NHS Bristol, North Somerset and South Gloucestershire CCG

Annual Report 2020/21

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Chair and Chief Executives' Introduction

This year has presented unparalleled challenges on a global scale. Within our own community, many have experienced grief and loss, increased isolation and a range of significant life changes. We've all had to grapple with different ways of living, working and coping.

The pandemic has shone a light on the power of community and the extraordinary results that can be achieved when everyone pulls together. Locally, we have expedited the digital transformation of health services, providing thousands of online appointments and consultations. We've pressed ahead with collaboration and innovation, ensuring that even in the most challenging times, those who need it most could access safe care.

None of this would've been possible without the dedication and commitment of all our health and care staff.

Everyone, from patient facing to operational staff, has worked tirelessly to ensure we continue to deliver the highest quality care, in the safest environment, to everyone who needs it. This includes embracing new ways of working, and contributing to vitally important work such as the sourcing and distribution of personal protective equipment (PPE), or providing infection control and prevention advice – including training those in care homes, working alongside a range of partners such as the fire service.

Our primary care networks (PCNs) have played a critical role this year, from transforming online access to GP services, to spearheading the delivery of the biggest vaccination effort in NHS history. Their speed and agility enabled us to vaccinate 62% of our eligible population within 23 weeks, receiving national recognition for their innovation and commitment.

Combined with hospital hubs, pharmacy sites, pop-up community clinics and the large-scale vaccination centre at Ashton Gate, the roll-out has demonstrated the strength of partnership – with communities themselves valued as equal partners. We want to thank the community groups, grassroots organisations, faith leaders and volunteers who have shaped and delivered the roll-out, and who continue to work with us to ensure we meet the needs of all.

Cross system collaboration has been central to a number of innovations this year. Our 'Covid virtual ward' was introduced in January to provide home-based care for people with suspected Coronavirus. The provision of pulse oximeters enabled those in high risk groups to monitor their blood oxygen levels from home. A new partnership between our hospitals and UK Biobank's Filton facility ensured that additional diagnostic services such as MRI scans could be carried out during the pandemic, improving access for patients and reducing wait times.

And we are now developing our community mental health framework, which is a real opportunity to transform care for the better. Under the developing plans, anyone experiencing a mental health concern would be able to access the right care quickly and easily, with a range of organisations and professionals working collaboratively to support them.

This is what we mean by truly integrated care – services that fit into people's lives, rather than the other way around. This work is closely aligned to the development of our six integrated care partnerships (ICPs).

Integrated care partnerships will bring GPs, mental health, community services, the voluntary sector and others together to deliver services that respond to the needs of their populations. Their local focus means they will be better able to provide high-quality, joined-up services that make sense to the people using them. It's an exciting opportunity to improve people's experiences - and working in partnership with communities will be key to getting it right.

Our collaboration as a system continues as we work together with our partners to restore routine services and reduce waiting list time for patients as we emerge from the pandemic. As part of the national accelerator programme, our staff will be pulling out all the stops this summer to treat more patients who have had to wait longer for planned operations. We will prioritise those with the greatest clinical need whilst also providing vital support and active management to those patients continuing to wait.

This year also marks the last in operation for Clinical Commissioning Groups across the country. In BNSSG, we received formal integrated care system (ICS) status in December 2020, something we have been working towards for some time. By April 2022 all ICSs will be statutory bodies. Our priority is to ensure a successful transition to the new arrangements, whilst maintaining a relentless focus on our mission to improve the health and care of our population.

We are exceptionally proud to serve the diverse communities of Bristol, North Somerset and South Gloucestershire. Thank you all for following the national guidance to keep yourselves, your loved ones and your communities as safe as possible. We know it hasn't always been easy. But by doing so, you've helped staff in local services to continue providing safe care.

The strengthened partnerships and strides made in the last year can only stand us in good stead as we embark on this new chapter. We look forward to a more hopeful year ahead, for all of us, and to working with you to keep people and communities at the heart of all we do.

PERFORMANCE REPORT

This performance overview provides a short summary of our purpose, the key risks to our objectives and summarises how we performed during the year. In line with guidance on annual reporting for 2020/21 we have not included a detailed performance analysis.

Chief Executive's Statement

2020/21 has been a year like no other with the impact of the covid-19 pandemic felt across every aspect of society. I want to pay tribute to colleagues across the CCG and the wider health and care system for their extraordinary efforts, managing our response to the pandemic, keeping our people safe, and supporting our essential services in the face of unprecedented challenges. My thoughts are with those who have lost loved-ones, friends and colleagues during this most testing of times. I also want to thank our communities, their responsible and considerate approach to accessing health and care has made an important contribution to how well we have been able to respond to the challenge; the response across our system has been tremendous, and I hope that you share my pride in the NHS.

This past year has seen our system face a greater challenge than we have seen before. In meeting this challenge, we have seen services transformed to help ensure our diverse communities continue to have access to 24 hours, seven days a week care.

Our GP practices have been pivotal, offering patients on-line consultations, text messaging, and video links. Patients are now able to contact their GPs, get test results, repeat medications, advice, and guidance, quickly and conveniently online or over the telephone. Not all patients are able to or want to use technology to access their practices - our work to understand the impact of new ways of working on people and the potential to widen health inequalities tells us this. Our GPs continue to offer face-to-face consultations for people who need them. In 2021/22 we will continue to work with primary care colleagues to improve access to their services.

Our Mass Vaccination programme has exceeded our hopes, with 85% of our eligible population receiving their first vaccinations, and with our Primary Care Networks providing over half of these vaccinations.

We have focused on mental health and wellbeing as the pandemic has taken its toll on our communities. Our work to reduce the risks to mental health has been commended nationally, and our increased investment has been used to enhance services to all of our population. We have commissioned a twenty-four hour, seven day a week phone line providing vital emotional

support to people when they most need it. Mental health and wellbeing will continue as a priority in 2021/22, when we will continue to work across the Healthier Together Partnership to develop our Community Mental Health Framework, tailoring much needed services to meet the needs of our diverse communities.

Throughout 2020/21 we have worked with our partners to meet new demands for services whilst reducing the care backlogs that have been a direct consequence of the pandemic. We have continued to provide services for cancer patients with video and telephone appointments where appropriate or face to face appointments where needed. It is important that people seek clinical advice if they have concerns about possible cancer symptoms and we continue to encourage people to contact their GP if they are worried.

To support the recovery of services we have worked differently with partners in both the NHS and independent sector to ensure that vital diagnostic services are available. With the introduction of a new test for colorectal cancer, and the commissioning of additional capacity, we aim to restore our services and to improve on previous year's performance, developing a sustainable approach for the future.

The impact of Covid-19 has heightened the health inequalities that already exist across our communities. If we are to serve our population, we must tackle these divides. Our Population Health Management Programme has already helped GPs support their most vulnerable patients. Together with the outstanding support of local community leaders and groups, the Programme has also helped us target our mass vaccination campaign, ensuring it meets the needs of our diverse communities. It has also continued to support programmes such as the redesign of stroke services and our emerging Integrated Care Partnerships. As we work to reduce health inequalities across Bristol, North Somerset and South Gloucestershire our Population Health Management Programme will play a key role, helping us to address inequalities in outcomes, experiences and access.

Transforming health and care is key to the restoration of sustainable services that meet the needs of people. The pandemic has shown how we are able to deliver significant change at pace through collaboration across health and social care, and by working with our communities. Our Healthier Together Partnership was recognised as a maturing Integrated Care System in December 2020, and the proposals in the White Paper "Integration and Innovation: working together to improve health and social care for all" provide an exciting opportunity for us to forge stronger relationships and achieve even more as we go forward together.

In 2021/22 we will lay the foundations of a statutory Integrated Care System that takes forward and delivers the radical change that our communities want, need and deserve. I believe that these proposals present a unique moment to build back better and different.

Julia Ross

Chief Executive and Accountable Officer

18th June 2021

Performance Overview

Our purpose and activities

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) is responsible for planning, buying and monitoring the majority of healthcare services for the one million people who live in our area. We are a membership organisation, led by GPs from the general practices in Bristol, North Somerset and South Gloucestershire. Our practices work across six localities and in 18 Primary Care Networks. Our Members use their knowledge of the local population's health needs to guide the services we plan and purchase. Our local GPs provide the clinical leadership for all of our commissioning activities. We work with patients and partners to plan health services for Bristol, North Somerset and South Gloucestershire residents, based on the identified needs of our population. Our Governing Body ensures that we meet our responsibilities and its membership includes three lay members, local GPs, a secondary care doctor, an independent registered nurse member and executive members. The CCG employs 466 staff, who work alongside colleagues in primary and secondary care, and in community services, as part of the Healthier Together Partnership across Bristol, North Somerset and South Gloucestershire to deliver our plans. The services we are responsible for include:

- Urgent and emergency care, such as NHS 111, A&E and ambulance services
- Planned hospital care, such as operations and treatments
- Community health services, such as community nursing and physiotherapy
- Rehabilitation for those recovering from illness and operations
- Maternity and new born services
- Infertility services
- Children and young people's health services
- Mental health services
- Continuing healthcare for people with on-going health needs, such as nursing care
- End of life care
- Commissioning primary care services from local GP practices.

NHS England commissions other primary care services such as dentists, pharmacists and opticians. Throughout the past year, we worked with patients, service users, carers and members of the public to understand what matters to them, to ensure that the services we

commission meet their needs, and to support the CCG and wider health and care system response to the Covid-19 pandemic.

Healthier Together – our local Integrated Care System

Our Healthier Together Partnership was established in 2016. Since then we have worked together across health, social care and local government, and with the voluntary sector and local communities, to improve the health and wellbeing of our population and take forward the integration of care across Bristol, North Somerset and South Gloucestershire. In December 2020, our Partnership was recognised by NHS England as a maturing Integrated Care System, reflecting the significant progress made in working collaboratively in the last year, and particularly in response to the Covid-19 pandemic.

In February 2021 the Department of Health and Social Care published a White Paper "Integration and Innovation: working together to improve health and social care for all" setting out recommendations for Integrated Care Systems. A key measure is the creation, in April 2022, of statutory Integrated Care Systems. This would see Clinical Commissioning Groups folded into new Integrated Care System NHS bodies and the establishment of statutory Integrated Care System Health and Care Partnerships. This clear direction of travel is one that our Healthier Together Partnership has been working towards for a number of years.

Recognising there is more to be done to change how we work together and make best use of the resources available, we are working to formalise how we operate as an Integrated Care System. Building shared ownership and a commitment to collaborative ways of working, including financial frameworks, organisational development, and putting citizens at the heart of everything we do, will help prepare our system for the exciting future legislative changes.

Our Covid-19 response

Our health and social care system focus has been responding to the Covid-19 pandemic in 2020/21. The extreme set of challenges presented by the pandemic have affected our population, our partnerships and our staff. Our response to the crisis, and the rapid transformation of services, has driven forward many of our long terms plans. By supporting strong clinical leadership throughout our system, we have seen an unprecedented pace of change. We have worked together with our partners to establish arrangements to coordinate our collective response to the Covid-19 pandemic, ensuring that we have in place clinically led plans that respond to the immediate needs of our population.

Our local Incident Control Centre has operated seven days a week throughout the pandemic. It is supported by a range of expert-led cells, made up of staff from across all parts of the local

health and care system. These cells have focused on specific operational issues to address the challenges presented by the pandemic such as prioritising resources, overseeing the distribution of personal protective equipment (PPE), providing infection control and prevention advice and guidance, providing support to care homes, and other key service areas such as primary care and mental health.

2020/21 has seen:

- A transformation in the way primary care works, with 100% of our GP practices offering video consultations, online consultations, and online bookings
- Support to the care home sector, with multi-agency local incident management, supportive funded nursing care and seven days a week infection prevention and control advice
- Support for people with learning disabilities and autism during periods of isolation, with an increase in liaison nursing across both our acute hospital trusts and the introduction of the Covid Hospital passport. Work to prioritise people with learning disabilities and autism on outpatients waiting lists is being progressed with both acute trusts and Healthier together teams to ensure there is equity of access to services
- A successful, clinically led, mass vaccination campaign, working with North Bristol Trust, the mass vaccination centre at Ashton Gate and Primary Care Networks
- An increase in community-based beds from 100 to 350
- Transformed acute care and outpatient services to help retain services as much as possible whilst meeting the demands of Covid-19

Alongside this transformation, we have worked to ensure that our local health services have remained open to all patients, meeting their needs seven-days a week, twenty-four hours a day. The following report provides a snapshot of our work during 2020/21.

Primary Care

We have worked with and supported our GP colleagues as they respond to the Covid-19 pandemic. During the initial stages of the pandemic, our GPs developed locality resilience plans with partners, including OneCare and Sirona, to ensure that clinical services continued to be available providing additional support for:

- care homes
- patients at an end of life
- patients discharged from hospital
- care for shielding patients

To support colleagues we:

- produced guidance for GPs to use when supporting patients who are shielding
- Secured GP cover for Covid-19 care sites housing homeless people not registered with a GP
- Rolled out digital support to care homes and social prescribers

As our primary care colleagues moved to remote working, we provided all of our practices with equipment and specialist software to enable staff to work securely and effectively from any location, including home. We supported GP practices to adopt different digital approaches to support patients. Our practices now offer online consultations where patients can access healthcare advice, enter a query, symptoms or other information. Patients can share information securely to help their GP decide on the appropriate action needed and share this back with the patient within two working days. These new ways of working are more convenient for many patients and leave more practice time for people who need more traditional contacts such as by phone or face to face.

SMS/text messaging and video consultations have played an important part in our primary care Covid-19 response and increasingly in mainstream practice for triaging and remote monitoring. Patients with smartphones can now cancel appointments by text, receive leaflets or web links relevant to their health, get normal test results, complete health surveys, and share information such as pictures with their GP. This is alongside accessing services using the NHS app. While it is not suitable for everyone, it does allow quick and convenient contact for those people who are smartphone literate. All our practices can now take direct bookings from our 111 service, and the Covid Clinical Assessment Service. We are proud that NHS Digital has commended our work to achieve this as ‘gold standard’.

Our primary care colleagues have worked with community partners to support people living in care homes with:

- Weekly ‘check ins’ for people identified as a clinical priority for assessment and care
- Timely access to clinical advice for staff and residents
- Personalised care and support plans for residents
- Pharmacy and medication support
- Sensitive and collaborative decisions about hospital admissions for residents

We have used our population health management expertise and mapping to develop guidance for GPs to help them identify vulnerable patients and understand what support they need.

Our GPs have also been at the front of the mass vaccination campaign for our local population. Alongside the nationally designated centre at Ashton Gate our GPs, through the Primary Care Networks, have set up 19 vaccination sites across Bristol, North Somerset and South Gloucestershire. These seven-day a week centres have made a significant contribution to the success of our mass vaccination campaign.

GPs have worked with community partners including Sirona care and health to ensure vaccinations are available to housebound patients and to all of our care homes. To support the GP led vaccination clinics we provided additional IT support including PCs, screens and bar code readers, and software enabling vaccination appointments to be booked by text as well as phone or letters.

To date we have, as a system, given over 94% of all those eligible people in Bristol, North Somerset and South Gloucestershire, their first vaccination. In total over 600,000 first and second vaccinations have been given, with our primary care colleagues providing over 70% of these.

We have used Our Population Health Management knowledge to support the vaccination campaign, taking what we know about the health of our population, Covid-19 testing results, hospital admission data and vaccination data, and using this to focus resources. This has allowed us to understand how to adapt and present information, and design clinics to support our diverse local communities. We are enormously grateful to the community leaders who have worked with us to ensure we reach everyone eligible to receive a Covid vaccination.

Blood Tests in the Community

Our local acute hospitals moved rapidly to digital consultations at the start of the Covid-19 pandemic to reduce the spread of infection. This lead to a step change in requests asking GPs to support blood tests (phlebotomy) in the community. The clinical processes, digital infrastructure, and laboratory processes were not set up to support this change at the start of the pandemic, creating problems across clinical pathways.

Working with GPs, hospital doctors, Sirona, digital and laboratory leads, an integrated approach that enables patients to have their blood tests in the community with an acute digital consultation was set up. A locality hub and GP pilot were quickly established leading to a new clinical model. We are working to ensure this innovative service is rolled out and sustained across all of Bristol, North Somerset and South Gloucestershire's GPs in 2021/22, making blood tests more convenient and accessible for the people we serve.

Long Covid Service

We have worked with our partners to understand more about the long-term health impacts of Covid-19, and in December 2020 our Long Covid service, led by Sirona care and health, went live. This therapy led service is for people across Bristol, North Somerset and South Gloucestershire experiencing the long-term effects of Covid. The service gives patients access to local specialists as well as national resources, such as the interactive rehabilitation programme on www.yourcovidrecovery.nhs.uk. We have worked closely with hospital and community services who are seeing people with Long Covid, such as post ICU clinics, chronic fatigue syndrome services, and mental health services.

We have allocated resources to develop a campaign to raise awareness of the support available, and to encourage people from groups disproportionately affected by Covid-19 to access help. We are developing innovative ways of engaging with communities to take a proactive approach to tackling health inequalities.

Mental Health

The work of our Mental Health Cell helped to understand the potential impact of Covid-19 on people's mental health and wellbeing. Working with our partners, including clinicians, front-line workers and people with lived experience, we developed 30 proposals to reduce the risks to mental ill health arising from Covid-19. This has taken a whole population approach, reflecting the need for early intervention and prevention, as well as proposals to protect services to ensure that capacity is in place to respond to increased demand. Over £3 million has been invested, increasing support for:

- Communities, schools and employees
- People affected by self-harm and experiencing suicidal ideation
- Psychological and counselling support through strengthening our Increasing Access to Psychological Therapies (IAPT) capacity
- People with severe and enduring mental illness
- Children and young people's mental health services (CAMHS)
- People with learning disabilities and autism
- People disproportionately affected by Covid-19 - including children and adults from minority ethnic communities, and communities with high levels of deprivation, people affected by trauma; and refugees and asylum seekers

We commissioned a twenty-four hour, seven-day a week phone line from Vita Health, our IAPT Provider, working in partnership with AWP, our Secondary Mental Health Provider. The

service, called *24/7 Support and Connect*, is a free NHS confidential helpline for people who live in Bristol, North Somerset & South Gloucestershire. Experienced counsellors, who offer emotional support and can connect people to support organisations available locally, staff the helpline. On average 20 people a day are contacting the service, which can be reached on 0800 0126549.

Covid-19 Infection Prevention and Control (IPC)

Ensuring we had effective IPC across our system was a key element of our immediate response to the Covid-19 pandemic. The CCG redeployed staff into the COVID IPC Cell, including IPC specialists, members of the Medicines Optimisation Team and members of our administrative teams, together with additional specialist support from Sirona and other partners. During the different phases of the pandemic IPC support has been available seven days a week to care homes and other social care providers, primary care and hospital staff, providing professionals across health and care settings with information and advice on preventing and managing Covid-19 infections.

Partnership working between the health and care system - local authorities and the NHS - social care providers, the Care Quality Commission, and Public Health England has been critical. Early in the first wave a successful IPC training programme for care homes was rolled out, quickly training super trainers to roll out training on the use of PPE, using a variety of methods including face-to-face training, where it was safe to do so. The training team included IPC leads, staff from the CCG Nursing and Quality Team, Adult Social Care, North Bristol NHS Trust, the local hospice and fire service.

Our IPC and PPE training has been adapted to support primary care and shared with GP practice champions to cascade training across practices. We have also offered the training to care home providers, and our team continues to offer and support update and refresher training to all care providers where required.

The focus on managing outbreaks of Covid-19 has continued, supporting social care providers so that services can reopen in a safe and timely manner after infection outbreaks. Alongside this, we have actively listened to the concerns of social care providers and shared information and guidance in direct response. Where this information has not already been available, our teams have produced evidence-based guidance. We have launched an audit tool for social care providers to use and continue to share advice and guidance. Our team continues to support the whole system and care providers with all Covid-19 IPC measures.

Maintaining Cancer Services

The NHS has continued to provide services for cancer patients throughout the Covid-19 pandemic, with hospitals remaining open for referrals throughout. Some patients have been seen via video or telephone where clinically appropriate, whilst others have been seen safely in face-to-face appointments. Following an initial fall at the start of the pandemic, Two Week Wait Pathway referrals have now largely recovered, and there have been national and local media campaigns to remind patients that the NHS is open for business and to urge those with possible cancer symptoms to present to their GPs for assessment.

Patients on cancer pathways have been prioritised for diagnostic investigations and procedures, ensuring timely treatment despite reductions in capacity across many hospital services. Some independent sector hospitals have undertaken suitable cancer treatments, whilst others have treated routine patients to free up capacity in NHS hospitals to enable cancer care to continue. Care and support for patients during and after treatment has continued to be provided by clinical nurse specialists and cancer support staff, often via telephone or video to avoid patients needing to attend hospital appointments for their safety.

Introduction of Faecal Immunochemical Test (qFIT)

Faecal Immunochemical Test (qFIT) was successfully piloted within Bristol, North Somerset and South Gloucestershire during 2018/19 for a specific cohort of patients with a low risk of colorectal cancer to enable GPs to decide if a patient should be referred on for a colonoscopy to further investigate their symptoms. Due to the Covid-19 pandemic and the associated IPC requirements, the number of available colonoscopies was reduced. New national guidance supported the use of a qFIT in assessing whether a patient with symptoms of possible colorectal cancer should be referred for assessment.

In response to this guidance, qFIT was introduced as part of the suspected colorectal cancer Two Week Wait Pathway in July 2020. Now patients with a low qFIT result remain under the care of their GP and do not need to be referred. However, if the GP has any ongoing concerns they can still refer their patients either for advice and guidance or to be seen within two weeks for a colorectal outpatient appointment.

Diagnostics

The combination of the Covid-19 pandemic and increasing demand has had a significant impact on our diagnostic services. We have worked hard with our partners and, with the help of some significant system schemes, have seen a return to almost pre-Covid levels of activity.

To improve services, reduce wait times, and support recovery we have:

- Invested in two new CT scanners, which will be in place and operational in Spring 2021.
- Worked with regional colleagues on a successful overseas recruitment campaign to attract radiographers, a staff group where there are significant shortages.
- Entered into a one-year contract with UK Biobank for MRI scanners to support recovery. This offers an off-site facility for patients needing simple MRI, reducing wait times and releasing capacity in the acute trusts for more complex scanning.
- Established a project to develop cannulation rooms to support radiography services for contrast scanning.
- Worked with a local independent sector provider to increase endoscopy services.
- Infection control guidance is being used to support teams and increase capacity for endoscopy
- Progressed waiting list initiatives and insourcing of diagnostic services to add capacity to address backlogs
- Validated the ultrasound waiting lists and established a clinically led review of pathways to ensure best use of ultrasound services
- Commissioned a new Clinical IT system across the system to improve efficiency for endoscopy.

We are working with partners and service users to develop our local response to the national diagnostic review and set out how we want our diagnostic services to look in the future.

NHS 111 First

NHS 111 First is a clinically led service aiming to increase the number of people contacting NHS 111 before they attend an Accident and Emergency Department (A&E) or other urgent care services.

NHS 111 First enables patients to be directed to the right place first time, potentially avoiding a hospital attendance or stay, and the associated healthcare acquired infection risks.

To support our NHS 111 First service we have:

- Carried out a targeted engagement and communications campaign
- Increased the number of community services as alternatives to secondary care pathways and A&E
- Directing more patients to Minor Injury Units and Urgent Care Centres
- Increased the capacity of NHS 111 to manage more calls
- Established regular clinical huddles with the engagement of all partners across our system to review, learn and refine the approach

Since the introduction of the service, the number of people directed to A&E departments has decreased, and the proportion of people directed to primary care, particularly pharmacies and the Community Pharmacy Consultation Service, has increased.

GP Community Pharmacy Consultation Service

The GP Community Pharmacy Consultation Service is a collaborative pilot scheme between practices and community pharmacists. The Scheme enables practice staff to refer registered patients with minor illnesses for a same-day consultation with a community pharmacist. As a result, patients are seen more quickly.

