NHS
Bath and
North East Somerset
Clinical Commissioning Group

Annual Report and Accounts 2019/2020

NHS Bath and North East Somerset Clinical Commissioning Group

The Bath and North East Somerset CCG website has now been archived. The new website for the single Bath and North East Somerset, Swindon and Wiltshire CCG is www.bswccg.nhs.uk

Twitter @NHSBSWCCG Facebook NHS BSW CCG Telephone: 0300 3047500

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Feedback to this document

We would very much like to hear your views on our Annual Report. To comment on the report, receive a copy in an alternative format, or get involved with shaping health services for the people of Bath and North East Somerset , please visit the new website for the single Bath and North East Somerset, Swindon and Wiltshire CCG at www.bswccg.nhs.uk.

Part One – Performance Report

Tracey Cox
Chief Executive
Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

25 June 2020

Performance Report

Overview

This section provides an overview of how the CCG worked, what it did, the risks it was exposed to, and how it performed over the course of 2019/20.

NHS organisations produce an annual report and financial accounts at the end of every financial year. In this report the CCG describes how it fulfilled its duties as laid out in the National Health Service Act 2006 for the 2019/20 reporting year.

Accountable Officer statement

Welcome to our seventh and final Annual Report and Accounts for Bath and North East Somerset Clinical Commissioning Group. This report explains what we have been doing during the year and how we have fulfilled our statutory duties in commissioning healthcare for our local population, as well as listing our achievements and our challenges.

Working as a single CCG

During 2019, Bath and North East Somerset, Swindon and Wiltshire CCGs announced their intention to merge into a single organisation on 1 April 2020. This move followed several years of close joint working and aligned with the local and national strategy for CCGs as set out in the NHS Long Term Plan. Subsequently, there are strong similarities in the annual reports for each organisation.

In early 2019, we strengthened our joint working by developing a joint executive team. Following NHS England's approval of the three organisations' intention to merge, we continued to strengthen our joint management team as we worked towards becoming a single organisation in April 2020 and an Integrated Care System by April 2021.

Working as a single CCG will enable us to provide a consistent vision and voice, while achieving high quality outcomes across the system. We are aiming to reduce variation in care and standardise best practice so everyone can access high quality treatment and services, regardless of where they live. Some of the service improvements we have already been delivering are highlighted in this report.

We have already seen the benefits that come from operating as a merged organisation, especially at a time of unprecedented challenges in the NHS. Our response to the Covid-19 pandemic was one that followed a joined-up approach and saw teams work together to remove duplication and variation, while enabling every part of the system to access the right support and expertise.

Performance during the year

We continued to focus on delivering key NHS priorities in 2019/20. Like many CCGs, we struggled to meet the National Access Standards, including the NHS Constitutional Measures, in 2019/20 due to high levels of demand and challenges with workforce availability. Though our performance is often better than the national average, and also in the top quartiles when compared to other CCGs, we anticipate access standards will still be a challenge during 2020/21 and potentially even further in the future as we deal with the impact of Covid-19 on routine health and care delivery.

We have been working with our providers to develop system-level approaches to resolve issues that are affecting the wider health and care system's ability to deliver national standards. We also worked with providers to ensure that patient safety was never compromised during times of increased pressure and demand for emergency care, and that waiting lists were managed in a way that maximised patient safety and clinical effectiveness. We have constantly aimed to improve the quality of health and care services in order to provide a positive patient experience and also to ensure that services are delivered safely and effectively. We have done this within our financial allocation and while managing ever-increasing demand.

Public engagement highlights of our year

Engagement with the public and patients is very important to us and the feedback they provide really does make a difference. During 2019/20 we carried out the following:

Our Health Our Future

As part of our response to the NHS Long Term Plan, we launched the Our Health Our Future summer-long engagement campaign, asking people living across Bath and North East Somerset, Swindon and Wiltshire what areas of healthcare they would most like the CCG to prioritise over the next five years. People were asked:

- What's the one thing you wish you'd known sooner to help you be as healthy as possible?
- What's the one thing that would help you to find and use health and care services more easily?
- What's the one thing that would help to make a difference to your health and care in the future?

Between Thursday 13 June and Wednesday 31 July, we carried out more than 1,000 face-to-face engagements and received more than 1,400 online survey responses.

The survey results were used to inform the new BSW Long Term Plan and can be seen in full by visiting www.bswstp.nhs.uk/ourhealthourfuture.

Development of a BSW-wide citizens panel

In January 2020, people living in Bath and North East Somerset, Swindon and Wiltshire were targeted as part of a member recruitment drive for the region's new citizens panel.

A new way of engaging with local people, the panel – known as the Our Health Our Future panel, as a continuation of the summer's engagement campaign – intends to act as an innovative forum in which members of the public can provide their views on local health and care issues.

People recruited to the panel will be invited to take part in regular surveys, as well as the occasional focus group.

Full reports from each survey will be made publicly available, and the insight captured from the questionnaires will be used to inform future decision making, strategy, service design and service change.

Transforming Maternity Services Together

The proposal to change the way maternity services are delivered across the region was developed by all the NHS organisations that plan and buy health services as well as those that provide or manage maternity services across B&NES, Swindon and Wiltshire. We engaged

widely across BSW and more than 2,400 people took part in public consultation between 12 November 2018 and 24 February 2019.

A team at the Centre for Healthcare Innovation and Improvement at the University of Bath School of Management analysed the survey responses. The full report and other consultation material was published online in January 2020 and are available on the Transforming Maternity Services Together website: www.transformingmaternity.org.uk.

The proposal to change maternity services was approved by the joint BSW Governing Bodies on 16 January 2020 and implementation of the proposal has begun.

Primary Care Networks

Primary care is the bedrock of healthcare in Bath and North East Somerset, Swindon and Wiltshire.

In July 2019, Primary Care Networks (PCNs) were introduced nationally as part of the NHS Long Term Plan. In its simplest terms, a PCN is a group of GP practices that work together across a defined area to serve a population of between 30,000 and 50,000 people. Across BSW, there are 94 GP practices working as 22 PCNs. In Swindon, there are six PCNs (with one unaffiliated practice) and each one has a clinical director whose role it is to ensure local needs are met.

Primary Care Networks help to make sure patients are supported and signposted to the health and care professional who is best placed to help – this could be a GP, a pharmacist, paramedic, physician associate, or a professional working in social care or the voluntary sector.

This not only supports patients to get appointments more quickly, but allows GPs to focus on the most complex patients and those most in need. They also represent a real change in how primary care operates, with practices now shifting from reactively providing appointments to proactively caring for people and communities. The development and mobilisation of PCNs has been instrumental in supporting our response to COVID -19 and has enabled GP practices to work collaboratively and effectively with neighbouring colleagues.

A focus on the BaNES locality

Cardiac rehabilitation

In 2019, the CCG expanded the rehabilitation offer for people who either had a cardiac event (heart attack, stent or heart surgery) or a diagnosis of heart failure. Rehabilitation classes are now offered in hospital or in the community on a range of days and times, and there is the option for home-based rehabilitation for people who prefer not to attend classes. The new services will ensure that people from groups who are traditionally less likely to access rehabilitation support will benefit. There is a specific focus on reducing health inequalities and reducing the mortality gap amongst different sections of the population caused by cardiac disease.

We worked to improve access to and take up of exercise-based rehabilitation for cardiac patients with a target of increasing the uptake of rehabilitation amongst eligible patients from 35 per cent to 65 per cent to prevent cardiac readmissions.

Better care for health conditions

During 2019 Bath and North East Somerset CCG was actively working to improve outcomes for patients in several different areas through the introduction of new ways of working.

In dermatology services, we worked with the Royal United Hospital to address an increase in demand for dermatology services, in part as a knock-on effect of an increase in cancer referrals. Bath and North East Somerset CCG has been training additional GPs with specialist interest to augment existing community service capacity, as well as introducing a tele-dermatology advice and guidance service which uses high quality medical photography as a tool to diagnose dermatological conditions.

In our musculoskeletal services, we successfully introduced a pilot First Contact Practitioner scheme to provide a registered physiotherapist as the first point of contact for patients, offering new expertise and giving patients faster access to the right care. Our First Contact Practitioners are qualified, autonomous clinical practitioners who can assess, diagnose, treat and discharge a person without a medical referral where appropriate. They are also an important resource to offer patients of our Primary Care Networks in our area.

Covid-19

The Covid-19 pandemic accelerated cross-CCG working prior to the official merger of the three organisations in April 2020. Multi-disciplinary teams were established to support areas such as clinical staffing, elective care, medicines management, safeguarding, primary care and mental health. An Incident Control Centre (ICC) was established at Southgate House in Devizes, and was manned by colleagues from each of the CCGs in Bath and North East Somerset, Swindon and Wiltshire. The ICC moved to a fully virtual setup in April 2020.

Community response hubs were set up in Bath and North East Somerset, Swindon and Wiltshire to ensure the CCG was able to work collaboratively with local authority partners, providers and the community and voluntary sector. The focus of these hubs was to support the rapid discharge of patients from the three acute hospitals and to deliver joined-up health and social care support to local residents, especially those identified as vulnerable. As the requirement for supporting shielded patients and managing patients in the community increased, the need for community-based solutions highlighted the value of the community response hubs in co-ordinating a joined up response across primary care, community providers, care homes, hospices, as well as acute settings.

At a strategic and system-wide level, the CCG's Chief Executive, along with the Senior Leadership Team, worked with their counterparts from local acute and community providers, emergency services and local authorities to co-ordinate planning and the wider response to emerging issues. Close contact was maintained with NHS England and Improvement and Public Health England in the South West to escalate issues and provide local feedback to national guidance and priorities.

The response to the pandemic was based on collaboration and communication at all levels of the health and social care system across Bath and North East Somerset, Swindon and Wiltshire, with a drive to continue providing the best services to people.

At the time of writing, Covid-19 is still very much active. The pandemic impacted on the local population, the health and care workforce and how colleagues work together across organisations in Bath and North East Somerset, Swindon and Wiltshire. During this time, the CCG has had to step away from the normal ways of working and use technology and innovation to enable teams to provide services in different ways. Processes are in place to capture the learning from this experience, which will help to identify services that need to be provided as before and those that could be delivered differently in the future. This piece of work is set to continue over the next few months.

Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG) priorities for 2020/21

During the year, the CCGs' Governing Bodies in Common agreed the key priorities for the new standalone BSW CCG.

Helping people to stay healthy and independent in old age will be a top priority over the next five years, along with offering more help for people with learning disabilities and improving access to mental health services.

The priorities were drawn up by the CCGs, local authorities, hospitals, other care providers and voluntary organisations, and based upon the feedback that was collected during an extensive public engagement exercise that was carried out in the summer of 2019 in response to the publication of the NHS Long Term Plan.

The priorities will:

- Help people to age well, stay well at home and improve how community services can help them

- Help to improve the quality of life for people with learning disabilities and autism and their families by improving access to services

- Help to deliver the best mental health support for local people, regardless of personal circumstances, age or individual need

The draft five-year plan is available to view on the BSW Sustainability and Transformation Partnership website at www.bswstp.nhs.uk.

Finally, I would like to personally thank everyone who works for our health and care services during these difficult and challenging times. I continue to be humbled and impressed by the dedication, passion and commitment displayed by health and care professionals across our local system, particularly in light of the ongoing demands being faced daily. I am confident that by working as a single CCG and as part of a wider system, we will be better placed to rise to these challenges so that our public, patients, family and friends can receive the best possible care.

Thank you for reading our report – I hope you find it informative and interesting.

Who we are and what we do

Our role

As a clinically-led statutory NHS body, Bath and North East Somerset Clinical Commissioning Group (CCG) was responsible for planning and commissioning health care services for our local area to achieve the best possible health outcomes for our local population, acting effectively, efficiently and economically. This has been done by assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

Being led by local doctors and elected members, lay members and a registered nurse – all of whom are close to patients and their needs – enabled Bath and North East Somerset CCG to improve the quality of care provided to all the people of B&NES. We have been supported by a very experienced team of dedicated NHS professionals.

Our vision

The vision for Bath and North East Somerset CCG guided and informed our work, along with the local population's health needs and experience of healthcare.

A Compassionate Community in which people are inspired and supported to look after themselves and each other.

Towards the end of 2019/20 we embarked on agreeing a vision for the new BSW CCG:

"Working together to empower people to lead their best life" is the one, unified vision for our organisation and all our partners working together across Bath and North East Somerset, Swindon and Wiltshire.

Our vision, the result we want to achieve for local people, informs the present and inspires the action needed to make change happen. It is underpinned by three core principles:

1. Collective voice – working together in collaboration as one whole system
2. Healthy communities – empowering people to lead on their health with their families, their communities and health professionals
3. Stories and strengths – holding people's strengths, stories and experiences, and what matters to them at the heart of our system

Our values

The values we were working to in early 2019/20 were:

- Being accountable
- Being caring
- Being collaborative
- Being curious
- Acting with integrity
- Being outcomes driven

Towards the end of 2019/20 colleagues across the three merging organisations developed five core values which will underpin the way we will work and help to guide our actions and the decisions we make for local people and communities:

1. Caring
2. Innovative
3. Inclusive
4. Accountable
5. Collaborative

Merger of Bath and North East Somerset, Swindon and Wiltshire CCGs

During 2019, Bath and North East Somerset, Swindon and Wiltshire (BSW) CCGs announced their intention to merge into a single organisation on 1 April 2020. This followed several years of closer joint working and aligned with both local and national direction of travel described in the NHS Long Term Plan.

To ensure that the health and care services we commission will meet the needs of the many different communities living across BSW, we will have distributed leadership across our three localities of BaNES, Swindon and Wiltshire, supporting services at a local level within an overall strategic approach and oversight. This means that our decision-making can be influenced and governed by GPs and other healthcare professionals who know and understand their local population and that we can respond to the variation in local population needs. There are several other factors that impact on our health and wellbeing, such as housing, transport and education. These factors all play a part in determining how healthy we are but can vary depending on where we live. As part of retaining a local focus, we will maintain strong links with our three local authorities.

Working as a single CCG will allow us to concentrate on supporting people to stay healthy and tackle the causes of illness. We value the diversity of our growing population, but we know there are huge social and economic inequalities and differences across BSW. We are aiming to reduce variation in care and standardise best practice so everyone can access high quality treatment and services, regardless of where they live. Some of the service improvements we have already been delivering together are highlighted throughout this report.

From 1 April 2020, BaNES, Swindon and Wiltshire CCG will serve a combined population of 944,000 people and have a core budget of over £1.236 billion, plus delegated authority for primary medical care services. Working together will also allow us to meet financial challenges, for example through economy of scale cost-savings and the streamlining of governance and administration which means we can invest more of our budget into frontline services.

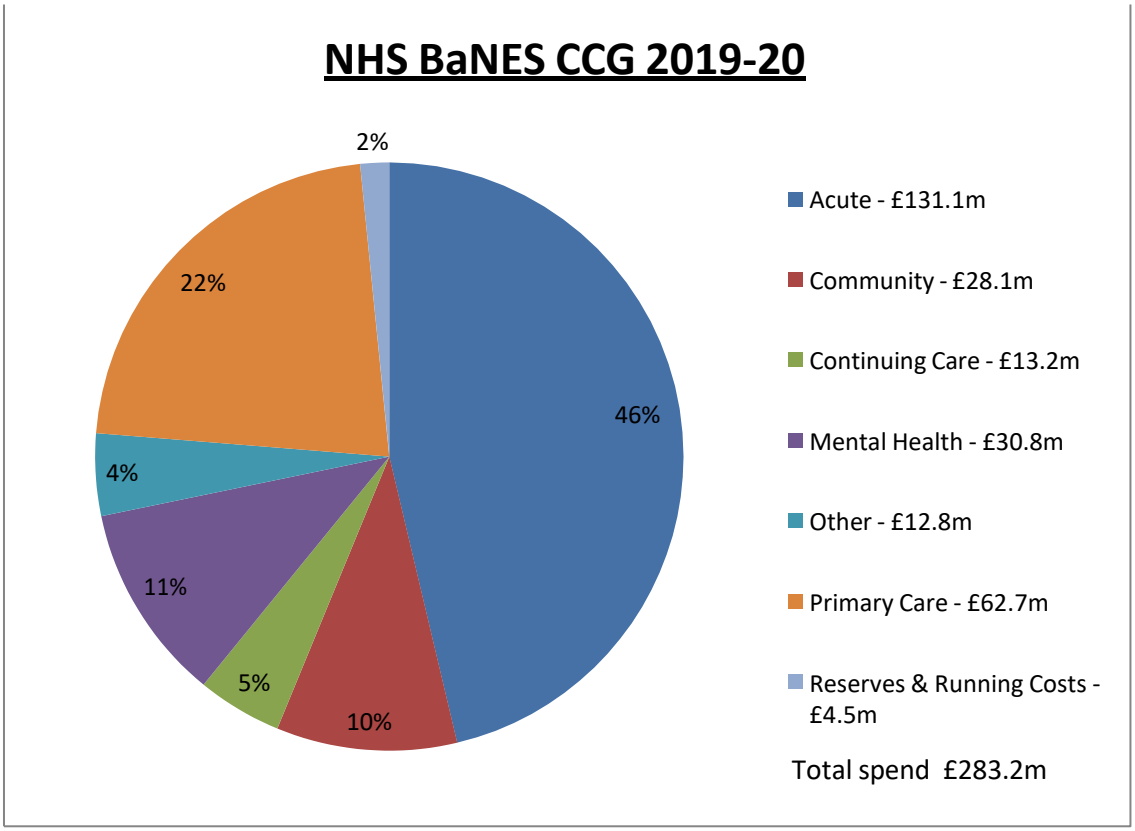
We have already seen many of the benefits of operating as a merged organisation in some of the most challenging times this country has seen for a long while. Our response to the Covid-19 pandemic has been supported by our joined up teams and enabled all parts of the system to access the right level of support and expertise.

The CCG's Incident Control Centre was set up in response to the Covid-19 pandemic.

We engaged with our members, the public and wider stakeholders over summer 2019 before submitting our application to merge in the autumn. Alongside approval by NHS England, we continued to engage with our GP members to agree the details of creating a merged organisation before they voted and supported our merger proposals in late autumn 2019.

Where the money goes

The CCG received £283.2m million in 2019/2020 to buy a full range of health services for local residents. Acute healthcare made up the highest percentage of expenditure (46%) with the next highest being Primary Care (including Delegated Commissioning) followed by Mental Health services.



Our population and their health

The number of patients registered with GP practices in B&NES is higher than the resident population, at 211,454 patients (February 2019) compared to 192,106 residents (2018 figures) (data source: B&NES Council).

As well as working with doctors, other clinicians and members of the public to understand what people want from their NHS, the CCG also worked closely with Bath and North East Somerset Council public health team to understand the health issues and needs amongst local communities. This included a yearly assessment of health needs based on available evidence, called the Joint Strategic Needs Assessment (JSNA).

Some of the key facts highlighted in the JSNA summary, which provide context for some of the decision making in relation to the 2020/21 BSW CCG Operational Plan include:

4,281 children and young people aged 5 to 19 in B&NES have at least one mental disorder.

18.9% (22,308 people) of the working age population (18-64 year olds) in B&NES have a common mental illness.

It is projected that the student age population will remain significant in B&NES.

There is projected to be a large increase in the number of older people in B&NES, for example, between 2016 and 2029 the number of people aged 75 and over in the local population is projected to increase by 36% (from 16,600 to 22,600 people).

There are many anticipated impacts as a result of an ageing population including requirements for people to work longer, additional strain on healthcare (particularly from long-term conditions) and difficulty enabling more people to live independently.

Working together to improve health and care

We believe that health in Bath and North East Somerset can only be improved through effective working with local partners and engaging clinicians to work with communities and patients to design services for the future.

We have increasingly worked together at both a local and system level to develop and improve services. At a local level we established an Integrated Care Alliance in B&NES which brings together colleagues from the Royal United Hospitals Foundation Trust, Virgin Care; primary care, the council; voluntary sector and Healthwatch. A new Health and Care Board has also been formed to take decisions informed by the collective experience of GPs, local Councillors and senior officers from the council and CCG.

Maternity services – as our response to the Better Birth recommendations and to improve experience for women, babies and families, we have created a clinically led BSW Local Maternity System. Over the past two years, we have reviewed maternity provision across BSW to drive service transformation at scale, focussing on a review of birthplace options to improve parity of choice, and the development of transitional care, and successfully bidding for funding to deliver innovative solutions and improvements in care.

Mental health – a new Thrive mental health programme has been created across BSW, working with our strategic partners and with people who experience our services. We have co-produced a draft mental health strategy with shared priorities across BSW including a review of the overall bed base, roll out of community places of calm, and co-creation with Primary Care Networks.

BSW Partnership (Sustainability and Transformation Partnership)

Health and social care organisations across Bath and North East Somerset, Swindon and Wiltshire (BSW) have been working together as BSW Partnership to join up and improve services for local people. The partnership is made up of CCGs, Councils, NHS health and care providers, a mental health trust, an ambulance trust and voluntary sector organisations. This allows organisations to improve the quality of services across the combined area, improve health outcomes and ensure services remain cost-effective and sustainable.

During 2019/20, there have been several developments across BSW which will help our partnership as we move towards an Integrated Care System. These include:

- Appointment of new BSW Partnership independent Chair to help deliver goals outlined in BSW's Five Year Plan
- Roll out of cross-BSW Trailblazer scheme to improve access for school pupils to specially trained mental health practitioners
- Cross-region public engagement exercise – Our Health, Our Future – to gather public views on future of health and care services. This feedback also informed the development of the BSW Five Year Plan
- Development of a cross-BSW Integrated Health and Care strategy
- Ongoing development of an alliance between the GWH, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust to help improve clinical services for those living in BSW
- Agreeing six strategic priorities to work on together:

1. Helping people to age well.
2. Helping people with learning disabilities and autism.
3. Helping people affected by mental health issues.
4. Improving the health and wellbeing of our population.
5. Developing healthy communities.
6. Transforming the way, we deliver care across BSW.

Key issues and risks

For 2019/20, we created a single Operational Plan for BSW which identified the key risks during this period as:

Maintaining financial stability and delivery of financial targets

The scale of financial challenge remained in 2019/20 despite significant progress in previous years and there was a risk for BSW that we would be unable to make appropriate progress in addressing the sustainability of individual organisations and the collective system's financial position.

Under the leadership of the new BSW Executive Directors, significant progress has been made to develop a refreshed financial recovery plan for all partners. Owned by all the constituent organisations within BSW and monitored by the BSW Partnership Executive Team and Sponsoring Board, it forms part of our Long Term Plan. The three individual CCGs have benefited from joint working in 2019/10 whilst planning for merger in April 2020 and we are now in a position to deliver the benefits we identified – see our Long Term Plan which provides more details (page 8 for the benefits).

Managing demand for services within planned levels

Recent years we saw growth in demand for services which challenged the capacity of providers to deliver and the CCGs to finance. In 2019/20, we set out our demand management plans with a BSW focus on frailty and pursuing the opportunities to deliver best practice care - following a Right Care approach but there was a risk that demand would be higher than we had planned with our providers.

We were largely successful in managing demand working on a BSW basis although there is some variation across the patch. Overall in 2019/20 GP referrals remained static; outpatient attendances were lower than plan; overall elective/ planned activity was lower than our plan, although day cases were higher than planned. Attendances at accident and emergency departments and emergency admissions to hospital were lower than we planned although four hour performance continued to be challenging.

