.20	26.03.20 (Private teleconference)
Dr Ed Ford (V) Chair	✓	✓	✓	✓	✓	✓	✓
James Rimmer (V) from 2.September 2019 Chief Executive			✓	✓	✓	✓	✓
Alison Henly (V) Director of Finance, Performance and Contracting	✓	✓	✓	✓	✓	✓	✓
Sandra Corry (V) Director of Quality and Nursing	✓	✓	✓	✓	✓	✓	✓
David Freeman (V) Chief Operating Officer (to 30 January 2020) Acting Chief Officer 1 Feb 2019 to 1 Sept 2019	✓	✓	✓	✓	✓		
Adrian Boyce (V) Interim Chief Operating Officer (rom 4 March 2019 to 4 September 2019	✓	✓					
Lou Evans (V) Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓	✓	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement	X	✓	X	✓	✓	✓	✓
Grahame Paine (V) from 1 October 2019 Non-Executive Director (Finance and Performance)				✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓ (by	✓	✓	✓	✓	✓	✓

NHS Somerset CCG Governing Body Meetings 2019/20 **Attendance Record**	✓ = Present X = Apologies Given						
(V) = voting Member (NV) = non-voting Member	23.05.19	25.07.19	19.09.19	28.11.19	16.01.20	30.01.20	26.03.20 (Private teleconference)
	telephone)						
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	X	✓	✓	X	X	✓	✓
Judith Goodchild (NV) Chair, Healthwatch	✓	✓	✓	✓	✓	✓	-
Wendy Grey (V) From 23 May 2019 Non-Executive Director, Member Practice Representative	✓	✓	✓	✓	✓	✓	✓
Maria Heard (NV) Programme Director Fit for my Future	✓	✓	✓	✓	✓	✓	✓
Trudi Mann (V) (rom 23 May 2019 Non-Executive Director, Member Practice Representative	✓	✓	✓	✓	✓	✓	✓
Dr Alex Murray (V) Governing Body GP to April 2019 Clinical Lead, Fit For My Future from April 2019	X	✓	-	-	✓	✓	X
Dr Jo Nicholl (V) (from 1 September 2019) Non-Executive Director, Member Practice Representative			✓	✓	X	✓	✓
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	X	✓	✓	✓	✓	X
Orla Dunn representing Trudi Grant		✓					
Sandra Wilson (NV) PPG Lay Observer	✓	✓	✓	✓	✓	✓	-

NHS Somerset CCG Clinical Executive Committee Meetings 2019/20 Attendance Record							✓ = Present X = Apologies Given			
(V) = Voting Member (NV) = Non-Voting Member	3.4.19	1.5.19	5.6.19	3.7.19	4.9.19	2.10.19	6.11.19	4.12.19	5.2.20	4.3.20
Dr Peter Bagshaw (V) Associate Clinical Director: Mental Health and Learning Disabilities									✓	✓
Mr Adrian Boyce (V) Interim Chief Operating Officer	X	X	✓	✓	✓					
Dr Will Chandler (V) Taunton GP Commissioning Locality Delegate	✓	✓	✓	✓	✓	✓	X	X	✓	✓
Mrs Sandra Corry V) Director of Quality and Nursing	✓	X	X	X	X	✓	X	✓	✓	✓
Dr Orla Dunn (NV) Consultant in Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓	X	X	✓
Dr Steve Edgar (V) South Somerset Commissioning Locality Delegate (Job Share with Dr Ian Wyer); and, CEC Vice Chair wef 1.12.19	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Dr Ed Ford (V) CCG Chair	✓	✓	X	✓	✓	✓	X	✓	X	X
Mr David Freeman (V) Chief Operating Officer, Interim Chief Officer; and, CEC Chair	X	✓	✓	✓	✓	✓	✓	✓		
Mr Shaun Green (NV) Deputy Director of Clinical Effectiveness and Medicines Management									✓	✓

Dr Will Harris (NV) Clinical Lead: Primary Care	✓	X								
Mrs Maria Heard (V) Programme Director: Fit For My Future	X	X	X	X	X	X	✓	✓	X	X
Mrs Alison Henly (V) Director of Finance, Performance and Contracting	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Dr Emma Keane (NV) Clinical Lead: Primary Care						✓	✓	✓	✓	✓
Dr Helen Kingston (V) East Mendip Commissioning Locality Delegate	✓	✓	X	✓	✓					
Dr Alex Murray (V) CEC Vice Chair (until 30.11.19); and, FFMF clinical director	X	✓	✓	✓	✓	X	✓	✓	✓	X
Dr Amelia Randle (V) Central and West Mendip Commissioning Localities' Delegate	X	X	✓	✓	✓	✓				
Mr James Rimmer Chief Executive and CEC Chair					✓	✓	✓	✓	✓	✓
Dr Kate Staveley (V) Clinical lead – Women and Children	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Dr Karen Sylvester (NV) LMC Representative	✓	✓	✓	✓	X	✓	X	✓	X	X
Dr Helen Thomas (NV) Clinical Lead: Urgent and Emergency Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Mrs Tracey Tilsley (NV) Associate Director of Corporate Business	X	X	X	X	X	X	X	X	X	X
Dr Ian Wyer (V) South Somerset Commissioning Locality Delegate (Job Share with Dr Steve Edgar)	✓	✓	X	✓	✓	✓	X	✓		

Notes:

James Rimmer joined the CCG on 1 September 2019 as interim Chief Executive and CEC Chair replacing David Freeman who had been seconded to the role of interim Chief Officer and CEC Chair in February 2019.

David Freeman returned to his substantive role of Chief Operating Officer on 1 September 2019 when James Rimmer joined the CCG as its interim Chief Executive. However, on Monday 20 January 2020 David Freeman moved to Swindon CCG as its Chief Operating Officer on nine months' secondment.

Mr Adrian Boyce left the CCG on 4 September 2019 when David Freeman returned to his substantive role of Chief Operating Officer.

Mr Shaun Green joined the CEC as a non-voting member in February 2020.

Dr Will Harris resigned from his position as Clinical Lead: Primary Care and left the CCG on 1 June 2019.

Dr Emma Keane was appointed to the post of Clinical Lead: Primary Care on 4 December 2019.

Dr Helen Kingston resigned from her position as East Mendip Commissioning Locality Delegate and left the CCG in September 2019.

Dr Amelia Randle resigned from her position as Central and West Mendip Commissioning Locality Delegate and left the CEC at the end of October 2019. She left the CCG on 31 March 2020.

Dr Ian Wyer resigned from his position as South Somerset Commissioning Locality Delegate and left the CEC in December 2019.

In January 2020, the revised Clinical Structure was confirmed as follows:

- Dr Alex Murray - Clinical Director, FFMF; and, Clinical Director, STP

- Dr Steve Edgar, CEC Vice Chair
- Dr Peter Bagshaw, Associate Clinical Director, Mental Health and Learning Disabilities
- Dr Will Chandler, Associate Clinical Director, Planned Care
- Dr Justin Harrington, Associate Clinical Director, Digital Health
- Dr Emma Keane, Associate Clinical Director, Primary Care
- Dr Helen Thomas, Associate Clinical Director, Same Day and Emergency Care
- Dr Kate Staveley, Associate Clinical Director, Women's and Children's Health
- Dr Tom MacConnell, Associate Clinical Director, Integrated Care, joined the CEC on 12 February 2020

There are currently vacancies for the following positions:

- Interim Chief Operating Officer (during David Freeman's secondment)
- Associate Clinical Director, Quality and Assurance

NHS Somerset CCG Audit Committee Meetings 2019/20 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	15.5.19	11.9.19	11.12.19	26.2.20
Lou Evans Audit Committee Chair and Non-Executive Director, Lay Member (Governance and Audit)	M	✓	✓	✓	✓
Dr Jayne Chidgey-Clark Non-Executive Director, Registered Nurse	M	✓	✓	✓	✓
Dr Geoff Sharp GP Member – left on 1 October 2019	M	✓	✓		
Dr Joanne Nicholl GP Member Practice delegate – joined on 1 October 2019	M		✓	✓	✓
Alison Henly Chief Finance Officer and Director of Performance	A	✓	✓	✓	x

Notes:

Representatives from External and Audit Internal and Counter Fraud were present at meetings throughout the year, with other representatives attending as required.

NHS Somerset CCG Patient Safety and Quality Assurance Committee Meetings 2019/20 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	10.04.19	13.06.19	17.07.19	12.09.19	16.10.19	13.11.19	15.01.20	11.03.20
Jayne Chidgey-Clark (Chair) Registered Nurse – Governing Body	M	✓	✓	✓	✓	✓	✓	✓	✓
Kate Staveley – GP Patient Safety Lead	M	x	x	x					
Sandra Corry – Director, Quality and Nursing	M	✓	✓	✓	x	✓	✓	x	x
David Freeman - Chief Operating Officer	M	x			x	x	x		
Adrian Boyce - Interim Chief Operating Officer	M		x	✓					
Alison Henley – Chief Finance Officer and Director of Performance	M	x	✓	x	✓	x	✓	✓	x
Basil Fozard - Non-Executive Director, Secondary Care Specialist Doctor	M	x	x	x	x	✓	x	✓	x
David Heath - Governing Body Lay Member	M	x							
Wendy Grey – Governing Body Lay Member	M		✓	✓	✓	✓	✓	✓	✓
Tanya Whittle – Deputy Director of Contracting	A	✓							✓
Carmen Chadwick-Cox - Deputy Director of Commissioning Planned Care	A						✓		