The service, originally piloted in Bristol, has been rolled out across Bristol, North Somerset and South Gloucestershire and now covers 51 GP practices. Over 188 pharmacies have received a referral, over 8,000 consultations have been carried out, and 90% of consultations have resulted in patients receiving definitive care from the pharmacist without the need for further appointments. This has helped to free up GP capacity, and means patients get advice and care on the same day they contacted their practice.

The Scheme resulted in:

- 71% of patients received advice (with 41% receiving an over the counter product)
- 12% of patients received a same-day GP appointment after the pharmacist decided it was necessary
- 17% of patients were signposted to another healthcare professional or back to their GP for a non-urgent appointment

Patients who have most benefited from the service are parents of young children and those between 25 and 40 years old.

From November 2020, the scheme was extended to include minor illness referrals from GPs as well as from NHS 111. Feedback from patients has been positive; the scheme helps them to gain advice from a community pharmacist in a timely manner and receive advice on self-caring for minor ailments. This has encouraged and taught them to manage minor ailments themselves or to self-refer to a community pharmacist in the future.

We are proud that our pilot has won the South West Region Excellence in Primary Care Award, part of the NHS Parliamentary Awards. It is now shortlisted in the national award finals, which will be announced in July.

We have commissioned a Community Pharmacy Patient Group Direction Service, complimenting the Community Pharmacy Consultation Service and rolled it out in collaboration with the Avon Local Pharmaceutical Committee. Using Patient Group Directions means that

community pharmacists can provide prescription-only treatments for certain conditions, meaning referrals to GP practices or out of hours providers for prescriptions can be reduced further. Patient Group Directions currently enable pharmacists to manage urinary tract infections, impetigo, mild inflammatory skin conditions, and conjunctivitis without the need for a GP appointment.

Local pharmacists have enthusiastically engaged with the service, with excellent attendance at face-to-face and online training events. The community pharmacy Patient Group Directions service continues to grow and there are now 144 pharmacies across Bristol, North Somerset and South Gloucestershire that are live with the service. By the end of February 2021 over 3,000 Patient Group Directions consultations had been provided, meaning that more than 3,000 appointments in other parts of the system were avoided, freeing capacity for other patients to be seen. The ongoing focus will be to work with the Local Pharmaceutical Committee (LPC) to increase the number of pharmacies accredited to provide the service to increase availability and patient choice

Transforming Stroke Services

Transforming stroke care for our population has been a longstanding ambition of our Healthier Together Partnership. In March 2021 we shared with our Local Authority Health Oversight & Scrutiny Committees (HOSCs) our plans to proceed to public consultation in the summer of 2021. This follows months of intensive work from our system Stroke Programme Board, made up of stroke survivors, clinicians and staff. The options being prepared for consultation are designed to reduce deaths from stroke, improve quality of care, support people's long-term rehabilitation and recovery, and enable higher quality of life after stroke. The proposals have gone through a rigorous clinical evaluation process, including independent review by the South West Clinical Senate.

Our shared vision is to prevent more strokes from happening and ensure that everyone in Bristol, North Somerset and South Gloucestershire has the best opportunity to survive and thrive after having a stroke. Despite the best efforts of our dedicated workforce, access to stroke care remains variable across our area and we are not consistently meeting national clinical standards. With demand for care projected to rise in the coming years, this is our opportunity to create a high quality and sustainable model of care that can meet our population's needs into the future.

Co-production has been a hallmark of this work so far, and this will continue as the programme progresses. Our Governing Body will be asked to approve moving to formal consultation in the

summer of 2021. We will actively seek the views and feedback of patients, members of the public and staff as we consult on the proposals.

Flu' Vaccination Campaign 2020/21

Seasonal flu is a key factor in NHS winter pressures and the national flu immunisation programme 2020/21 has been even more complex due to the potential risk of both flu and Covid-19. We started our planning early, working with our partners in general practice, community pharmacy, acute hospitals, local authorities and community providers to develop a system flu plan for 2020/21. Our plans included a programme for people in at risk groups, a workforce programme and a communications campaign to encourage the uptake of vaccinations

We have worked with and supported GP practices to encourage patients to be vaccinated against flu. We supported general practice and community pharmacies to ensure IPC measures were in place in all vaccination clinics and to maintain social distancing due to the pandemic. Some practices used community venues as mass vaccination sites, and as a visual reach out to the community to encourage uptake.

We developed a flu communications plan, which aimed to promote vaccinations in areas of low uptake. Leading the Healthier Together Partnership, we targeted communications to support our ethnic minorities and the development of a myth-busting flu video, to promote the importance of the flu vaccine for ethnic minority communities. Multilingual animations have also been published. We worked with ITV, BBC & Radio Ujima throughout the season, and established a campaign with local sports clubs such as Bristol Bears to share the Flu vaccination message: 'Take One for the Team'. Communications were also shared with learning disabilities champions in GP practices to support uptake. A Flu postcard door drop was completed in areas with the highest levels of deprivation.

To ensure consistent messaging across general practice, OneCare hosted a dedicated flu webpage on their GP Practice Team Net Platform, which included national and local guidance, with common frequently asked questions.

Working with our local authorities, Public Health England and the Screening and Immunisation Team, we produced winter resilience training for care homes to highlight the importance of vaccination for both patients and staff members.

We have worked hard to help reduce health inequalities in vaccination take up, including working with the Bristol Muslim Strategic Leadership Group, community pharmacy sector, Bristol City Council, North Bristol Trust and GP practices in Southmead and Easton.

Community clinics in these areas were established in January 2021 and feedback has been positive with helpful learning for future Flu & Covid-19 vaccination campaigns. Another pilot was undertaken by North Somerset Council to increase accessibility of the flu vaccine to homeless people and substance misuse service users.

The 100% flu vaccination offer has been made to frontline health care workers, and achievement is highlighted in the table below:

Table 1

Influenza vaccine uptake	2019/20	2020/21 (uptake as of 26/02/2021)	Change
UHBW*	84.7% -UHB, 84.0% Weston	86.4%	
Sirona*	BCH -74.0%, Sirona - 58.8%, 83.2% NSCP	86%	
AWP	55%	71%	
NBT	82%	65%	
* Classed as separate organisations in 2019/20			

We are working with our providers to increase their staff uptake.

Flu' vaccination uptake in 2020/21 has exceeded previous years. Uptake by people over 65 years' was 83.3%, exceeding the national ambition of 75% and national uptake of 81%. Uptake in the 'at-risk' group was 56%, better than the England average (53%) as was uptake in the two year old (64%) and three year old (65%) groups.

Patients who are shielding, deemed to be at higher risk of Covid-19 infection, were identified as a priority group for the influenza vaccine and a high uptake rate has been noted in this group. It is essential to increase flu vaccination levels for those who are living in the most deprived areas and from ethnic minority communities to help protect those who are more at risk both of getting Covid-19 and flu, and of higher impact from the effects of the viruses.

Safeguarding Children

Ensuring that we continued to provide safeguarding children training during the pandemic was very important. We have moved our traditional Level 3 training on-line, and eight sessions were delivered, reaching over 150 GPs and other practice staff. During these sessions representatives from our local authorities, joined our two Named GPs for Safeguarding Children to provide a multi-agency approach. Feedback has been overwhelmingly positive and we plan to continue to deliver these sessions throughout 2021.

Our Safeguarding Children Team also organised Level 3 Safeguarding Children Webinars, open to all primary care practitioners in Bristol, North Somerset and South Gloucestershire. Two of these webinars in September 2020, attended by over 140 practitioners, focused on child sexual exploitation and were delivered by Avon and Somerset Police Force's Topaz Unit. A further webinar was organised on Safeguarding Children with Learning Disabilities in January 2021, attended by 55 practitioners and provided by three social workers from each of our local authorities. Formal feedback for both webinars has been very positive, with the next webinar planned for April 2021.

Information about our safeguarding teams and details about the services provided can be found on our Remedy webpage, https://remedy.bnssgccg.nhs.uk/, including information about team contacts, referral processes, and training.

Learning Disabilities Mortality Review (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) Programme is designed to improve the quality and experience of services for people with learning disabilities. A review is undertaken when the death of a person with a learning disability is reported, whether they die in hospital or in the community. This involves looking at GP, hospital and community patient notes for the last couple of years of the person's life, against a set enquiry review template designed by the University of Bristol. During a review any next of kin, GP and staff who knew the person well, will be interviewed to get a portrait of the person and the care they received. The reviewer reports on their findings and makes recommendations.

In Bristol, North Somerset and South Gloucestershire we have introduced a Clinical Case Review Panel to strengthen the quality assurance and closure of reviews. We also provide additional support for reviewers, with a 'buddy system' for new reviewers, and a peer support group for all reviewers. We have a monthly LeDeR Steering Group chaired by our Independent Registered Nurse and with representatives from all health providers, local authorities, adult social care providers, the Care Quality Commission, GPs and NHSE regional LeDeR leads.

The LeDeR Steering Group provides strategic level oversight to the reviews, driving transformation to improve care with key roles to:

- Receive regular reports from the Local Area Contact (LAC) about themes and issues identified in reviews
- Monitor action plans resulting from local reviews of deaths to ensure recommendations are implemented and make improvements

- Take appropriate action as a result of information obtained from local reviews
- Support the identification of best practice in the review process and influence change.

Involvement of people who have a learning disability in this process is essential to support learning. In February 2020, we held our first LeDeR Service User Forum. The Service User Forum ensures people have the opportunity to contribute to the LeDeR review process, feeding back their comments and ideas on findings of reviews to the LeDeR Steering Group to help us identify service improvements. Unfortunately, we had to stand down the meetings because of Covid, but have continued to engage with North Somerset People First until the group can be safely re-established.

Over the course of 2020/21, we received 84 new notifications of death, and completed and closed 100 cases (this includes a number of cases notified from the previous year). Our data shows that people with a learning disability in our area live approximately 8 years longer than the LeDeR national average. The LeDeR national average is that people with learning disabilities live 20 years less than the general population. From the completed reviews 80% of people with a learning disability received satisfactory or good care.

Reviews identified the following areas for improvement in the care of people with learning disabilities:

- Uptake of annual health checks
- Early detection and access to screening programmes
- Management and treatment of constipation
- Management and treatment of epilepsy
- Different presentation of Covid-19 in people with learning disabilities
- Better management of illnesses, such as pneumonia and sepsis
- Listening to people and their families and making reasonable adjustments

Our programme of work for 2021/22 includes:

- Developing the LeDeR Steering Group work plan to ensure learning themes and recommendations inform the work programme of the Healthier Together Learning Disability and Autism Programme Board
- Ensure learning identified from reviews informs day-to-day practice of our providers and social care
- Continue to share and drive ‘learning into action’ with the aim of ensuring all people with a learning disability have good or excellent care

- Greater inclusion of people with learning disabilities in our work, including establishing an independent voice for self advocates with learning disabilities
- Hosting/contributing to learning events during 2021/22
- Continue to work with system partners, the West of England Academic Health Science Network Learning Disabilities Collaborative, and other regional groups, to share learning and best practice.

Continuing Health Care (CHC) and Funded Nursing Care (FNC)

Our CHC and FNC teams have worked throughout the Covid-19 pandemic to ensure that people who need these services have been able to access the necessary funding and care that they need. Our team has worked with Sirona to support additional community beds during the Covid-19 pandemic, and staff were redeployed to provide support where it was needed.

In 2020/21 our CHC team developed a detailed plan to ensure that we meet the requirements of the NHS CHC maturity framework and implement what we heard from our CHC team through listening and engagement. Progress to date includes:

- Clinical support to our team to ensure better care options are available for patients and families
- Adopting a 'one team' approach to increase equity of service provision by standardising our clinical pathways, improving transparency and communications with service users
- Patients have an identified case manager supporting them and their families with a direct line of communication for all involved
- Improved responses to the changing needs of patients who are at the end of life so that they get the best care and are supported to stay at home
- A joint funding panel with colleagues from local authorities to support a shared care approach to people who do not meet the criteria to be eligible for a fully funded health care package, but who have significant health needs

To ensure that we continue to improve our CHC and FNC services we are:

- carrying out our own audits of services,
- revising the quality assurance model for domiciliary and residential care providers
- commissioning bespoke training for our teams about the legal frameworks for funding care

Engaging people and communities

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to 'make arrangements' to involve the public in the commissioning of services for NHS patients (the 'public involvement duty'). For CCGs, this duty is outlined in Section 14Z2 of the Act. As an organisation, we are committed to going beyond our mandatory duties to put the voice of the people and communities we serve at the heart of everything we do. Throughout the past year, our engagement work has continued to focus on understanding what matters to the residents of Bristol, North Somerset and South Gloucestershire, ensuring that we are:

- Listening to the needs, concerns and ideas of the people and communities we serve
- Ensuring that our involvement and engagement reflects the depth and breadth of our whole population
- Taking the insights gained from working with people and communities and using them to improve patient experiences
- Continuously striving to design our services in partnership with the communities we serve through co-production

Despite the challenges that we and so many others have faced in the past year, we have worked in partnership with a wide range of people and organisations in the engagement work we have delivered to support the system response to Covid-19. This has allowed us to hear from a broad range of individuals including:

*Standard processes were paused in March due to COVID-19 pandemic, however an adapted method of online meetings and email updates was carried out

Our engagement activities include:

- Running a series of surveys and online listening events to understand and explore the impact of Covid-19 on people and communities across our area.
- Listening events focused on understanding the experience of groups and communities who were disproportionally impacted by Covid-19 and we used this feedback to help clinical and operational colleagues understand how changes put in place in response to Covid-19 - for example remote consultations, changes to urgent care - had impacted positively and negatively on people and communities.
- Supporting the development and implementation of NHS 111 First through on-line surveys, in-depth interviews with people with recent experience of urgent care services, and meetings with our Patient and Public Involvement Forum. We used this feedback to support the design of the new service and to guide the communications and evaluation strategy to support the delivery and monitoring of the service.
- Working together with people with lived experience of stroke and their family members and carers to support the reconfiguration of stroke services in our area. We have used a range of activities including focus groups, in-depth interviews and surveys, along with working in partnership with patient representatives to help inform the design and development of new pathways and services.

Insights from the Citizens' Panel, listening events and other engagement activities in the past year have helped to bring to life the experience of residents during the Covid-19 pandemic, and how it has affected their health, wellbeing and access to health services, including:

- Peoples' top concerns across the year focused on the impact of the pandemic on physical health, emotional wellbeing and mental health, social isolation and loneliness and the impact on health and care services (e.g. capacity to cope and access to services)
- Some people reported feeling concerned about accessing health and care services during the pandemic, due to concerns about safety, the capacity of health and care staff and also how to access services
- While most people support the use of remote consultations in primary care and outpatients, others were less comfortable with the concept due to concerns about access to technology and the quality of the interaction over the phone or video, compared to in-person
- People have made changes to their lifestyle in response to the pandemic, with some talking to others more about stress and anxiety, or increasing their physical activity

levels. However others have contacted GPs less and also reported difficulty sleeping and drinking more alcohol

- NHS organisations, doctors and nurses are trusted sources of information about Covid-19 and the Covid-19 vaccine

In December 2020 and January 2021, we gathered insights from multiple surveys and online engagement events from approximately 4,000 people to support the roll-out of the Covid-19 vaccine programme in our area. These activities helped to provide information about expected uptake of the vaccine and potential drivers and barriers to uptake, including:

- Majority of respondents likely to get the vaccine
- Perception of safety drives the largest change in claimed behaviour; age appears to be most correlated with safety concerns
- The primary drivers for uptake are 'prosocial' rather than individualistic
- The main concerns centre on the speed of development of vaccines and concerns around long-term safety and side effects.
- "Being able to review the evidence for myself" and "advice from my GP" appear to be the main drivers of reassurance

Following the online survey, we also ran a series of targeted engagement events in partnership with local authority partners and voluntary and community sector organisations to engage in a two-way dialogue to help address peoples' concerns or questions about the Covid-19 vaccination.

Through the year, we have also delivered representation on the Joint Impact Assessment Panel (JIAP). The JIAP brings together expertise across the organisation in quality, patient and public involvement (PPI), inclusion and equality, and communications. Through representation on the JIAP board, we have been able to provide constructive appraisals on project plans to assure the organisation maintains standards in our processes to ensure citizen insight and engagement drive what we do.

In total, in 2020/21, we received over 14,000 pieces of feedback through our public involvement, engagement and participation activity. Insights from working with people and communities plays a vital role in putting the voice of our population at the heart of everything we do. Some of the ways in which we have used feedback to help us in our work this year include:

- Insights from our Citizen's Panel during throughout the various stages of COVID-19 have helped us to shape and adapt our response to the pandemic. For example, early

insights indicated that mental health and wellbeing was a significant concern for certain groups within our population. As a result of these insights, we worked across system partners and our VCSE network to ensure that key support resources and information were made available to our population, in formats which could be accessed and used easily.

- Key learnings from a survey of over 4,000 people coming from our own Citizen's Panel and community engagement around the COVID-19 vaccine, which has helped us to identify those groups with the biggest hesitancy around the vaccine and to address their concerns and accessibility issues. This has resulted in a number of vaccine information events being hosted for large groups and individual communities, as well as community pop up vaccination clinics to facilitate easier access. Across Bristol, North Somerset and South Gloucestershire, the level of vaccination uptake is higher than the national average, but critically we have seen a significant increase in vaccine uptake from groups with the highest hesitancy as a result of our activities.
- Insights gathered from over 250 stroke survivors, health care staff and carers, which has helped us to design our plans for reconfiguration of stroke services across Bristol, North Somerset and South Gloucestershire. These plans will be subject to a public consultation in the summer of 2021.

Reducing health inequality

NHS commissioning organisations have a legal duty under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) to reduce inequalities. For CCGs, this duty is outlined in Section 14T of the Act.

Bristol, North Somerset and South Gloucestershire is a vibrant and dynamic area with a mix of urban and rural populations. Bristol is a largely urban area, whilst both North Somerset, with the exception of Weston-super-Mare, and South Gloucestershire are more rural. We have a diverse population with older populations in North Somerset and South Gloucestershire and a younger population living in Bristol. Our population is growing, with increases in the numbers of people aged between 15 and 24 years old and people over the age of 60 years. The population predicted to increase most significantly over the next 25 years is those aged 85 and over.

We have an ethnically diverse population, with Bristol having the greatest proportion of ethnic minorities (16%) compared to South Gloucestershire (5%) and North Somerset (2.7%). Our younger people tend to have the greatest number belonging to a ethnic minority. There are

significant pockets of deprivation within our area, with around one in ten people living in a deprived location. Average life expectancy varies between those living in the most and least deprived areas by around six years, with some places seeing a 15-year difference. If we describe our population as 100 people:

We know that the impact of Covid-19 is different for different parts of our population. Evidence is that:

- People who live in more deprived areas have higher diagnosis and death rates compared to those in less deprived areas.
- Hospitalisation and death disproportionally affects some groups, including older people, men, low-paid workers, and people from ethnic minority groups.
- Risk factors for Covid-19 more prevalent amongst these groups may include: poor housing, occupations which do not provide opportunities to work from home, unstable work conditions and income, stress, comorbidities such as high blood pressure, diabetes, obesity, and existing heart/lung disease.
- There has been a significant mortality increase in people with learning disabilities
- In addition, there will be considerable social and economic consequences, and effects on mental and physical health, arising from lockdown measures. Those “shielding” may be at especially high risk.

- Possible longer-term impact on children who were not able to attend school and/or who had limited access to home learning (inequalities in e.g. digital access, family capacity to support).

In many instances, lockdown will have made people's situation worse as parts of the economy have shut down or they have been put at greater risk of becoming infected with Covid-19, which would in turn affect their ability to work. To tackle the impact of Covid-19 on health inequalities we have:

- Worked with partners to make information more accessible to our diverse communities.
- Held listening events for people in our community to understand their needs and how we can support them.
- Invested in services to reduce the impact of Covid-19 on our population's mental health and improve mental wellbeing.
- Established a Bristol, North Somerset and South Gloucestershire Population Health, Prevention and Inequalities Group to direct and move towards whole system tackling of socio-economic and health inequalities.
- Ensured that quality and equality impact assessments are completed to identify and mitigate the impacts of our actions on specific parts of our community.
- Used our population health management and citizen insights to help monitor the impacts on health inequalities, and help us understand how best to target resources and actions

Population Health Management

Population Health Management (PHM) is the way we work together to understand and improve the health of people and communities using joined up health and social care data. This means that we bring together information about people's health, their needs and the type of care they receive, with other sources of information, such as surveys, listening events and research.

The past year has been immensely challenging but we have made good progress in our mission that all strategic planning and transformation work takes a value based, population health approach, and everyone has the access and ability to use Population Health Management tools and analytics.

During Covid-19 we have adapted our data sources to support a rapid and flexible response to planning and operational needs, for example incorporating COVID testing and vaccination data, and hospital admission data, which has helped us to support key programmes in the pandemic response.

We have been able to:

- Identify and map the population within Bristol, North Somerset and South Gloucestershire who are most vulnerable to Covid-19
- Develop community plans based on mutual aid and support among GP surgeries
- Support the mass vaccination programme to focus extra resources, and adapt information, for example translating into the most common local languages, and clinic design such as mobile clinics in community centres, to suit the needs of our diverse local communities
- Provide information about health risks, including from Covid-19, to clinicians in primary care and across the system to help support shared decision-making between clinicians and people
- Continue support to programmes such as the design of stroke services by showing where people are most vulnerable to having a stroke
- Better understand where variation and inequalities in care exist within our system

We have continued our participation in the National NHS PHM Development Programme, working with leaders from across our partner organisations including general practice, hospitals, social care, mental health, and community services. We have adapted the delivery of the programme to wrap around the new ways of working and have had a great response from the system, with over 70 colleagues from all partner organisations joining our system workshops.

In the last year, we have improved the information that planners and clinicians are receiving in order to inform decisions such as allocation of resource, risk management and communication with the public. We have developed methods for studying our health inequalities, which has led to insights that form the basis of our plans, especially within our pandemic response. We have also contributed to the integration of our system by allowing all partners to work from a shared understanding of our population's needs and developing a culture of thinking about the whole population, not just those who have been able to access services effectively.

Case Study - Quit for Covid

At the beginning of the Covid-19 pandemic in the UK, one of our GP clinical leads was consulting with a patient who was worried about smoking and was thinking of quitting because of the Covid-19 virus. We realised that during the pandemic people might be more concerned about their health and more likely to quit smoking. To encourage this we teamed up with the 'Action on Smoking and Health' (ASH) campaign charity and launched the 'Quit for Covid' campaign, starting with the Twitter hashtag #QuitforCovid.

Smoking is still the single biggest cause of poor health and one of the big reasons for the differences in cases of heart attacks, chronic lung disease and lung cancer between the least and most deprived communities. Stopping smoking helps prevent these conditions and helps with blood pressure, kidney function, wound healing and many other health issues.

The ‘Quit for Covid’ campaign was adopted as the official stop smoking campaign during the first phase of the pandemic by dozens of local authority teams, including in Bristol, North Somerset and South Gloucestershire, and was supported by Public Health England (PHE). Using social and traditional media, we were successful in getting our message out:

- On Twitter 1,840 users tweeted nearly 5,000 times using #QuitforCovid with a total reach of 9 million followers
- ASH hosted a virtual stop smoking clinic on Twitter for one hour every evening for the first few months of the campaign, where a smoking cessation expert could provide advice and answer user questions
- BBC Radio Bristol interview (https://www.bbc.co.uk/sounds/play/p083wnn3; 1hr 37mins) and article on www.bristol247.com/lifestyle/health/quit-for-covid/
- The campaign launch was featured by at least 19 national and international media outlets including the Guardian, Sun, Times, Yahoo News, ITV, Sky Radio and BBC Radio 5 live, as well as in at least 17 regional outlets

The contribution that our campaign made to changing smoking behaviour is impossible to estimate. However, the overall effect of the pandemic, and efforts by us and others to encourage quitting, appears to have had large positive benefits at regional and national levels. Research suggests that:

- Younger people and those with mental health problems were more likely to succeed
- In 2020, 36% of smokers tried to quit compared with 29% in 2019
- In 2020, 22% of people who tried to quit succeeded, compared with 14% in 2019
- In 2020, 8% of smokers had quit, compared with 4% in 2019
- Local teams also saw increased success rates and quit attempts in 2020 associated with their Quit for Covid campaigns

The Campaign brought public health teams across the South West Region together with ASH, the international campaigning charity, around a common message on smoking. Following the success of the ‘Quit for Covid’ campaign, ASH secured government funding for the ‘Today is the Day’ follow-on campaign, aimed at the most deprived areas of the country. All partners have agreed to continue working together to help us go smoke free by 2030.