Organisational change may be distracting

We identified in our joint Operating Plan that there was a risk that we would be distracted by organisational change during transition and as a result the pace of transformational change would be slower than we required. However, we tied the merger and transformational work closely together and made rapid progress with both.

Preparations for merger have been time consuming and have involved members of our staff in all areas of our work. We successfully met all the requirements for merger and became Bath and North East Somerset, Swindon and Wiltshire CCG on 1 April 2020. The success of our preparations for merger has been proven in the very effective mobilisation of our BSW response to Covid-19 which in turn has facilitated rapid transformational change in service delivery during the pandemic. We will now be assessing the benefits of maintaining some of these new ways of working going forward.

System behaviours and relationships

In our BSW Operating Plan for 2019/20, we identified a risk that relationships might deteriorate, and behaviours undermine collaborative working across boundaries.

During the last 12 months, our System Transformation Partnership and system relationships have been supported by a range of organisational development activities including workshops and development sessions. We have developed a shared vision for BSW, and we have developed a Long Term Plan for BSW together. We have also set out our aspirations to become an Integrated Care System. See pages 9 and 10 for more information about our vision and priorities for the next five years.

Recovering areas of poor performance and maintaining good performance

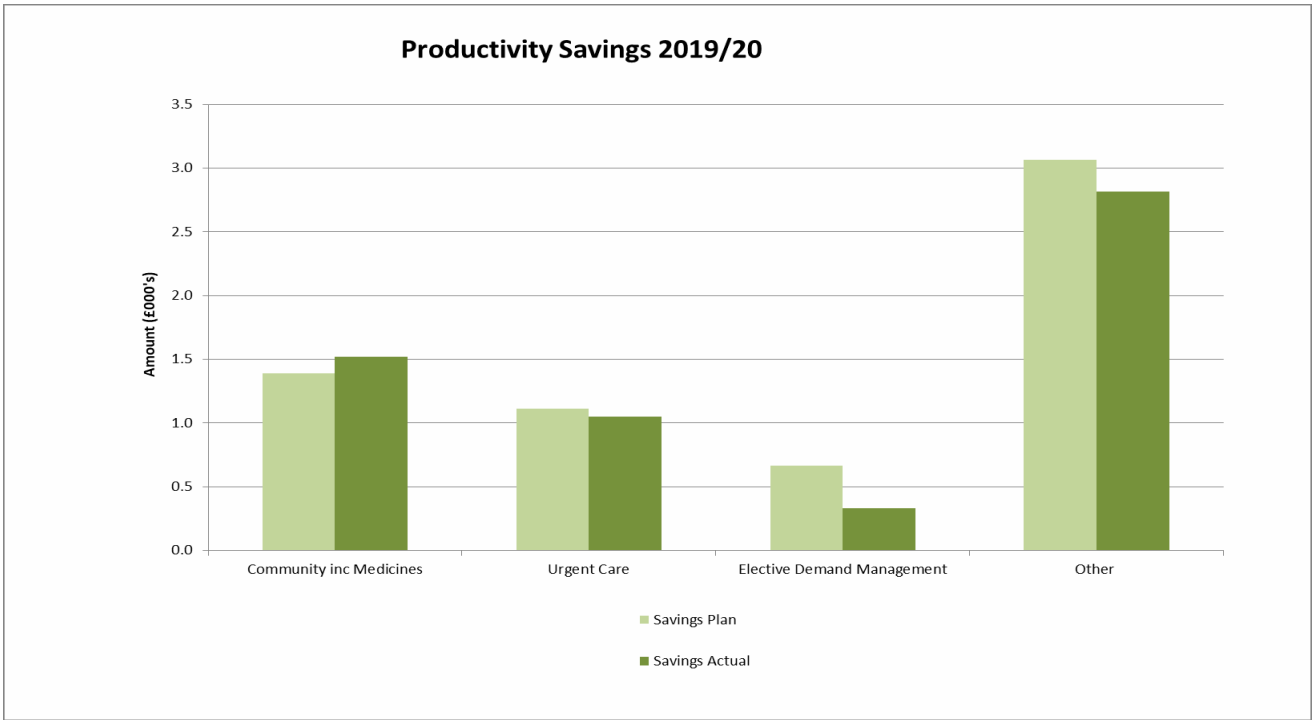
We were concerned that we might struggle to recover our A&E four hour performance and referral to treatment access times during 2019/20. As anticipated, due to very high levels of demand and shortages of workforce in some key areas we have struggled to meet some of the NHS constitutional targets. This will continue to be a challenge into 2020/21. The focus of our five year plan is on improving the health and wellbeing of our population across all age groups and changing the way we deliver services to meet the needs of our ageing population by expanding support in the community to maintain independence and speeding up discharge from hospital when this is needed. By working together with our system partners in BSW, we plan to improve access and outcomes for our population.

Going concern

Going concern is a fundamental principle in the preparation of the financial statements of any audited body. Under the going concern assumption, a CCG is viewed as being in a viable position to continue to operate for the foreseeable future with no necessary financial support or significant deviation from its planning assumptions.

To achieve financial balance; the CCG was required to deliver £6.2m of financial savings and efficiencies for the year. The CCG focused its efforts on a few key schemes to manage demand across the healthcare system.

During the year, the CCG saw the following programmes delivering or exceeding against plan:



Improvements on internal control processes

The CCG had sound processes for financial management and performance management across the range of its commissioned services and running costs. The financial management and budgetary control framework and supporting guidance provided a structure for the exercise of financial control, and regular performance monitoring enabled review of the quality and productivity of commissioned services.

The CCG internal audit function has been provided by an external firm of accountants. The full Head of Internal Audit Opinion is set out on pages 70 to 72.

Based on a full year's programme of internal audits and reviews, their opinion for the period 1 April 2019 to 31 March 2020 was: "Significant assurance with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control."

Performance report

Performance analysis

This section of the annual report sets out more detail about the CCG's performance during 2019/20. It provides detailed information on the health of the population, the delivery of local targets and what remedial actions are being put in place to improve performance. It also sets out the key risks for the new organisation and what it is doing to mitigate them.

2019/20 year end performance summary

NHS Oversight Framework

The NHS Oversight Framework for 2019/20 replaced the CCG Improvement and Assessment Framework (IAF). NHS England and NHS Improvement (NHSEI) are aligning their operating models to support system working. 2019/20 has been a transitional year, with NHSEI regional teams coming together to support local systems like BSW. This new approach to oversight set out how regional teams review performance and identify support needs across sustainability and transformation partnerships (STPs) and integrated care systems (ICSs).

As required by law, the annual assessment of CCGs by NHS England continued in 2019/20. It is a judgement, reached by considering a CCG's performance in each of the indicator areas over the full year and balanced against the financial management and qualitative assessment of the leadership of the CCG. Formally NHS England will continue to assess how CCGs work with others (including their local Health and Wellbeing Boards) to improve quality and outcomes for patients.

This integrated approach enables NHSEI regional teams to look at the support requirements for CCGs and providers in parallel so that support and intervention are mutually reinforcing. Intervention should be proportionate and based on the organisation's performance and the capability of the system to deal with any issues in the first instance.

The NHSEI regional team will determine how frequently they will review CCGs' and providers' support needs and segmentation based on their performance against the metrics in the assessment framework. These will include quality of care, population health, financial performance and sustainability, and delivery of national standards.

In 2019/20 the BSW CCGs were offered targeted support with improving performance of constitutional measures and working with the CCGs in preparing for the merger. The 2019/20 annual assessment process has reflected a transition year between the CCG Improvement and Assessment Framework and the NHS Oversight Framework as the Long Term Plan metrics that will be a key part of the new framework were in development. BaNES CCG maintained its Good overall rating from 2018/19 supported by Good ratings for Quality of Leadership and Financial Management.

There are sections in this report focussed on the priority areas in the NHS Outcomes Framework including:

- Quality of care – see Quality, engagement, health inequality and strategy (page 30)
- Population health – see Who we are and what we do (page 13)
- Financial performance – follows below in this section
- Sustainability – see Sustainable development (page 43)
- Delivery of national standards – follows below in this section

Performance reporting and management

During 2019/20 Bath and North East Somerset, Swindon and Wiltshire CCGs took a joint approach to the management of performance, supporting the development of a system approach and the movement towards a single CCG structure ready for 2020/21.

We have developed a new performance report appropriate for both CCG and STP use; the BSW Performance, Quality, Finance and Activity report.

In 2019/20 the performance and quality section of the report has included monthly or quarterly data with detailed narrative on performance delivery, current challenges and remedial actions. This section focuses on nationally reported performance metrics and key quality measures including:

- Planned care: referral to treatment times and waiting lists, diagnostics waiting times, cancer waiting times
- Urgent care: A&E, mixed sex accommodation, ambulance and NHS111
- Mental health: dementia diagnosis, access and treatment in psychological therapies, early intervention in psychosis, children's access to all general and eating disorders support and out of area admissions
- Local authority joint working: delayed transfers of care and care home admissions
- Community provision: community hospital length of stay, community services caseloads and access times.

This report has been strengthened with key financial metrics and analysis of hospital demand and activity.

This report is used in multiple forums as a key tool to provide knowledge, enable review and scrutiny and provide assurance:

- Governing Body meetings in common - providing assurance with an integrated view on the quality, performance and finance of the CCG.
- BSW Partnership (STP) Executive – including the CCG, local providers (acute and community), Local Authorities, NHSEI.
- NHSEI - providing assurance and narrative on the current system position and the actions being undertaken to recover / improve performance as needed.
- Joint Quality and Performance Assurance Committee (QPAC) - providing clinical and operational review and scrutiny of the report and feeding into Governing Body where required.
- Locality meetings – explaining the system performance so their impact on the locality can be understood and aligned with locality services.
- All colleagues - this report is also shared with all BSW CCG colleagues supporting integrated and smarter working.

The CCG's reporting suite and performance management processes supported quick identification and prioritisation of emerging performance risks and issues and allowed for development and tracking of quantified remedial plans. It then supported the tracking of actions and improvements across a number of CCG committees and allowed escalation or delegation to contractual meetings as and when required.

This report will be further developed in 2020/21 to report on the performance of the full range of services that the CCG and STP commission and deliver and demonstrate the delivery and impact of the Long Term Plan ambitions.

Delivery of national standards

One of the key pledges in the NHS Constitution is the right of everyone to access the care they need in the NHS. Many of the services operate across the BSW footprint so we are showing the performance across all three CCGs (our localities going forwards) within BSW and provide some insight into the challenges and how they have been responded to across this year 2019/20.

Figures quoted are the most recent available with benchmarking data. The NHS response to the Covid-19 situation in March 2019 has impacted some of the year end results and they may not be reflective of performance across the year.

Performance delivery of the national standards is managed with our Quality team who work with providers to ensure that patient safety is not compromised during times of increased pressure in A&E and that waiting lists are managed in a way that maximises patient safety and clinical effectiveness.

Clinically-led review of NHS Access Standards

NHS Access Standards are being reviewed with the aim of recommending updates and improvements to the current measures in line with the Long Term Plan and the latest clinical and operational evidence. The review is now in phase three: testing and evaluating proposals to ensure that they deliver the expected change in behaviour and experience for patients prior to making final recommendations for wider implementation. Full implementation is expected in 2020/21.

Access to urgent care

The A&E four hour target measures the time a patient spends in A&E from arrival to transfer, admission or discharge. A&E waiting times are often used as a barometer for overall performance of the NHS and social care system. This is because A&E waiting times can be affected by changing activity and pressures in other services such as the ambulance service, primary care, community-based care and social services.

For example, patients cannot be admitted quickly from A&E to a hospital ward if hospitals are full because of delays in transferring patients to other NHS services, or in arranging required social care. The target A&E performance is 95 per cent of patients waiting less than four hours. Provider performance was based on the latest data available is shown in the table below.

BaNES, Swindon and Wiltshire CCGs have participated in three local A&E Delivery Boards each managing the system around one of our main acute hospitals; Great Western Hospital NHS Foundation Trust (GWH), Royal United Hospitals Bath NHS Foundation Trust (RUH) and Salisbury NHS Foundation Trust (SFT), and more recently a Winter Risk Summit covering all of BSW was held. These arrangements have enabled a collaborative focus on performance of the urgent care systems, setting and reviewing improvement programmes with local targets for all providers and systems.

National Standard	Period reported	Target	Performance		BSW Total			BANES CCG		
			England	South West		vs Eng	vs SW		vs Eng	vs SW
Percentage of patients admitted, transferred or discharged from A&E within 4 hours*	Q4	95%	82.8%	75.4%	82.0%			78.1%		
Ambulance Response Times (minutes) Cat 1 Mean	total 2019/20	7.0	7.3	7.1	7.1			6.6		
Ambulance Response Times (minutes) Cat 1 90th percentile	total 2019/20	15.0	13.4	13.0	13.2			11.9		

NHS111 Answered in 60 seconds	Feb 2020	95%	69.8%	56.8%	56.4%			BSW shared service, so no CCG breakdown.
NHS111 % Calls clinically triaged	Feb 2020	50%	90.1%	82.0%	81.8%			

* Provider data: BANES - RUH, Swindon - GWH, Wiltshire – SFT

Key for benchmarking ratings			
vs Eng (England**) or SW** (South West): Compares BSW and CCG to England or South West result and target	Better than Eng or SW and/or target	Similar or within acceptable variance to Eng or SW and/or target	Worse than Eng or SW and target; outside amber tolerance

Throughout 2019/20, the local systems were not able to meet the national A&E four hour target. However, the national average rate for Q4 demonstrates that the target is not being achieved across the country. BaNES (RUH) performance was above the South West Q4 performance

Each system was monitored against a local plan. Sustained high demand across health and social care during 2019/20 continued to impact on performance, particularly in the system around the RUH. Winter pressure schemes were put in place in all systems to help support capacity and flow and in January the RUH, against previous years' trends, saw improvements as the schemes worked together. These schemes included:

- an additional emergency department registrar
- the discharge hub – supporting people ready for discharge who are waiting for transport or medication away from the wards
- medical take model – better managing patient admissions and reducing medical outliers
- the trauma assessment unit – a dedicated area for patients with complex injuries that need specialist orthopaedic treatment.

Ambulance response times for people with the most serious conditions (Category 1) are measured as a mean response time and at the 90th percentile which measures delivery on the 'every call counts' principle of the current standards which were introduced in 2017. For BaNES patients the national targets were met across the year. Performance across BSW was marginally outside the seven minute target but met the 90 per cent percentile target. Performance is impacted by the activity levels and in 2019/20 BaNES incidents were 6.1 per cent above contracted plan and 3.7 per cent over 2018/19 incidents.

The number of calls to NHS111 answered within 60 seconds was below the expected level. While performance was below target throughout the year, the extent of the variance grew during winter, so this is not reflective of the year-to-date performance. The level of clinical triage was very good though, as performance was significantly above the 50 per cent target at 81.8 per cent. The NHS 111 service was re-procured jointly by BaNES, Swindon and Wiltshire CCGs in 2017/18 and went live in May 2019 as part of the Integrated Urgent Care Service. The service is continuing to develop service capacity already including additional clinical triage and further stages will expand and develop the use of digital referral and triage.

Access to planned care

The 18 week referral to treatment target has been the key measure of the NHS constitution for planned care. In recognition of the continuing growth in referrals nationwide and the challenges in maintaining and increasing capacity and the increasing demands on hospital resources from urgent care admissions, in 2018/19 NHSE asked CCGs to move their focus to avoiding growth in the overall referral to treatment waiting list size.

National Standard	Period reported	Target	Performance		BSW Total			BANES CCG		
			England	South West		vs Eng	vs SW		vs Eng	vs SW
Referral To Treatment Overall Waiting List % growth March 2019	Feb 2020	0.0%	5.0%	3.4%	6.1%			17.2%		
Patients waiting 18 weeks or less from referral to hospital treatment	snapshot Feb 2020	92.0%	83.1%	81.5%	85.2%			87.5%		
Patients waiting over 52 weeks for treatment^	snapshot Feb 2020	0	1,724	419	27			3		
Patients waiting six weeks or more for Diagnostics	snapshot Feb 2020	1.0%	2.8%	5.7%	5.7%			7.9%		
Patients seen within two weeks of a referral for suspected Cancer	Q3 2019/20	93.0%	91.5%	88.9%	92.2%			93.6%		
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q3 2019/20	85.0%	77.5%	78.6%	81.3%			81.5%		

^ Comparison weighted by overall RTT waiting list

Key for benchmarking ratings			
vs Eng (England**) or SW** (South West): Compares BSW and CCG to England or South West result and target	Better than Eng or SW and/or target	Similar or within acceptable variance to Eng or SW and/or target	Worse than Eng or SW and target; outside amber tolerance

The overall waiting list has grown by 1,945 patients (17.2 per cent) to 13,227 BaNES patients waiting for treatment by February 2020 (from March 2019). The waiting list at the RUH (for all BSW patients) has grown by 2,893 patients to February 2020 and is the main driver of growth seen for BaNES and Wiltshire CCG's waiting lists. The largest increasing specialties are "other" (including pain, paediatrics and some specialist cancer surgery) by 1251, ENT by 727, urology by 471 and cardiology by 428. Although we wanted to manage the increase in waiting list size, we also recognise positive growth in referrals following a successful cancer early diagnosis campaign such as the promotion of bowel cancer screening last year.

In February 2020, 1,650 BaNES patients had been waiting over 18 weeks. This was reported as 87.5 per cent of patients waiting 18 weeks or less and although the 92 per cent standard was not achieved, BaNES performed better than England (83.1 per cent) and the South West (81.5 per cent).

We monitored the very long waiters and at the end of February 2020, three BaNES patients had been waiting over 52 weeks for treatment, one at RUH and one each at North Bristol Trust and, University Hospital's Bristol. We benchmarked this performance by looking at 52 week waiters as a proportion of the overall waiting list and BaNES compares well to England and the South West.

Referral to treatment performance (including diagnostics and cancer) is managed with the RUH in the RTT Steering Group and other BSW wide Elective Care Planning and Development Groups

both general and for specific specialties. Actions and developments in the year to support improved performance in referral to waiting times included:

- Tele-dermatology – in summer 2019 a virtual triage service was put in place at the RUH enabling consultants to view high quality images taken in general practice.
- Recruitment - providers are constantly focussed on recruitment and workforce to support their capacity to deliver services in a difficult market.
- Waiting list initiatives – additional clinics in ENT at the RUH and GWH have supported long waiters to be seen.
- Review of the outpatient model is underway across BSW. This is a national initiative to ensure we make best use of resources and technology.

Diagnostic waiting times have been challenging in the BSW system following on from 2018/19 and the 1 per cent target has not been met by the CCG in any month this year. In February, BaNES had 7.9 per cent patients waiting over six weeks which was driven by RUH at 8.5 per cent not meeting the target. In February, BaNES had 7.9 per cent of its patients waiting over six weeks was driven by RUH at 8.5 per cent not meeting the target.

England (2.8 per cent) and South West (5.7 per cent) results are also below the target.

It should be noted though that over 92 per cent of BaNES patients were waiting less than six weeks and diagnostics for urgent cases including cancer are prioritised so patients can not all be seen in the order referred.

To improve resilience and capacity the RUH undertook an equipment replacement programme for CT and MRI scanners which has had an impact on capacity in year and should support the future. Demand has also been increasing particularly for CT and Echos.

In Q3 2019/20 cancer measures were reported monthly but performance was considered on a quarterly basis. 93.6 per cent of BaNES patients referred for suspected cancer were seen within two weeks, meeting the national standard. Of those requiring treatment 81.5 per cent were treated within 62 days of referral, above the England and South West results but below the national standard.

BaNES CCG belonged to the Somerset, Wiltshire Avon and Gloucestershire Cancer Alliance (SWAG). The Alliance includes commissioners and providers and NHSEI and focuses on implementing and achieving the key ambitions of the cancer part of the NHS Long Term Plan. Specific actions in 2019/20 included:

- Piloting of the Rapid Diagnostic Services model for patients with vague symptoms which could be cancer but do not fall into existing pathway arrangements
- Working with local authorities to help improve awareness among the public of the signs and symptoms of cancer
- Supporting and enabling the use of the faecal immunochemical test (qFIT) in primary care to increase the proportion of symptomatic patients being diagnosed with colorectal cancer at an earlier stage
- Continuation of BSW STP cancer forum and information-sharing to help ensure awareness and understanding of issues, solutions and best practice across the STP footprint
- Support to GP practices from MacMillan GPs, Cancer Research UK, Cancer Alliances and CCG, to assist in early identification of patients with potential cancer
- Work with local trusts to implement national optimal timed cancer pathways
- Development and implementation of improved services for patients living with and beyond cancer, through the Personalised Care and Support agenda.

Access to mental health services

BSW CCGs have been working together on the BSW THRIVE work stream to redress the balance between physical and mental health. Our focus remains on co-creating early intervention and prevention models with people with lived experience and our system partners to improve outcomes.

In recent years national standards have been developed to enable us to measure waiting times for many mental health services. This allows us to understand our progress in delivering timely access to the mental health services people need.

National Standard	Period reported	Target	Performance		BSW Total			BANES CCG		
			England	South West		vs Eng	vs SW		vs Eng	vs SW
Improving Access to Psychological Therapies – access rate	Q3 2019/20	Q4 5.5%	4.61%	4.47%	4.72%			4.43%		
Improving Access to Psychological Therapies – recovery rate	Q3 2019/20	50%	50.9%	48.9%	51.8%			53.2%		
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Q3 ** 2019/20	50%	74.4%	74.5%	80.0%			100%		
Access to Children and Young People's Mental Health Services	Q3 ** 2019/20	33%	34.2%	29.8%	32.4%			33.2%		
Children and Young People Eating Disorders: seen within four weeks for non-urgent cases.	Q3 2019/20	95%	86.9%	87.0%	91.3%			92.9%		
Estimated diagnosis rate for people with dementia (diagnoses as % of prevalence)	Mar-20	66.7%	67.4%	61.8%	62.6%			63.2%		

Key for benchmarking ratings			
vs Eng (England**) or SW** (South West): Compares BSW and CCG to England or South West result and target	Better than Eng or SW and/or target	Similar or within acceptable variance to Eng or SW and/or target	Worse than Eng or SW and target; outside amber tolerance

Psychological therapies services are our community talking therapies service including group and 1:1 sessions. There was a national directive to increase the capacity of this service over the last few years while including specific services to support people with long term conditions. The BaNES service is working with the CCG towards delivering the additional capacity.

The National Institute for Health and Care Excellence (NICE) recommended package of care for people with a first episode of psychosis is often delivered in a mental health ward setting and we had good performance, but it will fluctuate due to the low numbers of people using the service.

Access to children and young people's mental health services, similar to adult's psychological therapies, is measured against an expected prevalence of need. We co-created a range of services sitting alongside our traditional Child and Adolescent Mental Health Services (CAMHS)

provision including an online support service and we are seeing good progress, with higher access than the overall South West though we were still below England.

There was a national directive to redevelop eating disorder services for children and young people and ensure all routine referrals were seen within four weeks from the end of 2019/20. The BaNES service was performing just under the new national standard but is ahead of the England and South West position.

BaNES CCG had not met the national standard for the dementia diagnosis rate, though BaNES has seen increasing numbers of diagnoses the prevalence is increasing faster. BSW localities all have ongoing improvement plans. The BSW CCGs appointed a joint DDR (dementia diagnosis rate) quality improvement practitioner to help support primary care and continue to ensure that patients and their families can access support when they need it.

