NHS Coventry and Warwickshire Clinical Commissioning Group

Annual Report

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1 April – 30 June 2022

Contents

Welcome to our Annual Report

We present to you our Annual Report, setting out the work of NHS Coventry and Warwickshire Clinical Commissioning Group for the period 1 April – 30 June 2022. This three month period has seen a continuation of the drive to improve health and care for our population, which was covered in our previous Annual Report, but also in the final three months of our existence as a Clinical Commissioning Group as we transitioned on the 1 July 2022 to become an Integrated Care Board (ICB).

We are proud of the improvements we have made in commissioning services which meet the needs of our population and provide good value for money. We continue to work towards achieving the best health outcomes for our population and focusing on the key priorities set by NHS England.

We're also thankful to all those who have taken time to get involved with our work as we re-establish face to face engagement activity. Listening to and understanding the views of our local population and then using that feedback to help plan, prioritise and deliver services, is crucial to what we do. The value of our strong relationships and engagement has been clear during the pandemic, where our partnerships across the health and care system, with the voluntary sector and with our diverse communities has meant that we have been able to support and care for our population.

PERFORMANCE REPORT

Performance Report

This statement has been prepared in accordance with the requirements set out in the Department of Health's Group Accounting Manual 2022-23.

Phil Johns

Chief Executive, Integrated Care Board

Previously Accountable Officer,
NHS Coventry and Warwickshire Clinical Commissioning Group
13 July 2023

Abbreviations

The NHS uses many abbreviations, and our CCG is no exception. We understand these can be difficult to understand if you're not familiar with them, so we always try to write them out in full but, just in case we miss any, here are the most common ones used, for reference:

First, there is us:

CCG – Clinical Commissioning Group, which you may sometimes see written as CWCCG for NHS Coventry and Warwickshire Clinical Commissioning Group

Then there are our local providers and hospitals:

- CWPT – Coventry and Warwickshire Partnership NHS Trust
- GEH – George Eliot Hospital NHS Trust
- SWFT – South Warwickshire Foundation NHS Trust
- UHCW – University Hospitals of Coventry and Warwickshire NHS Trust
- WMAS – West Midlands Ambulance Service

Then there are the local councils with whom we regularly work:

CCC – Coventry City Council
WCC – Warwickshire County Council

There are some organisations that provide assurance and oversight of our work:

- HWB – Health and Wellbeing Board. There are two in our area: one for Coventry, and one for Warwickshire.
- NHSE or NHSEI – NHS England, who recently joined with NHS Improvement and you may see abbreviated as NHSEI.

Other abbreviations and terminology:

- STP - Sustainability and Transformation Partnership
- System - the health and care system we operate in - Coventry and Warwickshire
- Place - a term used to describe a geographical area wherein all health and care providers will agree to work more collaboratively to improve the health and wellbeing of the population. We have four "places" across Coventry and Warwickshire: Coventry, Rugby, south Warwickshire and Warwickshire north.
- ICS – Integrated Care Systems are new partnerships between the organisations that meet health and care needs across an area including CCGs, healthcare providers and local authorities.
- ICP – Integrated Care Partnership
- ICB – Integrated Care Board
- PCN – Primary Care Networks. GP practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as Primary Care Networks.

Chief Officer's Overview

Welcome to the 1 April – 30 June 2022 Annual Report for NHS Coventry and Warwickshire Clinical Commissioning Group (CWCCG). This three month period saw a continuation of the drive to improve health and care for our population which was covered in our previous annual report, but also the final three months of our existence as a Clinical Commissioning Group, as we transitioned on the 1 July 2022 to becoming part of an Integrated Care Board (ICB).

The CCG was a clinically led organisation responsible for commissioning healthcare services on your behalf. This means we planned, budgeted, funded and arranged local health services with our allocation of £455,592,000 for the period 1 April – 30 June 2022.

As in previous years I would like to open by offering my sincere thanks to all staff across health and care and wider partners. As the Clinical Commissioning Group came to an end, I wanted to reflect on the contributions made, not just in the three months covered in this report, but in the lifetime of clinical commissioning in Coventry and Warwickshire. The work undertaken in the past ten years laid the strong foundations needed to achieve our Integrated Care System, from the development of strong joint working relationships between health and care organisations, to innovative new ways of delivering care, to our response to the pandemic and the challenges it caused. Everyone who is part of the system has contributed in some way to our successful transition and it is important to recognise the volume and quality of work which has been done. None of this would have been possible without our staff who have risen to the challenges in front of them and strived to improve the health and wellbeing of our population.

As this report marks the end of the CCG, I also want to thank the Governing Body Members for their guidance and support in helping us to commission safe, high quality health services. Our Chair Dr Sarah Raistrick has been a strong and consistent voice for the health system, our GPs and our patients over the years, and our transition to becoming a strong ICB would have been considerably more difficult without the work of our Governing Body.

The recovery from the pandemic and transition onwards is reflected in this report. At the start of the financial year, we focused our efforts on our elective services as we continued to recover from ongoing pressures, working as a system to support and share resources. We also focused on the mechanics of our transition into an ICB and what this means for delivering care in Coventry and Warwickshire in the future. This transition further enables all health and social care providers and commissioners to work together in partnership, removing some of the competition and barriers between services, and joining up care around people and communities.

A key feature of becoming an ICB is being able to address the other factors that might affect people's health such as housing, education and access to jobs. Our relationship with both of the Coventry and Warwickshire Health and Wellbeing Boards remains strong and I look forward to their continued input to improving the lives of our local population. We continue to also develop our Care Collaboratives and Place based arrangements which include all key NHS and Local Authority partners; Primary

Care Networks; Voluntary, Community and Social Enterprises and our communities working together to tackle inequalities.

As mentioned earlier, our key focus has been on how to maintain and restore services especially for elective care, cancer and diagnostics. There are examples of the improvements the system has delivered in this report and over the last year of the CCG.

From 1 April to 30 June 2022 the CCG's 120 Member GP Practices continued to support the vaccination programme in promoting and delivering the spring booster. Since the start of the vaccination programme last year Coventry and Warwickshire have consistently been one of the top performing areas in the country for percentage of population vaccinated and this great achievement is a credit to the combined work of everyone across the health and care system, working in partnership to set up and deliver the service. The Autumn booster campaign and using our learnings from previous campaigns ensures that vaccinations are available and accessible for all of our diverse population.

Along with our Primary Care Networks, we continued to put focus and resources on primary care workforce, IT and technology. The addition of new roles in Primary Care has helped to support access to a wider range of patients directly to specialists. In the three months covered in this report we have continued our campaign to support patients to be aware of these new roles, with information going to every household in Coventry and Warwickshire to outline our new ways of working.

There is a continued focus on integrated working and collaboration across the system. The work from both the previous financial year and the three months covered in this report show many examples of this. Integrated working doesn't just mean things which happen at scale and there are also many fantastic local initiatives which bring together local health providers, care services, voluntary sector organisations and communities, from GP practices joining together to hire care co-ordinators who can help people to access the support they need, to new remote monitoring technology which means local care homes can identify small changes in their residents' health and get them treatment early (page 40).

Internally there has been much focus on new branding for the organisation as we heard towards becoming an ICB. This has involved developing a new website, transforming our social media channels and continual engagement with stakeholders and partners on our ICB journey.

We continue to engage with our staff having held the first of many face to face Staff Away days for our staff, taking them on the journey of opportunities that lie ahead of us.

As I look to the future there are significant challenges facing all of us. As individuals we face ongoing challenges in preventing ill health and staying well. Organisations who support the population with their health and care, from the NHS and Local Authorities to grassroot community groups and the voluntary sector, have significant obstacles to overcome in meeting demand for services against a background of pressure on our recruitment and finances.

