NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2020/21

10 June 2021

Contents

PERFORMANCE REPORT

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
10 June 2021

1 INTRODUCTION

I am delighted to be writing the introduction to our 2020/21 annual report, which highlights both the successes and the challenges we have faced over the past 12 months. The COVID-19 pandemic has meant that the past year has been very demanding and difficult for everyone. This has presented the NHS both nationally and locally, here in Somerset, with some immense challenges.

Somerset's vision remains clear and focused. We will continue to work together to improve the health and wellbeing of everyone who lives and works in Somerset. This will only be possible if we work with our partners in the health and care system, our voluntary sector 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 not going to be easy, but it is vital that we achieve this so we can build stronger communities with services which support people to live happy, healthy lives.

The work we have put into building stronger relationships with our system partners in Somerset is already having a positive impact. We are committed to ensuring these relationships continue to grow and develop to enable us to better support the healthcare needs of our communities and colleagues. In December 2020, we were formally designated as an Integrated Care System (ICS). I was incredibly honoured to be appointed as Senior Responsible Officer (SRO) and will be working with leaders across the system to ensure that our move towards more integrated working is done collaboratively.

In February 2021, the Government published the White Paper 'Integration and Innovation: working together to improve health and social care for all'. This sets out the legislative proposals for a Health and Care Bill, which will further develop the collaborations seen in Somerset and which have been strengthened through the response to the pandemic.

I am also pleased to say that we are now out of 'special measures' and have been awarded a 'requires improvement' rating, which further builds on our grounding for the future as part of an ICS.

Our Health and Care Strategy for Somerset 'Fit for My Future' is still the vehicle to make the transformational changes in Somerset. The ambition is 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 that care is delivered as close to home as possible.

While this work was paused during 2020/21 due to the COVID-19 pandemic, we were still able to carry out a detailed review of mental health services. The result of this was a new model for the delivery of mental health services, co-produced with partners, patients, voluntary sector organisations and the people of Somerset.

We plan to take the learning from the pandemic and restart Fit For My Future (FFMF) in 2021/22, focussing on our community health and care settings. We will be engaging with our public and wider stakeholders to seek their views to help us shape and improve our emerging model; this will ultimately lead to a public consultation.

Clearly, however, the response to the COVID-19 pandemic has been the primary focus for the whole Somerset system during 2020/21.

I am immensely proud and incredibly humbled by the way colleagues responded to the challenges we faced during this time. Many of them were redeployed into frontline and new roles, supporting providers across Somerset.

With Somerset County Council (SCC) and our providers we worked hard to make sure our colleagues had the Personal Protective Equipment (PPE) required and that testing was available. When the COVID-19 vaccine was made available, we were part of the wider health and care team, which, supported by volunteers, rapidly rolled out 21 vaccination sites across the county, including two hospital hubs, 13 GP-led community locations, two large vaccination centres and four pharmacy led sites. This will continue through the next year.

In 2020/21 the Somerset Clinical Commissioning Group (CCG) has reported a breakeven position.

We have also experienced challenges in meeting a number of our performance and operational access standards due to the onset and ongoing impact of the pandemic. During this time our priority has been to keep patients safe, ensuring that those with the most urgent conditions continue to be prioritised.

At the end of February 2021, 62% of patients had been waiting for less than 18 weeks for their first definitive treatment: however, 3773 patients had been waiting for more than 52 weeks. The focus is now on recovery, to ensure that our waiting time standards are such that Somerset patients are able to access services when expected.

As I write this, we are still supporting the COVID-19 vaccination programme to ensure that, as a system, we can return to some form of normality as part of the Government's roadmap out of lockdown, and hopefully the widespread pandemic. Our focus is always to ensure that we are able to protect and keep the people of Somerset as safe as possible, and to support our health and care colleagues, ensuring their health and wellbeing remains paramount.

I hope that when you read this report you are heartened and proud of the achievements we have made as a CCG and as a wider Somerset system.

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
10 June 2021

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. Over the next 25 years, the overall population is forecast to rise by 15% and we expect the number of people over the age of 75 to double. This is likely to result in a significant rise in demand for health and care services.

While Somerset is relatively less deprived than other parts of England, there is disparity across the county, with high levels of deprivation in certain areas. People living in the more deprived areas in Somerset do not live as long as people from areas which are less deprived; they are also more likely to experience both physical and mental health issues.

Deprivation has an impact on life expectancy as well as its quality. Lifestyle and environmental factors, including smoking, obesity, housing, income, education, disability and vulnerability are 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. People are living longer but more are living with long-term conditions or health-limiting conditions. Typically, around 15 years of life can be spent managing these conditions.

An ageing population brings new challenges:

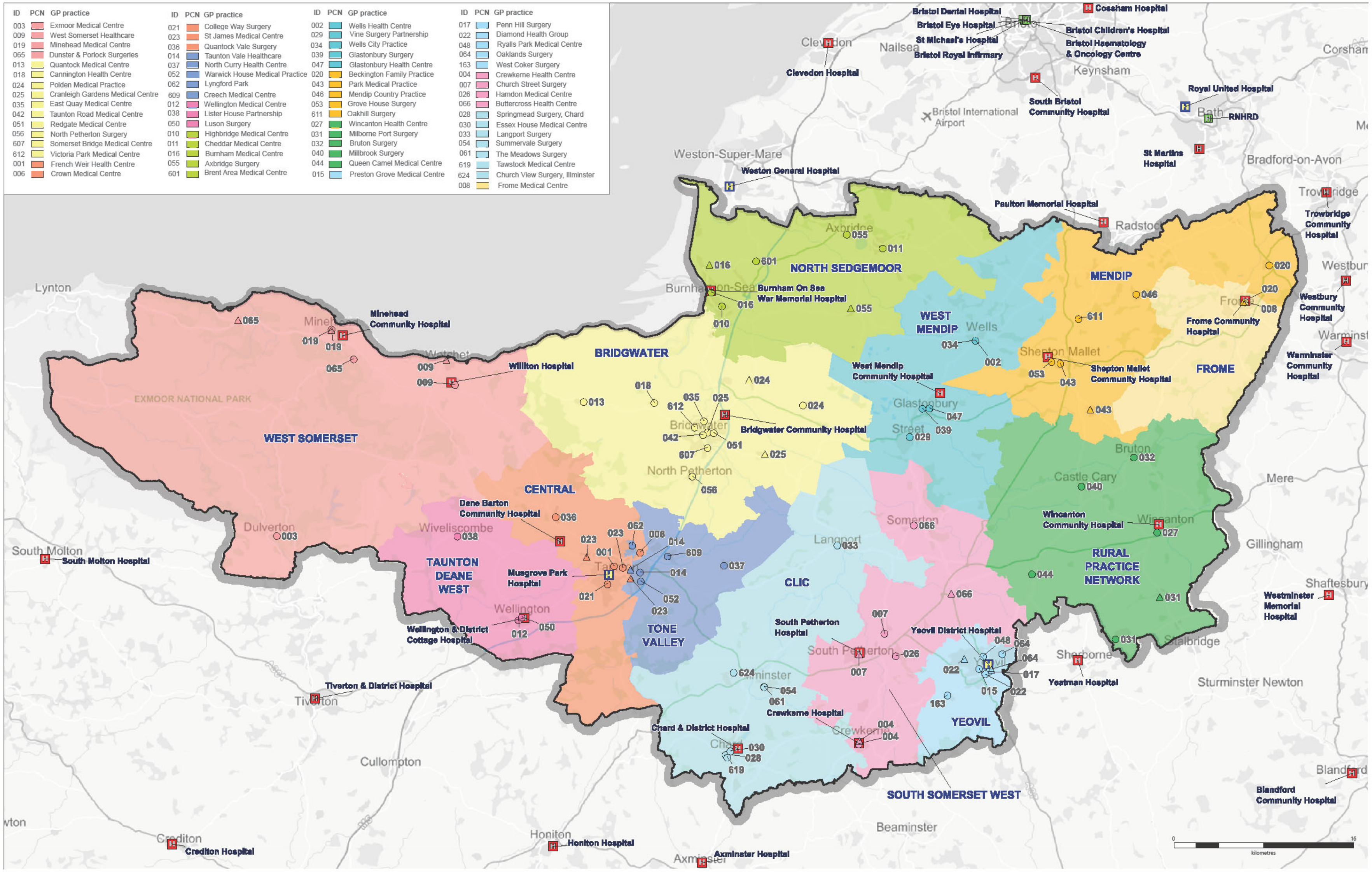
- the older we get the more likely we are to have more than one long-term condition affecting our health. Support for people with multiple conditions is more complex and needs to be much better integrated and supported

- the number of people living with dementia is expected to double by 2035, with lifestyle choices having a significant impact. This predicted figure could potentially be lower if people living with dementia could make radical changes to their lifestyle

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

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

The more we do to support health and wellbeing, as well as to address inequalities, the bigger the impact will be on individuals' quality of life and longevity. This will also help to address our financial position. It costs far less to help someone stay healthy than it does to treat and support them when they have become ill.



NHS Somerset Clinical Commissioning Group

Overview Map: GP Surgeries, Hospitals & Primary Care Networks

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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

2.1 System Working and Integrated Care System Development

For several years, the health and care organisations in Somerset have been working closely together. The aim is to provide joined-up commissioning and integrated provision of health and social care services.

In November 2020, we applied to NHS England and Improvement (NHSE) for formal designation of our Integrated Care System (ICS). This application was confirmed in December 2020 and we are now working closely with NHSE on our ICS development plan and how this will be developed going forward.

James Rimmer has been appointed as the substantive ICS Leader/Senior Responsible Officer (SRO) and Pat Flaherty has been appointed as the ICS Chair. By appointing these roles from within the Somerset system we can ensure that the vision and priorities of the ICS are fully aligned with the strategic direction of our component organisations.

Currently the ICS is not a legal entity; the legal responsibilities and associated governance lie with the constituent statutory entities. The ICS via the ICS Board will be the mechanism through which leaders from across the system will collectively oversee the transformation and alignment of health and care services, focused on the needs of our population. While we have made substantial progress in developing genuine partnership working and building structures to ensure appropriate delivery and governance, we now have the opportunity to enhance the maturity of our system to further develop and invest in new ways of working.

The chief executives of the statutory NHS and Somerset County Council (SCC) commissioning bodies and the NHS Foundation Trusts in Somerset form the core component of the ICS Leadership team, operating through the 'ICS Executives Group'. They are supported by leaders across our partnerships in Somerset, in particular, the Chair of the Primary Care Board and the Voluntary, Community and Social Enterprise (VCSE) sector. Our system benefits from strong working relationships between these leaders based on a culture of openness, support and constructive challenge.

During 2020/21, the Government published the White Paper 'Integration and Innovation: working together to improve health and social care for all'. This paper sets out the legislative proposals for a Health and Care Bill. It aims to build on the collaborations seen through the COVID-19 pandemic and removes some of the barriers that prevent systems from being truly integrated. Through legislation, the intent is to eliminate some of the transactional bureaucracy that has made prudent decision-making more difficult.

In summary, the proposals, which are expected to be in place by April 2022, will see a statutory ICS formed in each area, including Somerset. This will comprise:

- an ICS NHS body, and
- an ICS Health and Care Partnership

This will see CCG functions merging into the ICS NHS body, with social care being given a clearly defined role within an ICS to ensure it has a greater voice in NHS planning and allocation. NHS Trusts, NHS Foundation Trusts and local authorities will remain separate statutory bodies, with their duties broadly as they are in current legislation.

As part of the changes, a commitment has been made to support our staff by:

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

In Somerset, we are well prepared for these changes. Our vision remains:

We want people to live healthy independent lives, supported by thriving communities with timely and easy access to high quality and efficient public services when they need them.

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

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

1. enable people to live healthy independent lives, to prevent the onset of avoidable illness and support active self-management

2. ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting

3. provide support in neighbourhood areas with an emphasis on self-management and prevention

4. value all people alike, addressing inequalities and giving equal priority to physical and mental health

5. improve outcomes for people through personalised, co-ordinated support

We will achieve this by:

- shifting our focus towards prevention
- delivering improvements to population health
- moving to more personalised integrated services to support independence
- identifying and tackling inequalities wherever they exist
- shifting resources from hospital inpatient services towards community based services

- making provision of the right care at the right time by the right person, the simplest option for all

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

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

We have developed four workstreams, focussing on:

- mental health services
- community health and care services
- acute services
- provision and prevention

Although the pandemic paused much of our work, while we refocussed our efforts and redeployed our staff to respond, our workstreams will continue once we are able to, taking account of the learning and benefits we have gained during this period.

2.3 Mental Health

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

We have reviewed our acute inpatient services for people of working age, having developed three options for the future configuration of our inpatient acute adult wards. In September 2020, our Governing Body approved a proposal to relocate 14 adult mental health beds from Wells to Yeovil. This decision followed a two-and-a-half year period of engagement and consultation with staff, patients, carers and colleagues in the voluntary sector and people with an interest in mental health.

The COVID-19 pandemic has accelerated many of the positive transformational plans we had in place to improve community mental health services for adults in Somerset. Our focus now is firmly on more support

being available to more people as early as possible, so that they are supported to manage their mental health at home or in their local community, meaning that people's mental health does not deteriorate to the point where they require inpatient treatment and care. We believe that providing better care locally, and supporting people to stay at home wherever we safely can, provides the best outcomes and facilitates recovery.

2.4 Community Health and Care Services

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

The learning from the pandemic will be incorporated into the work we do in 2021/22 and we will be engaging with the public and wider stakeholders to gather views to help shape and improve the emerging model, ultimately leading to a public consultation on options for the future.

2.5 Acute Settings of Care

Our acute services currently serve 580,000 people (those registered with a GP) across Somerset. During 2021/22 we will be reviewing our services and considering how best to provide sustainable, safe, effective hospital-based services that meet the needs of our population both now and in the future.

2.6 Prevention

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

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

2.7 Inequalities

Reducing inequalities has always been important nationally and locally. The COVID-19 pandemic has exposed and amplified existing inequalities, combined with the lockdown impact on our economy and education. We are committed to reducing these inequalities to ensure parity of access and care for all.

3 PERFORMANCE REPORT OVERVIEW

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

The sections also include how we have delivered our key statutory responsibilities and workstreams, and our overall performance during 2020/21.

3.1 Managing and Preventing Long Term Conditions

The pandemic highlighted the particular risk factors of diabetes and obesity for COVID-19 complications. We have examined our diabetes population, establishing the numbers of people with higher levels of blood sugar and raised BMI. This makes them particularly vulnerable to the complications of COVID-19 as well as other medical problems. During this year we have worked hard to reduce the number of people in this position, by supporting them and GP practices to manage their care. We also provided a virtual clinic to all Somerset GP practices and worked with two practices to give some intensive support to the team on diabetes management.

The diabetes team also implemented an advice and guidance service, which negated the need for outpatient appointments and resulted in a faster response time for patients.

People in Somerset have also been able to access a self-management platform, My Diabetes My Way, which allowed people to better manage their condition during lockdown. Currently, 14% of people with diabetes in Somerset are self-managing using this platform. This has allowed users to not only reduce their blood cholesterol and blood pressure, but also their HbA1c levels.

In partnership with Somerset Activity Sports Partnership (SASP), individuals shielding in Somerset during the pandemic were offered information about safe exercise. They were also asked to complete a questionnaire about the support they would find helpful and we received more than 2,800 responses. The results have been analysed and provide clear direction for future working on deconditioning, in particular, understanding the factors which impact digital uptake, including accessibility and digital literacy.

We also worked in partnership with SASP and Sport England to offer virtual cycling to care homes in Somerset, providing a safe form of exercise while preventing deconditioning and falls.

A pilot project has also commenced, supporting people who are waiting for hip and knee surgery to get fit for surgery.

In addition, we displayed banners offering support with exercise programmes in vaccination centres across the county to motivate and encourage those who had been shielding to get involved.

3.2 Diabetes Prevention Programme

During 2020/21, our nationally commissioned diabetes prevention programme continued to operate. While it is still operating on a predominantly digital basis, those without access to the internet can contact the service via telephone.

Over the next three years, our ambition is to double attendance in line with pre COVID-19 plans, targeting practices which have yet to refer. The public are now able to self-refer to a digital diabetes prevention programme, and as a result we are attracting a different demographic to the course. Relevant supporting material has been developed and produced in four languages (Polish, Urdu, Hindi and Portuguese) ensuring that Somerset's key minority ethnic populations have equal access to the information.

The Diabetes Prevention Programme will focus on recruiting more people to the course. During 2020/21 we focused on supporting:

- the gypsy and traveller population, which is one of the larger ethnic minority groups in Somerset

- workplaces and businesses, engaging the working population, including ethnic minority employees across organisations, from the NHS to food production plants

- we approached community leaders in the ethnic minority population to offer focused campaigns and we also worked with Somerset Diverse Communities (https://ccslovesomerset.org/somerset-diverse-communities/) to ensure that we effectively engaged members of these groups

- we developed our relationship with the Community Council for Somerset, and Village Agents in particular, to help us better target and increase uptake of the Diabetes Prevention Progamme in rural communities

3.3 Diabetes Management

My Diabetes My Way is a self-management platform that allows patients to set goals, monitor their results and access education. On 31 March 2021 we had 4,420 users, which is about 12% of the registered diabetes population. During 2020/21 there was an increase in usage of the platform and we carried out an active recruitment campaign. Early data from My Diabetes My Way shows lowered levels of cholesterol, HbA1c and blood pressure in those people using it.

An open online course was held for people with diabetes during 2020/21 and attracted more than 1,000 people, including several from Somerset. Staff from the Diabetes team contributed to the faculty.

The impact of the pandemic meant that all face-to-face structured education ceased during 2020/21 and it is now delivered remotely. Although the number accessing structured education has decreased, people have accessed innovative online programmes for both Type 1 and Type 2 diabetes. In April 2021 we will review the educational offer for diabetes so that we can provide more choice to people in Somerset.

3.4 Respiratory Management

During 2020/21, we piloted a virtual community-facing respiratory physiotherapy service to support people with dysfunctional breathing and help with breathlessness. This continued over the winter period and the service has now seen more than 240 patients who may otherwise have required medical intervention, including admission.

We had hoped to develop a community-facing respiratory service, but were unable to attract recruits to funded posts in Somerset.

The Respiratory team also developed and offered a training programme for clinicians to enable them to work with respiratory patients and better support them closer to home. This attracted 25 people to the programme from primary and community care as well as care homes.

'My COPD' licences (which support the management of Chronic Obstructive Pulmonary Disease), another digital self-management tool, were distributed to 75 patients across Somerset during 2020/21 and we continue to encourage further uptake.

The respiratory programme launched a primary care based Asthma Interest Group, which will support the management of people in the community using action learning and quality improvement.

3.6 Cardio Vascular Disease

My Heart, a self- management app designed to support people requiring heart failure and cardiac rehabilitation, has been implemented in Somerset with more than 100 people accessing the platform. The app provided vital support to people when face-to-face services were not possible.

3.7 Somerset COVID-19 Recovery Service

Somerset CCG has established a service for people experiencing the long-term effects of COVID-19 in line with national requirements introduced in December 2020. The service operates in primary care settings with a team of GPs and other clinicians including occupational therapy, fatigue specialists, mental health, rehabilitation, and social prescribing. People referred to the service receive a virtual assessment before being offered a range of services to support their needs. Given that Long COVID is a new condition, a weekly multi-disciplinary team meeting is held, providing an opportunity to discuss complex cases and to learn from each other. The service is constantly

developing via test and learn and quality improvement methodology. In the first 14 weeks, the service received more than 100 referrals.

3.8 Neighbourhoods and Communities

A neighbourhood approach is comprised of local partnerships where all agencies and communities collaborate to support people to deliver fulfilled happy and healthy lives. It is a more integrated way of working.

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

Examples of this type of working include:

- collaboration and ‘huddles’ with health, social care, the voluntary sector and primary care, to support individuals to achieve the outcomes they want to achieve

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

- establishing the county Corona Helpers volunteers’ network which saw more than 1000 people come forward and participate in volunteering work with support provided to 100 volunteer groups

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

- work to support homeless people into safe accommodation

- agreeing countywide provision of safe sites and more relaxed enforcement approaches in respect of people within the gypsy, traveller and van-dwelling communities

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

3.9 Primary Care

Primary Care is an integral part of our communities and in 2020/21 there were three key priorities:

- ensuring there is a comprehensive local GP service
- making sure there are enough health and care staff locally to meet the health needs of the population
- improving the integration of the health and care services in each neighbourhood

In addition to delivering these existing priorities, during 2020/21 we also supported our primary care colleagues to achieve the following:

- Primary care continued to support the pandemic response, including being able to respond to additional waves of COVID-19 activity. This was achieved through the zoning of practice buildings and/or rapidly mobilising Primary Assessment Centres as required. Practice footfall was minimised to reduce the potential spread of the virus and to ensure the safety of staff and we provided a digital first approach with face-to-face assessments as required. We supported this approach by ensuring there was consistent and clear public messaging as well as robust patient information.

- Primary care ensured there was equitable and timely access for all patients, appreciating the reduction in capacity resulting from infection prevention control (IPC) requirements and staffing considerations, with demand being safely and effectively managed.

- Demand, particularly over the winter period, was managed by:

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

Primary Care Network (PCN) development continues and during 2020/21 we continued to increase the number of PCN staff in new roles.

To ensure any health inequalities demonstrated during the COVID-19 pandemic were addressed, (particularly within our Learning Disabilities (LD) and ethnic minority population), we prioritised health checks and ensured equitable access to primary care health services, taking account of individual needs. All of our PCN Clinical Directors are champions of health equality, and

general practice is committed to achieving (at least) the 67% target of health checks for people with a learning disability by 31 March 2021.

During 2020/21, we took action to improve GP registration for Gypsy and Traveller communities by providing guidance on having a non-discriminatory policy. We worked closely with practices to ensure they fully discharged their equality duties.

3.10 Urgent and Emergency Care

We have established a Somerset wide Accident and Emergency (A&E) Delivery Board for system-wide urgent and emergency care. This board is responsible for ensuring that the urgent and emergency care system is able to respond to the demand, surge and pressure throughout the year and to mitigate this where possible. The board is also responsible for ensuring that a robust winter plan is in place, one that that reflects a whole system approach to the delivery of services. The board works well together and has effective processes in place to support partner organisations during times of escalation.

In response to COVID-19, a new hospital avoidance and discharge service was established, the Somerset Hub for Co-ordinating Care. This new service supports both admission avoidance and hospital discharge through one central point with two key changes: our acute hospitals will facilitate a rapid multi-disciplinary team discharge lounge function; and community health and social care co-ordinate all care from a new hub, building on existing arrangements. The main components to the new service model have been drawn from the lessons learned previously in reducing delayed transfers of care, successfully implementing Home First pathways and achieving COVID-19 preparedness. This capacity has been expanded considerably in response to the pandemic:

- an expanded intermediate care service, which includes Discharge to Assess, a central co-ordination hub and expanded reablement services. This will see the current capacity to support people in their own homes doubled and an increase in pathway three beds. The service will also, for the first time, support discharges from community hospitals

- a significantly enhanced Rapid Response service which was able to double the capacity and saw consultant geriatricians and therapists joining the countywide team. In the future, the service will be available to support rapid hospital discharge in addition to its well-established vital role in preventing admissions. This expansion will be ongoing and permanent and we will start recruiting into the service soon

3.11 Think 111 First

The Think 111 First service is a nationally led campaign, which was successfully implemented within Somerset. In the light of the pandemic, due to social distancing and infection prevention precautions, the waiting areas in Emergency Departments (A&E) reduced. Given this reduction, it is even more

important to support the public, so they make the right healthcare choices and ensure their safety, as well as making sure they get the right treatment in the most appropriate place for their healthcare needs.

About 70% of Emergency Department (A&E) attendances nationally are made up of walk-in patients, so as patient numbers have increased since the initial lockdown, the NHS seeks to keep patients safe despite the reduced space in Emergency Department (A&E) waiting rooms. Evidence also indicates that a significant proportion of those attending an Emergency Department (A&E) could be seen elsewhere, for example, in a primary care facility or at a Minor Injury Unit (MIU).

Think 111 First is about offering people a different way of accessing and receiving healthcare, including a new way to access Emergency Departments (A&E). This means:

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

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

- avoiding risk of nosocomial (hospital-acquired) infection by ensuring fewer, less urgent patients attend Emergency Department (A&E) waiting rooms

- ensuring patients get clear direction about what they need to do and where they need to go to resolve their health issue

- protecting those most at risk (eg. people who are extremely clinically vulnerable to COVID-19) by providing them with an enhanced service

Think 111 First means that Somerset Urgent and Emergency Care Services (UECS) must ensure that:

- Emergency Departments (A&Es) are reserved for emergency patients, and that all patients still receive a timely response and are assessed safely and effectively regardless of how they make initial contact with UECS

- patients who do not need to attend an Emergency Department (A&E) are directed elsewhere to the full spectrum of available health services (eg. pharmacy, urgent dental services and voluntary services, as appropriate)

- patients can go directly to the centre or clinic they need rather than via an intermediary department (ED) via Same Day Emergency Care (SDEC) pathways

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

The Somerset IUCS is now able to book a timed slot for patients needing to be seen in an Emergency Department (A&E), ensuring patients are seen as safely and conveniently as possible. As part of the Think 111 First development work, prior to 1 December 2020, NHS 111 to Emergency Department (and MIUs) referral processes were put in place in Somerset to ensure Emergency Departments (A&E) and MIUs can accept booked patients. This allows the departments to better plan their day-to-day running of services and patients benefit from a better experience as they are seen close to their booked timed slot.

To further enhance Think 111 First, the IUCS has implemented clinician call-back (validation) for those who may need to attend an Emergency Department (A&E) following contacting NHS 111 (be it via telephone or online). This enhancement to the existing service is key to ensuring patients are directed to the most appropriate service for their clinical need. It also means that only those requiring Emergency Department (A&E) care are sent. Over time, this, coupled with Think 111 First, may have a positive impact on improving Emergency Department (A&E) waiting times for patients.

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

3.12 High Intensity Users

High Intensity Users (HIU), while a relatively small percentage of patients, are known to generate a disproportionately high percentage of Emergency Department (A&E) attendances and hospital admissions. The demand that this group of patients place on today's ambulance and unscheduled care services is considerable.

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

We have established a project to support the existing HIU groups already in place at the acute hospitals. The team works in the community, linking into the neighbourhood multi-disciplinary teams. They are building a trusted relationship with the HIUs to help understand the reasons for the behaviour and to work with them to implement person-centred solutions, developing strategies that address their needs and which will hopefully lead to behavioural changes that can be sustained.

3.13 Elective Care

This has been a challenging year for elective care. Somerset has come together as one system to understand the challenges faced (including

diagnostics and cancer) and to work together to recover the significant impact on waiting times and restore activity levels.

The four priority areas for 2020/21 to ensure elective care delivery continued were:

1 To maximise elective activity to deliver 90% of pre COVID-19 levels for inpatients and day-cases, and 100% for outpatients and diagnostics.

2 To reduce the number of longest waiting patients, particularly 52-week, 104-day cancer and six week diagnostic waits. Patients waiting a long time will all receive clinical risk assessments and be prioritised accordingly.

3 To maximise the use of the independent sector (IS) to, as a minimum, achieve the levels of activity set out in the IS provider trajectories.

4 To reduce acute referrals where better care can be provided in community settings.

During 2020/21, the Elective Care Plan aimed to maximise elective activity across Somerset. This achieved the following (approaching the end of the financial year):

- almost 70% of elective operations returned to pre COVID-19 levels
- 100% of outpatient attendance levels returned to pre COVID-19 levels
- up to a quarter of all outpatient attendances are now being offered as non-face-to-face interactions
- working with IS colleagues to continue to prioritise and reduce long waiting times

3.14 Diagnostics

Diagnostic waiting times grew during 2020/21, but across the system we took the decision to increase scanning capacity with mobile vans, as part of a wider strategic plan for radiology diagnostics. Magnetic Resonance Imaging (MRI) capacity was increased when the upgrade of one of our trust's onsite scanners was completed in January 2021. Challenges remain in returning ultrasound activity back to pre COVID-19 levels due to the disproportionate impact of social distancing measures in waiting areas on this high volume service.

Somerset made good progress in recovering endoscopy activity during 2020/21. This was delivered through a detailed knowledge of the new level of capacity required to meet demand, and the flexible use of all available capacity, such as the use of day surgery.

We also took learning from a number of NHSE 'Adopt & Adapt' programmes to further test opportunities for improvement across both endoscopy and

radiology. This included joint working on gastroenterology advice and guidance to primary care colleagues to further limit any potential unnecessary demand on endoscopy services. We also carried out work to test opportunities for improving the flow of patients in radiology waiting areas with the use of support workers.

As we approach the end of the financial year, we have been able to recover our diagnostic levels, in some areas, to in excess of pre COVID-19 levels.

3.15 Cancer Treatment

Somerset as a system continues to work collaboratively with the Somerset, Wiltshire, Avon, Gloucestershire (SWAG) Cancer Alliance. In 2020/21 we agreed a cancer recovery plan with the alliance, which focused on three main areas of achievement:

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

During 2020/21 we achieved the following:

- implemented Symptomatic Faecal Immunochemical Testing (FIT) in primary care, decreasing the demand on endoscopy and improving patient experience by providing a non-invasive triage test for patients presenting with symptoms of colorectal cancer

- continued provision of personalised care and support for patients living with and beyond cancer, including Holistic Needs Assessment and Care Planning, Treatment Summaries, Cancer Care Reviews and Personalised Stratified Follow Up (PSFU). PSFU improves the patient experience and quality of life for people following treatment for cancer, helping them to be more informed about the choices they make as well as making services more efficient and cost-effective. Through being supported to self-manage following the cancer treatment, the patient will have the information, advice and support to enable them to adapt to their condition and move on with their lives, either living with or beyond cancer.

3.16 End of Life Care

Sadly, for many people and their families both across the UK and the world, the COVID-19 pandemic ended people's lives early, sometimes very early. It brought into sharp focus our deeply human need to express and fulfil certain wishes at the end of our lives. It also highlighted how important it is, at the end of life, to be with the people who matter to us most. The pandemic, particularly

in the early phases, brought many challenges around this: to people, families and communities; to health and care teams, hospices and chaplaincy; as well as to spiritual and funeral services and bereavement support. Some people were not able to be by their loved one's side during the last days of life or even to attend their funeral. These types of situations were incredibly distressing for people, families and professionals alike. As the pandemic eases and life is able to return to normal there is bound to be a need for ongoing support, reflection and kindness as we all come to terms with what has happened.

Despite the urgent and challenging pressures brought by the pandemic, local organisations, professionals and communities stood resolute in their commitment to ensure that people were supported at the end of their lives: able to die with dignity, without pain and with as much contact as possible with those who mattered to them. People and professionals were courageous and creative in seeking to do this and many went way beyond ordinary expectations to ensure that this happened. In our communities, we saw and continue to see thousands of acts of kindness and compassion.