Financial performance

Bath and North East Somerset CCG achieved all its financial duties in 2019/20. This is demonstrated in the table on pages 26 and 27 and within the Annual Accounts. In addition, the CCG ended the year with a surplus of £18k, in line with NHS England/Improvement expectation.

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

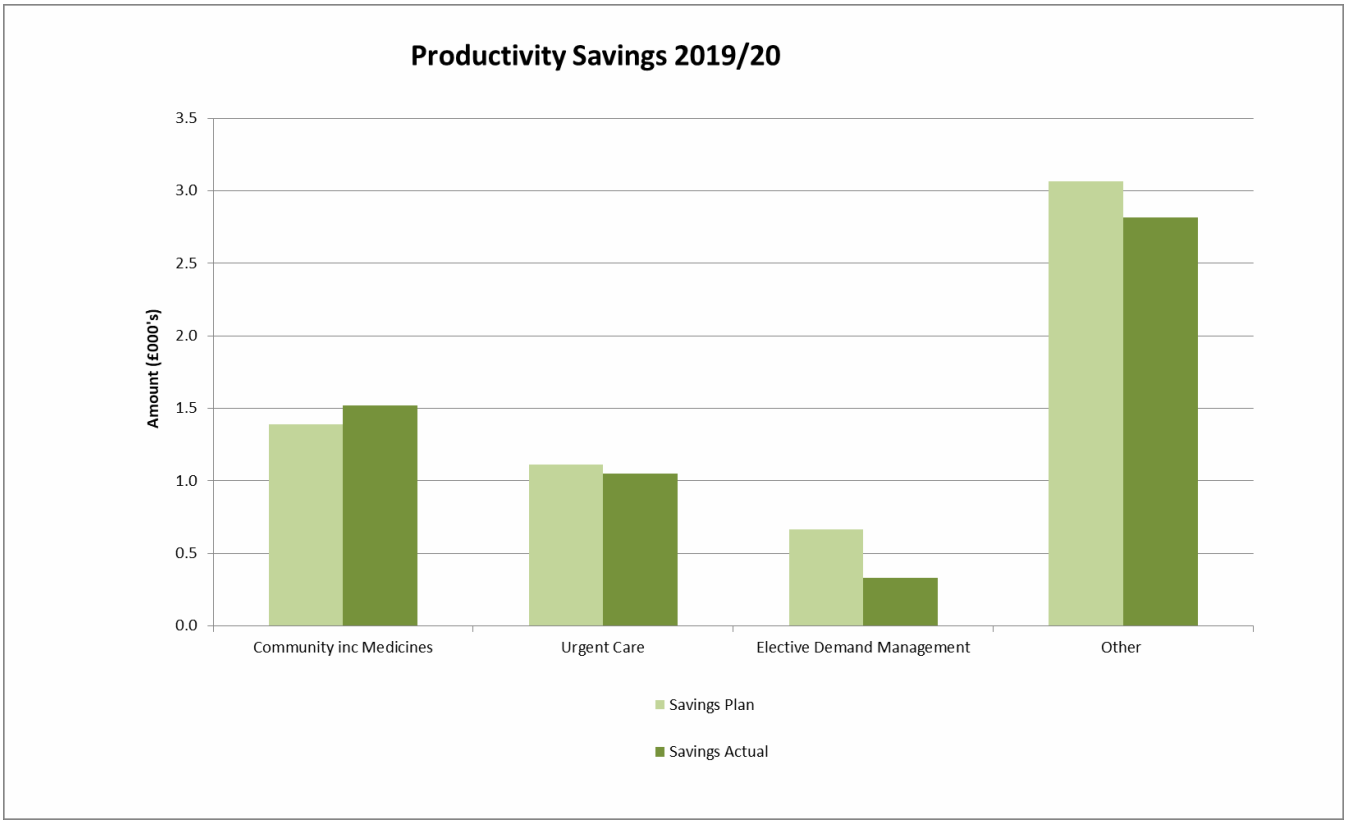
The financial landscape for 2020/21 and beyond is challenging. Nationally, CCG average growth in place-based allocations for 2020/21 is 3.99 per cent. The new Bath and North East Somerset, Swindon and Wiltshire CCG will receive 4.01 per cent. Pressures nationally on CCG budgets are expected to continue due to increasing demands for health services. In order to manage within allocated resources for 2020/21 the new Bath and North East Somerset, Swindon and Wiltshire CCG will need to deliver an efficiency programme of £24.5 million (1.8 per cent of notified allocation).

CCGs have several financial duties under the National Health Service Act 2006 (as amended). Full details of the CCG's financial performance are available in the annual accounts section. The CCG's performance against those duties in 2019/20 was as follows:

Duty	**Target £'000s**	**Actual Performance £'000s**	**Achievement**
Expenditure not to exceed income	287,788	287,770	Yes
Capital resource use does not exceed the amount specified in NHS Directions	208	208	Yes
Revenue resource use does not exceed the amount specified in NHS Directions	283,202	283,184	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in NHS Directions	208	208	Yes
Revenue administration resource use does not exceed the amount specified in NHS Directions– running costs	4,486	4,479	Yes

Productivity and savings

The CCG has achieved £5.7m (92%) of its savings programme target for the 2019/20 year of £6.2m. This has been achieved in the following areas:



Better Care Fund

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

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

The total value of the fund in 2019/20 is £19.7m (excluding additional contribution funding). £1.3m of this is provided from grants made directly to the local authority for disabilities facilities and social care adaptations, £1.4m from the main adult social care budget and £4.0m from the Improved Better Care Fund (iBCF). 2019/20 saw the inclusion of £0.7m of winter pressures funding previously paid to the CCG but which came this year via a grant under the umbrella of the BCF. The remaining £12.3m is provided from the CCG baseline allocation.

Note 18, page 28 of the financial statements details all, including additional contributions and services commissioned as per the pooled budget arrangement.

For 2019/20 we continued to learn from the metric information and to build on preventative and transformational schemes but also added several new initiatives.

This allowed us to identify that across the wider health and care system there are common barriers to achieving sustainable high quality services for local people. The risks associated with these common themes were grouped into the following headings:

- Capacity risks – this relates to the capacity of teams to tackle and implement the changes required within the Better Care Fund (BCF). In the third year of the BCF we have acknowledged the scale of change and transformation that we face locally and that we are faced with risks in capacity to achieve our ambitions. As a small organisation we also recognised that we do not always have the skill set to bring to projects to improve services. We have overcome this risk by learning from the wider care system and our local partners where possible but the BCF has also supported a number of fixed term posts including the continuation of the Trusted Assessor post where it was recognised that a specific skill or support to a project was required. We were also cognisant of the pressures on our services over the winter period and identified additional capacity in social work, commissioning and additional care home placements to successfully mitigate these pressures.

- Performance risks – associated with delivery of performance improvements, particularly related to DTOCs.

  The B&NES Better Care Fund schemes in 2019/20 were monitored and supported by the delivery of the BCF national metrics which cover non-elective admissions, delayed transfers of care, permanent admissions to care homes and people remaining at home 91 days after reablement and the selected local metrics. This led to a review and redesign in year of our local reablement model which included engagement from acute and community providers and is due to be rolled out in 2020/21.

- Financial risks - including the financial position for both the Council and CCG in dealing with growing demand and increased efficiency savings. The original Better Care Fund (BCF) has been supporting schemes for integrated health and social care initiatives financially since 2016. The original funding which is uplifted annually remains the cornerstone of the plan around which new schemes have been developed. This includes the Care Act Implementation budget which supports amongst other things assessments carried out by social workers following the changes to the Care Act in 2014. It has also underpinned our reablement offer within the block community services contract and our contracts with strategic partners. In 2017 we set up schemes to support both the increase in care home costs connected with the national changes to sleep-in cover and our own fair price of care review which aim to support the local care market. The focus for the year was in continuing to maintain support to these schemes and we fully utilised both the Disabled Facilities and Winter Pressures 2019/20 grants to do this.

- Market risks - in respect of market instability within the care home and home care sector and corresponding rising fee levels due to restricted availability.

  Over 2019/20 the iBCF funding has been used to develop new models of residential and nursing care; to support providers of complex and specialist packages and placements to deliver against national requirements for sleep-in cover. New reviews of provision of both domestic and homecare have been undertaken and the introduction of a framework agreement to increase flexibility and choice for individuals came online in year. Further market development during the year included a refresh of the fair price of care, a move towards increase in commissioning of high dependency residential care and discharge to assess beds which ensure that more people can make decisions about their long term care needs away from a hospital setting. We have continued to build our local knowledge of the care market and to develop our own brokerage service to support affordable quality provision in the area.

How risk and uncertainty are corrected

As described above, a regular review of timely information ensured the CCG retained a grip on performance across a wide range of areas. As well as information being routinely circulated,

metrics missing national or local performance standards, or showing a deteriorating trend are selected and highlighted within summary reporting. It is combined with narrative from commissioning leads and scrutinised at internal and external committees by senior leaders, clinicians and lay members. Where reporting is significantly off track, or enough reassurance cannot be provided, a deep dive review is conducted.

Regular scrutiny of performance takes place at contract meetings with providers, in which they are held to account via contractual levers where necessary. Where performance deviates from expected levels, recovery plans are sought from providers and milestones are tracked through contractual meetings or associated sub-groups.

Major performance issues are added to the CCG risk register where they receive the highest level of scrutiny.

Quality, engagement, health inequality and strategy

We have worked to ensure that we comply with the statutory duties laid down in the National Health Service Act 2006 (as amended).

In this section, we have reflected on our duties under:

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

Improvement in quality of services

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

Quality assurance

Commissioning for Quality and Innovation (CQUIN) is offered on an annual basis to all commissioned services that meet the minimum agreed contract value. CQUINs account for 1.25 per cent of a provider's total income for agreed quality improvement schemes and allow our partners to work at scale to facilitate change. The aim of the CQUIN scheme is to make sure quality is always part of the discussion between commissioners and providers. Providers of acute hospitals and ambulance, community and mental health services that use standard national contracts are also required to have a CQUIN scheme.

Further information about the national CQUIN schemes for 2019/20 can be found on the NHS England CQUIN website: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

Highlights from this year's CQUINs include:

- Increasing effective antibiotic use and delivering safer patient care
- Improving the uptake of the flu vaccination for frontline clinical staff
- Promoting our providers to offer screening, advice and referral interventions for smoking and alcohol
- Improving engagement and treatment for people using specific anxiety disorder measures
- Reducing the number of patient falls and achieving fewer falls with harm
- Improving stroke rehabilitation by promoting the completion of 6 months assessments.

In 2019/20, the responsibility for CQUIN assessment shifted from CCGs to NHS England. BaNES CCG continued to link in with providers to understand how they are progressing with implementing their CQUINs.

Patient experience

All feedback received is valued and acted on and concerns and complaints are viewed as a rich source of information.

Responses to concerns and complaints have been administered in line with the Local Authority Social Services and National Health Service (England) Complaints Regulations 2009.

We ensure that any concern or complaint raised by an individual is dealt with compassionately, effectively and in a timely manner.

In 2019/20, we received a total of eight complaints. Most individuals choose to provide feedback directly to the provider of their care if they are either satisfied or unhappy. This explains the low number received by the CCG. We monitor all feedback received directly by providers in contract monitoring meetings to identify themes and trends.

There were 179 patient advice and liaison service (PALS) contacts received directly by the CCG.

We have worked proactively with providers where complaints or concerns are raised to ensure that where required service improvements are implemented. Performance and quality standards are monitored through regular performance meetings with all providers.

Contact details for submitting feedback to the CCG are Bsccg.feedback@nhs.net

Never events

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

There have been two never events reported by the Royal United Hospital Bath in 2019/20. Both have undergone full investigations to identify learning in line with the National Serious Incident Framework.

Safeguarding

Following the publication of national statutory guidance, we reviewed our partnership arrangements for safeguarding children and worked with the council and Avon and Somerset Police to design a new model for our safeguarding boards. Our aim is to reduce duplication and join up safeguarding activities so that we can continue to protect the health, wellbeing and human rights of everyone living in B&NES. This work was published on time and the new arrangements are in place which include the Adult, Children and Community Safety Partnership working with an executive board including CCG, Police, local authority, Fire and Probation. Full details of these arrangements can be found on the link below; https://www.safeguarding-bathnes.org.uk/children/local-safeguarding-children-s-board/12-new-safeguarding-arrangements-bnes-september-2019.

There is work across Avon and Somerset areas to support five themed regional safeguarding subgroups these include:

- Contextual safeguarding
- Finance and resources
- Data and performance
- Learning and development
- Communications
- Independent scrutiny

In partnership with Swindon and Wiltshire CCGs, we have developed a single set of performance measures so that we can be assured that all the services we commission are effectively undertaking their safeguarding responsibilities.

We have developed the local Safeguarding Health Professional Network to align adult and child safeguarding more effectively and share good practice to learn from each other. We also have worked across the health sector and with our multi-agency partners to share information which relates to children, young people and adults who are at risk of exploitation.

We participated in three serious adult reviews which have now been published. These reviews all related to self-neglect and the learnings from these have resulted in us updating a self-neglect policy so that it better supports health professionals working with adults at risk. The policy also requires all organisations to nominate a self-neglect champion who is responsible for ensuring that all health professionals are aware of the learnings from the reviews.

We have completed the NHS England Quarterly safeguarding assurance tool and engaged with the discussions for the new NHSE&I safeguarding Commissioning Assurance Toolkit (sCAT) which will start from April 2020.

BaNES continued to plan and review the Joint Targeted Area Inspection (JTAI) process reviewing the two themes during this period. BaNES are expecting a JATI which reviews the safeguarding and looked after children arrangements and partnership work. The themes for 2020-21 are:

- prevention and early intervention
- older children in need of help and protection, and contextual safeguarding, including exploitation.

https://socialcareinspection.blog.gov.uk/2018/12/14/future-joint-targeted-area-inspection-themes-announced/

Children's Continuing Healthcare and SEND

Data from the department of education shows an increase in the number of children with special educational needs (SEND), this is currently 11.9 per cent of the population. There is also an increase in the number of children and young people with education health and care plans (3.1 per cent). This national trend is reflected within B&NES, where the number of children and young people with complex needs that require specialist statutory support through Education, Health and Care Plans (EHCP) has risen over the past four years. In 2019/2020, there were 1,220 children with EHCPs. Our vison is that children and young people with SEND should expect the best from all who provide services and we aim to improve lives and life chances.

The biggest area of increase is within autistic spectrum disorder (ASD) and social, emotional and mental health issues. We have reviewed and revised our provision for specialist mental health support for children. This has resulted in a system which aims to improve access and enable parents and children to self-refer. We have been working with partners to review the ASD pathways.

We have been working in partnership with key stakeholders to improve the early identification and notification system. This has resulted in earlier identification which means that children and young people receive support at the earliest opportunity. We have been developing systems to notify GPs of children who have an EHCP, which will improve support for GPs in identifying young people with a learning disability who would benefit from an annual learning disability health check.

We were pleased that our local area inspection for SEND by Ofsted and the CQC in March 2019 was very positive and identified a substantial number of strengths and included the following feedback:

"Local leaders are driven by strong shared values and provide the best for children and young people with SEN."

"Parents and carers feel they get information and support they need."

"Collaborative work underpins effectiveness of the local area."

Feedback from the inspection will be used alongside the regular feedback we receive from families to further improve our services. The revised multiagency SEND strategy 2020-2023 will outline how we will maintain and build on the strengths and areas that require improvements.

During the next year our plans include developing support for children with autism, to better understand the clinical nursing needs of children in special schools and to improve health involvement in annual EHCP reviews.

We have been working with other agencies to ensure children and young people receive the right support in educational settings to enable them to progress and improve the transition to adult services.

Quality improvement

We have a responsibility to ensure that the services we have commissioned are safe. We strive to ensure that individuals are not harmed when receiving healthcare, though occasionally, a Serious Incident or Patient Safety Incident occurs.

All serious incidents reported by provider organisations are reviewed at our Serious Incident Panel to ensure that a robust investigation is undertaken. Feedback is given to the provider organisation to promote learning and help prevent the incident from happening again in the future.

We review whether there are any:

- lessons that could be learnt by another organisation
- learnings about strengths and weaknesses of the wider system
- Quality Improvement projects that could be undertaken or any issues that require further research and development.

Research and development

Bath Research and Development (BRD) has provided us and other local primary and community providers in the region with research management and governance systems. This service, which is based at the University of Bath, is fully funded by the National Institute for Health Research. Research performance was reported to the CCG.

Our Director of Nursing has been the research and development lead for BaNES CCG and attended BRD Executive meetings, where wider research matters were discussed.

Optimising our use of medicines

The CCG had another successful year delivering savings in the medicines budget, including a forecast £1.4 million annual saving between our primary and secondary care 'high cost' medicines prescribing budgets. These savings have been achieved by continued use of IT systems that help ensure clinicians choose the most appropriate medicines at the point of prescribing. We have also worked with prescribers and individuals to achieve a high uptake of biosimilar medicines in secondary care, which are less expensive than their branded counterparts.

Some examples of progress include:

- Ongoing collaborative work around the appropriate use of antibiotics. This has resulted in a reduction of antibiotic prescribing, in particular, broad spectrum antibiotics.
- Continuing work on the appropriate use of medicines for anticoagulation to reduce the number of strokes.
- Implementation of the PINCER initiative to identify those at risk of harm from medication errors, supporting the national medication safety agenda.
- Working with community pharmacists to help identify medicines people may not require on their repeat prescriptions.

- An innovative prescription ordering direct service in one GP practice, to reduce medicines waste and streamline process for individuals to order their medicines.
- Developing the pharmacy workforce within primary care.
- Practice clerical staff have undertaken repeat prescription training to increase their knowledge and provide support in this area.
- Practices have undertaken an audit looking at anticoagulation monitoring, particularly of DOACs, to improve the safety of their use in primary care.
- A GP from each practice is due to attend an education session entitled “Prescribing for Chronic Pain” to support the Opioids Aware agenda.

Equality and diversity

Our work has always been carried out in line with the Equality Act 2010 and under Section 14T of the Health and Social Care Act 201241, and we are committed to eliminating all forms of discrimination, providing equal opportunities and protecting the human rights of those living in B&NES. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

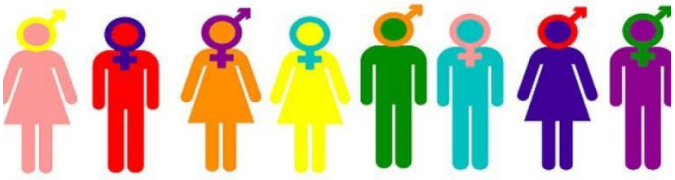
Using Equality Impact Assessments, we have adopted a robust approach that ensures that the impact of decisions which may affect individuals are analysed before their implementation. This tool has allowed us to assess the impact of our proposals on each of the nine protected groups which are highlighted in the Equality Act 2010, which in turn has enabled us to guarantee that our services result in high-quality health care that is fair, accessible to all and meets the needs of our diverse communities. Equality impact assessments have been an important part of commissioning projects, and ours are published here:

https://www.bathnes.gov.uk/services/your-council-and-democracy/equality-anddiversity/equality-impact-assessmentsequality-0

We have required all our healthcare service providers to comply with the Equality Act, Human Rights Act and the NHS Constitution. This has included ensuring that providers are assessed on equalities performance at all stages in procuring a contract and during our quality assurance programme receiving evidence that the organisations are making them accessible and that they meet the needs of the community.

As the number of CCG employees has been below the threshold of 150, we have not been required to publish equality data about our staff as it is difficult to publish some aspects of the data without compromising staff confidentiality. All our staff have been required to undertake three yearly training on equality and diversity.

We have been committed to improving our Equalities Data, Intelligence data, and our use of equality analysis data in our commissioning cycle. To help improve our equality data, we are building stronger relationships with protected groups and communities to better understand and fulfil their needs.



Reducing health inequalities

Throughout 2019/20, the CCG continued its commitment to ensuring equality, diversity, inclusion, and human rights are central to the way we commissioned and delivered healthcare services and

how we supported staff. Our aim was to reduce inequalities in health and healthcare access for people in Bath and North East Somerset.

As a commissioner the CCG had to ensure it eliminated unlawful discrimination, advanced the equality of opportunity and fostered good relations between different people when carrying out our public function.

An example of reducing health inequalities during 2019 was when we expanded the rehabilitation offer for people who either had a cardiac event (heart attack, stent or heart surgery) or a diagnosis of heart failure. Rehab classes are now offered in hospital or in the community on a range of days and times, and there is the option for home based rehab for people who prefer not to attend classes. The new services will ensure that people from groups who are traditionally less likely to access rehab will benefit. There is a specific focus on reducing health inequalities and reducing the mortality gap amongst different sections of the population caused by cardiac disease.

Complex discharges

Although the principles of discharging patients from hospital have not changed over many years, the process and pace of discharge planning has changed beyond all recognition. NHS resources provide for an increasingly ageing population, the needs of which are sometimes complex. Unnecessarily prolonged stays in hospital can result in several problems for complex individuals. To help reduce inequalities and ensure that hospital stays are not prolonged for this small group of patients, we have been working with Virgin Care Continuing Healthcare Team and the RUH to ensure people are able to leave hospital on the correct pathway. This has involved developing a joint protocol for complex discharges and to ensure that the correct funding is in place.

To support the complex discharges a one year post has been commissioned. The post is co-ordinated by a registered nurse with a background in CHC. The purpose of the Interim Health Funded Pathway is to ensure the timely discharge of a person with complex needs and who may be either in hospital or in a specialist unit. Two of the key benefits of this role are:

1. The tracking of a person's in-patient journey which ensures there is a robust discharge plan in place, which can be modified depending on the assessed needs of the patient.
2. Ensuring that a suitable care package is put together and ready to start at the point of discharge, which helps to reduce unnecessary delays in hospital discharges.

A valuable part of the role has been to support both the hospital and community settings in order to identify the most appropriate services which meet the assessed needs of the individual. This involves multi-professional working across health and social care, thus ensuring a systems approach to discharge planning.

Individual Funding Request (IFR)

The IFR Team log and process applications within 30 days of receipt. All Prior Approval applications are reviewed and completed, and letters sent with the decision within 30 days of review. The IFR Team also send out decisions from the IFR Monthly Panel within five working days. Currently, both processing applications and sending out decisions are achieved within timescales 100 per cent of the time.

An external audit of Prior Approval and IFR processes was carried out in June 2019 by our auditors KPMG. This noted that based on their review of Individual Funding Requests, the audit outcomes was significant assurance with minor improvement opportunities. The recommendations

made have all since been implemented. These were predominantly linked to ensuring correspondence relating to the outcome of IFR decisions was timely and clear.

From 1 April to 31 December 2019 the IFR Team received 1,134 applications for treatments for children and adults. Of these, 700 were approved by clinicians under the IFR process and 158 applications progressed to be considered by clinicians at the Individual Funding Monthly Panel. People who had their applications approved went on to receive the treatment requested, such as surgery or counselling. IFR applications are declined if they do not meet the local policy, which you can read here https://www.bswccg.nhs.uk/your-health/what-we-do-and-don-t-fund

Throughout the year BaNES CCG developed a collaborative working relationship with Swindon and Wiltshire CCG and have worked on aligning clinical policies.