Reducing inequality

We are committed to advancing equality and reducing health inequalities for the diverse population we serve. Implementation of the Public Sector Equality Duty 2011 forms the foundation of our equality and diversity activities. This Duty stipulates we must have due regard to eliminate discrimination and any other conduct prohibited by the Act, advance equality and foster good relations between one group and another and between the public and the CCG. The level of equality, diversity and inclusion and reducing health inequalities is integral to achieving our mission to have healthy fulfilled lives for our population and workforce.

The four objectives set out in the Equality Strategy are:

- To improve the use of equality analysis data in our commissioning cycle
- To build strong relationships with protected characteristic groups and communities to better understand their needs and improve our equality data
- To promote workforce equality and improve representation through effective employment practices
- To develop inclusive leadership throughout the CCG.

These objectives have driven our equality, diversity and inclusion initiatives over the past twelve months. The cells established as part of the immediate response to the Covid-19 pandemic have undertaken equality analysis, and Equality Impact Assessments, to inform their decisions and understand how our work affected our diverse communities. As a result, a number of mitigations were introduced, including: increased funding for mental health provision; the production of Covid-19 literature and videos in multiple languages; and hosting events targeted at different communities. We increased the provision of digital health to reduce hospital or clinic attendance, and where necessary continued to provide face-to-face appointments for individuals who have little or no access to telephone and digital health. These initiatives are recorded extensively in our Equality Annual Report for 2019-2020 (https://bnssgccg.nhs.uk/library/equality-annual-report-2019-20/)

Equality Impact Assessments also support our work towards reducing health inequalities. Alongside equality training, support via a panel of advisors (equality, quality, patient and public involvement), business intelligence and other research/evidence tools, and Equality Impact Assessments help the organisation to identify and mitigate health inequalities and embed good practice into our day-to-day work. Several of our work streams, including the Mental Health &

Wellbeing Strategy and primary care's 'Models of Care' and 'Quality & Resilience' work streams currently have specific goals to reduce health inequalities.

In addition to meeting the challenges brought by Covid-19, we have delivered against our statutory and mandatory duties in line with the Public Sector Equality Duty to eliminate unlawful discrimination, advance equality and foster good relationships between communities. We have recently published our equality data in the Equality Annual Report for 2019-2020, and the report highlights the equality, diversity and inclusion achievements for the year. The focus of our equality, diversity and inclusion practice for this period was 'diversifying voice and influence'; much of this has centred on increasing the opportunity for staff to have a voice in the decisions that affect them and creating a more inclusive work environment. We now have four active staff networks, which provide support to their members and work across a range of issues to improve systems, processes and practices. We have also diversified our engagement and listened to people from communities that have seldom engaged with the health and care service.

Our workforce is our most valuable asset and we have done more to support them including increasing our mental health and wellbeing offer, and helping staff to adapt their home environment so that they can safely work from home during the pandemic. Inclusive leadership has enabled the CCG to adapt to these challenging times and respond differently to the unique needs of the workforce and system. Our focus for the coming twelve months will be to revise the equality strategy, and the resultant action plan, with this aim in mind. The CCG has established an Inclusion Council, chaired by the Chief Executive. This new approach will enable us to develop a more ambitious strategy and action plan to drive cultural change and improve patient experience and outcomes.

Health and wellbeing strategy

The three Joint Strategic Needs Assessments set out the current and future health and care needs of our population and inform the three local authorities' Health and Wellbeing Strategies. Our local authority partners and we use the Joint Strategic Needs Assessments and the Health and Wellbeing Strategies to inform and guide how we plan and commission health, wellbeing and social care services across Bristol, North Somerset and South Gloucestershire. We have played an active role with our local Health and Wellbeing Boards for Bristol, North Somerset and South Gloucestershire. We are required to contribute to the delivery of our Joint health and Wellbeing Strategies under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007

The Bristol Health and Wellbeing Board

The Bristol Health and Wellbeing Board refreshed its plan on a page and performance framework in 2020, recognising the impact of Covid-19 and the need to focus on inequalities. The Health and Wellbeing Board focused on the Covid-19 response, receiving regular reports on outbreak management. Other topics covered by the Board included a Fuel Poverty Strategy and the One City Climate Strategy.

The North Somerset Health and Wellbeing Board

The North Somerset Health and Wellbeing Board set out its plans to develop a Joint Health and Wellbeing Strategy and Action Plan during 2020/21; currently in the process of consultation, the aim is to finalise the strategy and action plan for July 2021. At its meetings, the Health and Wellbeing Board received regular reports on the Covid-19 response and outbreak management. An all age Mental Health and Wellbeing Steering Group was established to support a joined up approach, monitoring existing work and providing a steer for future activity. This group co-ordinates ongoing work local to North Somerset and where appropriate feds into the Healthier Together work programme.

The South Gloucestershire Health and Wellbeing Board

The South Gloucestershire Health and Wellbeing Board set out plans to review its joint Health and Wellbeing and Inequalities Strategy, building on previous work through the lens of inequalities. The Health and Wellbeing Board, similarly to the other Health and Wellbeing Boards in our area, focused on the response to the Covid-19 pandemic.

Summary of performance 2020/21

How we measure performance

Performance management is a key role that ensures services delivered to our population achieve the desired outcomes and provide good value for money. Performance is monitored and reported through:

- Finance: detailed financial plans are created to plan for patient care activity and outcomes, and to monitor the in-year performance of our providers
- Performance against NHS Constitutional Standards
- Performance in quality and outcomes: to ensure services are safe, patients have a positive experience of healthcare, and improvements in clinical outcomes are delivered

Activity and NHS constitutional standards

The following table shows Bristol, North Somerset and South Gloucestershire performance against NHS Constitutional Standards. Meeting the standards set out in the NHS Constitution is an important responsibility, and we are committed to working with our providers to ensure that the services they provide meet the standards required. Throughout 2020/21 the Covid-19 pandemic had a significant impact on performance. We continued to see underperformance against key targets including A&E 4 hour waiting targets, planned admissions, and the number of patients waiting over 52 weeks for planned treatment. We have also seen underperformance against the key cancer waiting time targets, again due to the impact of the Covid-19 pandemic. We established Covid-19 escalation plans, with our system partners, which aimed at increasing capacity through new approaches to delivering services, and new partnerships. We have seen these deliver improvements in some areas of performance, however our system continues to miss key NHS Constitution standards and we continue to work with our partners to improve services.

Key to symbols in table 2 below:

 Better than last year but not achieving standard

 Achieving standard

 Worse than last year and not achieving standard

Indicator	Standard	2019/20	2020/21	Change
Percentage of patients admitted, transferred or discharged from A&E within 4 hours (BNSSG Acute Trusts)	95.00%	78.41%	81.58%	
Percentage of patients on an incomplete RTT Pathway waiting less than 18 weeks	92.00%	82.28%	70.97%	
Number of patients on an incomplete RTT Pathway waiting more than 52 weeks	0	71	4,327	
Percentage of patients waiting six weeks or more for a diagnostic test (15 key tests)	99.00%	88.59%	69.50%	
Maximum two-week wait for first appointment for patients referred urgently for suspected cancer	93.00%	86.54%	79.38%	
Maximum two-week wait for first appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93.00%	88.72%	58.10%	
Maximum 31 day wait from diagnosis to first definitive treatment for all cancers	96.00%	95.36%	95.21%	
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94.00%	87.59%	86.31%	
Maximum 31 day wait for subsequent treatment where that treatment is anticancer drug regimen	98.00%	98.86%	99.37%	
Maximum 31 day wait for subsequent treatment where that treatment is radiotherapy	94.00%	95.35%	98.68%	
Maximum 62 day wait from urgent GP referral (two-month wait) to first definitive treatment for cancer	85.00%	77.62%	75.58%	
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for cancer	90.00%	78.21%	72.46%	
Total Number of CDIFF Cases	195	195	294	
Total Number of MRSA Cases Reported	0	42	31	
Eliminating Mixed Sex Accommodation	0	17	Not available	Not available

Adoption of the going concern basis

The CCG has reported a small surplus of £20,039,000 (1.23%) against its Revenue Resource Limit of £1,634,962,000.

The CCG began the year with an accumulated deficit caused by prior year accumulated deficits, including of predecessor bodies, against its Revenue Resource Limit of £117,059,000.

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.

The Clinical Commissioning Group allocations for 2019/20 to 2023/24 were published in January 2019 and had final approval by the NHS England Board on 31 January 2019. The revenue allocations are backed by cash limits. Throughout this period, the CCG expects to maintain a positive cash flow and continue to meet the Better Payment Performance standard.

Subject to the recent published DHSC White Paper Integration and innovation: Working together to improve health and social care for all, the Clinical Commissioning Group may cease to exist after 2021/22, however all its services will continue to be provided the envisaged statutory Integrated Care System.

On this basis, the CCG considers it remains a Going Concern.

How financial performance was monitored in 2020/21

Financial performance management of NHS bodies was significantly different from previous years as a consequence of the Covid-19 pandemic. Within the context of this different regime the CCG and BNSSG system successfully delivered a breakeven financial position. As the pandemic progressed, financial performance was monitored and reported in different ways during 20/21:

April 2020 – September 2020

The CCG was not required to submit a financial plan for April to September, but was instead subject to a more simplified financial management regime where budgets were largely set nationally based on previous year spend and a ‘top up’ to expected breakeven and with fixed

‘block’ payments to NHS providers. Additional costs of managing the Covid pandemic and other reasonable over and underspends were then adjusted each month to continue to deliver a balanced financial position.

October 2020 – March 2021

The CCG was required to prepare and submit a financial plan to NHS England for the period October to March, including accounting for expected additional Covid costs. The plan was prepared at ‘system’ level with prospective allocations for additional Covid-19 costs, a ‘top up’ allocation to expected breakeven for all NHS organisations, and some growth funding for service development in the second half of the year to support recovery of elective care services and meet policy objectives in mental health and primary care.

Outside of this funding envelope, the CCG continued to claim reimbursement for some specific costs of managing the Covid-19 pandemic, notably the Hospital Discharge Programme and locally commissioned independent sector capacity

Two other notable changes to the finance regime were:

- NHS England used executive powers to manage the pandemic to remove commissioning responsibility for most major independent sector hospitals and directly commission nationally
- Non Contract Activity with NHS provider Trusts below £200,000 was not chargeable and providers were reimbursed nationally via a ’top up’ regime

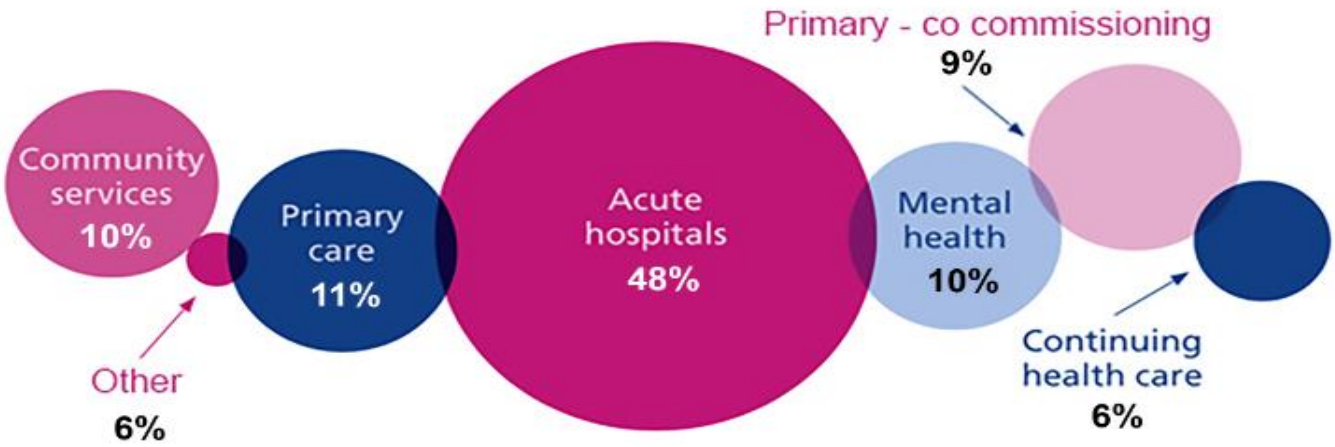
Taken in the round these changes ensured that:

- Unplanned additional costs of the Covid-19 pandemic were able to be funded and decisions made promptly
- Inter-NHS commissioning and contracting did not become a barrier or additional burden on the service
- There remained a mechanism for ensuring value for money
- Progress was made on the Long Term Plan objective of ‘system by default’ working

These are welcome initiatives, aligned to the NHS and CCG long-term financial objectives, but caution should be taken when making year-on-year comparisons of expenditure, or relative activity and performance levels.

Financial performance and outlook

The CCG spent £1.615 billion on behalf of the patient population during 2020/21. This is 1.23% lower than the notified allocation, achieving a small surplus of £20,039k. This surplus primarily arose due to delays in planned recovery of elective care during the final quarter of 2020/21 when the second wave of Covid again restricted much planned care activity. From October 2020 the CCG operated within a System Financial Envelope, together with other partners in Healthier Together. As well as delivering a small surplus position for the CCG; the CCG contributed a key leadership role to delivering breakeven or small surplus positions in all key partner organisations (UHBW, NBT, AWP and Sirona), and an overall NHS system breakeven position. This required both maintaining financial control and meeting budget targets; and also operating in a new, and arguably more complex, 'system' finance environment. The partners set an initial plan with an overall system deficit of £40 million caused by lower non-NHS income in NHS providers and higher levels of deferred annual leave, both a consequence of the impact of the Covid-19 pandemic on the funding envelope of the system. This planned deficit was accepted by the NHSE/I national team, and the areas of deficit could be directly attributed to the Covid-19 pandemic response and therefore represents a maintenance of financial cost control during the extraordinary Covid-19 period. Towards the end of the year NHS England provided additional funding to support this deficit and a small surplus arose due to delays in planned recovery of elective care during the final quarter of 2020/21 when the second wave of Covid again restricted much planned care activity. Our expenditure by main programme area in 2020/21 is shown in Table 3.



Bristol, North Somerset and South Gloucestershire CCG Programme Expenditure 2020-21	£m	Of which, Pass though 'system funding' £m	Of which, direct Covid expenditure £m
Acute Services	777	48	1
Mental Health Services	172	15	3
Community Health Services	169		35
Continuing Care Services	92		2
Primary Care Services	179		2
Primary Care Co-Commissioning	144		4
Other Programme Services	83		2
Total Commissioned Services	1,615	63	49
Running Costs	19		
TOTAL CCG NET EXPENDITURE	1,635	63	49

Allowing for the tremendous pressures on the service, and the revised focus and re-deployment of senior management resource during the pandemic, the CCG did retain a focus on delivering savings through the year, with particular focus on prescribing and continuing healthcare (CHC). The CCG delivered £7.3 million savings across the year.

Future Outlook

Achieving ongoing financial recovery across the Bristol, North Somerset and South Gloucestershire health system was not a requirement during the year but remains a key element of our system plans and the CCG objectives for 2021/22 and beyond.

Prior to the Covid-19 pandemic, the CCG had a bought forward accumulated deficit of £117m, and assessed an underlying annual deficit before savings of £37m year.

The CCG had developed a medium term financial plan as part of the BNSSG Long Term Plan. This provides a clear path to return to a balanced financial plan by 2022/23 and repay accumulated deficits by 2027/28. The key emerging financial goals for the coming year will be to:

- Maintain financial control during the ongoing Covid-19 pandemic and associated mass vaccination campaign

- Set a plan to return to the financial trajectory set out in the Long Term Plan, including 2021/22 priorities of community mental health and continued investment in new roles in primary care.
- Maximise the benefits of transformation and partnership working that the Covid-19 response has accelerated, whilst ensuring excess costs and reduced productivity are removed and reversed.
- Address the growth in elective care backlogs and increase in demand for mental health arising from the Covid-19 pandemic response, with support from additional government investment set out in the 2020 Spending Review.

Key risks and issues to delivering our objectives

We identified and reported on the following key risks to the delivery of our objectives and Operational Plan during 2020/21. Further information can be found in our Governance Statement in this report.

- As a result of the impact of Covid-19 there is a risk that the need to focus capacity to meet the demands on the system may result in the system and the CCG not delivering the objectives identified in the Governing Body Assurance Framework
- As a result of not being able to get the commitment needed across the system we are unable to develop effective ways of working to deliver performance, financial and population health outcomes in line with the system aims
- Without all system partners having strong engagement, understanding, shared purpose and commitment to developing ICPs, there is a risk that improvements in health outcomes and the benefits of ICPS are not achieved
- As a result of COVID 19 there is a risk that demand for MH services will increase by up to 30%which may result in a poorer access and outcomes for people, increased level of MH crisis and further spend on aspects of services like out of area placements and S117
- As a result of a lack of integrated services there is a risk that we reduce the life choices for individuals with learning disabilities and autism which may result in widening of health inequalities and the health of the population in the future
- Integrated children's commissioning with Local Authorities is not fully developed, there is a risk that we are not optimising the care children receive and impacting on their life course
- As a result of a lack of regular and accurate data, there is a risk that decisions made to support the transformation are not data driven which may result in not achieving

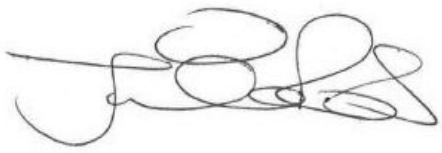
'leading' on the maturity framework, a poor service for the individuals and inequalities in the way we support our population

- There is a risk that a coherent People Plan for the CCG may not be developed and delivered if we do not bring together the many existing workstreams into one clear programme, develop an understanding of our current state of readiness and meaningfully engage with our workforce in the plan's development and ownership
- As a result of the current culture driven by Payment by Results there is a risk that there will be a continuing focus on activity rather than value which may result in failure to deliver improved population health and financial sustainability for the CCG and the system.

Other reported risks included:

- Increased waiting times across key services including A&E, 52 week waiting times, access to planned care and diagnostic services and cancer waiting times, waiting times for musculoskeletal (MSK) services and Attention Deficit & Hyperactivity Disorder (ADHD) services
- Higher potential of harm through contracting Healthcare Associated Infections
- Increased risk of health inequalities for cancer patients due to delays in diagnosis
- Risk to the establishment of the Individual Placement and Support Mental Health service
- Risk to the delivery of the Long Term Plan because of the impact of Covid-19

ACCOUNTABILITY REPORT



Julia Ross

Chief Executive and Accountable Officer

18th June 2021

Corporate Governance Report

The Corporate Governance Report provides information about the composition of the Governing Body, the statement of disclosure, and explains we had no personal data related incidents in 2020/21. We also report on complaints and provide our Modern Slavery Statement. This is in line with corporate governance best practice.

Members Report

Bristol, North Somerset and South Gloucestershire CCG is responsible for planning and commissioning health services for its local population. We were established by NHS England on 1st April 2018 and we operate in accordance with our Constitution. Our Governing Body is made up of local GPs, other clinicians, lay members, and executive directors. Our Chair is Dr Jonathan Hayes.

We are a clinically led membership organisation. Our member practices provide primary care services across Bristol, North Somerset and South Gloucestershire and are organised into six commissioning locality groups described in the Performance section of this report.

A list of our GP practices can be found at https://bnssgccg.nhs.uk/about-us/our-members/.

Composition of Governing Body

Our Governing Body is responsible for discharging the functions conferred on to it by legislation and through our Constitution. Our Governing Body met on line during 2020/21; details of attendance throughout the year are in our Governance Statement. During 2020/21, and up to the signing of this annual report and accounts, our voting Governing Body members were:

Name	Title	Tenure in 2020/21
Jon Hayes	Clinical Chair	2020/21 to present
John Cappock	Lay Member Finance	2020/21 to present
Nick Kennedy	Independent Secondary Care Doctor	2020/21 to present
Alison Moon	Independent Registered Nurse	2020/21 to present
John Rushforth	Deputy Chair, Lay Member Audit and Governance	2020/21 to present
Sarah Talbot-Williams	Lay Member Patient and Public Involvement	2020/21 to present

Kirsty Alexander	GP Locality Representative Bristol North and West	2020/21 to present
Julie Boardman	GP Locality Representative Bristol Inner City and East	1st April 2021 to present
Matt Cresswell	GP Locality Representative North Somerset Woodspring	1st April 2021 to present
Jon Evans	GP Locality Representative South Gloucestershire	2020/21 to present
Felicity Fay	GP Locality Representative South Gloucestershire	2020/21 - 31st March 2021
James Case	GP Locality Representative South Gloucestershire	1st April 2021 to present
Kevin Haggerty	GP Locality Representative North Somerset Weston and Worle,	2020/21 to present
Brian Hanratty	GP Locality Representative Bristol South	2020/21 to present
Rachael Kenyon	GP Locality Representative North Somerset Woodspring	2020/21 - 31st March 2021
Umber Malik	GP Locality Representative Bristol Inner City and East	1st September 2020 – 31st March 2021
David Soodeen	GP Locality Representative Bristol Inner City and East	2020/21 – 7th July 2020
Julia Ross	Chief Executive	2020/21 to present
Sarah Truelove	Chief Financial Officer	2020/21 to present

Non-voting executive directors attending the Governing Body:

Peter Brindle	Medical Director Clinical Effectiveness	2020/21 to present
Colin Bradbury	Area Director North Somerset	2020/21 to present
Deborah El-Sayed	Director of Transformation	2020/21 to present
David Jarrett	Area Director South Gloucestershire	2020/21 to present
Martin Jones	Medical Director Commissioning and Primary Care	2020/21 - 1st December 2020
Lisa Manson	Director of Commissioning	2020/21 to present
Rosi Shepherd	Director of Nursing and Quality	2020/21 to present

Our Governing Body committees are:

- Audit, Governance and Risk
- Remuneration
- Primary Care Commissioning
- Clinical Executive
- Strategic Finance
- Quality
- Patient and Public Involvement Forum

Details of the membership of our Governing Body committees and attendance, including the Audit, Governance and Risk Committee, are provided in the Governance Statement in this report. Further information about our Remuneration Committee can be found in the Remuneration Report in this report. Details of the declared interests of our Governing Body members and the members of Governing Body committees can be found at https://bnssgccg.nhs.uk/library/bnssg-ccg-register-interests/

Personal data related incidents

All information governance incidents are assessed in line with the NHS Digital "Guide to the Notification of Data Security and Protection Incidents". We have not had any externally reportable incidents during 2020/21. The CCG's Information Governance Group is routinely updated on any issues and remedial activities with learning cascaded to Information Asset Owners and materials published for staff. .

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

Bristol, North Somerset and South Gloucestershire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Compliments and Complaints – Patient Experience

Hearing the voice of local people and communities and engaging with them to co-design and co-create new services is at the core of our approach. We continually work to identify ways in which that voice is heard throughout our work. We will ensure that analysis and comparison of patient experience information enables us to identify themes and trends; to support ongoing improvement of the experience and quality of care.

Our Customer Services Team gathers feedback from patients through compliments and complaints, general (advice and liaison) enquiries, MP and Councillor enquiries, feedback from healthcare professionals, patient surveys and Healthwatch reports.

In 2020/21 we received 1,862 Patient Advice and Liaison Service (PALS) contacts, 328 formal complaints and 226 MP/Councillor enquiries. Each quarter, the Customer Services Team provides a report to the Quality Committee and the Governing Body which identifies key themes and trends from complaints. Investigating personnel and teams contribute to these reports, describing actions taken and any learning that has been implemented, demonstrating how patient experience shapes our services. During 2020/21 ten complaints were reported to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO declined to investigate seven of these complaints. The PHSO investigated one case related to Exceptional Funding and the complaint was not upheld. At the time of reporting decisions regarding two complaints, plus one from the previous year, were outstanding.