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

Key partners of the Programme Board also managed to continue progressing important strategic developments. These included:

- a new 'Talk About project', which has recently launched in Somerset to help families have important end of life conversations with their loved ones. These are enabled through trained Marie Curie champions who arrange meetings with the individual, helping them to talk through and record what matters to them

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

- progress in improving and promoting the use of digital technology and the sharing of people's end of life wishes across the various teams involved in supporting them. This was achieved through the Somerset Integrated Digital electronic Record (SIDeR) programme

- improving our recording of people's end of life care clinical needs by using the Somerset Treatment Escalation Plan (STEP). This has been

refreshed and translated into a number of other languages represented within Somerset communities

- developing an End of Life Care Education and Training strategy for use across multiple organisations, which will help improve knowledge, confidence and expertise across generic and specialised end of life care services across the county

- clinical audits and improvement plans: for example, an audit of the number of families who were trained to safely provide subcutaneous injections to their loved ones at the end of their life

- learning from national publications and local patient and family and professional experience

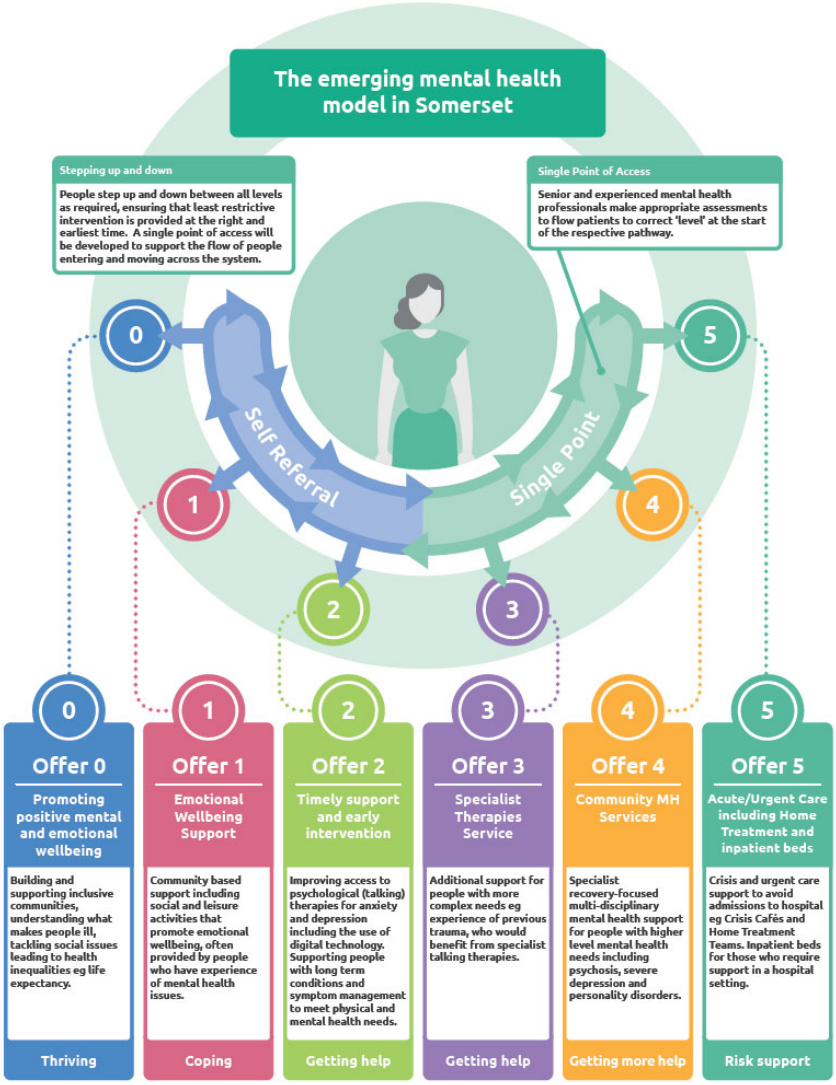
- oversight of the development of the end of life component to the rapid response team.

3.17 Mental Health – Adults and Children

Over recent years, mental health has become increasingly high profile in society and is reflected in Government policy and initiatives. There is a national aspiration to move towards parity of esteem between physical health and mental health and investment is beginning to reflect this. Historically, Somerset has been underfunded for mental health.

Both national and locally, there has been a strong emphasis on prevention, earlier intervention and better integration of services (health and social care, primary and secondary care, mental health and physical health care). This has shifted the balance towards community-based support, focussing on avoiding crises and managing them better when they do occur, and increasing the investment in mental health to improve the provision for, and outcomes of, those who need to access support.

Our aim in Somerset has been to address these themes within our work programme. We are committed to working towards delivering the outcomes required to improve mental health outcomes for the population of Somerset. We have developed the model below and have worked towards implementing it in 2020/21:



Planning for the COVID-19 post-pandemic state will affect our key priorities and projects planned 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.

Our focus for the year has been on the following:

- enhancing the Somerset population's mental and emotional wellbeing and resilience, with particular focus on staff health and wellbeing in the light of the COVID-19 pandemic
- 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
- concluding the Fit For My Future (FFMF) public consultation: the Governing Body of Somerset CCG approved a proposal to relocate

adult mental health beds from Wells to Yeovil. For further information, please visit: https://www.fitformyfuture.org.uk/mental-health/

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

- working in partnership as a whole health and care system to deliver better outcomes for our patients, including operating as a shadow ICS and the development of the Mental Health, Autism and Learning Disabilities Strategic Cell structure to oversee all matters pertaining to age, mental health, autism and learning disabilities

- embedding our new Open Mental Health model of community mental healthcare across the county (our trailblazer initiative funded by NHS England and NHS Improvement)

In 2020/21, we achieved the following:

- we worked to enhance the Somerset population's mental and emotional wellbeing and resilience for 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 refined and embedded our trailblazer initiative for our expanded community mental health service (Open Mental Health). We now have a holistic offer around mental health supported by both NHS and VCSE partners. This new way of working has been well received and is due to be evaluated over the course of 2021/22

  - our mental health crisis line (Mindline) offer was expanded and is now available 24/7, accepting calls from Somerset residents of all ages and providing dedicated support from clinicians where appropriate

  - our Psychological Therapies Service continues to have excellent waiting times and recovery rates: we are confident that we are offering a high quality service

  - Somerset also developed its Maternal Mental Health Service (MMHS) following selection as a fast follower site by NHSE. The MMHS combines maternity, reproductive health and psychological therapy for women experiencing moderate-severe mental health difficulties arising from or relating to the maternity experience, including birth trauma, perinatal loss or severe fear of childbirth (tokophobia)

- we developed specific support for health and care staff (including VCSE employees and volunteers), informed by staff feedback, including the establishment of the multi-disciplinary, pan-Somerset, organisationally agnostic Pastoral Care Cell, which has been leading on the commissioning of the following initiatives:

    - a clinically led staff resilience telephone line for all health and care staff across Somerset

    - the Thinking Pitstops training initiative which enables both clinicians and non-clinicians to deliver a brief intervention to support a colleague, peer or team member at a time of mental health need, in addition to being able to access traditional mental health services by referral

    - for the Mental Health Innovation of the Year Award, the HSJ (Health Service Journal) shortlisted the Somerset Emotional Wellbeing (SEW) podcast which is a library of free, on demand mental health and wellbeing conversations on different topics with a range of guests from across the Somerset system. These are being signposted to service users by mental health staff as part of their care pathways where appropriate

    - a staff health and wellbeing website which details all available support offers, curated by staff cohort, connects staff with their peers in a moderated forum, allows collection of primary data around employee wellbeing using metrics we have developed and is the home of the SEW podcast series.

- we worked to improve access to mental health support and earlier intervention by:

    - developing a wider menu of interventions in primary care to sit alongside the Improving Access to Psychological Therapies (IAPT) offer by creating the new Specialist Therapies Service, supporting and enhancing the Mindline open telephone 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

    - offering an increasing number of interventions remotely, with about 80% of patients having a positive experience of virtual face-to-face support (eg. by using the Attend Anywhere digital platform)

    - keeping mental health services "open for business" throughout the pandemic. We have also continued to promote services to referrers, and used social media and a radio advertising campaign to continue to raise awareness amongst the general population that services are there to support them through these difficult times

- introducing a new Somerset Bereavement Support Service in partnership with Public Health, Mind and Marie Curie

- created and promoted the above-mentioned weekly Somerset Emotional Wellbeing podcasts, hosted by two of our local GPs alongside subject matter expert guests. This provides emotional wellbeing support on demand and signposts to other local services

- improved the quality of services delivered - Getting It Right First Time - by:

  - working to ensure that physical health and mental health have parity of esteem to increase the life expectancy of all, especially those with severe and enduring mental illness, by placing the patient's needs at the heart of service development. Specifically, we have commissioned additional physical health support services for people with a serious mental illness. This will support primary care to deliver physical health checks, and will also build peer support capacity to increase uptake of the physical health checks, flu vaccinations and COVID-19 vaccinations as well as supporting individuals to access follow-up services to improve their physical wellbeing, eg. walking groups, smoking cessation services etc

  - wherever possible, co-producing our services with users, including our Experts by Experience panel, and making use of social media and other methods of communication to raise awareness

- improved the provision of support to people in crisis or who require inpatient care by:

  - working alongside our partner providers across the system to develop a 24/7 Crisis Resolution and Home Treatment Team (CRHTT) support function available for children, adults and older adults (including people with dementia). This also includes the delivery of appropriate Psychiatric Liaison Services at our acute hospital sites

  - establishing step up and step down beds, which have been well utilised across the county

  - launching our crisis safe spaces in four locations across Somerset. These spaces provide an effective alternative to the Emergency Department for people in crisis, as we know that A&E can be distressing for people experiencing a crisis in mental health

- we have enhanced sustainable recovery and resilience for those who have accessed mental health support by:

- working in tandem with our partner providers to develop and deliver a system-wide culture of individual personalised outcome based care planning (via DIALOG+) that sets the objectives for each individual with a clear recovery focus. Our key goals continue to be getting, and keeping, people well across our county

- developed our Mental Health Support Teams in Schools initiative, which aims to create new mental health support centred around schools and education

- Somerset was successfully awarded National Wave 2 'Trailblazer' status in July 2019. Somerset submitted a successful bid for Wave 3 'Trailblazer' status in July 2020, which has enabled us to implement a total of four teams across the county

- our innovative model is managed through a lead provider partnership between Somerset NHS Foundation Trust (SFT) and Young Somerset, working in collaboration with the four hosting Pupil Referral Unit (PRU) Schools, SCC Education (Educational Psychologists and Inclusion) and Somerset CCG. These new teams consist of operational and clinical leadership via CAMHS (Child and Adolescent Mental Health Services) mental health clinicians and education mental health practitioners via Young Somerset

- Somerset has enhanced the early intervention and prevention offer for children and young people's mental health:

  - Somerset Big Tent: a partnership alliance of VCSE organisations that provide a range of services including positive activities, therapeutic services and specialist support to increase positive wellbeing and improve mental health

  - Young Somerset Wellbeing Service: offering low intensity Cognitive Behavioural Therapy to young people aged 5 to 18 with mild to moderate mental health difficulties such as low mood, anxiety, stress, phobias, sleep problems and Obsessive Compulsive Disorder (OCD)

  - Virtual Hubs: a safe online space designed for young people, parents and guardians to find out about what services are available in their area. Every week, Young Somerset's team provide professional advice and guidance on how to maintain positive wellbeing and look after mental health

  - recommissioned The Space: this is a service to support and improve the mental health and emotional wellbeing of children and young people aged 4 to 18 years living in the Cheddar

Valley area of Somerset. The Space offers a wide range of support including counselling, youth activities, a youth club, a wellbeing garden and provides direct support to schools in their area

- recommissioned 2BU: this is a youth support group supporting LGBTQ+ young people in Somerset by making a difference and raising awareness of what many young people face in coming to terms with their gender or sexual identity. 2BU provides a range of support including group work for young people aged 13 to18

- partnered with MeeToo, to pilot a project to support young people in Somerset by creating a unique portal which sits inside the MeeToo app, MeeToo is a multi-award winning, fully moderated, peer support app for young people aged 11 to 18. The peer support model enables young people to talk about difficult things and to help themselves by helping each other. Five Somerset schools have had the opportunity to create their own bespoke information portals for their students including a directory of services which provide mental health and emotional wellbeing support for children and young people. An evaluation is currently underway with the aim to offer the app to all secondary school aged children in Somerset

- we worked towards improving services for people living with dementia. Dementia care services were more challenging to deliver throughout 2020/21 due to the clinical risks of COVID-19 for people living with dementia. We have established a new multi-organisational group to review and refine the dementia pathway from diagnosis through to treatment and ongoing support: the Dementia Operational Oversight group and the related Dementia Task and Finish group

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

3.18 Autism and Learning Disabilities

Our vision for the year has been to:

- make health and care services better so that more people with a learning disability, autism or both can live in the community, with the right support, close to home

- do things with people, not for them or to them
- promote rights, respect, choice and control
- improve equity of access and provision in mainstream services
- reduce health inequalities for people with a learning disability, autism or both
- reduce premature mortality in people with a learning disability, autism or both

In 2020/21 we achieved the following**:**

- Dr Peter Bagshaw was appointed as the clinical lead for learning disabilities, a crucial role for liaison and development of work with PCNs
- Somerset Transforming Care Partnership (TCP) has seen stable numbers of people being placed in specialist hospital beds, and discharge being impacted by COVID-19. We are anticipating that two patients will be discharged in April, returning the system to the target level
- Somerset TCP continues to work to improve the process around the Care Education and Treatment Review/Care Treatment Review CETRs/CTRs and Assuring Transformation (AT) database. This work will continue at pace in 2021/22
- an adult Admission Avoidance Register (AAR) is in place and monthly conversations are held to ensure that it works as efficiently as possible. 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). A children's AAR is also being developed. This will need further focus during the course of the next year
- 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), linking with the Learning Disability Mortality Reviews (LeDeR). This is to support the promotion of AHCs in addressing health inequalities and leading a healthy lifestyle, as well as improving care provider support to people with a learning disability or autism during AHCs, and providing support, training and resources to GP practices and PCNs. We have made significant progress in this work over the course of the year, following a challenging start as a result of the COVID-19 pandemic, and we are applying the learning arising from the pandemic and linking this to the Special Educational Needs and Disabilities (SEND)

inspection work. The national target stipulated that 67% of all AHCs should be completed by the end of March 2021. Although there is a data lag, early indicators suggest that we have achieved 70%

- further workstreams have been established, including work on advanced care planning, mental health support for people with a learning disability and establishing a working group to focus on the needs of young people and young adults. This SEND strand includes the adoption of Gloucestershire's "Supercharged Me" approach

- we have continued to work on the LeDeR programme, including:

  - the above described work on the annual health check programme, which includes:

    * project work in progress with learning disability service providers to increase confidence in undertaking AHCs including resources and training for practices

    * working in partnership with social care providers to improve support of AHCs, health action plans, updating care plans and pre-health check activities. This includes the role of social workers to support AHCs

    * working with the Parent Carer Forum, peer support groups and statutory partner agencies to promote awareness of AHCs

  - earlier recognition of swallowing problems/dysphagia to reduce occurrences of aspiration pneumonia (18% of deaths in Somerset): we have worked with Somerset Foundation Trust (SFT), learning disability and adult Speech and Language Therapy (SALT) teams and care homes to improve awareness and management of the condition, including: accurate transcription of care plans; publication of the dysphagia newsletter, including information resources, training and competencies links

  - earlier recognition of deterioration and treatment escalation: National Early Warning Score (NEWS2) information has been cascaded across the system and was well received. This is included as part of the Care Home "RESTORE2" community to acute pathway development project. (Note: RESTORE2 is a physical deterioration and escalation tool for care/nursing homes based on nationally recognised methodologies)

  - working with SFT to support GP practices to identify those most vulnerable, and to give additional focussed support to people with a learning disability during the winter and pandemic period. This includes communication of information and resources, SPA (Single Point of Access) referral form and AHCs

- regular publication of LeDeR newsletters and resources, including EasyRead versions, which have specifically focused on COVID-19 topics such as “Planning Ahead in a Pandemic”, “DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms” and “Caring for Someone during COVID-19” (End of Life (EOL) care)

- an informal local mini-review in mid-2020 into the deaths of a number of people in Somerset during the pandemic, reported through LeDeR, looking particularly at any ‘soft’ signs and the impact of COVID-19 which may have impacted on quality of healthcare (eg. reluctance to engage with services and possible delays in treatment)

- development of specific resources and guidance to support primary care with the COVID-19 restore aspect of AHCs and to share the lessons learned from the LeDeR reviews

- sharing of documentation with general practice, drawing on the national Public Health England (PHE) report and the LeDeR report of learning from the first 50 deaths due to COVID-19 and emphasising the importance of AHCs

- connecting with SFT’s learning disability services, for their expertise on how best to work with people who may be unable to tolerate injections and receive the COVID-19 vaccination, due to their needs, and to understand the reasonable adjustments that may be required

- strengthening the LeDeR team and governance through the creation of substantive/fixed terms posts, as well as the development of a LeDeR Policy and Terms of Reference for both the Steering Group and Quality Assurance Panel. Buddy support for reviewers has been put in place and one of the LeDeR team members is an experienced lead reviewer. These changes ensure we are now compliant with the Oliver McGowan recommendations as published in October 2020

- at the end of February 2020, plans were discussed with system partners to introduce 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, facilitated by Somerset CCG. We have since identified a local executive lead and will continue to progress this work into 2021/22

3.19 Women and Children’s Services

In Somerset, we are committed to developing safe, personalised, kind, professional and family-friendly care. Every woman, child and their family will have access to the information they need to enable them to make decisions about their care, and will be able to access support that is centred on their

individual needs and circumstances, no matter where they live in Somerset. For 2020/21 we identified three main priority areas: maternity transformation; Special Educational Needs and Disabilities (SEND); and vulnerable children. It has been an incredibly busy year, with much to do, but much progress has been made across all three of these critical areas.

3.20 Maternity transformation - Better Births implementation:

Despite the COVID-19 pandemic there was no significant variation in the birthrate in Somerset, and during the height of the COVID-19 period (March 2020 to November 2020) almost 3,250 women delivered babies across the Somerset Local Maternity and Neonatal System (LMNS). Part of the Maternity Transformation Plan was an emphasis on the increase of midwife-led deliveries (goal ≥15%). Somerset performance for the LMS was 20.8% for November 2020, a 2.8% increase compared to the last reporting period (September 2020). Reaction to the COVID-19 pandemic did have some consequences: for example, maternity services experienced an upturn in requests for planned home birth deliveries, which, where appropriate, they were able to meet.

Although it was essential to continue to deliver business as usual, there was a need to think of the best way to implement this within the restrictions imposed by operating within a pandemic. Despite creating some challenges, there were also some enablers. The priority remained the provision of safe and high quality services for mothers and babies. Virtual consultations for professionals to support each other and for families to access support were found to be of real benefit and will be embedded as a useful addition going forward.

Additionally, the need to find alternative venues for regular antenatal check-ups, to reduce pressure on hospitals and primary care, resulted in accelerating plans for community hubs, which were greatly valued and set a good foundation for the future in getting care closer to home. In total, seven community hubs are now in use, including the newly refurbished Bracken Birth Centre. These hubs are staffed by small teams of midwives, allowing more Somerset women to receive continuity of carer (CoC) during their pregnancy journey. Going forward, these maternity hubs will include health visitors, and the opportunity exists to invite others to attend to work alongside midwifery teams, such as breast-feeding supporters, smoking cessation advisors and more. Particular benefits during COVID-19 included joint working with social services to enable access to at-risk women that otherwise may have a partner present during appointments.

Ensuring that expectant mothers felt confident in accessing advice, support and services was key, and Somerset Maternity Voices Partnership (MVP) played a vital role, continuing their support to women during the pandemic, responding to concerns and raising queries with the maternity team. Access for partners has been an ongoing theme and the MVP has been working closely with the trusts in the system to ensure this has been facilitated wherever possible whilst balancing the need for safety. This platform has helped the MVP to explore new ways of engaging with users of maternity services, to ensure voices from a broad spectrum of women are heard.

As said, safety has remained paramount and, despite the additional pressures, the good improvements shown last year in meeting the requirements to reduce stillbirth, maternal, neonatal deaths and serious brain injury by 50% by 2025 were maintained.

The Saving Babies Lives Care Bundle version 2, which sets out rigorous requirements for ensuring safe services, was fully implemented in both trusts by September, meeting the national 'ask', and adjustments were made to mitigate a shortage of trained scanners to ensure that all expectant mothers who needed a scan could access one. Implementation of the Neonatal Critical Care Review during 2020/21 saw close working with the Neonatal Operational Delivery Network to develop a regional response and implementation plan. The LNMS has fully participated in the Maternity and Neonatal Safety Programme.

Another important ambition was to ensure that more than 35% of women receive Continuity of Carer (CoC) by April 2020, meaning that they are consistently supported by the same midwives throughout pregnancy, delivery and during the early days. It is well recognised that women from ethnic minority backgrounds are more at risk during pregnancy and birth, so an additional focus is to ensure that at least 35% of ethnic minority women receive Continuity of Carer by April 2021, with an ultimate target that 75% of ethnic minority women and women from deprived areas are supported in this way by 2024. Somerset is on target to achieve this, and our teams of midwives have been restructured to be compliant with the Continuity of Carer recommendations, enabling more women to receive this gold standard of care. To support this, software systems now capture ethnicity and postcodes for deprived areas in order to identify these women at booking. This rollout is already demonstrating benefits for high risk women, with particular benefits identified for women with previous gestational diabetes. Also, a task and finish group is reviewing access to Healthy Start vitamins for all women, to increase uptake of Vitamin D during the perinatal period with increased focus, which offers the supply of vitamins free of charge to all ethnic minority women who may be particularly vulnerable.

Other actions taken to support maternity services over the last year include:

- a range of digital resources which have been sourced to support Somerset women. These include the award winning 'Mum & Baby' app, a maternity toolkit and a number of animations. These all provide support, advice and signposting, and the app incudes personalised care plans and opportunities for reflection. Formal launch for the digital resources in November using the MYcare logo - 'Somerset Better Births', emphasising the coming together of Musgrove Park and Yeovil District hospitals to ensure that all women, no matter where they live in the county, can expect to receive consistent, high quality support and advice

- funding to support the full implementation of the National Bereavement Care Pathway across the LMNS, to link with an enhanced perinatal mental health support offer. In January, following a successful bid for

funding, we were excited to start implementing a new Maternal Mental Health service, giving additional expertise and up-skilling midwives to ensure that mother's needs are considered holistically, thinking about their mental health as well as their physical health

- closer working with voluntary community groups to develop peer support networks for perinatal mental health, bereavement and tokophobia

- a new role has been created for a Public Health Midwife, to work closely with maternity teams and our colleagues in Public Health, supporting women across Somerset to have a healthy pregnancy, including smoking cessation and healthy weight throughout

- joint maternity dashboard for accurate information and to identify anomalies, trends and unwarranted variation. This provides regular analysis to the LMNS Boards to monitor progress and, using the National Maternity Dashboard, enables us to see how our performance compares with other similar systems

- the development of stronger links with our neighbouring LMNSs for information sharing, peer review and seamless transitions for women between services has been crucial. For many women who live on the borders of Somerset and who may be closer to another county's services (and vice versa) it is essential to maintain these good links

- all pregnant women with Type 1 diabetes will be offered Continuous Glucose Monitoring to support them in managing their condition throughout their pregnancy from April 2021

- the LMNS has supported public health nurses (Health Visitors) to attend 'Emotion Coaching' training to support infant mental health

Although much has progressed through the maternity transformation programme, we cannot be complacent about the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused by failings within maternity services. The publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust, on 11 December 2020, which did a deep dive into 250 cases where things had gone wrong, showed that despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. There is therefore a national drive to address the seven Immediate and Essential Actions (IEA) that were identified to redouble efforts to bring forward lasting improvements in our maternity services. These requirements, and what we are currently doing locally to address the concerns, will be the main priority over the forthcoming year. We must ensure that all are sighted on any issues that might arise so that, as a system, we take collective responsibility for ensuring that women and their babies in Somerset continue to receive the best and safest possible care.

3.21 Special Educational Needs Disabilities (SEND)

Following the Ofsted/CQC inspection in March 2020, the Inspectorate team identified significant weakness in our area and that a Somerset whole system approach was needed to address nine priority areas for some of our most vulnerable children and young people.

Somerset CCG and Somerset County Council (SCC) were required to jointly develop a Written Statement of Action to show how these areas would be rectified. Following much work, which included actions to immediately begin to address some of the findings, the Statement was published in December 2020. The thrust of the plan involved travelling at pace towards an integrated approach between Somerset health services and SCC, putting the child and family firmly at the centre of all we do. It includes a focus on pathways and care-planning essential for quality, protection and safety. This joint Written Statement of Action (WSoA) therefore provides the local area with the opportunity to ensure that Somerset children and young people with SEND have the same access and opportunities as their peers to high quality local education, and health and social care provision, to enable them to achieve their aspirations, live healthy lives, and maximise their full potential.

Three key themes for the delivery of improvement were identified, acknowledging that there are principles that should run through each strand of work. These are:

- to work more closely with children and young people with SEND and their families to understand and learn from their experiences when formulating strategies to improve the support within the area

- to further improve leadership capacity across area services

- to continue to strengthen and embed partnership working across education, health and social care

To support overall improvement the priorities were grouped together in three areas:

1 Strategic Planning of Services

This theme centres on the changes that are needed so that agencies work together in a better way. For example, in the joint commissioning of services and the development of neuro-developmental pathways, specifically autism.

2 Inclusive Schools

This theme is about developing consistency in inclusion arrangements across Somerset schools and eliminating the variability and fragmentation of services available to children and young people with SEND and their families.

3 Inclusion Services

The focus of this theme concerns improving the identification of need, providing effective early support and increasing capacity within the system to meet demand whilst improving the timeliness of assessment and the quality of Education, Health and Care Plans (EHCP).

So far in 2020/21 we have:

- reviewed all mechanisms for supporting children who have an EHCP, or whose needs fall outside 'business as usual', and are developing clear and consistent pathways for securing support

- influenced national guidance for using the child or young person's NHS number on EHCPs. This was essential to ensure join-up, but to do this required a change of legislation. Champions from Somerset, supported by the Council for Disabled Children, were tenacious in achieving this important shift, with their efforts being recognised at national level

- produced a clear work plan for all children with behavioural presentations, regardless of cause, and created a more timely, cost effective and accessible process to both diagnose and exclude autism spectrum disorder (ASD) which is understood and contributed to by all parts of the system. This will be achieved by developing a robust autism and attention deficit hyperactivity disorder (ADHD) diagnostic pathway for children under the age of 18

This last piece of work has been substantial, but means that we have managed to create a collaborative, countywide approach to the problem, concentrating on the needs of children rather than on organisational needs, and recognising that, in a climate of increasing financial cuts, we need to pool our resources and work together to achieve an equitable countywide approach for our children. Thinking about the neuro-developmental pathway in three areas enabled us to concentrate on each of the factors that impact on the pathway in detail. Co-production was fundamental throughout and work on the pre-assessment pathway has created a supported pathway to be used predominantly through education settings. This will enable teachers, SENCos and educational psychologists to meet the needs of children whilst identifying those children that need to progress to an ASD or ADHD assessment. We have also co-produced a 'next steps' form to facilitate the referral processes to the ASD and ADHD assessments, adopting a 'tell it once' culture to gather relevant information and to include the voices of the parents and child. We have opened up the routes of referral to include schools and allied health professionals to ensure a more seamless process.

Importantly, in the last year we have found funding to create an interim solution so that all children that need an ASD or ADHD assessment can access one wherever they live, and we will use our learning and new processes from this to create a complete autism and ADHD pathway. This process continues from the next steps form through a multi-disciplinary triage procedure, which has included representation from health, education and

social care to understand the wider needs of the child. Children that are identified as needing an assessment can now access one, and the pilot work by one of our providers is helping us to look at different assessment processes to ensure that we are providing an appropriate assessment and spending our funding in the most cost effective way whilst still complying with NICE guidance. Our providers have been working collaboratively to develop a countywide consistent offer which will be funded through the interim solution and will inform the pathway work going forward.

In addition, we have started to collect information about the gaps in our systems, to flow into the joint commissioning work, so that we can provide for the needs of our children, rather than just providing the services that our organisations are able to deliver in isolation.

A central tenet throughout has been building confidence, competence and resilience between families and our clinicians so that families feel supported in what they do and that they are partners in the journey. This has involved changing the way we work with families and adopting a 'can-do' attitude that recognises that all children will have additional needs at some stage in their lives, and that their carers are central to providing that support. This helps us to be more clear about what we need to do to meet the needs of our children with SEND who may need additional input at various stages throughout their lives. We are looking forward to taking this journey together over the forthcoming year, to build on our successes and to make sure that all Somerset children are supported to be the best they can possibly be.

3.22 Vulnerable Children

Our poorest, most vulnerable children and hardest to reach families are likely to have the worst health outcomes, and are the most likely to have ongoing additional needs. They may not be identified as part of the SEND cohort. Our drive is to review the way that we currently operate, to support the development of streamlined systems with continuity within relationships with professionals so that families don't have to repeat their stories, and can develop trusting relationships. This will help to ensure early identification, early intervention and the right support at the right time. A large piece of work has looked at how decisions are made about care and funding for children who may have needs outside 'business as usual', to see how these can be better aligned and easier to navigate. This has included a revision of the way that children with medical needs are supported in school, and how personalised budgets could be utilised to be more flexible around need.

There are a number of areas where services for ill children have been eroded and gaps have emerged. There is also inequity of access to services across the county. We are in the process of reviewing all our health services, to restore and address where gaps have emerged and to ensure that all Somerset families can access the services they need with the same outcomes, no matter where they live in the county. For example, a new paediatric palliative care service has been put in place, bringing better consistency, and this will be further developed over the forthcoming year. Work has also been undertaken around the provision of Children and Young

People's Integrated Therapies, paediatric bladder and bowel services, newborn hearing screening and the services that surround Children in Care. We have also been working with our regional colleagues on a variety of other services that may need to have very specialist support such as Paediatric Intensive Care.

There is still much to do, but the work going forward will be supported by the implementation of the National Children's Transformation Plan. Priorities for 2021/22 will include looking at the asthma and obesity pathways, from community support and primary care, right the way through to very specialist medical services, and we are looking forward to being able to provide an update about these next year.

3.23 Medicines Optimisation

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

Making sure that patients are regularly monitored and reviewed helps to ensure that any potential side effects are identified and medicine related risks reduced. The COVID-19 pandemic meant that many Somerset patients had to shield and fewer patients were seen face-to-face. During 2020/21 the medicines optimisation team provided expert advice and guidance to help GP practices safely manage such patients during the pandemic.

The medicines optimisation team helped practices maintain a focus on non COVID-19 related safety issues during 2020/21 by continuing to develop new safety alerts and supporting the use of our Eclipse Live IT safety tool. Somerset continued to improve on national safety and quality benchmarking even during the COVID-19 pandemic and was one of the best performing CCGs for antimicrobial stewardship and management of respiratory disease.

During 2020/21, a large number of patients in care homes were unable to have a structured medication review because of COVID-19. The medicines optimisation team supported the production of additional guidance for care homes, in particular, advice about delivery of the vaccination programme for care home residents. De-prescribing of medicines no longer required remains a safety priority as we move forward, which will help to reduce the risk of side effects for this group of patients and deliver considerable cost savings.

Cardiovascular disease and respiratory disease have both been clinical areas of focus during 2020/21. While excellent progress has been made on respiratory disease, Somerset has more to do to improve the management and outcomes for patients with, and at risk of, cardiovascular disease.

During 2020/21, an additional 2000+ Somerset respiratory patients were 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, more potent statin doses being prescribed, and more patients without a statin but with a clinical need for one being started on a statin.