Engaging people and communities

We have been committed to putting people who use services, those who care for and support them, and the wider public, at the centre of everything we do, ensuring there was a public voice that could influence key decisions and help to shape our services. We believe that public participation helps us to understand people's needs and ensure that health and care services are better designed to meet these needs.

As outlined in the Health and Social Care Act 2012 (Section 14Z2 of the Act), all NHS organisations have an overarching obligation to involve local people in:

- The planning of new services
- The ongoing development of existing services
- The decision-making process behind any plans to significantly permanently or temporarily make changes to local services.

A fundamental principle of any CCG, and one held dear by BaNES CCG, is to ensure patients and members of the public are given regular opportunities to have their voices heard, and their ideas and suggestions not only listened to but seriously considered by the organisation's decision makers.

Regular meetings and roles

Your Health, Your Voice

Your Health, Your Voice group met every two months and provided an opportunity for representatives of the public to feedback on our plans to improve local health and care services. The group, chaired by our Lay Member for Patient and Public Involvement, acted as a critical friend to the CCG and discussed proposed service changes with commissioners from planning through to delivery.

Members were also encouraged to inform and support the CCG's engagement with the wider public, by advising us on different approaches and groups who we should consult with and sharing information and surveys with any other local/community groups they were involved with.

Areas of work members of Your Health, Your Voice were involved with included:

- Taking part in a survey about expanding the cardiac rehabilitation service.
- Contributing to the Healthwatch England survey 'What would you do?' which was about the Long Term Plan and what changes people would like to see in their local community.
- Taking part in the BSW Our Health, Our Future campaign and providing answers to the questions being asked.
- A discussion on tobacco control and how a smoke-free generation can be achieved. Members were able to share their views and ideas.
- Commenting on the plan for BaNES, Swindon and Wiltshire CCGs to merge.
- Giving their views about how to improve support for people managing chronic respiratory conditions.
- Talks on tackling air pollution in B&NES.

Other meetings attended by the public

Members of the public were welcome to attend our Governing Body meetings in public, to submit questions and to read the agenda and papers on our website. We regularly invited people to share

their personal experiences of health and care (patient stories) at the beginning of these meetings. The public was also able to attend our Primary Care Commissioning Committee (PCCC) meetings.

Looking ahead to 2020/21, work to continue diversifying the membership of the Your Health, Your Voice group will increase, supported by the introduction of a dedicated Engagement Manager post as part of the new BSW CCG Communications and Engagement team structure.

Our website informs the public about meetings they can attend: www.bswccg.nhs.uk

Some examples of patient and the public involvement in CCG activity over the last year include:

Engagement and consultations in 2019/20

Transforming Maternity Services Together

The proposal to change the way maternity services are delivered across the regions was developed by all the NHS organisations that plan and buy health services as well as those that provide or manage maternity services across B&NES, Swindon and Wiltshire. We engaged widely across BSW and more than 2,400 people took part in a public consultation between 12 November 2018 and 24 February 2019.

A team at the Centre for Healthcare Innovation and Improvement at the University of Bath School of Management analysed the survey responses. The full report and other consultation material was published online in January 2020 and are available on the Transforming Maternity Services Together website: www.transformingmaternity.org.uk.

The proposal to change maternity services was approved by the joint BSW Governing Bodies on 16 January 2020 and implementation of the proposal has begun.

Public engagement undertaken for implementation

Working in partnership with our Maternity Voices Partnership we continue to meet with mums and families to talk about the changes to the services and how it will affect them. Workshop sessions were held in March Paulton and Trowbridge to begin to co-design the future of postnatal care and develop the community hub model for maternity services. Further events were planned for Chippenham, Bath and Frome but were delayed due to the Covid-19 pandemic.

Our Health Our Future

People living across Bath and North East Somerset, Swindon and Wiltshire were asked, as part of a summer-long engagement campaign, to say what areas of healthcare they would most like the CCG to prioritise over the next five years.

The Our Health Our Future campaign hit the road in June 2019 and, for the following six weeks, members of the communications and engagement teams from Bath and North East Somerset, Swindon and Wiltshire CCGs visited towns and villages, as well as markets, shopping centres, universities, colleges and community meetings, throughout the region to ask people of all ages three simple questions:

- What's the one thing you wish you'd known sooner to help you be as healthy as possible?
- What's the one thing that would help you to find and use health and care services more easily?
- What's the one thing that would help to make a difference to your health and care in the future?

A suite of materials supported the campaign, with many of the posters and leaflets produced in Easy Read formats, as well as made available in different languages, such as Polish, to help make the campaign as accessible as possible.

Between Thursday 13 June and Wednesday 31 July 2019, the team carried out more than 1,000 face-to-face engagements and received more than 1,400 online survey responses.

Those who took part in the survey said they would like to be given more advice and information on how to live healthier lifestyles, as well as details of how to live well with common long-term conditions such as diabetes and high blood pressure.

The data also showed people wanted it to be as easy as possible to make appointments at their GP practices, and for waiting times for healthcare to be reduced.

Another common theme which emerged from the survey results showed that many people often felt as if they were not being listened to, or in some cases not taken seriously, by the healthcare professionals they were seeing.

There was also feedback from younger people, which showed they would value better access to mental health services and support.

The survey results were shared with the CCG's Executive Team and used to inform the new BSW Long Term Plan, and can be seen in full by visiting www.bswstp.nhs.uk/ourhealthourfuture.

Development of a BSW-wide citizens panel

In January 2020, people living in Bath and North East Somerset, Swindon and Wiltshire were targeted as part of a member recruitment drive for the region's new citizens panel.

A new way of engaging with local people, the panel – known as the Our Health Our Future panel, as a continuation of the summer's engagement campaign – intends to act as an innovative forum in which members of the public can provide their views on local health and care issues.

People recruited to the panel will be invited to take part in regular surveys, as well as the occasional focus group.

Full reports from each survey will be made publicly available, and the insight captured from the questionnaires will be used to inform future decision making, strategy, service design and service change.

The recruitment drive consisted of several face-to-face interviews that took place in a range of towns and cities, including Swindon, Marlborough, Trowbridge and Salisbury.

Assessment against the new Patient and Community Engagement indicator

Between January and March 2020, we undertook a self-assessment to review our work to engage with the people and communities we are responsible for commissioning services for. Building a positive relationship with patients and communities is a key commitment of the Five Year Forward View and the Long Term Plan and we know that better partnerships with people and communities is a priority for transforming and sustaining the NHS.

The national assessment of the CCG's scoring took place during March with results available in July 2020. We scored 11 (green) for 2019.

From April 2020, BSW CCG will have a dedicated public engagement team which includes a specialist clinical engagement role. The team will work with members of its forums, the lay Governing Body member for Patient and Public Engagement, other partners and the CCG Executive Team to agree its priorities for the coming year.

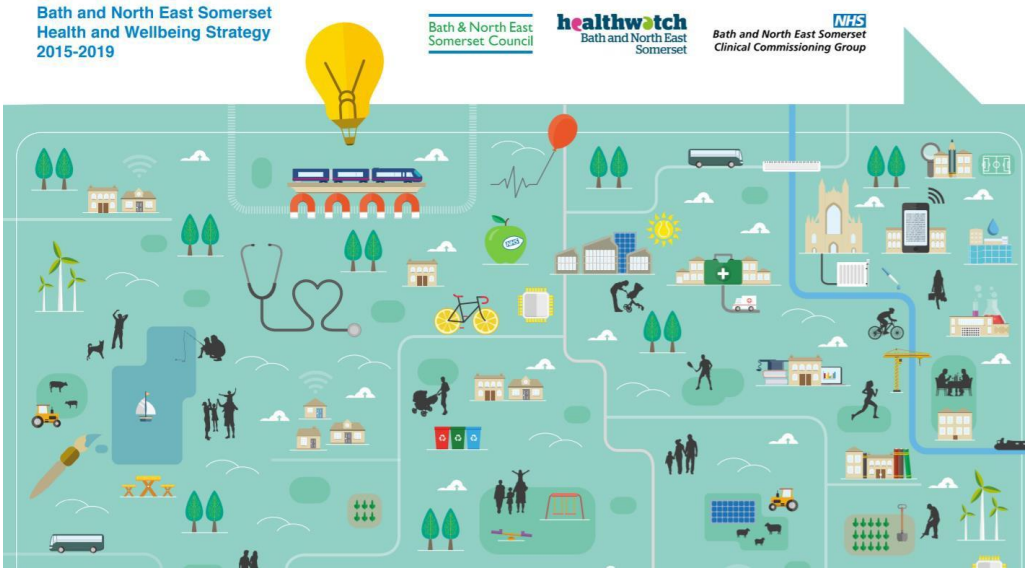
Health and wellbeing strategy

Health and Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population.

We have been active members of the Health and Wellbeing Board in Bath and North East Somerset and played a key role, working with our partners in delivering the Health and Wellbeing Vision for Bath and North East Somerset as set out in the Joint Health and Wellbeing Strategy.

The B&NES Joint Health and Wellbeing Strategy is the overarching plan for improving health and wellbeing and reducing health inequalities in the area.

Through this strategy, the Health and Wellbeing Board leads a joined up approach that supports and protects people's health and wellbeing.



The Joint Health and Wellbeing Strategy sets out a framework for partnership action against three themes:

- Theme one: Helping people to stay healthy
- Theme two: Improving the quality of people's lives
- Theme three: Creating fairer life chances

Under section 116B(1)(b) of the Local Government and Public Involvement Health Act 2007 we contributed to the delivery of the Health and Wellbeing Strategy by providing leadership to make innovation and change happen locally. We implemented new models of care (referred to elsewhere in this report) that supported people and organisations to innovate, set and adopt national best practice.

During 2019/20 two Health and Wellbeing meetings were held in September 2019 and January 2020. The other meetings in November 2019 and March 2020 were cancelled.

The focus for 2019/20 was:

- The implementation of the national Autism Strategy
- The seasonal flu vaccination programme and winter preparedness
- The commitment to a Community Asset Approach to Health and Wellbeing

Sustainable development

Sustainability Report 2019/20

Introduction

Sustainability has become increasingly important as the impact of lifestyle and business choices affects the world in which we live. We recognise the impact of commissioning and procurement decisions on the carbon footprint of the NHS, and the importance of being careful and considered in our use of scarce resources.

During 2019/20 we have delivered:

- Continued awareness-raising of our Sustainable Development Management Plan across the organisation through presentation to staff groups and formal reporting to the Joint Commissioning Committee and Board.
- Ongoing review of policies and procedures to ensure sustainability considerations are recognised, including our Procurement Policy.
- Ensuring our procurement protocols include environmental considerations including the use of Cabinet Office mandated standards for larger procurements.
- Ensuring oversight of provider engagement with sustainability matters through contractual mechanisms.
- Increased access to and use of Skype and conferencing facilities to reduce travel.
- Extension of our paperless approach through continued roll out of laptops and regular action to reduce retained paper records.
- Continuing initiatives to improve the working environment and staff wellbeing, including encouragement of physical activity and focussed action with NHS Property Services to address building and facilities improvement.

During 2020/21 our focus will be on the following objectives:

- Delivering the fourth year of our action plan approved by the Governing Body as part of the Sustainable Development Management Plan, and building on the successes of the previous years, to progress our priority areas of:
    - Continuing to raise awareness
    - Further including sustainability considerations in our activities
    - Encouraging provider improvement
    - Reducing our carbon footprint
    - Promoting healthier environments
    - Further ensuring our resilience planning responds to the adaptation agenda
    - Linking our estates and sustainability strategies

- Exploring opportunities for joint working with B&NES Council who have declared a climate emergency. The council have pledged to provide leadership to enable B&NES to become carbon neutral by 2030.

- Continued engagement with the BaNES, Swindon and Wiltshire Partnership Estates forum.

- Working with our landlord, NHS Property Services, and other tenants of the St Martin's Hospital site to understand and reduce energy and water usage and extend waste reduction and recycling initiatives.

Carbon emissions

Using the Sustainable Development Unit modelling tool, our estimated carbon footprint for 2019/20 from all our activities including services commissioned by us was 56,442 tonnes of carbon dioxide equivalent emissions (tCO2 e) (2018/19 53,854 tCO2 e). Within this figure, 55,839 tCO2 e are related to healthcare services commissioned by the CCG (2018/19 53,266 tCO2 e) and a further 537 tCO2 e (2018/19 527 tCO2 e) was generated through procurement and contracted out business support services, for example the Commissioning Support Unit, auditors, and payroll. These figures exclude the impact of delegated primary care services where we exercise a commissioning function on behalf of NHS England.

The main reason for the increase in carbon emissions from 2018/19 to 2019/20 was the increased spend by the CCG on the commissioning of healthcare.

Carbon footprint data for NHS organisations we commissioned services from will appear in their annual reports and carbon footprint data for the NHS South Central and West Commissioning Support Unit will be published as part of NHS England's annual report.

The CCG's carbon footprint was affected by the direct activities of our corporate and commissioning functions, and these areas were most easily influenced by CCG action.

In 2019/20, the CCG as a corporate body produced 87 tCO2 e compared to 70.8 tCO2 e in 2018/19. The specific impact of these is identified by area and the table below shows the changes between years:

CO2 emissions (tonnes of CO2e)	2019/20	2018/19	Change in tCO2e	% Change
Paper products	4.5	5.3	-0.8	-15.2%
ICT	4.3	2.3	2.0	87.0%
Food and catering	3.4	2.1	1.3	62.4%
Water and sanitation	0.4	0.3	0.1	34.5%
Waste products and recycling	0.8	2.0	-1.2	-59.8%
Travel	16.1	11.9	4.2	35.3%
Electricity	19.6	18.3	1.3	7.1%
Gas	37.9	28.7	9.2	32.1%
Total	**87.0**	**70.8**	**16.1**	**22.8%**

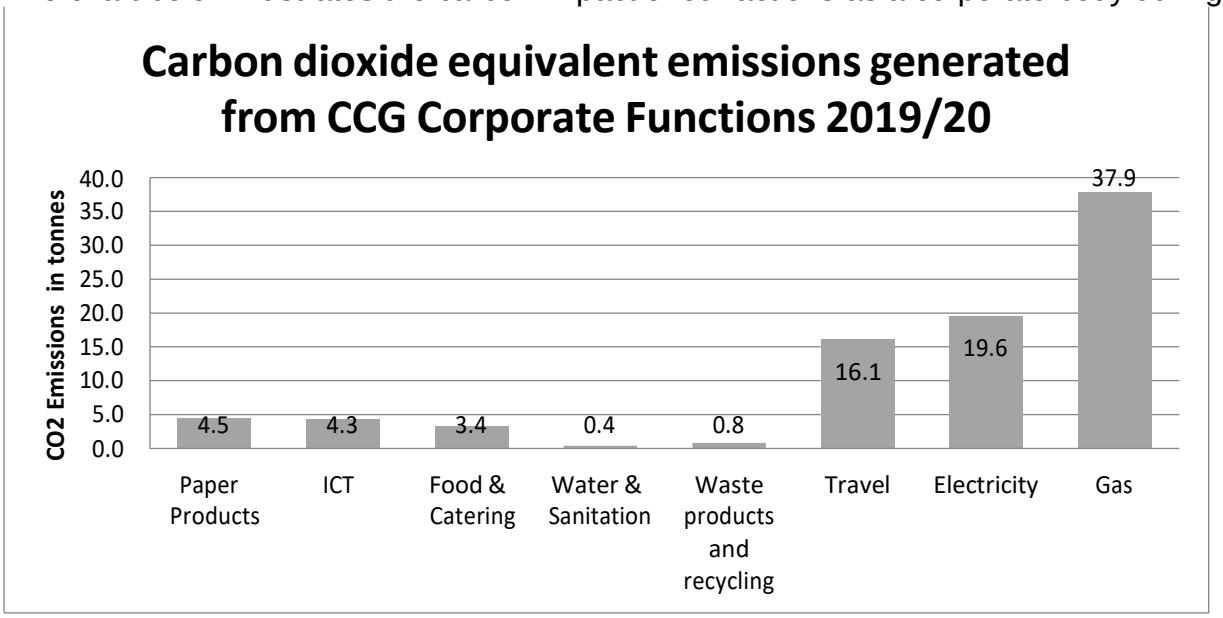
The increase in emissions relating to gas and electricity is a result of a greater occupancy for the CCG at Kempthorne and Midford House in 2019/20. This has resulted in a greater apportionment of usage and cost to these sites from Property Services.

The reduction in emissions relating to paper products can be attributed to the continued extension of our paperless approach to working. The emissions relating to ICT have increased, as we continue to invest in the technology required to support paperless working.

The increase in emissions related to travel is as a result of employees working over a larger geography in 2019/20. We continued to adopt Skype and conferencing facilities in order to reduce travel.
The increase in emissions relating to food and catering was due to an investment in water coolers for staff to support their wellbeing.

Further details regarding energy, water and waste are shown below.

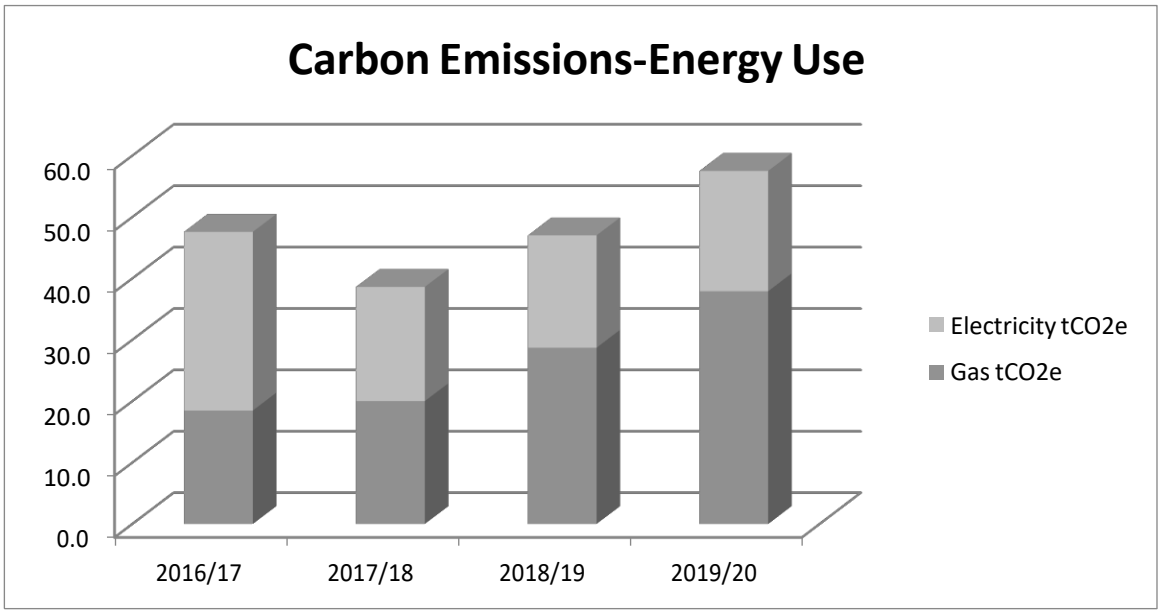
The chart below illustrates the carbon impact of our actions as a corporate body during 2019/20.



Energy

The table below and following chart show what our expenditure on energy for 2019/20 was compared to the previous three years, and the resulting modelled carbon emission impact. The data was based on apportioned usage across the St Martin's Hospital site. As noted above, gas and electricity consumption attributed to the CCG increased due to an increased occupancy of Kempthorne and Midford House. Despite this the emissions for electricity have not increased a proportionate amount due to electricity from the grid becoming greener, with a greater use of renewable energy sources.

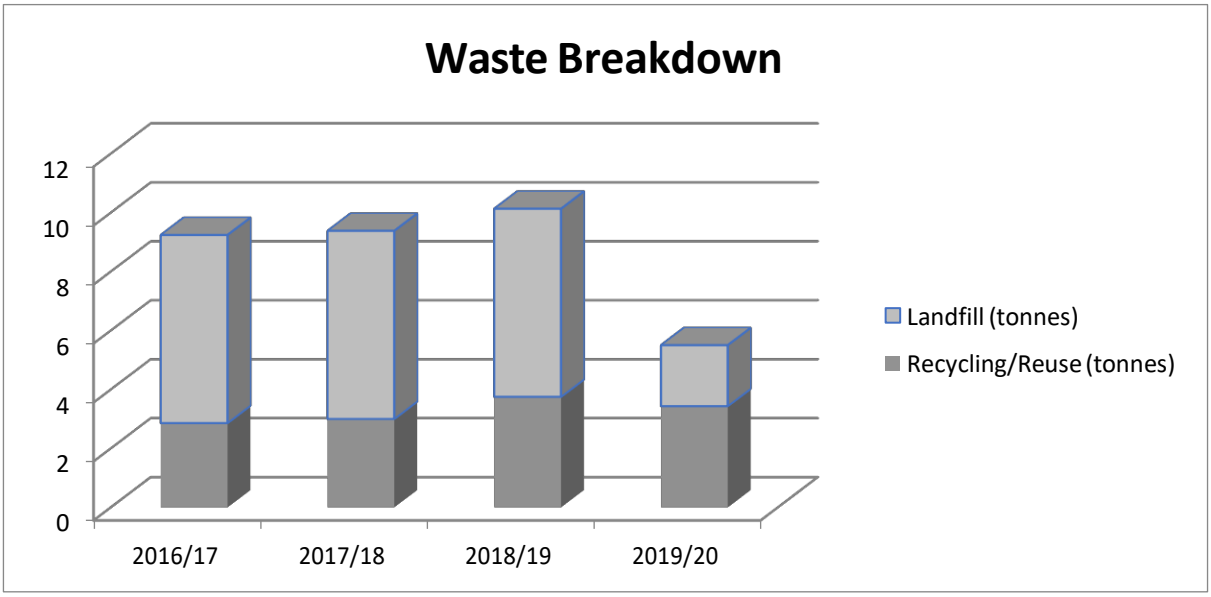
Resource		2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	88,393	94,549	135,219	182,550
	tCO2e	18.5	20.0	28.7	37.9
Electricity	Use (kWh)	56,330	41,822	51,924	62,056
	tCO2e	29.1	18.6	18.3	19.6
Total Energy CO2e		47.6	38.6	47.0	57.5
Total Energy Spend		10,103.0	7,948.0	12,738.0	17,051.0



Waste

The table below and following chart show the volume of waste arising from our activities and the resulting modelled carbon emissions impact. There has been a large decrease in the total volume of waste. The percentage of waste recycled has improved as a percentage of total waste.

Waste		2016/17	2017/18	2018/19	2019/20
Recycling/Reuse	(tonnes)	2.86	3.00	3.75	3.43
	tCO2e	0.06	0.07	0.09	0.07
Landfill	(tonnes)	6.38	6.38	6.38	2.07
	tCO2e	1.86	1.86	1.86	0.71
Total Waste (tonnes)		9.24	9.38	10.13	5.50
% Recycled or Re-used		30.95%	31.98%	37.02%	62.41%
Total Waste tCO2e		1.92	1.93	1.95	0.78



Water

The table below shows our expenditure on water and sewerage during 2019/20 as compared to the previous three years. As with energy, the data is based on apportioned usage across the St Martin's Hospital site. Usage and expenditure increased in 2019/20, with the amount apportioned to the CCG higher as a reflection of greater occupancy. Spend increased disproportionately to usage, suggesting this was driven by price increases.