We continue to use patient experience to inform service improvements. Throughout 2020/21, work included:

- Working processes for the Customer Services Team were reviewed and refined. This included revising how cases are managed and recorded, developing practices with other teams to make sure learning is captured and launching a tracker to ensure complaints and enquiries are managed swiftly and thoroughly.
- Quarterly reports were developed and improved to include further detail from other departments, to evidence learning from patient feedback. The reports

now include a section on equality monitoring data; obtained so we can understand who is using our services.

- A new patient feedback questionnaire was launched, to make sure we are hearing the views of our population. The data captured is included within the quarterly reports.
- An independent review of complaints handling was conducted and the findings were used to implement further developments. A Clinical Review Team has been established to provide a review and triage of cases, to ensure any risks are identified and that cases are handled in the most effective way. An external provider was also commissioned to provide training for teams assisting with response writing and the Customer Services Manager has delivered further internal training sessions to staff.
- Reviews of key policies and documentation for patients have been undertaken, to ensure that information is clear and accessible to our population. The Customer Services Team also continues to work on advances with their reporting system, to enable a swifter and more detailed review of information captured; so that further learning and key work streams can be identified.
- The Customer Services Manager has implemented regular meetings with colleagues from provider organisations; to ensure aligned working and effective communication throughout the pandemic.
- A new Standard Operating Procedure has been produced and a revised policy is being developed. These documents make clear the responsibilities of all staff concerning complaints handling and highlight the importance of investigating and responding in an open and transparent manner.
- The Customer Services Team continue to work closely with the Communications and Engagement team, to ensure that we are monitoring and responding feedback on our local healthcare services from a range of sources including social media, public engagement activities, Healthwatch reports, our Citizen's Panel and so on.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group.

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a

statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

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

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

As the 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 NHS Bristol, North Somerset and South Gloucestershire CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Governance Statement

Introduction and context

Bristol, North Somerset and South Gloucestershire CCG is a body corporate established by NHS England on 1 April 2018 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2020, the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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 Clinical Commissioning Group 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.

Governance arrangements and effectiveness

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

Our Constitution sets out the CCG's roles and responsibilities for commissioning healthcare for people within the Bristol, South Gloucestershire and North Somerset area. We describe in our Constitution our governing principles, and the rules and procedures we have in place to ensure probity and accountability in our day to day running; to ensure that decisions are taken in an open and transparent manner and that the interests of patients and the public remain central to our aims. Our Constitution is available on our website.

Bristol, North Somerset and South Gloucestershire CCG is a membership organisation. Our members include all providers of primary medical care services to the registered list of patients, under a General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Service (APMS) contract. Our Constitution includes details of our Membership and is available on our website https://bnssgccg.nhs.uk/library/bristol-north-somerset-and-south-gloucestershire-ccg-constitution/.

We have six localities across our area:

- Inner City and East (ICE) Bristol
- North and West Bristol
- South Bristol
- Weston, Worle and Villages
- Woodspring
- South Gloucestershire

GPs in each locality meet to discuss key commissioning matters. Our member practices each send an appointed representative to locality meetings. Our Members are collectively responsible for agreeing the CCG's Constitution and the governance

arrangements it describes, including the responsibilities of the Governing Body and its Members' terms of office.

We use our Internal Audit function to independently audit our systems of internal control and check that we are compliant with legal requirements and good practice.

The Governing Body

The main function of the Governing Body is to ensure that appropriate arrangements have been made for ensuring the CCG exercises its functions effectively, efficiently and economically, and that we comply with principles of good governance. Our Governing Body membership includes local GPs, three independent lay members, an independent secondary care doctor, an independent nurse and the CEO and CFO. All directors attend Governing Body meetings but do not have voting rights. A full list of members can be found on our website https://bnssgccg.nhs.uk/about-us/our-governing-body/.

Throughout 2020/21, our Governing Body met on-line due to the restrictions in place in response to the Covid-19 pandemic. The meetings held in April and May were not open to the public as we developed digital approaches to support the meetings. From June these meetings were open to the public. The papers and minutes of the meetings are available on our website https://bnssgccg.nhs.uk/events/ . The Governing Body met 12 times during 2020/21 and was quorate for each meeting. The membership and attendance at meetings during 2020/21 is at table 4.

The Governing Body is responsible for:

- Approving any functions of the CCG that are specified in regulations
- Setting out the vision and strategy of the CCG
- Signing off the annual commissioning plan, which sets out how it proposes to discharge its financial duties.
- Monitoring performance against plan
- Receiving assurance against strategic risks
- Receiving assurances about the quality of commissioned services
- Ensuring engagement with Members, the public and partners

- Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowance payable under any pension scheme it may establish
- Throughout the year the Governing Body received specific reports about the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase.

Governing Body Sub Committees

A number of committees of the Governing Body have been established and these are listed below with a summary of their purpose and functions. The Terms of Reference of these committees can be found at https://bnssgccg.nhs.uk/about-us/constitution-and-governance-handbook/ The Governing Body receives the minutes of the committees and these are available on our website at https://bnssgccg.nhs.uk/events/. During 2020/21 our committees met on-line and these arrangements will continue for the foreseeable future.

Audit, Governance and Risk Committee

The Audit, Governance and Risk Committee is accountable to the Governing Body and provides an independent objective view of and assurance on our controls and governance arrangements. The Committee is responsible for the oversight of financial reporting and disclosure. The Audit, Governance and Risk Committee is chaired by a lay member who is a qualified accountant and with experience at Director of Finance level. Membership of the Committee and attendance at meetings are detailed in table 4.

The Audit, Governance and Risk Committee provides assurance to the Governing Body that an appropriate system of internal control is in place, so that:

- We conduct our business in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Financial statements are prepared in a timely fashion and give a true and fair view of the financial position for the period in question
- We secure economic, efficient and effective use of resources

- Adequate arrangements are in place and that reasonable steps are taken to prevent and detect fraud and other irregularities
- We have established and maintain an effective system of integrated governance, risk management and internal control across the whole of the CCG's activities

During 2020/21, the Committee reviewed a number of internal audit reports and action plans; these are listed in the Head of Internal Audit Opinion section of this Governance Statement. In addition, the Committee has oversight of and receives regular reports on:

- The management of risk including the Governing Body Assurance Framework and Corporate Risk Register
- Counter fraud
- The management of interests including gifts and hospitality
- The management of Freedom of Information requests
- Waivers of standing orders and standing financial instructions

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body and makes recommendations about the remuneration fees and other allowances (including pension schemes) for employees not covered by Agenda for Change terms and conditions and other individuals who provide services to the CCG. Our Remuneration Committee is chaired by the Governing Body Lay Member for Patient and Public Involvement. Membership of the Committee and attendance are detailed in table 4.

Primary Care Commissioning Committee

As a CCG with delegated authority for the commissioning of primary medical care, we have established a committee that oversees the contracting of general practice services within the context of the CCG strategic plan. The Committee was chaired by the Governing Body Independent Registered Nurse up to October 2020 when the Governing Body Lay Member for Patient and Public Involvement took on the role of Chair. The Committee met on-line due to the restrictions in place in response to the Covid-19 pandemic.

The meetings held in April and May were not open to the public as we developed digital approaches to support the meetings. From June these meetings were open to the public. The papers for these meetings are available on our website. Membership and attendance at meetings are detailed in table 4.

The Committee receives monthly reports on primary care contracts, quality and financial performance. Contract reports cover all core contracts and performance relating to improved access and enhanced services. Contractual changes, including requests for mergers, boundary applications and temporary closures are considered by the Committee. Reports on primary care quality include regular 'deep dives' in key aspects of quality. Throughout the year the Committee received specific reports about the Bristol, North Somerset and South Gloucestershire Primary Care response to the Covid-19 pandemic and the recovery phase.

Our Internal Auditors gave our primary care delegated commissioning arrangements an audit opinion of substantial assurance.

Clinical Executive

During the year our Commissioning Executive changed its name to Clinical Executive, reflecting its clinical membership and its focus on the clinical leadership of commissioning. The Clinical Executive is accountable to the Governing Body. The Committee's remit includes development of the CCG's commissioning strategy and operational plan, and the CCG's procurement strategy. The Committee considers plans for the procurement of new services and disinvestment from existing services making, recommendations to the Governing Body where necessary. The Committee considers commissioning policies and individual funding policies and procedures, making recommendations to the Governing Body where appropriate. The Committee reviews provider performance against contracts, agreeing actions to be taken and monitoring improvement. The Committee's membership is primarily made up of CCG Clinical Leads and the Executive Team. Attendance at meetings is detailed in table 4. The Committee received specific reports about the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase.

During 2020/21 the Committee received monthly reports on urgent care and the schemes established to support performance, Individual Funding Requests and the

Corporate Risk Register and Governing Body Assurance Framework. The minutes of the Committee are available on our website (https://bnssgccg.nhs.uk/events/).

Quality Committee

The Quality Committee is chaired by the Governing Body Independent Registered Nurse and is accountable to the Governing Body. The Committee is responsible for ensuring that there is a cohesive and comprehensive structure in place for the oversight and monitoring of the quality of commissioned services, including patient safety, safeguarding children and young people and vulnerable adults and patient experience. This includes performance against NHS Constitution Standards. The Committee provides the Governing Body with assurance that CCG quality system and processes are robust, that commissioned services are being delivered in a high quality and safe manner, and that all relevant statutory and regulatory obligations are met. The Committee provides assurance that effective processes are in place for safeguarding children, young adults and vulnerable people. The Committee considers the CCG Improvement and Assessment Framework Clinical Indicators and assures plans to improve performance against clinical priority areas. The membership and attendance at meetings are detailed in table 4.

During 2020/21 the Committee received monthly reports from the Quality Surveillance Group, provider organisation risk registers, quality and performance, the Corporate Risk Register and the Governing Body Assurance Framework. Quarterly reports on Safeguarding for both Children and Adults, and Looked After Children were received. Other quarterly reports included patient experience reports, primary care quality reports, Individual Funding Requests, Serious Incident Reports, and Healthcare Acquired Infections. Regular reports were received focusing on mental health service provider quality assurance, Healthcare Acquired Infections, South West Ambulance Service performance, the review of Continuing Healthcare, Serious Case reviews and Domestic Homicide Reviews, Learning Disability Mortality Review reports, SEND activities, care home quality, updates on Contract Performance Notices, workforce assurance reports, and reports on the Improvement and Assessment Framework. The Committee received specific reports about the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase. The minutes of the Committee are available on our website (https://bnssgccg.nhs.uk/events/).

Strategic Finance Committee

The Strategic Finance Committee is accountable to the Governing Body and is chaired by the Lay Member, Strategic Finance. The Committee considers all draft strategic and financial plans prior to their submission to the Governing Body for approval, including the financial plans associated with the CCG's Operational Plan and savings plans. The Committee monitors the longer term financial strategic direction of the CCG, the delivery of savings plans and the CCG's in year financial performance, identifies key issues and risks requiring discussion and decision by the Governing Body. The Committee has oversight of procurements.

During 2020/21 the Committee received monthly reports on the financial position, the Financial Recovery Plan which included Control Centre deep dives, procurement plans and the Corporate Risk Register and Governing Body Assurance Framework. The Committee received specific reports about the strategic financial impact of the Bristol, North Somerset and South Gloucestershire response to the Covid-19 pandemic and the recovery phase.

The membership and attendance at meetings are detailed in table 4. The minutes of the Committee are available on our website (https://bnssgccg.nhs.uk/events/).

Patient and Public Involvement Forum

The Patient and Public Involvement Forum was placed on hold due to organisational pressures relating to COVID-19 on March 2020. In the absence of a full Patient and Public Involvement Forum governance process, a working group was convened, chaired by the Governing Body Lay Member for Patient and Public Involvement. The working Group included the chairs of each of the Area Patient and Public Involvement Forum, and the key anchor organisations as outlined in the Terms of Reference of the Patient and Public Involvement Forum. The group received updates on our response to COVID-19 through March, April and May 2020 and more formalised Patient and Public Involvement Forum working group meetings were held in August 2020, November 2020 and February 2021. Key areas discussed included:

- updates around engagement activities specifically relating to COVID-19 (for example Listening events and the development of an Equality Impact Assessment thematic report from the programmes responding to COVID-19),

- planning for a public consultation around the reconfiguration of Stroke Services,
- the 111 First programme for Urgent Care services and
- developments in response to the government white paper on legislative proposals for a Health and Care Bill including our designation as an Integrated Care System (ICS) and the development of Integrated Care Partnerships (ICP)

(table 4) **Attendance at Governing Body Meetings and its Committees**

Name	Title	number of meetings attended in 2020-21							
		GB	Audit	Rem	Com Exec	Quality	SFC	PCCC	
Dr Jonathan Hayes	Clinical Chair, Chair of Commissioning Executive	10/12			9/12		0/3		
Dr Kirsty Alexander	GP Locality Representative Bristol North and West	12/12			11/12				
Colin Bradbury	Area Director North Somerset	9/12			9/12			7/9	
Dr Peter Brindle	Medical Director Clinical Effectiveness	12/12			11/12	10/12			
John Cappock	Lay Member, Chair of Strategic Finance Committee May 2019 – present	12/12	5/5	1/1			12/12		
Deborah El-Sayed	Director of Transformation	12/12			10/12				
Dr Jon Evans	GP Locality Representative South Gloucestershire	12/12			10/12				
Dr Felicity Fay	GP Locality Representative South Gloucestershire	10/12							
Dr Kevin Haggerty	GP Locality Representative Weston and Worle	10/12			11/12				
Dr Brian Hanratty	GP Locality Representative Bristol South	11/12					8/9		
David Jarrett	Area Director South Gloucestershire	10/12			9/12			8/9	
Dr Martin Jones	Medical Director Commissioning and Primary Care	5/8			3/9	4/8		8/8	
Dr Nick Kennedy	Independent Secondary Care Doctor	12/12	5/5	1/1		12/12			
Dr Rachael Kenyon	GP Locality Representative Woodspring	8/12							
Dr Umber Malik	GP Locality Representative Bristol Inner City and East	5/6							
Lisa Manson	Director of Commissioning	12/12			12/12	6/12		5/9	
Alison Moon	Independent Registered Nurse, Chair of PCCC (April- Sept 2020) and Quality Committee	12/12		1/1		12/12		9/9	
Julia Ross	Chief Executive	12/12			11/12		9/12	7/9	
John Rushforth	Lay Member, Chair of Audit Governance and Risk Committee	11/12	5/5	1/1			12/12	9/9	
Rosi Shepherd	Director Nursing and Quality - January 2020 - present	12/12			10/12	10/12		6/9	
David Soodeen	GP Locality Representative Bristol Inner City and East	2/4			12/12				
Sarah Talbot Williams	Lay Member, Patient and Public Involvement Chair of Remuneration Committee, Patient and Public Involvement Forum and PCCC (Oct 20- March 21)	12/12		1/1		12/12		9/9	
Sarah Truelove	Chief Financial Officer	12/12			10/12		9/12	8/9*	

Christina Gray	Director of Public Health Bristol	8/12						
Andrew Appleton	Clinical Corporate Lead - Digital				9/12			
Sara Blackmore	Director of Public Health, South Gloucestershire Council				0/12			
Alison Bolam	Clinical Commissioning Area lead – Bristol				8/12			
Geeta Iyer	Clinical Corporate Lead - Primary Care Provider Development				11/12			
Michael Jenkins	Clinical Care Pathway Lead - Integrated Care				5/12			
Jeremy Maynard	Clinical Corporate Lead – Quality April 2019-January 2020				0/12			
Shaba Nabi	Clinical Corporate Lead - Prescribing				10/12			
David Peel	Clinical Care Pathway Lead - Planned Care				9/12			
Lesley Ward	Clinical Care Pathway Lead - Unplanned Care				10/12			
Alison Wint	Clinical Care Pathway Lead - Specialised Care				12/12			

*or nominated deputy

Annual Assessment of Committee Effectiveness

Our Governing Body committees carry out an annual assessment of effectiveness using a self-assessment checklist. Actions arising from the 2019/20 reviews were added to committee work programmes. The committees completed their annual assessment of effectiveness for 2020/21 in February 2021. Actions arising from the 2020/21 self-assessment will be included in the Committee work plans for 2021/22.

The Governing Body agreed in December 2020 to a three-year programme of review with one annual review conducted by an external body and two annual reviews conducted using internal resources. The internal reviews will be used to focus on specific themes for further exploration in the external review. A Well Led Review was subsequently commissioned. The final report will be available in summer 2021 and will be used to inform the governance arrangements for the new NHS ICS organisation to be established in April 2022. The outcomes of the Well Led Review will be reported in the 2021/22 Governance Statement.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. We have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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 and powers, supported where appropriate by resources commissioned from South Central and West Commissioning Support Unit (SCWCSU).

Risk management arrangements and effectiveness

Our Risk Management Framework defines the structures for the management and ownership of risk. It encapsulates our attitude to risk and defines how risks are dealt with and by whom. The Framework is updated annually and was last updated and approved by the Governing Body in November 2020. The Framework was updated to include the recommendations set out in the Risk Management Framework Internal Audit Report. These recommendations and our actions in response are detailed at page 79 of this statement.

Integrated governance including financial governance is assured through the Audit, Governance and Risk Committee and the Governing Body. The Governing Body receives the minutes of all of its committees, including the Audit, Governance and Risk Committee. The Audit, Governance and Risk Committee is responsible for the oversight of the Risk Management Framework, providing assurance to the Governing Body that the CCG has established an effective system of risk management and internal control. Key committees with responsibility for the management of risks are the Quality Committee, Strategic Finance Committee and Clinical Executive Committee. These committees are responsible for the review and scrutiny of specific risks and seek assurance that risks are properly managed. If a committee is not assured that risks are being properly managed that concern is escalated to the Governing Body.

The Risk Management Framework includes a statement on Risk Appetite. The Governing Body reviewed its Risk Appetite Statement in April 2021.

The Governing Body Assurance Framework identifies where there are risks to our principal objectives, the controls in place to mitigate those risks, and the assurances available to the Governing Body that risks are being managed. The Governing Body Assurance Framework indicates where there are potential gaps in controls and assurances and provides a summary of the actions in place to resolve these gaps. Our Governing Body Assurance Framework is reviewed by directors and is considered by the Governing Body committees as a standing item at their monthly meetings. The Audit, Governance and Risk Committee reviews the Governing Body Assurance Framework at its meetings. The Primary Care Commissioning Committee

and the Governing Body review the Governing Body Assurance Framework quarterly.

Risks are identified in a number of ways, including risk profiling through our programme management approach, incident reporting, complaints and litigation, data analysis, staff concerns/whistle blowing, and external and internal audit reports and other regulatory reporting mechanisms.

Risks are evaluated and assessed using a risk scoring matrix which is set out in our Risk Management Framework. Risk is reported through our Directorate and Corporate Risk Registers. Our Corporate Risk Register holds risks that have reached the CCG's risk threshold of 15 and above. It is reviewed by directors as a standing item at Executive Team meetings and is considered by the Governing Body committees as a standing item at their monthly meetings. The Audit, Governance and Risk Committee reviews the Corporate Risk Register at its meetings, the Primary Care Commissioning Committee, and the Governing Body review the Corporate Risk Register quarterly.

The assessment of risk is embedded within the reporting arrangements for the Governing Body and its committees as part of our standard template, which requires risks to be highlighted. Equality Impact Assessments are used to assist with the identification and mitigation of risks linked to inequalities. Equality Impact Assessments also form part of the standard template for papers to our Governing Body and committees.

There is a process in place for the reporting, investigation, management and learning from incidents. All serious incidents and risks are reported through incident reporting procedures, and the Risk Management Framework refers to our incident reporting procedures and Serious Reporting Policy. Incident reports and trends are used to identify risks, and this is detailed in the Risk Management Framework.

There is commitment to involving patients and members of the public at every stage of the commissioning cycle and this ensures ongoing opportunities for public stakeholders to highlight relevant risks and engage in discussions around how to mitigate them.

In support of the Risk Management Framework and Policy, the CCG has adopted policies that describe its arrangements for managing conflicts of interest and gifts

and hospitality, and our approach to tackling fraud and bribery. We have agreed detailed financial policies and have in place a Fraud and Bribery Policy.

Capacity to Handle Risk

It is the policy of the CCG to identify, minimise, control and, where possible, eliminate risks that may have an adverse impact on patients, staff and the organisation. As Accountable Officer, I carry ultimate responsibility for all risks within the CCG.

Our Risk Management Framework describes the governance structures and responsibilities for risk management within the organisation including the roles of the Governing Body and its committees. The Risk Management Framework requires the identification, management and minimisation of events or activities that could result in unnecessary risks to patients, staff, visitors and members of the public. The CCG is committed to possessing the attributes associated with an active learning organisation where lessons learned are embedded into the organisation's culture and practice.

The Risk Management Framework is available on our website https://bnssgccg.nhs.uk/library/risk-management-framework/. Following the findings of an internal audit into our arrangements for the management of risk, we reviewed and significantly updated our Risk Management Framework. This strengthened and highlighted the responsibilities of the CCG committees for the oversight of risk and the roles of the executives in ensuring risks are reviewed, monitored and updated.

The responsibility for risk management sits with me and the Deputy Chief Executive and Chief Finance Officer who takes an active role in managing risk and provides challenge and oversight.

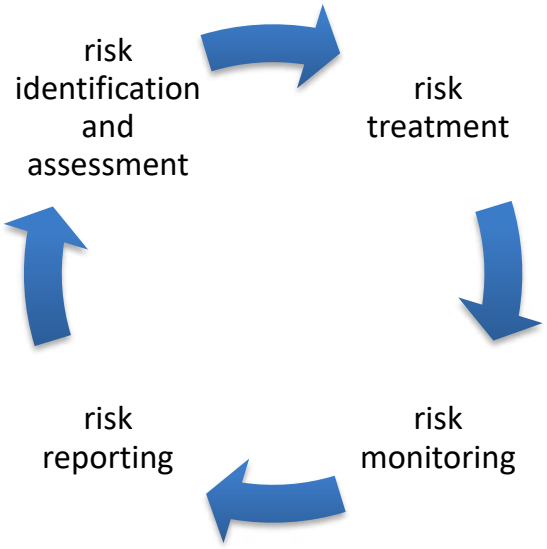
Risk is monitored through a structured reporting cycle. The Governing Body receives monthly reports on performance and quality, and finance. These reports provide timely, accurate data, which supports our Governing Body in the assessment of risks to our compliance with statutory obligations. The Governing Body and Primary Care Commissioning Committee review quarterly the Governing Body Assurance Framework and the Corporate Risk Register. The Governing Body is supported in its monitoring of risk by the Audit Governance and Risk, Quality Committee, Strategic Finance Committee, and Commissioning Executive. The Governing Body's regular

review and interrogation of these reports and other ad hoc reports enable it to have a robust and rigorous oversight of performance.

Staff are required to undertake training for the management of risk where relevant. In addition to core risk management training, training sessions are held and e-learning is available for key topics such as health and safety, manual handling, basic life support, infection control, fire safety, conflict resolution and information governance. Our employees must attend the courses or undertake e-learning on an annual, bi-annual, or three-yearly basis, as appropriate to their role. Learning is taken from good practice, performance management, continuing professional development where relevant, audit and the application of evidence based practice.

Risk Assessment

Our risk assessment and management process, as described above, is set out in the diagram below.