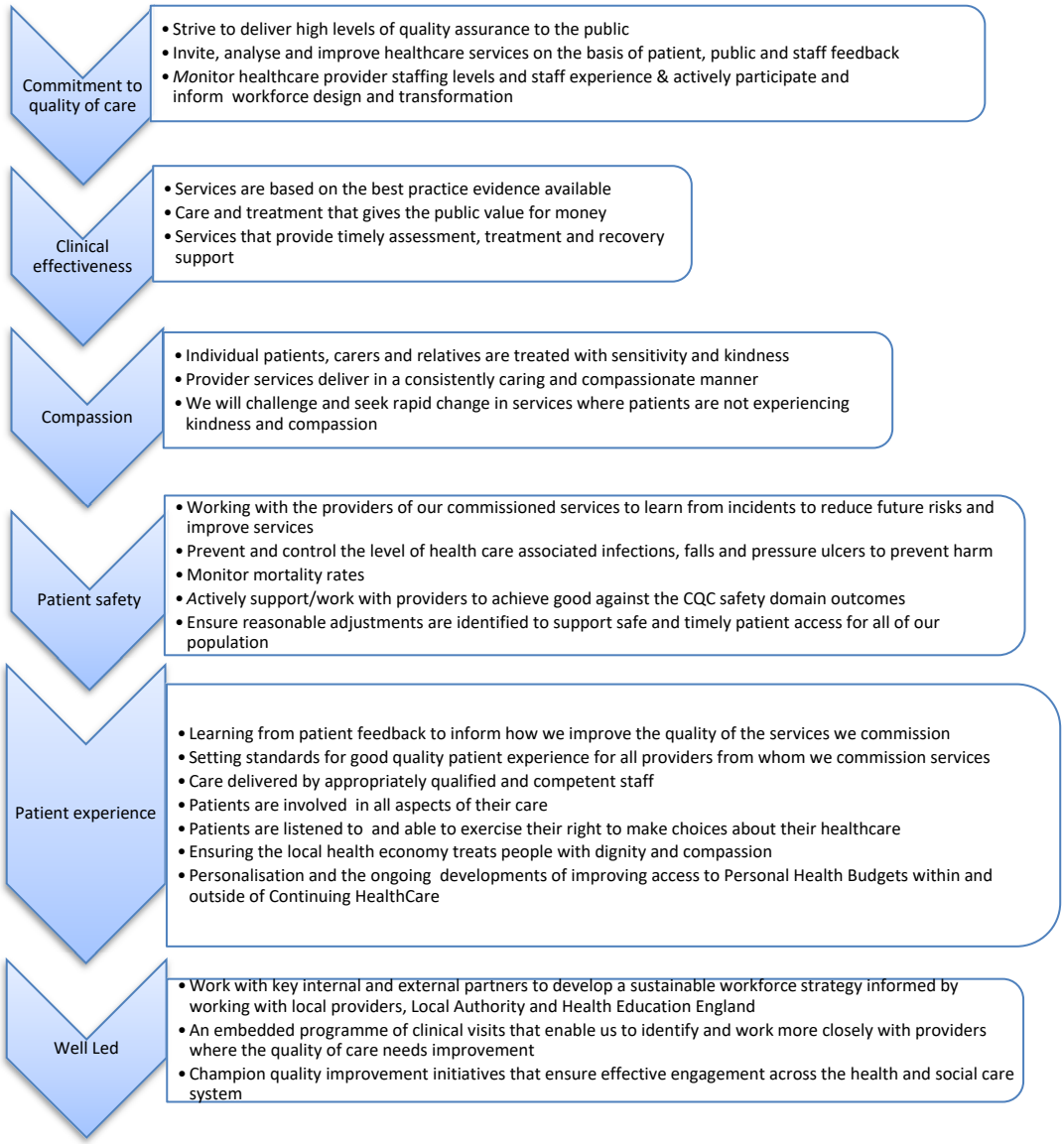
There has been considerable work throughout the year to build the foundations for medicines optimisation to take place on a system-wide basis across primary, acute and community care. With effective leadership this should greatly improve medicines optimisation outcomes for our patients.

Some significant areas remain to be reviewed and improved, such as the over-prescribing of opiate medication, which is a local and national issue.

3.24 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 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.

3.25 Our Quality and Safety Framework



During 2020/21, our quality monitoring and quality improvement activities have been very much shaped by the COVID-19 pandemic:

- firstly, we recognised there was a need to support the increased demands on frontline staff: to do this, both the CCG and our commissioned providers redeployed many of our staff with quality and safety functions to operational service delivery roles

- we marshalled our quality improvement activities to centre on those that would have the most impact on the safety and quality of services during the pandemic. The most critical element of this was support to our care homes

- we continued to ensure the protection of our most vulnerable people in Somerset, maintaining our statutory functions for the safeguarding of children and adults

- we supported the quality qssurance aspects for the set-up of our GP community COVID-19 vaccination centres.

3.26 Monitoring Quality

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

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

The quality and safety of commissioned health services continued to be monitored through our arrangements for governance with our Somerset system partners, with an assurance and exception reporting route to the Somerset Quality Surveillance Group (QSG). This ensures that quality and safety issues are taken into account in strategic decision-making within the 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, the Care Quality Commission (CQC) and a strong patient voice through Somerset Healthwatch membership.

3.27 Quality Improvement Initiatives

In recent years we have been working more closely with our service providers to reduce organisational and professional boundaries. The COVID-19 pandemic has had a positive influence in this respect and fostered stronger ties between services to achieve the best possible outcomes we could for our Somerset people. This was especially prominent in the way we worked with our care home service providers. It has created a much improved foundation for us to work across health and social care services in the future.

At the beginning of the pandemic, the Somerset system recognised the importance of supporting our care homes. This involved twice-weekly calls to all care homes within Somerset, to ascertain what support the care home needed that week. This varied from requirements for PPE, training staff how to put on and take off PPE, to supporting care home managers at difficult times. A key support was Infection Prevention and Control training to ensure all care homes in Somerset were up-to-date and importantly, understood the new guidance, which was changing rapidly. The quality and safety team kept in regular contact with care homes to ensure they were receiving and acting on guidance for infection control, managing patients who may be requiring hospital admission and assisting with queries and resolving identified problems relating to COVID-19 management. We have received positive feedback about how well our Somerset care homes felt the health system had supported them.

During the past year, it has been more important than ever to ensure that the transfer of care for people requiring movement and contact only happens when needed. We continued with the roll-out of an existing programme for the

early recognition and escalation of treatment for rapidly deteriorating patients. This was expanded from pilot sites to the whole of Somerset, using the RESTORE2 and RESTORE Mini tools, which support building system capacity to identify, respond and escalate deterioration using a common language. This means that communication about people whose health is deteriorating is carried out using a highly reliable system to support clinical decision-making about hospital admission. This was especially critical during the COVID-19 pandemic surges to both ensure swift transfer to hospital when needed, or to remain and be cared for at home when hospital treatment was not necessary.

As part of the COVID-19 response, we have worked to develop a multi-agency/multi-team support process to assist the management of COVID-19 cases and outbreaks in GP primary care services. This support process provided GP practices with a full risk assessment service, with advice about infection prevention and control and business continuity. The learning from these risk assessments was reviewed and sent to all Somerset practices, to spread the learning as 'Top Tips' for reducing the likelihood and impact of a COVID-19 outbreak within practices. A total of 47 risk assessments were undertaken across 30 practice sites.

In response to COVID-19, in order to reduce physical contact, there has been a rapid move to the use of digital access to services and the use of video consultation. The quality and safety team have supported these developments with a focus on maintaining quality, safety and equality of access in these changes. We carried out monthly reviews of feedback from patients and clinicians to develop understanding of issues that have arisen. From this feedback, we then supported services to improve access where patients had reported concerns about unintentional barriers to accessing primary care services. Many of these digital developments have been highly positive for patients in improving convenience and reducing travel, but we need to ensure it does not create inequality for those unable to access or unable to use online services. We will continue to work alongside the digital development programme to help realise improved digital access, moving from a pandemic response to a planned strategic approach.

During the year, we continued our support of capacity and capability for continuous quality improvement (QI) through training and coaching our local workforce. To comply with social distancing requirements, the Somerset Quality Improvement Faculty (SQIF) - a collaboration with our local partner services and agencies - adapted our quality improvement training offer into a programme to be delivered through video conferencing. This has turned out to be a case of necessity instigating invention, with the revised programme likely to become our new standard method for training events. We supported a number of online QI training events including:

- coaching six teams linked to Primary Care Networks who undertook the Somerset Silver level QI training, and

- providing QI training for 90 trainee GPs in partnership with the Royal College of GPs Severn Faculty

We also jointly provided virtual QI training to teams of staff at Somerset County Council on their Co-Labs team improvement training programme.

3.28 Complaints

To allow health care providers in all sectors to concentrate their efforts on frontline duties and the response to the COVID-19 pandemic, a system wide national pause of the NHS complaints' process was announced for the period April to June 2020. During this phase, the CCG introduced a triage process to ensure that any complaints that were considered to be high priority received a timely response. Normal complaint processes were resumed from 1 July 2020 and assurance was sought from our providers that plans were in place to address their backlogs.

The following figures reflect the number of formal complaints which have been managed by Somerset CCG during the year. It should be noted that NHS England have retained responsibility for managing primary care complaints and therefore, any complaints relating to primary care are not included in this report.

During 2020/21, Somerset CCG closed 45 formal complaints. The main themes arising from these were:

- access to services - 20
- quality of care - 6
- diagnosis - 4

Referring to access to services, the highest number of complaints related to applications to the Evidence Based Interventions Panel which were declined. This Panel considers applications for treatment and surgical procedures that are not routinely commissioned/funded. This was followed by concerns about the outcome of NHS Continuing Healthcare (CHC) funding assessments/ applications. A number of complaints were also received about the Autistic Spectrum Condition/Attention Deficit Hyperactivity Disorder/Special Educational Needs and Disability (ASC/ADHD/SEND) pathway in Somerset. The complaints about the quality of care related to care provided in a range of different settings by different providers, but included two patients who were considered to be on the End of Life pathway. Complaints were also received from individuals who either did not agree with their diagnosis or felt they had been misdiagnosed.

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

- the CCG has worked in partnership with parents/carers and partners to design a new Autistic Spectrum Condition/Attention Deficit Hyperactivity Disorder pathway and introduced a new Multi-Disciplinary Team (MDT) triage process. The CCG has also been working with Somerset County Council to support the work to improve

the Special Educational Needs and Disability (SEND) service in Somerset

- it was identified that access to the Image Exchange Portal (IEP) system, which is used to view X-ray images, was not robust. The CCG contracting team are supporting the providers in their proposed change of pathway, to address the issue

- the experience of some complainants is being used to inform work led by the CCG mental health commissioning team to improve access to mental health services and make them more person-centred

Further details on complaints will be available in the Annual Complaints Report 2020/21, which will be published on the Somerset CCG website later in the year.

3.29 Safeguarding – Children and Children Looked After (CLA)

We are responsible for ensuring that statutory responsibilities to safeguard and promote the welfare of children are embedded in the services we commission in Somerset. This extends to children who are looked after by the local authority and by extension, Somerset Care Leavers. We make sure that we and the services we commission work within legislation and according to the national, regional and local guidance to safeguard and promote the welfare of children.

During 2020/21 and the COVID-19 pandemic, the Somerset focus for safeguarding adults, children, and Children Looked After (CLA) has been to ensure that statutory functions were met and safeguarding responses and interventions were provided across all three areas of responsibility.

We set up a multi-agency Safeguarding Cell which developed a collaborative approach to safeguarding risks and challenges by all partners as they arose. We had and continue to have three key priorities:

- continuation and recommencing the work that was initiated before the pandemic to improve safeguarding and CLA services, responses and outcomes for children, young people and adults at risk

- in partnership with other agencies, monitoring safeguarding and CLA provision, and working together to address any single or multi agency gaps

- continuation of new ways of working to support the health and wider system in preparing for a potential second wave

The mechanisms in place to achieve this include:

- monthly safeguarding cell meetings, attended by multi agency partners

- agreement of contingency plans which can be implemented in the case of a second or third wave

- continuation of all statutory health assessments for CLA, using virtual platforms to ensure delays were minimised when face-to-face contact was not recommended during periods of lockdown

- weekly Adoption system calls to better facilitate Statutory Adoption Medical Reviews

- monthly Statutory Health Assessment system calls to facilitate timely and high quality assessments

- provision of COVID-19 safe health advice and support to local authority social workers when CLA required transition from one residential placement to another

- development of a comprehensive CLA and Care Leaver dashboard to ensure health activity and performance is monitored in a similar format to that of the existing children's safeguarding dashboard and with the aim of amalgamating the two

This has been further progressed:

- by beginning to change focus on meeting safeguarding outcomes and priorities through an ICS

- by reinstating Safeguarding Assurance and Liaison meetings with trusts

- by working with SCC to:

    - jointly commission a Statutory Initial Health Assessment pathway
    - jointly commission an Adoption Medical Review pathway
    - improve joint Health and SCC reporting of health activity and performance data

- by embedding lessons learned regarding virtual platforms, to provide improved health assessment options for CLA and improve children and young people's access to healthcare

- through membership of the Safeguarding Boards and Partnerships and all associated groups

3.30 Safeguarding Adults

Everyone has the right to live their lives free from abuse and neglect. Some adults are unable to protect themselves from abuse or neglect because they have needs for care and support. Other adults are unable to protect themselves because of the severe level of coercion, control, exploitation and/or violence they experience. Our key aim is to ensure that the CCG and

its commissioned providers protect the rights of adults to live free from abuse and neglect, in a way that supports them in making choices and having control about how they want to live.

Following a review against national guidelines, we have increased our Safeguarding Adults provision this year. We have appointed a Named GP for Safeguarding Adults and a Deputy Designated Nurse for Safeguarding Adults. The Named GP and Deputy Nurse work alongside the Designated Nurse for Safeguarding Adults. The team provides expert advice and guidance to the CCG in order that we fulfil our duties in a number of areas. These include:

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

The expansion of the safeguarding adults' provision has brought benefits to colleagues working in primary care. The Named GP has led a number of training sessions for GP practices to support their knowledge and understanding of safeguarding adults, domestic abuse, and the Mental Capacity Act. GP practices have contacted the Named GP for advice and support about people living in complex circumstances. The Named GP has supported the GP practices and enabled them to work with other agencies to take steps to either prevent or stop abuse or neglect occurring.

In addition to providing specialist advice and support, the safeguarding adults team works with our NHS hospitals and community services to monitor how all of the commissioned services support adults who need safeguarding. We also monitor how they work with other agencies. We usually do this by requiring our trusts to provide monthly information on a safeguarding dashboard. Our smaller providers and GP practices are required to complete an annual safeguarding report. We also attend the trusts' and other providers' safeguarding committee meetings. Performance and risk is reported to our Patient Safety and Quality Assurance Committee.

Despite the additional pressures on our trusts during the pandemic, they have been able to continue sending us the monthly information on the safeguarding dashboard, meaning we have been able to continue monitoring performance in relation to safeguarding adults and the Mental Capacity Act.

The information on the dashboard confirms that, despite the pandemic, the majority of staff have been able to stay up-to-date with their basic safeguarding adults training. The average percentage of staff that were up-to-date across both trusts for level 1 safeguarding adults training was 91% as at the end of January 2021. The average percentage for level 2 at this time was 88%.

During the pandemic, we have also supported colleagues working in GP practices to maintain their safeguarding knowledge by providing virtual safeguarding training, best practice meetings and supervision. These

sessions have been well attended, demonstrating commitment across GP practices to provide effective support to adults who need safeguarding.

We are a member of the Somerset Safeguarding Adults Board (SSAB). The Board is made up of senior people from organisations who have a role in preventing neglect and abuse happening to adults who need care and support. The Board ensures that agencies all work together to minimise the risk of abuse to adults at risk of harm. The Board also monitors how effectively agencies work together. During the pandemic the Board agreed to suspend some activities for various periods of time, to enable services to be able to respond to the pandemic. A number of priority work streams continued and focussed particularly on how agencies were responding to adults during the pandemic.

This year, the Safeguarding Adults team contributed to the work of the SSAB through its attendance at meetings including all five sub-groups. The CCG Designated Nurse for Safeguarding Adults chaired the Policy and Procedures group and the Learning and Development group. Further information about the activity of the Board over the past year can be found here.

3.31 Domestic Abuse

In 2020, the CCG was successful in a second bid for funding from the Pathfinder Consortium to support improvements in how NHS hospitals and community services respond to and support people who use our services and are experiencing domestic abuse. The money from the bid has been used to fund two posts to help drive these improvements. The posts are called Health Domestic Violence and Abuse Advocates. Their role is to educate and support staff working in our trusts and GP practices about how to support people who are experiencing domestic abuse. They have specialist knowledge about domestic abuse and are employed by the Somerset Integrated Domestic Abuse Service. The advocates will respond to enquiries from GP practices and trust staff, and when necessary can provide direct interventions to individuals experiencing abuse and violence.

Our trusts have also invested in this area by each employing a Domestic Abuse Co-ordinator who will work in partnership with the Health Advocates. In 2021/22, we will monitor the referral rates to our domestic abuse services from the trusts and GP practices to evaluate if this work has improved the identification of and response to domestic abuse and violence in Somerset.

Guidance produced by the Department of Health has established domestic abuse as a major concern for all healthcare professionals and identifies the NHS as the one service that almost all victims of domestic abuse come into contact with regularly within their lifetime (either as their first or only point of contact with professionals). The guidance recognises that the NHS spends more time dealing with the impact of violence than any other agency and states there is a strong need to improve health commissioning of universal and specialist services to interrupt perpetrators and support victims of domestic abuse. The Domestic Abuse Bill proposes a new national Domestic

Abuse Commissioner that will monitor how effective domestic abuse service provision is across the country.

The COVID-19 pandemic has highlighted domestic abuse as a national issue. We have worked closely with SCC and other partners to monitor and respond to the effects of lockdown on domestic abuse. For example, our pharmacies in Somerset have supported a number of local and national initiatives to enable victims of domestic abuse to find a safe space to talk about what is happening to them and seek help. People can go to a pharmacy and 'Ask for Ani'. These three words will alert the staff member in the pharmacy that the person needs help. The staff member will then guide them to a private consulting room where they can be put in touch with specialist services.

Our Safeguarding Adults Team has also supported the work of the Domestic Abuse Board, and has participated in eight active Domestic Homicide Reviews and four informal learning reviews.

3.32 Prevent

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

This year, the CCG Safeguarding Adults Team has:

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

Compliance with Prevent training has improved significantly over the course of the year, despite the pandemic, but has still not, as an average, reached the target of 85%. The average compliance across the trusts for all levels of Prevent training has improved this year, with an average of 80% of staff being up-to-date with the basic level of training and 73.5% being up-to-date with the higher level of training.

3.33 Violence Reduction Unit

The CCG has been working with the Avon and Somerset Violence Reduction Unit to develop how we will work with other agencies to prevent the occurrence of serious violence across Somerset. This will enable us to respond effectively to the proposed new duties in relation to serious violence.

3.34 Support to the wider system during the COVID-19 pandemic

The Safeguarding Adults team has undertaken a number of activities to support the wider system during the pandemic. This has included the following:

- providing specialist advice about safeguarding adults, domestic abuse and The Mental Capacity Act to colleagues across the system

- providing content to and oversight of a number of guidance documents and pathways to enable staff to provide care for people in a way that supports their human rights and ensures decisions are made appropriately for those people who cannot make the decisions themselves. Examples of documents that we contributed to include guidance for COVID-19 testing, and provision of vaccinations for people who are unable to consent

- providing written guidance to colleagues working in GP practices about how to manage virtual consultations safely from a safeguarding point of view

- providing written guidance to GP practices about Treatment Escalation Plans to enable them to comply with the Mental Capacity Act and ensure human rights are upheld

- supporting the health system programme with treatment escalation plans, and giving advice in relation to the Mental Capacity Act

- members of the safeguarding team are supporting the mass vaccination programme across the whole of Somerset

- supporting the work programme of the domestic abuse COVID-19 task group. This included enabling pharmacies to have access to local services, information and resources about domestic abuse in their consulting rooms. This meant that people who asked for a safe space to talk about their domestic abuse could receive a timely response from local services

Our priorities for next year will be to prepare for the implementation of the Liberty Protection Safeguards, to continue our improvement work for domestic abuse and to apply the proposed arrangements of an integrated care system to our response to adults who are experiencing abuse and neglect.

3.35 Continuing Health Care (CHC)

Somerset CCG holds the statutory responsibility to deliver the CHC process aligned to the principles 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 SCC, with a focus on embedding quality and efficiency in practice.

In March 2020, Continuing Healthcare (CHC) was formally stood down from assessment activity by the Department of Health and Social Care. As laid out in the formal Discharge Guidance March 2020, the majority of our CHC staff were redeployed to support the management of the COVID-19 pandemic in Somerset. We redeployed staff to areas such as care homes and inpatient wards as well as to community nursing teams. During this time CHC retained a core group of clinical and administrative staff who were able to undertake an enhanced support role, making regular welfare checks of all of our vulnerable patients and, where possible, undertaking remote review of patients notified to the service. Of particular note, our CHC staff intensified their focus on care management of funded patients, ensuring that care continued to be delivered and that patients, families and providers had what was needed to deliver safe and sustainable care. This included:

- Personal Protective Equipment (PPE)
- guidance and information on how to access lateral flow testing
- partnership working with Somerset County Council to support access to vaccinations of CHC funded patients and carers
- advance Funded Nursing Care payments to residential providers for patients awaiting assessment

CHC returned to business as usual, with a focus on assessment and review, in September 2020. However, as the demand for competent, trained staff to support the COVID-19 vaccination programme intensified, CHC again redeployed some of their clinical staff in support. It is anticipated that these staff will start to return to CHC and their assessment roles no later than 30 April 2021.

In relation to assessments, the CHC team, together with our system partners, identified those patients who were discharged between March 2020 and August 2020, who may be in need of continuing care and were awaiting assessment. It is expected that this deferred backlog of assessments will be completed by 31 March 2021, in line with NHS England expectations, using the Trusted Assessor approach.

With our Somerset system colleagues we have also worked to implement assessment and care need reviews to identify ongoing funding arrangements for patients who need consideration or who checklist positive under the new six-week funding arrangements as set out in the revised Discharge Guidance September 2020. Referral arrangements were agreed with our system partners so that assessments from CHC and social care were timely and identified alternative funding streams to support transition.

The CHC team has also undertaken a review of how we operate in our day-to-day work to understand the opportunities for digital technology to support greater efficiency. This would move our day-to-day working towards paper-light, virtual working arrangements, and improved electronic transfer of information to support our assessment and review process in line with the

expectations of the NHS England CHC Strategic Improvement Programme. The outcome of this review has been the development of a scoping paper that outlines digital solution options for the CCG leadership team to consider as part of our ongoing service improvement programme.

The CHC Quality and Safeguarding Team has progressed many initiatives in support of our funded patients and the wider residents of Somerset. In particular, the following quality work has been supported:

- nursing home joint Quality Assurance Framework (QAF), which was paused between April and October to allow providers to focus on the priority of planning and response to the pandemic

- joint development of the Learning Disability (LD) QAF with SCC, which we hope to launch with providers in time for quarter 2

- increased support to providers using quality improvement meetings to enable intensive focus to safely increase capacity across the sector to assist the Somerset COVID-19 pandemic response

- successful challenge of an external local authority in support of reinstating an individual's rights to Section 117 eligibility, which relates to the rights to funded aftercare for those who have been detained under section 3 of the Mental Health Act

- active promotion of dysphasia awareness training as mandatory across all providers, with a particular focus on learning disability services where dysphagia management is a priority in reducing premature death

- the team continues its work with partners to prioritise improvements to the quality of care provision and wellbeing outcomes for our funded patients

Throughout the pandemic, the CHC, Quality and Safeguarding teams have continued to take action and support the safety of vulnerable individuals. In particular they have:

- progressed 28 reviews due to safeguarding enquiries between April 2020 and March 2021

- undertaken a Safeguarding Adult Referral (SAR) made to the Safeguarding Adults Assurance Board (SAAB) to request an independent enquiry into prolonged abuse experienced by a resident Somerset tenant

- completed whole service concern reviews for three providers

- arranged a secondment post and established a process to address CHC-community deprivations of liberty This is now providing a safeguard against disproportionate restriction to vulnerable people

- progressed three appeals relating to deprivation of liberty through the Court of Protection during COVID-19 pandemic delays

- supported training and development of enhanced Mental Capacity Act awareness for more than 70 CHC staff in preparation for the implementation of the Liberty Protection Safeguards (LPS)

3.36 Infection Prevention and Control

On 12 January 2020, it was announced by the World Health Organization (WHO) that a novel coronavirus had been identified in samples obtained from Wuhan City, Hubei Province, China. Since then the name has been reclassified as SARS Coronavirus-2 (SARS-CoV-2), and is now commonly known as COVID-19. Public Health England (PHE) set out guidelines for Infection Prevention and Control (IPC) for both primary care and secondary care.

COVID-19 was declared as a pandemic on 11 March 2020, and as of 29 March 2020, 638,000 cases had been identified in 206 countries.

Somerset CCG swiftly put together an Emergency Planning team, conducting daily operational and strategic meetings and the diversion of Infection Prevention and Control (IPC) team resources to support the incident response. The CCG works in agreement with the Somerset Memorandum of Understanding (MOU) (2015) that outlines how key partners work together to reduce morbidity and mortality associated with outbreaks.

Preventing and controlling the spread of COVID-19 became the CCG's infection prevention and control priority throughout 2020/2021. The CCG worked collaboratively with a number of agencies, communicating the infection prevention and control messages, engaging and collaborating with primary, secondary and health and social care providers, to apply national guidance within their settings and protect the population against transmission of the virus. The support included regular telephone calls; meetings; visits; constant review of the situation on the ground; providing advice about necessary actions; providing on-line and face-to-face training about Personal Protective Equipment (PPE) and infection prevention and control.

The CCG's Infection Prevention and Control key priorities for 2020/2021 included a deep dive into Methicillin-sensitive Staphylococcus aureus (MSSA) cases; monitoring and reviewing the gram negative bloodstream infections (GNBSIs), and focus on a 10% year-on-year reduction of E Coli bacteraemia as set in previous years; implementation of the Antimicrobial Stewardship five year plan; and improving infection prevention and control measures in care homes by creating a Somerset Care Homes infection prevention and control link practitioner group. These priority work streams were not completed due to COVID-19 work and are identified as priorities for 2021/2022. Monitoring did continue as part of the work undertaken by the Somerset Infection Prevention Antimicrobial Assurance Committee (SIPAAC) and has been added to the CCG's infection prevention and control work plan.

It has been highlighted that nationally there is a rise in C-diff (Clostridium difficile) and there are plans for this to be reviewed in the coming year with the regional C-Diff collaborative. Regionally, there has been a reduction in E-coli, but Somerset CCG remains an outlier with higher numbers compared to peers.

We will continue to tackle the rising number of GNBSIs, alongside the management of cases of Methicillin-Sensitive Staphylococcus Aureus (MSSAs) and other healthcare associated infections and priority organisms, through the Somerset Infection Prevention Antimicrobial Assurance Committee (SIPAAC). In 2020/2021, the SIPAAC continued to meet quarterly to monitor, manage, seek assurance from providers and to provide assurances to stakeholders regarding infection prevention and control measures in Somerset.

Mandatory Healthcare Associated Infections (HCAI) surveillance is carried out by providers, with the following infections reported on the Public Health England (PHE) national data capture system for healthcare associated infection, with the following organisms being subject to mandatory surveillance on the Public Health England Portal: MRSA; MSSA; C. difficile and GNBSIs.

The Infection Prevention and Control teams carried out post-infection reviews of seven MRSA blood stream infections, of which three were assigned as community cases. There were 135 C.diff infections with community and hospital onset; 142 MSSA blood stream infections and 464 E.Coli blood stream infections. It is in the CCG's annual infection prevention and control plan for 2021/22 to carry out deep dives on MSSA and GNBSI infections.

Outcome Measures – YTD 2020/21

CCG OVERALL	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Trajectory
MRSA BSI	1	0	0	0	1	1	0	1	1	1	0	1	7	Zero tolerance
C Diff	4	10	10	12	14	20	13	12	13	5	14	8	135	124*
E. Coli	44	28	30	41	49	44	39	28	43	32	49	37	464	406*
MSSA	12	17	9	16	10	10	7	8	9	12	14	18	142	None set

Significant challenges remain across health and social care in addressing healthcare associated infections and Somerset CCG prioritises ensuring that infection prevention and control is consistently part of patient safety wherever care is delivered. A two-year strategy and work plan has been devised to ensure prioritisation and review of infection prevention and control work.

3.37 Personal Protective Equipment (PPE)

Whilst PPE has always been utilised by healthcare workers and social carestaff, the COVID-19 pandemic required a further level of protection against the virus: these requirements were set nationally. Somerset NHS Foundation Trust (SFT) and Yeovil District Hospital NHS Foundation Trust YDH) PPE requirements have, on the whole, been provided through a nationally co-ordinated 'pallet-push' delivery system. Other areas of health and social care have been supported by more localised arrangements. In Somerset, this was achieved by the CCG and SCC working together through a multi-disciplinary team comprising Health and Government staff through a PPE Cell. Its remit included:

- providing a strategic overview of PPE across the whole Somerset system
- co-ordinating mutual aid requests for PPE once all other sourcing routes had failed (applying when necessary a risk-based assessment of need approach to inform decision-making)
- management and distribution of the limited stocks received from different sourcing arrangements which included donations and mutual aid, Local Resilience Forum and locally sourced/purchase items
- signposting to Public Health and Somerset CCG internal resources ie. the infection prevention and control team for specific advice and guidance on PPE
- communication and reporting processes that included internal and external requirements

We did this by the setting up a PPE mailbox, hosted by the CCG, with the majority of the localised sourcing, storage and distribution of products being undertaken by Somerset County Council. This provided a seamless countywide approach, which resulted in more than 12 million items of PPE being delivered, predominately during the first wave of the pandemic.

The national sourcing and distribution of products has now been fully established and trusts continue to be serviced via the national pallet-push delivery model, which is supported by an IT system that looks at usage and runs an automated demand model to replenish stocks. Other health and social care organisations, such as primary care and pharmacists, are supported by a national PPE portal where eligible organisations can request a weekly stock of items, the volumes of which have been agreed at a national level. Somerset still continues to hold mutual aid stocks for those organisations not eligible to utilise the portal and will continue to do so, in line with national guidance.

3.38 COVID-19 Testing in Somerset

Somerset CCG has worked collaboratively to support the wider system to implement testing by partaking in South West regional meetings and being part of both local and strategic groups to implement national guidance as it adapted throughout the pandemic.

The CCG has commissioned a community agile swabbing service specifically aimed at early identification of COVID-19 positive people who could not access testing through the already established services within Somerset. The agile swabbing service enables all members of the community to access swabbing to avoid delays in health and social care provision and/or receipt. The service has been well received and we continue to see a growth in the uptake of the service.

The CCG remains committed to working with both local and national teams to provide testing services which are easily accessible for all Somerset residents.

3.39 COVID-19 Mass Vaccination Programme in Somerset

Working together as a system, Somerset began its COVID-19 mass vaccination programme in December 2020. Health and care teams, supported by an army of volunteers, have worked tirelessly to support the roll out of the programme across 21 vaccination sites across the county, including two hospital hubs, 13 GP-led community locations, two large vaccination centres at Taunton Racecourse and the Bath and West Showground, Shepton Mallet, and four pharmacy-led sites at Taunton, Yeovil, Bruton and Burnham-on Sea. Two types of vaccination, Astrazeneca and Pfizer, are being administered to the population of Somerset in line with guidance issued by the Joint Committee on Vaccinations and Immunisations (JCVI). Vaccinations are expected to continue in 2021, along with booster doses next winter.