Water		2016/17	2017/18	2018/19	2019/20
Mains	m3	548	360	322	426
	tCO2e	0.50	0.32	0.29	0.39
Water & Sewage Spend		£1,979	£1,014	£1,796	£3,461

Commissioning

As commissioners, our most significant impact was through the services we commissioned, which we influenced through both contractual mechanisms and partnership approaches. We reviewed the sustainability information for those NHS providers from whom we commissioned the highest volume of services, which disappointingly continues to show a mixed picture. We are pleased to note that North Bristol NHS Trust achieved an excellent score for their sustainability reporting and that Royal United Hospitals Bath NHS Foundation Trust achieved a good score. In contrast, other main NHS providers of services to our population had minimum or poor scores, although University Hospitals Bristol NHS Foundation Trust does have Sustainable Development Management Plan and Healthy Travel Plan in place. We continue to look at ways of increasing our engagement with providers on this important issue.

Part Two – Accountability report

Tracey Cox
Chief Executive

25 June 2020

Accountability Report
Corporate Governance Report

This section explains the composition and organisation of the CCG's governance structures and how they have supported the delivery of the CCG's objectives.

Members' report for 2019/20

The CCG's constitution outlines how the organisation will deliver its statutory duties. The new model CCG Constitution was adopted in June 2019 following extensive consultation with the membership, as a first step to streamlining governance arrangements across the prospective Bath and North East Somerset, Swindon and Wiltshire (BSW) CCG's footprint, with a single management structure.

In October 2019, NHSE approved the BSW CCGs' application for merger from 1 April 2020. Work on developing the constitution for the BSW CCG commenced in November 2019 and was concluded with NHSE's approval of the BSW CCG constitution in March 2020.

The BaNES CCG constitution is now on an archived website. The constitution for the new CCG can be found on the new website www.bswccg.nhs.uk

Member profiles

The CCG was led by an elected Clinical Chair, Dr Ian Orpen. During the year several changes were made to the membership of the Governing Body as set out below.

The establishment (ongoing from 1 March 2019) of the single management team of the BaNES, Swindon and Wiltshire (BSW) CCGs resulted in the following changes to the BaNES CCG Governing Body during the year.

Executive appointments

- Lisa Harvey, Director of Nursing and Quality and Registered Nurse stood down as of 31 July 2019.
- Gill May was appointed as BSW CCGs joint Director of Nursing and Quality from July 2019.
- The role of Registered Nurse was differentiated and separated out from the role of Director of Nursing and Quality to introduce resilience to the Governing Body. Margaret Arnold was appointed as Registered Nurse to the BaNES CCG Governing Body for a fixed term from 1 August 2019 to 31 March 2020.
- Sarah James, Chief Financial Officer stood down as of June 2019
- Caroline Gregory was appointed as BSW CCGs joint Chief Finance Officer from June 2019

GP member appointments

Following the establishment of the Primary Care Networks in June 2019, Dr Liz Hersch and Dr Daisy Curling stood down as GP members of the Governing Body in July 2019 to take up roles as Clinical Directors for their Primary Care Networks. To ensure the Governing Body retained the balance of clinical leadership Dr Louise Abson and Dr Sarah Thoday were elected as GP members to the Governing Body on fixed term appointment from 1 August 2019 to 31 March 2020.

Member practices

The CCG comprised 24 member practices. From June 2019 with the establishment of the Primary Care Networks, the member practices were set up as follows:

Primary Care Network	Member practices
Bath Independents	Batheaston Medical Centre, Bath

Clinical Director: Daisy Curling	Fairfield Park Health Centre, Bath Widcombe, Bath
Heart of Bath Clinical Director: Arun Gadhok	Heart of Bath Medical Partnership
Keynsham Clinical Director: Charles Bleakley	St Augustines, Keynsham Temple House Practice, Keynsham West View Surgery, Keynsham
Minerva Clinical Director: Sam Robinson	Combe Down Surgery, Bath Grosvenor Place Surgery, Bath Newbridge Surgery, Bath Rush Hill and Weston Surgery, Bath St Michael's and The Beehive, Bath
Three Valleys Clinical Director: Elizabeth Hersch	Hope House Surgery, Radstock Westfield Surgery, Radstock St Chads and Chilcompton Surgeries, Keynsham Somerton House Surgery, Radstock St Marys Surgery, Timsbury Hillcrest Surgery, Peasedown St John Elm Hayes Surgery, Paulton Harptree Surgery, West Harptree Chew Medical Practice, Chew Stoke
Unity: Clinical Director: James Brooks	Monmouth Surgery, Bath Pulteney Practice, Bath University Medical Centre, Bath

Composition of the Governing Body

The Governing Body is in place to ensure the CCG has the appropriate arrangements to discharge its functions effectively, efficiently and economically.

An ongoing role of the Governing Body is to review the CCG's governance arrangements and ensure we continue to adhere to the principles of good governance.

Each member of the Governing Body has a responsibility to ensure the CCG performs its duties in accordance with the terms of the constitution, with each member bringing a unique perspective, informed by their individual expertise and experience. It has been certified that the CCG has complied with its statutory duties, as laid out in the National Health Service Act 2006 (as amended).

The membership of the Bath and North East Somerset CCG Governing Body, from 1 April 2019 to 31 March 2020, is set out below, and reflects the establishment of a single BSW Senior Management Team.

Title	Name
Clinical Chair	Dr Ian Orpen
BSW Chief Executive	Tracey Cox

Chief Financial Officer	Sarah James (until June 2019)
BSW Chief Finance Officer	Caroline Gregory (from June 2019)
Director of Transformation and Strategy	Nicki Millin (from July 2010)
Director of Nursing and Quality and Registered Nurse	Lisa Harvey (until July 2019)
BSW Director of Nursing and Quality	Gill May (from July 2019)
Registered Nurse	Margaret Arnold (from July 2019)
Medical Director	Dr Ruth Grabham
GP Representative	Dr Liz Hersch (until July 2019)
GP Representative	Dr Daisy Curling (until July 2019)
GP Representative	Dr Louise Abson (from 1 August 2019)
GP Representative	Dr Sarah Thoday (from 1 August 2019)
GP Representative	Dr Bryn Bird
GP Representative	Dr Timothy Sephton
Practice Manager	John Moon
Lay Member (Public and Patient Engagement / Vice Chair)	Suzannah Power
Lay Member (Audit and Governance) from 1 April 2019	Peter Lucas
Lay Member (Quality)	Katie Hall
Secondary Care Specialist	Vacant

There are several members of the Governing Body who were in post until March 2020 and have not transferred to the new BSW CCG and I formally give a vote of thanks for all their hard work during their time with the CCG.

Below are the names of the people who were previous members of the BaNES CCG Governing Body since its inception in 2013 and thanks go to them for their contributions over the years.

Dr Ian Orpen
Dr Simon Douglas
Dr Ruth Grabham
Dr James Hampton
Dr Timothy Sephton
Dr Elizabeth Hersch
Dr Sarah Thoday
Dr Shanil Mantri
Dr Jonathon Osborn
Dr Brynn Bird
Dr Daisy Curling
Dr Louise Abson
Dr Mark Daly
Myles Taylor
Helen Harris

Tracey Cox
Sarah James
Caroline Gregory
Dawn Clarke
Val Janson
Lisa Harvey
Gill May
Maggie Arnold
Roger Stead
John Holden
Peter Lucas
Jean Paul Sanders
Suzannah Power
Katie Hall
John Moon

Register of interests

We recognise that effective handling of conflicts of interest is crucial to give confidence to patients, tax payers, healthcare providers and Parliament that our commissioning decisions are robust, fair

and transparent and offer value for money. In managing conflicts of interest, we follow Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) which sets out the minimum requirements of what we must do in terms of managing conflicts of interest, and the NHSE statutory guidance Managing conflicts of interest (2017).

Our Standards of Business Conduct Policy complies with national guidance and sets out our expectations regarding standards of business conduct for the CCG, including the management of conflicts of interest. The Policy ensures that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation. The Policy also provides guidance to all member practices, staff and Governing Body members on the receipt of gifts and hospitality.

We maintain and regularly review a register of staff's declarations of interest. We published a register of our Governing Body members' interests, and how we managed these, on our website which is now archived.

Statement as to disclosure to auditors

Everyone who is a member of the CCG at the time the members' report was approved confirms:

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

Note: Relevant audit information means information needed by the CCG's auditor about preparing this report.

Modern Slavery Act

Bath and North East Somerset CCG fully supported the Government's objectives to eradicate modern slavery and human trafficking, the organisations does not meet the requirements needed for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Statement of the Chief Executive's responsibilities as Accountable Officer of Bath and North East Somerset Clinical Commissioning Group

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). Tracey Cox is the Accountable Officer of NHS Bath and North East Somerset CCG, a role she also holds for Swindon and Wiltshire CCGs.

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

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

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed and disclose and explain any material departures in the accounts.
- Prepare the financial statements on a going concern basis.
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take responsibility for the Annual Report and Accounts and the judgement 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 Bath and North East Somerset Clinical Commissioning Group'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."

“I also confirm that:

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

Tracey Cox
Chief Executive Officer
Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

25 June 2020

Governance statement

Introduction and context

Bath and North East Somerset CCG was a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As of 1 April 2018, the CCG has not been 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 Clinical Commissioning Group's policies, aims and objectives, while safeguarding the public funds and assets for which I am personally responsible for, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter."

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

Governance arrangements and effectiveness

The CCG's constitution set out the principles of good governance and delegated authority to members or employees participating in joint arrangements to make decisions on its behalf through the following committees:

The Governing Body ensured the CCG had appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the group's principles of good governance. Reporting to the CCG Governing Body, the following subgroups enabled it to discharge its responsibilities and manage its performance, quality and risk effectively:

Statutory Committees:
- Audit Committee
- Remuneration and Nominations Committee
- Primary Care Commissioning Committee

Non-statutory Committees:
- Finance and Performance Committee (till 31 August 2019, superseded by the BSW Finance Committee)
- BSW Finance Committee (from 1 September 2019)

- Quality Committee (till August 2019, superseded by the BSW Quality and Performance Committee)
- BSW Quality and Performance Committee (from 1 September 2019)
- Joint Commissioning Committee (CCG / B&NES Council)

The Governing Body has worked diligently to carry out its responsibilities as a statutory body. The agenda and papers of the Governing Body's meetings in public were placed on the CCG's website in advance of the meetings and acted as a public record of the decisions taken and performance to date.

Following the appointment of Tracey Cox as Chief Executive for the BSW CCGs in March 2019, work has continued during the year to establish a single Senior Executive Team across BSW. The following appointments have been made:

Director of Strategy and Transformation/Deputy Chief Executive – Nicki Millin (from 1 July 2019)
Chief Finance Officer – Caroline Gregory (from 3 June 2019)
Director of Nursing and Quality – Gill May (from 1 July 2019)
Medical Director – Ruth Grabham (from February 2020)
Chief Operation Officer (BaNES) – Corinne Edwards (from 1 July 2019)
Chief Operating Officer (Swindon) – David Freeman (interim appointment from 20 January 2020)
Chief Operating Officer (Wiltshire) – Ted Wilson (interim appointment from 1 October 2019 – 31 March 2020). Elizabeth Disney (from 2 March 2020)
Interim Director of People and OD - Alison Kingscott and Sheridan Flavin (from September 2019)
Director of Corporate Affairs – Julie-Anne Wales (from October 2019)

The Governing Body has understood its responsibility to listen to and engage with its stakeholders, and actively seek their opinion.

The Audit Committee was accountable to the CCG's Governing Body to provide an independent and objective view of the CCG's financial systems, financial information and regulations and directions in so far as they relate to finance. The Committee provided assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- business is conducted 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 of the CCG for the period in question
- affairs are managed to secure economic, efficient and effective use of resources
- reasonable steps are taken to prevent and detect fraud and other irregularities.

The Committee met seven times during the year, four of which (from September 2019 onwards) were meetings in common with the Audit Committees of the Swindon and Wiltshire CCGs' Governing Bodies as part of the planned streamlined governance arrangements across BSW and moving towards a single CCG.

Highlights of work undertaken during the year have included considering, reviewing and approving, as appropriate:

- internal and external audit plans for the year
- the CCG's Board Assurance Framework
- Counter Fraud and Security Management reports
- the CCG's Register of Gifts and Hospitality
- the CCG's Annual Report and Accounts 2019/20 and Letter of Representation

- BSW Model of IT Support Business Case
- Mental Health Investment Standards Review
- BSW policy merger arrangement
- Aligning Risk Management Systems and Processes across BSW.

In accordance with the Audit Committee's Terms of Reference other members of CCG staff attended on an as required basis. Membership details and attendance are reported below.

The Remuneration and Nomination Committee was accountable to the CCG's Governing Body to make recommendations on determinations about the remuneration, fees and other allowances for senior management and for people who provide services to the group. The committee oversees and provides assurance on senior management and Governing Body terms and conditions outside NHS Agenda for Change.

The Remuneration Committee met seven times during the year, five of which were meetings in common with the Remuneration Committees of the Swindon and Wiltshire CCGs' Governing Bodies as part of the planned streamlined governance arrangements across BSW and moving towards a single CCG.

The Primary Care Commissioning Committee (PCCC) was established in accordance with the statutory requirements that come with the delegation of primary care commissioning functions, to enable the committee members to make collective decisions on the review, planning and procurement of primary care services in Bath and North East Somerset under delegated responsibility from NHS England, reporting to the Governing Body and to NHS England. The Primary Care Commissioning Committee oversees the work of the Primary Care Operational Group (PCOG), and the primary care work plans as established by the CCG as part of the Five Year Forward View and the General Practice Forward View Plan.

During 2019/20 the PCCC met five times, two of which (from October 2019 onwards) were meetings in common with the PCCCs of the Swindon and Wiltshire CCGs' Governing Bodies as part of the planned streamlined governance arrangements across BSW and moving towards a single CCG. Topics discussed at the meetings include quality and finance reporting, operational reports, the formation of the Primary Care Networks, extended access for primary care services, primary care engagement, system working across BaNES, Swindon and Wiltshire CCGs, and a review of risks. Membership details and attendance are reported below.

BSW Quality Assurance and Performance Committee: the functions of the Quality Committee were assured and discharged by the BSW Quality Assurance and Performance Committee from September 2019 as part of the streamlined governance arrangements across BSW and moving towards a single CCG. The committee provides assurance to the CCG's Governing Body of the quality of services commissioned and promote a culture of continuous improvement and innovation with respect to safety of services, clinical effectiveness and patient experience. It oversees the development and monitoring of the overall strategy for quality improvement, in partnership with patients, carers and the wider community and monitors performance against service delivery indicators. Membership details and attendance are reported below.

BSW Finance Committee: the functions of the Finance Committee were assured and discharged by the BSW Finance Committee from September 2019 as part of the streamlined governance arrangements across BSW and moving towards a single CCG. The committee provides a robust performance framework which proactively manages the CCG's financial, performance and improving value schemes. Advice and support to the Governing Body, and to the Accountable Officer in scrutinising and monitoring the delivery of key financial targets and priorities as outlined in the CCG's strategic and operational plans.

Total number of meetings		9	7	6	5	4	6	2	4
Number of meetings which have been in common		6	4	5	2	0	0	0	0
Name	**Title**	**GB**	**Audit**	**Rem**	**PCCC**	**Finance and Performance Committee (until Aug 2019)**	**BSW Finance and Performance Committee (from September 2019)**	**Quality and Performance Committee (until August 2019)**	**BSW Quality and Performance Committee (from September 2019)**
Dr Ian Orpen	Clinical Chair	5/9 (Chair)	n/a	4/6	n/a	3/5 (Chair)	5/6	n/a	n/a
Dr Ruth Grabham	Medical Director	8/9	n/a	n/a	3/5	3/5	n/a	1/2	
Dr Bryn Bird	GP Member	8/9	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Tim Sephton	GP Member	3/9	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Liz Hersch (until July 2019)	GP Member	1/3	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Daisy Curling (until July 2019)	GP Member	3/3	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Louise Abson (1 Aug 2019 – 31 March 2020)	GP Member	3/6	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Dr Sarah Thoday (1 Aug 2019 – 31 March 2020)	GP Member	4/6	n/a	n/a	n/a	n/a	n/a	n/a	n/a
John Moon	GP Practice Manager	7/9	n/a	n/a	5/5	n/a	n/a	n/a	n/a
Peter Lucas	Lay Member Audit and Governance	7/9	7/7 (Chair)	4/6	2/5	4/4	6/6	n/a	n/a
Katie Hall	Lay Member Quality	8/9	5/7	5/6	5/5	n/a	n/a	2/2 (Chair)	3/4
Suzannah Power	Lay Member Patient and Public Engagement	8/9	4/7	5/6	5/5 (Chair)	n/a	n/a	1/2	n/a
Tracey Cox	Chief Executive Officer (BSW CCGs)	7/9	3/7	5/6	n/a	0/4	3/6	n/a	n/a
Sarah James (until June 2019)	Chief Financial	1/1	2/2	n/a	1/1	1/1	n/a	n/a	n/a

	Officer								
Caroline Gregory (from June 2019)	Chief Financial Officer (BSW CCGs)	7/8	5/5	n/a	3/4	2/3	6/6	n/a	n/a
Lisa Harvey (until July 2019)	Director of Nursing and Quality; Registered Nurse	3/3	1/3	n/a	2/3	1/3	n/a	2/2	n/a
Gill May (from July 2019)	Director of Nursing and Quality (BSW CCGs)	7/8	n/a	n/a	2/2	n/a	n/a	n/a	4/4
Margaret Arnold (1 Aug 2019 – 31 March 2020)	Registered Nurse	6/6	3/5	n/a	n/a	n/a	n/a	n/a	n/a
Executive officers in attendance (non-voting)									
Corinne Edwards	Chief Operating Officer, BaNES	2/6							
Julie-Anne Wales,	Director of Corporate Affairs	6/9							
Sheridin Flavin (from September 2019)	Interim Executive Director of People and Organisational Development	3/3							
Alison Kingscott, (from September 2019)	Interim Executive Director of People and Organisational Development	3/3							

Relation with shareholders

While the CCG did not have shareholders as a public-sector organisation, the Governing Body held a successful Annual General Meeting (AGM) to engage with its major stakeholders including the public, providers and patients.

The Governing Body understood its responsibility to listen and engage with its stakeholders and actively seeks their opinion.

UK Code of Corporate Governance

NHS bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of statutory functions

Considering recommendations of the 1983 Harris Review, the CCG has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, we 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 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 the CCG's statutory duties.

Arrangements put in place by the CCG and explained within the corporate governance framework, have been developed with extensive expert input, to ensure compliance with the all relevant legislation. That advice also informs the matters reserved for the Governing Body's decisions and adherence to the scheme of delegation as outlined in the NHS Constitution.

Risk management arrangements and effectiveness

Bath and North East Somerset (BaNES) CCG, Swindon CCG and Wiltshire CCG separately have had a statutory responsibility to patients, staff and the public to ensure that we have effective processes, policies and people in place to deliver our objectives and to control any risks that we face in achieving them.

The Governing Bodies of each CCG recognise that sound risk management in the CCG and its partner bodies is essential for meeting objectives and identifying and managing future opportunities. The Governing Bodies ensure risk management forms a fundamental element of our philosophy, practices and our business rather than a separate programme, and are committed to ensuring that risk management is embedded throughout our organisations and is part of our everyday practice.

The CCGs promote and embed a culture of transparency, openness and honesty to ensure risks are properly identified, evaluated, documented and managed. This has been underpinned by a robust framework that reflects the concepts of effective governance and strong internal control, aligned to management systems, corporate planning, clinician-led commissioning and strategy development.

In October 2019, the Governing Bodies of BaNES, Swindon and Wiltshire (BSW) CCGs met in common, and approved the BSW Risk Management Strategy (October 2019 – March 2022), which aligns the systems and process relating to risk management across the BSW patch. The BSW

Risk Management Strategy represents the combined risk management approach of BaNES CCG, Swindon CCG and Wiltshire CCG in support of the commissioning alliance and the ongoing approach for the merged organisation.

The BSW Risk Management Strategy sets out the overall aims, objectives and processes for Risk Management across BSW and when working in conjunction with partners and stakeholders. It sets out the Risk Management Framework and how BSW will approach the consideration of financial, organisational, reputational and project risks, both clinical and non-clinical and for all parts of the organisation. The roles and responsibilities of key individuals and committees including accountability levels regarding risk management are also included. Risk identification, recording, assessment and scoring are also detailed within the strategy.

BSW's risk appetite is also defined within the strategy and is mapped out to show the level of risk the CCGs will tolerate against the categories of risk they face across all business areas. BSW will not accept levels of risk rated high (scored 16 or above on the risk matrix) and will ensure that plans are put into place to lower the level of risk whenever a critical risk has been identified. Plans to reduce the risk to a rating that will be tolerated will be put in place.

Following agreement of the three CCGs Governing Bodies in October 2019 to align risk management processes across BSW, it was agreed to establish a BSW wide Risk Management Panel to provide a more effective oversight and scrutiny of risks across the area. This BSW Risk Management Panel replaced the standalone Risk Management Panels in BaNES, Swindon and Wiltshire and held its first meeting in November 2019.

Risk management is the responsibility of everyone within the BSW CCGs. The review and maintenance of an effective risk management system involves all staff and, as appropriate, key stakeholders and is applied to all systems and processes, corporate and financial.

Capacity to handle risk

The Governing Bodies of the BSW CCGs are responsible for the performance of the individual CCGs and as such need to be simultaneously entrepreneurial in driving the organisation forward while keeping it under prudent control. It needs to strike a balance between controls, assurance and strategy, risk taking and delivery. A risk management audit for Swindon CCG was undertaken by PWC in December 2019 with an overall assurance rating of "Low Risk". KPMG undertook risk management audits for BaNES CCG and Wiltshire CCG in December 2019 and found "Significant assurance with minor improvement opportunities" for both CCGs.

The Audit Committee was responsible for commissioning internal audits to provide assurance to each Governing Body on the robustness and effectiveness of risk management within the individual CCG. From autumn 2019, the three CCG's Audit Committees held meetings in common, as part of streamlining governance arrangements in anticipation of the CCGs' merger.

The BSW Risk Management Panel was established to: ensure that the three CCGs have adequate arrangements in place for risk management; to provide assurance on this to the Audit Committees of the three CCGs; to take action to effectively manage and co-ordinate risk management activity; and to establish a strategic approach to risk management across BSW, ensuring that the approach is pro-active. The panel provided reports to the CCGs' Audit Committees on assurances relating to the effective operation of risk management systems and controls across BSW. In the event of a significant risk being identified, the risk will be reported to the BSW panel immediately. The core members of the panel include: the BSW Chief Executive Officer (Chair); the BSW Director of Strategy and Transformation (Vice-Chair); the BSW Chief Financial Officer; the BSW Director of

Nursing and Quality; the BSW Director of Corporate Affairs; the BSW Director of Commissioning; and the Chief Operating Officers for the three CCGs.

The BSW Chief Executive Officer was accountable to each Governing Body for the safe management of risk within the organisations. This responsibility is delegated to the Chief Financial Officer on a day to day basis.

The Chief Financial Officer has overall responsibility for the operational management of risk within the CCG.