Name	Member (M)/ In Attendance (A)	10.04.19	13.06.19	17.07.19	12.09.19	16.10.19	13.11.19	15.01.20	11.03.20
Jacqui Damant - Associate Director of Contracting	A								✓
Debbie Rigby – Deputy Director, Quality and Nursing	A	✓	✓	x	✓	x			
Val Janson - Deputy Director of Quality and Nursing	A						✓	✓	✓
Karen Taylor – Associate Director of Safety and Quality Improvement	A	✓	✓	✓		✓		✓	✓
Shaun Green – Associate Director Head of Medicines Management and Clinical Effectiveness	A						✓		
Jonathan Davies – Quality Lead for Primary Care, GPN, GPs with Special Interests and Quality Improvement	A		✓		✓		✓		
Charlotte Brown – Adult Safeguarding Lead Nurse	A	✓		✓			✓	✓	
Maria Davis – Designated Nurse Safeguarding Children and Children Looked After	A	✓	✓					x	
Mel Munday – Deputy Designated Nurse for Safeguarding Children	A								✓
Sarah Ashe – Designated Nurse Safeguarding Looked After Children	A		✓		✓			✓	
Phoebe Sherry-Watt - Associate Director of CHC Services	A		✓		✓				
Sam Peterson – Patient Safety Facilitator	A	✓							
Lee Reed – Quality and Equality Officer	A	✓	✓			✓	✓		

Name	Member (M)/ In Attendance (A)	10.04.19	13.06.19	17.07.19	12.09.19	16.10.19	13.11.19	15.01.20	11.03.20
Jacqui Cross – Infection Prevention and Control Lead Nurse	A						✓	x	
Julia Bloomfield - Infection Prevention and Control Nurse Specialist	A							✓	✓
Shona Turnbull Kirk – Designated Clinical Officer	A			✓	✓				
Victoria Wright – Mental Health Commissioning Manager	A			✓					
Lisa Jones – Quality Improvement Facilitator: Community Services, Mental Health and Learning Disabilities	A				✓				✓
Paul Townsend – Director of Mental Health and Learning Disabilities Care, Somerset Partnership NHS Foundation Trust	A						✓		
Justin Harrington – Chief Clinical Information Officer	A						✓		
Hugh Archibald - Quality Lead - Urgent Care and Risk Management	A							✓	
Eelke Zoestbergen - Quality Lead for Community Services, Learning Disabilities and Mental Health	A								✓

Notes:

During the year the format of the Committee changed so that only core Members were required to attend each meeting, with other representatives attending as required, to present papers

NHS Somerset CCG Remuneration Committee Meetings 2019/20 **Attendance Record**	✓ = Present X = Apologies Given	
(V) = voting Member (NV) = non-voting Member	22.8.19	31.10.19
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓
Lou Evans (V) – Committee Chair Vice Chair and Non-Executive Director, Governance and Audit	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	✓
Grahame Paine (V) from 1 October 2019 Non-Executive Director (Finance and Performance)		✓

Notes:

Dr Ed Ford, Chair and Marianne King, Associate Director of Organisational Development and Workforce attended all meetings (NV capacity).

.

NHS Somerset CCG Primary Care Commissioning Committee 2019/20 Attendance Record	✓ = Present X = Apologies Given

(M) Committee member (A) In attendance	Committee Role (eg. Executive, Lay, GP, etc)	24/04/ 2019	06/06/ 2019	05/09/ 2019	13/01/ 2020
David Health (M)	Chair, Non-Executive Director	✓	✓	✓	✓
Dr Basil Fozard (M)	Vice Chair, Non-Executive Director	✓	x	✓	✓
David Freeman (M) / Adrian Boyce (June 2019) / David Freeman (M -September 19)	Chief Operating Officer, CCG		x	x	**x**
Alison Henly (M)	Director of Finance, Performance and Contracting	✓	✓	✓	✓
Sandra Corry (M)	Director of Quality and Nursing, CCG	x	✓	x	**x**
Sharon Wilson (M) / Laila Pennington (M – December onwards)	Interim Head of Primary Care, NHS E / Head of Primary Care, NHS E	✓	✓	x	**x**
Amanda Fisk (M)	Director of Assurance and Delivery, NHS E	x	x	x	**x**
Trudi Grant (M)/ Louise Woolway (M – December 19 onwards)	Public Health, SCC	x	✓	✓	✓
Dr Will Harris (M) / Dr Emma Keane (December 19 onwards)	GP Clinical Lead, CCG	✓			✓
John Burrows (M) / (A from June 2019)	Assistant Head of Finance (Primary Care)	✓	✓	✓	**x**
Kevin Davis (M)	Acting Director of Finance, NHS E	x			
Dr Chris Campbell (M)	External GP	x	x	x	✓
Martin Davidson (M)	PPG Chair Rep	✓	✓	✓	✓
Dr Nick Bray (M)	LMC Representative	✓	x	x	**x**
Judith Goodchild (M)	Chair of the Board, Healthwatch	x	✓	x	✓
Tanya Whittle (M)	Deputy Director of Contracting, CCG	✓	✓	✓	✓
Michael Bainbridge (M)	Associate Director of Primary Care, CCG	✓	✓	✓	✓
Karen Taylor (M)	Associate Director of Safety and Quality Improvement, CCG	x	✓	✓	✓
Carol Ogilvie	Senior Finance Manager, NHS E	x			
Sandra Wilson (A)	Chair, Somerset PPG Chairs Network				
Dr Barry Moyse (A – on behalf of Dr Nick Bray)				✓	

NHS Somerset CCG Primary Care Joint Committee 2019/20 Attendance Record	✓ = Present X = Apologies Given

(M) Committee member (A) In attendance	Committee Role (eg. Executive, Lay, GP, etc)	14 March 2019	24 April 2019
David Health (M)	Chair, Non-Executive Director	✓	✓
Dr Basil Fozard (M)	Vice Chair, Non-Executive Director	✓	✓
David Freeman (M)	Chief Operating Officer, CCG	x	
Alison Henly (M)	Chief Finance Officer and Director of Performance, CCG	✓	✓
Sandra Corry (M)	Director of Quality and Nursing, CCG	x	x
Sharon Wilson (M)	Interim Head of Primary Care, NHS E	✓	✓
Amanda Fisk (M)	Director of Assurance and Delivery, NHS E	x	x
Trudi Grant (M)	Public Health, SCC	✓	x
Dr Will Harris (M)	GP Clinical Lead, CCG	✓	✓
John Burrows (M)	Assistant Head of Finance (Primary Care) / Associate Director of Finance – Projects, NHS E / CCG (Dec onwards)	✓	✓
Kevin Davis (M)	Acting Director of Finance, NHS E	x	x
Dr Chris Campbell (M)	External GP	x	x
Martin Davidson (M)	PPG Chair Rep	✓	✓
Dr Nick Bray (M)	LMC Representative	x	✓
Judith Goodchild (M)	Chair of the Board, Healthwatch	✓	x
Tanya Whittle (M)	Deputy Director of Contracting, CCG	✓	✓
Michael Bainbridge (M)	Associate Director of Primary Care, CCG	✓	✓
Karen Taylor (M)	Associate Director of Safety and Quality Improvement, CCG	✓	x
Carol Ogilvie (A)	Senior Finance Manager, NHS E	✓	x
Sandra Wilson (A)	Chair, Somerset PPG Chairs Network	✓	

Notes:

Due to NHS Somerset CCG taking on fully delegated commissioning responsibilities of Primary Care, the Somerset Primary Care Joint Committee held its final meeting on Thursday 24 April 2019. This Committee then became the Primary Care Commissioning Committee, with a slightly amended membership. The first meeting of this reformed Committee was held on Thursday 24 April 2019. For ease, attendance has been split into two tables.

The December Commissioning Committee meeting was rearranged due to Purdah. This meeting took place on 13 January 2020.

NHS Somerset CCG Finance and Performance Committee Meetings 2019/20 Attendance Record	✓ = Present X = Apologies Given

Name	10 April 2019	15 May 2019	13 June 2019	17 July 2019	14 Aug 2019	12 Sept 2019	16 Oct 2019	13 Nov 2019	12 Dec 2019	15 Jan 2020	12 Feb 2020	11 March 2020
Adrian Boyce	x	✓	✓	✓	✓							
Sandra Corry	x	x	✓	x	✓	x	x	x	x	x	✓	x
Lou Evans	x	✓	✓	✓	✓	x	✓	✓		observing		
Ed Ford	✓	✓	✓	✓	x	✓	x	✓	✓	x	x	x
David Freeman	✓	✓	✓	x	✓	✓	x	x	✓	✓		
Alison Henly	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Trudi Mann				✓	✓	✓	✓	✓	✓	✓	✓	x
Grahame Paine							✓	✓	✓	✓	✓	✓
James Rimmer						✓						

Notes: James Rimmer was no longer a member of this committee from October 2019

REMUNERATION AND STAFF REPORT

8. REMUNERATION REPORT

This section of the report contains details of remuneration and pension entitlements for senior managers of the Clinical Commissioning Group in line with Section 234B and Schedule 7A of the Companies Act.

Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members. In defining this, the scope the CCG have used is to include members of the decision making groups within the CCG, which the CCG has defined as the Governing Body, excluding those members with no voting rights. Senior managers (excluding Lay Members) are generally employed on permanent contracts with a six month period of notice.

The CCG's Remuneration Committee is chaired by a Non-Executive Director, the Vice Chairman of the Governing Body. It is the Remuneration Committee that determines the reward packages of Executive Directors, whilst taking account of the Pay Framework for Very Senior Managers (VSM) published by the Department of Health.

The table below details the remuneration levels for all senior managers in the CCG.