As at 11 April 2021, 396,291 vaccinations have been administered in Somerset, and uptake continues to be high. The detailed breakdown of those that have had at least a first dose as at 21 March 2021 is as follows:

Cohort Group	**% Uptake as at 11 April 2021**
80 +	98.7%
75 - 79	100%
70 - 74	99.4%
65 - 69	91.8%
60 - 64	97.1%
55 - 59	95.8%
50 - 54	90.3%

The vaccination programme has not only focused on offering vaccinations to the eligible cohorts but has continued to analyse, update and ensure vaccine confidence. In addition to the vaccination sites, roving teams of vaccinators have worked closely with GP practices to deliver vaccines to the most vulnerable residents, including hospital inpatients, housebound people, people with learning disabilities, homeless people and seldom-reached communities, to ensure that everyone has equal access to the vaccination programme.

The vaccination programme across Somerset was achieved by the dedication of thousands of health and care staff and our community volunteers, who continue to give up their time to help us roll out our local NHS vaccination programme quickly and efficiently. We will continue to work closely with our health and care partners as further priority groups are invited to have their vaccination.

3.40 Workforce - Our People

The number and complexity of the patients cared for by our workforce continues to increase and there is much to be done in terms of nurses, therapists, doctors, support staff, midwives and health visitors, to name but a few. Going forward, we need more training, more recruitment, better retention and greater return to practice numbers.

During 2020/21, and as a result of the COVID-19 pandemic, we witnessed the increased agility of colleagues within both trusts to other roles, depending on need, in order to respond to COVID-19: for example, theatre staff to critical care, local authority staff to social care, and movement of our colleagues within the CCG to partner organisations - trusts and local authority - redeployed according to demand. A Memorandum of Understanding is in place between partner organisations to redeploy colleagues within the Somerset system (and for Nightingale hospitals) should the need arise again.

We have a strong ethos of partnership working across all Somerset system partners around colleague engagement. During 2019/20 we developed an engagement programme called Our Shared Endeavour (OSE) which enabled cross-sector colleagues to work together to identify opportunities to collaborate on key workforce priorities. Four topics were identified:

- shared training
- Somerset career journeys
- shared mediation and coaching
- Somerset talent management

These are integrated within our ICS Workforce Strategy for 2020/21 and will support the delivery of the People Plan, in particular, helping to retain talent within the county and also attracting people into health and social care careers.

Colleague wellbeing and psychological health has come under increased focus during the COVID-19 pandemic, with recent agreement to develop a

system-wide Colleague Emotional Wellbeing and Psychological Health strategy, using a stepped-care model approach to emotional and psychological support for all our colleagues. Early initiatives include the ongoing investment in a colleague telephone line, following a successful trial during the initial phase of the pandemic, which offers psychological first-aid and rapid access counselling to all colleagues, especially those at high risk. We have also developed a range of other interventions spanning all levels of intensity, including routine team 'huddles', reflective conversations, Schwartz Rounds, TRiM (trauma risk management) emotional first-aid and further specialist input.

We have also been working as a Somerset system to create a shared and consistent organisational culture where everyone feels they belong, are empowered to learn, and which has civility at its core. This includes addressing systemic inequality that is felt by our colleagues, including our recruitment processes, so that we achieve representation at all levels, as well as making sure we listen to and act upon the views and experiences of our colleagues. This also covers actions to support and promote compassionate and inclusive leadership.

During 2020/21, we identified Executive Board members with a responsibility for championing equality, diversity and inequalities. Our key partners (eg. Somerset NHS Foundation Trust (SFT), Yeovil District Hospital NHS Foundation Trust (YDH) and Somerset County Council (SCC)) have leads for equality and diversity operationally. There are now plans to take this further and create a pan-Somerset equality leads network that will share ideas and resources to achieve maximum impact, working closely with equality colleague networks to deliver change

3.41 Digital

The past year, due to the COVID-19 pandemic, has seen the greatest ever pace and scale of digital change. The CCG's Digital Team has proudly worked on an amazing and demanding portfolio during 2020/21, continuing to collaborate and extend our work with local groups and organisations in Somerset, as well as linking with neighbouring communities across the South West. The #OneTeam approach of matrix working is a core value within the Digital Team, always seeking to further develop and engage with clinical, executive, operational and patient groups. We have continued our ethos of 'Clinically Led, Digitally Enabled', maintaining our direction of strategic vision, and recognising the value of engaging people in awareness and development of where digital transformation can make a positive difference to experiences in our access to health and care services.

The Somerset digital footprint includes the following core organisations:

- Somerset CCG
- Somerset GP Practices
- Somerset County Council (SCC)
- Yeovil District Hospital NHS Foundation Trust (YDH)
- Somerset NHS Foundation Trust (SFT)

- St Margaret's Hospice
- Meddcare/Out Of Hours

Other organisations we have engaged with, who are vital to the delivery of effective care, include:

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

Our work to engage with local people and representative groups has continued to grow, with the extension of our Digital People's Champion Group, alongside stronger links established with the CCG's Equality and Diversity lead, our Communication and Engagement Team,and the associated networks of local contacts.

3.42 COVID-19 Response

The Digital Team formed the core of a Digital Cell as part of the Somerset incident response and delivered a number of activities at significant pace for colleagues and services across general practices and the CCG. Of particular focus in the first wave of response was the ordering, supply and distribution of more than 600 laptops to primary care to support agile and safer working whilst they continued to deliver GP services remotely. This was essential to provide a safe primary care service for our citizens. Similarly, a number of laptops were provided for CCG staff to enable home working.

Significant work was required for both groups to give them safe and secure access to HSCIC connections through Virtual Private Network (VPN) technologies.

We have been supporting our CCG colleagues and GP practices in a new way of working, including the adoption of Microsoft Teams at pace, enabling safer working from home. This provided the ability to readily arrange, host and attend meetings in a convenient, secure and robust manner, which had previously been not been available with other products and without which the internal work of the CCG would have been significantly impacted. Extensive input and support was required from both the Digital Team and the South Central and West Commissioning Support Unit (SCW CSU). We also supported partner organisations such as the trusts and social care, with their response to the pandemic, together with the adoption and harmonisation of new software.

Later waves of digital activity saw the need to support the set-up of antibody testing and PCN mass vaccination services across NHS and community sites with infrastructure, to include hardware, internet connectivity and access to national software systems. As we move into recovery wave planning, digital input is helping to shape further new services for people needing complex multi-disciplinary team support during their COVID-19 recovery.

Many members of the digital team have led and facilitated elements of the digital requirements for new services; helped to create a shielded patient list; supported and created outbound PCN communications, and advised and signposted digital issues with nationally mandated systems. For the PCN vaccination services, the digital team chaired daily PCN digital support meetings, led a One Team Digital Technical Team across the CCG, SCW CSU and SFT, and produced daily PCN newsletter communications over the first few months of the vaccination programme. Support is now being offered as and when required for changes in location or service improvements, as well as continuing to attend regular countywide mass vaccination co-ordination calls and weekly digital check-ins with SCW CSU and PCN leads.

During summer 2020, the care homes DES (Directed Enhanced Service) was introduced to ensure care homes could connect through the Digital Social Care programme with local PCNs and practices. An initial digital baseline was established to understand progress already underway with NHS Mail and completion of the Data Security and Protection Toolkit, identifying an accelerated pace of engagement, and support was required to activate use. Digital and Information Governance Team resources were gathered for early work to understand the need for information sharing in a virtual cross-organisational environment, and established a virtual platform for multi-disciplinary teams to safely and securely exchange information to support delivery of care services. Additional funding was secured to appoint additional resource to support care homes with digital connectivity and to improve their digital baseline.

COVID-19 has accelerated the full digital agenda and raised resultant expectations. This collaborative approach to digital transformation work will continue and increase as we prepare for ICS development.

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

- rollout of MS Teams to the CCG and 65 General Practice estate:
    - selected by Microsoft as a champion CCG to promote our journey for other CCGs across the country
    - support with training materials
    - organised a training day to understand our business challenges
    - continuation of training sessions and feedback andlessons learned

- rollout of online and video consultations across the GP estate, working with the South West Academic Science Network (SW AHSN), SCW CSU and primary care

- promotion of the NHS App and digital access to primary care through online consultations and GP online services

- supporting the technical development and promoting of the Think 111 service

- engaging with and chairing a Digital Forum comprising operational leads across partner organisations to share learning and promote good practice

- engaging and working with the Digital People's Champion's Group

- improving social media platforms and communications to the public via the "Your Somerset" SCC newsletter, Facebook, Twitter and Instagram

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

- continuing to fund Health Connections Mendip for employing Digital Connectors

- employing three Digital Outreach Team Communicators as a pilot project across the Taunton PCNs to promote digital tools to the public and educate practice staff on enabling and encouraging usage of the same

- expanding the Digital Outreach Team Communicators' team to care homes by employing two more team members

Further Digital Team changes have been made to aid our response to the new awareness and growing need for digital transformation and support. We:

- employed a digital apprentice, to support the team with all projects and to help improve engagement with the younger generation through relevant social media, supporting Freshers' fairs and digital promotion events across a number of academic settings in Somerset

- confirmed an additional Clinical Lead role to support the artificial intelligence programme of work

- created three Lead Officer roles and a Digital Data Project Officer role as part of a new digital graduate scheme

- established a new digital data workstream to support primary care data analytics and the wider strategic approach to Population Intelligence

- early planning is underway to identify other primary care clinical roles (Pharmacist, Practice Nurse) and health and social care digital engagement opportunities

3.43 Digital Inclusion

The COVID-19 pandemic has highlighted the impact of a divide between those able and willing to access support digitally and those digitally excluded. With the increased opportunity for thinking 'digital first', we need to ensure a level of equality and equity in access to our health and care services, noting that people need capability (access, digital literacy), opportunity and motivation to engage. With the need for a priority focus on digital inclusion being requested by the CCG Governing Body in September 2020, we have continued to build on inclusion work across the digital portfolio, with factors for inclusion considered and regular liaison with both the CCG's Equality and Diversity Lead and the CCG Engagement Lead, to ensure links are made to relevant forums and community groups.

We have engaged in a number of new opportunities for Somerset and have become involved with some new initiatives in the South West, spanning both Devon and Somerset in the final part of 2020. These initiatives are funded through three routes - by South West Local Economic Partnership (SWLEP) with Department for Education, NHSX (Empower the Person Team) and Innovate UK award as a partner with the Healthwave Hub and SW Academic Health Science Network. These projects are sponsored and led by Allison Nation, Associate Director of Digital Strategy, and are being promoted across all areas of the county, with a particular need to focus on supporting the West Somerset community.

As part of the Digital Team development and close working with teams in primary care, we continue to develop our 'joining the DOTs' approach, by extending the team with our Digital Outreach Team (DOTs). This has recently been expanded to include DOTs now appointed to work with care homes across Somerset, all promoting and supporting digital skills, access and integration.

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

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

Many of these discussions recognise the need to support people, both local population and workforce, in improving digital skill and literacy. In 2020/21 we

have worked with Somerset workforce leads, aware that digital is a core competency for working in health and care, and engaged with SWLEP and two training providers in developing our workforce (COSMIC and Bridgwater and Taunton College), to focus on:

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

- upskilling the health and social care workforce

From January 2021, 12 week 'bootcamps' have been providing 60 hours of digital skills learning to approximately 50 people in Somerset. These bootcamps have been offered to staff across the health and care system, including care home staff. The aim is to upskill our health and care workforce in order that attendees are able to either step into a job in the sector, or to seek promotion or a digital champion role, during April-September 2021. There is also potential for engaging with attendees who are living with learning disability, mental health or physical long term conditions to develop a new expert patient role as part of our digital transformation work.

Recognising both the essential need for this initiative and the current COVID-19 pressures on our system to release current staff to attend, we have agreed an extension of these schemes to run further bootcamps throughout 2021. Further bootcamps are likely in 2022, linking with other large organisations in the South West.

The NHSX 'proof of concept' project around alternative ways to promote the national NHS App, and linked with our work with Healthwave Hub, which held a number of user engagement workshops, the insights gained around capability, opportunity and motivation resulted in two 'intervention' approaches:

1 to increase the use of the NHS App amongst younger people, and
2 to increase the use of linked profiles for parents/carers

Other initiatives underway include:

- working with the schools and the Personal, Social, Health, Education (PSHE) education curriculum to increase uptake of the NHS App by younger people

- working with Family Centres to introduce the NHS App to new parents (promoting linked profiles)

In December 2020, Healthwave ran a virtual tutor session to talk about healthcare management to understand what students do to manage their health both online and offline. They shared the functionality of the NHS App, encouraged students to download and register for the App, and further encouraged them to use it. They also asked the students to review the information about the NHS App on the nhs.uk website. They have now created a social media campaign, having considered 'How might an NHS App

promotional campaign be made to appeal to 16-20 year olds?' This work has created a blueprint for NHSX to inform rollout and uptake in national planning, and our local success has seen downloads at a rate accelerated above national rates, as more people use the NHS App to access this digital 'front door' platform to support their healthcare needs.

3.44 Digital Transformation

We continue to deliver the Somerset Integrated Digital Electronic Record (SIDeR) Programme, joining up specific records and stakeholder organisations including:

- the SIDeR shared care record (SSCR) went live in November 2020 containing GP and Yeovil Hospital data, with St Margaret's Hospice adding to the service from 23 December. By the end of March 2021, the SSCR has already been accessed more than 11,670 times

- more than 2,770 End of Life care plans have been completed on SIDeR by primary, secondary and hospice care staff

- more than 6,700 special patient notes have been created and shared through Black Pear integration of EMIS with 111/Out of Hours

- EMIS Viewer (read-only access to primary care records) has been used more than 500,000 times to-date, across all clinical and care settings in Somerset

- working with community pharmacies to support existing use of EMIS Viewer and working with Somerset LPC to consider access to SSCR in community pharmacies from late 2021

- setting up a service so that children's social care records can access and include the NHS number, to use this as the single digital identifier / key for everyone

- creation of three digital Community Mental Health Service dialogue forms

- more than1,830 acute records have been updated to highlight people with a learning disability and/or autism following formal assessment, in order to better support them as and when they next present for treatment in a hospital setting

- 4,500 Treatment Escalation Plans have been created in care settings across Somerset in the past 12 months and digitally shared with GP practices

- with an additional funding opportunity for Scale Up of Remote Monitoring, the introduction of a SCW CSU project manager working in the team to develop a Clinical Assessment Form (CAF) accessible via SIDeR, as well as pilot adoption and launch of several apps supporting

learning disabilities and mental health in a communal programme of work with colleagues from Somerset County Council

- working to create a digital Somerset Treatment Escalation Plan (STEP), accessible via SIDeR

- developing a digital Advance Care Plan (ACP) for Marie Curie to complete with relevant patients, accessible via SIDeR

- creating links to other shared care records to reflect patient flow and access to their records at the point of care

- enabling more effective prescribing and medicines reconciliation through the use of open standards interoperability between systems and care settings

- exploring the potential of intelligent home monitoring for patients living with symptoms of mild dementia to enable them to stay in their own homes and provide proactive care before clinical problems or adverse events occur

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

3.45 Data Security and Protection

A key enabler for digital transformation is establishing good information governance and safe, secure digital systems with clear processes and support. The Digital Team continues to work in close liaison with the Information Governance Team, and has engaged in the following activities during 2020/21:

- implementation of DocuSign for electronic data and information sharing agreements

- 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 as part of the Cyber Security Action Plan, with the CCG Governing Body briefed about the Board Cyber Toolkit for development during 2021/22

- provided education and communications for colleagues across initiatives

- secured funding via NHSE to support Estates and Technology Transformation Fund projects, the emerging Digital First primary care approach, and Clinical Leads

- addressed security and information governance aspects in deployment of Microsoft Teams at pace for video conferencing across CCG corporate teams, and in general practices, to support virtual working and information sharing for multi-disciplinary teams

- addressed data processing and information governance aspects for new data flows, ie. national reporting requirement with GPs for the new pulse oximetry data returns

3.46 Digital Connectivity

One of the key building blocks for successful transformation of services is the provision of reliable and secure technology. This has remained a continued core programme during the year, with the following highlights as part of GP IT and CCG Corporate IT service delivery, supported by our SCW CSU colleagues:

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

- HSCN migration from N3

- N365 rollout planned, currently rolling out to digital champions for testing

- 'Axe the Fax'

- continuing to route electronic messages via MESH (National data standard)

- assisting with the national transfer of the care pilot with Dorset County Hospital

- Electronic Referral Service: 98% of referrals are now sent this way, with increased use of electronic Advice & Guidance

- Electronic Prescription Service: the majority of practices are now using, or are being encouraged to use, Electronic Repeat Dispensing

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

- working with LPC to embed community pharmacists who will support digital progression between PCNs and other providers

- discharge medicines service

- enabling the community pharmacy consultation service

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

- continuing our contribution to regional discussions for the ‘One South West’ Local Health and Care Record Programme

- enabling the development of digital skills andcapabilities in the workforce through a range of projects

- the Digital Team attended Spread Academy to learn more about how to ignite and maximise culture change

3.47 Data Analytics and Population Intelligence

The need for primary care data analytics has been part of a developing programme for the last few years, and with the increasing focus on need for system level population health management, this was the time for action. The Digital Team has been extended to appoint to two new roles - Digital Data Projects Lead Officer and a digital graduate as a Data Digital Outreach Team (Data DOT). This part of the portfolio has started work with the Somerset Local Medical Council (LMC) and our general practices to open up new analytics functionality through EMIS Enterprise Search and Reports, in order to streamline effort of analytics for required data returns. Through practice and PCN growing focus on managing cohorts of patients, and the emerging strategic approach for population data, the next year is an exciting one to evolve our system thinking.

As part of the strategic approach, working across the system, and the links from the Joint Strategic Needs Assessment (JSNA) with the Somerset Public Health team, the need for a collaborative approach to data and actionable insight is key. Population health management is a key feature of national focus. Recognising the ICS developments required, the need to consider the wider determinants, the work already underway, through both health-focused discussions and a local authority intelligence partnership, a combined approach of Population Intelligence is emerging.

Population Intelligence will form a significant strategic programme for 2021/22, in a similar way the SIDeR Programme (for shared care records for direct care) was developed over the past three years. This will build on the previous data strategy, noting key themes of people (analytic skills across the workforce), process (governance and access) and technology (tools and systems), and a collaborative approach to joining data sets, shared analytics and actionable insight.

Notable progress has been achieved during 2020/21, with continued commitment to some initiatives alongside new COVID-19 related demands:

- we restarted the work to explore the development of Somerset Unified Dataset through strategic data discussions (working group established)

- we extended use of artificial intelligence to three further PCNs to improve direct care and care planning through the BRAVE AI tool

- we connected digital systems for a system wide bed state and availability dashboard

- we instigated remote monitoring and pulse oximetry

- we rolled out EMIS Search and Reports to report on COVID-19 oximetry data

- development of warehouse options

- exploration of ethics understanding and practical use

- cancer workstream support for ICE system accessibility and C The Signs investigation into data inter-operability

- COVID-19 recovery: we established new Pulse Oximetry weekly reporting to NHS Digital

- investigation of primary care workforce data

In summary, 2020/21 has been an amazing year for digital transformation, with recognition for the commitment of the Digital Team celebrated with a presentation by one of our Non-Executive Directors of the British Computer Society (BCS) vITal Workers achievement during the COVID-19 pandemic.

We continue to work with BCS, The Chartered Institute of IT, to ensure the Digital Team aligns with their standards and processes. Further to this, we have adopted the '15seconds30min' movement with principles to reduce frustration and increase joy in work, acknowledging where small improvements of digital transformation can help to make a difference in delivering our health and care services.

3.48 Estates

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

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

- work for the people that use them
- help to deliver our clinical strategy

- be safe, well maintained, effective and welcoming
- support our aim to value all people alike
- reflect our design aspirations

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

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

- ensuring that the health estate promotes colleague wellbeing and productivity

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

- ensuring that the current health estate is fit for purpose

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

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

The work programme focusses on:

- supporting the Fit For My Future health and care services strategy review, system alignment and enablement of Long Term Plan delivery

- oversight and monitoring of capital delivery programmes (New Hospital Programme £450 million, STPW1-4b capital £98 million), along with other smaller centrally and locally funded programmes

- development of a primary care estates strategy and forward capital pipeline

- system-wide prioritised capital pipeline to support future funding opportunities

- working towards net zero carbon NHS Estates, including ensuring delivery through modern methods of construction, standardisation of design and intelligent procurement

- oversight of estates' efficiency initiatives in line with the requirements of the Lord Carter review

- disposal of surplus land with a view to reinvesting proceeds in the local NHS wherever possible

- optimisation of gains through Section 106 and Community Infrastructure Levy

- working with partners across Somerset through the ICS and One Public Estate Programme

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 outdated, requiring investment in order to provide compliant premises. Somerset Foundation Trust (SFT) (formerly Taunton and Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust) were successful in obtaining funding of £83.5 million through the Wave 3 STP capital bidding process and the Full Business Case (FBC) has been approved by NHSI/DHSC. SFT was also 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. The scheme supports delivery of recurrent savings across the STP. Construction on both schemes commenced in August 2020.

3.49 Sustainable Development

The CCG adopted the Sustainable Development and Carbon Reduction Strategy and the associated plans that were originally put in place by Somerset Primary Care Trust (predecessor of the CCG) and we have continued to meet the 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:

- support the cycle to work scheme which also helps to improve the health and wellbeing of staff as well as supporting initiatives amongst staff to increase walking and running

- help the national NHS target of reducing carbon emissions through employee travel

- work with the waste management service provider to increase the amount of recycled materials and promote these opportunities with our staff

- reduce the use of printers and consumables and promote a paperless environment and ensure recycling of the printer consumables through the service provider

- continue to integrate the principles of sustainability across the organisation, including reducing use of single use plastics where possible

- recycle our electrical and IT equipment

The requirement to work from home has introduced new ways of working at pace. These are effective at reducing travel and other consumables. The aim is to take the learning from the pandemic and build it into our strategies moving forward.

In January 2020 the NHS launched their campaign 'For a Greener NHS' and in October 2020, published a report 'Delivering a Net Zero Carbon NHS'. This report provides a detailed account of the NHS modelling and analytics underpinning the latest NHS carbon footprint, trajectories to net zero and the interventions required to achieve that ambition. Laying out the direction, scale and pace of change, it also describes an iterative and adaptive approach, which will periodically review progress and aims to increase the level of ambition over time. The Somerset system will be incorporating this framework into its planning to ensure that collectively we can deliver these ambitions in Somerset.

3.50 Engaging people and communities

The voice of the patient and public should be at the heart of everything we do. Our ambition is to be a system leader that supports our providers to improve and innovate. Participation helps us to understand people's needs, improve access to services and reduce health inequalities. 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 2020/21 were:

- delivering on our communications and engagement strategy 2019-2022
- growing our reach into our communities to both listen and inform
- to complete our first formal public consultation in a number of years

Our communications and engagement strategy identifies four objectives:

Our communications and engagement strategy

NHS Somerset Clinical Commissioning Group

Our vision

We want people to live healthy 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.

Our values

Quality Improvement | Integrated Working | Personal Integrity | Compassion | Self-Awareness

Our communication and engagement objectives

To build trusted relationships with groups and individuals in Somerset

To encourage the public to have their say by making it as easy as possible for them to talk to us

To make sure everyone can access information about what we are doing and why we are doing it

To support our staff to hear the public voice in the commissioning of services

Working together to improve health and wellbeing

Despite the challenges of the COVID-19 pandemic in 2020/21, we achieved the following:

- completed a formal public consultation on the proposed relocation of acute inpatient mental health services
- developed a Somerset Citizens' Panel hosted by the online engagement platform, Bang the Table
- co-produced a stakeholder database with a lead VCSE infrastructure organisation, Spark Somerset. This has helped us to reach communities we do not engage with enough
- grown our social media presence, including Facebook and Twitter

- regularly used our Somerset Engagement Advisory Group (SEAG) to check and challenge our commissioning decisions, plans and communications

- supported and worked with our Patient Participation Group Chairs (PPG) Network

- provided a Patient Advice and Liaison Service (PALS) that has supported 589 people find the information they needed about NHS services in Somerset

- provided communications and engagement leadership for the COVID-19 vaccination programme, including answering and recording 537 queries and using these to inform our communications and programme delivery

- heard from 307 Children and Young People about their views of emotional health and wellbeing services in Somerset and we will be using this information to inform our commissioning decisions going forward

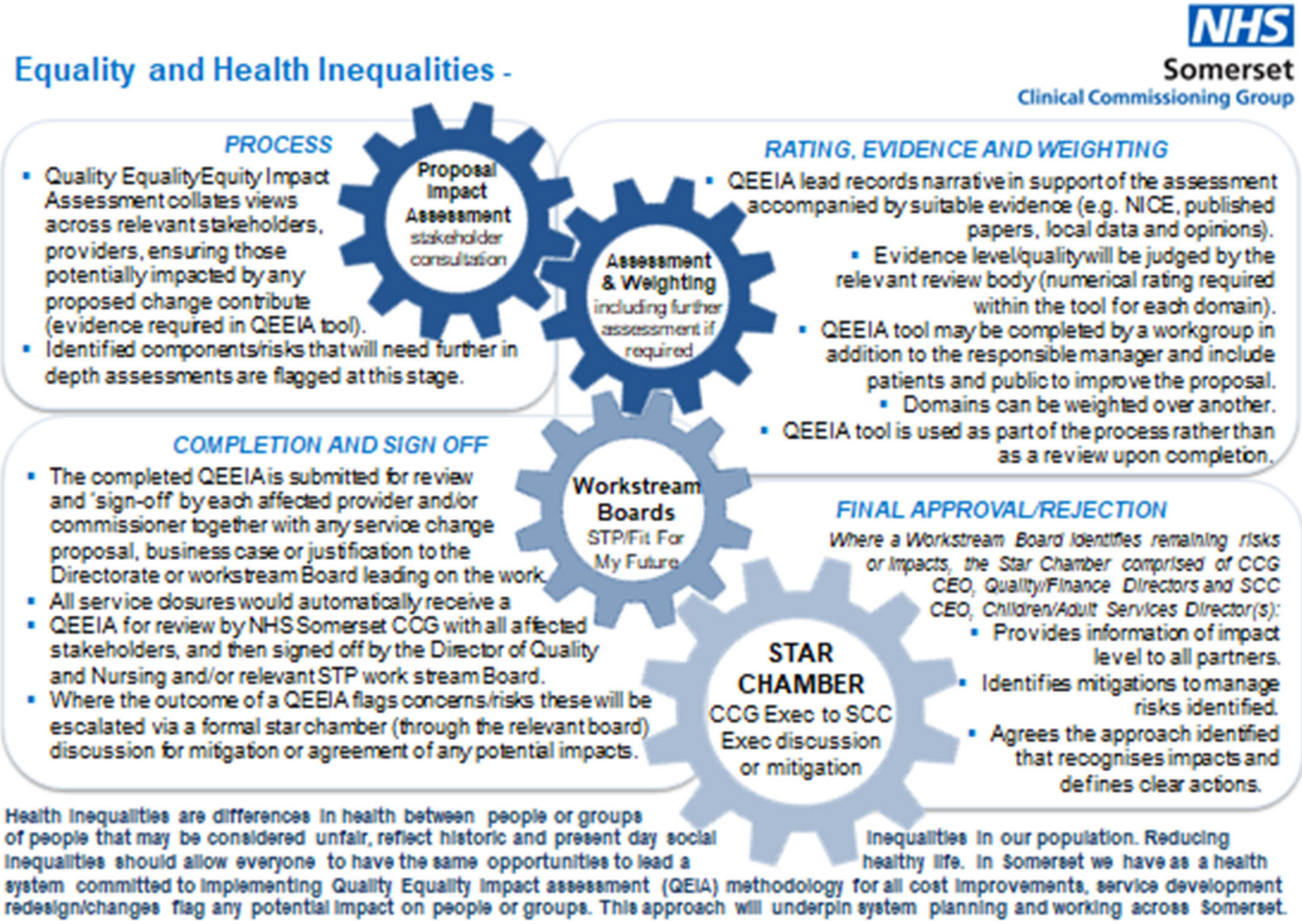
- worked with Somerset Diverse Communities and Diversity Voice to ensure our communications meet the needs of our (ethnic minority communities

3.51 Equality and Health Inequalities

The COVID-19 pandemic has shone a light on health inequalities. We are committed to addressing these inequalities in relation to access, experience and outcomes, ensuring that the needs of our communities remain at the heart of our commissioning. Throughout this performance report, many of the achievements support the reduction of health inequalities within Somerset.

We know that people access services and require support in a range of different ways and 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, people experiencing homelessness, 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.



During the last 12 months, we have increased our level of out-reach to groups who are at risk of less favourable outcomes in respect of COVID-19, along with support around more general access to health services. In addition, we have continued some of the work that started before the pandemic to improve access to services. Some of the key highlights are:

- we have worked with homeless hostels and other partners across the county to provide dental hygiene workshops, flu clinics and sexual health packs, and proactively supported Severe Weather Planning in respect of COVID-safe temporary accommodation throughout the 20/21 winter period

- we have visited all known unauthorised Gypsy, Roma and Traveller encampments and provided support and signposting into services such as primary care, maternity, health visitors and dental services

- we have undertaken numerous multi-agency visits to the roadside "New Traveller" encampments to provide additional support to enable compliance with COVID-19 guidance, such as provision of hand sanitiser and public health information, along with signposting into other statutory services, such as housing advice, sexual health, etc

- we were a contributor to the NHS England/Improvement Virtual Pride event and submitted the “Go West” video showing statutory, community and private organisations in support of LGBT inclusion within the NHS https://youtu.be/s0Jdysr2mGk

- we launched Our Black Lives Matter pledge and associated action plan to show organisational support and appetite to improve experiences of our colleagues and patients https://www.somersetccg.nhs.uk/our-black-lives-matter-pledge

- we brought together our Colleagues’ Forum and Equality Steering Group to address the impacts of COVID-19 on our ethnic minority colleagues and patients

- in partnership with 2BU-Somerset, we facilitated a focus group of our children and young people who identify as Lesbian, Gay, Bisexual and Trans (LGBT) on the impacts of lockdown and other restrictions

- we have committed to the Equality Republic initiative facilitated by BRAP to address intersectionality across all of the protected characteristics, taking a more holistic view of people rather than a particular aspect of them

- we have continued to progress the local LGBT Action Plan and share our work with the national team

- we appointed an Inclusivity Lead into our “High Performing Organisation” work to ensure that the individual needs of colleagues are considered as part of organisational change

- our Quality and Equality Officer provides ongoing support to our Fit For My Future team to ensure that areas of equality, diversity and inclusion are considered as part of service redesign and implementation

- we have embarked on a digital inclusion project to ensure that all people are able to engage fully with our online health provisions where they wish to do so

- we continue to work with Healthwatch Somerset to promote the use of GP Access Cards, particularly in respect of our homeless population, but also our travelling communities and non-UK nationals to encourage access to primary care services

- we have worked with Somerset NHS Foundation Trust and Somerset County Council to provide two FTE (full time equivalent) nurses working exclusively within the homeless communities across Somerset

- we have supported the #SomersetProud poster initiative led by Somerset NHS Foundation Trust to promote public bodies in Somerset

as “safe” employers for people who identify as LGBT. This is through promotion within primary care and pharmacy

- we have launched our monthly “Lunch & Learn” sessions looking at a variety of aspects of barriers health services. In February 2021, we had our first session which looked at barriers within ethnic minority groups. In March 2021, we looked at barriers in respect of LGBT. In April 2021 we will focus on Gypsy, Roma and Traveller communities. Further Lunch and Learn are planned throughout 2021 and into 2022.