Senior managers and project managers are empowered to manage the risks within their areas and to escalate risks appropriately. All staff members and contractors working for the CCG have a responsibility for following the approved risk management strategy and are required to report risks to their managers for assessment and subsequent risk scoring, using the approved risk matrix. If a risk is thought to be of corporate significance, the senior manager will apply for the risk to be entered onto the corporate risk register. If approved by the Risk Management Panel for entry, the risk is then subject to the management and escalation processes of corporate risks as shown in the Risk Management Strategy. A programme of risk management training for staff is being developed and will be rolled out across the BSW patch.

The BSW CCGs are committed to maintaining a sound system of internal control, including risk management. By doing this, the CCGs aim to ensure they can maintain a safe environment for patients, through the services they commission, staff and visitors, minimise financial loss to the organisations and demonstrate to the public that they are safe, effective and efficient organisations.

Risk assessment

Risk assessment and management are an intrinsic part of the BSW CCGs operation. The BSW Corporate Risk Register, which was created before the merger, is a live document and should be viewed as a communication tool and an action plan giving details of current controls and auditable actions for risk treatment. Actions should always be specific, measurable, achievable, relevant and time-bounded (SMART). It is a record that aims to illustrate the operational risk profile of the CCG by reflecting the extent to which our operational objectives are threatened by the uncertainty that risk presents.

The BSW Corporate Risk Register was subject to regular reviews by several committees including:

- The CCG's Governing Body
- The CCG's Audit Committee
- BSW Risk Management Panel

The CCG's Governing Body and Audit Committee regularly consider whether the sources of assurance that it has for managing and mitigating risks remain effective and sufficiently robust. The CCG has developed a risk matrix which is used for all risks within the organisation.

Each risk includes:

- Category of risk
- Description of the risk
- Date entered
- Existing controls and assurances

- Original risk score
- Target risk score
- Strategy to manage risk
- Proposed actions and delivery dates
- Progress
- Date of latest review
- Current risk score (likelihood and impact)
- Who owns and who manages the risk?

The CCGs have a Quality and Equality Impact Assessment (QEIA) process in place which provides the framework to ensure compliance with statutory obligations and to identify any risks to the organisations. Impacts are also assessed through the cover sheets for all reports that are presented to the Governing Bodies and other committees to ensure it is integral to planning and implementation. The CCGs have an active framework for patient and public engagement and actively attend the Health and Wellbeing Boards of their respective local authority. A network of patient participation groups and regular events seek the views of patients and the public. The QEIA process is currently being reviewed in order to develop a BSW process post-merger.

The Board Assurance Framework (BAF) records the strategic risks affecting BSW's strategic objectives. The BAF is a high-level management assessment process and records the strength of, and gaps in, our internal control to manage the risk to the delivery of our strategic objectives. By reviewing actual assurances, the adequacy of internal controls can be confirmed or modified.

The BAF allows the CCGs to determine where to make the most efficient use of resources and to address identified issues to improve the quality and safety of care. It is the role of the Governing Body to focus on those risks and events which may compromise the achievement of the BSW's strategic objectives and support an organisational culture that allows the organisation to anticipate and respond appropriately to adverse events.

The BAF lists the:

- Strategic objectives and outcomes that are at risk
- Description of the risk to delivery and risk score
- Controls in place to manage the risk (and any gaps in controls)
- Assurance that our controls are working (and any gaps in assurance)
- Actions to mitigate risk and fill gaps in controls and assurances
- Risk appetite - level of risk the Governing Body is willing to tolerate for the specific risk.

All identified operational risks are recorded on the BSW Corporate Risk Register. Where risks cannot be managed within the specific area of responsibility, these are escalated to the next level of governance to be managed appropriately.

The BSW Corporate Risk Register and the BAF are reviewed regularly by the Risk Management Panel, the CCG's Audit Committee and by the CCG's Governing Body.

The CCGs actively deter risks through the adoption of robust counter fraud and security management methodology. All three CCGs have a contract with TIAA to provide counter fraud management. BaNES CCG rated itself as green against the national standards for counter fraud and security management in 2019/20.

The CCG's Audit Committee critically reviewed the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the

CCG's activities which supports the achievement of the organisation's objectives. The Audit Committee reviewed its Terms of Reference during the year and undertook a self-assessment against areas of best practice; it is compliant in all areas that it must and should do.

The highest scoring BSW risks identified during 2019/20 related to:

1. Failure to achieve and maintain key NHS Constitutional Targets, such as the A&E four hour standard which together with 'Winter Pressures' could result in patients coming to harm.

2. Issues around Ambulance Performance, including call stacking, response delays and cost.

3. Increased demands on Primary Care / GP Practices.

The BSW Risk Management Panel scrutinised the Corporate Risk Register and the BAF at each of its meetings and informed the CCGs' Audit Committees and Governing Bodies on progress against mitigating actions.

Other sources of assurance

Internal Control Framework

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

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

The CCG's system of internal control has been in place for the year ended 31 March 2020, and up to the date of approval of the Annual Report and Accounts.

The CCG assessed itself against the new standards and was able to demonstrate compliance for all areas and noted improvements in the following:

- Risk management – tracking and reporting system in place with regular reporting to the appropriate committee. All risks on Risk Register are now financially assessed on a regular basis and any that are considered material, are reported through to the Finance Committee.
- Support from third parties – service providers have good local knowledge, possess the relevant expertise, share and continuously implement best practice except for some services provided by the CSU.
- Finance Committee – Committee Chair is not required to produce an annual report for the Governing Body because the terms of reference for this committee make it clear that it has no decision-making powers and instead reports on performance through to the CCG's Annual Report.

This assessment was endorsed by the CCG's Governing Body and the CCG's Audit Committee continued to provide oversight and scrutiny on the internal control environment derived through reviews undertaken against areas deemed as high risk by internal audit, counter fraud and security management.

Annual audit of conflicts of interest management

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

The CCG's internal auditors carried out an audit on managing conflicts of interest which was presented to the January 2020 Audit Committees meeting in common. A high level review was conducted on the CCG's compliance with the eight areas in NHS England's (NHSE) statutory guidance on managing Conflicts of Interest (CoI). This internal audit is required by NHSE as a result of the increasing number of CCGs with delegated commissioning arrangements, as well as the increased piloting of joint and integrated ways of working to ensure that the CCGs were complying with NHSE statutory guidance on managing conflicts of interest.

During December 2019 and January 2020, internal auditors KPMG reviewed our arrangements to manage conflicts of interests within the CCG. The audit concluded that we had strong, established processes in place to manage conflicts of interest, and that we demonstrated compliance with the NHSE's conflicts of interest statutory guidance. The audit returned an assessment of 'significant assurance with minor improvement opportunities' which related to the way in which we maintained oversight of the management of conflicts of interest in procurements.

Data quality

Regular reports are presented to the Governing Body to provide assurance on all CCG activities and include, but are not limited to; strategic planning, patient safety and quality of clinical care, organisation development, performance management and the achievement of national and local NHS targets, financial management reports, patient engagement, stakeholder engagement, emergency planning, compliance with the NHS Constitution and identified risks and actions.

Substantial improvements have been made in relation to the quality of the information and data analysis provided to the Governing Body, its committees and programme boards following the decision to repatriate services from the CSU and develop the skills internally to review and report on data.

Information governance

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

The CCG placed high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. It has established an Information Governance (IG) Management Framework and is developing information governance processes and procedures in line with the Data Security and Protection Toolkit.

Progress against these are monitored through the BSW Information Governance Steering Group, chaired by the Senior Information Risk Owner (SIRO). All CCG staff are mandated to complete an IG training module annually, thereby ensuring that staff are aware of their IG responsibilities. There are processes in place for incident reporting and investigation of serious incidents.

The CCG continued to develop information risk assessment and management procedures to ensure a fully embedded information risk culture throughout the organisation. It focused on the need to ensure robust data sharing agreements were in place between its partner organisations and Data Protection Impact Assessments were being undertaken for any service changes. During 2019/20, BaNES CCG had an incident involving data loss which was reported to the Information Commissioners Office (ICO). This was further investigated with local action undertaken by the CCG and the ICO decided no further action was required.

The Data Security and Protection (DSP) Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy.

The toolkit has been developed in response to the National Data Guardian (NDG) Review of data security, consent and opt-outs and is the successor framework to the Information Governance Toolkit.

The status of health and care organisations' DSP Toolkits is shared with the Care Quality Commission, NHS England and NHS Improvement. The DSP Toolkit status is important evidence for the key line of enquiry on information in a CQC Well-Led inspection. Organisations will be listed on the DSP Toolkit with their status displayed available for commissioners, partner organisations and the public.

BaNES, Swindon and Wiltshire CCGs have submitted a DSP Toolkit and have achieved the required standards.

Business critical models

The CCGs have in place an appropriate and proportionate approach to providing quality assurance of business critical models. This is in line with the recommendations of the 2013 Macpherson Report.

Third party assurances

As a commissioning organisation, the CCG has routinely contracted with third party providers to deliver healthcare services. These services are contracted using NHS standard contracts using national terms and conditions. The CCG places reliance on these contracts to make sure that services remain effective as well as regular performance monitoring reports and meetings with providers.

The CCG also uses third party providers to deliver some of its back-office processes:

- It is nationally mandated for the CCG to use NHS Shared Business Services for the provision of back office financial services. These services are provided to the CCG under a contract between NHS England and NHS Shared Business services. The CCG places reliance on NHS England to manage this contract and report back on any control issues identified.
- The CCG sub-contracts the provision of several of its corporate services to the South Central and West Commissioning Support Unit (CSU). The CCG reviews the performance of this service level agreement monthly and in addition, the Audit Committee reviews the findings from the Service Audit Report (SAR) which the CSU commissions from Deloitte to assess the reasonableness of the controls it has in place.
- The CCG has a pooled budget arrangement with B&NES Council for the provision of community, mental health, and children's services. Specific services within this arrangement predominantly relating to the management of out of hospital care are managed through the

Better Care Fund. This is formalised through a Section 75 agreement and performance is reviewed in year through the Joint Commissioning Group who report up to the CCG's Governing Body.

Control issues

During 2019/20, the CCG has formally reported one control issue to NHSE: The CCG's performance monitoring processes have identified and continue to report NHS constitution targets not met by providers. Reporting and monitoring processes are in place to track performance of providers against constitutional targets, this is an ongoing process and regular meetings with providers have taken place and continue to take place to ensure that action plans are being implemented to improve performance.

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

The CCG was faced with a very challenging financial position again at the start of 2019/20 and it needed to deliver a QIPP programme of £6.2m to secure financial balance and deliver its target surplus. The CCG focused its efforts on a few key schemes setting sizeable efficiency targets for prescribing, alignment of clinical policies and delayed discharges. Overall QIPP is expected to deliver at 92 per cent for the year.

The CCG has met its financial target to breakeven in year. Expenditure has been examined in detail by the Finance Committee on a bi-monthly basis. This helps to identify potential financial issues and pressures at the earliest opportunity to enable remedies to be taken where necessary.

All spend is subject to the controls laid out in the CCG's Prime Financial Policies. These controls have been put in place to ensure that the CCG delivered value for money.

The CCG has continued to review its running costs to ensure it delivered value for money and has underspent against the allocation in year. The underspend has been reinvested in patient services.

Delegation of functions

The CCG has not delegated any of its statutory functions.

The CCG has had a service level agreement in place with South, Central and West Commissioning Support Unit for the provision of a range of services including: Procurement, Provider Performance Management, Health Intelligence Analytics, Human Resources, Health and Safety support, Freedom of Information Requests, Information Governance, IT Technology and Support, IT Programmes and Planning, Data Services Management, and GP Information Technology.

Counter fraud arrangements

The CCG has continued throughout 2019/20 with the services of an accredited Local Counter Fraud Specialist (LCFS) who ensures through their annual work plan that:

- Fraud risk assessment is completed
- Staff awareness-raising of the risks of fraud and the action to take in a case of suspected fraud is undertaken regularly
- The CCG has an appropriate Anti-Fraud, Corruption, and Bribery Policy and Whistleblowing Policy in place and communicated to staff

- Suspected frauds are investigated in an appropriate and timely manner.

Proactive reviews of systems, processes and controls by both Internal Audit and the LCFS also contribute to the identification of the risk of fraud.

The LCFS continues to attend the Audit Committee meetings in common with all three CCGs. These arrangements are secured through a formal contract with our professional Counter-Fraud service provider. We believe these arrangements to be robust and comprehensive and will continue into 2020/21 for the combined BSW CCG.

Tracey Cox
Chief Executive Officer
Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group

25 June 2020

Head of Internal Audit Opinion 2019/20

Basis of opinion for the period 1 April 2019 to 31 March 2020

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the CCG's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the system of internal control. This opinion will in turn assist the Governing Body in the completion of its AGS and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the CCG. The opinion is derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Governing Body takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion;

- Overall opinion; and
- Commentary.

Basis for the opinion

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning aspects of the risk and assurance framework and supporting processes; and
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

Overall opinion

Our overall opinion for the period 1 April 2019 to 31 March 2020 is that:

'Significant assurance with minor improvements required' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1 April 2019 to 31 March 2020 inclusive and is based on the seven audits that we completed during 2019/2020.

The design and operation of the Assurance Framework and associated processes

Overall our review found that the Assurance framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Governing Body. The Assurance Framework reflects the organisation's key objectives and risks and is reviewed on a bi-monthly basis by the Governing Body and by the Audit Committee. It was reviewed most recently by the Audit Committee on 7 May 2020.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We issued two 'partial with improvement required' and no 'no assurance' ratings in respect of 2019/20 assignments. For the remaining reviews completed we issued two 'significant' assurance ratings and three 'significant assurance with minor improvement opportunities' ratings. Our audits have identified one high priority recommendation.

Therefore, this does not prevent us from issuing significant assurance with minor improvements required. We do not consider the ratings, and specifically, the detailed findings within these reviews, to impact on our overall audit opinion as the CCG has agreed plans and is in the process of implementing actions to mitigate the risk identified.

KPMG LLP
Chartered Accountants
London
9 June 2020

Accountability report

Remuneration and staff report

This section sets out the CCG's remuneration policy for directors and senior managers and how it has been implemented.

Remuneration report

Remuneration and Nomination Committee

The Remuneration and Nomination Committee was accountable to the CCG's Governing Body to make recommendations on determinations about the remuneration, fees and other allowances for senior management and for people who provide services to the group.

Policy on the remuneration of senior managers

Executive senior managers are on permanent NHS contracts except two interim Directors. All directors are employed with terms and conditions including duration, notice periods and termination payments in accordance with existing Agenda for Change and 'very senior manager' (VSM) arrangements.

Amendments to VSM and Governing Body members' salaries are reviewed annually by the Remuneration and Nomination Committee, which makes recommendations to the Governing Body. Salaries exclude on-call payments. Senior Manager performance is monitored through the formal appraisal process, based on organisational and individual objectives.

Remuneration is designed to fairly reward each individual based on their contribution to the CCG's success taking into account the need to recruit, retain and motivate skilled and experienced professionals. Remuneration must take into account considerations of equal pay, value for money in the use of public resources, and the CCG's obligation to remain within its financial allocations.

Executive Directors pay is set in accordance with the guidance Clinical Commissioning Groups: Remuneration Guidance for Chief Officers and Chief Finance Officers, existing VSM pay scales, terms and conditions apply.

For other Governing Body members, the CCG relies on available guidance and comparative data from other NHS organisations and CCGs to determine appropriate remuneration packages. In the case of GP members, a comparison with salary in their general practitioner role is also taken into account along with any loss of seniority pay due to the time commitment to the CCG.

The length of contract and terms and conditions for staff are set out in the Agenda for Change, NHS Terms and Conditions of Service Handbook. The CCG's Constitution determined the composition of the CCG's Governing Body, as well as the ways in which individuals were appointed or elected, and terms of office.

GPs and practice managers were appointed for a set period as detailed in the CCG's constitution which is approved by member GP practices and are as follows:

	Term of office	**Notice period**
Clinical Chair	4 years, renewable by one 4-year term	6 months
Lay Members	4 years, renewable by one 4-year term	3 months
Registered Nurse	4 years, renewable by one 4-year term	3 months
Secondary Care Doctor	4 years, renewable by one	3 months

	4-year term	
Locality GP representatives	2 years initially and then 4 years (no maximum term)	3 months
Practice Manager representative	4 years (No maximum term)	3 months
Chief Executive	Permanent	6 months
Director of Nursing and Quality	Permanent	3 months
Chief Finance Officer	Permanent	3 months

Senior manager remuneration (including salary and pension entitlements) 2019/20. (audited)

Name and title	From[1]	To [1]	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100 [6]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Dr Ian Orpen, Chair of the CCG	01/04/2019	31/03/2020	85-90	200	0	0	0	85-90
Dr Ruth Grabham, Medical Director	01/04/2019	29/02/2020	75-80	200	0	0	0-2.5	75-80
Dr Ruth Grabham, BSW Medical Director	01/03/2020	Present	0-5	0			0-2.5	0-5
Tracey Cox, Chief Executive Officer [2]	01/04/2019	Present	20-25	500	0	0	0-2.5	20-25
Sarah James,Chief Finance officer	01/04/2020	31/05/2020	15-20	0	0	0	50-52.5	65-70
Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member [5]	01/04/2019	31/07/2019	60-65		0	0	0	60-65
Corinne Edwards, Chief Operating Officer , B & NES Locality	01/04/2019	Present	105-110	200	0	0	90-92.5	195-200
Alison Kingscott, Interim BSW Director [2]	01/09/2019	Present	5-10		0	0	2.5-5	5-10
Sheridan Flavin, Interim BSW Director [2]	01/09/2019	Present	5-10		0	0	2.5-5	5-10
Julie-Anne Wales, BSW Director of Corporate Affairs [2]	01/10/2019	Present	5-10		0	0	7.5-10	15-20
Caroline Gregory, Chief Finance Officer [2]	01/06/2019	Present	15-20		0	0	10-12.5	25-30
Gill May - Director of Nursing & Quality [2]	01/07/2020	Present	10-15		0	0	10-12.5	25-30
NikKi Millin , Director of Strategy and Transformation- [2]	01/07/2019	Present	15-20		0	0	5-7.5	20-25
Dr Elizabeth Hersch, GP Cluster Lead [3]	01/04/2019	31/07/2019	5-10		0	0	0	5-10
Dr Daisy Curling, GP Cluster Lead [3]	01/04/2019	31/07/2019	5-10		0	0	0	5-10
Dr Timothy Sephton, GP Cluster Lead [3]	01/04/2019	Present	25-30		0	0	5-7.5	30-35
Dr Brynn Bird, GP Cluster Lead [3]	01/04/2019	Present	25-30		0	0	20-22.5	45-50
Dr Louise Abson, GP Board member [3]	01/08/2019	Present	20-25		0	0	15-17.5	35-40
Dr Sarah Thoday, GP Board member [3]	01/08/2019	Present	25-30		0	0	60-62.5	90-95
John Moon, Practice Manager representative.	01/04/2019	Present	10-15		0	0	N/A	10-15
Katie Hall, Lay Member for Quality	01/04/2019	Present	5-10		0	0	N/A	5-10
Suzannah Power, Lay Member for Patient and Public Involvement	01/04/2019	Present	15-20		0	0	N/A	15-20
Maggie Arnold, Registered nurse member	01/08/2020	Present	0-5		0	0	N/A	0-5
Peter Lucas , Lay member for Audit and Governance	01/04/2019	Present	15-20		0	0	N/A	15-20

Notes to the Senior Management remuneration table 2019/20 (audited)

Notes: to salary table

1. Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.

2. The salary figures shown for senior managers shown above exclude recharges made to: (I) BSW Sustainability & Transformation Partnership (STP) ; and (il) NHS Swindon and NHS Wiltshire CCG's as part of the Banes, Swindon & Wiltshire (BSW) shared roles in 2019/20. The total salaries across ***all*** *organisations for the period in which they served in these roles are as follows: Tracey Cox £140-145k, Ruth Grabham £85k-90k, Alison Kingscott £30k-35k, Sheridan Flavin £30-35k,Julie- Ann Wales £45-50k, Caroline Gregory £95-100K,Gill May £80-85k,Nikki Millin £95-100k*

3. The costs for Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Timothy Sephton, Dr Brynn Bird, Dr Sarah Thoday and Dr Louise Abson include remuneration for work completed for the CCG other than board duties, on commissioning and re-design of clinical services.

4. Lay Members are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits for Katie Hall, Suzannah Power, Maggie Arnold and Peter Lucas.

5. Lisa Harvey received a termination payment for loss of office of £160- 165k *, this is in addition to her salary above.*

6. Taxable benefits refer to where governing body members are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on mileage payments.

For comparison – the table below shows the senior manager remuneration for 2018/19 - audited

Name and title[3] [4]	From[1]	To	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100 [6]	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Dr Ian Orpen, Chair of the CCG	01/04/2018	Present	90-95	200	0	0	0-2.5	90-95
Dr Ruth Grabham, Medical Director	01/04/2018	Present	85-90	0	0	0	(2.5)-(5)	80-85
Tracey Cox, Chief Officer [2]	01/04/2018	Present	70-75[2]	200	0	0	190-192.5	265-270
Sarah James, Chief Financial Officer	01/04/2018	Present	95-100	200	0	0	67.5-70	165-170
Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member	01/04/2018	Present	80-85	100	0	0	22.5-25	105-110
Corinne Edwards, Interim Chief Operating Officer	01/09/2018	Present	55-60	100	0	0	50-52.5	110-115
Dr Elizabeth Hersch, GP Cluster Lead	01/04/2018	Present	25-30	100	0	0	(0)-(2.5)	25-30
Dr Daisy Curling, GP Cluster Lead	01/04/2018	Present	25-30	0	0	0	(0)-(2.5)	25-30
Dr Timothy Sephton, GP Cluster Lead	01/04/2018	Present	25-30	0	0	0	2.5-5	30-35
Dr Brynn Bird, GP Cluster Lead	01/08/2018	Present	15-20	0	0	0	10-12.5	25-30
John Moon, Practice Manager Representative	01/04/2018	Present	10-15	0	0	0	0	10-15
Katie Hall, Lay Member for Quality	01/04/2018	Present	5-10	0	0	0	N/A	5-10
John Holden, Lay Member for Audit and Governance [5]	01/04/2018	Present	15-20	0	0	0	N/A	15-20
Suzannah Power, Lay Member for Patient and Public Involvement	01/04/2018	Present	15-20	100	0	0	N/A	15-20

Notes:

1. Where senior managers were in post for part of the financial year, salaries and figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.

2. The salary figures shown for Tracey Cox (Chief Officer) exclude recharges made to: (I) BSW Sustainability & Transformation Partnership (STP) for Interim Senior Responsible Officer role held since August 2018; and (iI) NHS Swindon and NHS Wiltshire CCG's as part of the Banes, Swindon & Wiltshire (BSW) Chief Executive shared role held since 1st March 2019. The total salary across ***all*** *organisations for the year was in the salary band of 120k-125k.*

3. The costs for Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Timothy Sephton and Dr Brynn Bird include remuneration for work completed for the CCG other than board duties, on commissioning and re-design of clinical services.

4. Lay Members are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits for Katie Hall, John Holden and Suzannah Power

5. John Moon was not a member of the NHS Pension scheme during the financial year

6. Taxable benefits refer to where governing body members are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on mileage payments.