Risks are identified and assessed using a risk-scoring matrix, risks are analysed, the actions required to mitigate them are identified and implemented and the impact of these mitigations is monitored. Risk reporting to the Governing Body and its committees is through the Governing Body Assurance Framework and the Corporate Risk Register. Major risks to governance, risk management and internal control in 2020/21 that have affected the CCG are detailed below and at page 73 'Control Issues':

- As a result of the impact of Covid-19 there is a risk that the need to focus capacity to meet the demands on the system may result in the system and the CCG not delivering the objectives identified in the Governing Body Assurance Framework
- As a result of not being able to get the commitment needed across the system we are unable to develop effective ways of working to deliver performance, financial and population health outcomes in line with the system aims
- Without all system partners having strong engagement, understanding, shared purpose and commitment to developing ICPs, there is a risk that improvements in health outcomes and the benefits of ICPs are not achieved
- As a result of COVID 19 there is a risk that demand for MH services will increase by up to 30%which may result in a poorer access and outcomes for people, increased level of MH crisis and further spend on aspects of services like out of area placements and S117
- As a result of a lack of integrated services there is a risk that we reduce the life choices for individuals with learning disabilities and autism which may result in widening of health inequalities and the health of the population in the future
- Integrated children's commissioning with Local Authorities is not fully developed, there is a risk that we are not optimising the care children receive and impacting on their life course
- As a result of a lack of regular and accurate data, there is a risk that decisions made to support the transformation are not data driven which may result in not achieving 'leading' on the maturity framework, a poor service for the individuals and inequalities in the way we support our population
- There is a risk that a coherent People Plan for the CCG may not be developed and delivered if we do not bring together the many existing work streams into one clear programme, develop an understanding of our current state of readiness and meaningfully engage with our workforce in the plan's development and ownership
- As a result of the current culture driven by Payment by Results there is a risk that there will be a continuing focus on activity rather than value which may

result in failure to deliver improved population health and financial sustainability for the CCG and the system.

Other reported risks included:

- Increased waiting times across key services including A&E, 52 week waiting times, access to planned care and diagnostic services and cancer waiting times, waiting times for MSK services and ADHD services
- Patients were at risk of potential harm through contracting Healthcare Associated Infections
- Increased risk of health inequalities for cancer patients due to delays in diagnosis
- Risk to the establishment of the IPS Mental Health service
- Risk to the delivery of the Long Term Plan due to the impact of Covid-19

Other sources of assurance

Internal Control Framework

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

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

Our system of internal control is described through our Standing Orders, Scheme of Reservation and Delegation, and Detailed Financial Policies. These ensure compliance with our statutory requirements for the management of governance. Internal audit and the counter-fraud service provide an independent review of our internal controls.

The risk assessment component of our internal system of control is contained in our Risk Management Framework and Policy. The Governing Body Assurance Framework provides an overview of controls and assurance in place to achieve the CCG's principal objectives.

Our Governing Body has a clear understanding of the key pressures facing the organisation. A key element of our control is providing assurance through regular reporting to the Governing Body, which includes a range of reports including but not limited to:

• Audit and assurance reports

• Minutes of committees of the Governing Body and other key groups

• Strategic planning

• Reports on patient safety and quality of clinical care

• Performance management

• Financial management

Our procurement activities are carried out within the framework of control set out in legislation and regulation. The CCG has a range of policies relating to information governance, human resources, health and safety, equalities and diversity, and emergency preparedness and resilience, all of which contribute to the internal control framework.

As Accountable Officer, I am responsible for reviewing the effectiveness of the system of control and for providing leadership and direction to staff. Other members of the Executive Team have lead responsibility for the specific systems of control as set out below:

Deputy Chief Executive/Chief Finance Officer:

- Governance framework and risk management framework,
- Financial controls and financial risk
- Management of information governance and related risks as the Senior Information Risk Officer (SIRO)
- Customer experience and complaints

Director of Nursing and Quality:

- Quality of commissioned services
- Patient safety and safeguarding

The Director of Commissioning:

- Arrangements for commissioning of services, including procurement
- Performance of commissioned services

The role of all of our Executive Directors is to ensure that appropriate arrangements and systems are in place so that risks are:

- identified and assessed
- eliminated or reduced to an acceptable level
- effectively managed

Executive Directors ensure that staff comply with our policies and procedures and statutory as well as regulatory requirements.

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.

I can confirm that the annual internal audit of Conflicts of Interest has been completed and the CCG received an internal audit opinion of 'Substantial assurance'. There were no areas where the CCG was found to be either partially compliant or non-compliant.

Data Quality

The information used by the Governing Body and its Committees enables the CCG to carry out its responsibilities and discharge its statutory functions. Information is strategic operational, financial, or relates to performance, quality and patient experience. The Governing Body and its Committees are engaged in a continuous cycle of improvement with regard to the quality of the information received. The reports received have undergone regular review and improvement. The Governing Body has found the quality of data to be acceptable. No risks relating to the quality of data were highlighted in 2020/21.

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 an information governance 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. The Data Security and Protection Toolkit for 2020/21 is on track to achieve the status of 'Standards Exceeded' by the 30th June 2021 deadline. An independent assessment of the Data Security and Protection Toolkit for 2020/21 will be undertaken before submission as part of the internal audit process

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient, staff and corporate information. We have established an Information Governance Management Framework and have developed information governance processes and procedures in line with the Information Governance Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff Data Security and Information Governance Handbook to ensure staff are aware of their information governance roles and responsibilities.

Information risk management is considered to be the responsibility of all staff. Our Chief Financial Officer is the Senior Information Risk Owner (SIRO) and is responsible for providing assurance to the Governing Body and to me regarding information governance. The SIRO is familiar with, and takes ownership of, information risk management, acting as advocate for information risk management on the Governing Body. The Director of Nursing and Quality is our Caldicott Guardian, actively supporting the CCG and enabling information to be shared where appropriate.

There are processes in place for incident reporting and the investigation of serious incidents and this encompasses information governance. The NHS Digital Guide to the Notification of Data Security and Protection Incidents is used in the investigation of all information governance related incidents.

Business Critical Models

I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models, in line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models.

Third party assurances

The CCG purchases services from the South Central and West Commissioning Support Unit. These services include HR, procurement, IT, and information governance support. Independent assurances on these services are provided through service auditor reports. Day to day assurance of the above services is achieved through regular performance meetings attended by senior members of staff from both organisations. The Service Auditor Reports are shared with the CCG's Chief Financial Officer, and reviewed, and reported through the Audit, Governance and Risk Committee via the Internal Auditors. The Internal Auditor reviewed:

- The Service Auditor Report from the internal auditors of NHS Shared Business Services who provide services to the CCG. The report was unqualified for 22 out of 23 control objectives. The exception identified related to the operating effectiveness of controls relating to the authorisation of manual credits. Management actions are in place to address the issue.
- The Service Auditor Report from the internal auditors for NHS Digital in regards to GP Payments. Testing for one of the controls (controls were in place to provide reasonable assurance that access to systems is controlled) identified an exception, but there was no significant impact for the CCG on its overall control environment.
- The Service Auditor Report from the internal auditors for NHS Business Services Authority in regards to prescription payments. Exceptions were identified on testing for three of the controls although there was no significant impact for the CCG on its overall control environment.
- The Service Auditor Report from the internal auditors for the South Central and West Commissioning Support Unit covering financial and payroll services. This received a Qualified Opinion as one control was found not to operate effectively

during the period from 1st April 2020 to 31st March 2021. There was no significant impact for the CCG on its overall control environment.

Capita Business Services Limited provides primary care support services for processing GP, ophthalmic and pharmacy payments and pensions administration. Assurance is provided within an Independent Service Auditor's ISAE 3402 third party assurance report, which informs the CCG's Annual Governance Statement. The Service Auditors noted minor exceptions on three out of 16 control objectives, controls for two of the areas could not be operated throughout the financial year due to operational changes made because of the pandemic.

Control Issues

The following control issues and remedial actions were identified and reported in the 2020/21 Month 9 return to NHS England:

Issue: Quality and Performance – Mental Health

Mitigation: The CCG, with public health colleagues, has led the Bristol, North Somerset and South Gloucestershire system response to the Covid-19 pandemic affecting people's mental health and has developed a mental health business case. We meet weekly with Avon and Wiltshire Partnership Trust to discuss the issues.

Issue: A&E Performance is not delivered to NHS Constitution Standards

Mitigation: A&E performance has been significantly challenged as a result of the Covid-19 pandemic. An agreed winter plan is refreshed monthly to mitigate forecast bed deficits, with a focus on community admission avoidance and discharge schemes, including extra investment in community beds. Additionally, a three-phase COVID surge plan was agreed in early November and is being used to complement existing daily OPEL system escalation processes to create extra capacity in the system and improve performance. Strategic IPC support is in place to support providers managing outbreaks.

Issue: RTT is not delivered to NHS Constitution Standards

Mitigation: COVID-19 and its disruption to wider healthcare performance has acutely affected planned care performance. In response to these challenges, our system agreed a plan to increase elective activity for September 2020 to April 2021.

Issue: Ambulance services

Mitigation: Whilst maintaining strong resourcing levels, the ambulance service has experienced increased levels of activity and high levels of hospital handover delays, which increased the amount of cases waiting in the clinical call stack and affected performance levels, especially Category 2 and Category 3 performance. To mitigate the handover delays and improve performance, actions taken have included increasing ambulance validation in 111, developing access to 24/7 mental health crisis services, developing direct referral protocols and alternative destinations to ED, developing the directory of services, and the implementation of safely reducing avoidable conveyance schemes such as improved access to care plans.

Issue: Finance, Governance and Control - Internal Audit

Mitigation: Audit Opinions of Partial Assurance have been received in relation to Risk Management and Appraisals. Actions to address issues identified in the audits are detailed in the Head of Internal Audit Opinion of this statement, at page 78.

Review of economy, efficiency & effectiveness of the use of resources

We undertake a comprehensive range of contract monitoring, benchmarking and budget monitoring to ensure the robust management of our resources.

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance.

Detailed performance, quality and finance reports, which include the use of comparative analysis to assess performance, are presented at each Governing Body meeting. These reports provide an overview of progress against key indicators and financial objectives.

Our Audit, Governance and Risk Committee oversees internal and external audit, reviews financial and information systems and monitors the integrity of the financial statements. The Audit, Governance and Risk Committee receives regular reports from Internal and External Audit as well as Counter Fraud. External Audit, as part of its audit plan, reviews the CCG's governance arrangements to identify whether it has in place appropriate arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our Standing Orders, Scheme of Reservation and Delegation and Detailed Financial Policies underpin the use of economic, efficient and effective resources. These are supplemented by budgetary controls and commissioning and other policies and procedures. The Internal Audit Reports relating to our main accounting process have provided assurance regarding these arrangements.

Regular contract management processes are established with main providers to link service quality, performance and financial management; these have been adapted to reflect the system response to the Covid-19 pandemic.

Financial planning and in-year performance monitoring

In response to the Covid-19 pandemic, NHS England and Improvement suspended the routine NHS financial performance management regime and throughout most of the financial year, enacted Level 4 Incident powers which enabled NHS England and Improvement to direct NHS resources. The CCG operated under two distinct financial frameworks during the year:

April - September

The CCG was not required to submit a financial plan for April to September, but was instead subject to a more simplified financial management regime where budgets were largely set nationally based on previous year spend and a ‘top up’ to expected breakeven and with fixed ‘block’ payments to NHS providers. Additional costs of managing the Covid pandemic and other reasonable over and underspends were then adjusted each month to continue to deliver a balanced financial position.

October - March

The CCG was required to prepare and submit a financial plan to NHS England for period October 2020 to March 2021, including accounting for expected additional Covid costs. The plan was prepared at ‘system’ level with prospective allocations for additional Covid costs, a ‘top up’ allocation to expected breakeven for all NHS organisations, and some growth funding for service development in the second half of the year to support recovery of elective care services and meet policy objectives in mental health and primary care.

Outside of this funding envelope, the CCG continued to claim reimbursement for some specific costs of managing the Covid pandemic, notably the Hospital Discharge Programme and locally commissioned independent sector capacity.

Two other notable changes to the finance regime were that:

- NHS England used executive powers to manage the pandemic to remove commissioning responsibility for most major independent sector hospitals and directly commission nationally
- Non Contract Activity with NHS provider Trusts below a £200k de-minimus was not chargeable and providers were reimbursed nationally via the 'top up' regime

Taken in the round these changes ensured that:

- Unplanned additional costs of the Covid pandemic were able to be funded and decisions made promptly
- Inter-NHS commissioning and contracting did not become a barrier or additional burden on the service
- There remained a mechanism for ensuring value for money
- Progress was made on the Long Term Plan objective of 'system by default' working

These initiatives align to the NHS and CCG long-term financial objectives, but caution should be applied when making year on year comparisons of expenditure, or relative activity and performance levels

In response to this, a number of actions have been taken:

- The Audit Governance and Risk Committee and Strategic Finance Committee have received regular briefings on these changes
- Routine and significant reviews and updates of Finance, Information and Corporate Services Directorate Risk Register
- Periodic reviews of the CCG's financial governance arrangements
- Commissioned an advisory internal audit on the impact of system decision making on CCG control environment

- Provision of greater levels of information on the provider sector financial position

Alongside this, where practicable and proportionate, existing financial control mechanisms were maintained.

We have clear and appropriate controls in place for the planning and monitoring of our financial activity including the development and monitoring of savings programmes through a robust programme management approach.

A detailed internal budgeting process and reconciliation to the Long Term Financial Plan has been established to support delivery of the financial plan.

Regular financial monitoring and reporting arrangements exist and these are accompanied by actions to address emerging financial risks, and development and delivery of recovery plans.

There is robust challenge from the Strategic Finance Committee on the CCG's financial performance, including contract monitoring and the delivery of savings programmes, along with further review from the Governing Body.

Central management costs

Our central management costs are contained within our Running Cost Allowance. The CCG identified and delivered savings to achieve the reduced Running Cost Allowance of £18.3million in 2020/21.

Delegation of functions

Where the CCG has chosen to commission business functions from other organisations, services are managed against a service level agreement and subject to regular performance review and independent audit where applicable.
The CCG commissions the South Central and West Commissioning Support Unit to provide a number of services. Feedback is gained on business, use of resources and responses to risk through independent assurance, principally Service Auditor Reports.
The CCG receives general ledger services from Shared Business Services Limited, and payroll services from North Bristol Trust.

Counter fraud arrangements

An annual Counter Fraud Plan is overseen by the Audit, Governance and Risk Committee and focuses on fraud prevention and deterrence. We have a Counter

Fraud Bribery and Corruption Policy, which helps staff to understand in simple terms what fraud, bribery and corruption are and contains useful guides on how to identify fraud together with details on how to report and how cases will be dealt with. The policy also emphasises that it is the responsibility of all staff to work to prevent fraud and protect the assets of the NHS. The policy is supported by the Management of Conflicts of Interest and Gifts and Hospitality Policies, which set out the honest, transparent and accountable culture that the Clinical Commissioning Group expects. A Local Counter Fraud Specialist (LCFS) is contracted by the CCG to provide counter fraud training to all staff as part of the staff induction programme. Counter Fraud training is also a mandatory element of the CCG e-learning programme.

Our Chief Finance Officer is responsible for overseeing and providing strategic management and support for all counter fraud, bribery and corruption work within the organisation. The Counter Fraud Specialist works in consultation with the Chief Finance Officer to identify and report cases of actual or suspected fraud and will ensure that learning identified from any subsequent investigation is implemented.

The Audit, Governance and Risk Committee receives an annual report against each of the Standards for Commissioners, and identified risks are addressed in an annual work plan that is overseen by the Committee.

Appropriate action is taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations, in line with NHSCFA Standards.

Head of Internal Audit Opinion

Following completion of 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 an overall Head of Internal Audit Opinion that:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

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

Area of Audit	Level of Assurance Given
Conflicts of Interest	Substantial Assurance
Risk Management	Partial Assurance
Key Financial Controls - Payments to Staff	Reasonable Assurance
Cyber Security – including GP IT	Reasonable Assurance
Appraisals	Partial Assurance
Governance – EPRR	Substantial Assurance
Out of Area Placements	Reasonable Assurance
Safeguarding	Reasonable Assurance
Primary Care Delegated Commissioning	Substantial Assurance
Financial Management and Controls	Advisory only

The control issues identified in the Risk Management and Appraisals audit reports and the actions and progress to date include (table 5):

Control Issue leading to the conclusion	Management Action progress to date
Appraisals Audit	
The requirements of the Appraisal Policy and the functionality for line managers viewing reports on ConsultOD will be further promoted across the CCG, with Directors and line managers responsible for escalating the message and culture of compliance through their teams.	The requirement to complete appraisals has been discussed at the CCG's Strategic Development Forum with senior leaders recognising the importance that appraisal have in the support, development and management of staff and their engagement in meaningful working relationship. Information sources have been shared and the work to update the accuracy of the ESR database will support managers being able to view information about direct reports.
Sourcing information from ConsultOD to monitor compliance for addressing at directorate meetings	Work to update the accuracy of the ESR database is in the final stages and the Director and Exec PA will have access to directorate information as a result. This will be completed by the end of April
Risk Management Framework Audit	

The risk management framework (RMF) will be reviewed and updated to include: • a review of guidance from the HM Treasury Orange book and other risk management standards; • consideration of how dependencies are mapped where risks are influenced by external stakeholders • the risk register templates will be amended to group risk and their inherent scores, with controls and residual scores following to help frame the impact of the work undertaken to control the risk; and • risk being reviewed and linked to the relevant committee that provides scrutiny in that area, with assurance provided to the Audit, Governance and Risk Committee on these risks.	• Review completed and Framework updated to reflect recommendations. • Revised Framework agreed by Governing Body Nov 2020 • Risk Register templates updated and to be adopted April 2021 • Committees roles strengthened in terms of reference and framework to highlight scrutiny and oversight of risk • Reports to Audit, Governance and Risk Committee show committees review risks and recommend actions to the Governing Body • Exploration of other methods of providing assurance to Audit, Governance and Risk Committee ongoing at Feb 2021
The updated Risk Management Framework will be communicated across the CCG, with supporting training for the directorate risk leads who will disseminate through their individual directorates. With focus upon risk descriptions, inherent versus residual scores, wording mitigating actions and links to the Governing Body assurance framework.	Framework has been shared through internal networks and training sessions held with 4 or 6 directorates. Sessions planned for remaining 2 directorates
The Governing Body will develop the existing risk appetite statement to provide enhanced guidance on the level of risk it is willing to be exposed to in pursuit of its objectives. This includes identification of levels of risk that can be accepted in pursuit of objectives and mapping of risk appetite to risk scores to highlight where risks are in excess of the Governing Body's appetite.	Risk Appetite has been reviewed
The framework for how the Governing Body and its sub-committees review and scrutinise risks will be revisited to ensure suitable oversight of key risks (see Action 1.1 above). This	Terms of reference for all committees updated to reflect role scrutiny and oversight of risk and included in framework

responsibility will be updated within each set of terms of reference	
The Governing Body will agree areas for which subcommittees should seek assurance that risks to corporate objectives are managed effectively and challenge risk management through regular deep dives of directorate and corporate risks. Standing agenda items with suitable time allotted will be included for each sub-committee meeting and detailed minutes will be kept to evidence the scrutiny undertaken and assurance gained.	• agree areas for which subcommittees should seek assurance agreed by governing body and committees and recorded on CRR and on GBAF • Agenda items given appropriate time for discussion • minutes reflect discussions

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 implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, and Audit, Governance and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place:

• The Audit, Governance and Risk Committee agrees an annual plan for work to be undertaken by Internal Audit focusing on areas of particular concern or risk. Reports are made to the Committee on audit findings, with assurance and recommendations being given. Discussions are also held with the External Auditors regarding audit plans, and regular reports are made to the Audit Committee on progress and findings.

• The Audit, Governance and Risk Committee reports to the Governing Body on the development, implementation and monitoring of integrated governance by providing assurance on the systems and processes by which the CCG leads, directs and controls its function in order to achieve organisational objectives, safety and quality of service.

• Internal Audit and Counter Fraud provide assurances through their reports on various aspects of internal control to the Audit, Governance and Risk Committee. These reports also provide assurances and support for the work undertaken by the external auditors.

• The Governing Body receives reports on significant risk identified through the risk register and Governing Body Assurance Framework reports

Conclusion

With the exception of the control issues identified and reported in the 2020/21 Month 9 return to NHS England, no significant control issues have been identified during the year.

Remuneration and Staff Report

The Remuneration and Staff Report provides information about the remuneration of our directors and senior managers, and other matters such as compensation on early retirement or for loss of office, any payments to past directors, the fair pay disclosure and staff numbers and costs. We also report on staff sickness absence, key staff policies, how we engage with staff, and our Freedom to Speak Up arrangements. This is in line with corporate governance best practice.

Remuneration Report

Remuneration Committee and our policy on the remuneration of senior managers and Very Senior Managers

The Remuneration Committee makes recommendations to the Governing Body about the remuneration and allowances for Very Senior Managers (VSM) and persons in senior positions within the CCG. Details of the members of the Committee are given in the Governance Statement in this report.

The policy on the remuneration of VSM, including members of the Governing Body, has been set using NHS England guidance. We have applied national remuneration guidance for VSM pay for 2020/21 and will continue to apply this guidance for the foreseeable future.

Remuneration of Very Senior Managers

Advance approval of the Chief Secretary to the Treasury (CST) is required for remuneration packages at £150,000 or above. Where we have VSM roles that fall into this category we have to complete business cases for the posts, taking into consideration:

- Influence and impact of role
- The specialist nature of the role including the skills and experience required
- Labour market considerations
- Relevant supporting benchmarking data
- The package of the previous incumbent or any obvious comparators
- Only when appropriate, biographical information

Very senior manager remuneration (including salary and pension entitlements)

Table 6 This Statement is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements

				2020-2021						2019-2020					
		Start Date	End Date	Salary	Expense payments (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 (Note 6)	Total
				(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
								(Note 9)							
Julia Ross (note 11)	Chief Executive	01/04/2018	31/03/2021	160-165	0	0	0	0	30-35	160-165	0	0	0	225-227.5	385-390
Jon Hayes	Clinical Chair	01/04/2018	31/03/2021	80-85	0	0	0	0	80-85	80-85	0	0	0	20-22.5	100-105
Sarah Truelove	Deputy Chief Executive/Chief Finance Officer	01/04/2018	31/03/2021	150-155	0	0	0	0	150-155	150-155	0	0	0	0	150-155
Lisa Manson	Director of Commissioning	01/04/2018	31/03/2021	130-135	0	0	0	25-27.5	160-165	130-135	0	0	0	0	125-130
Rosalind Shepherd	Director of Nursing and Quality	01/01/2020	31/03/2021	105-110	0	0	0	150-152.5	255-260	20-25	0	0	0	30-32.5	55-60
Deborah El-Sayed	Director of Transformation	01/04/2018	31/03/2021	115-120	0	0	0	25-27.5	145-150	115-120	0	0	0	22.5-25	140-145

David Jarrett	Area Director - South Gloucestershire and Bristol	01/04/2018	31/03/2021	105-110	0	0	0	22.5-25	130-135	105-110	0	0	0	30-32.5	135-140
Colin Bradbury	Area Director - North Somerset	01/04/2018	31/03/2021	105-110	0	0	0	25-27.5	135-140	105-110	0	0	0	22.5-25	130-135
Peter Brindle (Note 2 & 11)	Medical Director - Clinical Effectiveness	01/04/2018	31/03/2021	115-120	0	0	0	0	100-105	115-120	0	0	0	55-57.5	170-175
Martin Jones	Medical Director - Commissioning and Primary Care	01/04/2018	01/12/20	55-60	0	0	0	2.5-5	60-65	85-90	0	0	0	27.5-30	110-115
David Soodeen (Note 3 & 10)	GP Locality Representative	01/04/2018	07/07/2020	40-45	0	0	0	0	40-45	70-75	0	0	0	17.5-20	90-95
Kirsty Alexander (Note 4 & 10)	GP Locality Representative	01/04/2018	31/03/2021	55-60	0	0	0	0	55-60	55-60	0	0	0	60-62.5	115-120
Brian Hanratty (Note 5 & 10)	GP Locality Representative	01/04/2018	31/03/2021	50-55	0	0	0	0	50-55	45-50	0	0	0	10-12.5	55-60
Kevin Haggerty (Note 6 & 10)	GP Locality Representative	01/04/2018	31/03/2021	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40

Rachael Kenyon (Note 6 &10)	GP Locality Representative	01/04/2018	31/03/2021	35-40	0	0	0	0	35-40	35-40	0	0	0	2.5-5	40-45
Jon Evans (Note 6 &10)	GP Locality Representative	01/04/2018	31/03/2021	35-40	0	0	0	0	35-40	35-40	0	0	0	7.5-10	40-45
Felicity Fay (Note 6 & 10)	GP Locality Representative	01/04/2018	31/03/2021	25-30	0	0	0	0	25-30	20-25	0	0	0	0	20-25
Umber Malik (Note 7)	GP Locality Representative	01/09/2010	31/03/2021	35-40	0	0	0	0	35-40	0	0	0	0	0	0
John Rushforth	Independent Lay Member - Chair Audit, Governance and Risk	01/04/2018	31/03/2021	20-25	500	0	0	0	20-25	20-25	600	0	0	0	25-30
John Cappock	Independent Lay Member - Strategic Finance	13/05/2019	31/03/2021	20-25	0	0	0	0	20-25	15-20	0	0	0	0	15-20
Sarah Talbot-Williams	Independent Lay Member - Patient and Public Engagement	01/04/2018	31/03/2021	25-30	0	0	0	0	25-30	25-30	300	0	0	0	25-30
Alison Moon	Independent Lay Member - Registered Nurse	01/04/2018	31/03/2021	25-30	0	0	0	0	25-30	25-30	400	0	0	0	25-30

Nick Kennedy	Independent Lay Member - Secondary Care Doctor	01/04/2018	31/03/2021	25-30	0	0	0	0	25-30	25-30	600	0	0	0	25-30
Christina Gray (Note 8)	Representative local authority - Public Health	01/04/2019	31/03/2021	0	0	0	0	0	0	0	0	0	0	0	0

Notes:
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

1 The taxable expenses are payments for home to office travel.
2 The salary in the table excludes the salary for his secondment role at NETSCC, University of Southampton from 1 April 2020 to 31 July 2020. The total salary for 2020/21 including the payment for the secondment would be within the band £120,000 to £125,000

3 In the salary figure. £4,312 relates to the Governing Body role and the remainder are for payments for Locality Leadership Group and clinical lead roles. The salary in the table excludes the salary for his secondment role at South West Clinical Networks which is hosted by NHS England. The total salary for 2020/21 including the payment of the secondment would be within band £45,000 to £50,000.