3.52 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 Mike Best	SCC
Cllr Brian Hamilton	South Somerset District Council
Cllr Janet Keen	Sedgemoor District Council
Cllr Chris Booth	Somerset West and Taunton Council
Cllr Ros Wyke	Mendip District Council
Dr Ed Ford (Vice Chair)	NHS Somerset CCG
Alex Murray	NHS Somerset CCG
James Rimmer	NHS Somerset CCG
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 (HWB) 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 HWB will:

- oversee, where appropriate, the use of resources across a wide spectrum of services and interventions, to ensure that the Somerset

Health and Wellbeing Board Strategy (SHWBS) and other 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 about how they can achieve the best possible quality of life and be supported to exercise choice and control over their own health and wellbeing and that of the people living around them

The Somerset HWB developed a Health and Wellbeing Strategy for Somerset 'Improving Lives', which has been agreed by both Somerset County Council and Somerset CCG. The HWB has an annual programme of work which addresses a number of key priorities that 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 HWB is the partnership which has oversight responsibility for the Somerset Sustainability and Transformation Partnership (STP), and has received regular reports and been consulted on developments.

3.53 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.

Somerset CCG is part of the Avon and Somerset Local Resilience Forum (LRF) and the Local Health Resilience Partnership (LHRP) that covers Bristol, North Somerset, Somerset and South Gloucestershire. Planning is co-ordinated through the LHRP and we have been an active member of both the executive and tactical steering groups. During 2020/21 we worked in partnership with NHS England to ensure there was a co-ordinated response to escalation pressures and emergency planning for health services in Somerset. Organisations across Somerset also work closely together to ensure that plans are as integrated and effective as possible.

Our CCG has emergency response plans in place which are fully compliant with the NHS England Emergency Preparedness, Resilience and Response Framework 2015. We regularly review and make improvements to our incident response and business continuity plans and we have a work programme for regularly testing these plans. The results of these tests 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 also met with our two key providers to review their plans. Somerset CCG, SFT and YDH are all fully compliant with the standards set out.

During 2020/21, Somerset's Emergency Planning capacity concentrated heavily on the COVID-19 pandemic response, planning and preparation for the end of the transition period for exit from the European Union (EU), and winter planning. The CCG worked closely with all partners across Somerset and the wider South West region to respond to these pressures and provide assurance that local health services were responding effectively. In particular, the CCG has worked in close collaboration with colleagues in the SCC Public Health team and Civil Contingencies Units to ensure our response is both well co-ordinated and effective.

We have both an Incident Response and Business Continuity and Service Recovery Plan, which have been put into practice to respond to the incident. Teams within the CCG have used their plans to identify and prioritise the critical services that have to continue, releasing capacity where appropriate to support the incident response command and control framework. Our Incident Co-ordination Centre (ICC) and supporting team have been working remotely during the year. Colleagues were given equipment and remote access, allowing them to work away from the usual office base. These systems were 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 via home broadband and systems, as well as by remote login to CCG networks. We have been using MS Teams extensively to ensure day-to-day business continues. Our IT services provider has its own disaster recovery and network business continuity plan, which provides additional network security and has the ability to mitigate supply disruption in one area from the wider network.

The Incident Management team is led by the Incident Director and is supported by the on-call Director rota, which operates 24/7. All communications are managed through telephone and email with 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. The CCG and system partners used a shared NHS Futures platform to log and share important information. The COVID-19 incident, risk and issues log aligns 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.

The approach to learning from the pandemic has been underpinned by the following:

- the strong partnerships already developed through the Somerset Health and Social Care Emergency Planning Group stimulated

excellent collaboration and information sharing at the onset of COVID-19

- the establishment of a COVID-19 response page on the NHS Futures Platform to record and share information

- a strong incident co-ordination team has been enhanced and developed, supported by a cell structure which has strengthened the CCG's resilience for managing wave 2, along with winter, EU Exit and any other incident that may arise

- creation of task and finish cells, to have nominated subject matter experts who are able to respond quickly to priority risks, issues and questions as they arise. Some task and finish cells are expected to be stood up for the length of the COVID-19 response (eg. PPE), whereas others will exist to respond to specific questions as they arise. Generic Terms of Reference (ToRs) were developed for these groups

- clear decision-making and recording process developed for task and finish cells, with clear escalation routes for decision at an executive level, and to maintain principles of subsidiarity

- restoration has become a dynamic process which has run in tandem with the incident response. The recovery of services is closely linked to learning from the response and to the new ways of working adopted during the pandemic

- we have adopted an approach to learning based on continual improvement. We have used fixed events such as workshops, surveys and debriefings to build on our learning and develop our incident response. We have also used regular forums, such as the system tactical calls, to identify issues and respond quickly to find and adopt solutions. The key has been to delegate decision-making to the appropriate forum or executive level and then record these decisions and actions accordingly

Through regular multi-agency Health and Care Tactical Co-ordination Cell system calls, and the Somerset Health and Social care Emergency Planning group, the CCG has led system learning. A multi-agency table top exercise held on 28 October 2020 reviewed lessons identified and considered how they have been incorporated into planning, identifying key risks and concerns in readiness for wave 2 and the concurrent winter pressures. This also allowed us to close the loop on lessons identified and how they have been incorporated into planning.

The key outputs were:

- consensus that the system is well integrated and able to identify and resolve problems swiftly

- that the use of new technologies had been enthusiastically adopted and continued to be developed

- that the system had proved its ability to stand up operational responses at short notice

- that sharing of knowledge and information resources had been effective

3.54 Risk Management

Somerset CCG's policy and approach to risk management is set out in detail in the Governance Statement (pages 122-125). 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. In this way, we aim to ensure that we can maintain quality and safety for patients, staff and visitors through the services we commission, and minimise financial loss to the organisation.

3.55 Overview of NHS Somerset CCG Risks

In 2020/21 we saw the outbreak of the COVID-19 pandemic. It was important ensure that the CCG's risk management process was integrated into 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 specifically related to crisis or major incidents. The improvements maintained compliance with the CCG's Risk Management Strategy and further strengthened the CCG governance, in addition to reducing negative and unquantified impact arising from risk to the CCG and the health system. Additionally, CCG responsibilities during the incident and post-crisis learning for risk management were also identified in the review. Where capacity to manage risk was affected by competing priorities, we focussed on existing or new risks that were sensitive to the pandemic, and in a timely manner, which represented frequency of risk change.

In April 2020, we integrated the risk management process 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 the 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 were entered into the CCG risk management process. The risk monitoring activities, specified within the CCG Risk Management Strategy policy, were then used to enable timely reporting of risk within the CCG governance structure.

As described above we managed a range of risks identified relating to the COVID-19 pandemic during 2020/21. The following describes key areas of risk rated at 12 and above and the actions taken in mitigation.

COVID-19 pandemic business continuity

The COVID-19 pandemic raised risks of our ability as a system to deliver business as usual activity. In response to this we undertook a variety of actions which included:

- establishing Covid-19 testing for colleagues to reduce spread of the virus and enable appropriate self-isolation
- expansion of testing capacity to include lateral flow testing in the community
- Primary Care cell supporting resilience and service continuity in GP practices
- additional winter funding allocation for primary care to support workforce mitigation
- Pastoral Cell/Resilience Hub established to support workforce wellbeing during pandemic

COVID-19 personal protection

There was significant risk identified in relation to availability of Personal Protective Equipment (PPE) during the early stages of the pandemic response. In response to this we took a range of actions including:

- working across the Somerset system with partners to link into national supply chain systems
- regular stock monitoring
- risk assessment
- PPE cell established
- mutual aid between partner organisations

COVID-19 mass vaccination delivery

The mass vaccination programme has been successfully delivered for the people of Somerset, however, risks to implementation were identified and as part of the roll out of the programme the actions we took included:

- Senior Responsible Officer identified for programme
- System Programme Board established
- Operational Group and associated working groups established
- reporting links into national programme
- vaccination hubs and sites identified for delivery of vaccinations
- Project manager assigned to each vaccination site
- support provision for all sites with delivery of all aspects necessary to stand up vaccination centres

Sustainability of and Access to Health Care Services

We have managed several risks relating to growth in demand for services across the system such as Urgent and Emergency Care and Mental Health Services. As examples, the actions taken to mitigate risks in these areas have included:

- single point of access and additional Child and Adolescent Mental Health Services (CAMHS) transformation services established
- expansion in Mental Health Service Team (MHST) services for children
- Somerset Winter Planning Group meets monthly to ensure planning is in place for winter pressures
- regular escalation calls are in place to provide a collaborative response to peaks in demand across the system
- Somerset Urgent Care Operation Group and Somerset A&E Delivery Board oversee urgent and emergency care planning and activity
- Rapid Response Service - Home First team support to enable patients to remain at home
- GP 999 Car - hospital avoidance scheme
- Monitor and Review Framework - Somerset OPEL framework
- Clinical Assessment Service - Devon Doctors referral to ED reduction scheme

Workforce Sustainability

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

- Local Workforce Action Board (LWAB) established to oversee system workforce
- CCG Sustainability Policy used to monitor, engage and support GP practices experiencing critical workforce challenges
- Social care network forum and Primary Care Workforce Implementation Groups set up under LWAB to identify priorities and actions needed across the system
- Workforce planning groups
- Independent review workforce analysis conducted to inform LWAB and local providers with recommendations
- Early Adopter site for Maternity Care Assistants and working with Universities to Assist
- Local pathways development programme by Providers to support staff into registrant roles
- Strategic apprenticeships plan
- Nurse degree training access via local provider
- Breaking barriers project
- Clear project
- Health Education England - Pooled training allocation budgets
- Long term plan workforce plan

- Degree pathway
- Career pathways for critical roles
- One year system workforce / NHS People Plan

Financial management and achievement of efficiency savings

The Operational Planning Process for 2020/21 was suspended nationally in March 2020 because of the Covid-19 pandemic, which meant the financial framework for the first 6 months of the year was based on a reclaim process where CCGs and wider were reimbursed for their total costs incurred. The Somerset system has submitted a Phase 3 plan for 2020/21 with the expectation that the relevant QIPP/CIP targets are realistic and can be delivered in 2020/21. The Somerset Finance Group are assessing the underlying system position post 2020/21 and as part of this are ensuring as much recurrent CIP/QIPP is delivered in 2020/21 to reduce the impact on future years

We prepare Operational and Financial plans on an annual basis, and these inform our budget setting for the financial year, against which financial performance is then monitored.

Through a robust financial management, monitoring and reporting process within the CCG we ensure that:

- strategic financial issues are identified and reported
- arrangements are in place to ensure sound financial control
- monthly finance reports are produced to inform the CCG Governing Body and Finance and Performance Committee of the latest financial position
- joint system financial reporting monthly to the STP to identify any financial/performance issues and variance and to inform discussions to identify plans for mitigating actions
- system focus on Turnaround and Transformation plans to reduce costs across the Somerset system

We continue to develop Financial Recovery plans in conjunction with our system partners for 2020/21 and beyond.

Financial stability within the CCG and the STP

In March 2020, as part of the wider Somerset STP, we submitted a draft financial plan for 2020/21 which did not deliver the required financial targets set by NHS England. In addition to the financial gap to the required financial improvement trajectory our financial plan assumed a high level of programme savings opportunities for which detailed delivery plans required further development across the Somerset system.

Subsequently, operational and financial planning for 2020/21 was suspended during the COVID-19 pandemic response period.

In response to COVID-19, a temporary financial regime was put in place to cover the period 1 April 2020 to 30 September 2020. The principle of the approach was that during this period we were expected to breakeven on an in-year basis. CCGs were monitored against an adjusted funding allocation. Actual expenditure was reviewed centrally, and a retrospective non-recurrent adjustment actioned for reasonable variances between actual expenditure and the allocated funding resource. We have been fully funded for this period and therefore broke even financially, as required.

Guidance for Phase 3 of the COVID-19 response was released on 31 July 2020 and further guidance for financial arrangements and system financial envelopes for the period from 1 October 2020 to 31 March 2021 was released on 15 September 2020. A balanced system financial plan was subsequently submitted for the remainder of the financial year.

The Somerset health system will continue to work together to identify and deliver against improvement and transformation plans for the future. A range of detailed CIP and QIPP plans will continue to be developed across the Somerset system for future financial years.

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

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

- A&E and Elective care delivery boards
- Contract and performance meetings
- Activity and Performance meetings
- Phase 3 Covid Re-Start Plans 20/21
- Operational planning 21/22
- Improvement plans and trajectories
- 999 and ED Validation within IUC Clinical Assessment Service
- 111 Online – Validation of ED and 999 (lower acuity) dispositions
- High Intensity Users work stream - 6 weekly Steering and implementation group. Mapped local High Intensity Users schemes and MDMs. Scheme in development for implementation Winter 2020
- GP999 car contract extended as an alternative to DCA
- Directory of Services nil returns reviewed regularly for pathway development
- Primary Care Network. Same day requests through CAS
- Somerset HALO- supporting both acute sites (Winter 2020)
- Crisis Café – non-medical alternative to mental health. Virtual alternatives in place
- 24/7 Crisis line expansion mental health services
- Two Full time Trusted Assessors in post (YDH and MPH) to aide acute hospital flow

- The LARCH (Listening and Responding to Care Homes) collaborative is Somerset wide – preventing avoidable hospital admission from care homes [inc. use of RESTORE2 and Treatment escalation plans])
- Same Day Emergency Care – admission avoidance
- Intermediate Care/Home First redesign including doubling capacity of Rapid Response and Pathways out of hospital. (On trajectory plan for Winter 2020)
- Trusted Assessor project

Increased demand on Urgent Care and Mental Health Services

During 2020/21 and through Covid-19 pandemic we have seen an increase in demand for access to urgent care and mental health services across the Somerset system. In response to the risks identified we have taken the following actions:

- Alliance additional capacity (CMHS transformation workstream)
- demand and capacity modelling
- prevention agenda (emotional wellbeing, resilience, and wider determinants of health) included in mental health response
- funding to meet anticipated increase in demand
- Mental Health, Learning Disabilities and Autism (MHLDA) cell and public health meetings
- Somerset Winter planning group - monthly
- Escalation Calls - twice weekly/OPEL increased
- Somerset Urgent Care Operation Group and Somerset A&E Delivery Board
- Rapid Response service - Home First team support to enable patients to remain at home
- introducing a GP 999 Car - hospital avoidance scheme
- Monitor and Review Framework - Somerset OPEL framework
- Clinical Assessment Service - Devon Doctors referral to ED reduction scheme

Quality of services

Examples of risks with elements of service quality which we managed during 2020/21 include services for patients with complex needs and Urgent Care out of hours services. Some of the actions taken to mitigate these risks have included:

- touch point calls - weekly with CQC, Devon Doctors and Devon CCG
- contract review meetings with Devon Doctors
- CQC improvement plan - performance and quality
- clinical recruitment plan
- Integrated Urgent Care lead clinician with the Clinical Advisory Service
- patients with complex needs (inc. S117 provision) Proposal
- Complex Case panel to support management of patients with complex needs

More detail about our risk management framework and arrangements is included in the Governance Statement. This can be found on pages 122-125.

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 2020/21' issued by the Department of Health. The financial information included in this section of the Annual Report is taken from the 2020/21 financial statements.

4.2 Financial Duties

During 2020/21, our performance against our financial duties is outlined in the table below:

2020/21 Target Performance	Achieved
Expenditure not to exceed income	✓
Capital resource use does not exceed the amount specified in Directions	✓
Revenue resource use does not exceed the amount specified in Directions	✓
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	N/A
Revenue administration resource use does not exceed the amount specified in Directions	✓

Specific details regarding these duties are provided below.

4.3 Overview

On 17 March 2020, in response to the COVID-19 pandemic, a letter was issued by Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, which set out 'Next Steps on NHS Response to COVID-19'.

These guidelines fundamentally changed the financial arrangements for NHS commissioners and providers for 2020/21 and suspended work on the annual planning process. A revised approach to the financial management of CCGs was adopted, with the expectation that during the period 1 April to 30 September 2020, CCGs would be expected to financially break-even. To achieve this expectation, CCG funding allocations were non-recurrently adjusted for this period and a retrospective adjustment process was implemented to reimburse reasonable variances between actual expenditure and allocated funds. Somerset CCG's expenditure was fully funded for this period, enabling the organisation to achieve a financial break-even position.

For the second half of the financial year, STPs and ICSs were issued with fixed funding envelopes. The Somerset system submitted financial plans to NHS England and NHS Improvement demonstrating how they would achieve a financial break-even position for the remainder of the financial year. Somerset CCG has delivered a year-end financial position within its allocated financial resource.

4.4 Analysis of Revenue Performance

	2020/21 £'000
In year revenue resource limit	993,562
Overspend variance against revenue resource limit	0
Percentage variance against revenue resource limit	0%

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

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

The CCG has an established Audit Committee whose role is centred on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee is appointed by the Governing Body and currently comprises two Lay Members. It is hoped that a third Lay Member will be appointed soon. Lou Evans (Vice Chair of the Governing Body) chairs the Audit Committee. Four meetings were held during the year, and the committee members considered:

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

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

A full set of Somerset CCG's Annual Accounts for 2020/21 are included in Appendix 1 of this report and describe how we have used our resources to deliver health services to residents of Somerset during 2020/21. 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 Trust's website at: www.somersetccg.nhs.uk/

Going Concern

4.5 Introduction

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

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

The Department of Health Group Accounting Manual for 2020/21 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 judgement is being made about the outcome of an event or condition. Therefore, usually the 12-month period from approval of the accounts is considered appropriate.

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

The Financial Reporting Council, in their publication '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 or risks to report, these are reported to the Clinical Executive Committee, and to the Governing Body as part of the regular quarterly update, at the public meetings.

Financial Assumptions for 2020/21

4.7 Outturn

In response to the COVID-19 pandemic a letter was issued on 17 March 2020 by Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer, which set out 'Next Steps on NHS Response to COVID-19'. These guidelines fundamentally changed financial arrangements for NHS commissioners and providers for 2020/21 and suspended work on the annual planning process. A revised approach to the financial management of CCGs was adopted, with the expectation that, during the period 1 April to 30 September 2020, CCGs would be expected to financially breakeven. To achieve this expectation CCG funding allocations were non-recurrently adjusted for this period and a retrospective adjustment process was implemented to reimburse reasonable variances between actual expenditure and allocated funds. Somerset CCG's expenditure was fully funded for this period, enabling the organisation to achieve a financial breakeven position.

For the second half of the financial year STPs and ICSs were issued with fixed funding envelopes. The Somerset system submitted financial plans to NHS England and NHS Improvement demonstrating how they would achieve a financial breakeven position for the remainder of the financial year. Somerset CCG has delivered a financial position within its allocated financial resource for this period and has therefore subsequently delivered a financial breakeven position for the full financial year.

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 accrual 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 2020/21 and is planning to do so on an ongoing basis.

4.9 Contingent Liabilities

The CCG has contingent liabilities in 2020/21 relating to:

- continuing healthcare (CHC) cases - to reflect a risk associated with the provisions estimate made for pending CHC eligibility assessments and appeals
- 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 Operational Financial Planning 2021/22

Due to current circumstances relating to the COVID-19 pandemic, operational planning for 2021/22 has been delayed. The Government has agreed an overall financial settlement for the NHS for the first half of the 2021/22 financial year (H1). ICS financial plans are due for submission on 6 May 2021, with full activity, workforce and narrative plans due for final submission by 3 June 2021.

The financial settlement for months 7-12 (H2) of the 2021/22 financial year will be agreed once there is greater certainty around the circumstances facing the NHS going into the second half of the financial year. Operational planning for H2 will therefore be anticipated later in the year when this financial settlement has been determined.

The CCG will continue to work in partnership with the Somerset system to support a system-based approach to funding and planning for 2021/22 and to deliver national priorities for the year ahead, including:

- supporting the health and wellbeing of staff and taking action on recruitment and retention

- delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19

- building on what has been learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

- expanding primary care capacity to improve access, local health outcomes and address health inequalities

- transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay

- working collaboratively across systems to deliver on these priorities

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

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

The operational plan for 2020/21 will be presented to the Governing Body when finalised and monthly finance reports will specifically highlight progress against these plans.

4.12 Planning Assumptions

The financial plan for 2021/22 will be based on a number of planning assumptions, adopted from national planning guidance and local decisions.

The H1 2021/22 financial plan will reflect the following:

- the on-going impact of COVID-19 across services
- requirements for recovery of elective care and mental health services

- block payment arrangements that will remain in place for relationships between NHS commissioners and NHS providers. Signed contracts between NHS commissioners and NHS providers are not required for the H1 (April-September 2021) 2021/22 period

- a return to contractual arrangements with all non-NHS providers. This includes putting in place contracts for acute independent sector (IS) services which were covered by the national IS contract during 2020/21

- the application of additional growth funding

- the availability of additional national financial support to NHS providers to recognise the impact of the COVID-19 pandemic on services funded through non-NHS income streams

- efficiency requirements for NHS and non-NHS providers. For non-NHS providers of services within the scope of the National Tariff Payment System (NTPS), an annualised efficiency requirement of 1.1% has been set in the NTPS 2021/22 consultation prices. For NHS providers, a general efficiency requirement of 0.28% for the six-month H1 period has been applied to the growth in NHS provider block payments. In addition, for those systems with carry-forward 2019/20 control total gaps (CCGs and providers) which are effectively funded through the H2 2020/21 system top-up or CCG programme allocation adjustments, an additional efficiency requirement has been applied to reduce the level of deficit funding. Systems will be asked to deliver the equivalent of an additional annualised 0.50% efficiency from Q2 to begin to recover the shortfall funded through the system funding envelope construction, up to a maximum of the system 2019/20 control total shortfall (ie. the annual 2019/20 shortfall divided by two to represent the six-month H1 period). The H1 additional efficiency requirement is 0.25% which equates to 50% of the 0.50% annualised efficiency requirement. There will be a continued efficiency requirement into the second half of 2021/22

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

4.13 Financial Governance Arrangements During the Coronavirus Pandemic

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

NHS England and NHS Improvement have emphasised the importance of maintaining financial control and stewardship of public funds during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards have been required to continue to comply with their legal responsibilities and

have regard to their duties as set out in Managing Public Money and other related guidance.

In response to this, Somerset CCG undertook a review of financial governance to ensure that decisions to commit resources in response to COVID-19 were robust. The specific processes put in place included the following;

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

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

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

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

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

4.14 Recommendation

Having considered the going concern guidelines, the financial reporting and governance arrangements of the CCG, approach to the development of operating plans for 2021/22 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 2020/21 on a going concern basis.

4.15 2020/21 Revenue Resource Limit

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

Revenue expenditure covers general day-to-day running costs and other areas of ongoing expenditure. The CCG has met its statutory duty to operate within its revenue resource limit for 2020/21.

The CCG's performance for 2020/21 is as follows:

	2020/21 £'000
Total net operating cost for the financial year	993,562
Final in year revenue resource limit for the year	993,562
Under/(over) spend against revenue resource limit	**0**

This table highlights that in 2020/21 Somerset CCG operated within its revenue resource limit.

4.16 Better Payment Practice Code

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

Our performance for the year ended 31 March 2021 is summarised below:

Measure of compliance	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,513	159,468	9,751	134,507
Total Non-NHS Trade Invoices paid within target	9,513	159,468	9,746	134,020
Percentage of Non-NHS Trade invoices paid within target	**100.00%**	**100.00%**	**99.95%**	**99.64%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,203	619,369	3,584	583,307
Total NHS Trade Invoices Paid within target	1,202	619,369	3,570	583,189
Percentage of NHS Trade Invoices paid within target	**99.92%**	**100.00%**	**99.61%**	**99.98%**

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

4.17 Cash Limit

The CCG is required not to exceed the cash limit set by NHS England, which sets the amount of cash drawings that the CCG can make in the financial year. The CCG drew cash totalling £976.4 million (98.3%) against a cash limit of £993.6 million, therefore meeting this requirement.

4.18 Running Costs

The CCG was funded a total of £11.02 million in 2020/21 to support headquarters and administration costs. This included additional funding of £0.602 million released in-year to support an increase in employers' pension contributions. To facilitate the effective running of the organisation, the CCG continues to review those functions which it provides in-house and those which are provided by South, Central and West Commissioning Support Unit (SCWS). The value of services commissioned via the SCWS is £2.965 million, 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 2020/21 totalled £10.927 million.

4.19 Accounting Policies

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

4.20 Governing Body and Clinical Executive Committee Members

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

4.21 External Audit

Grant Thornton UK LLP is the appointed external auditor for the CCG. The total fee paid to Grant Thornton UK LLP in 2020/21 was £77,400 including VAT to cover the cost of the statutory audit, new Value for Money audit requirements and associated services.

4.22 Governance Statement

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

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

www.somersetccg.nhs.uk

4.23 Performance Summary

NHS England and NHS Improvement jointly assess CCG and Provider performance against the Oversight Framework, which was brought into effect in 2019/20 (and replaced the former CCG Assessment and Improvement Framework). The measures included in this Framework focus on how the CCG works with partners to improve quality and outcomes for patients across Sustainability and Transformation Partnerships and Integrated Care Systems.

During 2020/21 Somerset CCG has experienced challenges in meeting a number of the performance and operational access standards due to the onset and ongoing impact of COVID-19. All Referral to Treatment (RTT) Diagnostic performance measures continue to be heavily impacted by the COVID-19 outbreak due to lost outpatient and surgical capacity, a shortfall of staff, social distancing and patient choice not to attend. Throughout the year the emphasis has been to keep patients safe, ensuring that those with the most urgent conditions continue to be prioritised.

Day surgery, inpatient theatres, diagnostic and outpatient capacity were restored to near pre COVID-19 levels in November and December 2020. However, capacity was once again repurposed during the most recent wave of COVID-19, resulting in a reduction in operating theatres, to support the expansion of critical care beds and staffing, and the re-purposing of outpatient areas to locate vaccination clinics. In February 2021, 39,137 patients were on an incomplete pathway awaiting their first definitive treatment: the volume of pathways reported in February 2021 is approaching the pre COVID-19 level of 39,287 following an initial steep reduction in overall waiting list size (linked to the reduction in demand) at the onset of the pandemic. As referral demand restored, the volume of patients on an incomplete pathways increased, nearing pre COVID-19 levels in February 2021.

As a result of the reduction in routine referrals and the rapid treatment of those patients referred on a suspected cancer or urgent pathway, there has been a significant decline in the proportion of patients waiting for less than18 weeks on an incomplete pathway. Whereas the former resulted in fewer patients waiting for less than 18 weeks due to their urgency, there was also a significant increase in the volume of patients waiting in excess of 18 weeks due to routine services being stood down and, in turn, fewer RTT clock stops completing. The combination of these factors resulted in the initial deterioration in 18 week performance, which dropped from 81.3% in February to 43.5% in July; however, as a result of the increased demand and routine services being reinstated, the number of patients waiting for less than 18 weeks has been steadily increasing, with 62.0% of patients waiting for less than 18 weeks for their first definitive treatment in February 2021.

The number of long-waiting patients has significantly increased since February 2020 (the last month unaffected by COVID-19): in February 2020, 21 patients were waiting in excess of 52 weeks compared to 3,773 in February 2021. The increase in very long waits is attributed to a combination of reduced capacity due to COVID-19, the prioritisation of urgent and cancer

patients, and an increase in the number of patients choosing to delay treatment.

The percentage of patients receiving their diagnostic test or procedure within six weeks in February 2021 was 64.24%, which is a significant decline compared to February 2020, the last month unaffected by COVID-19. The most challenged diagnostic modalities are radiology (MRI and CT), endoscopy and echocardiograms.

The Somerset system has set four key priorities for elective care in order to reduce referrals into secondary care when better care can be provided in the community, to maximise elective activity, reduce the volume of the longest waiting patients (and particularly those exceeding 52 weeks) and to maximise use of the independent sector.

During the cumulative period April 2020 to January 2021 the CCG has achieved only one of the nine cancer standards (31-Day Subsequent Cancer Treatments-Anti Cancer Drug Regimens). In January 2021, 85.7% of patients referred on a suspected cancer pathway waited less than two weeks compared to the 93% standard, and 74.01% of patients received their first definitive cancer treatment within 62 days of GP referral compared to the 85% standard. During 2020/21, actions have focused on restoring suspected cancer referrals to pre-pandemic levels, ensuring there is sufficient capacity to manage increased demand and prioritising cancer in line with the national prioritisation framework in order to reduce the 62 day backlog.

During 2020/21, there have been challenges across Somerset in providers consistently meeting the 4-hour Accident & Emergency (A&E) constitutional standard, whereby 95% of patients should be seen, treated and either admitted or discharged within four hours of arrival at hospital. While Yeovil District Hospital NHS Foundation Trust has consistently met the standard, and is one of the top performers both regionally and nationally, Somerset NHS Foundation Trust, Royal United Hospital Bath NHS Foundation Trust and University Hospitals Bristol and Weston NHS Foundation Trust have faced significant challenges in meeting the standard. This reflects the patient acuity and increasing pressure on bed availability (and impact upon hospital flow) associated with the increase in COVID-19 related admissions. However, positively, the A&E demand significantly reduced during 2020/21 when compared to the previous year due to a combination of the Think 111 First pathway, the clinical validation of NHS 111 calls with a low acuity ambulance or A&E disposition re-directed to a more appropriate community service, and COVID-19 lockdowns influencing patterns of attendance. Recovery plans, focusing on internal actions, are in place to further 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
10 June 2021

ACCOUNTABILITY REPORT

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group10 June 2021

5 CORPORATE GOVERNANCE REPORT

5.1 Members Report

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

The key roles undertaken by the Governing Body Non-Executive leadership (as at 31 March 2021) 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 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-Clark	Registered Nurse Non-Executive Director	Quality and Safety Committee Chair Colleague Champion Remuneration Committee Member Audit Committee Vice Chair
Dr Ed Ford	CCG Chair Member Practice Representative, Non-Executive Director	Emergency Planning Resilience and Response (EPRR) Non Executive Lead Clinical Executive Committee Finance and Performance Committee Health and Well Being Board
Wendy Grey	Member Practice Representative, Non-Executive Director	Quality and Safety Committee Equality Steering Group Chair
Trudi Mann	Member Practice Representative, Non-Executive Director	Vice Chair Finance and Performance Committee

The CCG register of interests, which includes details of company directorships and other significant interests held by senior CCG leaders, is available on the CCG website at: https://www.somersetccg.nhs.uk/publications/lists-and-registers/.

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

5.2 Statement of Disclosure to Auditors

Each individual who is a member of the CCG Members' Report, confirmed at the Governing Body of 10 June 2021, the following:

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

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

5.3 Modern Slavery Act

NHS Somerset CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2021 is published on our website at https://www.somersetccg.nhs.uk/publications/modern-day-slavery-and-human-trafficking-statement/.