8.1 **Senior manager remuneration (including salary and pension entitlements)**

		Total 2019/20						Total 2018/19					
		Salary	**Expense payment (taxable)**	**Performance Pay and Bonuses**	**Long Term Performance Pay and Bonuses**	**All Pension Related Benefits**	**Total**	**Salary**	**Expense payments (taxable)**	**Performance Pay and Bonuses**	**Long Term Performance Pay and Bonuses**	**All Pension Related Benefits**	**Total**
Name	**Title**	**(bands of £5,000)**	**(rounded to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**	**(bands of £5,000)**	**(rounded to the nearest £100)**	**(bands of £5,000)**	**(bands of £5,000)**	**(bands of £2,500)**	**(bands of £5,000)**
		£'000	**£'00**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'00**	**£'000**	**£'000**	**£'000**	**£'000**
James Rimmer	Chief Executive (from 02/9/19)	85-90	0	0	0	30-32.5	115-120	-	-	-	-	-	-
David Freeman	Acting Chief Officer (from 01/2/19 to 01/9/19) and Chief Operating Officer (to 20/1/20)	100-105	0	0	0	50-52.5	150-155	80-85	0	0	0	40-42.5	120-125
Adrian Boyce	Interim Chief Operating Officer (from 04/3/19 to 04/9/19)	65-70	0	0	0	0	65-70	10-15	0	0	0	0	10-15
Alison Henly	Director of Finance, Performance and Contracting	110-115	67	0	0	22.5-25	140-145	105-110	57	0	0	47.5-50	165-170
Maria Heard	Programme Director of Fit for My Future	95-100	0	0	0	27.5-30	120-125	5-10	0	0	0	22.5-25	30-35
Sandra Corry	Director of Quality and Nursing	90-95	0	0	0	10-12.5	100-105	90-95	0	0	0	5-7.5	95-100
Edward Ford	Chair	90-95	0	0	0	30-32.5	120-125	80-85	0	0	0	15-17.5	95-100
Lou Evans	Vice-Chair and Non Exec Director Governance and Audit	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
David Heath	Non Exec Director, Patient and Public	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15

	Engagement												
Basil Fozard	Non Exec Director, Secondary Care Doctor	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Dr Jayne Chidgey-Clark	Non Exec Director and Registered Nurse	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Wendy Grey	Non Exec Director, Member Practice Representative (from 23/5/19)	25-30	0	0	0	10-12.5	20-25	-	-	-	-	-	-
Joanne Nicholl	Non Exec Director, Member Practice Representative (from 01/9/19)	10-15	0	0	0	2.5-5	15-20	-	-	-	-	-	-
Trudi Mann	Non Exec Director, Member Practice Representative (from 23/5/19)	25-30	0	0	0	0	25-30	-	-	-	-	-	-
Grahame Paine	Non Exec Director, Finance and Performance (from 01/10/19)	5-10	0	0	0	0	5-10	-	-	-	-	-	-

Officer Holder Changes:

James Rimmer was appointed to the post of Chief Executive from 2 September 2019. This appointment is a secondment from Weston Area Health NHS Trust.

David Freeman held the post of Interim Chief Officer until the appointment of James Rimmer from 2 September 2019. From the 2 September 2019 to 20 January 2020 David Freeman returned to his substantive post of Chief Operating Officer and has been seconded to Swindon CCG since 20 January 2020.

Adrian Boyce was appointed as the Interim Chief Operating Officer from 4 March 2019 until 4 September 2019. This appointment was via an external agency, for which fees were payable in addition to the remuneration reported in the table above.
Dr Joanne Nicholl was appointed as a Non-Executive Director and Member Practice Representative from 1 September 2019.

Trudi Mann was appointed as a Non-Executive Director and Member Practice Representative from 23 May 2019.

Grahame Paine was appointed as a Non-Executive Director (Finance and Performance) from 1 October 2019.

Wendy Grey was appointed as a Non-Executive Director and Member Practice Representative from 23 May 2019.

Other Notes:

A Somerset Sustainability and Transformation Team was contracted on behalf of Somerset Clinical Commissioning Group, Taunton and Somerset NHS Foundation Trust, Yeovil District Hospitals NHS Foundation Trust and Somerset Partnership NHS Foundation Trust. This was supported by Attain and as such is not reflected in the table above.

Expense payments relate to Lease Cars.

No senior manager waived his/her remuneration.

No annual and long term performance related bonus payments were made to any senior managers in 2019/20.

The next table details the pension entitlements for each of the senior managers who received pensionable remuneration through the NHS pension scheme.

Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

8.2 **Pension benefits as at 31 March 2020**

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at Pension age at 31 March 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Cash equivalent transfer value at 1 April 2019	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2020	Employer's contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
James Rimmer	Chief Executive	0-2.5	0	60-65	150-155	1,184	14	1,275	0
David Freeman	Acting Chief Officer (from 01/2/19 to 01/9/19) and Chief Operating Officer (to 30/1/20)	2.5-5	0-2.5	30-35	60-65	454	26	520	0
Alison Henly	Director of Finance, Performance and Contracting	0-2.5	0	40-45	95-100	695	24	752	0
Maria Heard	Programme Director of Fit for My Future	0-2.5	0	10-15	0-5	119	14	149	0
Sandra Corry	Director of Quality and Nursing	0-2.5	2.5-5	40-45	120-125	874	32	939	0
Edward Ford	Chair	0-2.5	0	5-10	0	63	16	87	0
Joanne Nicholl	Non Exec Director	0-2.5	0-2.5	5-10	15-20	128	5	143	0

Notes:

Lay members do not receive pensionable remuneration.

Pensionable contributions may include more than just those from CCG employment. Where a GP is under a contract of service with the CCG and pays pension contributions then they are classed as 'NHS staff (Officer)' for pension purposes. The figures provided by NHS Pensions cover only the 'Officer' element of the GP's pension entitlement.

8.3 Cash equivalent transfer values

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

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

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

8.4 Real Increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

8.5 Compensation on early retirement of for loss of office

NHS England has set restrictions on the payment of any compensation within the CCG. There have been no compensation terms agreed by NHS England.

8.6 Payments to past members

The Clinical Commissioning Group has made no payments to past directors during 2019/20.

8.7 Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director/Member of the Governing Body in NHS Somerset CCG in the financial year 2019/20 was £182,501 (2018/19: £130,000). This was 4.90 times (2018/19: 4.00) the median remuneration of the workforce, which was £37,267 (2018/19: £32,525).

In 2019/20, zero employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £7,626 to £182,501 (2018/19: £11,808 to £130,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The remuneration report and following disclosures in the Accountability Report have been audited by Grant Thornton UK LLP, NHS Somerset CCG's external auditors.

- Single total figure of remuneration for each director
- CETV disclosures for each director
- Payments to past directors
- Payments for loss of office
- "fair pay" (pay multiples)
- Exit packages
- Analysis of staff numbers and costs
- Disclosures on Parliamentary accountability.

8.8 Explanation of Key Terms used in Remuneration and Pension Reports

Term	Definition
Annual Performance Related Bonuses	Money or other assets received or receivable for the financial year as a result of achieving performance measures and targets for the period 1 April 2019 to 31 March 2020.
Cash Equivalent Transfer Value (CETV)	A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
Employer's	The amount that the Clinical Commissioning Group has

Term	Definition
contribution to stakeholder pension	contributed to individual's stakeholder pension schemes.
Lump sum at pension age related to real increase in pension	The amount by which the lump sum to which an individual will be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 31 March 2020	The amount of lump sum pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2020
Real increase in CETV	This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Real increase in pensions at pension age	The amount by which the pension to which an individual will be entitled at pension age has increased during the year
Total accrued pension at pension age at 31 March 2020	The amount of annual pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2020

8.9 Remuneration for the Accountable Officer and Directors

The remuneration of the Chief Executive and Directors within the CCG is the responsibility of the Remuneration Committee. The committee now comprises five voting members and two non-voting members.

The membership and attendance at the NHS Somerset CCG Remuneration Committee during 2019/20 is set out below:

NHS Somerset CCG Remuneration Committee Meetings 2019/20 Attendance Record		✓ = Present X = Apologies Given
(V) = voting Member (NV) = non-voting Member	22.08.19	31.10.19
Lou Evans (V) Remuneration Committee Chair, and CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓

NHS Somerset CCG Remuneration Committee Meetings 2019/20 Attendance Record	✓ = Present X = Apologies Given	
(V) = voting Member (NV) = non-voting Member	22.08.19	31.10.19
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement, and Chair of the Primary Care Commissioning Committee.	✓	✓
Grahame Paine (V) from 1 October 2019 Non-Executive Director (Finance and Performance)		✓
Marianne King (NV) Associate Director of Human Resources and Organisational Development	✓	✓
Dr Edward Ford (NV) Governing Body Chair	✓	✓
Note: No additional persons attended the Committee in order to provide legal advice on compliance with any relevant legislation.		

Note:

Dr Ed Ford, Chair and Marianne King, Associate Director of Workforce and OD attended all meetings (Non-voting capacity).

During 2019/20 the Clinical Commissioning Group also established a committee to oversee the appointments and remuneration for Non-Executive Directors. This Committee shall make determinations about the appointment, pay and remuneration for Non-Executive Directors of the Clinical Commissioning Group Governing Body.

8.10 Policy on Remuneration of Senior Managers

A benchmarking exercise was carried out across the South West to determine Senior Manager pay scales when the CCG became fully authorised in April 2013. The recommendations were implemented in determining Senior Manager terms and conditions of employment. Further benchmarking exercises continue to take place with CCG's in the South West to ensure that pay scales remain competitive and in line with the NHS's current financial position.

Agenda for Change guidelines will be taken into consideration when assessing whether to award an inflationary increase to Directors.

8.11 Policy on Contracts

All Senior Managers are on permanent contracts with a six months' notice period in place.

9. STAFF REPORT

9.1 Number of senior managers

The number of senior managers is set out below in paragraph 9.4.