4 In the salary figure, £12,287 relates to the Governing Body role and the remainder are for Locality Leadership Group and clinical lead roles.

5 In the salary figure, £12,320 relates to the Governing Body role and the remainder are for Locality Leadership Group and clinical lead roles.

6 In the salary figure, £12,320 relates to the Governing Body role and the remainder are for the Locality Leadership Group role.

7 In the salary figure from September 2020 to March 2021, £7,187 relates to the Governing Body role and the remainder are for Locality Leadership Group, clinical lead and CEPN roles.

8 This is non - remunerated post.

9 All Pensions Related Benefits
The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to :

A change in role with a resulting change in pay and impact on pension benefits

A change in the pension scheme
itself

Changes in the contribution rates

Changes in the wider remuneration package of an individual.

10 All Pensions Related Benefits - GP Locality Representative figures
The contracts for the GP Locality Representative governing board appointments were reviewed in 2020/21 and defined as contract for services. GP's contract for services are pensioned via the GP Solo process whereby the earnings and pension contributions are added to GP's practitioner pension account. These are not reported as pension benefits and hence not included All Pension - related benefits in 2020/21. In 2019/20 these contracts were defined as contract of service. The pension benefits were reported and included in the All Pension - related benefits figures.

11 The All Pension Related Benefit calculation has produced negative figures for these employees due to changes in their circumstances in the year. The negatives figures are not reported in the table but they are still included in Total Pay Banding

Pension benefits as at 31 March 2021

Table 7 This Statement is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements

		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 Case 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)				
Name	Title	£000	£000	£000	£000	£000	£000	£000	£000
Julia Ross	Chief Executive	0	0	55-60	175-180	1499	0	1439	0
Lisa Manson	Director of Commissioning	0-2.5	0	45-50	100-105	780	25	838	0
Rosalind Shepherd	Director of Nursing and Quality	5-7.5	20-22.5	45-50	140-145	877	171	1081	0
Deborah El-Sayed	Director of Transformation	0-2.5	0	35-40	65-70	589	23	639	0
David Jarrett (note 4)	Area Director – Bristol and South Gloucestershire	0-2.5	0	35-40	70-75	529	20	573	0
Colin Bradbury	Area Director - North Somerset	0-2.5	0	25-30	45-50	437	20	479	0
Peter Brindle	Medical Director - Clinical Effectiveness	0-2.5	0	40-45	85-90	790	0	823	0
Martin Jones (note 5)	Medical Director - Commissioning and Primary Care	0-2.5	0-2.5	10-15	40-45	346	0	0	0

Pension benefits as at 31 March 2020

Table 8 This Statement is audited by the external auditors and is covered by the audit opinion issued on the CCG's financial statements

		Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2020	Lump sum at pension age related to accrued pension at 21 March 2020	Cash Equivalent transfer Value at 1 April 2019	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employer's contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name	Title	£000	£000	£000	£000	£000	£000	£000	£000
Julia Ross	Chief Executive	5-7.5	15-17.5	60-65	190-195	1196	131	1499	0
Lisa Manson	Director of Commissioning	0-2.5	0	45-50	95-100	747	0	780	0
Rosalind Shepherd	Director of Nursing and Quality	0-2.5	0-2.5	35-40	115-120	804	12	877	0
Deborah El-Sayed	Director of Transformation	0-2.5	0	30-35	65-70	541	18	589	0
David Jarrett (note 4)	Area Director - South Gloucestershire	0-2.5	0-2.5	30-35	70-75	485	19	534	0
Colin Bradbury	Area Director - North Somerset	0-2.5	0	25-30	45-50	397	16	437	0
Peter Brindle	Medical Director - Clinical Effectiveness	2.5-5	2.5-5	40-45	90-95	694	60	790	0
Martin Jones	Medical Director - Commissioning and Primary Care	0-2.5	5-7.5	15-20	45-50	308	42	370	0

Notes:

1. The CCG has no pension liabilities for Sarah Truelove, Deputy Chief Executive and Chief Finance Officer or Dr K Haggerty Sarah Truelove and Dr K Haggerty are not in the NHS Pension Scheme.

2 Independent Lay Members do not receive pensionable pay.

3 The contracts for the GP Locality Representative governing board appointments were reviewed in 2020/21 and were defined as contract for services. GP's contract for services are pensioned via the GP Solo process whereby the earnings and pension contributions are added to GP's practitioner pension account. The above table only reports on pension contributions on contracts of service.

4 The pensions figure reported in 2019/20 for D Jarret were found to be incorrect. In the table, Pension benefits as at 31 March 2021 the Cash Equivalent Transfer Value at 1 April 2020 is correctly reported at £529,000.

5 No Cash Equivalent transfer Value at 31.3.2021 as the member is over the age of 60.

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 that the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the Scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV 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).

Pension and Lump sum data

The pension and lump sums figures above from NHS Pensions are derived from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement (a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.) There is considerable uncertainty on how the affected benefits within the new NHS 2015 scheme would be adjusted in future once legal proceedings are completed.

Compensation on early retirement or for loss of office

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements. No payments for compensation on early retirement or for loss of office were received by any senior managers in 2020/21 (nil 2019/20).

Payments to past members

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements. No compensation was paid to any former senior manager in 2020/21 (nil 2019/20).

Pay multiples

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements. 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 highest paid director/member is Julia Ross, Chief Executive.

The banded remuneration of the highest paid director/member in Bristol, North Somerset and South Gloucestershire CCG in the financial year 2020-21 was £160,000 to £165,000 (2019-20 £175,000-£180,000). This was 4.29 times (2019-20, 4.76) 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 (2019/20 nil).

The remuneration range was from £12,320 to £160,696 (2019/20 £6,160 - £176,000).

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

In 2020/21 the pay multiply was 4.29. This is lower than the previous year due to the band range of the highest paid director/member being lower. In 2019/20 the highest paid-director/member was an interim Director engaged via her owned company. This engagement ended in the financial year 2020/21.

Staff Report

Number of Senior Managers, Staff Numbers and Costs

This statement is audited by the External Auditors and is covered by the Audit Opinion issued on the CCG's Financial Statements.

Table 9 Staff costs 2020/21

		Admin			Programme			Total	2020-21
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	10,286	587	10,873	5,555	839	6,394	15,841	1,426	17,267
Social security costs	1,170	-	1,170	577	-	577	1,747	-	1,747
Employer contributions to the NHS Pension Scheme	2,096	-	2,096	1,051	-	1,051	3,147	-	3,147
Apprenticeship Levy	73	-	73	-	-	-	73	-	73
Gross employee benefits expenditure	**13,625**	**587**	**14,212**	**7,183**	**839**	**8,022**	**20,808**	**1,426**	**22,234**

Table 10 Staff costs 2019/20

	Admin			**Programme**			**Total**		**2019-2020**
	Permanent Employees	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**	**Permanent Employees**	**Other**	**Total**
Employee Benefits	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	10,560	563	**11,123**	4,020	609	**4,629**	14,580	1,172	**15,752**
Social security costs	1,245		**1,245**	397		**397**	1,642	-	**1,642**
Employer contributions to the NHS Pension Scheme	2,019		**2,019**	789		**789**	2,808	-	**2,808**
Apprenticeship Levy	66		**66**	-	-	**-**	66	-	**66**
Gross employee benefits expenditure	**13,890**	**563**	**14,453**	**5,206**	**609**	**5,815**	**19,096**	**1,172**	**20,268**

Staff Numbers 2020/21

This statement is audited by the external auditors and is covered by the audit opinion issued on CCG's financial statements.

There was an average of number 76 Senior Managers between 1 April 2020 and 31 March 2021. Table 11

Senior Managers (WTE)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Very Senior Manager	5	3	8	0	0	0	5	3	8
Band 9	2	1	5	3	1	4	5	2	9
Band 8D	3	5	6	1	1	2	2	6	8
Band 8C	19	9	27	1	0	1	19	9	28
Band 8B	13	8	22	0	1	1	14	9	23
Total	**42**	**26**	**68**	**5**	**3**	**8**	**47**	**29**	**76**

Our average number by Staff, by Staff categories between 1 April 2020 to 31 March 2021. Table 12

Staff Category (WTE)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Administrative and Clerical	162	59	221	3	1	4	165	60	225
Medical and Dental	5	5	10	1	0	1	6	5	11
Add Professional. Scientific and Technical	14	6	20	0	0	0	14	6	20
Nursing and Midwifery	53	7	60	1	0	1	54	7	61
Allied Health Professionals	1	0	1	0	0	0	1	0	1
Senior Managers	42	26	68	5	3	8	47	29	76
Total	**277**	**103**	**380**	**10**	**4**	**14**	**287**	**107**	**394**

Staff Composition 2020/21

There were 83 Senior Managers (headcount) between 1 April 2020 and 31 March 2021. Table 13

Senior Managers (headcount)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Very Senior Manager	5	4	9	0	0	0	5	4	9
Band 9	4	1	5	5	1	6	9	2	11
Band 8D	1	5	6	1	1	2	2	6	8
Band 8C	19	9	28	1	0	1	20	9	29
Band 8B	16	9	25	0	1	1	16	10	26
Total	**45**	**28**	**73**	**7**	**3**	**10**	**52**	**31**	**83**

Staff Numbers 2019/20

This statement is audited by the external auditors and is covered by the audit opinion issued on CCG's financial statements.

There was an average number of 72 Senior Managers between 1 April 2019 and 31 March 2020. Table 14

Senior Managers (WTE)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Very Senior Manager	5	4	9	1	0	1	6	4	10
Band 9	2	0	2	2	2	4	4	2	6
Band 8D	3	4	7	0	0	0	3	4	7
Band 8C	19	9	28	0	0	0	19	9	28
Band 8B	13	8	21	0	0	0	13	8	21
Total	**42**	**25**	**67**	**3**	**2**	**5**	**45**	**27**	**72**

Our average number of staff, by staff categories between 1 April 2019 to 31 March 2020. Table 15

Staff Category (WTE)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Administrative and Clerical	155	64	219	2	6	8	157	70	227
Medical and Dental	5	5	10	1	0	1	6	5	11
Add Professional. Scientific and Technical	14	6	20	0	0	0	14	6	20
Nursing and Midwifery	16	4	20	0	0	0	16	4	20
Allied Health Professionals	0	0	0	0	0	0	0	0	0
Senior Managers	42	25	67	3	2	5	45	27	72
Total	**232**	**104**	**336**	**6**	**8**	**14**	**238**	**112**	**350**

Staff Composition 2019/20

There were 82 Senior Managers (headcount) between 1 April 2019 and 31 March 2020. Table 16

Senior Managers (headcount)	Permanent			Other			Total		
	Female	Male	Total	Female	Male	Total	Female	Male	Total
Very Senior Manager	5	4	9	1	0	1	6	4	10
Band 9	2	0	2	3	3	6	5	3	8
Band 8D	3	4	7	1	0	1	4	4	8
Band 8C	21	10	31	1	0	1	22	10	32
Band 8B	16	8	24	0	0	0	16	8	24
Total	**47**	**26**	**73**	**6**	**3**	**9**	**53**	**29**	**82**

Sickness absence data

We have a detailed and robust Sickness Absence Policy. A range of services are available to support staff at work or returning to work. These services include access to Occupational Health and an Employee Assistance Programme, which includes access to counselling sessions. Human resource support staff have worked with managers on best practice for managing sickness absence, how to identify and

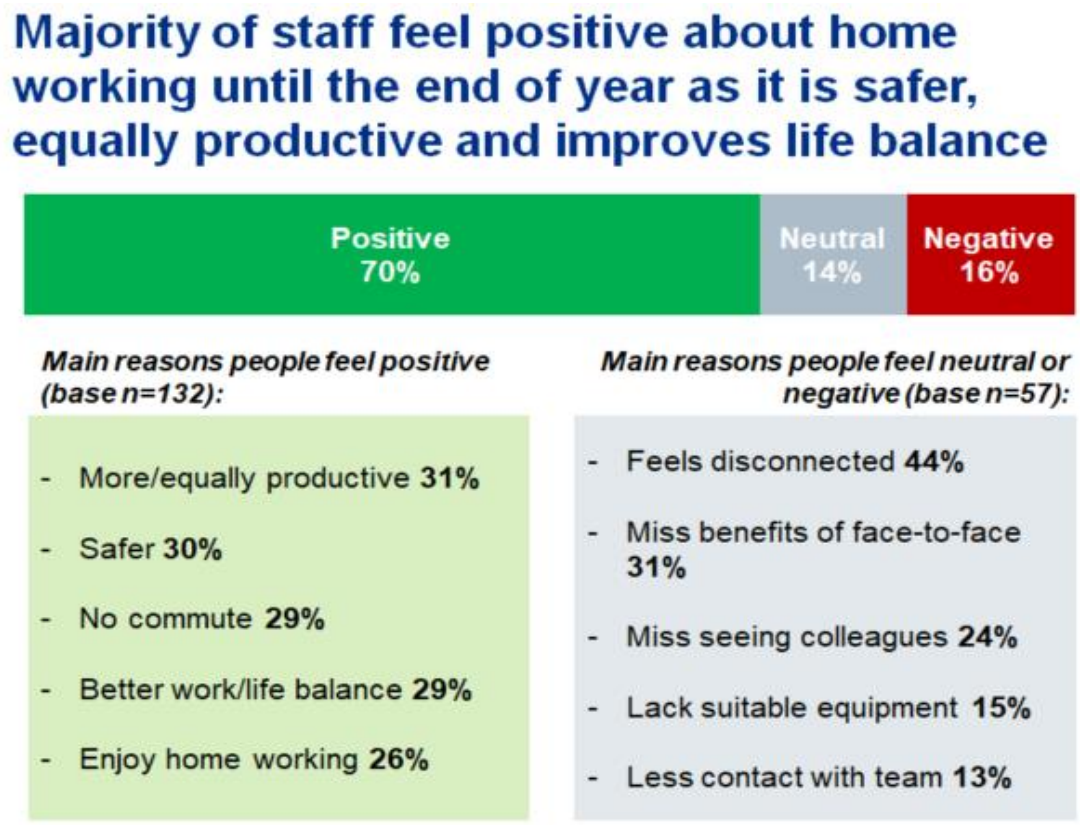
manage stress, how to support employees with disabilities in the workplace and how to increase wellbeing amongst staff.

In order to fully support our staff as the country went into lockdown on 22nd March 2020 we set up a Wellbeing Working Group to support the Business Critical Response Centre. This was an integral part of ensuring that we were listening to staff and responding to their concerns through providing a comprehensive wellbeing support offer. The Group developed a temperature check survey, which was sent out to all staff, initially weekly and then fortnightly. The feedback enabled us to understand how well supported and connected staff were feeling and enabled us to respond in real time to any concerns. From March 2020 to June 2020 we were able to see concerns alleviate as we put in place measures to respond.

This included developing:

- A wellbeing handbook,
- A wellbeing podcast,
- A parents and carers network, and
- Regular activities to ensure staff were connected, for example through 'Virtual Kitchen Club' a weekly informal catch-up, our Gardening Club and a varied programme of lunch and learns on key topics, such as inviting Bristol Credit Union to talk about financial support that was available.

During the peak of the pandemic, having supported staff to make the transition to home working, we also prepared a guide to support any member of staff being redeployed to other organisations or areas of work. We held two webinars to answer staff questions, which proved popular, with over 300 people taking part. A survey at the beginning of September 2020 gave feedback on how staff felt about the continuation of remote working.



Not all staff will feel the same and work continues to provide support through line manager briefings to ensure that activities and messages for staff are consistent, and that individual needs can be addressed.

We are required to report annual sickness absence data for the calendar year 2020.

The CCG had an average number of full time equivalent members of staff (FTE) of 379.55 over the period January 2020 to December 2020. The full time equivalent possible working days available was138,079. The table below has been provided by the Department of Health and Social Care using the Electronic Staff Record Data Warehouse

Table 17

	Number of FTE staff (average 1 January 2020 to 31 December 2020)	Sum of FTE Days Sick	Sum of FTE Days Available	FTE sickness absence %	Average Annual Sick Days per FTE
NHS Bristol, North Somerset and South Gloucestershire CCG	379.55	2,320.1	138,079	1.68%	6.1

Staff turnover percentages

Bristol, North Somerset and South Gloucestershire staff turnover is reported via NHS digital, (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2020), a series of official statistics publication complying with the UK Statistics Authority's Code of Practice. During the period December 2019 to December 2020 there have been 120 members of staff join the CCG and 58 staff members who have left. Staff turnover measures the number of staff who leave an organisation during a period of time. The CCG staff turnover for the period December 2019 to December 2020 is reported as 13.5% based on a headcount of 58 leavers.

Whilst the turnover rate measures the outflow of people from an organisation and is expressed in terms of the number of people who leave over a period of time, the stability rate calculates the proportion of the workforce who remain employed for a specified period and measures how effectively the organisation is retaining staff. The CCG's stability index is reported as 85.4% of employees were retained during the period December 2019 and December 2020.

Staff engagement percentages

Staff engagement remains important and in 2020 the CCG participated in the Annual NHS Staff Survey. There were 384 responses, which equates to a response rate of 85%. This matched the response rate from 2019 demonstrating good staff engagement. The CCG performance was higher than the 79% national average from similar organisations. The full Staff survey can be found at NHS Staff Survey 2020 Benchmark Reports (nhsstaffsurveyresults.com).

The organisation maintains staff engagement through a variety of routes including our staff networks in the following areas: disability, LGBTQ+, parents and carers. The CCG also has an Inclusion Council and a Staff Partnership Forum. A variety of communication methods are used to maintain staff engagement including the weekly Have We Got News For You sessions with the Chief Executive and the Voice, a weekly email bulletin, and the Chief Executive's blog.

Staff policies

We have continued our policy development programme reflecting the Terms and Conditions of Employment set out under Agenda for Change. During 2020/21 we reviewed our pay protection and organisational change policies. Each policy is accompanied by an Equality Impact Assessment to identify and mitigate any risks to staff on the basis of any protected characteristics as defined in the Equality Act 2010. We have also reviewed our recruitment policy and continue with our corporate and local induction arrangements to ensure that we fill any vacancies with high calibre people in a fair and equitable manner. Our recruitment metrics indicate that we attract candidates from ethnic minority communities; however, shortlisting does not translate into appointments. One of our priorities this year is to close the shortlisting to appointment gap for people who hold this protected characteristic to improve equality of opportunities. We are an accredited "Disability Confident" employer, which ensures all declared disabled applicants are guaranteed an interview if they meet the essential requirements of the person specification of a role. The Recruitment and Selection Policy outlines the requirements for recruiting managers to make reasonable adjustments for disabled candidates where applicable, and this is reinforced through the line management training courses run for all staff with people management responsibilities as part of the HR Policy Toolkit training. Further information about our work related to equality and diversity can be found in the Performance Analysis section of this report.

We will continue to develop new staff policies and review existing policies. All of these will be subject to consultation with staff and Trade Union representatives through the Staff Partnership Forum, which continues to meet regularly and provides a constructive space for collaboration between staff representatives, and management. The work of the SPF has included development of activities to

support organisational development, including our exit interview arrangements and response to the annual Staff Survey.

Freedom to Speak Up

We have in place policies to support staff when raising concerns, including our Freedom to Speak Up Policy, Fraud and Bribery Policy, and Bullying and Harassment Policy. Freedom to Speak Up was introduced by Sir Robert Francis following a 2015 review into NHS 'whistleblowing' processes. It incorporates whistleblowing and extends beyond that to develop cultures where concerns are identified and addressed at an early stage before people feel the need to 'blow the whistle'.

Freedom to Speak Up is hugely important to us and we are committed to ensuring that a culture of speaking up is embedded throughout our organisation, and that effective processes are in place to support staff. Our Freedom to Speak Up Policy provides a framework that supports a culture where staff feel comfortable to raise concerns. The policy gives guidance and advice to staff on raising a concern. Our Freedom to Speak Up network includes our Freedom to Speak Up Guardian, Sarah Talbot-Williams, a Governing Body Lay Member, and two champions, Sarah Truelove and David Jarrett, both Executive Directors.

We have consistently promoted the opportunity for staff to use the FTSU route to raise concerns in 2020/2021

Other employee matters

Health and Safety

The CCG is committed to ensuring the health, safety and welfare of all its employees and of other persons who may be affected by its activities. Our policy has been prepared to reflect our moral and legal obligations under the Health and Safety at Work Act 1974. We commission University Hospitals Bristol and Weston to provide us with Health and Safety advice and guidance and act as our "competent person".

We have engaged with our landlords to understand how we make our office Covid secure, following Government guidance, and have engaged our Staff Partnership

Forum in the developments, which have been communicated to staff. Staff are required to work from home routinely to reduce the risks of exposure to Coronavirus.

We take steps to ensure that our statutory duties are met at all times including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013' (RIDDOR). The Governing Body provides leadership to ensure that exemplary health and safety practices are firmly embedded throughout the organisation to provide a secure and healthy environment in which to work, and has systems in place to identify and manage incidents and risks and eliminate or reduce any identified hazards. There have been no notifiable incidents during 2020/21

Every employee is given the necessary information, instruction and training to be able to work safely; mandatory training is refreshed on an annual basis. This includes the support that we have put in place for employees during the pandemic, which is described in more detail below.

Additional support for remote working and pandemic response

In recognition of the shift away from office working arrangements, staff are able to access, on loan, equipment from the South Plaza office. This includes chairs, monitors and other equipment to replicate as far as practically possible the office workstation set up. Staff already had laptops as a result of previous investment in portable IT. A grant of £100 per individual has been offered to support the purchase of equipment that cannot be loaned, and which is essential for working from home. This offer is consistent with other NHS organisations.