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

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

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

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

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

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

Breakdown of CCG Senior Leaders and their roles in the CCG governance structure as at 31 March 2021

		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	✓	✓			✓		✓	
Director of Commissioning	Neil Hales	✓	✓				✓	✓	
Programme Director, Fit For My Future	Maria Heard	✓	✓						
Acting Director of Quality and Nursing	Val Janson	✓	✓			✓		✓	
GP Clinical Leadership									
Associate Clinical Director, Mental Health	Dr Peter Bagshaw		✓						
Associate Clinical Director, Planned Care	Dr Will Chandler		✓						
Consultant in Public Health, SCC	Dr Orla Dunn		✓						
CCG Chair	Dr Ed Ford	✓	✓					✓	✓
Associate Clinical Director: Digital Strategy	Dr Justin Harrington		✓						
Local Medical Committee	Dr Tim Horlock		✓						
Associate Clinical Director, Primary Care	Dr Emma Keane		✓				✓		
Associate Clinical Director, Integrated Care	Dr Tom MacConnell		✓						
Clinical Director, Fit For My Future Clinical Director, STP CEC Vice Chair	Dr Alex Murray		✓						✓

		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**
Associate Director, Women's and Children's Health	Dr Kate Staveley		✓			✓	✓		
Associate Clinical Director: Same Day and Urgent Care	Dr Helen Thomas		✓						
Clinical Lead: Evidence Based Interventions/Medicines Management	Dr Andrew Tressider		✓						
Clinical Lead, Cancer	Dr Angela Beattie		Devt Session						
Clinical Lead, Diabetes and Integrated Care	Dr Henk Bruggers		Devt Session						
Clinical Lead, Emotional Wellbeing (Children and Young People)	Dr Theresa Foxton		Devt Session						
Clinical Lead, Respiratory, and Integrated and Planned Care	Dr Steve Holmes		Devt Session						
Clinical Lead, Named GP for Safeguarding Children and Adults	Dr Jo Nicholl		Devt Session						
Clinical Lead, Primary Care	Dr Jill Wilson		Devt Session						
Non-Executive Leadership									
Non-Executive Director, Colleague Champion, Registered Nurse, Audit Committee Vice Chair	Dr Jayne Chidgey-Clark	✓		✓	✓	✓			
Vice Chair and Non-Executive Director, Lay Member, Governance and Audit	Lou Evans	✓		✓	✓		✓	✓	
Non-Executive Director, Secondary Care Specialist Doctor	Dr Basil Fozard	✓			✓	✓	✓		
Director of Public Health, Somerset County Council	Dr Trudi Grant	✓							✓
Non-Executive Director, Member Practice Representative	Wendy Grey	✓				✓			

		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**
Non-Executive Director Lay Member, Patient and Public Involvement and Chair of the Joint Committee (Primary Care)	David Heath	✓		✓	✓		✓		
Non-Executive Director, Member Practice Representative	Trudi Mann	✓						✓	
Non-Executive Director, Finance and Performance	Grahame Paine	✓			✓			✓	

6 STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

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

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

- the propriety and regularity of the public finances for which the Accountable Officer is answerable

- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)

- for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)

- the relevant responsibilities of accounting officers under Managing Public Money

- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the Health and Social Care Act 2012 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the Health and Social Care Act

- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the Health and Social Care Act 2012

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

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

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis

- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements

- prepare the financial statements on a going concern basis

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

I also confirm that:

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

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

James Rimmer
Chief Executive
NHS Somerset Clinical Commissioning Group
10 June 2021

7 GOVERNANCE STATEMENT

7.1 Introduction and Context

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

The CCG's statutory functions are set out under the Health and Social Care Act 2012. The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2021, the CCG is not subject to any directions from NHS England issued under Section 14Z15 of the National Health Service Act 2006.

7.2 Scope of Responsibility

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

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

7.3 Governance arrangements and effectiveness

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

NHS Somerset CCG is a membership body comprising 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 Member Practice representatives have been appointed to the Governing Body, although one vacancy remains unfilled as at the end of March 2021. Details of the membership and the attendance of those members are set out in Annex 2 to the Governance Statement.

Organisational structure and accountabilities are clear and well defined. Where capacity and/or capability gaps have been identified, actions are put in place with expected outcomes and timescales. NHS Somerset CCG clearly articulates its values to stakeholders through its Commissioning Plan and associated strategies. The Organisational Development plan includes undertaking a Staff Survey, implementing the High Performing Organisation (HPO) Programme and developing actions to address issues for development. Stakeholder surveys for 2020/21 were postponed due to the COVID-19 pandemic response.

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 Executive Lead: James Rimmer Non-Executive Lead: n/a The Clinical Executive Committee (CEC) is the primary executive decision-making body of the CCG, authorised to make decisions within the powers delegated to it by the CCG Governing Body and is accountable to the CCG Governing Body. Its main functions are: • responsible for developing the CCG strategy, clinical and other policies, and operational plans for consideration and approval by the Governing Body • within the strategic and operational planning framework agreed by the Governing Body, the Clinical Executive Committee is the primary decision making body responsible for delivery of these plans. It is held to account for progress against these plans • to oversee and performance manage clinical commissioning teams and to receive updates on key areas of responsibility

Committee	Key roles and responsibilities
	• 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: Vacant Executive Lead: Alison Henly Non-Executive Lead: Lou Evans The Audit Committee provides assurance to the Governing Body by reviewing the CCG's systems of financial reporting and internal control and ensuring that an effective programme of audit and counter fraud is in place. In particular: • the committee shall critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with internal and external auditors, and counter fraud is maintained • the Committee shall review the work and findings of the external auditor and consider the implications and management's responses to their work • the Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Governing Body • the Committee shall ensure that there is specialist counter-fraud information, guidance and service provision within the CCG and that policies and procedures for all work related to fraud and corruption are in place, as required by the Secretary of State's Directions and by the Counter Fraud Authority • the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across

Committee	Key roles and responsibilities
	the whole of the CCG's activities (both clinical and non-clinical), that supports the achievement of the CCG's objectives • the Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation • the Committee shall request and review reports and positive assurances from officers and managers on the overall arrangements for governance, risk management and internal control and ensure robust action plans are in place, and delivered, to address any areas of weakness • the Audit Committee shall review the Annual Report and Financial Statements before submission to the Governing Body • the Committee should also ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board • where the Committee considers that there is evidence of ultra vires or improper actions, it shall report them to the Governing Body through its Chair
Remuneration Committee	Non-Executive Lead: Lou Evans [Executive and Clinical Leads only attend upon invitation] • The Committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG (Accountable Officer, other officer members and senior employees) and people who provide services to the CCG (including salary, any performance-related elements/bonuses, other benefits including pensions and cars, and contractual terms and termination of employment). • The Remuneration Committee shall make recommendations to the Governing Body on any proposed remuneration for individual CEC Members for specific work in addition to their CEC role. • The Remuneration Committee is authorised by the Governing Body to obtain legal, remuneration or other professional advice as and when required, at the CCG's expense, and to appoint and secure the attendance of external consultants and advisors if it considers this beneficial.

Committee	Key roles and responsibilities
	• The Remuneration Committee is authorised to decide on the most appropriate action needed by the Governing Body in the achievement of its Terms of Reference.
Primary Care Commissioning Committee	GP Clinical Lead: Dr Emma Keane Executive Lead: Alison Henly Non-Executive Lead: David Heath The Primary Care Commissioning Committee has delegated powers of responsibility from the Governing Body to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following: • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract) • Newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”) • Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF) • Decision making on whether to establish new GP practices in an area • Approving practice mergers; and • Making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes). The committee also carries out the following activities: • Plan, commission and deliver primary medical services for the population of Somerset • Make primary care commissioning decisions; contribute to the development of the primary care strategy, ensuring recommendations are in line with the CCG Governing Body’s Health and Care Strategy • Oversee the implementation and delivery of the primary care strategy and work plan • To secure the provision of comprehensive and high quality primary medical service in Somerset

Committee	Key roles and responsibilities
	• To co-ordinate a common approach to the commissioning of primary care services generally • To make decisions on investment on the infrastructure of primary medical services, to ensure adequate and high quality provision as well as value for money for the public • Undertake reviews of primary medical services in Somerset • To manage the commissioning budget for primary medical services in Somerset • Provide oversight across a number of functions, including but not limited to: primary cre workforce; primary care premises; primary care information management and technology (IM&T); Primary Care Networks (PCNs)
Finance and Performance Committee	GP Clinical Lead: Dr Ed Ford Executive Lead: Neil Hales Non-Executive Lead: Grahame Paine The purpose of this Committee is to provide assurance to the CCG Governing Body on the CCG's finance and performance. The Committee will look at the overall Somerset system position in terms of finance and performance. As an assurance Committee of the Governing Body, it will hold to account the CCG Executive team for delivery of the financial and performance plan, and recommend further areas for turnaround and performance improvement. This will be done through: • reviewing the financial and service performance of the CCG against statutory financial targets, financial control targets and the annual commissioning plan • reviewing the CCG's financial, performance and improving value schemes (QIPP) agenda and provide assurance to the Board in the delivery against annual plans • reviewing performance improvement plans, identifying areas for further improvement or commissioner actions and monitors trajectories towards improvement • monitoring the overall process of financial planning across the system and reviewing through the 5 year financial plan • where finance and performance issues are raised then these will be highlighted to the Clinical Executive Committee, A&E Delivery Board and Elective Care Delivery Board to agree actions and mitigations (via the CCG's Chief Officer) to rectify the issue

Committee	Key roles and responsibilities
	• 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 CCG that focuses on Patient Safety and Quality Improvement • provide assurance on all NHS Provider services governance arrangements and patient safety performance, through receiving exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services. The Committee will report areas of concerns and quality improvement to the Somerset CCG Governing Body • monitor serious incidents, incidents and action plans linked to key areas of responsibility where Somerset CCG: - are Lead Commissioners - have statutory responsibility - or where responsibility falls directly to Somerset CCG for improving the quality of services • to ensure that key themes and lessons learned from serious incidents, safeguarding, domestic homicide reviews and significant event audits are identified and shared across all NHS providers for continuous quality improvement of service provision and to prevent re-occurrence • to monitor mortality data and review findings, including Learning Disability Mortality Reviews (LeDeR) and the implementation of improvement actions • monitor progress in promoting harm free care across all NHS providers to include a focus on organisational actions to reduce pressure ulcer incidence, falls, health care acquired infection and medication incidents • receive assurance from the Clinical Executive Committee that service strategy and redesign have prioritised quality and safety alongside service delivery efficiency

Committee	Key roles and responsibilities
	• review service and pathway redesign proposals and make recommendations about patient safety concerns and outcome of quality impact assessments to the Clinical Executive Committee • receive focussed subject matter reports from the Clinical Executive Committee as required, with evidence that quality and patient safety issues and safeguarding alerts in respect of health services are fully considered, risks identified and reduced or mitigated • have oversight of the CCGs providers integrated quality dashboard and request attendance of providers, as required • provide a forum for representatives from the CCG's directorates to work collaboratively with members of the Committee to provide assurance around patient safety/quality improvement aspects of the Health and Care Strategy • receive reports on the CCGs duty to promote quality improvement in primary care. Assurance for quality and safety in primary care is currently discharged through the Joint Committee for Primary Care • receive reports on patient experience of NHS services from patient surveys, real time feedback, Friends and Family test and complaints and PALS enquiries and Health Watch to identify lessons learned and inform commissioning • ensure engagement with GP Localities and practices, and establish feedback mechanisms so that lessons learnt from complaints and incidents are shared in order to improve and inform services • to receive reports on the quality and safety of services jointly commissioned with Somerset County Council

The CCG's performance of effectiveness and capability is subject to continuous assessment including regular checkpoint assessments with NHS England/NHS Improvement. The regularity during 2020/21 has been affected by the ongoing COVID-19 pandemic.

The CCG had planned to run a local survey of partner organisations in order to get their feedback to inform its development plans. Unfortunately, the pressures of the COVID-19 pandemic made this impractical to deliver and so the plans will be carried forward and planned for future years.

The CCG met the requirements of the Community and Patient Involvement Indicator in 2020, having scored an overall green star rating.

During 2020/21 the CCG formally consulted on mental health service developments and we have fulfilled our statutory duties to secure public involvement in the planning, development and consideration of proposals for changes in commissioning. We reviewed our acute inpatient services for people of working age, having developed three options for the future configuration of our inpatient acute adult wards. In September 2020 our Governing Body approved a proposal to relocate 14 adult mental health beds from Wells to Yeovil. This decision followed a two and a half year period of engagement and consultation with staff, patients, carers and colleagues in the voluntary sector and people with and interest in mental health.

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 2021, 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

7.6 Summary

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

The Chair of the CCG has continued to hold monthly meetings with the Executives and Non-Executives of the Governing Body during 2020/21. These have all be conducted virtually using MS Teams and this approach will continue during 2021/22 and will be arranged by the Secretariat Support to the meeting. The public meetings have continued to be formally minuted.

The Chair of the Committee and the Executive Director (where possible 2x2 executive/NED pairings) has been meeting on a regular basis virtually. For most committees and meetings this was carried out on a monthly basis but was at the discretion of the Committee Chair and lead Executive.

7.7 Arrangements

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

- report they key decisions that 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

7.8 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.

7.9 Policy Decisions

During this period where formal meetings have had to be suspended, the CCG has had to be flexible and ensure that changes have been implemented where necessary 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 are 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 has been adopted 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.

7.10 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.

7.11 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

7.12 Discharge of Statutory Functions

In the light of recommendations of the 1983 Harris Review, Somerset CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk Management Arrangements and Effectiveness

7.13 The CCG Risk Management Strategy

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

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. During 2020/21 the CCG has worked to embed the new strategy and approach to risk management whilst having to balance the delivery against the operational pressures of responding to the COVID-19 pandemic.

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

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

In November 2020 the CCG Governing Body agreed a new Health and Care Strategy as part of the ICS development and risk management strategy improvement. As a result, the CCG agreed revised strategic aims and objectives.

During 2020/21, following the CCG's designation as an ICS, work has commenced with system partners to develop a risk management framework to support the transition into a Somerset ICS.

7.14 Capacity to Handle Risk

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

The CCG is committed to maintaining high risk capability (the knowledge and leadership competencies of individuals or a collective group in maximise their ability to comply with and deliver the CCG Risk Management Strategy policy). It is also committed to support the successful achievement of high risk capability: anyone who has contractual employment within the CCG undertakes risk management training in addition to an overview of the CCG risk management as part of the CCG induction training programme. The CCG's Corporate Business team provides overall risk management support within the CCG and has continued to work in collaboration with CCG Risk Champions during 2020/21. This has supported the upskilling of teams so that their ability to manage risk and add value to their team within the function of risk management could be maximised.

CCG risk capacity is calculated through the resources (financial, human, equipment and estate) required (the risk exposure the CCG "must" take in order to reach an aim/objective) and resources available to manage materialised and non-materialised risk. Through adherence to the CCG Risk Management Strategy policy and using the risk monitoring activities through the assurance flow within the CCG governance structure, CCG risk capacity is reported, managed and monitored by the CCG statutory and non-statutory forums. The CCG's Governing Body sets the tolerance for risk capacity against CCG strategic aims in alignment for its ability to handle risk.
An internal audit of risk management processes and the assurance framework was undertaken during 2020/21 and presented to the Audit Committee. The purpose of this audit was to give sufficient, continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services. The outcomes of this audit are identified in section 7.29 of this report.

7.15 Risk Appetite

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

The CCG Governing Body is responsible for:

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

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

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

7.16 Risk Assessment

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

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

Other Sources of Assurance

7.17 Internal Control Framework

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

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

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

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

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

All reports presented to the Governing Body include identified risks. All strategic documents are reviewed by the Clinical Executive Committee and clinical risks to delivery considered. The effectiveness of the Committee Structure is continually reviewed internally via the Governing Body review programme and against best practice where available. During 2020/21 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 2020/21, the CCG Governing Body has continued to oversee and monitor the implementation of the Health and Care Strategy work programme, Fit for My Future. The CCG Governing Body and Clinical Executive Committee review the organisational compliance and delivery of the strategic objectives against the Assurance Framework and Corporate Risk register. The frequency of reporting has been impacted by the response to the pandemic and the cycle has been adjusted accordingly.

Attendance at the Governing Body is recorded in the minutes and full membership of the Governing Body has been present at the majority of the Governing Body meetings and seminars during 2020/21.

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

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

The Governing Body's performance, effectiveness and capability is subject to continuous assessment. The usual pattern of formal quarterly assurance meetings with NHS England was disrupted by the pandemic response but the Chief Executive has had regular meetings with the NHS England Regional Director and Director of Strategy and Transformation in order to provide assurance of the continued effective delivery of local services.

7.18 Annual Audit of Conflicts of Interest Management

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

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

The audit found that, overall, the CCG has controls in place to manage conflicts of interests through the administration processes undertaken by the Executive Assistant, Committee meetings discussion, decision-making,

contract procurement and commissioning process. The audit raised one overall medium rated finding in relation to the maintenance of the registers. 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 no major instances of non-compliance with the current controls, leading to a final assessment of moderate assurance relating to control design, and moderate assurance relating to control effectiveness.

7.19 Data Security

The UK is subject to the UK General Data Protection Regulation and UK Data Protection Act 2018 following the completion of the exit from the EU on 1 January 2021. Any information breaches are assessed and, where appropriate, reported through the Data Security and Protection (DSP) Toolkit, as set out in the NHS Digital guidance document - 'Guide to the Notification of Data Security and Protection Incidents'. The Security of Network and Information Systems (NIS) Directive also requires reporting of relevant incidents to the Department of Health and Social Care. As there is no link between the DSP toolkit and the Strategic Executive Information System (STEIS), DSP Toolkit reportable incidents also need to be reported on STEIS. NHS Somerset CCG had no incidents which met the DSP Toolkit reporting threshold during 2020/21.

7.20 Data Quality

The CCG recognises the fundamental importance of reliable information and meets its responsibility in ensuring that good quality data is collated and appropriately used. All decisions, whether clinical, managerial or financial need to be based on information which is of the highest quality. During financial year 2020/21 we have continued to focus upon data quality in conjunction with our principal business analytics partner, South Central and West CSU. The data used by the Governing Body and delegated Committees/Groups is obtained through various sources, the majority of which are national systems and official NHS data sets. The provider data is quality assured through contract and performance monitoring and against the Secondary Uses Service (SUS).

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

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

7.21 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular, personal identifiable information. The NHS Information Governance Framework is supported by the Data Security and Protection (DSP) toolkit, and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.
All organisations that have access to NHS patient information are required to provide assurances that they are practising good information governance and use the DSP Toolkit to evidence this through publication of annual assessments. The DSP Toolkit is part of a framework for assuring that organisations are implementing the ten National Data Guardian data security standards as well as their statutory obligations for data protection and data security. The annual assessment and submission process completed by commissioned organisations provides assurance to the CCG, as the commissioner of health services for the population of Somerset, that commissioned services meet the required standards for information governance.

We place high importance on ensuring that robust information governance systems and processes are in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the DSP Toolkit and good information governance practice. All staff are required to undertake annual information governance training and we have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

91% of all staff had completed their information governance training by 31 March 2021. The target for reaching 95% compliance has been extended nationally to 30 June 2021.

NHS Somerset CCG submitted a Data Security and Protection (DSP) Toolkit for 2019/20 with a rating designation of ‘exceeds expectations’. The CCG has been working towards the completed of the toolkit for 2020/21 but, in line with the revised national timetable, will not be submitting its final submission for 2020/21 until 30 June 2021.

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

7.22 Business Critical Models

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

7.23 Third Party Assurances

NHS Somerset CCG contracts with a range of third party providers in order to deliver both healthcare services to the population of Somerset and to support the corporate functions of the CCG, for example through the commissioning support service (CSU) and external payroll services: further details can be found in 7.25 Delegation of Functions.

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

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

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

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

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

As well as overseeing the anti-fraud, bribery and corruption arrangements in place at providers, the CCG must also ensure that its own counter fraud measures remain robust. Somerset CCG has well-established counter fraud arrangements in order to help us achieve the standards set out by the NHS Counter Fraud Authority. The CCG engages an Accredited Counter Fraud Specialist to implement an ongoing programme of anti-fraud, bribery and corruption work across the whole organisation. During 2020/21 work has involved the delivery of an annual work plan which follows the NHS Counter Fraud Authority standards to ensure our resources are protected from fraud, bribery and corruption, as well as addressing all four key areas of the national counter fraud strategy: namely, strategic governance; inform and involve; prevent and deter; and hold to account.

Somerset has historically taken a very robust approach to counter fraud work. The Local Counter Fraud Specialist (LCFS) is well resourced in terms of work plan days and the Audit Committee and senior management throughout the CCG understand the importance of counter fraud work and fully support the LCFS and the Director of Finance, Performance and Contracting in conducting that work.

The LCFS has developed key relationships with the following teams/directorates: Human Resources, Recruitment, Payroll, Risk

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

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

The CCG has a Whistleblowing Policy and reporting processes which are well publicised to staff, alongside two Freedom to Speak Up Champions. The CCG is confident these processes are effective. No cases have been reported during 2020/21.

Under normal financial arrangements, the CCG would include a challenging Quality, Improvement, Productivity, Prevention (QIPP) savings programme within its annual financial plans. However, due to changes within the NHS financial regime for 2020/21, in response to the COVID-19 pandemic, the annual planning process was suspended for the first half of the financial year, along with expectations for efficiency savings. Planning for the latter half of the financial year included an expectation that a level of efficiency savings would be delivered in-year in relation to Continuing Healthcare services, GP Prescribing and CCG running costs. Through ICS meetings, local leaders continue to discuss QIPP/CIP assumptions to inform future planning decisions and ensure that a robust peer challenge is in place across Somerset, but to also confirm that clear assumptions and monitoring are in place to ensure no double-counting across organisations.

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

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

As part of the developing and continued working towards a single system of finance, activity and workforce, the individual operational and financial plans of the Somerset Health Partners are developed, cross-checked and triangulated as one, through established joint working and strengthened governance, as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery. The Somerset approach to managing the system as a single health and care system, supported by a long term strategy, continues to be developed to ensure alignment and delivery of the aims for the system as a whole. This forward strategy will build on and refresh the already

approved estates programme, capital plans, and digital plans. Future plans will continue to focus on managing demand and reducing cost across the system. This includes a focus on clinical variation (using Rightcare, Getting It Right First Time, Model Hospital, Reference Costs and more benchmarks), and looking at elective and non-elective pathways, medication, continuing healthcare, and optimisation in both the short and longer term through changes to the models of care. We also have a system-wide planning approach to the efficient and cost effective use of bed capacity across all ICS Partners.

7.25 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 Somerset CCG, regular reports are received about 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. No significant internal control failures have been identified throughout the financial year 2020/21 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 of performance can be monitored and managed. In addition, to deliver assurance about the internal controls and control procedures operated by all Commissioning Support Units (CSUs), NHS England engages a reporting accountant to prepare a report on internal controls. The objective 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. No exceptions were identified within the SAR for the Non-Clinical Procurement service for 2020/21.

Type II ISAE 3402 Service Auditor reports, which assess the state of the control environment for the period 1 April 2020 to 31 March 2021, have also been received and reviewed for the following services used by the CCG:

NHS Business Services Authority provide and maintain the Electronic Staff Record system (ESR system) and the prescriptions payment process on behalf of the CCG. The 2020/21 SAR covering the ESR system presented a qualified opinion with exceptions identified in relation to two control objectives. The CCG considers that these exceptions had no significant impact on the service provided to the CCG.

The 2020/21 SAR covering the prescriptions payment process system presented a qualified opinion with exceptions identified in relation to three control objectives. The CCG considers that these exceptions had no significant impact on the service provided to the CCG.

NHS Shared Business Services Limited provide finance and accounting services to the CCG. The 2020/21 SAR presented a qualified opinion with one exception reported regarding the operating effectiveness of controls relating to the authorisation of manual credits. The CCG considers that this exception had no significant impact on the service provided to the CCG.

NHS Digital make GP Payments on behalf of the CCG. The 2020/21 SAR presented a qualified opinion with exceptions reported for two control areas. The CCG considers that these exceptions had no significant impact on the service provided to the CCG.

Capita Primary Care Support England (PCSE) provide administrative and support services as part of the delegated commissioning function for Primary Care Medical services. The 2020/21 Service Auditor Report for Capita PCSE identified a qualified opinion relating to 3 out of 16 control objectives, although the controls for two of the areas could not be operated throughout the financial year due to operational changes made because of the pandemic. One of these control exceptions related to the Ophthalmic Payments System, which is not relevant to the functions delegated to the CCG. The CCG considers that these exceptions had no significant impact on the service provided to the CCG.

7.26 The Better Care Fund

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

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

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

- the Disabled Facilities Grant – managed via District Councils
- mandated NHS (CCG) Contributions
- the Improved Better Care Fund (contributions via Somerset County Council)

Each year, local systems are required to provide a plan and progress reports on the use of the BCF. Given the impact of the COVID-19 pandemic, the resources required to manage this and the importance of stabilising local services and plans, the 2019/20 plan was rolled over into 2020/21. Better Care Fund plans are required to have oversight and sign off by Health and Wellbeing Boards and this is the case for Somerset.

During 2020/21 the Somerset BCF continued to help drive forward our person-centred integration agenda and the 2020/21 plan secured and stabilised investment in:

- social prescribing and community based support
- major and minor home adaptations and equipment
- carers support services
- core health and social care services
- intermediate care services (including Rapid Response and Home First)
- COVID-specific Hospital Discharge Schemes
- additional social care support for people able to leave hospital at weekends

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

7.27 Control Issues

In January 2021, 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 2020/21. These areas, along with the mitigating actions, are shown in the table below.

Control Issue	Mitigating Actions in Place
For all areas	Due to the continued impact of the COVID-19 pandemic the CCG will not achieve a range of required access and waiting time performance targets throughout this financial year. National operational priorities over the past year have been focussed on the NHS response to the COVID-19 pandemic, with most recent priority being given to ensuring we make maximum use of our available capacity whilst we remain in a level 4 incident.
Quality and Performance - Accident and Emergency	A&E performance has been impacted as a result of the COVID-19 pandemic, with testing and IPC protocols reducing the speed of flow in the Emergency Department. From December 2020 Somerset started to see a significant increase in the number of patients testing positive with COVID in the community, resulting in a significant increase in the patients admitted with COVID-19 and creating additional bed pressures, as have the required implementation of IPC protocols for quarantining, cohorting and deep cleaning. A winter plan incorporating a bed model (which forecasted the potential bed deficits) was agreed by Somerset System Partners and factored in mitigations to prevent avoidable admissions to hospital and to facilitate earlier discharge of patients from hospital (intermediate care, rapid response discharge schemes, Care Homes and the IUCS/CAS). The A&E Delivery Board has continued to meet throughout 2020/21 to ensure urgent care plans continue to be implemented and progressed.
Quality and Performance - RTT/52 week wait	There has been a significant impact on Elective Waiting Times due to the COVID-19 pandemic and in November 2020 18 week performance was 65.49% (Somerset FT 63.64%, YDH 75.37% and Other Providers 62.54%). There has been a significant increase in the number of 52 week waits increasing from 21 in February 2020 (pre-COVID) to 1,849 in November 2020. At Somerset FT the Trust lost 2 theatres (1 to increase critical care capacity and 1 to maintain the delivery of endoscopies). Plans were developed for Ophthalmology (cataracts) where long wait patients from Somerset Foundation Trust were to be offered treatment in Yeovil in order to improve waiting times and equalise waits across Somerset and plans were also being developed for Orthopaedics adopting a similar approach. However as a consequence of the increase in COVID-19 cases there has been a significant impact upon the delivery of elective services and plans have had to be put on hold. Whilst the Somerset System re-start performance is behind the Phase 3 plan as at November the overall numbers of patients on an RTT waiting list and those waiting in excess of 18 weeks were lower (better) than the Phase 3 Plan.
Quality and Performance - Mental Health and Dementia	Services continued to operate during the COVID Pandemic with clinicians maintaining services by dealing with referrals via telephone, video and webinar interventions (and in person where clinically appropriate). In addition the population of Somerset have also had access to a 24/7 phone line to access support. The Mindline Somerset service has been in place since the start of the COVID-19 pandemic lockdown (week

Control Issue	Mitigating Actions in Place
	beginning 23 March) and was available to callers of all ages. This service (which was commissioned by Somerset County Council (Public Health)) offers callers a supported conversation and provided increased access to Mental Health Services within Somerset. The full suite of mental health monitoring continues to be received and reviewed on a monthly basis and discussions with the providers continue to take place.
Quality and Performance - Access to Service/Capacity	Access performance has significantly deteriorated as a result of the COVID-19 pandemic with patients waiting longer for their diagnostic tests, procedure or first definitive treatment. In November 2020 diagnostic 6 week performance was 68.94% against the 99% target and RTT 18 week performance was 65.49% against the 92% standard. To improve waiting times in Somerset providers secured additional capacity in order to return to pre-COVID levels and Phase 3 plans have been monitored via the Provider Adapt and Adopt Programme. Performance remained challenged across a number of Adapt and Apopt Programmes (including Out Patients, MRI and CT) due to COVID related factors, although Endoscopy performance has been better than planned. The CCG has controls in place for managing provider performance, including monthly Finance and Performance Committee meetings, Patient Safety and Quality meetings and the System Performance and Activity Group where all local system partners are in attendance. 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.

7.28 Counter Fraud Arrangements

The 2020/21 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 2020/21 was risk-based and has been aligned to counter fraud objectives as per the NHS Counter Fraud Authority (NHSCFA) Standards for Commissioners 2020/21. 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.

7.29 Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG'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, about the adequacy and effectiveness of the internal control system to ensure the achievement of the CCG's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the CCG's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also

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

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

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

- any reliance that is being placed upon third party assurances

Overall, we are able to provide moderate assurance that there is a sound system of internal control designed to meet the CCG's objectives and that controls are being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

In forming our view we have taken into account that:

- the CCG is anticipating to deliver a breakeven position for the financial year. Due to the COVID-19 pandemic, the financial position for the first six months was managed nationally for all CCGs on a breakeven basis. For the second six months, the Somerset Integrated Care System was provided with a financial envelope with local agreement for the allocations. It is understood that the CCG is anticipating to deliver within these plans and a breakeven position is forecast against its financial resource for the full financial year. As a result, the CCG's brought forward cumulative financial deficit will remain at £19,581 million

- the CCG has displayed strong controls in relation to the key financial systems

- despite the impact on the staff due to the COVID-19 pandemic, we have been able to complete sufficient audit work to provide an overall opinion. There have been no limitations in scope due to the homeworking restrictions. The Primary Care Commissioning audit was cancelled during the year, as a number of the CCG's primary care team were re-assigned to support the COVID-19 response and vaccination programme. During March 2020, we had undertaken the mandated audit on primary care commissioning, which provided substantial assurance over the design of the processes

- rhe COVID-19 pandemic has resulted in aspects of the NHS Constitutions Standards not being met. However, from the work we have undertaken and the reports provided, it was evident that the Audit Committee and Governing Body have been kept informed on the issues on a timely basis

- the CCG has embedded robust risk management processes, together with a new format of the Governing Body Assurance Framework which will reflect the assurances and controls that are in place for delivering the strategic objectives; these are 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 entry and the accuracy of financial reports. Overall the CCG has sound controls in place to ensure the financial performance and activities can be managed and reported effectively. Our review did not identify any significant areas of improvement. Therefore, we have provided substantial assurance on both control design and operational effectiveness **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. • During our sample testing of User Access of Oracle, Journal Entries, Control Accounts and Cash Reconciliation (outsourced to SBS), and the Governing Body Finance Reports, we did not identify any exceptions in relation to authorisation process and reporting accuracy. • The CCG has been achieving 100% on reconciling items that only relate to the current month from the SBS Reci packs since September. Of the 130 providers who use SBS, the CCG is now rated the top in the country and scores highly on the good financial controls metrics. No recommendations were raised
Area of Audit: Conflicts of Interest; **Director:** James Rimmer, Chief Executive
Design: moderate **Effectiveness**: moderate **Recommendations**: 1 medium significance, 3 low significance.
Summary of report: The purpose of this audit was an assessment of the CCG's controls in place to ensure conflicts of interest are identified and managed appropriately.