Becoming an ICB on 1 July 2022 meant that we now have an opportunity to build upon the collaborative approach that has

been developed and improve healthcare outcomes for everyone in Coventry and Warwickshire. We have the legislative backing to now go faster and further, bringing together the Clinical Commissioning Group and the Health and Care Partnership, governed by leaders from across health and care, to deliver the four aims of our ICS:

- **Improve outcomes** in population health and healthcare
- **Tackle inequalities** in outcomes, experience and access
- **Enhance productivity** and **value for money**
- Help the NHS **support broader social and economic development.**

As you will see from the detail in this report, the Clinical Commissioning Group and those working for it have left us in the best possible position to move forward and deliver those aims. I would like to once again take this opportunity to again thank all of our colleagues for their contribution and efforts towards creating better health outcomes for the people of Coventry and Warwickshire.

Phil Johns

Accountable Officer

NHS Coventry and Warwickshire Clinical Commissioning Group

Performance Overview

About this overview:

Thank you for taking the time to read our annual report for 1 April – 30 June 2022. This section of the report will give you a high-level snapshot of the organisation, what we have done, the challenges we have faced and what we've done to meet those challenges.

Performance summary

In this section are some of the key improvements we have made and examples of how we have delivered against our statutory duties.

We are proud of the work that we have delivered in commissioning services and the positive impacts this has had on our population while continuing to address the pandemic. Our decision to commission a service was based on a number of different factors including the needs of our population, identified through ongoing engagement with people, as well as the Joint Strategic Needs Assessment along with local and national health and wellbeing priorities.

We continued to build on existing strong relationships across the system and have worked very closely with representatives of the public, clinicians, NHS England, providers, public health consultants, social care, our two local authorities, the other local CCGs and voluntary sector providers to ensure that we better understood the needs of our communities so that the services we commissioned are of the right quality, delivered in the right place and can best improve health outcomes.

In line with national priorities in 2022-23 the CCG, whilst continuing to respond to the needs of the Covid-19 pandemic, was also restoring services and prioritising Elective recovery to reduce waiting list backlogs. Delivery of the Covid-19 Vaccination programme; the expansion of primary care to improve access, local outcomes and address health inequalities; and the increase in mental health services to manage the increasing demand, were also key deliverables for the CCG.

In the Performance Analysis section of the report, we focus on how the CCG has performed during the period 1 April – 30 June 2022 and the monitoring mechanisms in place to assure the organisation that it is meeting these requirements. The review of performance helps inform the Review of Effectiveness which can be found within the Governance Statement.

Performance is assessed through a number of methods including the Oversight Framework, the NHS Constitution, the long term plan and number of local metrics that ensure that the organisation is meeting its priority outcomes.

The continuing impact of COVID-19 has seen challenges to people's physical and mental health, and resultant extraordinary pressures on the NHS and Social Care. Further details of this are provided in the sections below with the performance tables from page 77 summarising the main priorities of the NHS constitution.

Although the overall elective waiting list has been increasing, the number of patients that have been waiting the longest are reducing and receiving treatment and the CCG performed well against the regional and national average. The CCG was also one of the best performing CCGs in England against the percentage of diagnostics

that take place within 6 weeks of referral.

Cancer performance has been particularly challenging across all main providers of the CCG and the System-wide action plan that is now place with all partners engaged will hope to recover this performance throughout 2022-23.

Health Inequalities has been and will continue to be a key focus for the ICB going forward. The health inequalities strategy has been devised by a wide range of stakeholders and will support the priority outcomes and enable effective reduction in health inequalities.

About NHS Coventry and Warwickshire Clinical Commissioning Group: our purpose and our activities

From 1 April-30June 2022, NHS Coventry and Warwickshire Clinical Commissioning Group (CCG) was a statutory organisation, and our commissioning activities were in line with the statutory responsibilities outlined in our Constitution.

We were responsible for the planning, organising and buying of NHS healthcare for the population of Coventry and Warwickshire.

The CCG was made up of 120 GP member practices across Coventry and Warwickshire, which provide primary care services to the people living in the area. The member practices elected a clinical chair and three local GPs who, along with our Chief Nursing Officer, Secondary Care Consultant, three lay members, Chief Finance Officer and Accountable Officer, made up our Governing Body.

Our vision was:

- To prevent illness before it occurs
- To ensure faster access to GPs
- To provide excellent specialised hospital services where and when they are needed most
- For everyone to lead healthier and more fulfilled lives

The Governing Body was responsible for ensuring that the CCG fulfilled the statutory duties delegated to the CCG by NHS England.

The CCG received funding from NHS England to plan and buy services for our population from qualified NHS and other health and care providers. The CCG worked with clinical and management experts to ensure that local people have access to the right services at the right quality and at a price the NHS can afford. We were also responsible for monitoring and evaluating the performance of the services we commission to make sure they meet the needs of our local population.

During 1 April – 30 June 2022 we continued to focus on how we could make the NHS work in the best way possible, help people to live well, improve care and tackle inequalities, support our staff, make the best use of data and technology and make the most of taxpayer investment in the NHS. As ever, we have taken every opportunity to work with our local population, providers and other stakeholders to make these decisions together, and ensure what we do and the services we commission are right for the people of Coventry and Warwickshire.

Part of the CCG's work involved continuing to respond to the COVID-19 pandemic along with elective recovery across Coventry and Warwickshire.

The services we commission:

Primary care services

We commissioned general practice services which provide the first point of contact in the healthcare system, acting as the "front door" of the NHS.

Community health services

These services include treatment by district nurses, advice from health visitors, rehabilitation, physiotherapy, and occupational therapy to help people recover from injury.

Hospital services

For people who are ill or injured and need more specialist help. In our area, this is often provided by University Hospitals Coventry and Warwickshire NHS Trust (UHCW) in Coventry and by the Hospital of St Cross in Rugby. George Eliot Hospital Trust in Nuneaton and Warwick Hospital in Warwick.

Mental health services

Talking therapies for people with common mental health problems, and care from mental health teams for people with more complex needs.

Medication

This is the medication that patients are prescribed by their GP, consultant, or other qualified NHS practitioner.

Other services

The CCG also commissioned a range of other services, including:

- Hospice care, including children's hospice care.
- Personalised packages of care, which includes Continuing Healthcare and funded nurse care services from a number of nursing homes and other care providers.
- Emergency ambulance services and non-emergency patient transport provided by West Midlands Ambulance Service NHS Trust (WMAS).
- The NHS 111 service provider.

A range of services from the voluntary and community sector, including respite and end of life care and some support for service user and carer organisations.

The CCG commissioned collaboratively with the other local CCGs, Coventry Public Health, Warwickshire Public Heath, Coventry City Council and Warwickshire County Council as well as working with regional and national specialist teams who commission specialist services.

Transition

Everyone working in health and social care in Coventry and Warwickshire has a common purpose.

We want people to start well, live well, and age well.

We want to prevent them from becoming unwell wherever possible. If they are ill, we want to support them to get better as quickly as possible and we want to help everyone to manage as independently as they can.

To do this, we need to all work together in partnership, removing the barriers between services and joining up care around people and communities.

Providing good health care is only one way to improve people's health and wellbeing. Working together in an Integrated Care System (ICS) enables us to address the other factors that might affect people's health such as housing, education and access to jobs.

NHS England has set out the following as the four core purposes of ICSs:

a. improve outcomes in population health and healthcare.

b. tackle inequalities in outcomes, experience, and access.

c. enhance productivity and value for money.

d. help the NHS support broader social and economic development.