As well as the continued requirement for staff to complete their Display Screen Equipment (DSE) mandatory training, supplementary information on adopting the correct posture released by the Health and Safety Executive has been shared with staff. The screensaver on laptops was customised to promote wellbeing messages, including the importance of taking regular breaks and posture, as we recognise that domestic settings will be variable.

In line with NHS direction, the CCG established a process for staff to engage with line managers to complete an individual risk assessment. Through individuals working from home risks have been mitigated. As well as generic risk assessment, a process has been established for individuals to request the facility to work from an

office base. The facility to work from an office not only assists with delivery of work related outputs, it also supports individuals experiencing mental health issues associated with isolation caused through working from home or at risk of domestic violence and other challenging situations.

We encourage the use of the Employee Assistance Programme which provides staff with access to a range of support measures including a 24/7 telephone helpline offering practical information, emotional support, and online counselling services. Staff also have access to an online health and wellbeing portal that provides extensive resources including personal wellbeing programmes, videos and webinars.

Organisational Development

Our Organisational Development reflects the NHS People Plan. Our CCG plan will ensure that we address the requirements set out for organisations that are employers of NHS staff as well as part of systems. We will have a CCG plan and this will be closely aligned with the Healthier Together People Plan.

We already have in place many arrangements to support and develop individuals and teams working in the CCG, including our arrangements for wellbeing, communication and recruitment; as well as appraisal, learning and development and our arrangements for Freedom to Speak Up.

Our plan will continue to evolve and change depending on the nature of our work and the direction that we need to take. This year we have identified a nominated executive lead for staff wellbeing, David Jarrett, and a responsible lay member, Alison Moon.

To ensure that the CCG recruits the best staff, and that colleagues have the right conditions to perform to the best of their abilities, our plan will be our promise to our people that:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning

- We work flexibly
- We are a team

We have formed a People Steering Group to oversee the development of our plan and delivery of its key components. Our Chief Executive chairs this group, with support from across the organisation, including the Staff Partnership Forum

Our Inclusion Council, also chaired by the Chief Executive, has representation from all our staff networks. This Council will mainstream equality, diversity and inclusion into our organisational processes and culture, ensuring that it becomes 'everyone's business'.

CCG appraisal arrangements have been reviewed by our internal auditors, who acknowledged that the policy and process is well designed. Recommendations for improvement have been made and are now monitored through our Audit, Governance and Risk Committee. New NHS pay progression arrangements that were to be introduced in 2019 with links to appraisal were suspended due to the pandemic.

Our Learning and Development Panel has continued to function providing opportunities for individuals to access Continuing Professional Development. This has included access for ethnic minority staff to the Stepping Up Programme, (a 12-month development programme for aspiring leaders from under-represented groups) as well as providing access to apprenticeships through our Digital Apprenticeship Service account. We have developed opportunities for CCG apprentices to access an Associate Project Management Programme to enhance their skills.

Trade Union Facility Time Reporting Requirements

The total number of employees who were relevant union officials during the period 1st April 2020 to 31st March 2021 is: table 18

Number of employees who were relevant union officials during the relevant period	Full time equivalent number
0	0

Expenditure on consultancy

The consultancy expenditure for the financial year 2020/21 was £261,000 and this can be analysed as follows: table 19:

Consultancy Category	2020/21 £'000	2019/20 £'000
Finance	11	11
Human Resources, Training and Education	0	0
Technical	62	118
Organisation and Change Management	136	224
Procurement	0	139
Property and Construction	0	15
Strategy	52	186
Total	261	693

The consultancy Organisation and Change Management spend relates to the professional development of the Governing Body and directors of £52,000 and the review of the Continuing Healthcare department of £50,000.

Off-payroll engagements

NHS bodies are required to include disclosures in 2020/21 about their off-payroll engagements, and the details for the CCG are set out in the tables below.

Table 20: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2021 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	3
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	1
for between two and three years at the time of reporting	2
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

Bristol, North Somerset and South Gloucestershire CCG confirms that all existing off-payroll engagements have been subject to an assessment for IR35 purposes using 'HMRC Check employment status for tax' tool.

Table 21: New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 21 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:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
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

Table 22: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	24

Note

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months
(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero.

Exit packages, including special (non-contractual) payments

Table 23: Exit Packages

These statements are audited by the external auditors and is covered by the audit opinion issued on CCG's financial statements.

There were no exit packages in 2020/21 but two payments for lieu in notice.

Exit package cost band (including any special payment element))	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s	Whole numbers only	£s
Less than £10,000	0	0	2	6,235	2	6,235	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**6,235**	**2**	**6,235**	**0**	**0**
				Agrees to A below				

Redundancy and other departure costs have been paid accordance with provisions of the NHS Terms and Conditions of Service (Agenda for Change).

Exit costs in this note are the full costs of departures agreed in the year. Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not include in the table.
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.

Table 24: Analysis of Other Departures 2020/21

Type of Other Departures		**Agreements Number**	**Total Value of Agreements £000s**	
Voluntary redundancies including early retirement contractual costs		0	0	
Mutually agreed resignations (MARS) contractual costs		0	0	
Early retirement in the efficiency of the service contractual costs		0	0	
Contractual payments in lieu of notice *		2	6	
Exit payments following Employment Tribunals or court orders		0	0	
Non-contractual payments requiring HMT approval **		0	0	
Total		**2**	**6**	**Agrees to total in Table 23**

As single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note XX which will be the number of individuals.

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

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

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Table 25: Exit Packages 2019/20

There were no exit packages in 2019/20 but two payments for lieu in notice

There were no exit packages in 2019/20 but two payments for lieu in notice. **Exit package cost band (including any special payment element))**	**Number of compulsory redundancies**	**Cost of compulsory redundancies**	**Number of other departures agreed**	**Cost of other departures agreed**	**Total number of exit packages**	**Total cost of exit packages**	**Number of departures where special payments have been made**	**Cost of special payment element included in exit packages**
	Whole numbers only	**£s**	**Whole numbers only**	**£s**	**Whole numbers only**	**£s**	**Whole numbers only**	**£s**
Less than £10,000	0	0	1	5,718	1	5,718	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	1	25,965	1	25,965	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**31,683**	**2**	**31,683**	**0**	**0**
				Agrees to A below				

Redundancy and other departure costs have been paid accordance with provisions of the NHS Terms and Conditions of Service (Agenda for Change).

Exit costs in this note are the full costs of departures agreed in the year. Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the Pension Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not include in the table.

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.

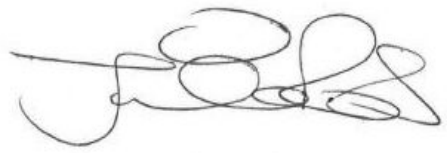
Table 26: Analysis of Other Departures 2019/20

Type of Other Departures			**Agreements Number**	**Total Value of Agreements £000s**	
Voluntary redundancies including early retirement contractual costs			0	0	
Mutually agreed resignations (MARS) contractual costs			0	0	
Early retirement in the efficiency of the service contractual costs			0	0	
Contractual payments in lieu of notice *			2	32	
Exit payments following Employment Tribunals or court orders			0	0	
Non-contractual payments requiring HMT approval **			0	0	
Total			**2**	**32**	**Agrees to total in Table 25**

Parliamentary Accountability and Audit Report

Bristol, North Somerset and South Gloucestershire 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 page 114 - 147. An audit certificate and report is also included in this Annual Report at page 148

ANNUAL ACCOUNTS



Julia Ross

Chief Executive and Accountable Officer

18th June 2021

Data entered below will be used throughout the workbook:

Entity name:	NHS Bristol, North Somerset and South Gloucestershire 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:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	3	(5,665)	(6,602)
Other operating income	3	-	(82)
Total operating income		**(5,665)**	**(6,684)**
Staff costs	4	22,234	20,268
Purchase of goods and services	5	1,589,875	1,426,825
Depreciation and impairment charges	5	112	104
Provision expense	5	1,106	5
Other Operating Expenditure	5	7,261	5,317
Total operating expenditure		**1,620,588**	**1,452,519**
Net Operating Expenditure		**1,614,923**	**1,445,835**
Finance income		-	-
Finance expense		-	-
Net Expenditure for the Year		**1,614,923**	**1,445,835**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**1,614,923**	**1,445,835**
Comprehensive Expenditure for the year		**1,614,923**	**1,445,835**

The notes on pages 121 to 147 form part of this statement.

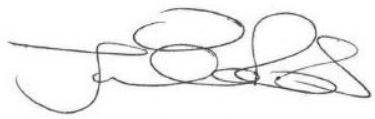
Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	8	159	189
Intangible assets	9	170	-
Total non-current assets		**329**	**189**
Current assets:			
Trade and other receivables	10	49,737	17,735
Cash and cash equivalents	11	1,688	63
Total current assets		**51,425**	**17,798**
Total assets		**51,754**	**17,987**
Current liabilities			
Trade and other payables	12	(118,077)	(88,446)
Provisions	13	(1,164)	(58)
Total current liabilities		**(119,241)**	**(88,504)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(67,487)**	**(70,517)**
Assets less Liabilities		**(67,487)**	**(70,517)**
Financed by Taxpayers' Equity			
General fund		(67,487)	(70,517)
Total Taxpayers' Equity:		**(67,487)**	**(70,517)**

The notes on pages 121 to 147 form part of this statement.

The financial statements on pages 117 to 147 were approved by the Chair of the Audit, Governance and Risk Committee on 12th June 2021 with delegated authority from the Governing Body and signed on its behalf by:

Chief Executive Officer/Chief Accountable Officer



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	**(70,517)**	**(70,517)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21		
Net operating expenditure for the financial year	**(1,614,923)**	**(1,614,923)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(1,614,923)**	**(1,614,923)**
Net funding	1,617,953	**1,617,953**
Balance at 31 March 2021	**(67,487)**	**(67,487)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20		
Balance at 01 April 2019	**(82,705)**	**(82,705)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20		
Net operating costs for the financial year	(1,445,835)	(1,445,835)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(1,445,835)**	**(1,445,835)**
Net funding	1,458,023	1,458,023
Balance at 31 March 2020	**(70,517)**	**(70,517)**

The notes on pages 121 to 147 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		(1,614,923)	(1,445,835)
Depreciation and amortisation	5	112	104
Finance costs	13	14	0
(Increase)/decrease in trade & other receivables	10	(32,001)	(3,407)
Increase/(decrease) in trade & other payables	12	29,378	(8,731)
Increase/(decrease) in provisions	13	1,092	5
Net Cash Inflow (Outflow) from Operating Activities		**(1,616,328)**	**(1,457,864)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	8	0	(116)
Net Cash Inflow (Outflow) from Investing Activities		**0**	**(116)**
Net Cash Inflow (Outflow) before Financing		**(1,616,328)**	**(1,457,980)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,617,953	1,458,023
Net Cash Inflow (Outflow) from Financing Activities		**1,617,953**	**1,458,023**
Net Increase (Decrease) in Cash & Cash Equivalents	11	**1,625**	**43**
Cash & Cash Equivalents at the Beginning of the Financial Year		**63**	20
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**1,688**	**63**

The notes on pages 121 to 147 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 Group, 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.

The Clinical Commissioning Group allocations for 2019/20 to 2023/24 were published in January 2019 and had final approval by the NHS England Board on 31 January 2019. The revenue allocations are backed by cash limits. Throughout this period, the CCG expects to maintain a positive cash flow and continue to meet the Better Payment Performance standard.

Subject to the recent published DHSC White Paper Integration and innovation: Working together to improve health and social care for all, the Clinical Commissioning Group may cease to exist after 2021/22, however all its services will continue to be provided by the envisaged statutory Integrated Care System.

On this basis, the CCG considers it remains a Going Concern.

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 Better Care Fund Aligned Budgets

The CCG and Bristol City Council, North Somerset Council and South Gloucestershire Council have agreed to treat the Better Care Fund as a non-pooled fund. The terms of this are set out in the section 75 agreement. Both parties have chosen to contract with individual providers without reference to each other using their own sources of funding alone and it is for this reason that neither party considers they are operating a pooled budget.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

The CCG reviews the Section 75 agreements with Bristol City Council, North Somerset Council and South Gloucestershire Council to determine which party has control over the services being delivered, in accordance with IFRS 11 and the accounting policy at 1.3. As control of each of the elements of the Section 75 agreements resides with either the CCG or the relevant Council, the CCG considers that there is not a joint arrangement as defined in IFRS 11.

The CCG entered into new s256 agreements with Bristol City Council, North Somerset Council and South Gloucestershire Council in 2020-21. The programme will support the implementation of the BNSSG Healthier Together Single System Plan, including supporting the transition and restoration of services impacted significantly by the Covid pandemic, through alignment of a number of key priority areas which benefit the population of BNSSG; will seek to improve the financial sustainability of both the NHS and Local Authority; and meet the strategic goals of health, public health and social care commissioners. The CCG considers that is not a joint arrangement under IFRS 11 as funding decisions are taken by a majority of CCG membership on the Financial Governance group.

This has been treated as a prepayment in the 2020-21 accounts as the related programme expenditure will fall in 2021-22 and 2022-23.

1.4.1 Critical Judgements in Applying Accounting Policies

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

The Clinical Commissioning Group has implemented the Better Care Fund Initiative via an aligned budget arrangements under Section 75 of the NHS Act 2006 with Bristol City Council, North Somerset Council and South Gloucestershire Council.

Management has reviewed the accounting transaction regarding the Better Care Fund and has made a judgement that the appropriate accounting arrangement is alignment (also see note 1.3 above).

1.4.2 Key Sources of Estimation Uncertainty

During March 2020 there was a global pandemic caused by novel coronviarus - Covid 19. The impact of Covid on delivery of healthcare has been significant; and also has led to changes in funding allocations to CCG, temporary suspension of CHC and Care Act assessment processes, and commissioning arrangements with NHS providers (NHS standard contract and PbR regime were suspended, for example). This means that when arriving at estimates there is less scope to rely on precedent and historic trends.
There are no other sources of estimation uncertainty that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year that require disclosure.

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.

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.

The Clinical Commissioning Group's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such the Clinical Commissioning Group's income from other activities is very limited. The most significant element being R&D income. The Clinical Commissioning Group does not enter into long term revenue contracts (most income arises from recharging past performance) and so the assessment indicates that there is no impact on income recognition from adopting IFRS 15.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

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.

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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Purchase of Goods, Services and Other Expenses

The purchase of goods, services and 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 **Property, Plant & Equipment**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.9.2 **Measurement**

IT equipment and furniture and fittings 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.

1.9.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10 **Intangible Assets**

1.10.1 **Recognition**

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

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

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

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

1.10.2 **Measurement**

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11 **Depreciation, Amortisation & Impairments**

Depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, 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 **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.

1.12.1 **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.

1.13 **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.

1.14 **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.

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.

1.15 **Clinical Negligence Costs**

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

1.16 **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.

1.17 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme, Clinical Commissioning Groups contributed annually to a national fund up to 2016-17, which has been used to settle these claims. There has been no further contribution from the Clinical Commissioning Group (see guidance note below from NHSE) as the national fund is deemed to be sufficient to cover any further outstanding claims.

Claims that have arisen since April 2013 with a retrospective element dating back to a maximum of 1.4.2013, have been assessed and, if appropriate, paid from the current year budget. Therefore, in each accounting period there may be some costs relating to previous years but the budget has funding for this (based on historical spend being built into the baseline) which obviates the need for a provision. It is also very difficult to estimate the level of retrospective liabilities as cases are not known until a claim is made and an estimate cannot be made with any certainty.

Guidance note: **NHS England: Settlement of legacy PUPoC NHS Continuing Healthcare (NHS CHC) liabilities – Updated Process and Guidance on Completion of the Financial CHC Non-ISFE return for 17-18**

'As confirmed in the letter from Louise Hampson, Interim Director of Financial Control dated 29 December 2016, NHS England will continue to make reimbursements to CCGs from the centrally held reserve in relation to PUPoC CHC claims and no further contribution will be required from CCGs.'

1.18 **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.

1.18.1 **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.

1.18.2 **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.

1.18.3 **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.

1.18.4 **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.

1.19 **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.

1.19.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.19.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Clinical Commissioning Group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.19.3 **Other Financial Liabilities**

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

1.20 **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.

1.21 **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. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Clinical Commissioning Group's surplus/deficit in the period in which they arise.

1.22 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 **Grants Payable (where relevant)**

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.

1.24 **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.
- 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.

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. This accounting change will have minimal impact on the Clinical Commissioning Group's financial position.

It is estimated that the implementation of IFRS 16 Leases will not have a significant impact on the accounts. It is anticipated that the leases will be valued at £2m with matching liability obligations to the lessor.

2 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	2020-21 Variance £'000	Target Achieved	2019-20 Target £'000	2019-20 Performance £'000	2019-20 Variance £'000
Expenditure not to exceed income	1,640,878	1,620,839	20,039	**Yes**	1,418,582	1,452,635	(34,053)
Capital resource use does not exceed the amount specified in Directions	252	252	-	**Yes**	116	116	-
Revenue resource use does not exceed the amount specified in Directions	1,634,962	1,614,923	20,039	**Yes**	1,411,782	1,445,835	(34,053)
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-		-	-	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-		-	-	
Revenue administration resource use does not exceed the amount specified in Directions	19,496	19,362	134	**Yes**	21,665	20,637	1,028

It is allowable to use Running Costs allocations to support programme expenditure

Financial Performance 2020-21

The CCG achieved an in-year surplus of £20,039k against its overall revenue funding in 2020-21 of £1,634,962k. It has therefore met its statutory duty to at least break-even.

The CCG has an historic accumulated debt of £117,059k.

In March 2020 there was a global pandemic 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 and the economy (through social distancing and the so-called 'lockdown') has been dramatic.

Two specific items of relevance for the CCG's financial performance are:
• The UK Government publically stated that it would fund the NHS 'whatever it takes' to manage the pandemic
• A significant overhaul of the financial architecture of the NHS, for example suspending the current financial performance management regime, moving all NHS providers onto a cost based 'block' payment regime, authorising pre-payments of one month's operating costs to NHS providers, centralising the procurement of Independent Sector Capacity, providing new funding for Hospital Discharge Programme and NHS Nightingale 'surge' capacity.

As the pandemic progressed, financial performance was monitored and reported in different ways in 20/21:

April 2020 – September 2020

The CCG was not required to submit a financial plan for April to September, but was instead subject to a more simplified financial management regime where budgets were largely set nationally based on previous year spend and a 'top up' to expected breakeven and with fixed 'block' payments to NHS providers. Additional costs of managing the Covid pandemic and other reasonable over and underspends were then adjusted each month to continue to deliver a balanced financial position.

October 2020 – March 2021

The CCG was required to prepare and submit a financial plan to NHS England for the period October to March, including accounting for expected additional Covid costs. The plan was prepared at 'system' level with prospective allocations for additional Covid costs, a 'top up' allocation to expected breakeven for all NHS organisations, and some growth funding for service development in the second half of the year to support recovery of elective care services and meet policy objectives in mental health and primary care.
Outside of this funding envelope the CCG continued to claim reimbursement for some specific costs of managing the Covid pandemic, notably the Hospital Discharge Programme and locally commissioned independent sector capacity

Two other notable changes to the finance regime were:

• NHS England used executive powers to manage the pandemic to remove commissioning responsibility for most major independent sector hospitals and directly commission nationally
• Non Contract Activity with NHS provider Trusts below £200,000 was not chargeable and providers were reimbursed nationally via a 'top up' regime.

Taken in the round these changes ensured that:

• Unplanned additional costs of the Covid-19 pandemic were able to be funded and decisions made promptly
• Inter-NHS commissioning and contracting did not become a barrier or additional burden on the service
• There remained a mechanism for ensuring value for money
• Progress was made on the Long Term Plan objective of 'system by default' working

These initiatives are aligned to the NHS and CCG long term financial objectives, but caution should be taken when making year-on-year comparisons of expenditure, or relative activity and performance levels.

	2020-21 £000s	2019-20 £000s
Programme Expenditure	1,601,191	1,431,800
Administration Expenditure	19,397	20,719
Total Expenditure	**1,620,588**	**1,452,519**
Programme Income	(5,630)	(6,602)
Administration Income	(35)	(82)
Total Income	**(5,665)**	**(6,684)**
Total Net Expenditure for the year	**1,614,923**	**1,445,835**
Revenue Resource Limit (RRL)	**1,634,962**	**1,411,782**
Surplus/(Deficit)	**20,039**	**(34,053)**
Surplus/(Deficit) % of Revenue Resource Limit	**1.23%**	**-2.41%**

3.1 Other Operating Revenue

	2020-21 Total £'000	2019-20 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**5,588**	6,438
Other Contract income	**77**	164
Total Income from sale of goods and services	**5,665**	**6,602**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	**-**	82
Total Other operating income	**-**	**82**
Total Operating Income	**5,665**	**6,684**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Clinical Commissioning Group and credited to the General Fund.

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no money from sale of goods.

£ 5.5m (£5.2m 2019-2020) of this revenue figure relates to income from the Department of Health for Research and Development.

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

	Non-patient care services to other bodies £'000	Other Contract income £'000
Source of Revenue		
NHS	100	-
Non NHS	5,488	77
Total	**5,588**	**77**

	Non-patient care services to other bodies £'000	Other Contract income £'000
Timing of Revenue		
Point in time	5,588	77
Total	**5,588**	**77**

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	15,841	1,426	17,267
Social security costs	1,747	0	1,747
Employer Contributions to NHS Pension scheme	3,147	0	3,147
Apprenticeship Levy	73	0	73
Gross employee benefits expenditure	**20,808**	**1,426**	**22,234**
Total - Net admin employee benefits including capitalised costs	**20,808**	**1,426**	**22,234**
Less: Employee costs capitalised	0	0	0
Total - Net employee benefits excluding capitalised costs	**20,808**	**1,426**	**22,234**

4.1.1 Employee benefits	Total		2019-20
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	14,580	1,172	15,752
Social security costs	1,642	0	1,642
Employer Contributions to NHS Pension scheme	2,808	0	2,808
Apprenticeship Levy	66	0	66
Gross employee benefits expenditure	**19,096**	**1,172**	**20,268**
Total - Net admin employee benefits including capitalised costs	**19,096**	**1,172**	**20,268**
Less: Employee costs capitalised	0	0	0
Total - Net employee benefits excluding capitalised costs	**19,096**	**1,172**	**20,268**

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	380.00	14.04	394.04	336.44	13.85	350.29
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Staff Annual Leave Accrual Balances

	Permanent Staff £'000	Temp/Agency £'000	Other £'000	Total £'000
Employee accrued benefits liability as at 31st December 2020	(206)	0	0	(206)

4.4 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	-	-	2	6,235	2	6,235
£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	**-**	**-**	**2**	**6,235**	**2**	**6,235**

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	5,718	1	5,718
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	1	25,965	1	25,965
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**2**	**31,683**	**2**	**31,683**

Analysis of Other Agreed Departures

	2020-21 Other agreed departures		2019-20 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	2	6,235	2	31,683
Total	**2**	**6,235**	**2**	**31,683**

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 (Agenda for Change).

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

4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 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.