Overall, the CCG has controls in place to manage conflicts of interests through the administration processes undertaken by the Executive Assistant, Committee meetings discussion, decision-making, contract procurement and commissioning process. We raised one overall medium rated finding in relation to the maintenance of the registers. As a result, we have provided moderate assurance over the design effectiveness and moderate assurance over the operational effectiveness.

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

- The CCG's Standards of Business Conduct and Managing Conflicts of Interest Policy (the CoI 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 COI Policy provides the process for recognising and managing breaches, which will be published on the CCGs register of breaches. The CCG is unaware of any breaches and therefore a register has not yet been published to the website.
- Declarations of interest are consistently completed during the recruitment process. Sample testing did not identify any exceptions.

Opportunities for enhancement

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

- The CCG's Registers have not been kept up to date to include all fields required under the National Guidance, and not all staff have updated their declaration of interests or made nil return in the past 12 months. The GP Practices register does not include sufficient detail around the Primary Care Networks for the GP practices as well as issues with sign off dates for GP declarations.
- The CCG's Standards of Business Conduct was due for review in October 2020. This review has not taken place due to other pressures but consideration has been given to reviewing the contents in time for the Audit Committee in February. Benchmarking with the guidance was completed and some minor exceptions were highlighted.
- All appropriate CCG staff and Governing Body and Committee members will be required to undertake mandatory annual online training which is be provided by NHS England. All staff will receive information about declaring interests as part of induction. All staff should have completed annual COI training by 31 January. Compliance with level one training currently at 71.17%. Staff were not completing the CoI training earlier in the year, due to the light touch governance regime. However, a review of the governance arrangements was undertaken in November 2020 and the COI level one training has been made mandatory again.
- As per the guidance, declarations of interest should be invited at all Governing Body and Committee meetings. A governance update has meant that all non-public facing meetings would not have minutes taken, but instead all actions would be reported on an action log. We sampled the last three meetings of the Clinical Executive Committee, Governing Body, Primary Care Commissioning Committee, Patient Safety and Quality Assurance Committee and Finance and Performance Committee. We found that Declarations of Interest was a standing agenda item on all Governing Body and Committee meeting, with the exception of the Finance and Performance Committee.

Area of Audit: Assurance framework and Risk Management Processes **Director**: James Rimmer, Chief Executive		
Design: Substantial	**Effectiveness:** Moderate	**Recommendations:** 1 medium significance

Summary of report:

It is essential that there is an effective and efficient risk management process and assurance framework in place to give sufficient, continuous and reliable assurance on organisational stewardship and the management of the major risks to organisational success and delivery of improved, cost effective, public services.

Over the past year, the CCG has been implementing new risk management processes which have included updates to the corporate risk register, training to staff, reporting mechanisms, monitoring requirements with key performance indicators and a new policy and procedures. It has developed its strategic aims and objectives and the CCG is working towards a new Governance Body Assurance Framework (GBAF).

The CCG strategic aims and objectives were agreed by the Governing Body (GB) in November 2020 and the strategic risks and risk appetite statement is still being developed in collaboration with the Directors.

The COVID-19 pandemic and vaccination programme has impacted the initial plans to have a fully mature risk management process and robust GBAF by 31 March 2021, however, significant progress has been achieved, in particular on the risk management processes.

The audit is scoped to take into account of the external factors impacting on the organisation's progress but it will provide a level of assurance on the progress made and direction of travel to complete processes and documentation.

The following areas of good practice were identified:

- The CCG launched the Risk Management Improvement Project in 2019 to address the issues identified from the 2017 and 2018 risk and governance reviews. The current 'Risk Management Strategy' was approved in November 2019 after a full review of the CCG's risk management framework and system. The Strategy encompasses comprehensive aspects in identifying, assessing and monitoring risk, controls, assurance, accountability, reporting, roles and responsibility, tolerance, blueprint, appetite, acceptable/unacceptable risk and escalation routes.
- During 2020/21, the CCG's reporting cycles, and strategic aims and objectives have been developed and approved by the Governing Body. Revised risk and GBAF reporting specifications are being developed, but remain to be finalised and approved. The Strategy will be updated accordingly in 2021/22 to reflect the aspects that require changing since the improvement being implemented.
- The risk appetite statement and matrix have been developed and are to be considered and taken forward for approval during 2021/22.
- The risk team delivered training sessions to all relevant staff to introduce the new risk management arrangements and process. In accordance to the feedback received after the training and staff survey results, further 1:1 training has been arranged to cover Datix usage, risk review and monitoring in practice. A resource folder has been created to provide supplementary help material.
- A Risk Management Group (RMG) has been established at the CCG to meet three times a year, in line with the risk reporting cycle, to provide assurance to the Clinical Executive Committee (CEC) and GB by reviewing the establishment and maintenance of an effective

system of risk management for risks to the achievement of the CCG's strategic, corporate and directorate risks.

- The Corporate Risk Register (CRR) has been reviewed in detail at the RMG to consolidate risks that are under the same domain and approve ratings of the risks by looking at the current controls in place and challenges the CCG faces.
- The corporate business risk team issue a communication through the CCG staff wide communication vehicles to advise staff when risk updates are required (currently every 2 months). This is also followed up with a reminder. The Finance directorate plan to align their risk reviews with the mandatory update and monthly CEC risk update; once in place this can be evidenced as a valuable approach and reflected in other directorates.
- Following the CCG Staff risk Survey undertaken in October 2020, one of the key reasons for staff feeling less confident of the risk management processes were concerns around capacity and complexity. The risk team therefore reduced the requirements in Datix population to ensure key fields were being completed. The risk team may propose further reduction if required.
- As per the GBAF and Risk Reporting Specification outlined, the production of reports for the groups and committees is planned to be automated if possible and standardised to some extent to ensure accurate and sufficient risk review and escalation. The proposed GBAF can clearly demonstrate the movement of key risks corresponding to each strategic aims and objectives.

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

- Key areas of the Datix risk register have not been populated for all risks (mainly the lower level risks), and 34% of open risks have not been reviewed in the past two months as required.

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

Design: N/A **Effectiveness:** N/A **Recommendations:** 5 medium significance

Summary of report:
Following recommendations to improve the level of assurance provided against self-assessments, NHS Digital published new guidance for NHS organisations and independent assurance providers with regards to all 2020/21 assessments and established a fixed audit scope, which includes a review of 13 mandatory assertions using NHS Digital's Independent Assessment Framework. The framework requires independent assurance providers to assess both the CCG's DSP Toolkit compliance and the broader maturity of its data security and protection control environment, in order to inform and drive measurable improvement of data security across the NHS. The audit approach established by the framework is therefore significantly more detailed and goes beyond what is asked in the DSP Toolkit and a higher amount of evidence is now required to demonstrate compliance compared to previous years.

The purpose of this audit was to provide an independent high-level review of the assertions and evidence items in the DSP Toolkit self-assessment return as it stood in March 2021 and to identify how compliance could be improved for the 2020/21 year-end return. We have reviewed and assessed the evidence provided for the 13 assertions included in the fixed audit scope by NHS Digital.

The following areas of good practice were identified:

The evidence provided for 30 of the 35 mandatory sub-assertions included in our sample was found to be satisfactory and in line with the requirements of the Independent Assessment Framework. Good practice was evidenced in the following areas:

- There are approved policies and local procedures in place defining the CCG's approach to data protection by design and by default, which include pseudonymisation requirements and list the technical and physical controls for preventing information from being inappropriately copied or physically accessed
- The CCG has an approved Risk Management Framework in place, which includes the roles and responsibilities of members of staff and provides a step by step guide for identifying, assessing and evaluating risks and incidents
- Members of staff are supported in understanding their obligations under the National Data Guardian's Data Security Standards through a robust induction training process and the CCG has conducted a thorough training needs analysis exercise for 2020/21 and established a remediation plan
- The CCG has an approved IT Infrastructure Patching Policy in place that establishes the standard procedures for the identification of vulnerabilities and the timely installation of patches to limit the exposure and effect of common malware threats to the CCG's IT infrastructure
- The CCG has informal procedures in place relating to the procurement of services from suppliers that provide health and social care services or have access to the CCG's data and has documented evidence of the basic due diligence undertaken in determining that IT suppliers have appropriate certifications and accreditations.

Opportunities for enhancement

During our testing we found that there was insufficient evidence to completely support, at the time of the audit, 5 of the 35 mandatory sub-assertions included in our sample (a compliance score of 86%).

The key exceptions relate to the absence of sufficient evidence to support the following:

- An audit has been undertaken during the reporting period to assess the CCG's compliance with the GDPR's data protection by design requirements
- Process reviews are held at least once per year where data security is put at risk and following data security incidents
- The CCG has a formal data security incident response and management plan in place, which has been tested to ensure all parties understand their roles and responsibilities
- The CCG's patching arrangements and status of the CCG's IT estate are reported to senior management on a regular basis
- All infrastructure is running operating systems and software packages that are patched regularly and are in vendor support.

The key actions that the CCG needs to take are:

- Perform data protection by design audits on an annual basis, with clear action plans, action owners and target implementation dates, which should be formally signed off and monitored by the CCG's Information Governance, Records Management and Caldicott Committee (IGRMCC)
- Establish appropriate reporting arrangements with the SCW CSU to ensure that all information governance and cyber security incidents and near misses are reported to the CCG's SIRO and the Information Governance, Records Management and Caldicott Committee (IGRMCC) on a routine basis

- Define the CCG's data security incident response and management procedures and put arrangements in place for the CCG's business continuity and incident response procedures to be tested on at least an annual basis
- Put arrangements in place to ensure that patch management and asset management activities relating to the CCG's IT infrastructure are regularly reported to the CCG's SIRO and the IGRMCC
- Review the accuracy and completeness of the CCG's hardware and software asset registers on a regular basis and put arrangements in place for the status of the registers to be reported to senior management, including the CCG's SIRO and the IGRMCC, on a regular basis.

Area of Audit: Partnership Working and ICS Development
Director: James Rimmer, Chief Executive

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

Summary of report:
This audit aims to support the development of the Somerset Integrated Care System (ICS) governance structure, the accountability arrangements for the organisations within it and its reporting mechanisms. The robustness of the partnership arrangements across the ICS organisations will impact on the effectiveness of the following:

- Financial controls and reporting within organisations and as an ICS
- Operational performance and reporting
- Governance structures at the ICS and links into the constituent organisations governance arrangements
- Decision-making and assurance processes
- Processes to prioritise system priorities and ensure that these align to organisational priorities
- Strategic commissioning arrangements.
- Integrated care provider partnership arrangements.

Good corporate governance is critical to the achievement of the ICS's objectives and those of the organisations that make up its membership. Corporate governance extends from policy setting through to control objectives and is based on the people, ethos and culture established within the organisations. Effective partnership working and embedded corporate governance across the ICS should equip the organisations with a mechanism for ensuring the achievement of their own and the ICS's strategic aims.

This was a joint audit on behalf of NHS Somerset CCG, Somerset NHS Foundation Trust and Yeovil District Hospital Foundation Trust.

In December 2020 Somerset was designated by NHS England and Improvement as an Integrated Care System, in line with the ambition set out in the Long Term Plan.

Key Findings:
A number of observations were highlighted, which were all inter-linked but would not all need to be addressed in the short-term. The national direction for delivery of the integration and social care agenda has to be determined, then legislation will follow and timeframes dictated. The observations are set out in more detail in the body of the report, with a narrative and areas for consideration. They have been structured around the following six themes:

1. Development of the ICS Strategy
2. Framework to support the strategy
3. Strategic Commissioning
4. Provider Collaboration

5. Health and Social Care integration
6. Implications for the ICS structure.

The Fit for My Future Strategy and Improving Lives Strategy exist, together with a number of other strategies. The principles of the vision for Somerset on addressing its population health and wellbeing needs have been identified but a 'stocktake' to identify any gaps and a map to link arrangements for delivery, would assist this.

An ICS governance structure has been proposed, in collaboration with the partners. We held interviews with a sample of the partner organisations which identified a number of concerns, particularly around the fact the proposal would hinder progress and the governance was overly complex. In addition, it was observed that the Health & Wellbeing Board did not appear to be effectively embedded.

As a result of the existing national arrangements in place, work-arounds have been found, some of them successful. From discussion with staff and knowledge of the NHS in Somerset, the partnership response to the COVID-19 pandemic and addressing the SEND report were cited as good outcomes. Learning from areas of good partnership arrangements needs to be harnessed. However, the development of activities from the bottom-up has possibly contributed to the multiple presentation of reports to a number of committees, the majority of which had the same attendees. This has increased the burden on valuable officer time and possibly the ability to make efficient and effective decisions in the correct forum.

There is a need to have a clear System / ICS Strategy that covers health, social care and wellbeing. From this, a framework to articulate the priorities, outcome measures, time frames for delivery, delegation and responsibility, assurance mechanisms and reporting routes for escalation. In conjunction with the development of the framework, the structure of the ICS Committees / groups would be clarified.

Strategic commissioning arrangements to be set at a high level, in partnership with assurance mechanisms. Joint operational commissioning arrangements (where applicable), linking with providers would be part of the 'business as usual' processes.

Work on the form, membership and support function of the Provider Collaboration is well underway. This should include all providers across health, social care, voluntary sector etc. The ICS system needs to have the support from all partners with clear understanding for each elements' role. Organisational development support, throughout all levels of the organisation, supported by workforce plans and technology, are fundamental enablers in order for the strategic commissioning priorities to be delivered.

Overall Conclusion:
ICS governance does need to be clear and simple. It isn't always about the structure of committees and groups but the culture.

Management Response:
The draft report has been reviewed by key leads across the Somerset ICS partner organisations. We feel the observations that have been made under each of the headings are a fair reflection of the current position in respect of the ICS governance, strategy and structure. However, as this report was drafted prior to the publication of the Health and Care White Paper we feel there will be greater benefit in using these reflections to inform the development of the ICS going forward, rather than having an action plan in response to historic arrangements. There is already good

progress being made with developing options for how the statutory organisations may be configured in Somerset in response to the White Paper as well as enhancing partnership ways of working across the ICS. Consideration is now also being given to the next stage in taking forward the FFMF strategy and objectives.

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

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

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

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

- the work of the internal auditors
- Executive Directors, Senior Managers and Clinical Leads within the CCG who have responsibility for the development and maintenance of the internal control framework
- available performance information
- comments made by the external auditors in their annual audit letter and other reports.

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

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

As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described in pages 112-118.

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

- Governing Body

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

7.31 Conclusion

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

James Rimmer
Chief Executive
NHS Somerset CCG
10 June 2021

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 31 March 2021 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
Axbridge and Wedmore Surgeries	Axbridge Surgery, Houlgate Way, Axbridge, BS26 2BJ
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
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
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 – Rural Practice Network 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
Brent Area Medical Centre (Patients are covered by the North Sedgemoor PCN)	Brent Area Medical Centre, Anvil House, East Brent, Highbridge, Somerset, TA9 4JD
Cheddar Medical Centre (Patients are covered by the North Sedgemoor PCN)	Cheddar Medical Centre, Roynon Way, Cheddar, Somerset, BS27 3NZ

Annex 2 (Governance Statement)

NHS Somerset CCG Governing Body Meetings 2020/21 **Attendance Record**	✓ = Present X = Apologies Given								
(V) = voting Member (NV) = non-voting Member	23.04.20 (private meeting)	21.05.20 (private meeting)	18.06.20	30.07.20	24.09.20	26.11.20	28.01.21	25.02.21 (private meeting)	25.03.21
Dr Ed Ford (V) Chair	✓	✓	✓	**X**	**X**	**X**	✓	✓	✓
James Rimmer (V) Chief Executive	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	✓	✓	✓	✓	✓	**X**	✓
Sandra Corry (V) Director of Quality and Nursing	✓	✓	✓	✓	✓	**X**	**X**	**X**	**X**
Lou Evans (V) Acting Chair from July-December 2020 Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	**X**	✓	✓	✓	✓	✓	✓	✓	✓
Judith Goodchild (NV) Chair, Healthwatch	N/A	N/A	**X**	✓	✓	✓	✓	N/A	✓
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓	**X**	✓
Wendy Grey (V) Non-Executive Director, Member Practice Representative	**X**	✓	✓	✓	✓	**X**	✓	✓	✓
Neil Hales Interim Director of Commissioning (from 1 January 2021)							✓	✓	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	✓	✓	✓	✓	✓	✓	✓	✓

NHS Somerset CCG Governing Body Meetings 2020/21 **Attendance Record**	✓ = Present X = Apologies Given								
(V) = voting Member (NV) = non-voting Member	23.04.20 (private meeting)	21.05.20 (private meeting)	18.06.20	30.07.20	24.09.20	26.11.20	28.01.21	25.02.21 (private meeting)	25.03.21
Maria Heard (NV) SRO COVID-19 Programme Director Fit for my Future	✓	✓	✓	✓	✓	✓	✓	**x**	✓
Alison Henly (V) Director of Finance, Performance and Contracting	✓	✓	✓	✓	✓	✓	✓	**x**	✓
Val Janson Acting Director of Quality and Nursing (from October 2020)						✓	✓	✓	✓
Trudi Mann (V Non-Executive Director, Member Practice Representative	✓	✓	✓	✓	✓	✓	✓	**x**	✓
Dr Alex Murray (NV) Lead Clinician for Medical/Primary Care input to COVID-19 Clinical Lead, Fit For My Future	✓	✓	**x**	✓	✓	✓	**x**	✓	✓
Dr Jo Nicholl (V) Non-Executive Director, Member Practice Representative (to 30 April 2020)	✓								
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandra Wilson (NV) PPG Lay Observer	N/A	N/A	✓	✓	✓	✓	✓	N/A	**x**

NHS Somerset CCG Clinical Executive Committee Meetings 2020/21 Attendance Record							✓ = Present X = Apologies Given			
(V) = Voting Member (NV) = Non-Voting Member	1.4.20	6.5.20	3.6.20	1.7.20	2.9.20	7.10.20	4.11.20	2.12.20	3.2.21	3.3.21
Dr Peter Bagshaw (V) Associate Clinical Director: Adult Mental Health	x	✓	✓	✓	✓	✓	x	✓	✓	✓
Dr Will Chandler (V) Associate Clinical Director: Planned Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Sandra Corry (V) Director of Quality and Nursing	x	x	x	x	✓	✓	x	x	x	x
Dr Orla Dunn (NV) Consultant in Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Ed Ford (V) CCG Chair	✓	✓	x	✓	x	x	x	x	✓	✓
Mr Shaun Green (NV) Deputy Director of Clinical Effectiveness and Medicines Management	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Neil Hales (V) Director of Commissioning									✓	✓
Dr Justin Harrington (V) Associate Clinical Director: Digital Strategy	✓	✓	x	✓	✓	✓	x	x	x	x
Mrs Maria Heard (V) Programme Director: Fit For My Future	x	x	x	✓	✓	✓	✓	✓	✓	✓
Mrs Alison Henly (V) Director of Finance, Performance and Contracting	✓	x	✓	✓	x	✓	✓	x	x	✓
Dr Tim Horlock (NV) LMC Representative	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Mrs Val Janson (V) Acting Director of Quality and Nursing									✓	✓
Dr Emma Keane (V)	✓	✓	✓	✓	x	✓	x	x	x	x

Associate Clinical Director: Primary Care										
Dr Tom MacConnell (V) Associate Clinical Director: Integrated Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Alex Murray (V) CEC Vice Chair (wef 1 May 2020) and Clinical Director: FFMF and Clinical Lead: STP	✓	✓	✓	x	✓	✓	✓	✓	✓	✓
Mr James Rimmer (V) Chief Executive and CEC Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	x
Dr Kate Staveley (V) Associate Clinical Director: Women's and Children's Health	✓	✓	✓	✓	✓	✓	✓	✓	✓	x
Dr Helen Thomas (V) Associate Clinical Director: Same Day and Urgent Care	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Andrew Tresidder (NV) Clinical Lead: Evidence Based Interventions / Medicines Management	x	✓	x	✓	✓	✓	✓	✓	✓	✓

Notes:

- Dr Steve Edgar resigned from his role at the CCG and left on 30 April 2020
- Mr David Freeman resigned from the CCG after being appointed to the position of Chief Operating Officer at Swindon CCG in October 2020 following a successful nine months' secondment
- Mr Neil Hales joined the CCG as Director of Commissioning in January 2021
- Mrs Val Janson deputised for Mrs Sandra Corry at the CEC meetings with effect from February 2021

NHS Somerset CCG Audit Committee Meetings 2020/21 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	17.6.20	23.9.20	9.12.20	18.3.21
Lou Evans Audit Committee Chair and Non-Executive Director, Lay Member (Governance and Audit)	M	✓	✓	✓	✓
Dr Jayne Chidgey-Clark Audit Committee Vice Chair, Non-Executive Director, Registered Nurse	M	✓	✓	✓	✓
Alison Henly Director of Finance, Performance and Contracting	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 2020/21 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	15/04/ 2020	13/05/ 2020	17/06/ 2020	15/07/ 2020	12/08/ 2020	16/09/ 2020	14/10/ 2020	11/11/ 2020	16/12/ 2020	20/01/ 2021	24/02/ 2021	
Jayne Chidgey-Clark (Chair) Registered Nurse – Governing Body	M	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	
Sandra Corry – Director, Quality and Nursing	M	✓	✓	✓	✓	✓	x	✓	x				
Alison Henly – Director of Finance, Performance and Contracting	M	✓	✓	✓	x	✓	✓	✓	✓	x			
Basil Fozard - Non-Executive Director, Secondary Care Specialist Doctor	M	✓	x	x	✓	✓	x	✓	✓	✓	✓	✓	
Wendy Grey – Non-Executive Director	M		✓	✓	✓	✓	✓	✓	✓	x	✓	✓	
Val Janson - Deputy Director of Quality and Nursing	M	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Karen Taylor – Associate Director of Safety and Quality Improvement	M	✓	✓	✓	x	✓	✓	✓	✓	x	✓	✓	

Name	Member (M)/ In Attendance (A)	15/04/ 2020	13/05/ 2020	17/06/ 2020	15/07/ 2020	12/08/ 2020	16/09/ 2020	14/10/ 2020	11/11/ 2020	16/12/ 2020	20/01/ 2021	24/02/ 2021	
Theresa Reynolds – Assistant Quality Manager	A		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Martine Lee – Notetaker	A	✓	✓	✓	✓	✓	✓	✓					
Shaun Green – Associate Director Head of Medicines Management and Clinical Effectiveness	M			✓	x	x	✓	✓	x	x	x	x	
Dr Alex Murray – Clinical Director	M										✓	✓	
Kathy French – Interim Deputy Director of Quality and Nursing	M											✓	
Charlotte Blocke – Note taker	A											✓	
Marianne King	A				✓								
Alison Rowswell	A					✓							
Helen Wheldon	A					✓							
Georgina Hallett - Quality Lead for Planned Care and Patient Safety	A						✓						
Emily Taylor	A						✓						
Peter Bagshaw	A							✓					
Becky Applewood	A							✓					
Graham Brant	A							✓					
Jo Langley-White	A							✓					
Neil Jackson	A										✓		
Neil Hales – Director of Commissioning	M											✓	

Name	Member (M)/ In Attendance (A)	15/04/ 2020	13/05/ 2020	17/06/ 2020	15/07/ 2020	12/08/ 2020	16/09/ 2020	14/10/ 2020	11/11/ 2020	16/12/ 2020	20/01/ 2021	24/02/ 2021	
Phoebe Sherry-Watt - Associate Director of CHC Services	A											✓	
Hugh Archibald - Quality Lead - Urgent Care and Risk Management	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 2020/21 **Attendance Record**	✓ = Present X = Apologies Given				
(V) = voting Member (NV) = non-voting Member	23 April 2020	21 May 2020	25 June 2020	9 October 2020	12 March 2021
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	✓	**X**	✓
Lou Evans (V) – Committee Chair Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓	**X**	**X**	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	✓	✓	✓	✓
Marianne King Associate Director of Organisational Development and Workforce	✓	✓	**X**	✓	✓
Grahame Paine (V) from 1 October 2019 Non-Executive Director (Finance and Performance)	✓	✓	✓	✓	✓
James Rimmer (NV) Chief Executive			✓	✓	✓

Notes:

Dr Ed Ford, Somerset Chair was invited to and attended the Remuneration Committee Meetings held on 23 April 2020, 21 May 2020 and 25 June 2020 (NV capacity)

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NHS Somerset CCG Primary Care Commissioning Committee 2020 Attendance Record	✓ = Present X = Apologies Given

(M) Committee member (A) In attendance	Committee Role (eg. Executive, Lay, GP, etc)	10/03/ 2020	10/06/ 2020	17/09/ 2020	/12/20 20
David Heath (M)	Chair, Non-Executive Director	✓	✓	✓	✓
Dr Basil Fozard (M)	Vice Chair, Non-Executive Director	x	✓	x	x
Alison Henly (M)	Director of Finance, Performance and Contracting	✓	✓	✓	✓
Sandra Corry (M)	Director of Quality and Nursing, CCG	x	x	x	x
Laila Pennington (M)	Head of Primary Care, NHS E	x	x	x	x
Amanda Fisk (M)	Director of Assurance and Delivery, NHS E	x	x	x	x
Louise Woolway (M)	Deputy Director of Public Health, SCC	x	x	x	✓
Dr Emma Keane (M)	Associate Clinical Director of Primary Care, CCG	✓	✓	✓	x
Dr Chris Campbell (M)	External GP	x	✓	✓	x
Dr Nick Bray / Dr Karen Sylvester (June 2020 onwards) (M)	LMC Representative	x	✓	✓	✓
Judith Goodchild (M)	Chair of the Board, Healthwatch	✓	✓	✓	✓
Tanya Whittle (M)	Deputy Director of Contracting, CCG	✓	✓	✓	x
Michael Bainbridge (M)	Associate Director of Primary Care, CCG	✓	✓	x	✓
Karen Taylor (M – on behalf of Sandra Corry)	Associate Director of Safety and Quality Improvement, CCG	✓	✓		
Val Janson (M – on behalf of Sandra Corry)	Deputy Director of Quality and Nursing, CCG			✓	✓
Martin Davidson (M – left Sept 2020	Chair, Somerset PPG Chairs Network	x	x		
Sandra Wilson (M for Sept 2020)	Chair, Somerset PPG Chairs Network			✓	✓
Jill Hellens (A – on behalf of Dr Nick Bray)		✓			
Jacqui Damant (A - presenting)	Associate Director of Finance, CCG	✓	✓	✓	✓
Lou Evans (A)	NED, CCG			✓	✓
Kelly Coller (A- presenting)	Assistant Primary Care Contract Manager	✓			
Jessica Harris (A – Observing March / September presenting)	Primary Care Development Manager, CCG	✓		✓	
Sam Checkovage (A – presenting)	Assistant Commissioning Manager, CCG			✓	
Jonathan Davis (A – presenting)	Quality Lead for Primary Care, CCG			✓	
Julie White (A – presenting)	Estates Capital Bid Manager, CCG			✓	
James Warren (A – presenting)	Urgent Care Project Manager, CCG			✓	

(M) Committee member (A) In attendance	Committee Role (eg. Executive, Lay, GP, etc)	10/03/ 2020	10/06/ 2020	17/09/ 2020	/12/20 20
Lisa Pyrke (A – presenting)	Interim Communications Manager, CCG				✓
Robert Moorcock (A – presenting)	Primary Care Contract Officer, CCG				✓
Phillip Godfrey (A – presenting)	Primary Care Contract Manager, CCG				✓
James Rimmer (A – presenting)	Chief Executive, CCG	✓			
Andrew Hill (A – presenting in Part B)	Associate Director of Integrated Care, CCG			✓	
Julia Bloomfield (A – Observing)	Infection Prevention and Control Nurse Specialist, CCG	✓			
Emily Parsons (A – Observing)	Primary Care Administration Apprentice, CCG				✓
Ed Garvey (A – Observing)	Primary Care Commissioning Officer, CCG				✓
Adrian Chamberlain (A – Observing)	Interim Primary Care Development Manager, CCG				✓

NHS Somerset CCG Finance and Performance Committee Meetings 2020/21 Attendance Record	✓ = Present X = Apologies Given

Name	15 April 2020	13 May 2020	17 June 2020	15 July 2020	12 Aug 2020	16 Sept 2020	14 Oct 2020	11 Nov 2020	16 Dec 2020	19 Jan 2021	23 Feb 2021	24 Mar 2021
Sandra Corry	✓	✓	✓	✓	✓	x	✓	x	x	x	x	x
Lou Evans	x	x	x	x	✓	x	✓	✓	✓	✓	x	x
Ed Ford	x	x	x	x	x	x	x	x	✓	x	x	x
Neil Hales										✓	✓	✓
Alison Henly	✓	✓	✓	✓	✓	✓	✓	✓	x	x	x	✓
Trudi Mann	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Grahame Paine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Val Janson												✓

REMUNERATION AND STAFF REPORT

8 REMUNERATION REPORT

This section of the report contains details of remuneration and pension entitlements for senior managers of the CCG in line with 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 has used is to include members of the decision-making groups within the CCG, which the CCG has defined as the Governing Body, excluding those members with no voting rights. Senior managers (excluding Lay Members) are generally employed on permanent contracts with a six month period of notice.

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

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

8.1 Senior manager remuneration (including salary and pension entitlements) – (subject to audit)

		Total 2020/21						Total 2019/20					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total
Name	Title	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£	£'000	£'000	£'000	£'000	£'000	£	£'000	£'000	£'000	£'000
James Rimmer	Chief Executive	155-160	0	0	0	67.5-70	225-230	85-90	0	0	0	62.5-65	150-155
Neil Hales	Interim Director of Commissioning (from 04/01/2021)	30-35	0	0	0	0	30-35	0	0	0	0	0	0
Alison Henly	Director of Finance, Performance and Contracting	110-115	7,500	0	0	15-17.5	135-140	110-115	6,700	0	0	45-47.5	160-165
Maria Heard	Programme Director of Fit for My Future	105-110	0	0	0	27.5-30	135-140	95-100	0	0	0	32.5-35	125-130
Sandra Corry	Director of Quality and Nursing	90-95	0	0	0	0	90-95	90-95	0	0	0	30-32.5	125-130
Valerie Janson	Acting Director of Quality and Nursing (from 16/11/2020)	35-40	0	0	0	20-22.5	55-60	0	0	0	0	0	0
Edward Ford	Chair	90-95	0	0	0	0	90-95	90-95	0	0	0	32.5-35	120-125
Lou Evans	Vice-Chair and Non Exec Director Governance and Audit	30-35	0	0	0	0	30-35	35-40	0	0	0	0	35-40
David Heath	Non Exec Director, Patient and Public Engagement	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Basil Fozard	Non Exec Director, Secondary Care Doctor	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10

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	25-30	0	0	0	0	25-30	25-30	0	0	0	0	25-30
Joanne Nicholl	Non Exec Director, Member Practice Representative (to 30/04/2020)	0-5	0	0	0	0	0-5	10-15	0	0	0	2.5-5	15-20
Trudi Mann	Non Exec Director, Member Practice Representative	25-30	0	0	0	0	25-30	25-30	0	0	0	0	25-30
Grahame Paine	Non Exec Director, Finance and Performance	15-20	0	0	0	0	15-20	5-10	0	0	0	0	5-10

Officer Holder Changes:

James Rimmer was appointed to the additional post of Senior Responsible Officer for the Somerset Integrated Care System from October 2020. This resulted in an increase in salary and the table above includes an additional £8k related to this post for the six months from October 2020 to March 2021.
Neil Hales was appointed as Interim Director of Commissioning on 4 January 2021. This appointment is an off-payroll engagement.
Valerie Janson was appointed as Acting Director of Quality and Nursing on 16 November 2020.
Dr Joanne Nicholl resigned from the post of Non-Executive Director on 30 April 2020. The salary banding for Dr Nicholl reported in the table above includes £2k for her additional Clinical Lead role while in office as a Non-Executive Director.