9.2 Staff numbers and costs

The NHS Somerset CCG's total staff costs for the year ended 31 March 2020 are summarised in the following table:

	Total		
	Permanent Employees £'000 N4G	Other £'000 N4H	Total £'000 N4I
Salaries and wages	8,975	1,189	10,164
Social security costs	937	45	982
Employer contributions to the NHS Pension Scheme	1,670	51	1,721
Other pension costs	2	-	2
Apprenticeship levy	29	-	29
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	3	-	3
Gross Employee Benefits Expenditure	**11,616**	**1,285**	**12,901**
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure incl. capitalised costs	**11,616**	**1,285**	**12,901**
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excl. capitalised costs	**11,616**	**1,285**	**12,901**

9.3 Average Number of Persons Employed

The average number of Clinical Commissioning Group staff employed by staff grouping is as follows:

Average number of people employed				
	Permanently employed	Other	2019/20 Total	2018/19 Total
	Number	Number	Number	Number
Medical and dental	5	0	5	6
Administration and estates	152	10	162	132
Healthcare assistants and other support staff	1	0	1	1
Nursing, midwifery and health visiting staff	57	0	57	53
Scientific, therapeutic and technical staff	0	0	0	0
Social Care Staff	2	0	2	2
Total	**217**	**10**	**227**	**198**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**-**	-	-	-

The majority of employees are members of the NHS defined benefit pension scheme. Details of the scheme and its accounting treatment may be found within the accounting policies disclosed in the full audited annual accounts.

9.4 Staff composition

The breakdown of the gender profile for the CCG as at the end of March 2020 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	**43%**	**57%**	**14**
Membership Body Clinical Executive Committee Voting Members	**50%**	**50%**	**14**
Very Senior Managers	**20%**	**80%**	**5**
All substantive CCG Staff	**21%**	**79%**	**275**

9.5 Trade Union Facility Time

The trade union (facility time publication requirements) regulations 2017 came in to force on 1 April 2017.

In line with these new regulations, all organisations employing more than 49 staff, must publish information on facility time, which is agreed time off from an individual's job to carry out a trade union role.

Our organisation
Somerset Clinical Commissioning Group
1 April 2019 to 31 March 2020

Employees in our organisation
50 to 1,500 employees

Trade union representatives and full-time equivalents
Trade union representatives: 1
FTE trade union representatives: 1.00

Percentage of working hours spent on facility time
0% of working hours: 0 representatives
1 to 50% of working hours: 1 representative
51 to 99% of working hours: 0 representatives
100% of working hours: 0 representatives

Total pay bill and facility time costs
Total pay bill: £12,900,746
Total cost of facility time: £4,018
Percentage of pay spent on facility time: 0.03%

Paid trade union activities
Hours spent on paid facility time: 156
Hours spent on paid trade union activities: 0
Percentage of total paid facility time hours spent on paid TU activities: 0%

9.6 Sickness absence data and ill health retirements

The CCG has a clear and robust Management of Sickness Absence Policy.

Sickness absence data for Somerset Clinical Commissioning Group is available via the following link: NHS Sickness Absence Rates - NHS Digital

9.7 Staff Policies

The Clinical Commissioning Group has applied the following new or updated staff policies in 2019/20:

The Disciplinary Policy
The Grievance Disputes Policy
The Capability Policy
The Sickness Absence Management Policy

9.8 Expenditure on consultancy

The Clinical Commissioning Group consultancy expenditure in 2019/20 was £449,000 (2018/19 £128,000), as per note 5 in the annual accounts

9.9 Off-payroll engagements

For all off-payroll engagements as at 31 March 2020, for more than £245 per day and that last longer than six months.

Table 1: Off-payroll engagements longer than 6 months

	Number
Number of existing engagements as of 31 March 2020	13
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	1
for 4 or more years at the time of reporting	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than 6 months:

Table 2: New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	8
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	8
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020.

Table 3: Off-payroll engagements / senior official engagements

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	3
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	15

During the year there have been 3 incidences where senior officer positions have been held by off-payroll members of staff. This includes the current Chief Executive, an Interim Chief Operating Officer and the current ‘Fit For My Future’ Programme Director.

The Clinical Commissioning Group has been without a substantive Accountable Officer since the departure of the previous post-holder, who was on a fixed term contract. The role had been covered by acting up arrangements following his departure, due to the developing direction of Strategic Commissioning and joint working with Somerset County Council. In the further interim a secondment opportunity has arisen with an experienced Chief Executive to lead the Somerset system through the transformation required. Following this, a

permanent appointment will be made now that it is clear what the role will be to support the new integrated care system.

It was considered that there was not sufficient capacity or capability within the organisation to provide cover for the position of Chief Operating Officer. The requirement was for a short term appointment, for a period of 6 months, and there was a requirement for the individual to be in post as soon as possible due to the scope and influence of the role of Chief Operating Officer. An off-payroll member of staff was able to deliver high quality work for a short term appointment without significant delays of recruiting traditionally to the post.

It was considered that there was not sufficient capacity or capability within the organisation to provide cover for the position of Programme Director for the Fit For My Future Programme. The post is a fixed term appointment and there was a requirement for the individual to be in post as soon as possible to ensure that the impetus of the project was maintained after the resignation of the previous post holder. An off-payroll member of staff was available with the relevant skills to deliver high quality work without significant delays of recruiting traditionally to the post.

9.10 **Exit packages, including special (non-contractual) payments**

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook and are in line with statutory requirements. Exit costs in this note are accounted for in full in the year of departure. Where NHS Somerset CCG has agreed early retirements, the additional costs are met by NHS Somerset CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table below.

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	1	8,808	1	8,808	0	0
£10,001 - £25,000	1	23,490	0	0	1	23,490	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	**1**	**23,490**	**1**	**8,808**	**2**	**32,298**	**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 in Table 2 below will not necessarily match the total numbers in Table 1 above, which will be the number of individuals.

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*	1	8,808
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	**1**	**8,808**

*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 non-contractual payments in lieu of notice.

No exit packages were payable to Senior Managers during 2019/20.

Parliamentary Accountability and Audit Report

9.11 NHS Somerset CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at **Appendix One**.

ANNUAL ACCOUNTS

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
18 June 2020

Appendix One

Entity name:	NHS Somerset CCG
This year	2019-20
Last year	2018-19
This year ended	31-March-2020
Last year ended	31-March-2019
This year commencing:	01-April-2019
Last year commencing:	01-April-2018

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Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services	2	(1,685)	(1,839)
Other operating income	2	(1,042)	(1,408)
Total operating income		**(2,727)**	**(3,247)**
Staff costs	4	12,901	10,486
Purchase of goods and services	5	883,288	752,733
Depreciation and impairment charges	5	100	96
Provision expense	5	(831)	1,541
Other Operating Expenditure	5	320	178
Total operating expenditure		**895,778**	**765,034**
Net Operating Expenditure		**893,051**	**761,787**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**893,051**	**761,787**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**893,051**	**761,787**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**893,051**	**761,787**

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Non-current assets:			
Property, plant and equipment	13	228	280
Intangible assets	14	1	5
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		229	285
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	5,657	4,484
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	69	48
Total current assets		**5,728**	4,534
Non-current assets held for sale	21	-	-
Total current assets		**5,728**	4,534
Total assets		**5,957**	4,819
Current liabilities			
Trade and other payables	23	(45,732)	(42,800)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(275)	(1,555)
Total current liabilities		**(46,007)**	(44,355)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(40,050)**	(39,536)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(40,050)**	(39,536)
Financed by Taxpayers' Equity			
General fund		(40,050)	(39,536)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(40,050)**	(39,536)

The notes on pages 5 to 40 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 18 June 2020 and signed on its behalf by:

James Rimmer
Accountable Officer
NHS Somerset Clinical Commissioning Group

31 March 2020

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(39,536)	0	0	**(39,536)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(39,536)**	**0**	**0**	**(39,536)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(893,051)			**(893,051)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve		**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(893,051)**	**0**	**0**	**(893,051)**
Net funding	892,537	0	0	**892,537**
Balance at 31 March 2020	**(40,050)**	**0**	**0**	**(40,050)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(37,997)	0	0	**(37,997)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(37,997)**	**0**	**0**	**(37,997)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Impact of applying IFRS 9 to Opening Balances	0			0
Impact of applying IFRS 15 to Opening Balances	0			0
Net operating costs for the financial year	(761,787)			(761,787)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve		0		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(761,787)**	**0**	**0**	**(761,787)**
Net funding	760,248	0	0	760,248
Balance at 31 March 2019	**(39,536)**	**0**	**0**	**(39,536)**

The notes on pages 5 to 40 form part of this statement

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(893,051)	(761,787)
Depreciation and amortisation	5	100	96
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(1,173)	3,140
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	2,888	(2,503)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(449)	(708)
Increase/(decrease) in provisions	30	(831)	1,541
Net Cash Inflow (Outflow) from Operating Activities		**(892,516)**	(760,221)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	(50)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	(50)
Net Cash Inflow (Outflow) before Financing		**(892,516)**	(760,271)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		892,537	760,248
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**892,537**	760,248
Net Increase (Decrease) in Cash & Cash Equivalents	20	**21**	(23)
Cash & Cash Equivalents at the Beginning of the Financial Year		**48**	71
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		**69**	48

The notes on pages 5 to 40 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2019-20 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Somerset County Council [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for learning disability services, community equipment services, carers services and the Better Care Fund and a memorandum note to the accounts provides details of the income and expenditure.
The pool is hosted by Somerset County Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 Revenue

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.
Somerset Clinical Commissioning Group considers that it does not have any revenue sources to which application of the Standard would have any material impact.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are within fourteen days of invoice date.

The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period. Permission levels for the carry forward of leave have been reviewed and extended for 2019/20 due to the inability of staff to take leave during the COVID-19 crisis period.

Notes to the financial statements

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 **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.