4.5.2 Full actuarial (funding) valuation

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

The 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	Notes
Purchase of goods and services			
Services from other CCGs and NHS England	6,762	6,778	
Services from foundation trusts	417,139	314,180	
Services from other NHS trusts	455,785	474,570	
Services from Other WGA bodies	1,221	1,238	
Purchase of healthcare from non-NHS bodies	392,575	337,718	
Purchase of social care	6,652	4,055	
Prescribing costs	139,329	129,951	
GPMS/APMS and PCTMS	152,828	143,440	
Supplies and services – clinical	4,498	5,155	
Supplies and services – general	259	90	
Consultancy services	261	693	
Establishment	6,435	2,602	
Transport	14	105	
Premises	3,935	4,091	
Audit fees	93	78	1, 2 & 3
Other non statutory audit expenditure			
· Internal audit services	-	-	
· Other services	-	-	
Other professional fees	1,269	1,392	4
Legal fees	422	315	
Education, training and conferences	398	374	
Total Purchase of goods and services	**1,589,875**	**1,426,825**	5
Depreciation and impairment charges			
Depreciation	112	73	
Amortisation	-	31	
Total Depreciation and impairment charges	**112**	**104**	
Provision expense			
Change in discount rate	14	-	
Provisions	1,092	5	
Total Provision expense	**1,106**	**5**	
Other Operating Expenditure			
Chair and Non Executive Members	239	258	
Grants to Other bodies	1,418	-	
Research and development (excluding staff costs)	5,560	5,059	
Expected credit loss on receivables	44	-	
Total Other Operating Expenditure	**7,261**	**5,317**	
Total Operating Expenditure	**1,598,354**	**1,473,251**	

Notes

1. External audit liability is capped at £2m.
2. External audit fees including VAT £84,960 (£78,000 2019-2020) - Note: The accounts have under-accrued the fee by £4,320.
3. External audit fees for Mental Health Investment Standard £12,000 including VAT
4. Internal Audit services are provided by an external provider RSM Risk Assurance Services LLP and fees for 2020-2021 totalled £62,400 net of VAT (£62,400 2019-2020) and these fees are included in the 'Other professional fees'.
5. Expenditure on Covid totalled £48.4m of which £32.6m related to the Hospital Discharge Programme

6.1 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	21,370	580,734	24,007	510,243
Total Non-NHS Trade Invoices paid within target	20,879	572,781	23,657	501,135
Percentage of Non-NHS Trade invoices paid within target	**97.70%**	**98.63%**	**98.54%**	**98.21%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,596	905,247	4,963	833,213
Total NHS Trade Invoices Paid within target	1,565	904,895	4,904	831,076
Percentage of NHS Trade Invoices paid within target	**98.06%**	**99.96%**	**98.81%**	**99.74%**

There were no payments made from claims under Late Payment of Commercial Debts (Interest) Act 1998.

7. Operating Leases

7.1 As lessee

The Clinical Commissioning Group occupies and commissioning services in properties owned and managed by NHS Property Services Ltd and Community Health Partnerships Ltd. The costs incurred in relation to NHS Property Services Ltd and Community Health Partnerships are shown on Note 7.1 below.

Whilst our arrangements with Community Health Partnerships Ltd and NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed.

Consequently, this note includes only the known future lease payments from the other rental arrangements and does not include future minimum lease payments for these arrangements.

7.1.1 Payments recognised as an Expense

	2020-21				2019-20			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	-	2,856	-	**2,856**	-	2,715	-	**2,715**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**2,856**	**-**	**2,856**	**-**	**2,715**	**-**	**2,715**

7.1.2 Future minimum lease payments

	2020-21				2019-20			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	-	-	-	**-**	-	-	-	**-**
Between one and five years	-	-	-	**-**	-	-	-	**-**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

8 Property, plant and equipment

2020-21	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2020	721	100	821
Additions purchased	82	-	82
Cost/Valuation at 31 March 2021	**803**	**100**	**903**
Depreciation 01 April 2020	532	100	632
Charged during the year	112	-	112
Depreciation at 31 March 2021	**644**	**100**	**744**
Net Book Value at 31 March 2021	**159**	**-**	**159**
Purchased	159	-	159
Total at 31 March 2021	**159**	**-**	**159**
Asset financing:			
Owned	159	-	159
Total at 31 March 2021	**159**	**-**	**159**

8.1 Cost or valuation of fully depreciated assets

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

	2020-21 £'000	2019-20 £'000
Information technology	584	365
Furniture & fittings	102	102
Total	**686**	**467**

8.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	1	5
Furniture & fittings	1	5

9 Intangible non-current assets

2020-21	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2020	62	**62**
Additions purchased	170	**170**
Cost / Valuation At 31 March 2021	**232**	**232**
Amortisation 01 April 2020	62	**62**
Amortisation At 31 March 2021	**62**	**62**
Net Book Value at 31 March 2021	**170**	**170**

9.1 Cost or valuation of fully amortised assets

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

	2020-21 £'000	2019-20 £'000
Computer software: purchased	62	62
Total	**62**	**62**

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	2	5

10.1 Trade and other receivables

	Current 2020-21 £'000	Current 2019-20 £'000
NHS receivables: Revenue	25,280	7,229
NHS prepayments	391	4,742
NHS accrued income	29	142
Non-NHS and Other WGA receivables: Revenue	3,608	2,208
Non-NHS and Other WGA prepayments	20,133	2,823
Non-NHS and Other WGA accrued income	-	210
Expected credit loss allowance-receivables	(47)	(3)
VAT	336	336
Other receivables and accruals	7	48
Total Trade & other receivables	**49,737**	**17,735**
Total current and non-current	**49,737**	**17,735**
Included above:		
Prepaid pensions contributions	-	-

The great majority of trade is with NHS England. As NHS England is funded by Government no credit scoring is considered necessary.

£28,794,679 of the amount above has subsequently been recovered post the statement of financial position date.

10.2 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	-	909	494	27
By three to six months	30	44	15	-
By more than six months	141	2	581	-
Total	**171**	**955**	**1,090**	**27**

10.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2020	(3)	**(3)**
Lifetime expected credit losses on trade and other receivables-Stage 2	(44)	**(44)**
Total	**(47)**	**(47)**

10.4 Provision matrix on lifetime credit loss

Non NHS Debt	31-Mar-21 % Lifetime expected credit loss rate	31-Mar-21 £'000 Gross Carrying amount	31-Mar-21 £'000 Lifetime expected credit loss
Current		89	
1-30 days	1	10	
31-60 days	2	9	
61-90 days	20		
Greater than 90 days	100	47	47
Total expected credit loss	**123**	**155**	**47**

Non NHS Debt	31-Mar-20 % Lifetime expected credit loss rate	31-Mar-20 £'000 Gross Carrying amount	31-Mar-20 £'000 Lifetime expected credit loss
Current		74	3
1-30 days	2	2	
31-60 days	4	10	
61-90 days			
Greater than 90 days			
Total expected credit loss	**6**	**86**	**3**

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2021.

11 Cash and cash equivalents

	2020-21 £'000	2019-20 £'000
Balance at 01 April 2020	63	20
Net change in year	1,625	43
Balance at 31 March 2021	**1,688**	**63**
Made up of:		
Cash with the Government Banking Service	1,687	62
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**1,688**	**63**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2021	**1,688**	**63**

12 Trade and other payables	Current 2020-21 £'000	Current 2019-20 £'000
NHS payables: Revenue	2,624	4,436
NHS accruals	130	6,066
Non-NHS and Other WGA payables: Revenue	16,859	5,474
Non-NHS and Other WGA payables: Capital	252	-
Non-NHS and Other WGA accruals	95,076	70,080
Non-NHS and Other WGA deferred income	460	-
Social security costs	278	259
Tax	230	216
Other payables and accruals	2,168	1,915
Total Trade & Other Payables	**118,077**	**88,446**
Total current and non-current	**118,077**	**88,446**

There are no liabilities included in the above for person/people due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £1,474,971 outstanding pension contributions at 31 March 2021.

13 Provisions

	Current 2020-21 £'000	Current 2019-20 £'000
Restructuring	911	-
Redundancy	-	58
Legal claims	253	-
Total	**1,164**	**58**
Total current and non-current	**1,164**	**58**

	Restructuring £'000	Redundancy £'000	Legal Claims £'000	Total £'000
Balance at 01 April 2020	**-**	**58**	**-**	**58**
				-
Arising during the year	900	-	250	**1,150**
Reversed unused		(58)	-	**(58)**
Change in discount rate	11	-	3	**14**
Balance at 31 March 2021	**911**	**-**	**253**	**1,164**
Expected timing of cash flows:				
Within one year	911	-	253	**1,164**
Between one and five years	-		-	**-**
After five years	-		-	**-**
Balance at 31 March 2021	**911**	**-**	**253**	**1,164**

The Restructuring provision consists of £568k for early cancellation of lease for part of head office arising from changing working from home policies and impact of the recently published Government White Paper on the transition from CCGs to Integrated Care Systems; and £332k early voluntary redundancies associated with the impact of the recently published Government White Paper on the transition from CCGs to Intergrated Care Systems;

The Redundancy provision brought forward is a result of the merger of the three BNSSG CCGs in April 2018. The postholder has been appointed to permanent position within the Clinical Commissioning Group and the provision has been reversed.

The Legal provision of £250k is for a judicial review arising from the Stroke Service redesign programme which is scheduled for public consultation during Summer 2021.

14 Financial instruments

14.1 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. Disclosures of fair values are not required as per IFRS 7 as the SOFP carrying amount is a reasonable approximation of fair value and mainly relate to short term trade receivables and payables.

Because the 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 Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and internal auditors.

14.1.1 Currency risk

The 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 Clinical Commissioning Group has no overseas operations. The Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

14.1.2 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.

14.1.3 Credit risk

Because the majority of the Clinical Commissioning Group and revenue comes parliamentary funding, the 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.

14.1.4 Liquidity risk

The Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

14.1.5 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.

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Total 2020-21 £'000	Financial Assets measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Trade and other receivables with NHSE bodies	1,437	1,437	6,132	6,132
Trade and other receivables with other DHSC group bodies	24,314	24,314	1,523	1,523
Trade and other receivables with external bodies	3,172	3,172	2,182	2,182
Cash and cash equivalents	1,688	1,688	63	63
Total at 31 March 2021	**30,611**	**30,611**	**9,900**	**9,900**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Total 2020-21 £'000	Financial Liabilities measured at amortised cost 2019-20 £'000	Total 2019-20 £'000
Trade and other payables with NHSE bodies	1,101	1,101	1,094	1,094
Trade and other payables with other DHSC group bodies	26,007	26,007	30,064	30,064
Trade and other payables with external bodies	90,001	90,001	56,812	56,812
Total at 31 March 2021	**117,109**	**117,109**	**87,970**	**87,970**

14.4 Maturity of Financial liabilities	2020-21 Payable to DHSC £'000	2020-21 Payable to Other bodies £'000	2020-21 Total £'000	2019-20 Payable to DHSC £'000	2019-20 Payable to Other bodies £'000	2019-20 Total £'000
In one year or less	3	117,106	117,109	166	87,804	87,970
Total at 31 March 2021	**3**	**117,106**	**117,109**	**166**	**87,804**	**87,970**

15 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning Healthcare	1,620,588	(5,665)	**1,614,923**	51,754	(119,241)	**(67,487)**
Total	**1,620,588**	**(5,665)**	**1,614,923**	**51,754**	**(119,241)**	**(67,487)**

15.1 Reconciliation between Operating Segments and SoCNE

	2020-21 £'000
Total net expenditure reported for operating segments	1,614,923
Total net expenditure per the Statement of Comprehensive Net Expenditure	1,614,923

15.2 Reconciliation between Operating Segments and SoFP

	2020-21 £'000
Total assets reported for operating segments	51,754
Total assets per Statement of Financial Position	**51,754**

	2020-21 £'000
Total liabilities reported for operating segments	(119,241)
Total liabilities per Statement of Financial Position	**(119,241)**

16 Related party transactions

Details of related party transactions with individuals are as follows:

	2020-21				2019-20			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Deborah El-Sayed (Director of Transformation) - Bristish Red Cross, Trustee British Red Cross	528	0	0	0	357	0	0	0
Peter Brindle (Medical Director -Clinical Effectiveness), Rachel Kenyon (GP Locality Representative), Jon Evans (GP Locality Representative), Kirsty Alexander (Chair N&W Locality - CCG GB member and Children and Young Person Clinical Lead support), Felicity Fay (LLG Commissioning Lead) - GP Care Peter Brindle and Rachel Kenyon are shareholders in GP Care, Jon Evans belongs to a GP Practice that is a shareholder in GP Care, Felicity Fay and Kirsty Alexander are partners in organisations that are shareholders in GP Care	1,481	0	6	0	1,237	0	37	0
Alison Moon (Indpendent Lay member- Registered Nurse) - St Peter's Hospice. Alison Moon is a Trustee of St Peter's Hospice	1,985	0	7	0	1,941	0	0	0
Kevin Haggerty (Weston, Worle and Villages Locality Lead & North Somerset Governing Body Representative) - Pier Health Group Ltd. Kevin Haggerty is a Director of Pier Health Group Ltd	0	0	65	0	0	0	0	0
Sarah Truelove (Deputy Chief Executive Officer and Chief Finance Officer) - BRISTOL INFRACARE DEVELOPMENTS 1 LTD. Sarah Truelove is Director of Bristol Infracare LIFT Ltd. BRISTOL INFRACARE DEVELOPMENTS 1 LTD is part of Bristol Infracare LIFT Ltd.	47	0	0	0	0	0	0	0

The Department of Health and Social Care is the parent department and 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;
- NHS Foundation Trusts - significant parties University Hospitals NHS FT & South Western Ambulance FT;
- NHS Trusts - significant parties Weston Area Health NHS Trust & North Bristol NHS Trust;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. These transactions with Bristol City Council, North Somerset Council and South Gloucestershire Council have a total net spend of £109.6m in 2020/21 (£79.6m 2019/20). See table below for further details.

Expenditure with Local Authorities

	2020-21 £m	2019-20 £m	Increase £m	Hospital Discharge Prog £m	Other £m
Bristol City Council	44.4	31.3	13.1	10.3	2.8
North Somerset Council	37.8	31.3	6.5	6.3	0.2
South Gloucs Council	27.4	17.0	10.4	6.1	4.3
Total	**109.6**	**79.6**	**30.0**	**22.7**	**7.3**

17 Losses and special payments

Losses

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

	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Cash losses	-	-	1	0
Total	**-**	**-**	**1**	**0**

There was no losses in 2020-21 (2019-2020 one cash totallong £187 write off a salary pverpayment).

BRISTOL, NORTH SOMERSET & SOUTH GLOUCESTERSHIRE CCG

Head of internal audit opinion 2020/2021

11 June 2021

RSM

1. HEAD OF INTERNAL AUDIT OPINION

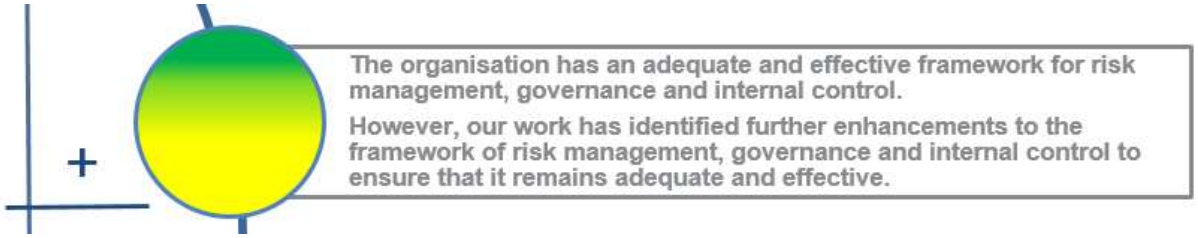
In accordance with Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

This document provides our annual internal audit opinion for 2020/2021.

1.1 The head of internal audit opinion

Our head of internal audit opinion for BNSSG is as follows:

Head of internal audit opinion 2020/21



Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

1.2 Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee. Our opinion is subject to inherent limitations, as detailed below:

- the opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. As such, the assurance framework is one component that the Governing Body takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management / lead individual;
- the opinion is based on the testing we have undertaken, which was limited to the area being audited, as detailed in the agreed audit scope;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance;

- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention;

- it remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be seen as a substitute for management's responsibilities around the design and effective operation of these systems; and

- our internal audit work for 2020/21 has been undertaken through the substantial operational disruptions caused by the Covid-19 pandemic. In undertaking our audit work, we recognise that there has been a significant impact on both the operations of the organisation and its risk profile, and our annual opinion should be read in this context..

1.3 Factors and findings which have informed our opinion

We have provided either a substantial or reasonable level of assurance in most of the areas reviewed to date, with the exception of the partial assurance opinions in the audit areas of **Appraisals,** and **Risk Management**. Since conclusion of these audit assignments, CCG management have provided updates to the Audit, Governance and Risk (AGR) Committee on progress made to implement the agreed improvement actions.

Appraisals

This audit looked at the CCGs new policy and process for annual and mid-year appraisals. Whilst we found the new policy and process to be well designed, there was a lack of consistent application which indicated a poor culture of compliance with the new process. At the time of audit only 30% of CCG staff had logged a completed appraisal, however, positive feedback was gathered from those that had completed a recent appraisal. Since conclusion of the audit, an update report was provided to the AGR Committee in February 2021 which stated progress against the audit actions and showed that an additional 61 staff had logged a completed appraisal in the ConsultOD system, with further improvement still required. With the current remote working arrangements, it is important for staff wellbeing, development and accountability that the appraisal process is effective and taking place in a timely manner. We will continue to follow up and report progress to the Audit Governance and Risk Committee.

Risk Management

During the risk management review, we observed limited scrutiny by the Governing Body and sub-committees of principal risks, due to limitations in design of the committee terms of reference in setting out responsibilities for risk and assurance. Responsibilities for scrutiny of risks had not been clearly articulated through the terms of reference for each sub-committee (e.g. Quality Committee and Commissioning Executive Committee), resulting in insufficient assurance being provided to the Audit, Governance and Risk Committee over risks to achievement of objectives in each area of responsibility of each committee. There was limited guidance for management as to the level of risk the CCG is willing to accept in pursuit of its objectives, with no clear link from target risk scores to the risk appetite statement. We did however note good practice around the embedding of Covid-19 related risk management practices into the corporate risk register.

Since the audit, we have provided risk training to the executive team and the Governing Body has approved an updated risk management framework, committee terms of reference and risk register. A directorate programme of awareness raising has taken place between December 2020 – March 2021 to help embed the improved risk culture across the CCG.

Other internal audit reviews

The remainder of our audit assignment reports issued have received substantial or reasonable assurance opinions and have not identified any significant control issues, however, it is noted that the performance around out of area placements will be kept under review to ensure the new governance framework is having the desired impact.

Substantial Assurance

- Conflicts of Interest
- Emergency Preparedness, Resistance and Response – Governance
- Primary Care Delegated Commissioning – Finance

Reasonable Assurance

- Cyber Security including GP IT
- Out of Area Placements
- Payments to Staff
- Safeguarding
- Locality Partnerships and Integration (DRAFT)

Advisory

- System Financial Management (DRAFT)
- Data Security Protection Toolkit (DRAFT)

No significant issues were noted as part of these advisory reviews.

1.4 Topics judged relevant for consideration as part of the annual governance statement

Based on the work we have undertaken on the CCG's system on internal control, we would highlight the partial assurance opinions discussed above and believe management should consider these for their relevance for inclusion in the Annual Governance Statement (AGS). The CCG may wish to consider whether any other issues have arisen, including the results of any external reviews (CQC / NHSE / external project consultants) which may warrant consideration for inclusion in the AGS.

Service Auditor reports

We reviewed the Service Auditor Report from the internal auditors of NHS Shared Business Services who, provide services to the CCG. The report was unqualified for 22 out of 23 control objectives. The exception identified related to the operating effectiveness of controls relating to the authorisation of manual credits. Management actions are in place to address the issue.

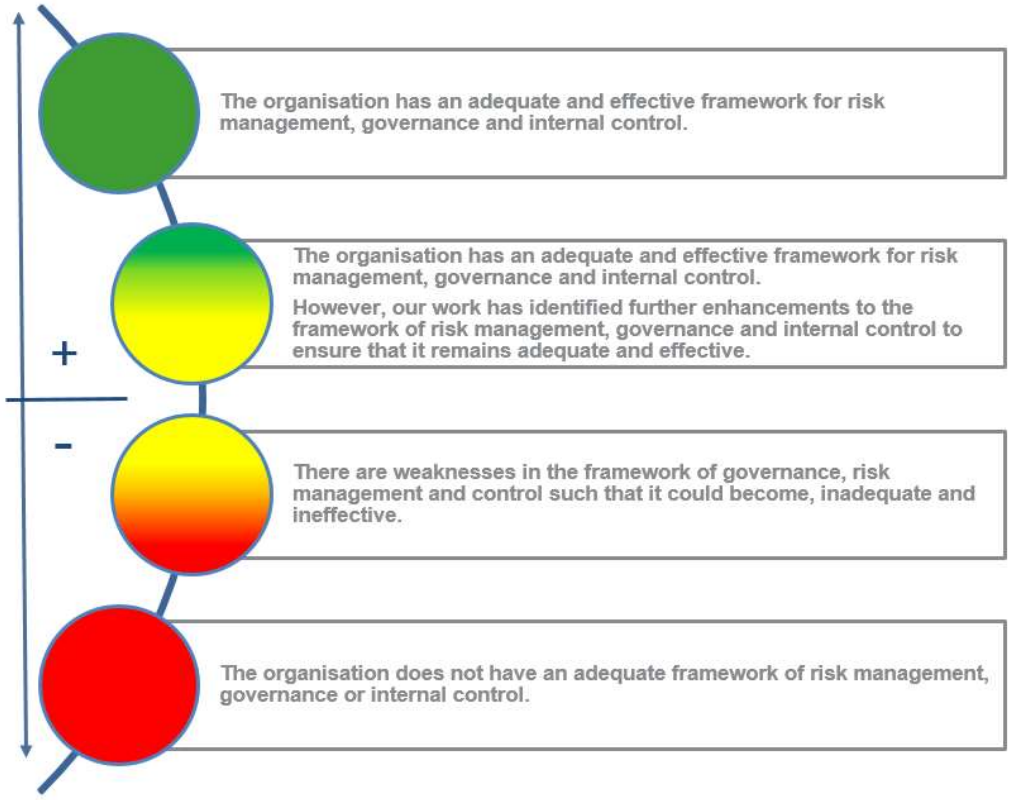
We reviewed the Service Auditor Report from the internal auditors for NHS Digital with regards to GP Payments. Testing for one of the controls (*controls are in place to provide reasonable assurance that access to systems is controlled)* identified an exception, but there was no significant impact for the CCG on its overall control environment.

We reviewed the Service Auditor Report from the internal auditors for NHS Business Services Authority with regards to prescription payments. Exceptions were identified on testing for three of the controls although there was no significant impact for the CCG on its overall control environment.

We reviewed the Service Auditor Report from the internal auditors for Capita. The Service Auditors noted minor exceptions on three out of 16 control objectives, controls for two of the areas could not be operated throughout the financial year due to operational changes made because of the pandemic.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • Limitations in the individual audit assignments • The adequacy and effectiveness of the risk management and / or governance control framework • The impact of weakness identified • The level of risk exposure • The response to management actions raised and timeliness of actions taken

FOR FURTHER INFORMATION CONTACT

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Independent auditor's report to the members of the Governing Body of NHS Bristol, North Somerset and South Gloucestershire CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Bristol, North Somerset and South Gloucestershire 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 Annual 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 Annual 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.

Qualified opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

Section 256 of the National Health Service Act 2006 gives CCGs the power to make payments to local authorities for the delivery of health-related services. On 26 March 2021, the CCG used surplus funds to make payments of £20 million to several local authorities for such services to be delivered in the 2021/22 financial year. Paragraph A4.8.5 of 'Managing Public Money', issued by HM Treasury, states: "Payments in advance of need should be exceptional and should only be considered if a good value for money case for the Exchequer can be made. Even then, as advance payments lead to higher Exchequer financing costs, such payments are novel and contentious and require specific Treasury approval. Advance payment should never be used to circumvent expenditure controls or budgetary limits". The CCG made payments in advance of need and has not provided any evidence of specific Treasury approval for these payments to be made.

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, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, 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, particularly where there is a risk that the year-end position of the CCG could be misrepresented by overstatement.
- 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;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of non-NHS accruals, (including elevating the inherent risk of our non-NHS expenditure sampling and extended work on the non-NHS payables balance) and the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. 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 breach of the requirement for expenditure recorded in the financial statements to be applied to the purposes intended by Parliament, the potential for fraud in revenue and expenditure

recognition, and the significant accounting estimates related to non-NHS accruals, prescribing accruals, and provisions.

- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

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 Annual 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 Bristol, North Somerset and South Gloucestershire 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.

JD Roberts

Jon Roberts, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

18 June 2021:

Independent auditor's report to the members of the Governing Body of NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

In our auditor's report issued on 18 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 18 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 Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group 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.

JD Roberts

Jon Roberts, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

4 August 2021