During 1 April – 30 June 2022, Coventry and Warwickshire ICS partners continued to work together to deliver the national aim and bring health and care organisations closer together. Examples of the improvements this collaboration delivered include our Elective Accelerator programme which delivered real success in supporting the restoration of patient services across Coventry and Warwickshire, increasing new appointments, and reducing waiting lists, while our vaccination programme delivered first and second doses as well as boosters, reaching out to our diverse communities to ensure everyone had the facts about vaccination and access to local vaccination. We will embed the learnings from COVID-19 and continue to develop new ways of collaborative working to drive integration in 2022-23 and beyond.

Coventry and Warwickshire ICS bring partners together to deliver on the core purposes and to address the challenges across our system, many of which commenced prior to the pandemic. These include:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible

Working closely together provides a better opportunity to address health inequalities in our system, tackle the wider determinants of health such as housing or socio-economic exclusion, and improve the health and wellbeing of everyone in Coventry and Warwickshire. To support this we have well-developed, distributed Place based activities which include all key NHS and local authority partners, Primary Care Networks, our

Voluntary Community Sector and our communities.

Patients, staff, and local residents can find out more about the ICS and opportunities to get involved by going to the Partnership's website at www.happyhealthylives.uk Alternatively, connect at facebook.com/healthyhappycw or follow on Twitter at twitter.com/healthyhappycw

Our Governing Body and Chief Officers

The individuals below were in post in the CCG for the whole of the period 1 April 2022- 30 June 2022. The Annual Report and Accounts were signed in July 2023 by Phil Johns who became the Chief Executive Officer of NHS Coventry and Warwickshire Integrated Care Board from 1 July 2022 and remains in post at the signing of the accounts.

Dr Sarah Raistrick

Chair

Phil Johns

Accountable Officer

Adrian Stokes

Chief Finance Officer

Jo Galloway

Chief Nursing Officer

Dr Deepika Yadav

Practice Member (Coventry)

Dr Sukhi Dhesi

Practice Member (South Warwickshire)

Dr Jonathan Menon

Practice Member (Rugby)

Dr Arshad Khan

Practive Member (Warwickshire North from February 2022)

Richard Percival

Lay Member, Governance and Audit and Conflicts of Interest Guardian

Zubair Khan

Lay Member

Ghulam Vohra

Lay Member

Elaine Strathan-Hall

Registered Nurse

Colette Marshall

Secondary Care Specialist

Allison Duggal

Director of Public Health (Coventry) (Non-voting) (from March 2022)

Dr Shade Agboola

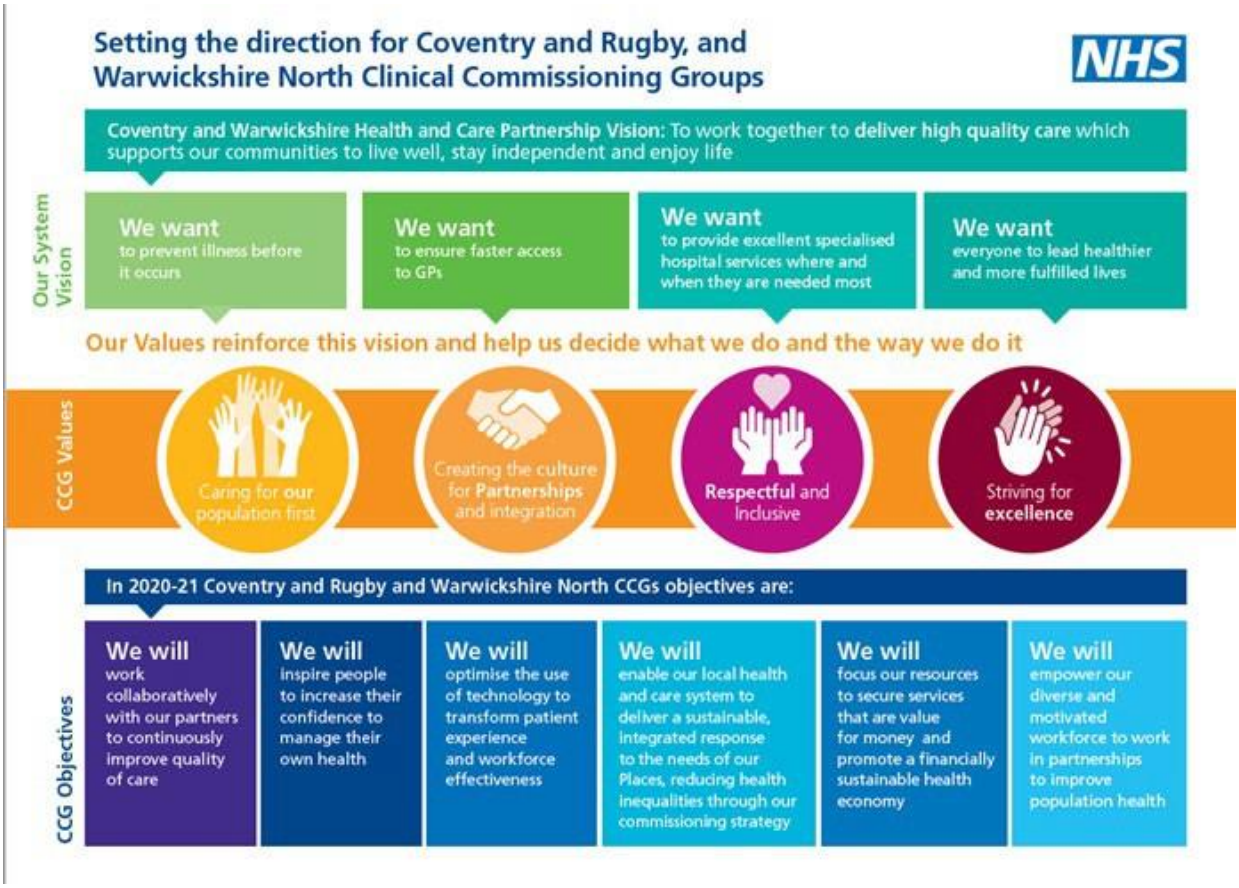
Director of Public Health Warwickshire (Non-voting)

Alison Cartwright

Chief Officer Performance and Delivery (Non-voting)

Our Values

NHS Coventry and Warwickshire CCG continued to uphold the values of the predecessor CCGs (as below).



Our Population

We have a diverse population that continues to grow. We needed to commission services for our local population that are flexible and could respond to this diversity and their changing needs, with more services provided closer to the patients' homes. We are committed to tackling the challenges that come with an ageing population and to improving the quality of life for those with long term conditions.

The table below breaks down our population in various categories:

Population

	Total population	Population, under 16	Population aged 18 to 64	Population, 65-84	All persons aged 85 and over
	2020	2020	2020	2020	2020
	People	People	People	People	People
Coventry	379,387	72,983	248,117	43,678	6,785
North Warwickshire	65,452	11,428	38,357	12,546	1,740
Nuneaton and Bedworth	130,373	25,737	76,672	22,369	2,801
Rugby	110,650	22,463	64,624	18,046	2,838
Stratford-on-Avon	132,402	22,150	73,901	28,881	4,739
Warwick	144,909	24,926	89,844	23,235	4,040

Ethnicity

	Total BME population	Residents who are Asian/Asian British	Residents who are Black/African/ Caribbean/Black British	Residents who are Mixed/multiple ethnic groups	Residents who are White	Residents who are Other ethnic group
	2011	2011	2011	2011	2011	2011
	People	People	People	People	People	People
Coventry	82,931	51,598	17,764	8,230	234,029	5,339
North Warwickshire	1,305	580	172	506	60,709	47
Nuneaton and Bedworth	10,860	7,880	1,047	1,396	114,392	537
Rugby	9,510	5,225	1,987	1,986	90,565	312
Stratford-on-Avon	3,178	1,466	264	1,258	117,307	190
Warwick	14,933	9,945	973	2,803	122,715	1,212