Other Notes:
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 2020/21.

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 2021 (subject to audit)

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at Pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash equivalent transfer value at 1 April 2020	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2021	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	2.5-5.0	2.5-5.0	70-75	155-160	1,275	77	1,399	0
Alison Henly	Director of Finance, Performance and Contracting	0-2.5	0	40-45	95-100	752	18	799	0
Maria Heard	Programme Director of Fit for My Future	0-2.5	0	10-15	0-5	149	17	183	0
Sandra Corry	Director of Quality and Nursing	0-2.5	0-2.5	40-45	120-125	939	23	991	0
Valerie Janson	Acting Director of Quality and Nursing (from 16/11/2020)	0-2.5	2.5-5.0	25-30	70-75	531	19	624	0
Joanne Nicholl	Non Exec Director	0-2.5	0-2.5	5-10	20-25	143	0	171	0

Notes:

1. Lay members do not receive pensionable remuneration.
2. Pensionable contributions may include more than just those from CCG employment. Where a GP is under a contract of service with the CCG and pays pension contributions then they are classed as 'NHS staff (Officer)' for pension purposes. The figures provided by NHS Pensions cover only the 'Officer' element of the GP's pension entitlement.

8.3 Cash equivalent transfer values

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

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

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

8.4 Real Increase in CETV

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

8.5 Compensation on early retirement of for loss of office (subject to audit)

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

8.6 Payments to past members (subject to audit)

The CCG has made no payments to past directors during 2020/21.

8.7 Pay multiples (subject to audit)

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 2020/21 was £180,000 to £185,000 (2019/20: £180,000 to £185,000). This was 4.82 times (2019/20: 4.90) the median remuneration of the workforce, which was £37,890 (2019/20: £37,267).

In 2020/21, no employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £7,626 to £182,501 (2019/20: £7,626 to £182,501).

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 on pages 163-177 have been audited by Grant Thornton UK LLP, Somerset CCG's external auditors.

- Disclosures on Parliamentary accountability
- 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.

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 2020 to 31 March 2021.
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 contribution to stakeholder pension	The amount that the CCG has contributed to individual's stakeholder pension schemes.
Lump sum at pension age related to real increase in pension	The amount by which the lump sum to which an individual will be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 31 March 2021	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 2021
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 2021	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 2021

8.9 Remuneration of the Accountable Officer and Directors

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

The membership and attendance at the Somerset CCG Remuneration Committee during 2020/21 is set out below:

Somerset CCG Remuneration Committee Meetings 2020/21 Attendance Record	✓ = Present X = Apologies Given				
(V) = voting Member (NV) = non-voting Member	23 April 2020	21 May 2020	25 June 2020	9 October 2020	12 March 2021
Lou Evans (V) Remuneration Committee Chair, CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	✓	X	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓	X	X	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement, and Chair of the Primary Care Commissioning Committee.	✓	✓	✓	✓	✓
Grahame Paine (V) Non-Executive Director (Finance and Performance)	✓	✓	✓	✓	✓
Marianne King (NV) Associate Director of Organisational Development and Workforce	✓	✓	X	✓	✓
James Rimmer (NV) Chief Executive			✓	✓	✓
Notes: Dr Ed Ford, Somerset Chair was invited to and attended the Remuneration Committee Meetings held on 23 April 2020, 21 May 2020 and 25 June 2020 (NV capacity). No additional persons attended the Committee in order to provide legal advice on compliance with any relevant legislation.					

The CCG also has an established committee to oversee the appointments and remuneration for Non Executive Directors. This Committee makes determinations about the appointment, pay and remuneration for Non-Executive Directors of the CCG Governing Body.

8.10 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 are taken into consideration when assessing whether to award an inflationary increase to Directors.

8.11 Remuneration of Very Senior Managers (VSMs)

The CCG has a senior manager in post with a salary that exceeds £150,000 per annum. Guidance was sought from the Director of Workforce and Organisational Development at NHS England and NHS Improvement to determine a suitable remuneration banding to recognise the responsibilities and complexities of this position. This was subsequently reviewed and approved by the CCG's Remuneration Committee and received final approval from NHS England and NHS Improvement.

8.12 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 (subject to audit)

The Somerset CCG's total staff costs for the year ended 31 March 2021 are summarised in the following table. These figures are to ensure consistency with information within the financial statements:

	Total		
	Permanent Employees	Other	Total
	£'000	£'000	£'000
	N4G	N4H	N4I
Salaries and wages	10,293	598	10,891
Social security costs	1,095	14	1,109
Employer contributions to the NHS Pension Scheme	1,988	16	2,004
Other pension costs	2	-	2
Apprenticeship levy	38	-	38
Other post-employment benefits	-	-	
Other employment benefits	-	-	
Termination benefits	-	-	
Gross Employee Benefits Expenditure	**13,416**	**628**	**14,044**
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure incl. capitalised costs	**13,416**	**628**	**14,044**
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excl. capitalised costs	**13,416**	**628**	**14,044**

9.3 Average Number of Persons Employed (subject to audit)

The average number of CCG staff employed by staff grouping is as follows:

Average number of people employed				
			2020/21	2019/20
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	6	0	6	5
Administration and estates	169	7	176	162
Healthcare assistants and other support staff	0	0	0	1
Nursing, midwifery and health visiting staff	58	0	58	57
Scientific, therapeutic and technical staff	0	0	0	0
Social Care Staff	2	0	2	2
Total	**236**	**7**	**243**	**227**
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 2021 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	50%	50%	14
Membership Body Clinical Executive Committee Voting Members	47%	53%	17
Very Senior Managers	20%	80%	5
All substantive CCG Staff	19%	81%	299

9.5 Trade Union Facility Time

The trade union (facility time publication requirements) regulations 2017 came into 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 CCG
1 April 2020 to 31 March 2021

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: £14,044,057
Total cost of facility time: £742
Percentage of pay spent on facility time: 0.005%

Paid trade union activities
Hours spent on paid facility time: 26
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 CCG is available via the following link:
NHS Sickness Absence Rates - NHS Digital

9.7 Staff engagement percentages

In the NHS National Staff Survey, staff engagement is measured across three themes:

Theme	NHS Somerset CCG Staff Engagement Scores
Advocacy	7.27
Motivation	7.23
Involvement	7.26
Overall staff engagement	**7.25**

The themes are summary scores for groups of questions, which taken together give more information about each area of interest. They are worked out by assigning values to responses (on a scale from 0 to 10) and calculating their average. All values reported relate to an average (mean) score, where a higher score indicates a more favourable outcome for the given indicator.

Staff engagement levels demonstrate the health of the workforce within the CCG. The CCG has developed a High Performing Organisation Programme of work over the last 18 months and this has involved numerous engagement activities and events with all CCG colleagues to ensure that focus is given to speaking up, our culture of compassion, and learning.

9.8 Staff Policies

The CCG has applied the following new or updated staff policies in 2020/21:

The Retirement Policy and Procedure
The Grievance and Disputes Policy

9.9 Staff Diversity and Inclusion Policy, initiatives and longer term ambitions

Whilst Somerset CCG does not hold a staff facing Diversity and Inclusion Policy, there are a number of programmes within the organisation which support our aims.

These include:

Measure	Detail
Equality Steering Group	The CCG has an equality steering group under which matters of both internal (staff facing) and external (patient facing) matters of diversity and inclusion (D&I) are discussed. Whilst D&I is a core consideration for all staff, this group seeks to respond to more complex matters regarding D&I and to contribute towards ethical decision making within the organisation.
Black Lives Matter Group	The CCG has a black lives matter group to support BAME staff within the organisation.
Inclusion High Performing Organisation Champion	Alongside our core role of Equality and Diversity officer, the organisation has appointed an Inclusion champion as part of the High Performing Organisation group to promote inclusion and diversity across the organisation.
Disability Confident Scheme	The CCG is a member of the Disability Confident scheme, which supports employers to make the most of the talents disabled people bring to the workplace.
Recruitment practices	The CCG operates a blind recruitment practice, to ensure that details such as gender, age, race etc. are not provided to recruiting managers for shortlisting purposes.
Equality training	The CCG has a mandatory training requirement for all members of staff, which must be renewed annually.

9.10 Expenditure on consultancy

The CCG consultancy expenditure in 2020/21 was £196,000 (2019/20 £449,000), as per note 5 in the annual accounts.

9.11 Off-payroll engagements

For all off-payroll engagements as at 31 March 2021, 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 2021	4
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	3
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
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 2020 and 31 March 2021, 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 2020 and 31 March 2021	1
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	1
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 2020 and 31 March 2021.

Table 3: Off-payroll engagements / senior official engagements

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	1
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	15

During the year there has been 1 incidence where a senior officer position has been held by an off-payroll member of staff. This relates to the Interim Director of Commissioning post.

It was considered that there was not sufficient capacity or capability within the organisation to provide cover for the previously vacant position of Chief Operating Officer. Instead, an off-payroll member of staff was able to deliver high quality work for a short term appointment to the post of Interim Director of Commissioning, avoiding significant delays in recruiting traditionally to the

vacant post. This post holder will be in position for one year as Somerset continues to design the structure for the Integrated Care System.

9.12 Exit packages, including special (non-contractual) payments – (subject to audit)

Somerset CCG has not paid any exit packages during 2020/21.

9.13 Parliamentary Accountability and Audit Report

NHS Somerset CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at **Appendix 1**.

Appendix 1

ANNUAL ACCOUNTS

James Rimmer
Chief Executive
NHS Somerset CCG
10 June 2021

Appendix One

Entity name:	NHS Somerset CCG
This year	2020-21
Last year	2019-20
This year ended	31-March-2021
Last year ended	31-March-2020
This year commencing:	01-April-2020
Last year commencing:	01-April-2019

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The Primary Statements:

Notes to the financial statements

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Revenue from sale of goods and services	2	(1,392)	(1,685)
Other operating income	2	(596)	(1,042)
Total operating income		**(1,988)**	(2,727)
Staff costs	4	14,044	12,901
Purchase of goods and services	5	980,696	883,288
Depreciation and impairment charges	5	79	100
Provision expense	5	298	(831)
Other Operating Expenditure	5	433	320
Total operating expenditure		**995,550**	895,778
Net Operating Expenditure		**993,562**	893,051
Total Comprehensive Expenditure for the year		**993,562**	893,051

The notes on pages 5 to 23 form part of this statement

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	8	220	228
Intangible assets	9	-	1
Total non-current assets		**220**	229
Current assets:			
Inventories	10	2	2
Trade and other receivables	11	6,410	5,657
Cash and cash equivalents	12	44	69
Total current assets		**6,456**	5,728
Total assets		**6,676**	5,957
Current liabilities			
Trade and other payables	13	(63,583)	(45,732)
Provisions	14	(570)	(275)
Total current liabilities		**(64,153)**	(46,007)
Non-Current Assets less Current Liabilities		**(57,477)**	(40,050)
Total Assets less Liabilities		**(57,477)**	(40,050)
Financed by Taxpayers' Equity			
General fund		(57,477)	(40,050)
Total taxpayers' equity:		**(57,477)**	(40,050)

The notes on pages 5 to 23 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 10 June 2021 and signed on its behalf by:

James Rimmer
Accountable Officer
NHS Somerset Clinical Commissioning Group

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21		
Balance at 01 April 2020	**(40,050)**	**(40,050)**
Net operating expenditure for the financial year	**(993,562)**	**(993,562)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(993,562)**	**(993,562)**
Net funding	**976,135**	**976,135**
Balance at 31 March 2021	**(57,477)**	**(57,477)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20		
Balance at 01 April 2019	(39,536)	(39,536)
Net operating costs for the financial year	(893,051)	(893,051)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(893,051)	(893,051)
Net funding	892,537	892,537
Balance at 31 March 2020	(40,050)	(40,050)

The notes on pages 5 to 23 form part of this statement

Statement of Cash Flows for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(993,562)	(893,051)
Depreciation and amortisation	5	79	100
(Increase)/decrease in trade & other receivables	11	(753)	(1,173)
Increase/(decrease) in trade & other payables	13	17,825	2,888
Provisions utilised	14	(4)	(449)
Increase/(decrease) in provisions	14	299	(831)
Net Cash Inflow (Outflow) from Operating Activities		**(976,116)**	(892,516)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	8	(44)	0
Net Cash Inflow (Outflow) from Investing Activities		**(44)**	0
Net Cash Inflow (Outflow) before Financing		**(976,160)**	(892,516)
Cash Flows from Financing Activities			
Net Funding Received		976,135	892,537
Net Cash Inflow (Outflow) from Financing Activities		**976,135**	892,537
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(25)**	21
Cash & Cash Equivalents at the Beginning of the Financial Year		**69**	48
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**44**	**69**

The notes on pages 5 to 23 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 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 provision, carers services and the Better Care Fund and a memorandum note to the accounts provides details of the income and expenditure.
The pool is hosted by Somerset County Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

1.5 **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 2020/21 due to the inability of staff to take leave during the COVID-19 crisis period.

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 if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

Notes to the financial statements

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.
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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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.
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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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.

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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.

Notes to the financial statements

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.

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 **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.

1.13 **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.

1.13.1 **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.

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

1.15 **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.

1.16 **Provisions**
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of -0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) 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% (2019-20: 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% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.17 **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.

Notes to the financial statements

1.18 **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.

1.19 **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.

1.20 **Contingent liabilities and contingent assets**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

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

1.21 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.21.1 **Financial Assets at Amortised cost**

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

1.21.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.21.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.21.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.22 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.23 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.24 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Somerset Clinical Commissioning Group does not have any exposure to foreign currencies.

Notes to the financial statements

1.25 **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 over the past year and, as a result, there is less certainty than usual about the value of some expenditure accruals and provisions made as at 31st March. The Clinical Commissioning Group has considered the impact of these estimates and has elected to continue to estimate on an historic basis. This is due to a lack of precedent to establish a more accurate estimate and these estimates are temporary in nature and are expected to revert to long term trends in time; therefore using an historic basis still presents a true and fair view of the expenditure, assets and liabilities and financial performance of the Clinical Commissioning Group.

1.25.1 **Critical accounting judgements in applying accounting policies**

No critical judgments with a significant effect on the amounts recognised on the financial statements were required.

1.26 **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.

1.27 **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 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

No assessment of the impact has been evaluated in respect of IFRS16 this financial year.

● 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.

IFRS 17 is still under consideration and no assessment of impact has been evaluated to date.

2 Other Operating Revenue

	2020-21 Total £'000	2019-20 Total £'000
Revenue from sale of goods and services (contracts)		
Education, training and research	**538**	842
Non-patient care services to other bodies	**854**	843
Total Revenue from sale of goods and services	**1,392**	1,685
Other operating revenue		
Non cash apprenticeship training grants revenue	**27**	11
Other non contract revenue	**569**	1,031
Total Other operating revenue	**596**	1,042
Total Operating Revenue	**1,988**	2,727

3 Disaggregation of Revenue - revenue from sale of good and services (contracts)

	Education, training and research £'000	Non-patient care services to other bodies £'000	Total £'000
Source of Revenue			
NHS	-	20	20
Non NHS	538	834	1,372
Total	**538**	**854**	**1,392**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Total £'000
Timing of Revenue			
Point in time	538	854	1,392
Over time	-	-	-
Total	**538**	**854**	**1,392**

4 Employee benefits and staff numbers

4.1.1 Employee benefits	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	10,293	598	10,891
Social security costs	1,095	14	1,109
Employer Contributions to NHS Pension scheme	1,988	16	2,004
Other pension costs	2	-	2
Apprenticeship Levy	38	-	38
Gross employee benefits expenditure	**13,416**	**628**	**14,044**
Less recoveries in respect of employee benefits	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**13,416**	**628**	**14,044**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**13,416**	**628**	**14,044**

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
Termination benefits	3	-	3
Gross employee benefits expenditure	11,616	1,285	12,901
Less recoveries in respect of employee benefits	**-**	**-**	**-**
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

4.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**236**	**7**	**243**	217	10	227
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	-	-	-

4.3 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	**£**	**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	**-**	**-**	**-**	**-**	**-**	**-**

	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**

Analysis of Other Agreed Departures

	2020-21 Other agreed departures		2019-20 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
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**1**	**8,808**

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.

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

4.4 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5 Operating expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,966	3,995
Services from foundation trusts	612,700	550,695
Services from other NHS trusts	8,176	26,263
Services from Other WGA bodies	6	33
Purchase of healthcare from non-NHS bodies	128,110	91,743
Purchase of social care	36,384	35,166
Prescribing costs	90,208	83,123
General Ophthalmic services	479	573
GPMS/APMS and PCTMS	91,309	84,529
Supplies and services – clinical	27	22
Supplies and services – general	2,412	1,818
Consultancy services	196	449
Establishment	1,683	322
Transport	3,465	2,567
Premises	943	787
Audit fees	77	63
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	12	-
Other professional fees	247	162
Legal fees	159	159
Education, training and conferences	1,110	808
Non cash apprenticeship training grants	27	11
Total Purchase of goods and services	**980,696**	883,288
Depreciation and impairment charges		
Depreciation	78	96
Amortisation	1	4
Total Depreciation and impairment charges	**79**	100
Provision expense		
Provisions	298	(831)
Total Provision expense	**298**	(831)
Other Operating Expenditure		
Chair and Non Executive Members	273	310
Grants to Other bodies	150	-
Clinical negligence	10	10
Total Other Operating Expenditure	**433**	320
Total operating expenditure, excluding Staff Costs	**981,506**	882,877

Notes

1. External Audit Fees Net of VAT total £64,500.
2. The auditor's liability for external audit work carried out for the financial year 2020/21 is limited to £2,000,000.
3. Internal Audit - As Internal Audit is carried out by a different organisation to our Statutory Audit, the Department of Health guidance is to show Internal Audit costs in 'Other professional fees'.

6 Better Payment Practice Code

Measure of compliance	2020-21 Number	2020-21 £'000	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,513	159,468	9,751	134,507
Total Non-NHS Trade Invoices paid within target	9,513	159,468	9,746	134,020
Percentage of Non-NHS Trade invoices paid within target	**100.00%**	**100.00%**	99.95%	99.64%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,203	619,369	3,584	583,307
Total NHS Trade Invoices Paid within target	1,202	619,369	3,570	583,189
Percentage of NHS Trade Invoices paid within target	**99.92%**	**100.00%**	99.61%	99.98%

7 Operating Leases

7.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Services Ltd. In 2020-21 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 7.1.1.

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.

7.1.1 Payments recognised as an Expense	2020-21			2019-20		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	884	12	**896**	681	11	692
Total	**884**	**12**	**896**	681	11	692

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for these arrangements only.

7.1.2 Future minimum lease payments	2020-21			2019-20		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	-	12	**12**	-	17	17
Between one and five years	-	0	**0**	-	5	5
Total	**-**	**12**	**12**	-	22	22

8 Property, plant and equipment

2020-21	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	599	119	**718**
Additions purchased	70	-	**70**
Disposals other than by sale	(52)	-	**(52)**
Cost/Valuation at 31 March 2021	**617**	**119**	**736**
Depreciation 01 April 2020	426	64	**490**
Disposals other than by sale	(52)	-	**(52)**
Charged during the year	63	15	**78**
Depreciation at 31 March 2021	**437**	**79**	**516**
Net Book Value at 31 March 2021	**180**	**40**	**220**
Purchased	180	40	**220**
Total at 31 March 2021	**180**	**40**	**220**
Asset financing:			
Owned	180	40	**220**
Total at 31 March 2021	**180**	**40**	**220**

8.1 Economic lives

	Minimum Life (years)	Maximum Life
Information technology	5	7
Furniture & fittings	7	10

9 Intangible non-current assets

2020-21	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2020	20	**20**
Disposals other than by sale	(4)	**(4)**
Cost / Valuation At 31 March 2021	**16**	**16**
Amortisation 01 April 2020	19	**19**
Disposals other than by sale	(4)	**(4)**
Charged during the year	1	**1**
Amortisation At 31 March 2021	**16**	**16**
Net Book Value at 31 March 2021	**-**	**-**
Purchased	-	**-**
Total at 31 March 2021	**-**	**-**

9.1 Economic lives

	Minimum Life (years)	Maximum Life
Computer software: purchased	5	5

10 Inventories

	Energy £'000	Total £'000
Balance at 01 April 2020	2	**2**
Balance at 31 March 2021	**2**	**2**

11.1 Trade and other receivables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	3,621	-	125	-
NHS prepayments	67	-	2,308	-
NHS accrued income	724	-	633	-
Non-NHS and Other WGA receivables: Revenue	351	-	340	-
Non-NHS and Other WGA prepayments	1,122	-	1,354	-
Non-NHS and Other WGA accrued income	327	-	692	-
VAT	198	-	205	-
Total Trade & other receivables	**6,410**	**-**	5,657	-
Total current and non current	**6,410**		5,657	

The great majority of trade is with NHS England. As NHS England is funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary. The level of trade with non-NHS organisations is immaterial and is covered by contractual terms, therefore no credit scoring of them is considered necessary.

11.2 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	**2020-21 Non DHSC Group Bodies £'000**	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	3,039	117	71	238
By three to six months	100	9	95	-
By more than six months	25	-	-	47
Total	**3,164**	**126**	166	285

12 Cash and cash equivalents

	2020-21 £'000	2019-20 £'000
Balance at 01 April 2020	69	48
Net change in year	(25)	21
Balance at 31 March 2021	**44**	69
Made up of:		
Cash with the Government Banking Service	44	69
Cash in hand	-	-
Cash and cash equivalents as in statement of financial position	**44**	69
Total bank overdrafts	**-**	-
Balance at 31 March 2021	**44**	69

13 Trade and other payables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS payables: Revenue	6,444	-	3,538	-
NHS accruals	263	-	2,379	-
Non-NHS and Other WGA payables: Revenue	7,358	-	8,061	-
Non-NHS and Other WGA payables: Capital	70	-	44	-
Non-NHS and Other WGA accruals	42,805	-	26,991	-
Social security costs	167	-	156	-
Tax	131	-	118	-
Other payables and accruals	6,345	-	4,445	-
Total Trade & Other Payables	**63,583**	**-**	45,732	-
Total current and non-current	**63,583**		45,732	

Other payables include £690,209 outstanding pension contributions at 31 March 2021

14 Provisions

	Current 2020-21 £'000	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Legal claims	353	-	248	-
Continuing care	217	-	27	-
Other	-	-	-	-
Total	**570**	**-**	275	-
Total current and non-current	**570**		275	

	Legal Claims £'000	**Continuing Care £'000**	**Total £'000**
Balance at 01 April 2020	**248**	**27**	**275**
Arising during the year	105	217	**322**
Utilised during the year	-	(4)	**(4)**
Reversed unused	-	(23)	**(23)**
Balance at 31 March 2021	**353**	**217**	**570**
Expected timing of cash flows:			
Within one year	353	217	**570**
Balance at 31 March 2021	**353**	**217**	**570**

The above is based on information currently held by Somerset Clinical Commissioning Group.

Following a staffing restructure within the Clinical Commissioning Group there remains a legal case outstanding as at 31 March 2021 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 15.

The 'Continuing Care' provision is an assessment of continuing care cases which are currently being reviewed by the Clinical Commissioning Group's assessment panel. This has been based on the best professional judgement in line with IAS37. All of the cases awaiting panel have been provided for and the calculation has been based on estimated cost and the probability of success. The probability factor applied is based on success rates in the current financial year. A contingent liability in respect of this provision is shown in note 15.

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 in respect of periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group. The total value of the Previously Unassessed Periods of Care (PUPoC) NHS Continuing Healthcare contingent liability accounted for by NHS England on behalf of this Clinical Commissioning Group at 31 March 2021 is £23k.

15 Contingencies

	2020-21 £'000	2019-20 £'000
Contingent liabilities		
Continuing Healthcare	54	10
Litigation	18	16
Net value of contingent liabilities	**72**	26

There are no contingent assets

16 Financial instruments

16.1 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.

16.1.1 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.

16.1.2 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.

16.1.3 Credit risk

Because the majority of the NHS Somerset Clinical Commissioning Group revenue comes 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.

16.1.4 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.

16.1.5 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.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	**Total 2020-21 £'000**
Trade and other receivables with NHSE bodies	1,411	1,411
Trade and other receivables with other DHSC group bodies	3,401	3,401
Trade and other receivables with external bodies	211	211
Cash and cash equivalents	44	44
Total at 31 March 2021	**5,067**	**5,067**

	Financial Assets measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
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
Cash and cash equivalents	69	69
Total at 31 March 2020	1,859	1,859

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	**Total 2020-21 £'000**
Trade and other payables with NHSE bodies	426	**426**
Trade and other payables with other DHSC group bodies	19,682	**19,682**
Trade and other payables with external bodies	43,177	**43,177**
Total at 31 March 2021	**63,285**	**63,285**

	Financial Liabilities measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
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
Total at 31 March 2020	45,459	45,459

17 Operating segments

The Clinical Commissioning Group has only one operating segment, that of commissioning healthcare services for the population of Somerset.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Somerset Clinical Commissioning Group	995,550	(1,988)	**993,562**	6,676	(64,153)	**(57,477)**
Total	**995,550**	**(1,988)**	**993,562**	**6,676**	**(64,153)**	**(57,477)**

18 Joint arrangements - interests in joint operations

NHS Somerset Clinical Commissioning Group is party to a number of pooled budget agreements with Somerset County Council. Under these arrangements funds are pooled under s75 of the Health Act 2006 for the provision of the following services;

Community Equipment Services
Carers Services
Learning Disability Services
The Better Care Fund

			Amounts recognised in Entities books ONLY 2020-21	2019-20
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Expenditure**	**Expenditure**
			£'000	**£'000**
Community Equipment Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase of healthcare equipment services	1,412*	1,273
Carers Services Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase of Carers services	226	226
Learning Disability Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase of Learning Disability services	22,261	23,333
Better Care Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase of health and social care services	40,619^	38,424^

* Excludes £167,400 included within Hospital Discharge Programme recharge
^ Excludes £203,500 included within Carers Pooled Budget figure

19 Related party transactions

31 March 2021	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
Ed Ford, Chair, is a GP Partner at Minehead Medical Centre (transactions disclosed for Minehead Medical Centre)	2,129	76	0	0
Maria Heard, Programme Director of Fit for my Future, is a Non-Executive Director of South West Academic Health Science Network (from 04/05/20) (transactions disclosed for South West Academic Health Science Network)	33	2	8	2

Note

In formulating this note the Clinical Commisioning Group has considered all declarations of interest for Governing Body Members.

Under IAS 24, related party transactions have only been disclosed where they meet the following criteria:
(i) have control or joint control over the reporting entity;
(ii) have significant influence over the reporting entity; or
(iii) are a member of the key management personnel

The Register of Interests can be found on our website www.somersetccg.nhs.uk/publications/lists-and-registers/

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

NHS England
South, Central and West Commissioning Support

NHS FOUNDATION TRUSTS

Dorset County Hospital NHS Foundation Trust
Guy's And St Thomas' NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Devon And Exeter NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
Somerset NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust

NHS TRUSTS

Avon And Wiltshire Mental Health Partnership NHS Trust
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust
University Hospitals Plymouth NHS Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Somerset County Council, NHS Property Services Limited, National Insurance Fund, NHS Pension Scheme and Her Majesty's Revenue and Customs.

20 Events after the end of the reporting period

Finance and contracting arrangements for H1 (April to September) 2021/22

Due to current circumstances relating to the COVID-19 pandemic operational planning for 2021/22 has been delayed. The Government has agreed an overall financial settlement for the NHS for the first half of the 2021/22 financial year (H1) and Integrated Care System (ICS) financial plans are due for submission on 6th May 2021.

The H1 2021/22 financial plan will reflect that;
* The COVID-19 pandemic will continue to have an ongoing impact across services.
* There is a requirement for the recovery of elective care and mental health services.
* Block payment arrangements will remain in place for relationships between NHS commissioners and NHS providers. Signed contracts between NHS commissioners and NHS providers are not required for the H1 2021/22 period.
* There will be a return to contractual arrangements with all non-NHS providers. This includes putting in place contracts for acute independent sector (IS) services which were covered by the national IS contract during 2020/21.

This is considered to be a non-adjusting event in respect of the 2020/21 Annual Accounts of the CCG.

21 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:

	2020-21 Target £'000	**2020-21 Performance £'000**	**Duty Achieved?**	2019/20 Target £'000	2019/20 Performance £'000	Duty Achieved?
Expenditure not to exceed income	995,620	995,620	**Yes**	879,797	895,822	No
Capital resource use does not exceed the amount specified in Directions	70	70	**Yes**	44	44	Yes
Revenue resource use does not exceed the amount specified in Directions	993,562	993,562	**Yes**	877,026	893,051	No
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**Yes**	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	**Yes**	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	11,142	10,927	**Yes**	12,367	11,923	Yes

The target and performance values for 'Capital resource use on specified matter(s)' and 'Revenue resource use on specified matter(s)' have been restated for 2019/20. These values were incorrectly reported in this disclosure note for the 2019/20 accounts and should have been reported as zero balances.

In response to the Covid-19 pandemic a letter was issued on 17 March 2020 by Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer which set out 'Next Steps on NHS Response to Covid-19'. These guidelines fundamentally changed financial arrangements for NHS commissioners and providers for 2020/21 and suspended work on the annual planning process. A revised approach to the financial management of CCGs was adopted, with the expectation that during the period 1 April to 30 September 2020 CCGs would be expected to financially break-even. To achieve this expectation CCG funding allocations were non-recurrently adjusted for this period and a retrospective adjustment process was implemented to reimburse reasonable variances between actual expenditure and allocated funds. Somerset Clinical Commissioning Group's expenditure was fully funded for this period, enabling the organisation to achieve a financial break-even position.

For the second half of the financial year STPs and ICSs were issued with fixed funding envelopes. The Somerset system submitted financial plans to NHS England and NHS Improvement demonstrating how they would achieve a financial break-even position for the remainder of the financial year. Somerset Clinical Commissioning Group has delivered a financial position within its allocated financial resource for this period and has therefore subsequently delivered a financial break-even position for the full financial year.

Independent auditor's report to the members of the Governing Body of NHS Somerset CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Somerset CCG (the 'CCG') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

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

Conclusions relating to going concern

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

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of 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 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

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

Matters on which we are required to report by exception

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

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

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

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

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

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

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

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the

financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).

- We enquired of management and the Audit Committee concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit Committee as to whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud. We also enquired of internal audit and the local counter fraud specialist whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journals, management estimates and transactions outside the course of business**.**
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual and high risk journals made during the year and accounts production stage; and
  - considering the reasonableness of estimates and judgements made by management.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to year end expenditure accruals.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation;
  - knowledge of the health sector and economy in which the CCG operates; and
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation;
    - NHS England's rules and related guidance; and
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure, its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement; and

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

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

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

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

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

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

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

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for the NHS Somerset CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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

Jackson Murray

Jackson Murray, Key Audit Partner

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

Bristol

14 June 2021

Independent auditor's report to the members of the Governing Body of NHS Somerset CCG

In our auditor's report issued on 14 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the CCG for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 14 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

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

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

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

Responsibilities of the Accountable Officer

The Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;

- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

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

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of NHS Somerset CCG for the year ended 31 March 2021 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 audit certificate 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

15 September 2021