1.9 **Grants Payable**

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

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

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

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

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

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

1.11.2 **Measurement**

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

Notes to the financial statements

1.11.3 **Depreciation, Amortisation & Impairments**
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **Donated Assets**
Somerset Clinical Commissioning Group does not have any donated assets.

1.13 **Government grant funded assets**
Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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

1.14.1 **The Clinical Commissioning Group as Lessee**
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.15 **Inventories**
Inventories are valued at the lower of cost and net realisable value.

1.16 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.17 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

Notes to the financial statements

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

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

1.20 **Carbon Reduction Commitment Scheme**
The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is not registered with the CRC scheme.

1.21 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.22 **Financial Assets**
Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

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

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

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

1.22.4 **Impairment**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

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

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

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

1.24 **Value Added Tax**
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Notes to the financial statements

1.25 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Somerset Clinical Commissioning Group does not have any exposure to foreign currencies.

1.26 **Third Party Assets**

Somerset Clinical Commissioning Group does not have any third party assets.

1.27 **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).

1.28 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.
In March 2020 a global pandemic was declared, caused by novel coronavirus - Covid 19. This has radically changed demand for healthcare in the short term and, as a result, there is less certainty than usual about the value of primary care prescribing spend in March and the value of partially completed care hospital activity as at 31st March. The Clinical Commissioning Group has considered the impact of these estimates and elected to continue to estimate on a historic basis. This is due to the lack of precedent to establish a more accurate estimate, and the two estimates are temporary in nature and are expected to revert to long term trends in time; and therefore using historic basis still presents a true and fair view of the expenditure, assets and liabilities and financial performance of the Clinical Commissioning Group.

1.28.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.
* Valuation assumptions for property, plant and equipment – note 13
* Provisions recognised as at 31 March 2020 – note 30
* Income and expenditure accruals – notes 17 and 23

1.29 **Gifts**

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

1.30 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2019-20. These Standards are still subject to HM Treasury FReM adoption. The HM Treasury, in conjunction with the Financial Reporting Advisory Board (FRAB), have decided that, considering extraordinary pressures during the COVID-19 crisis, IFRS 16 will be deferred in the public sector for bodies applying the FReM, for a further year, to 2021/22. The government implementation date for IFRS 17 is still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2021 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**842**	714
Non-patient care services to other bodies	**843**	1,125
Patient transport services	**-**	-
Prescription fees and charges	**-**	-
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**-**	-
Recoveries in respect of employee benefits	**-**	-
Total Income from sale of goods and services	**1,685**	**1,839**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**11**	5
Other non contract revenue	**1,031**	1,403
Total Other operating income	**1,042**	**1,408**
Total Operating Income	**2,727**	**3,247**

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	716	25	-	-	-	-	-	-
Non NHS	126	818	-	-	-	-	-	-
Total	**842**	**843**	**-**	**-**	**-**	**-**	**-**	**-**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	842	843	-	-	-	-	-	-
Over time	-	-	-	-	-	-	-	-
Total	**842**	**843**	**-**	**-**	**-**	**-**	**-**	**-**

3.2 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

	2019-20 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits — Total — 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**8,975**	**1,189**	**10,164**
Social security costs	**937**	**45**	**982**
Employer Contributions to NHS Pension scheme	**1,670**	**51**	**1,721**
Other pension costs	**2**	**-**	**2**
Apprenticeship Levy	**29**	**-**	**29**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**3**	**-**	**3**
Gross employee benefits expenditure	11,616	1,285	12,901
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	11,616	1,285	12,901
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	11,616	1,285	12,901

4.1.1 Employee benefits — Total — 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**7,645**	**689**	**8,334**
Social security costs	**825**	**24**	**849**
Employer Contributions to NHS Pension scheme	**1,006**	**29**	**1,035**
Other pension costs	**1**	**-**	**1**
Apprenticeship Levy	**27**	**-**	**27**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**240**	**-**	**240**
Gross employee benefits expenditure	9,744	742	10,486
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	9,744	742	10,486
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	9,744	742	10,486

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2019-20 Total £'000	2018-19 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**-**	**-**	**-**	**-**
Social security costs	**-**	**-**	**-**	**-**
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**	**-**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-	-

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**217**	**10**	**227**	**191**	**7**	**198**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		**2019-20 Other agreed departures**		**2019-20 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	1	8,808	1	8,808
£10,001 to £25,000	1	23,490	-	-	1	23,490
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**23,490**	**1**	**8,808**	**2**	**32,298**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	2	19,890	2	19,890
£10,001 to £25,000	-	-	1	21,333	1	21,333
£25,001 to £50,000	-	-	1	39,000	1	39,000
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**1**	**160,000**	**4**	**80,223**	**5**	**240,223**

	2019-20 Departures where special payments have been made		2018-19 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2019-20 Other agreed departures		2018-19 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	8,808	4	80,223
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**1**	**8,808**	**4**	**80,223**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook and are in line with statutory requirements.

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

Where **NHS Somerset CCG** has agreed early retirements, the additional costs are met by NHS Somerset CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

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

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 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 the CCG accounts.

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019 updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,995	4,593
Services from foundation trusts	550,695	503,812
Services from other NHS trusts	26,263	24,761
Provider Sustainability Fund	-	-
Services from Other WGA bodies	33	34
Purchase of healthcare from non-NHS bodies	91,743	88,304
Purchase of social care	35,166	34,398
General Dental services and personal dental services	-	-
Prescribing costs	83,123	78,909
Pharmaceutical services	-	-
General Ophthalmic services	573	540
GPMS/APMS and PCTMS	84,529	9,707
Supplies and services – clinical	22	-
Supplies and services – general	1,818	2,272
Consultancy services	449	128
Establishment	322	801
Transport	2,567	2,683
Premises	787	826
Audit fees	63	63
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees	162	122
Legal fees	159	132
Education, training and conferences	808	643
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	11	5
Total Purchase of goods and services	**883,288**	**752,733**
Depreciation and impairment charges		
Depreciation	96	92
Amortisation	4	4
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**100**	**96**
Provision expense		
Change in discount rate	-	-
Provisions	(831)	1,541
Total Provision expense	**(831)**	**1,541**
Other Operating Expenditure		
Chair and Non Executive Members	310	170
Grants to Other bodies	-	-
Clinical negligence	10	8
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	0	-
Total Other Operating Expenditure	**320**	**178**
Total operating expenditure	**882,877**	**754,548**

Notes

1. External Audit Fees Net of Vat total £52,500.
2. The auditor's liability for external audit work carried out for the financial year 2019/20 is limited to £2,000,000.
3. GPMS/APMS and PCTMS - includes costs for Primary Care Medical services. Somerset CCG received delegated responsibility from NHS England for commissioning these services from 1st April 2019.
4. Non cash apprenticeship training grants now reported under puchase of goods and services

6.1 Better Payment Practice Code

Measure of compliance	**2019-20 Number**	**2019-20 £'000**	2018-19 **Number**	2018-19 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,751	134,507	9,794	129,156
Total Non-NHS Trade Invoices paid within target	9,746	134,020	9,754	128,637
Percentage of Non-NHS Trade invoices paid within target	**99.95%**	**99.64%**	**99.59%**	**99.60%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,584	583,307	3,406	538,557
Total NHS Trade Invoices Paid within target	3,570	583,189	3,401	538,171
Percentage of NHS Trade Invoices paid within target	**99.61%**	**99.98%**	**99.85%**	**99.93%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2019-20 £'000**	2018-19 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Income Generation Activities

The Clinical Commissioning Group did not have any income generation activities in 2019-20.

8. Investment revenue

The Clinical Commissioning Group did not have any Investment Revenue as at 31 March 2020.

9. Other gains and losses

The Clinical Commissioning Group did not have any other gains and losses as at 31 March 2020.

10.1 Finance costs

The Clinical Commissioning Group did not have any Finance Costs as at 31 March 2020.

10.2 Finance income

The Clinical Commissioning Group did not have any Finance income as at 31 March 2020.

11. Net gain/(loss) on transfer by absorption

The Clinical Commissioning Group have not transferred any function(s) that gave rise to any recognised gain or loss as at 31 March 2020.

12. Operating Leases

12.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Services Ltd. In 2019-20 the charge to the Clinical Commissioning Group included charges for properties that it occupied as well as charges relating to under recovered costs for properties where the Clinical Commissioning Group was identified as the lead commissioner. This is reflected in Note 12.1.1.

The Clinical Commissioning Group also has annual commitments under lease agreements for fleet vehicles and photocopiers. There are no contingent rentals or purchase options built within any of the current lease arrangements.

12.1.1 Payments recognised as an Expense

	2019-20				2018-19			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	-	681	11	**692**	-	750	14	**764**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**681**	**11**	**692**	**-**	**750**	**14**	**764**

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only.

12.1.2 Future minimum lease payments

	2019-20				2018-19			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payable:								
No later than one year	-	-	17	**17**	-	-	17	**17**
Between one and five years	-	-	5	**5**	-	-	19	**19**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**22**	**22**	**-**	**-**	**36**	**36**

12.2 As lessor

The Clinical Commissioning Group did not have any leases let as at 31 March 2020.

13 Property, plant and equipment

2019-20	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2019	-	-	-	-	-	-	555	119	674
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	44	-	44
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**599**	**119**	**718**
Depreciation 01 April 2019	-	-	-	-	-	-	346	48	394
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	80	16	96
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**426**	**64**	**490**
Net Book Value at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**173**	**55**	**228**
Purchased	-	-	-	-	-	-	173	55	228
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**173**	**55**	**228**
Asset financing:									
Owned	-	-	-	-	-	-	173	55	228
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**173**	**55**	**228**

Revaluation Reserve Balance for Property, Plant & Equipment

The Clinical Commissioning Group did not have any Revaluation Reserve Balances as at 31 March 2020.