Life Expectancy

	Life expectancy at birth - male	Life expectancy at birth - female	Healthy life expectancy at birth - male	Healthy life expectancy at birth - female	Inequality in life expectancy at birth - male
	2018-20	2018-20	2018-20	2018-20	2018-20
	Years	Years	Years	Years	Years
Coventry	78.0	82.0	61.1	64.0	10.7
North Warwickshire	78.7	82.0	no value	no value	5.7
Nuneaton and Bedworth	77.3	81.7	no value	no value	9.9
Rugby	79.7	83.6	no value	no value	6.8
Stratford-on-Avon	81.4	85.0	no value	no value	3.5
Warwick	80.9	84.2	no value	no value	7.7

Deprivation

	IMD: Barriers to Housing and Services - proportion of LSOAs in most deprived 10% nationally	IMD: Crime - proportion of LSOAs in most deprived 10% nationally	IMD: Education Skills and Training Deprivation - proportion of LSOAs in most deprived 10% nationally	IMD: Employment - proportion of LSOAs in most deprived 10% nationally	IMD: Health Deprivation and Disability - proportion of LSOAs in most deprived 10% nationally	IMD: Income Deprivation - proportion of LSOAs in most deprived 10% nationally	IMD: IDACI - proportion of LSOAs in most deprived 10% nationally	IMD: IDAOPI - proportion of LSOAs in most deprived 10% nationally	IMD: Living Environment Deprivation - proportion of LSOAs in most deprived 10% nationally
	2019	2019	2019	2019	2019	2019	2019	2019	2019
	%	%	%	%	%	%	%	%	%
Coventry	2.56	4.10	9.23	11.28	12.82	15.90	16.41	19.49	19.49
North Warwickshire	10.53	2.63	7.89	2.63	0.00	2.63	2.63	0.00	7.89
Nuneaton and Bedworth	1.23	9.88	13.58	8.64	3.70	4.94	11.11	6.17	1.23
Rugby	9.84	1.64	1.64	0.00	0.00	0.00	0.00	0.00	0.00
Stratford-on-Avon	16.44	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8.22
Warwick	4.65	4.65	1.16	1.16	0.00	0.00	0.00	0.00	3.49

Data sourced from Coventry City Council – Insights Development Manager

Health and wellbeing strategy

Our activities demonstrate that we have shown regard to Section 11 6B (1) (b) of the Local Government and Public Involvement in Health Act 2007.

The CCG continued to be an active member of the Coventry and Warwickshire Health and Wellbeing Board, supporting the ongoing response to the pandemic and he recovery of services.

The Health and Wellbeing Board's duty is to improve the health and wellbeing of local people and reduce health inequalities. The members of the board work together to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way and so offer better services. The Board is an important part of the wider plans to make the NHS work better by strengthening working relationships between health and social care; encourage the development of more joined up services and give communities a greater say in understanding and addressing local health and care needs.

Both Coventry and Warwickshire Health and Wellbeing Boards continued to meet together during 1 April – 30 June 2022 as part of the "Place Forum".

Like all areas in the country, local NHS organisations across Coventry and Warwickshire, including our CCG, have joined with local councils to form the Coventry and Warwickshire Health and Care Partnership.

The aim of the partnership is to share knowledge and resources to improve health and care. We are working closely together to help everyone lead healthier and more fulfilled lives, be part of a strong community and benefit from effective and sustainable health and care services where and when they need them most.

In reviewing the CCG's contribution to the delivery of the joint Health and Wellbeing Strategy, we consulted with both the Coventry and Warwickshire Health and Wellbeing Boards.

Cllr Kamran Caan, Chair Coventry Health and Wellbeing Board and Cabinet Member for Public Health and Sport at Coventry City Council said:

"The Health and Wellbeing Board are really pleased with how well the CCG works with us. Covid-19 has had an unprecedented impact on us all and the partnerships and system working in Coventry proved invaluable in delivering services to the people of Coventry during these exceptionally challenging times, and onwards as we restore services.

Our partnership has enabled us to put people and communities at the heart of everything we do. The transition of Coventry and Warwickshire CCG to an Integrated Care Board in July 2022 will strengthen services as we will be able to work closer together to create a better system that improves the health, wellbeing, and overall happiness of people and families across Coventry and Warwickshire and addresses health inequalities. I look forward to working with the new ICB as we continue our work to recover from the impact of the pandemic."

Warwickshire County Councillor Margaret Bell, Chair of Warwickshire Health and Wellbeing Board said:

"As Chair of Warwickshire HWBB I have been delighted to work in partnership with the CCG to deliver the best for our residents. Our partnership this year has been particularly important as we prepare for the Integrated Care System and seek to bring closer together Health and Adult Social Care. We are working to build integrated care pathways to improve the service for all those who require it. I am delighted that a key priority in the establishment of the ICS is the reduction of health inequalities. As a member of the Integrated Care Partnership I look forward to working with the Chair and other members of the partnership to improve the health and care outcomes for all our residents."

As a system the partnership remains fully committed to delivering the Five-Year Plan, focusing initially on a number of key priorities. Our overarching priority as a system is to enable people across Coventry and Warwickshire to start well, live well and age well, promote independence and put people at the heart of everything we do. We will achieve this through:

- Enabling everyone to keep well by making healthy choices and providing services that help prevent illness, promote wellbeing, and reduce health inequalities
- Working together to tackle the underlying causes of illness, build community resilience, and ensure everyone has access to jobs, secure housing and feels connected to people around them
- Providing the best possible care within available resources as close to home as possible and joined up around the people and communities we serve
- Using technology to improve health and care including a single electronic care record and providing people with digital access to advice and support
- Valuing our staff by enabling them to work flexibly, investing in their development and working to increase diversity in leadership teams.

During 1 April – 30 June 2022 the system response to COVID- 19 has continued to be transformational and built on our existing work to transition from operating as a Sustainability and Transformation Partnership into an Integrated Care System. This includes:

- A common vison and agreed principles regarding the way partners will work together.
- Well established ICS leadership and governance arrangements
- Well developed, distributed Place based arrangements which include all key NHS and LA partners, PCNs, VCS and our communities working together to tackle inequalities
- A history of strong clinical leadership in supporting service transformation, including the Out of Hospital arrangements, integrated discharge teams and more recently, the redesign of Stroke services
- A strong commitment to support and develop our workforce so that they can offer the best care to our patients and communities
- Growing capability and capacity to deliver a Population Health Management approach at all levels of our architecture
- An emerging system approach and governance structure that supports collective management of quality, performance, and finance

We will embed the learning from COVID-19 and continue to develop new ways of collaborative working to drive integration faster and further in 2022-23 and beyond.