Pension Disclosure 2019/20 - audited

Pensions Disclosure - 2019-20 - UNAUDITED:

Name and title [1,2]	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	(d) [6] Lump sum at pension age related to accrued pension at 31st March 2020 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2019	(f) Real increase in Cash Equivalent Transfer Value [4]	(g) Cash Equivalent Transfer Value at 31 March 2020 [3]
	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*
Dr Ian Orpen, Chair of the CCG	0	0	10-15	35-40	257	0	265
Dr Ruth Grabham, Medical Director	0-2.5	0-2.5	20-25	65-70	491	11	529
Tracey Cox, Chief Executive Officer	0-2.5	0	50-55	125-130	950	5	1,004
Sarah James, Chief Financial Officer	2.5-5	5-7.5	40-45	110-115	755	52	891
Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member	0	0	20-25	65-70	473	2	494
Corinne Edwards, Chief Operating Officer	2.5-5	7.5-10	35-40	80-85	575	81	688
Alison Kingscott, Interim BSW Director	0-2.5	2.5-5	30-35	80-85	624	27	689
Sheridan Flavin, Interim BSW Director	0-2.5	0	10-15	0	142	18	177
Julie-Anne Wales, BSW Director of Corporate Affairs.	0-2.5	5-7.5	30-35	95-100	647	55	776
Caroline Gregory, Chief Finance Officer	2.5-5	5-7.5	40-45	95-100	815	99	699
Gill May - Director of Nursing & Quality	2.5-5	12.5-15	50-55	155-160	1,227	138	1,063
NikKi Millin , Director of Strategy and Transformation-	2.5-5	0-2.5	55-60	135-140	1,135	75	1,035
Dr Elizabeth Hersch, GP Cluster Lead	0	0	10-15	20-25	178	0	185
Dr Daisy Curling, GP Cluster Lead	0	0	10-15	30-35	198	0	204
Dr Timothy Sephton, GP Cluster Lead	0-2.5	0-2.5	0-5	5-10	51	3	59
Dr Brynn Bird, GP Cluster Lead	0-2.5	0	10-15	0	117	9	134
Dr Louise Abson, GP Board member.	0-2.5	0-2.5	10-15	30-35	192	15	220
Dr Sarah Thoday, GP Board member	2.5-5	0	15-20	0	147	40	211

Notes to the pensions table 2019/20 – audited

Notes:

1. Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.

2. The figures for Dr Ian Orpen, Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Timothy Sephton, Dr Brynn Bird Dr Sarah Thoday and Dr Louise Abson have been calculated based on officer service (work undertaken for the CCG) only and do not take into account any practitioner benefits (work undertaken as a GP).

3. 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 members accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

5. The 19/20 values for accrued pension, lump sum and CETV have been calculated by NHS Pensions with no allowance for a potential adjustment arising from a legal case known as the McCloud judgement. This case concerned potential age discrimination over the way in which UK public sector pension schemes introduced a Career Average Related Earnings benefit design in 2015 for all members excluding the oldest members who remained on a final salary design.

6. There are a number of posts which are shared across NHS BANES CCG, NHS Swindon CCG and NHS Wiltshire CCG - Tracey Cox, Caroline Gregory, Gill May, Nikki Millin, Alison Kingscott, Sheridan Flavin, Julie-Anne Wales and Dr Ruth Grabham. The accrued pension, lump sum and CETV values at 31st March 2020 reflect the pension earned throughout 2019/20. It is not possible to identify the values that apply specifically to one CCG.

7. There is no lump sum for members of the 2008 and 2015 schemes, where this applies, nil is shown.

For comparison the table below shows the pension disclosure for senior managers for 2018/19 – audited.

Pension disclosure - 2018/19

Name and title[1] [2]	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2019 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2018	(f) Real increase in Cash Equivalent Transfer Value[4]	(g) Cash Equivalent Transfer Value at 31 March 2019[3]	(h) Employer's contribution to stakeholder pension
	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*
Dr Ian Orpen, Chair of the CCG	0-2.5	0-2.5	10-15	35-40	250	0	257	Nil
Dr Ruth Grabham, Medical Director	0-2.5	0-2.5	20-25	60-65	426	52	491	Nil
Tracey Cox, Chief Officer	7.5-10	20-22.5	50-55	125-130	671	259	950	Nil
Sarah James, Chief Financial Officer	2.5-5	5-7.5	35-40	100-105	601	136	755	Nil
Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member	0-2.5	2.5-5	20-25	65-70	384	78	473	Nil
Corinne Edwards, Interim Chief Operating Officer	2.5-5	2.5-5	30-35	70-75	425	80	575	Nil
Dr Elizabeth Hersch, GP Cluster Lead	0-2.5	0-(2.5)	10-15	20-25	152	22	178	Nil
Dr Daisy Curling, GP Cluster Lead	0-2.5	0-(2.5)	10-15	30-35	164	29	198	Nil
Dr Timothy Sephton, GP Cluster Lead	0-2.5	0-(2.5)	0-5	5-10	40	10	51	Nil
Dr Brynn Bird, GP Cluster Lead	0-2.5	0-2.5	10-15	0-5	90	25	117	Nil

Notes:

1. Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.

2. The figures for Dr Ian Orpen, Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Timothy Sephton and Dr Brynn Bird have been calculated based on officer service (work undertaken for the CCG) only and do not take into account any practitioner benefits (work undertaken as a GP).

3. 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 members accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Cash Equivalent Transfer Value

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

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

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

Real increase in CETV

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

The method for calculating the CETV changed after August 2019. The Government announced that public sector pension schemes would be required to apply the same indexation to part of a public service scheme pension known as the Guaranteed Minimum Pension (GMP), as applied to the remainder of the pension. Previously, the GMP did not receive full indexation. Therefore, the CETV values for 31 March 2019 and 31 March 2020 may have been calculated using different methodologies, and this may have had an impact on the real increase in the CETV figure.

Compensation on early retirement or for loss of office

During 2019/20, in the lead-up to the merger with NHS Wiltshire CCG and NHS Swindon CCG, there was one compulsory redundancy. The cost of this redundancy was £195,417 – this is also shown In the Exit Packages disclosure on page 91.

There were no staff who took early retirement in 2019/2020 due to ill health.

Payments to past members

During 2019/20 there were no payments made to past members (2018/19: nil).

Pay multiples 2019/20 – audited

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

The banded remuneration of the highest paid director / member in NHS Bath and North East Somerset CCG in the financial year 2019/20 was £90,000 - £95,000 (2018/19: £90,000 - £95,000). Based on a whole time equivalent, this salary was in the band of £150,000 - £155,000 (2018/19: £150,000 - £155,000). This was 3.14 (2018/19: 3.49) times the median remuneration of the remainder of the workforce, which was £48,324 (2018/19: £43,682).

In 2019/20, 1 (2018/19: 1) employee received remuneration in excess of the highest paid director / member in NHS Bath and North East Somerset CCG in whole-time equivalent terms. This employee had a whole-time equivalent salary in the band of £155,000 - £160,000 (2018/19: £155,000 - £160,000). This relates to a clinical employee working one session per week at an actual cost in the band £15,000 - £20,000 (2018/19: £15,000 - £20,000).
Full-time equivalent remuneration ranged from £19,000 to £156,000 (2018/19: £18,000 to £157,000).

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

Staff report

Number of senior managers

The CCG has categorised members of the Governing Body as being senior managers and their salaries are included on page 76.

The CCG defines a senior manager as a person in a senior position who has authority or responsibility for directing or controlling major activities within the CCG. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual parts of the organisation.

As at 31 March 2020, the number of senior managers by Agenda for Change band was:

Agenda for Change Band	Number of senior managers
Very Senior manager	13*
Band 9	1

*This is a BSW wide figure

The CCG also had one GP Clinical Chair, six GP Governing Body members and six other Governing Body members.

Staff numbers and costs

As of 31 March 2020, BaNES CCG had 88 employees, excluding Governing Body members. The workforce was made up of employees from a wide range of professional groups. Of the 88 employees, 63 were permanently employed. 25 staff were employed on fixed term or bank contracts.

Employee benefits

Employee benefits	Admin			Programme			Total		2019-20
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	2,743	175	**2,919**	1,265	131	**1,396**	4,008	306	**4,315**
Social security costs	290	-	**290**	123	-	**123**	413	-	**413**
Employer contributions to the NHS Pension Scheme	596	-	**596**	152	-	**152**	748	-	**748**
Other pension costs	0	-	**0**	1	-	**1**	1	-	**1**
Apprenticeship Levy	4	-	**4**	1	-	**1**	5	-	**5**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**3,634**	**175**	**3,809**	**1,542**	**131**	**1,673**	**5,176**	**306**	**5,482**
Less recoveries in respect of employee benefits (note 4.1.2)	(645)	-	**(645)**	(73)	-	**(73)**	(718)	-	**(718)**
Total - Net admin employee benefits including capitalised costs	**2,989**	**175**	**3,164**	**1,469**	**131**	**1,600**	**4,458**	**306**	**4,764**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**2,989**	**175**	**3,164**	**1,469**	**131**	**1,600**	**4,458**	**306**	**4,764**

Employee benefits	Admin			Programme			Total		2018-19
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits									
Salaries and wages	2,279	203	**2,483**	1,344	139	**1,483**	3,623	342	**3,966**
Social security costs	252	-	**252**	140	-	**140**	392	-	**392**
Employer contributions to the NHS Pension Scheme	310	-	**310**	236	-	**236**	546	-	**546**
Other pension costs	0	-	**0**	1	-	**1**	1	-	**1**
Apprenticeship Levy	3	-		-	-		3		**3**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	4	-	**4**	-	-	**-**	4	-	**4**
Gross employee benefits expenditure	**2,848**	**203**	**3,049**	**1,721**	**139**	**1,860**	**4,569**	**342**	**4,912**
Less recoveries in respect of employee benefits (note 4.1.2)	(420)	-	**(420)**	(161)	(26)	**(186)**	(581)	(26)	**(607)**
Total - Net admin employee benefits including capitalised costs	**2,428**	**203**	**2,629**	**1,560**	**114**	**1,673**	**3,988**	**317**	**4,305**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**2,428**	**203**	**2,629**	**1,560**	**114**	**1,673**	**3,988**	**317**	**4,305**

Staff composition

The figures presented in Table 1 below exclude non-executive directors / lay Governing Body members but include executive board members / Governing Body members.

Table 1: Number and status of staff as at 31 March 2020

	Headcount
Fixed Term Temp	**27**
Active assignment	26
Internal secondment	1
Permanent	**61**
Acting up	4
Active assignment	52
Internal secondment	4
Out on external secondment - Paid	1
Grand Total	**88**

The figures presented in Table 2 below offers an analysis of the number of persons of each sex who were directors, senior managers and employees of the company.

Table 2: Staff by gender

	Female Headcount	Male Headcount	Total
Governing Body Members and very senior managers*	10	4	14
All other CCG staff	73	15	88
Total	83	19	102

Sickness absence data

The organisation has an approved policy and associated procedure to help with the management of sickness absence.

Sickness absence is managed in a supportive and effective manner by CCG managers, with professional advice and support from human resources, occupational health and staff support services. The CCG's approach to managing sickness absence is governed by a clear HR policy and this is further reinforced by the provision of HR support and training sessions for all line managers on the effective management of sickness absence.

Managers ensure the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to the CCG's Integrated Governance Committee on a quarterly basis as part of the workforce reporting mechanism. This committee includes both lay members and executive directors of the CCG.

Staff sickness, absence and ill health retirements in 2019/20

This table shows the rolling 12-month absence rate from 1 April 2019 to 31 March 2020.

Absence % (FTE)	Absence Days	Abs (FTE)	Avail (FTE)
2.04%	674	563.75	27,702.36

ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year.

Absence levels have varied significantly throughout the year and are heavily influenced by cases of long term sickness. Absence is currently running at an average of 2.04% which is a slight decrease on the previous year.

Staff turnover (headcount) averaged 127.75 per cent for the year 1 April 2019 to 31 March 2020.

Sum of FTE Days Sick	Sum of FTE Days Available	Average Annual Sick Days per FTE	Occurrences (Months of Data)
540.11	28,627.46	6.89	64

Source: Source: NHS Digital - Sickness Absence Publication - based on data from the ESR Data Warehouse

ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365-day year. Average annual sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE and multiplying by 225 (the typical number of working days per year).

There may be inconsistencies between this data and the statutory basis for accounts, in terms of the organisation against which staff are reported for a particular month.

There were no ill-health retirements during 2019/20 (2018/19: nil).

Colleagues policies/disabled employees

The CCG has developed an integrated approach to delivering workforce equality, so it does not have a separate policy for disabled employees or for any other protected characteristics, but it has incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance to discipline. Our aim is to operate in ways that do not discriminate against potential or current employees with any of the protected characteristics specified in the Equality Act 2010, and to support our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

We monitor our employee profile by each of the nine protected characteristics. This helps us to identify and address areas of under-representation in a systematic manner as and when opportunities arise.

Policies continue to be reviewed and updated in line with the review cycle. All staff policies are discussed at the Staff Partnership Forum (SPF) prior to, and after adoption of, to ensure they are embedded in the organisation.

All our staff policies are accessible to our staff via our intranet.

Colleague Partnership Forum

The Joint Colleague Partnership commenced from March 2019. Since January 2020 this forum has concentrated on policy reviews in preparation for the merger of the three CCGs in April 2020. As a new organisation, policies needed to be reviewed and merged into one BSW policy this work commenced in January 2020 and was completed in April. Policies have been reviewed by the Executive Management Team and discussed at the Joint Colleague Partnership Forum and approved by the Governing Body for implementation in 2020.

Employee consultation and engagement

Consultation with all CCG staff took place from 6 January to 2 February 2020 in relation to staff transferring to a new, merged organisation. The consultation document had been previously reviewed by the BSW Joint Colleague Partnership Forum. The consultation was to engage with colleagues collectively and individually on the process of transition and the implications for individuals, not whether the transfer would take place. One measure was introduced, to align and bring forward the pay date of all colleagues to a single date.

The consultation generated questions from colleagues which were summarised regularly in an FAQ document. Upon conclusion of the consultation, the outcome document was published to all colleagues. The consultation resulted in one change: to allow colleagues to carry over up to one week of annual leave (pro rata) into the new financial year and therefore the new organisation.

Pulse surveys
To measure colleague engagement across BaNES, Swindon and Wiltshire CCGs, pulse surveys were introduced. These short, specific surveys provided colleagues with a formal opportunity to share how they were feeling, raise any concerns and highlight where things are working well.

Pulse surveys were run for two weeks at a time in December and March and approximately a third of colleagues completed them.

The results were presented back to the executive leadership team, colleague partnership forum and shared with all colleagues. Quick win improvement actions were identified and implemented.

Colleague wellbeing

Colleagues working on the BaNES Locality Wellbeing Group have been actively involved across a range of initiatives over the past year, linking up with local authority representatives too.

The physical activities partially supported by the Wellbeing fund, have continued with the running of a weekly yoga class in the evenings and a Weekly Summer Festival of Wellbeing Activity held during the day which included such classes as mindfulness, Tai Chi, Feldenkrais and hand reflexology.

Water cooler machines were installed in both the kitchens

to compliment the water heater machines and the popular weekly ‘Staff Fruit Bowl’ was started. A lunch time meet and talk session was hosted by the two Mental First Aiders and the Virgin Care Health Improvement Practitioner ran Health Check assessments for those aged 50+, and a lesser version for younger colleagues, for a day in January and February which were fully booked.

Poster campaigns continued with the ‘Retake your Lunch Break’ message, encouraging staff to leave their desks at lunch time as well as encouraging lunch break walking groups. Colleagues took advantage of the local authority run workshop event to help them manage their emails more efficiently which was a good example of integration across both organisations.

Organisational Development

An Organisational Development (OD) and HR plan was developed as part of the merger process and included the advice for recruitment of, and development of the Governing Body. It also included all the engagement work on the merger for colleagues as well as the co-creation of values and behaviours of the new CCG.

Amalgamated HR polices for the new CCG have been developed and many will be presented at the first Governing Body meeting in April 2020.

A new OD plan for the future of the new BSW CCG is in development and is will be completed by the end of April 2020. The plan will be important to continue to support colleagues through a considerable period of change, of which the merger is just one part as we consider new ways of working, new bases and development of the Integrated Care System.

Creating Change Together

In response to formal approval for the merger of BaNES, Swindon and Wiltshire CCGs to go ahead, we created an internal change campaign to support colleagues through the merger journey.

With its own branding, Creating Change Together looked and felt different to other internal communications and spanned all three CCGs. It comprised a regular newsletter, posters, had dedicated updates at colleague meetings and included the pulse surveys.

Colleagues were encouraged to get involved with the merger and were asked for feedback on the proposed vision for the new organisation, invited to workshops to help create new core values, had their say in focus groups to help design an intranet and website with great content and user experience.

The journey through the merger process was captured in a colleague video and was shared with colleagues on 1 April to mark the launch of our new organisation.

Other employee matters

The Trade Union (Facility Time Publication Requirements) – Regulations 2017

The CCG confirms that there are no relevant union officials who are staff members of the CCG. No employee of the CCG takes time off during their working hours for the purpose of taking part in any activities in relation to which they are acting as a representative of a union.

Expenditure on consultancy

For 2019/20 the spend on consultancy services is £38k (2018/19 £12k), which includes £35k on Marketing and PR Consultancy, £1k of VAT consultancy services (2018/19 £2k), £1k on consultancy services associated with Human Resources and Organisational Development, £1k on the CCG's share of costs associated with an independent review of the Local Safeguarding Children's Board (LSCB) for Avon and Somerset.

The CCG's external auditor, Grant Thornton, were paid £43k (including VAT) for Audit Services in the reporting year 2019/20 relating to statutory audit work carried out. These statutory services include both the audit of the CCG's financial statements and related reporting, and other statutory activities such as value for money work.

The CCG has also accrued an additional £11.5k in respect of a separate, nationally-mandated audit of mental health expenditure.

Off payroll engagements – audited

NHS bodies are required to include disclosures about their off-payroll engagements. Off-payroll engagements as of 31 March, for more than £245 per day and that last longer than six months:

Table 1: All off-payroll engagements as at 31st March 2020, for more than £245 per day AND that last longer than six months.

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

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

Table 2: all new off-payroll engagements between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Total number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
Of which….	
Number assessed as caught by IR35	0
Number assessed as NOT caught by IR35	1
Number engaged directly (via PSC contracted to department) and are on 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 3: For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020:

Number of off-payroll engagements of board member, and / or senior officers with significant financial responsibility, during the financial year.	0
Total number 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.	23

Exit packages

The following table summarises the exit package payments made in 2019/20.

	2019-20 Compulsory redundancies Number	£	2019-20 Other agreed departures Number	£	2019-20 Number	Total £
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	40,655	1	35,417	2	76,072
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**200,655**	**1**	**35,417**	**3**	**236,072**

	2018-19 Compulsory redundancies Number	£	2018-19 Other agreed departures Number	£	2018-19 Number	Total £
Less than £10,000	-	-	1	3,871	1	3,871
£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	**-**	**-**	**1**	**3,871**	**1**	**3,871**

Analysis of Other Agreed Departures

	2019-20 Other agreed departures Number	£	2018-19 Other agreed departures Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	35,417	1	3,871
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**1**	**35,417**	**1**	**3,871**

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

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change rules for compulsory redundancy.

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

Where the CCG has agreed early retirements, the additional costs are met by CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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

Part Three – Accountability and Audit Report

Audit Opinion

Independent auditor's report to the members of the Governing Body of NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group in respect of NHS Bath and North East Somerset Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Bath and North East Somerset Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2020, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2020 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Accountable Officer and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the CCG's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the CCG's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial

statements are authorised for issue.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the CCG's financial statements shall be prepared on a going concern basis, we considered the risks associated with the CCG's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the CCG's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Emphasis of matter – Demise of the Organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 21 in the financial statements, which indicates that NHS Bath and North East Somerset Clinical Commissioning Group merged with NHS Swindon Clinical Commissioning Group, and NHS Wiltshire Clinical Commissioning Group, to become NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group with effect from 1 April 2020. NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group took over the services and functions of NHS Bath and North East Somerset Clinical Commissioning Group

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2019 to 2020 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities set out on page(s) 55 to 56, 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 Governing Body is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Report on other legal and regulatory requirements – Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - 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 2020.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Bath and North East Somerset Clinical Commissioning Group 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 NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group as a body, in respect of NHS Bath and North East Somerset Clinical Commissioning Group, 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 NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group those matters we are required to state to them in an auditor's report in respect of NHS Bath and North East Somerset Clinical Commissioning Group, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group and NHS Bath and North East Somerset Clinical Commissioning Group and the members of the Governing Bodies of both Clinical Commissioning Groups, as a body, for our audit work, for this report, or for the opinions we have formed.

Julie Masci, Key Audit Partner

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

Bristol

25 June 2020

Data entered below will be used throughout the workbook:

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

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The Primary Statements:

Notes to the Accounts

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

	Note	2019-20 £'000	2018-19 £'000
Income from sale of goods and services [1]	2	(4,102)	(2,831)
Other operating income	2	(485)	(5)
Total operating income		**(4,586)**	**(2,836)**
Staff costs	4	5,481	4,912
Purchase of goods and services	5	282,324	269,071
Depreciation and impairment charges	5	8	4
Provision expense	5	(164)	205
Other Operating Expenditure [2]	5	122	136
Total operating expenditure		**287,770**	**274,328**
Net Operating Expenditure		**283,184**	**271,492**
Finance income		-	-
Finance expense		-	0
Net expenditure for the year		**283,184**	**271,492**
Total Net Expenditure for the Financial Year		**283,184**	**271,492**
Comprehensive Expenditure for the year ended 31st March 2020		**283,184**	**271,492**

[1] Income from sale of goods and services includes £2.25m from the main provider in respect of system transformation and winter pressure monies being returned through the CCG in year.

[2] Other operating expenditure consists of Chair and Non-executive costs (£118k) and Clinical Negligence costs (£4k) 2018/19 prior year included Chair and Non-executive costs (£132k), Clinical negligence costs (£4k).

Statement of Financial Position as at 31 March 2020

	Note	2019-20 £'000	2018-19 £'000
Non-current assets:			
Property, plant and equipment	10	234	34
Total non-current assets		234	34
Current assets:			
Trade and other receivables	11	2,304	1,727
Cash and cash equivalents	12	87	1
Total current assets		**2,391**	1,728
Total current assets		**2,391**	1,728
Total assets		**2,625**	1,761
Current liabilities			
Trade and other payables	13	(21,555)	(20,723)
Provisions	14	-	(205)
Total current liabilities		**(21,555)**	(20,928)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(18,930)**	(19,167)
Total non-current liabilities		**-**	-
Assets less Liabilities		**(18,930)**	(19,167)
Financed by Taxpayers' Equity			
General fund		(18,930)	(19,167)
Total taxpayers' equity:		**(18,930)**	(19,167)

The notes on pages 5 to 29 form part of this statement

The financial statements on pages 1 to 41 were approved by the Governing Body on 25/06/2020 and signed on its behalf by:

Tracey Cox

Chief Executive
Tracey Cox

Caroline Gregory

Chief Financial Officer
Caroline Gregory

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(19,167)	0	0	**(19,167)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(283,184)			**(283,184)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(283,184)**	**0**	**0**	**(283,184)**
Net funding	283,421	0	0	**283,421**
Balance at 31 March 2020	**(18,930)**	**0**	**0**	**(18,930)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(13,056)	0	0	**(13,056)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating costs for the financial year	(271,492)			(271,492)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(271,492)**	**0**	**0**	**(271,492)**
Net funding	265,382	0	0	265,382
Balance at 31 March 2019	**(19,167)**	**0**	**0**	**(19,167)**

The notes on pages 5 to 29 form part of this statement

Statement of Cash Flows for the year ended 31 March 2020

	Note	**2019-20 £'000**	2018-19 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year	5	(283,184)	(271,492)
Depreciation and amortisation	5	8	4
Impairments and reversals	5	0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	11	(577)	(260)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	832	6,101
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	14	(41)	0
Increase/(decrease) in provisions	14	(164)	205
Net Cash Inflow (Outflow) from Operating Activities		**(283,127)**	(265,441)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(208)	(18)
Net Cash Inflow (Outflow) from Investing Activities		**(208)**	(18)
Net Cash Inflow (Outflow) before Financing		**(283,335)**	(265,459)
Cash Flows from Financing Activities			
Parliamentary Funding Received		283,421	265,382
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**283,421**	265,382
Net Increase (Decrease) in Cash & Cash Equivalents	12	**86**	(77)
Cash & Cash Equivalents at the Beginning of the Financial Year		**1**	78
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**87**	1

The notes on pages 5 to 29 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on a going concern basis .
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

On 1st April 2020 , B&NES CCG will merge with neighbouring CCGs to form Bath , Swindon and Wiltshire (BSW) CCG. It's services will continue to be provided using the assets at it's disposal and therefore the accounts have been prepared on a going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention .