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction
The Clinical Commissioning Group has no additions to assets under construction at 31 March 2020.

13.2 Donated assets
The Clinical Commissioning Group did not hold any donated assets at 31 March 2020.

13.3 Government granted assets
The Clinical Commissioning Group did not hold any government granted assets at 31 March 2020.

13.4 Property revaluation
The Clinical Commissioning Group did not have any property revaluations at 31 March 2020.

13.5 Compensation from third parties
The Clinical Commissioning Group did not have any compensation from third parties for assets impaired, lost or given up at 31 March 2020.

13.6 Write downs to recoverable amount
The Clinical Commissioning Group did not have any assets written down to recoverable amounts at 31 March 2020.

13.7 Temporarily idle assets
The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2020.

13.8 Cost or valuation of fully depreciated assets
The Clinical Commissioning Group did not have any fully depreciated assets with any value still in use as at 31 March 2020.

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	5	7
Furniture & fittings	7	10

14 Intangible non-current assets

2019-20	Computer Software: Purchased £'000	Computer Software: Internally Generated £'000	Licences & Trademarks £'000	Patents £'000	Development Expenditure (internally generated) £'000	Total £'000
Cost or valuation at 01 April 2019	20	-	-	-	-	**20**
Additions purchased	-	-	-	-	-	**-**
Additions internally generated	-	-	-	-	-	**-**
Additions donated	-	-	-	-	-	**-**
Additions government granted	-	-	-	-	-	**-**
Additions leased	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Reclassified as held for sale and reversals	-	-	-	-	-	**-**
Disposals other than by sale	-	-	-	-	-	**-**
Upward revaluation gains	-	-	-	-	-	**-**
Impairments charged	-	-	-	-	-	**-**
Reversal of impairments	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	-	-	**-**
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	**-**
Cost / Valuation At 31 March 2020	**20**	**-**	**-**	**-**	**-**	**20**
Amortisation 01 April 2019	15	-	-	-	-	**15**
Reclassifications	-	-	-	-	-	**-**
Reclassified as held for sale and reversals	-	-	-	-	-	**-**
Disposals other than by sale	-	-	-	-	-	**-**
Upward revaluation gains	-	-	-	-	-	**-**
Impairments charged	-	-	-	-	-	**-**
Reversal of impairments	-	-	-	-	-	**-**
Charged during the year	4	-	-	-	-	**4**
Transfer (to) from other public sector body	-	-	-	-	-	**-**
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	**-**
Amortisation At 31 March 2020	**19**	**-**	**-**	**-**	**-**	**19**
Net Book Value at 31 March 2020	**1**	**-**	**-**	**-**	**-**	**1**
Purchased	1	-	-	-	-	**1**
Donated	-	-	-	-	-	**-**
Government Granted	-	-	-	-	-	**-**
Total at 31 March 2020	**1**	**-**	**-**	**-**	**-**	**1**

Revaluation Reserve Balance for intangible assets

The Clinical Commissioning Group did not have any Revaluation Reserve Balances as at 31 March 2020.

14 Intangible non-current assets cont'd

14.1 Donated assets

The Clinical Commissioning Group did not hold any intangible non-current donated assets at 31 March 2020.

14.2 Government granted assets

The Clinical Commissioning Group did not hold any intangible non-current government granted assets at 31 March 2020.

14.3 Revaluation

The Clinical Commissioning Group did not have any revaluations at 31 March 2020.

14.4 Compensation from third parties

The Clinical Commissioning Group did not have any compensation from third parties for intangible non-current assets impaired, lost or given up at 31 March 2020.

14.5 Write downs to recoverable amount

The Clinical Commissioning Group did not have any intangible non-current assets written down to recoverable amounts at 31 March 2020.

14.6 Non-capitalised assets

The Clinical Commissioning Group did not have any significant intangible non-current assets not recognised as assets because they didn't meet the recognition criteria of IAS38 as at 31 March 2020.

14.7 Temporarily idle assets

The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2020.

14.8 Cost or valuation of fully amortised assets

The Clinical Commissioning Group did not have any fully amortised assets still in use as at 31 March 2020.

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	5	5
Computer software: internally generated	0	0
Licences & trademarks	0	0
Patents	0	0
Development expenditure (internally generated)	0	0

15 Investment property

The Clinical Commissioning Group did not have any investment property as at 31 March 2020.

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2019	-	-	2	-	-	-	**2**
Additions	-	-	-	-	-	-	**-**
Inventories recognised as an expense in the period	-	-	-	-	-	-	**-**
Write-down of inventories (including losses)	-	-	-	-	-	-	**-**
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	-	-	-	-	-	**-**
Transfer (to) from -Goods for resale	-	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**2**	**-**	**-**	**-**	**2**

17.1 Trade and other receivables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS receivables: Revenue	125	-	155	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	2,308	-	2,239	-
NHS accrued income	633	-	446	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	340	-	433	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,354	-	1,018	-
Non-NHS and Other WGA accrued income	692	-	66	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	205	-	126	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	0	-	1	-
Total Trade & other receivables	**5,657**	**-**	**4,484**	**-**
Total current and non current	**5,657**		**4,484**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	**2019-20 Non DHSC Group Bodies £'000**	**2018-19 DHSC Group Bodies £'000**	**2018-19 Non DHSC Group Bodies £'000**
By up to three months	71	238	57	272
By three to six months	95	-	-	36
By more than six months	-	47	-	15
Total	**166**	**285**	**57**	**323**

17.3 Loss allowance on asset classes

There has been no movement in loss allowances for 2019/20.

18 Other financial assets
The Clinical Commissioning Group did not have any other financial assets as at 31 March 2020.

19 Other current assets
The Clinical Commissioning Group did not have any other current assets as at 31 March 2020.

20 Cash and cash equivalents

	2019-20 £'000	2018-19 £'000
Balance at 01 April 2019	48	71
Net change in year	21	(23)
Balance at 31 March 2020	**69**	**48**
Made up of:		
Cash with the Government Banking Service	69	48
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**69**	**48**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**69**	**48**
Patients' money held by the clinical commissioning group, not included above	-	-

21 Non-current assets held for sale
The Clinical Commissioning Group did not have any non-current assets held for sale as at 31 March 2020.

22 Analysis of impairments and reversals
The Clinical Commissioning Group did not make any impairments in 2019/20

23 Trade and other payables	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	3,538	-	2,816	-
NHS payables: Capital	-	-	-	-
NHS accruals	2,379	-	2,710	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	8,061	-	9,379	-
Non-NHS and Other WGA payables: Capital	44	-	-	-
Non-NHS and Other WGA accruals	26,991	-	27,015	-
Non-NHS and Other WGA deferred income	-	-	16	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	156	-	119	-
VAT	-	-	-	-
Tax	118	-	102	-
Payments received on account	-	-	-	-
Other payables and accruals	4,445	-	643	-
Total Trade & Other Payables	**45,732**	**-**	**42,800**	**-**
Total current and non-current	**45,732**		**42,800**	

Other payables include £672,656 outstanding pension contributions at 31 March 2020

24 Other financial liabilities
The Clinical Commissioning Group did not have any other financial liabilities as at 31 March 2020.

25 Other liabilities
The Clinical Commissioning Group did not have any other liabilities as at 31 March 2020.

26 Borrowings
The Clinical Commissioning Group did not have any borrowings as at 31 March 2020.

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group does not have any private finance initiative, LIFT or other service concession arrangements that were included or excluded from the Statement of Financial Position as at 31 March 2020.

28 Finance lease obligations
The Clinical Commissioning Group did not have any finance lease obligations as at 31 March 2020.

29 Finance lease receivables
The Clinical Commissioning Group did not have any finance lease receivables as at 31 March 2020.

29.1 Finance leases as lessor
The Clinical Commissioning Group did not have any unguaranteed residual value accruing as at 31 March 2020.
The Clinical Commissioning Group did not have any accumulated allowance for uncollectible lease receivables as at 31 March 2020.

29.2 Rental revenue
The Clinical Commissioning Group did not have any rental revenue as at 31 March 2020.

30 Provisions

	Current 2019-20 £'000	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	29	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	248	-	1,019	-
Continuing care	27	-	507	-
Other	-	-	-	-
Total	**275**	**-**	**1,555**	**-**
Total current and non-current	**275**		**1,555**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2019	**-**	**-**	**-**	**29**	**-**	**-**	**1,019**	**507**	**-**	**1,555**
Arising during the year	-	-	-	-	-	-	248	27	-	**275**
Utilised during the year	-	-	-	(29)	-	-	-	(420)	-	**(449)**
Reversed unused	-	-	-	-	-	-	(1,019)	(87)	-	**(1,106)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**248**	**27**	**-**	**275**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	248	27	-	**275**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**	**248**	**27**	**-**	**275**

The above is based on the information currently held by Somerset Clinical Commissioning Group, if the provision assessment was under assessed by 10% the impact would be £28k

Following a staffing restructure within the Clinical Commissioning Group there remains a legal case outstanding as at 31 March 2020 in respect of a redundancy. A provision has therefore been made for the probability adjusted value of this legal claim. A contingent liability in respect of this provision is shown in note 31.

The "Continuing Care" provision is an assessment of the continuing care cases which are currently being reviewed by the Clinical Commissioning Group's assessment panel. This has been based on the best professional judgement in line with IAS37. All of the cases awaiting panel have been provided for and the calculation has been based on estimated cost and the probability of success. The probability factor applied is based on success rates in the current financial year. A contingent liability in respect of this provision is shown in note 31.
Under the Accounts Direction 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 Previously Unassessed Periods of Care NHS Continuing Healthcare contingent liability accounted for by NHS England on behalf of this Clinical Commissioning Group at 31 March 2020 is £101k

31 Contingencies

	2019-20 £'000	2018-19 £'000
Contingent liabilities		
Equal Pay	-	-
NHS Resolution Legal Claims	-	-
Employment Tribunal	-	-
NHS Resolution employee liability claim	-	-
Redundancy	-	2
Continuing Healthcare	10	85
Litigation	16	103
Her Majesty's Revenue and Customs	-	-
Amounts recoverable against contingent liabilities	-	-
Net value of contingent liabilities	**26**	**190**
Contingent assets		
Amounts payable against contingent assets	-	-
Net value of contingent assets	**-**	**-**

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group did not have any contracted capital commitments not otherwise included in these financial statements as at 31 March 2020.