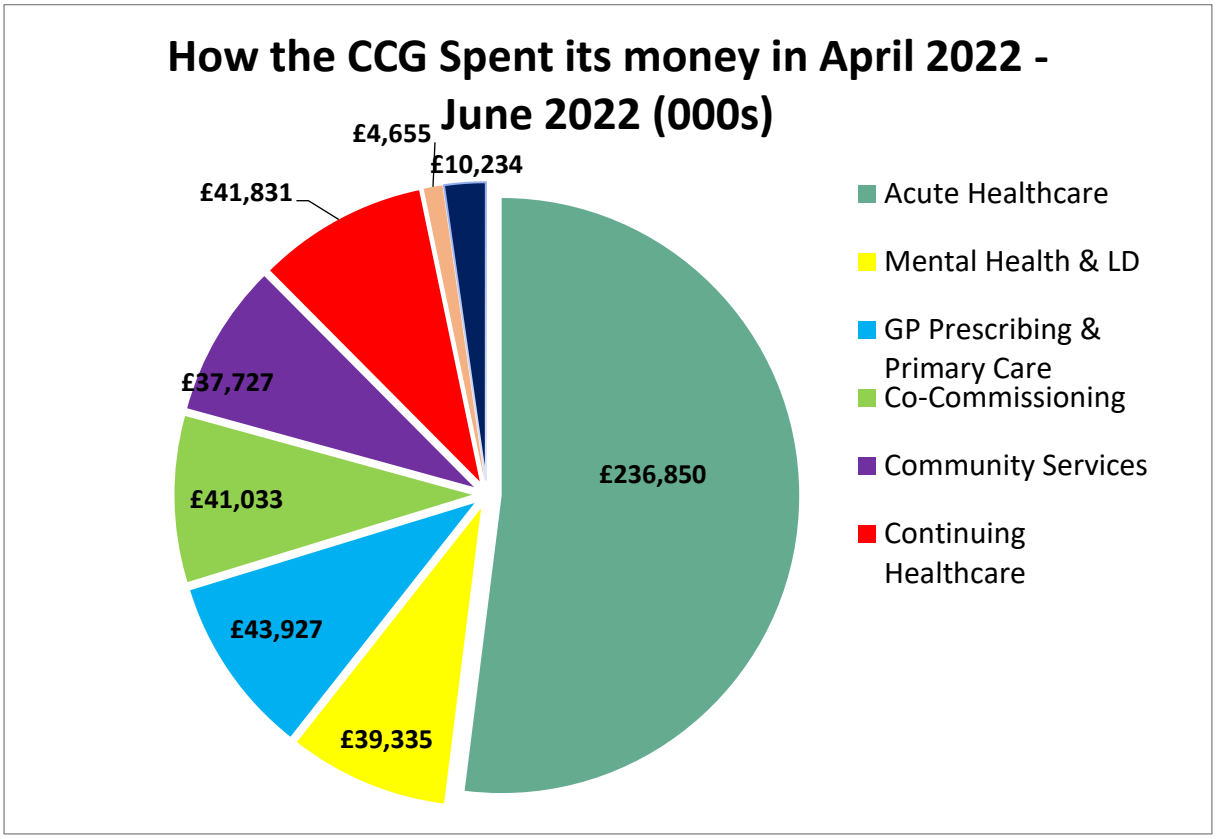
Patients, staff and local residents can find out more about opportunities to get involved by emailing info@bettercarecovwarks.org.uk, or by going to the Partnership's website at www.happyhealthylives.uk

Alternatively, connect at facebook.com/healthyhappycw or follow on Twitter at twitter.com/healthyhappycw

The money we spend

The CCG received an allocation of £455,592,000 for the period 1 April – 30 June 2022. Most of the money is spent with our main providers locally – University Hospitals Coventry and Warwickshire NHS Trust (which includes the Hospital of St Cross in Rugby), George Eliot Hospital NHS Trust, Coventry and Warwickshire Partnership NHS Trust and South Warwickshire Foundation Trust. These organisations provide most of our Acute Healthcare, Community and Mental Health Services.

The chart below shows the expenditure by category of care, you will find more details of how we achieved our financial duties on page 80 of this report.

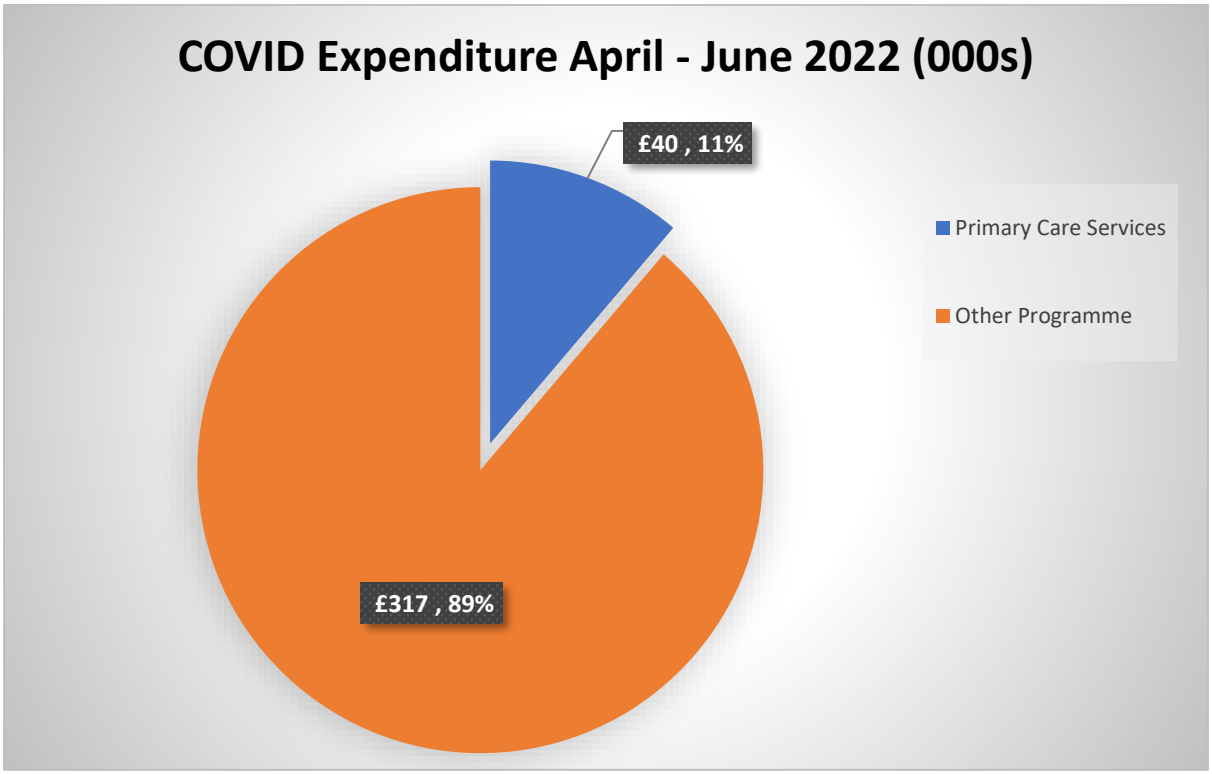


How the CCG Spent its money in 2022/23 (000s)

KEY	AREA	
	Acute Healthcare	**£236,850**
	Mental Health & LD	**£39,335**
	GP Prescribing & Primary Care	**£43,927**
	Co-Commissioning	**£41,033**
	Community Services	**£37,727**
	Continuing Healthcare	**£41,831**
	CCG Running Costs	**£4,655**
	Clinical Support	**£10,234**
	Total	£455,592

COVID Expenditure 1 April – 30 June 2022

The CCG has incurred expenditure of £317k in response to COVID during April - June 2022, with COVID being funding through core allocations with the exception of COVID vaccinations. Most of the expenditure (£170k) was for patient transfer service.



COVID Expenditure April-June 2022 (000s)

Primary Care Services	**£40**
Other Programme	**£317**

Going concern

These accounts have been prepared on the 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.

As set out in below in Events after the Reporting Period on 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups were abolished and the functions, assets and liabilities of Coventry and Warwickshire CCG were transferred to NHS Coventry and Warwickshire Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. It remains the case that the Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2022-23 and CCG published allocations can be found on the NHS England website for 2022-23 and 2023-24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the Coventry and Warwickshire Integrated Care Board, rather than Coventry and Warwickshire CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, is not considered to impact on going concern. Our considerations cover the period through to 31 July 2024, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, the Governing Body have a reasonable expectation that the CCG (and the successor commissioning organisation) will have adequate resources to continue in operational existence for the foreseeable future.

Events After the Reporting Period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of NHS Coventry and Warwickshire CCG will transfer to Coventry and Warwickshire Integrated Care Board from 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of the financial statements.

Key issues and risks to achieving our objectives

The CCG identified risks that that may prevent the CCG from achieving its objectives through its system of risk management.