1.3 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 or Section 10 of the Childrens Act 2004, the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement. Note 18 to the accounts provides details of the income and expenditure.

If the Clinical Commissioning Group is in a “jointly controlled operation”, the Clinical Commissioning Group recognises:

· The assets the Clinical Commissioning Group controls;
· The liabilities the Clinical Commissioning Group incurs;
· The expenses the Clinical Commissioning Group incurs; and,
· The Clinical Commissioning Group’s share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a “jointly controlled assets” arrangement, in addition to the above, the Clinical Commissioning Group recognises:

· The Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
· The Clinical Commissioning Group’s share of any liabilities incurred jointly; and,
· The Clinical Commissioning Group’s share of the expenses jointly incurred.

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.

1.4.1 Critical Judgements in Applying Accounting Policies.

The Clinical Commissioning Group in acting as a host of the BaNES, Swindon and Wiltshire Strategic Transformation Partnership under an agency type arrangement have applied critical judgement in applying the necessary accounting treatment for this. This is in line with the requirements of IFRS 10 and IFRS 11 and the treatment has been to exclude all transactions relating to the host arrangement as joint control does not exist and therefore net accounting has been applied.

1.4.2 Key Sources of Estimation Uncertainty

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

- The Clinical Commissioning Group makes an assessment of prescribing expenditure for the year. Supporting information is subject to a time lag of 2 months which makes the value of the estimate for later months of the year potentially significant. This affects all CCGs. The monthly average variability across the year for 2019/20 of prescribing spend was in the region of 4% but this does not lead to material impact in terms of financial value.

- The Clinical Commissioning Group has included an estimate of the costs incurred by it's main providers and local authorities in respect of COVID 19 for the period up to 31st March 2020. The costs have been covered by an additional allocation from NHSE.

Notes to the financial statements

1.5 **Revenue**

The transition to IFRS 15 was ***completed in 2018/19*** in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application. However, the clinical commissioning group has had no material impact arising due to IFRS 15 and there were no required adjustments to opening brought forward balances due to IFRS 15.

In the adoption 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 allocations (Parliamentary Funding) from the Department of Health within the approved cash limit, which is credited to the General Fund of the Clinical Commissioning Group. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received. Parliamentary funding is recognised in the financial period in which the cash is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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

1.6 **Employee Benefits**

1.6.1 **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.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

b) Full actuarial (funding) valuation

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

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

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process

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.

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 **Grants Payable**

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

Notes to the financial statements

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**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

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

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

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.

Notes to the financial statements

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.

1.10.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.
At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 **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.

1.11.1 **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.

1.11.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

Notes to the financial statements

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

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:
Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.5% (2018-19: positive 0.29%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:
• A nominal short-term rate of 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.55% (2018-19:1.14%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2018-19: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

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 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

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

Notes to the financial statements

1.19 **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.

The Clinical Commissioning Group has included receivables and cash or cash equivalents in the 2019/20 accounts which have been recognised at historic cost.

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.

1.19.1 **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.

1.19.2 **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.

1.19.3 **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.

1.19.4 **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.

1.19.5 **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.

The Clinical Commissioning Group has included only payables in the 2019/20 accounts which have been recognised at historic cost.

1.19.6 **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.

1.19.7 **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.

[Disclose how fair value is determined.]

1.19.8 **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.

Notes to the financial statements

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 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

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 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 **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 2019-20. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021/22 and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2021 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Financial performance targets 2019-20

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

	2019-20 Target £'000	2019-20 Performance £'000	2019-20 Variance £'000	2019-20 Target achieved Yes/No
Expenditure not to exceed income[1]	287,788	287,770	(18)	Yes
Capital resource use does not exceed the amount specified in Directions	208	208	-	Yes
Revenue resource use does not exceed the amount specified in Directions	283,202	283,184	(18)	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,486	4,479	(7)	Yes

[1] Revenue Resource plus total operating income in SOCNE.

NHS England set the CCG a Revenue Resource Limit of £283,202,000 for 2019/20 and the CCG achieved an underspend of £18,000 against this target.

The CCG spent within it's Capital resource limit of £208,000.

The CCG spent within it's full administration costs budget of £4,486,000.

Financial performance targets 2018-19

	2018-19 Target £'000	2018-19 Performance £'000	2018-19 Variance £'000	2018-19 Target achieved Yes/No
Expenditure not to exceed income[1]	274,367	274,328	(39)	Yes
Capital resource use does not exceed the amount specified in Directions	18	18	-	Yes
Revenue resource use does not exceed the amount specified in Directions	271,531	271,492	(39)	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4,282	4,282	-	Yes

[1] Revenue Resource plus total operating income detailed in SOCNE

NHS England set the Clinical Commissioning Group a Revenue Resource Limit of £271,531,000 for 2018-19, and the Clinical Commissioning Group achieved an underspend of £39,000 against this target.

The Clinical Commissioning Group spent in full its administration costs budget of no more than £4,282,000.

2 Other Operating Revenue

	2019-20 Total £'000	2018-19 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**0**	(0)
Non-patient care services to other bodies [1]	**1,087**	2,170
Income generation	**-**	-
Other Contract income [2]	**2,296**	55
Recoveries in respect of employee benefits	**718**	607
Total Income from sale of goods and services	**4,102**	**2,832**
Other operating income		
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**21**	5
Other non contract revenue[3]	**464**	-
Total Other operating income	**485**	**5**
Total Operating Income	**4,586**	**2,837**

[1].The decrease is due to a number of non recurring allocations received in 2018/19 such as GP IT , the ETTF scheme and mental health care partnerships.

[2] Other contract income includes £2.25m from the main provider in respect of system transformation and winter pressure monies being returned through the CCG in year.

[3]Other non contract revenue relates to a contribution from Wiltshire CCG under the MOU arrangement of administration costs between the CCGs.

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

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	-	1,058	2,250	375
Non NHS	-	29	46	343
Total	**-**	**1,087**	**2,296**	**718**

	Education, training and research	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	-	1,087	2,296	718
Over time	-	-	-	-
Total	**-**	**1,087**	**2,296**	**718**

3.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract

	2018-19 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

Total 2019-20

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**4,008**	**306**	**4,315**
Social security costs	**413**	**-**	**413**
Employer Contributions to NHS Pension scheme	**748**	**-**	**748**
Other pension costs	**1**	**-**	**1**
Apprenticeship Levy	**4**	**-**	**4**
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	5,175	306	5,481
Less recoveries in respect of employee benefits (note 4.1.2)	**(718)**	**-**	**(718)**
Total - Net admin employee benefits including capitalised costs	4,457	306	4,763
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,457	306	4,763

Total 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**3,623**	**342**	**3,965**
Social security costs	**392**	**-**	**392**
Employer Contributions to NHS Pension scheme	**546**	**-**	**546**
Other pension costs	**1**	**-**	**1**
Apprenticeship Levy	**3**	**-**	**3**
Termination benefits	**4**	**-**	**4**
Gross employee benefits expenditure	4,570	**342**	4,912
Less recoveries in respect of employee benefits (note 4.1.2)	**(581)**	**(26)**	**(607)**
Total - Net admin employee benefits including capitalised costs	3,989	317	4,306
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	3,989	317	4,306

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2019-20 Total £'000	2018-19 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(572)**	**-**	**(572)**	**(469)**
Social security costs	**(68)**	**-**	**(68)**	**(49)**
Employer contributions to the NHS Pension Scheme	**(78)**	**-**	**(78)**	**(88)**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	(718)	-	(718)	(607)

4.2 Average number of people employed

	2019-20			2018-19		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**67**	**3**	**70**	**69**	**8**	**77**

Of the above ,there are no people engaged on capital projects in either 2018/19 or 2019/20.

4.3 Exit packages agreed in the financial year

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20	
	Number	£	Number	£	Number	Total £
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	40,655	1	35,417	2	76,072
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**200,655**	**1**	**35,417**	**3**	**236,072**

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19	
	Number	£	Number	£	Number	Total £
Less than £10,000	-	-	1	3,871	1	3,871
£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	**-**	**-**	**1**	**3,871**	**1**	**3,871**

Analysis of Other Agreed Departures

	2019-20 Other agreed departures		2018-19 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	35,417	1	3,871
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**1**	**35,417**	**1**	**3,871**

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

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change rules for compulsory redundancy.

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

Where the CCG has agreed early retirements, the additional costs are met by CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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

4.4 Pension costs

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

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

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

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

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

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019 updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.4.2 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Total £'000	2018-19 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,645	1,969
Services from foundation trusts[1]	119,626	114,877
Services from other NHS trusts	25,486	24,403
Services from Other WGA bodies[2]	36	224
Purchase of healthcare from non-NHS bodies [3]	74,908	70,437
Prescribing costs[4]	25,696	24,435
Pharmaceutical services	3	5
General Ophthalmic services	0	1
GPMS/APMS and PCTMS	30,904	29,605
Supplies and services – clinical	1,484	1,314
Supplies and services – general [5]	1,379	490
Consultancy services	38	12
Establishment	701	836
Transport	5	5
Premises [6]	85	204
Audit fees [7]	43	43
Other non statutory audit expenditure		
· Other services [8]	12	10
Other professional fees [9]	65	53
Legal fees	14	2
Education, training and conferences	192	148
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**282,324**	**269,073**
Depreciation and impairment charges		
Depreciation [10]	8	4
Total Depreciation and impairment charges	**8**	**4**
Provision expense		
Provisions [11]	(164)	205
Total Provision expense	**(164)**	**205**
Other Operating Expenditure		
Chair and Non Executive Members	118	131
Clinical negligence	4	4
Research and development (excluding staff costs)	-	1
Other expenditure	-	-
Total Other Operating Expenditure	**122**	**136**
Total operating expenditure	**282,289**	**269,419**

[1] This relates to increased expenditure for acute hospital contracts, most notably the RUH NHS Foundation Trust

[2] The reduction in expenditure relates to the dietetics service moving to the RUH and now shown against expenditure with FTs.

[3] The increase is due to 1) contracts with the local authority mainly Continuing Care Placements and 2) inflationary and activity increases on healthcare services provided by non NHS organisations.

[4] The increase relates to GP prescribing.

[5] The increase in expenditure relates to a number of areas including 1) GP IT implementation, 2) Diabetes Transformation Fund and 3) a Digitalisation project with the RUH and AHSN West of England.

[6] The decrease relates to reduced occupation of property on the St Martins site.

[7] In accordance with SI 2008 no 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, there is no limitation of auditor liability in respect of death or personal injury, fraud or fraudulent misrepresentation by it or its employees. In all other instances a total aggregate limit of £2m applies. The fee shown is inclusive of VAT, the net amount paid is £36k.

[8] The other audit services relates to expected costs for the audit of the Mental Health Investment Standard (MHIS) for the year.

[9] Internal Audit fees of £35k are included in this spend.

[10] The Depreciation relates to the non-current equipment assets held on the balance sheet.

[11] The reduction in the provision relates to CHC estimated CHC claims in 2018/19 which were not required.

6.1 Better Payment Practice Code

Measure of compliance	**2019-20 Number**	**2019-20 £'000**	2018-19 **Number**	2018-19 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	6,180	110,433	5,641	104,336
Total Non-NHS Trade Invoices paid within target	6,076	102,756	5,561	103,619
Percentage of Non-NHS Trade invoices paid within target	**98.32%**	**93.05%**	**98.58%**	**99.31%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,674	151,052	2,882	139,837
Total NHS Trade Invoices Paid within target	2,645	150,700	2,860	139,726
Percentage of NHS Trade Invoices paid within target	**98.92%**	**99.77%**	**99.24%**	**99.92%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2019-20 £'000**	2018-19 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7. Investment revenue

	2019-20 £'000	2018-19 £'000
Interest Revenue		
Bank interest	-	-
Total interest revenue	**-**	**-**
Total investment revenue	**-**	**-**

8. Finance costs

	2019-20 £'000	2018-19 £'000
Interest on late payment of commercial debt	-	-
Other interest expense	-	-
Total interest	**-**	**-**
Other finance costs	-	-
Total finance costs	**-**	**-**

9. Operating Leases

9.1 As lessee

9.1.1 Payments recognised as an Expense

	2019-20				2018/19			
	Land	Buildings	Other	Total	Land	Buildings	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	40	2	**42**	-	97	1	**98**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**40**	**2**	**42**	**-**	**97**	**1**	**98**

9.1.2 Future minimum lease payments

	2019-20				2018/19			
	Land	Buildings	Other	Total	Land	Buildings	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Payable:								
No later than one year	-	-	1	**1**	-	-	1	**1**
Between one and five years	-	-	1	**1**	-	-	2	**2**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**2**	**2**	**-**	**-**	**3**	**3**

The decrease in lease payments relates to the reduction in occupation of property on the St Martins site .

10 Property, plant and equipment

2019-20	Information technology £'000	Total £'000
Cost or valuation at 01 April 2019	38	38
Addition of assets under construction and payments on account		-
Additions purchased	208	208
Cost/Valuation at 31 March 2020	**246**	**246**
Depreciation 01 April 2019	4	4
Charged during the year	8	8
Depreciation at 31 March 2020	**12**	**12**
Net Book Value at 31 March 2020	**234**	**234**
Purchased	234	234
Government Granted	-	-
Total at 31 March 2020	**234**	**234**
Asset financing:		
Owned	234	234
Total at 31 March 2020	**234**	**234**

11.1 Trade and other receivables	**Current 2019-20 £'000**	**Non-current 2019-20 £'000**	Current 2018-19 £'000	Non-current 2018-19 £'000
NHS receivables: Revenue	502	-	487	-
NHS prepayments	622	-	613	-
NHS accrued income[1]	699	-	83	-
Non-NHS and Other WGA receivables: Revenue	170	-	82	-
Non-NHS and Other WGA prepayments	201	-	294	-
Non-NHS and Other WGA accrued income	65	-	93	-
VAT	13	-	74	-
Other receivables and accruals	32	-	1	-
Total Trade & other receivables	**2,304**	**-**	**1,727**	**-**
Total current and non current	**2,304**		**1,727**	
Included above:				
There were no prepaid pensions contributions in the receivable figures.	-		-	

[1] The increase in accrued income relates to the contribution from Wiltshire CCG towards administration costs under the MOU agreement.

11.2 Receivables past their due date but not impaired

	2019-20 DHSC Group Bodies £'000	**2019-20 Non DHSC Group Bodies £'000**	**2018-19 DHSC Group Bodies £'000**	**2018-19 Non DHSC Group Bodies £'000**
By up to three months	5	104	457	25
By three to six months	14	-	-	-
By more than six months	-	-	-	-
Total	**19**	**104**	**457**	**25**

12 Cash and cash equivalents

	2019-20	2018-19
	£'000	£'000
Balance at 01 April 2019	1	78
Net change in year	86	(77)
Balance at 31 March 2020	**87**	**1**
Made up of:		
Cash with the Government Banking Service	87	1
Cash with Commercial banks	-	-
Cash and cash equivalents as in statement of financial position	**87**	**1**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2020	**87**	**1**
	-	-

13 Trade and other payables	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	2,152	-	2,524	-
NHS payables: Capital	-	-	-	-
NHS accruals	5,376	-	6,022	-
NHS deferred income	-	-	5	-
Non-NHS and Other WGA payables: Revenue	1,810	-	1,920	-
Non-NHS and Other WGA accruals[1]	11,084	-	6,592	-
Non-NHS and Other WGA deferred income	28	-	29	-
Social security costs	63	-	62	-
VAT	-	-	-	-
Tax	50	-	59	-
Payments received on account	8	-	-	-
Other payables and accruals[2]	986	-	3,512	-
Total Trade & Other Payables	**21,555**	**-**	**20,723**	**-**
Total current and non-current	**21,555**		**20,723**	

[1]The increase in Non NHS accruals relates to a reclassification of accruals previously in 'Other payables and accruals', plus an overall increase in the value of year end accruals in line with the CCG's increased level of allocation and expenditure in 2019/20.

[2] Other payables - see above.

Other payables includes £380k for outstanding pensions contributions (including GP pensions) (2018/19 £271k)

14 Provisions

	Current 2019-20 £'000	Non-current 2019-20 £'000	Current 2018-19 £'000	Non-current 2018-19 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	41	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	-	-	164	-
Other	-	-	-	-
Total	**-**	**-**	**205**	**-**
Total current and non-current	**-**		**205**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2019	**-**	**-**	**-**	**41**	**164**	**205**
Arising during the year	-	-	-	-	-	**-**
Utilised during the year	-	-	-	(41)	-	**(41)**
Reversed unused	-	-	-	-	(164)	**(164)**
Unwinding of discount	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**-**	**-**	**-**	**-**	**-**

15 Commitments

15.1 1 Other financial commitments

The BaNES Clinical Commissioning Group has not entered into non-cancellable contracts.

16 Financial instruments

16.1 1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because BaNES Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the BaNES Clinical Commissioning Group and internal auditors.

16.1.1 Currency risk

BaNES Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The BaNES Clinical Commissioning Group therefore has low exposure to currency rate fluctuations.

16.1.2 terest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the BaNES Clinical Commissioning Group and revenue comes parliamentary funding, BaNES Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

16.1.4 ty risk

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

16.1.5 cial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 2019-20 £'000	Equity Instruments designated at FVOCI 2019-20 £'000	Total 2019-20 £'000
Trade and other receivables with NHSE bodies	1,189		1,189
Trade and other receivables with other DHSC group bodies	30		30
Trade and other receivables with external bodies	248		248
Other financial assets	-		-
Cash and cash equivalents	87		87
Total at 31 March 2020	**1,555**	**-**	**1,555**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2019-20 £'000	Other 2019-20 £'000	Total 2019-20 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	2,154		**2,154**
Trade and other payables with other DHSC group bodies	10,130		**10,130**
Trade and other payables with external bodies	9,122		**9,122**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2020	**21,407**	**-**	**21,407**

17 Operating segments
The CCG considers it has only one operating segment , namely the commissioning of healthcare services.

18. Pooled Budgets

The Clinical Commissioning Group has Pooled Budget arrangements with Bath and North East Somerset Council under section 31 of the Health Act 1999.

The pools are hosted by Bath and North East Somerset Council.

There are four Pooled Budgets being Community Equipment, Better Care Fund, Children & Young People with multiple & complex needs and Adult Learning Difficulties.
The audited memorandum accounts for these Pooled Budgets are appended below:

	Total	Better Care Fund	Adult Learning Disability	Children and Young People with Multiple Equi and Complex Needs	Community Development
	£000	£000	£000	£000	£000
Gross Funding					
Bath & North East Somerset Council	**58,990**	33,888	22,385	2,514	203
Bath & North East Somerset Clinical Commissioning Group	**46,470**	38,778	6,827	392	473
Income from client contributions	**1,423**		1,423	0	0
Grant Funding	**897**		853		44
Total Funding	**107,781**	72,666	31,488	2,907	720
Net overspend/(underspend) funded as detailed below					
Bath & North East Somerset Council	3,119	0	474	2,644	
Bath & North East Somerset Clinical Commissioning Group	562	0	145	418	
Total Overspend/(Underspend)	**3,681**	0	619	3,062	0

The Memorandum Accounts for above Pooled Budgets were signed on 26th April 2020 by the Chief Financial Officer of Bath & North East Somerset Local Authority.

These statements confirm that the Memorandum Accounts accurately disclose the income received and expenditure incurred in accordance with the Partnership Agreement, as amended by subsequent agreed variations, entered into under section 75 of the NHS Act of 2006.

The NHS clinical commissioning group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2019-20	2018-19
	£'000	£'000
Income	0	0
Expenditure	47,032	48,822

19 Related party transactions

Details of related party transactions with individuals are as follows:
Note: These include payments to practices under normal course of business where the GPs are partners of those practices are not exceptional payments in nature.

		Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£'000	£'000	£'000	£'000
Heart of Bath Medical Centre[1]	Dr Ian Orpen	3,531	0	24	0
St Chad's Surgery[1]	Dr Elizabeth Hersch	2,213	0	0	0
Chew Medical Practice[1]	Dr Timothy Sephton	2,714	0	0	0
Widcombe Surgery[1]	Dr Daisy Curling	917	0	0	0
Swindon CCG	Tracey Cox[2] and other Gov Body members	381	230	12	0
Wiltshire CCG	Tracey Cox[2] and other Gov Body members	275	410	17	464

[1] The Clinical Commissioning Group has made payments for local enhanced service SLA's and dispensing drugs to GP practices of which members of the Governing Body are partners. The GPs are recognised as related parties as they are key decision makers for the practices. These payments have been made to an organisation and not to the individuals and include payments made under delegated commissioning which was in place from 1st April 2017.
[2] Tracey Cox is the Chief Executive Officer for BSW covering BaNES, Swindon and Wiltshire CCGs from 1st March 2019

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with the entities named below for which the Department is regarded as the parent organisation.
NHS England
NHS Business Services Authority
NHS Resolution
Avon and Wiltshire Mental Health Partnership NHST
North Bristol NHST
Oxford Health NHS Foundation Trust
Royal United Hospitals Bath NHSFT
South West Ambulance NHSFT
University Hospitals Bristol NHSFT

In addition, the Clinical Commissioning Group had a number of material transactions with other Government departments and other central and local

20 Events after the end of the reporting period.

On the 1st April 2020, NHS B&NES CCG merged with NHS Swindon CCG and Wiltshire CCG to form NHS B&NES , Swindon and Wiltshire CCG (BSW CCG).
All assets and liabilities of NHS B&NES CCG transferred on that date to the new organisation and NHS B&NES CCG ceased to exist.

Analysis of balances transferred to successor organisation

Summarised Statement of Financial position as at 31st March 2020		Amounts transferred to :
	B&NES CCG	BSW CCG
	£'000	£'000
Non current assets	234	234
Current assets	2,391	2,391
Current liabilities	(21,555)	(21,555)
Non Current liabilities	-	-
Net assets/liabilities	(18,930)	(18,930)

21. Losses and special payments

The CCG has no losses or special payment cases to report in 2019/20.