32.2 Other financial commitments

The Clinical Commissioning Group did not have any non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) as at the 31 March 2020.

33 Financial instruments

33.1 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 Somerset 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 Somerset Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Somerset Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

The NHS Somerset 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 Somerset Clinical Commissioning Group has no overseas operations. The NHS Somerset Clinical Commissioning Group therefore has low exposure to currency rate fluctuations.

33.1.2 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.

33.1.3 Credit risk

Because the majority of the NHS Somerset Clinical Commissioning Group revenue comes from parliamentary funding, NHS Somerset 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.

33.1.4 Liquidity risk

NHS Somerset Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Somerset Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Somerset Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33.1.5 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.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Equity Instruments designated at FVOCI 2019-20 £'000	Total 2019-20 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	127		127
Trade and other receivables with other DHSC group bodies	1,367		1,367
Trade and other receivables with external bodies	296		296
Other financial assets	-		-
Cash and cash equivalents	69		69
Total at 31 March 2020	**1,859**	**-**	**1,859**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Other 2019-20 £'000	Total 2019-20 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	773		**773**
Trade and other payables with other DHSC group bodies	17,415		**17,415**
Trade and other payables with external bodies	27,271		**27,271**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2020	**45,459**	**-**	**45,459**

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Somerset Clinical Commissioning Group	895,778	(2,727)	**893,051**	5,957	(46,007)	**(40,050)**
Total	**895,778**	**(2,727)**	**893,051**	**5,957**	**(46,007)**	**(40,050)**

34.1 Reconciliation between Operating Segments and SoCNE

	2019-20 £'000
Total net expenditure reported for operating segments	893,051
Total net expenditure per the Statement of Comprehensive Net Expenditure	893,051

34.2 Reconciliation between Operating Segments and SoFP

	2019-20 £'000
Total assets reported for operating segments	5,957
Total assets per Statement of Financial Position	**5,957**

	2019-20 £'000
Total liabilities reported for operating segments	(46,007)
Total liabilities per Statement of Financial Position	**(46,007)**

35 Joint arrangements - interests in joint operations

Integrated Community Equipment Service Pooled Fund

NHS Somerset Clinical Commissioning Group is party to an Integrated Community Equipment Service pooled budget with Somerset County Council. Under this arrangement funds are pooled under s75 of the Health Act 2006 for the provision of Community Equipment in Somerset.

The pool is hosted by Somerset County Council. As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pool, which are then used to purchase healthcare equipment services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

	2019-20 £'000	2018-19 £'000
Income		
Expenditure	1,273	1,260

Carers Services Pooled Fund

NHS Somerset Clinical Commissioning Group is party to a Carers Service pooled budget with Somerset County Council. Under this arrangement funds are pooled under s75 of the Health Act 2006 for the provision of Carers Services in Somerset.

The pool is hosted by Somerset County Council. As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pool, which are then used to purchase Carers services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

	2019-20 £'000	2018-19 £'000
Income		
Expenditure	226	225

Learning Disability Service Pooled Fund

NHS Somerset Clinical Commissioning Group is party to a Learning Disability Service pooled budget with Somerset County Council. Under this arrangement funds are pooled under s75 of the Health Act 2006 for the provision of Learning Disability Services in Somerset.

The pool is hosted by Somerset County Council. As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pool, which are then used to purchase Learning Disability services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

	2019-20 £'000	2018-19 £'000
Income		
Expenditure	23,333	23,254

Better Care Fund

The Clinical Commissioning Group entered into a Better Care Fund partnership agreement under s75 of the Health Act 2006 with Somerset County Council on 1st April 2015.

As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pools, which are then used to purchase health and social care services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

The Clinical Commissioning Group’s share of expenditure for each pooled budget area within the Better Care Fund in the financial year were as follows:

	2019-20 £'000	2018-19 £'000
Income		
Expenditure	38,424*	36,320*

* Less (£203,500) included within Carers Pooled Budget figure above

35 Joint arrangements - interests in joint operations

35.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2019-20				Amounts recognised in Entities books ONLY 2018-19			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Integrated Community Equipment Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase healthcare equipment services	-	-	-	1,273	-	-	-	1,260
Carers Services Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Carers services	-	-	-	226	-	-	-	225
Learning Disability Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Learning Disability services	-	-	-	23,333	-	-	-	23,254
Better Care Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase health and social care services	-	-	-	38,424	-	-	-	36,320

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

The Clinical Commissioning Group did not have any interests in entities not accounted for under IFRS 10 or IFRS 11 as at 31st March 2020.

36 NHS Lift investments

The Clinical Commissioning Group did not have any NHS LIFT investments as at 31 March 2020.

37 Related party transactions

Details of related party transactions with individuals are as follows:

Appendix 1

31 March 2020	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
Interim Chief Operating Officer Adrian Boyce (**left 04/09/19**) is a director of Ascendor Solutions Ltd (no expenditure incurred with this organisation in year), his brother is Adult Service User Governor at Northamptonshire Healthcare NHS Foundation Trust (expenditure incurred with this organisation in year), and his niece is directorate manager for Generalist & Specialist Surgery at Northampton General Hospital NHS Trust (expenditure incurred with this organisation in year)	11	0	0	0
Non-Executive Director and Registered Nurse Dr Jayne Chidgey-Clark is a director of JCC Partnership Limited and is specialist advisor to the Care Quality Commission (no expenditure incurred with these organisations in year). Her spouse is a director and company secretary of JCC Partnership Limited (no expenditure incurred with these organisations in year) and was Interim Head of Quality for NHS England Specialist Commissioning (South West) **(withdrawn 03/04/19)** (expenditure incurred with this organisation in year), and Interim Adult Safeguarding Consultant at East Kent CCGs **(from 23/09/19 to 20/03/20)** (no expenditure incurred with these organisations in year). Jayne Chidgey-Clark is the CCG nominated Governor of Somerset Partnership NHS Foundation Trust (expenditure incurred with this organisation in year)	147,647	90	1,719	138
Director of Quality and Patient Safety Sandra Corry has a 5% share in her spouse's consultancy company QSI Limited which provides support to Health and Social Care sectors. Her spouse was employed by Somerset CCG as LeDeR Reviewer for the South West Region **(withdrawn 31/05/19)** and through QSI Limited, holds part time various CCGs role with across the SW region **(added 01/04/19)** (no organisation incurred with this organisation in year)	0	0	0	0
Vice Chair and Non Executive Director Lou Evans is the Clinical Commissioning Group's nominated governor for Yeovil District Hospital NHS Foundation Trust (expenditure incurred with this organisation in year), and was a director at Martin Brooks Associates Limited **(withdrawn 30/04/19**), , was National Advisor to GPiC Ltd **(withdrawn 30/06/19)** and is NED Chair of Chrysalis Supported Association Limited **(from 01/07/2019)** (no expenditure incurred with these organisations in year**)**.	100,871	0	186	644
Chair Dr Ed Ford is a GP Partner at Minehead Medical Centre, which is a training practice and a member of Somerset Primary Care Limited. Dr Ford is a CCG member and Vice-chair of the Health and Wellbeing Board, a first responder for Somerset Accident Voluntary Emergency Service**.** His family have been ratified as Foster Carers for Somerset County Council. His spouse was the Community Development and Liaison Practitioner for Musgrove Park Hospital **(withdrawn 04/04/19)** and is Associate Director Primary Care Nursing and Allied Health Care Professionals at Musgrove Park Hospital (expenditure incurred with these organisations in year)	266,972	818	8,082	1,912
Non-Executive Director and Secondary Care Doctor Basil Fozard is a Bank Locum Consultant at The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust. His daughter is a GP in North London, his daughter is a specialist registrar for Child and Adolescent Mental Health Services (CAMHS) at Tavistock & Portman NHS Foundation Trust and University College London Hospitals NHS Foundation Trust), and his son is a Clinical Research Fellow in ENT at University College London Hospitals NHS Foundation Trust **(removed 27/05/19)**. His spouse is a mental health act panel member at Dorset Healthcare NHS Foundation Trust (expenditure incurred with these organisations in year)	556	0	63	0
Interim Chief Officer **(until 01/09/19)**, and Chief Operating Officer David Freeman **(left 19/01/20)** is non-executive director of the South West Academic Health & Science Network (SW AHSN) and his step-daughter is a junior reporter with the Somerset County Gazette, part of Newsquest Media Group Ltd (expenditure incurred with these organisations in year)	32	0	11	0
Chair of Healthwatch Somerset Judith Goodchild has no interests to declare	0	0	0	0
Non-Executive Director Wendy Grey **(appointed 23/05/19)** is director of Gemini Healthcare Consultancy Ltd **(added 08/07/19)**, and was employed as Transformation lead for Symphony Healthcare Services **(until 29/08/19)** (expenditure incurred with these organisations in year), Her husband, son, and daughter-in-law are all employed by Yeovil District Hospital NHS Foundation Trust (expenditure incurred with this organisation in year), and her sister is employed as a solicitor by Battens Solicitors in Sherborne (no expenditure incurred with these organisations in year).	103,093	0	194	644