Risks can be identified at any level in the organisation and each department has a local risk register with a process for escalating the highest rated risks to the Corporate Risk Register (CRR).

The CRR set out the description of the risk including the cause and potential outcome; Chief Lead for the risk;

mitigations in place; assurances that the mitigations are effective; initial and residual risk scores; and further actions to mitigate the risk that are not yet in place.

The CRR was presented to the Finance and Performance Committee, Clinical Quality and Governance Committee and Audit Committee for scrutiny and assurance.

The CCG had a Governing Body Assurance Framework which provided a means for the CCG to manage the principle risks to achieving the strategic objectives.

During the period 1 April – 30 June, four risks were identified as control risks which were Urgent and Emergency Care, Transforming Care, Elective Care – Recovery and Cancer.

Urgent and Emergency Care
If there is a demand and capacity deficit across urgent and emergency care services, there is a risk that patients will not be seen in the right care setting within the right timeframes, leading to increased ambulance handover delays, resulting in patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.

Mitigations to manage this risk included:

- Local Urgent Care Boards at Place to manage demand and capacity.
- Daily Medically Fit for Discharge meetings with providers and Local Authorities.
- Plans in place for surge capacity.
- Delivery monitored through contracting meetings.

Transforming Care
If the ICB is unable to provide the necessary support to those with a Learning Disability and/or Autism in the community, then there is a risk that more people with a Learning Disability and/or Autism will be admitted to hospital or the that number of people in hospital will not reduce, resulting in significantly adverse impacts on the quality of life for these people and their families.

Mitigations to manage this risk included:

- Increased operational capacity for delivery of effective discharge and admission avoidance.
- Intensive Support Team and Community Forensic Service being established on recurrent basis to support all-age people with learning disabilities and/or autism.
- Local Government Association peer review in early 2021, discharge assurance process under review, weekly system discharge planning and admission avoidance meeting, Root Cause Analyses for all admissions:
- 21/22 Operational plan and three year road map, system wide governance arrangements,
- National guidance, Building the right support (2015), Long Term Plan Objectives
- LD and Autism Board, strategic steering group and LD/A finance meeting, Operational Steering Group. Weekly Discharge Assurance and Admission Avoidance meeting.
- Escalation meetings with NHSE/I, Monthly regional SRO meetings.
- Monthly performance reports regarding key metrics to Finance and Performance Committee. Bi-

monthly Clinical Quality and Governance Committee reports.

Elective Care – Recovery
If the system is not able to align its elective recovery programme to the national recovery proposals, there is a risk that patients will not be seen in the right care setting within the right timeframes, resulting in patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.

Mitigations to manage this risk included:

- A clinical review of all inpatients waiting has been undertaken to be clear around the clinical priority of patients, and the system is working collectively to ensure equity across the system.
- Monthly system Elective Care Board in place including all partners across the system to support elective recovery.
- Weekly escalation meetings with overall system review of waiting lists and mutual aid / transfer of priority patients as needed to support equitable delivery to priority patients and reduction of 104 weeks waits across the system.

Cancer
If we do not utilise our capacity and manage our cancer referrals effectively there is a risk that patients will continue to wait longer for both diagnosis and treatment. Resulting in failure of key cancer standards and sub-optimal pathways for our patients with variation across our ICS for both access and inequalities potentially.

Mitigations to manage this risk included:

- Ensuring screening programmes are effective and delivering within timescales.
- Bi-Weekly operational meetings in place to share learning, track patients and identify key risk specialties.
- Shared learning across our ICS through Cancer Managers group
- System wide oversight included as standing agenda item at C&W Cancer Board. A range of initiatives currently under review to support improved position.
- ICS/providers establish access to weekly Chief Operating Officers (escalation) activity monitored via governance boards.

Performance Analysis

This section looks at the performance of the CCG during 1 April – 30 June 2022 in more detail including a number of case studies, how we demonstrate how we met our statutory duties and performance measures.

Primary Care

Throughout 1 April – 30 June 2022 the CCG's 120 Member GP Practices continued to rise to the challenge of responding to the COVID-19 pandemic, while at the same time learning to live with COVID and shaping a new, post-COVID, normal. In line with national guidance and local prioritisation processes, local practices focused on restoring services, meeting new care demands and supporting the whole system response to care backlogs that had arisen as a direct result of the pandemic.

The success of the COVID vaccination programme has, both locally and nationally, proven beyond doubt the value and potential of PCNs. As a system we continue to prioritise support for PCN development, and this will be a key on-going area of focus for the ICB moving into 2022-23, with a particular focus on working with our local PCNs to implement new requirements relating to anticipatory care and personalised care. Another on-going priority will be improving timely access to primary care, with all PCNs due to commence planning for delivery of a new Enhanced Access service which will go live from 1 October 2022.

As a system moving into 2022-23, we retain our commitment for general practice and PCNs to be at the very heart of our future Integrated Care System and our belief that a thriving general practice is the foundation for developing a new service model in which patients experience properly joined up care, at the right time, in the optimal care setting as required by the NHS Long Term Plan.

Primary Care Workforce

In terms of deliverables for the general practice and PCNs, the period 1 April to 30 June 2022 has continued to be challenging but, in many ways, also a very positive period.

Despite all that the COVID-19 pandemic has thrown at them, the general practice workforce has stepped up to respond to what has been asked of them and, together with their unwavering desire to do the right things for their patients, they have had the support of a pro-active and ever-growing Training Hub and a GP Workforce Clinical Lead to ensure that they have the support that they require to live, work, train and learn in Coventry and Warwickshire.

The Training Hub website https://www.cwtraininghub.co.uk/ is an amazing resource for all general practice staff to visit and obtain all the information that they require to support them. It includes a wide range of initiatives to support the GP workforce – from the new Health and Wellbeing package, through to equal support and opportunities to participate in local training and nationally funded schemes.

Further to the recruitment of PCN additional roles in 2021-22, these roles require support in terms of their training, education and professional development needs and once again a wide-ranging support offer is available – from local mentors to network opportunities. The Annual Report highlights 2 case studies of the work being undertaken by these new roles that are now in general

practice supporting patient care and alleviating pressure on the traditional GP practice workforce. We look to continue the number of additional roles across Coventry and Warwickshire in 2022/23

Health and Wellbeing of the workforce was an area of particular focus recognising the toll that the last 2 years have undoubtedly taken as general practice played a critical role within the health and care system's response to the COVID-19 pandemic. To support, a wide-ranging programme including national, regional and local initiatives has been put in place, including the recruitment of Health and Wellbeing Champions, a mental health support offer and an Employee Assistance Programme offering a wide range of advice and benefits. Work will continue in 2022/23 to ensure that the health and wellbeing is promoted to all.

Without doubt recruiting and retaining our GP practice workforce is becoming increasingly challenging. We have developed a wide range of schemes to support newly qualified clinicians, supporting portfolio careers for mid-career clinicians and maximising the support and learning we can offer and capture from those later on in their careers. As demand and complexity of patient care increase, we recognise much has been done but there remains much more to do. 2022/23 will see us continue with the schemes already established, whilst establishing others which focus on 'growing of our own' workforce. We will seek to increase placements in GP practices and look to recruit and train our own nursing workforce and other healthcare professionals, so that, ultimately, we have much greater control of our own destiny.

GP Information Communication and Technology (ICT)

The period 1 April – 30 June 2022 as with the previous year has continued to be challenging with the COVID-19 pandemic continuing to impact the way that general practice works.

The focus in the GP ICT arena has been on 3 main areas:

1. Infrastructure and cyber security;
2. Supporting new ways of working as a result of the pandemic;
3. Enhancing the digital offer to GP practices to support efficiency and improve patient care.

Taking each area in turn

Firstly, the CCG invested in ICT hardware and software to ensure resilience and security. This is especially important and we now see an almost total reliance on a digital platform/network/infrastructure for clinical systems, document management systems and ever increasingly telephony systems. Ensuring these systems have adequate 'bandwidth' to support our new ways of working and are reliable and secure has been a real focus and one which has been delivered.

Secondly, ensuring GP practices and their workforce have the infrastructure, tools and skills to deliver remote working, a triage model of care and to be able to support the new digital channels of online and video consultation has been a real priority. Everyone – the GP practice workforce and patients alike – has quickly adapted to new ways of working. In 2022/23 we will look to very much build on these new ways of working and ensure digital channels are embedded into our GP practice offer to the

population; whilst of course ensuring we do not exclude anyone from engaging with their GP practice should the digital channels not be an option.

Finally, as a CCG working with our GP practices and the collaboration of the Federations (which brings together the 4 local provider GP Federations/Alliance), we have supported the implementation of several solutions that help to increase practice efficiency and improve patient outcomes. Examples include the roll out of Voice over Internet protocol (VoIP) telephony, which provides much improved telephony capacity with no restrictions on the amount of lines going in and out of a practice and provides management reporting to support capacity planning; the introduction of remote monitoring whereby software is utilised to monitor patients with long terms conditions and in Learning Disability and Care Homes so that practices are able to provide pro-active care before any crisis and potential hospital admission is required; and the use of software to identify those in our population who require proactive health care for long term conditions.

As we look forward towards the new Integrated Care System we are confident that we have a robust and secure ICT platform across Coventry and Warwickshire. Our next challenge is to maximise interoperability, again with a view to reduce unnecessary bureaucracy, improve efficiency and improve patient care and outcomes.

Case Study: Cancer Care Coordinator – Arden PCN

Why change was needed

Arden PCN wanted to improve the support offered to patients who are either waiting for or have a cancer diagnosis.

Waiting for a cancer diagnosis, or receiving confirmation that someone has cancer, is always an extremely difficult experience for a patient. Furthermore, the range of services and support available to patients can be difficult to navigate whilst they are still coming to terms with their diagnosis.

There are also many patients who are reluctant to come forward for routine cancer screening appointments. Often, they either underestimate their risk of developing cancer, or they are put off from attending a screening appointment out of fear of receiving a cancer diagnosis. However, we know that cancer screening saves thousands of lives each year and so it is crucial that eligible patients come forward so they can receive their diagnosis as early as possible which gives them the best chance of beating cancer.

We decided that we needed a specialist cancer care coordinator to support patients throughout the cancer diagnosis pathway and ensure they have access to the best possible advice and treatment.

What we did

A new Cancer Care Coordinator, Hayley, was appointed in the PCN. Hayley's role was to:

- Support patients from pre-diagnosis right through their cancer treatment.
- Be informed when a patient goes onto the two-week referral process and, if appropriate, be there to offer tailored support that meets the need of the patient at a time when they are often feeling vulnerable, frightened, and disempowered.
- Contact patients who are due to for cancer screening and

discusses the process with them so they understand what is involved and make them feel more comfortable in coming forward for screening.

- Support patients throughout their cancer journey and help them to navigate and access the various support services that are available locally.

Support the development of personalised plans, utilising decision aids, providing information and training opportunities, making appointments, coordination and navigation for people and their carers across health and care services.

Hayley has raised cervical and bowel cancer screening rates at Arden by personalised contact, expertise, persistence, and patience.

What's next

The Cancer Care Coordinator role will continue to support patients and their families with cancer diagnoses. We will look at how we can expand this role across other PCNs within the system so we can improve the support offered to cancer patients across Coventry and Warwickshire.

Case Study – Multidisciplinary team (MDT) – Dene and Stour PCN

Why change was needed

For many patients, their GP's surgery is their first port of call if they need non-urgent medical treatment. However, often a patient will have complex health needs that requires support from health professionals other than their GP.

Before the introduction of multidisciplinary teams (MDTs), a GP would have to refer the patient to several other health professionals, which would mean multiple appointments in different locations and often patients were waiting longer to receive the care they needed.

What we did

Three new roles were created within Dene and Stour PCN: Health and Wellbeing Coach, Social Prescriber, and Care Coordinator. Each of these roles offer patients timely and convenient access to health and wellbeing support that is delivered from their GP surgery.

Once an assessment is made of a patient's needs, they can be referred to see one or more of the new Wellbeing team who will then contact them by phone in the first instance to discuss their health needs and start to create a care plan. The Wellbeing team will continue to support the patient on an ongoing basis, working together where appropriate, to help the patient improve their health and wellbeing.

The introduction of MDTs in Dene and Stour PCN has dramatically increased the scope of support that GP surgeries can offer to patients. The new Wellbeing team can support patients with issues such as housing, homelessness, addiction, bereavement, and debt, that would have previously required referrals to external services.

Patients are already enjoying the benefits of these new roles, including quicker, more flexible, and more holistic treatment that has been improved by the sharing of knowledge and skills between the MDTs. Furthermore, even if the patient does require a referral to an external service, the Wellbeing teams can offer vital support while the patient waits for their appointment.

The feedback from patients around the introduction of the MDTs has been overwhelmingly positive and there have been many positive outcomes because of the support the new roles have provided.

What's next

Due to the success of the introduction of MDTs in Dene and Stour PCN, the CCG will look at how this model can be replicated in other PCNs across the system. The move towards an Integrated Care System makes it easier for PCNs to work together and share best practice that will improve the treatment patients receive.

Change in action

Patient X is an example of how the introduction of MDTs are benefitting the treatment that patients receive.

Patient X is a 59-year-old male who lives alone, has a history of mental health problems and is a frequent user of the GP practice. He was referred to the Wellbeing team for support with finance and housing issues, bereavement, and anxiety.

The Health and Wellbeing Coach and the Social Prescriber roles were identified as the roles that could meet the patient's needs.

The Health and Wellbeing Coach offered tailored support to the patient who, when he was referred, was emotional, stressed, teary and defensive as well as being heavily overweight and having breathing problems. He was offered a range of support including breathing techniques and meditation to help with anxiety, bereavement support, nutritional and exercise advice. The Health and Wellbeing coach also offered an outlet for him to talk to.

The Social Prescriber assessed the specialist support that the patient needed and signposted him to professionals who were able to help. The patient received help with debt advice, housing support, a duty solicitor advised the patient of what action he needed to take, he was allocated a support worker and he was offered advice on what benefits to apply for in order to help him manage his finances.

The results were that the patient felt "more in control" after face-to-face appointments with the Wellbeing team and the advice he received "gave him direction". The team reported that he looked a different man after just 2 weeks. He had made real progress and was calm, happy, his sense of humour had returned, and he had managed to let go of some of the pain he was holding onto. His demeanour was completely changed, and he was optimistic and excited about his future.

Primary care case study

Accessing Primary care – a local communications approach

Working closely with local GPs, primary care colleagues and board GPs to create a suite of social media materials aimed at patients. These materials highlight the new and embedded way practices will triage patient calls while reassuring the public they will be seen in person if clinically necessary by a member of the practice team.

These materials have been shared with all 120 practices across Coventry and Warwickshire encouraging them to post of their social media channels, print posters for waiting rooms and display on their websites. In addition, the CCG and local health partners have also been sharing the information on social media and the materials have also been shared with NHS England Midlands colleagues to share best practice and key messages across the area. These materials are also hosted on the GP Gateway website as well as being regularly promoted via the CCG Practice newsletter.

The materials cover key areas of messaging such as but not limited to:

- Why can't I get an appointment like I use to?
- How is my practice working now?
- What will reception staff ask me?
- What happens when I go to my practice?
- How do I see another clinician at my practice?