Programme Director: Fit For My Future Maria Heard is on secondment from South, Central and West Commissioning Support. Her parent is a community paediatric consultant with Sussex Community NHS Foundation Trust (expenditure incurred with these organisations in year)	3,951	0	448	0
Non Executive Director, Patient & Public Engagement David Heath is Chair of Western Region and National Board Member of the Consumer Council for Water, Board Member for the Solicitors Regulation Authority, Non-executive director of Bath and Wells Multi-academy trust, and Chair of Policy and Public Affairs Board for the Institute and Faculty of Actuaries (no expenditure incurred with these organisations in year)	0	0	0	0
Chief Finance Officer and Director of Performance Alison Henly's son is undertaking a voluntary placement at Vaughan Lee Nursing Home as part of the Duke of Edinburgh bronze scheme (**added 02/07/19**) (no expenditure incurred with this organisation in year)	0	0	0	0
Non-Executive Director Trudi Mann provides strategic management support to the Taunton & Area Federation of GPs (expenditure incurred with this organisation in year), and is a volunteer with the Royal Voluntary Service **(from 09/10/19**) (no expenditure incurred with this organisation in year). Her sister-in-law is Deputy Practice Manager at Minehead Medical Centre **(from 05/11/19)** (expenditure incurred with this organisation in year)	2,130	0	0	0
Non-Executive Director Joanne Nicholl **(appointed 01/09/19)** was a partner at Preston Grove Medical Centre **(until 17/12/19) (expenditure incurred with this organisation in year)** and was practice representative on Yeovil Primary Care Network **(until 16/12/19**) (no expenditure incurred with this organisation in year)	1,516	0	1	0
Non-executive director Grahame Paine (**appointed 01/10/19**) is non-executive director at Weston College (**from 24/10/19**) (no expenditure incurred with this organisation in year)	0	0	0	0
Chief Executive James Rimmer **(appointed 02/09/19)** is on secondment from Weston Area NHS Trust (expenditure incurred with this organisation in year), and is the Exec Chair of Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance, a member of the National Institute of Health Research (NIHR) Commissioned Panel for Health Services and Delivery Research Programme, an occasional newspaper reviewer for BBC Radio Somerset, a Trustee for Changing Tunes charity, and is a visiting lecturer at the University of Bristol. His wife is Consultant Senior Lecturer in Public Health at University of Bristol, and is leading a NHIR childhood obesity study, and is part of a research team in a NHIR School for Public Health study. (no expenditure incurred with these organisations in year)	16,488	0	606	0
PPG Lay Observer Sandra Wilson is chair of Somerset PPG Chairs Network, Chair of Exmoor Medical Centre PPG (expenditure incurred with this organisation in year), Healthwatch Somerset Board Member, and Director of YLEM Ltd which supplies computer & IT Equipment and services (no expenditure incurred with these organisations in year)	1,103	0	0	0

Note
The related parties have been identified through the register of members' interests, but have been amended to include related parties only. Under IAS 24 a person is a related party if they: -
(i) have control or joint control over the reporting entity;
(ii) have significant influence over the reporting entity; or
(iii) are a member of the key management personnel
All relevant organisations have then been checked for the level of business activity on both the purchase and sales ledgers i.e. a governor of Yeovil District Hospital NHS Foundation Trust will have the total of all the annual transactions along with the year end debtor and creditor values noted against their name.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

Appendix 2

31 March 2020	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
NHS England	0	90	318	126
South, Central and West Commissioning Support	3,946	0	448	0
NHS Herefordshire Clinical Commissioning Group	0	0	0	0
NHS Ashford Clinical Commissioning Group	0	0	0	0
NHS Canterbury and Coastal Clinical Commissioning Group	0	0	0	0
NHS South Kent Coast Clinical Commissioning Group	0	0	0	0
NHS Thanet Clinical Commissioning Group	0	0	0	0
NHS FOUNDATION TRUSTS				
Dorset County Hospital NHS Foundation Trust	2,307	0	100	0
Dorset Healthcare NHS Foundation Trust	122	0	0	0
Northamptonshire Healthcare NHS Foundation Trust	2	0	0	0
Royal Devon and Exeter NHS Foundation Trust	4,208	0	15	281
Royal United Hospital Bath NHS Foundation Trust	34,881	0	123	189
Salisbury NHS Foundation Trust	679	0	59	100
Somerset Partnership NHS Foundation Trust	147,647	0	1,401	12
South Western Ambulance Service NHS Foundation Trust	24,697	0	126	1
Sussex Community Health NHS Foundation Trust	5	0	0	0
Taunton & Somerset NHS Foundation Trust	221,219	0	485	1,465
Tavistock & Portman NHS Foundation Trust	28	0	0	0
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust	138	0	10	0
University College London Hospitals NHS Foundation Trust	268	0	53	0
University Hospitals Bristol NHS Foundation Trust	9,863	0	275	7
Yeovil District Hospital NHS Foundation Trust	100,871	0	186	644
NHS TRUSTS				
North Bristol NHS Trust	7,236	0	61	205
Northampton General Hospital NHS Trust	9	0	0	0
Northern Devon Healthcare NHS Trust	585	0	3	3
Weston Area Health NHS Trust	16,488	0	606	0

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Somerset County Council, NHS Property Services Limited, National Insurance Fund, NHS Pension Scheme and Her Majesty Revenue and Customs.

38 Events after the end of the reporting period

Revised arrangements for NHS contracting and payment during the COVID-19 pandemic:

Following publication of a letter to NHS bodies from Sir Simon Stevens and Amanda Pritchard on 17 March 2020, significant changes have been made to contracting and payment arrangements between commissioners and a) NHS Trusts/NHS foundation trusts and b) other non-NHS providers for the period 1st April to 31st July 2020.

The principles of the approach are to;
• provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract, that they will continue to be paid for the period April to July 2020; and
• minimise the burden of formal contract documentation and contract management processes, so that staff can focus fully on the COVID-19 response.

This is considered to be a non-adjusting event in respect of the 2019/20 Annual Accounts of the CCG.

Funded Nursing Care Rate 2019/20

On 30 April 2020 the Department of Health and Social Care announced that there will be a revision to the Funded Nursing Care (FNC) Rate for 2019/20. This will require backdated payments in 2020/21 for payments made in 2019/20. Somerset CCG estimates that the total cost of this backdated payment within Somerset will be approximately £1.3 million. CCGs were advised by NHS England not to take any action for this in relation to 2019/20 Annual Accounts. NHS England & NHS Improvement have made a national provision for the additional charge for 2019/20 accounts purposes and therefore this should not impact CCG accounts in 2020/21.

39 Third party assets

The Clinical Commissioning Group held no third party assets as at 31 March 2020.

40 Financial performance targets

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

	2019-20 Target	**2019-20 Performance**	2018-19 Target	2018-19 Performance
Expenditure not to exceed income	879,797	895,822	765,033	765,033
Capital resource use does not exceed the amount specified in Directions	44	44	50	50
Revenue resource use does not exceed the amount specified in Directions	877,026	893,051	761,787	761,787
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	44	44	50	50
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	864,659	881,128	749,837	751,062
Revenue administration resource use does not exceed the amount specified in Directions	12,367	11,923	11,950	10,725

For the financial year 2019/20 (1 April 2019 to 31 March 2020), Somerset Clinical Commissioning Group had a planned in year deficit position of £4.5m and was eligible to receive Commissioner Sustainability Funding (CSF) of £4.5m to enable delivery of a break even position for the financial year. The Clinical Commissioning Group did not deliver to plan for the financial year with a deterioration of £13.1m from the planned position. This resulted in the loss of the final two quarters of CSF for 2019/20, equating to £2.925m. This results in a total deficit of £16.025m for the 2019/20 financial year. The required protocol for a deterioration from financial plans was adhered to and this position was discussed and approved with NHS England prior to the financial year end.

As a result of the Clinical Commissioning Group's breach of its duty to breakeven against revenue resource limit for the year ending 31 March 2020 a referral has been made under section 30 of the Local Audit and Accountability Act 2014, by the CCG's appointed auditors, to the Secretary of State and NHS England, to notify them of this breach.

41 Analysis of charitable reserves

The Clinical Commissioning Group has no charitable reserves as at 31 March 2020.

Independent auditor's report to the members of the Governing Body of NHS Somerset CCG

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Somerset CCG (the 'CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accountable Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the CCG's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the CCG's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going

concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the CCG's financial statements shall be prepared on a going concern basis, we considered the risks associated with the CCG's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the CCG's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

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 absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported expenditure of £895.8 million against income of £879.8 million and a deficit of £16 million in its financial statements for the year ending 31 March 2020. The CCG thereby breached two of its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that annual expenditure does not exceed income and revenue resource use does not exceed the amount specified by direction of the NHS Commissioning Board, otherwise known as NHS England.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of the above matters except on 15 April 2020 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS Somerset CCG's planned breach of its revenue resource limit for the year ending 31 March 2020.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

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

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

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

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, except for the effects of the matter described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, NHS Somerset CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion

Our review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

The CCG agreed a financial plan with NHS England to deliver a deficit of £4.5 million for 2019/20. Achievement of this target would have made the CCG eligible for Commissioner Sustainability Funding of £4.5 million, which would have resulted in a breakeven position at year end. During the year, the CCG's financial position deteriorated and it was unable to recover the position by the year-end, resulting in the CCG reporting a deficit of £16 million. The main reasons for the deterioration in the financial position were:

- the CCG planned to make efficiency savings of £22.8 million but was only able to deliver savings of £16.8 million; and
- increased activity within the CCG's main acute providers which resulted in overspends on the CCG's contracts with these providers.

This matter identifies weaknesses in the CCG's arrangements for setting a sustainable budget with sufficient capacity to absorb emerging cost pressures. This matter is evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to

whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Somerset CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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

Jackson Murray

Jackson Murray, Key Audit Partner

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

Bristol

24 June 2020