Foleshill Practice

In the summer of 2021, the Alliance Teaching Practice Foleshill Surgery site moved to new, energy efficient and purpose-built premises on Livingstone Road, Coventry.

The new surgery is known as the 'UK's greenest health building'. Built with specially designed Portakabin modules, the surgery is the first healthcare building in the UK to receive Passivhaus certification, a rigorous global standard for energy-efficient design. Foleshill not only leads the way for carbon emissions reduction in this type of building but demonstrates its potential for repetition and upscaling across the future health estate.

The building is highly insulated with sustainable innovations including solar panels, triple glazed windows, LED lighting, and a heat recovery system. It is warm in the winter and cool in the summer, with very low energy costs. It also has electric car charging points and bike storage.

NHS 111 first – local festive campaign

Local social media designs were created to encourage people to think of NHS 111 first over the festive period should they need non-urgent health advice. The images depict a festive gingerbread man having a range of injuries that NHS 111 would be able to support with. The images cover a range of health issues like:

- Poorly child
- Suspected injured bone
- A Fall
- Burn/scald
- Fever/ high temperature

These images have been recognised regionally and have been shared across our system and neighbouring areas via the NHS Midlands weekly

communication to enhance consistent messaging and partnership working.

Engaging People and Communities

Due to the COVID-19 pandemic and social distancing requirements, our engagement this year was virtual to begin with, with some face-to-face events in early 2022. All Clinical Commissioning Groups have a legal duty to involve patients and the public in commissioning activity. This duty is outlined in Section 14Z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012.To fulfil the public involvement duty, we must make arrangements for the public to be involved in the planning of services and the development and consideration of proposals for changes which might impact on services.

Our CCG has several structures, processes and assurance methods in place which help us more effectively involve our population in commissioning.

In this section, we will outline some of those methods and demonstrate how the CCG has fulfilled its statutory duties of patient and public participation in commissioning health and care.

The CCG constitution

Our constitution details the ways in which the elected and appointed representatives of the Clinical Commissioning Group organise and are accountable for the commissioning of health services for the population we service.

The constitution outlines in schedule 15, which details our principles in relation to patient and public involvement:

- How we involve our population in our commissioning work
- The principles we follow to involve our population
- How we ensure transparent decision making

Our constitution is available to read on our website.

Our Patient and Public Involvement Lay Person

We believe it is crucial to good commissioning that the voice of the public is listened to and championed at every opportunity. For this reason, we have appointed Lay Members specialising in patient and public involvement who sits on our Governing Body.

Our communications and engagement strategy

Our Communications and engagement strategy, is available on our website and, sets out the strategic vision for communications and engagement at our CCG. It outlined our long-term approach to communication and involvement and detailed how we would meet our statutory obligations. It described how we worked to continuously improve our work, adopting new and innovative approaches that would support the CCG to meet the challenges it faced, as well as being tailored to meet the diverse needs of our population.

This document is available on the NHS Coventry and Warwickshire CCG website.

Patient and public participation in commissioning health and care: statutory guidance for Clinical Commissioning Groups and NHS England

This guidance, available online on NHS England's website, supports the CCG to involve patients and the public in our work in a meaningful way to improve services, including giving clear advice on the legal duty to involve.

The guidance sets out ten key actions for CCGs on how to embed involvement in our work.

Governing Body Reports

Communications and engagement reports were submitted to Governing Body meetings. These reports sought to assure the Governing Body that the Communications and Engagement team was supporting the CCG to meet the statutory obligations for patient and public involvement in commissioning health and care. The Governing Body reports are made public and available on our website: Governing Body Meeting Reports.

This effort was rewarded, as we saw some of our most informative, valuable engagement with our local communities on topics such as maternity and child health services and planned care, including many groups, helping us to understand the specific needs of those communities. This will really help us to commission services which truly meet the needs of our whole population in the future, improving accessibility, advancing equality, and reducing health inequalities.

Improving our engagement with seldom heard groups and vulnerable communities

A big focus for us during 1 April – 30 June 2022 was to continue to improve our engagement with seldom heard groups and vulnerable communities.

Typically, these groups struggle to engage in ways that are meaningful, which can be for a variety of reasons such as language, culture, or accessibility. This lack of engagement can also mean that the needs of those groups are not always considered, furthering the divide many already feel between their needs and the services we offer.

It is a priority of the CCG to ensure that all the voices of our diverse population are heard and have a chance to input into our work. To achieve this, we work closely with the voluntary sector proactively, attending targeted groups and events to ensure people are given the opportunity to make their voices heard.

During 1 April – 30 June 2022, we continued to really try to improve our connections to these groups and our involvement with the community and voluntary sector organisations who represent them.

Our Case Studies

Some of our work is presented as case studies to show how the CCG, partner organisations and members of the public worked together to solve a problem, overcome a challenge, and improve health and care services. Within our case studies, we have demonstrated the challenge we faced, what we did, who we worked, the outcome and our next steps.

Case study – Remote Monitoring

The challenge

The COVID-19 pandemic caused multiple pressures on the NHS, with care homes finding it difficult to have GP visits in person due to infection prevention control procedures. Remote monitoring of patients was required to ease the GP workload and to empower care home staff to capacity boost through technology.

In 2020, four STPs in the West Midlands

were appointed by NHSX to procure a remote monitoring system across the patch for care homes. Following a strict procurement process, Docobo, a digital health and management service, was awarded the contract to provide a range of services including virtual ward rounds.

What we did

The Docobo team worked closely with local GPs and CCGs to roll out patient remote monitoring to 23 care homes in Warwickshire. The service was also rolled out to at home patients with chronic disease (COPD) due to their vulnerability to COVID-19. This supported in the reduction of home visits.

Remote patient monitoring enables primary and community care to access clinical data and makes it easier for Care Team Leaders to contact GPs about unwell residents.

It means Care Team Leaders are fully in charge of regularly checking their residents for any issues, and then they can flag up any problems. This early detection aims to avoid patients needing to attend Urgent care or A&E by flagging any potential risks or concerns earlier via the digital health system.

Who we worked with

The project was headed up by NHS Coventry and Warwickshire CCG, who worked closely with:

- GP surgeries in the area
- Care homes
- Docobo Ltd
- George Elliot Hospital
- Integrated Care Community (ICC) nursing hub, which looks after patients in their place of residence or in the community.

The outcome

Over the last 12 months, adopting this new technology has demonstrated many benefits for GPs and practice managers, as well as for Care Home residents and staff. GP surgeries are saving an average of 19 hours of GP time per month, care homes have fed back on the ease of use, the quality of clinical response and the speed of response of the system, and the fact that it leads to a reduction in GP call outs to care homes.

Quote from a Care Home, Registered Manager: "As soon as I and the senior staff did the training, we were off! The training was brilliant. The staff embraced the Docobo solution. They keep up to date with the monthly data they have to input and have done so right from the beginning - it soon became the norm. Data collection gets done really quickly, as it's an easy system to use. Question Sets are really simple, there is just one button to use and it's very hard to get wrong. The seven senior staff on days and nights all embraced it as its very simple and not complicated at all"

Quote from a Care Home, Deputy Manager: "We have seen a difference – medical team picked up and treated very quickly. A few weeks ago, we were doing a virtual ward with a GP and when doing the 'wellbeing question set' it flagged up a problem – this was cascaded quickly, and the patient put on medication – this all came from doing the 'wellbeing question set' and syncing the data."

Since July 2020, the team has successfully rolled out the Docobo remote monitoring solution to 18 practices and 26 care homes in the county.

71% of clinical leads at GP practices who look after care homes said they had less contact from care homes as a result of the remote monitoring service.

Data feedback showed that there was reduction in workload for GPs and the streamlining of processes:

- 106 alerts meant that a GP/CP visits were avoided
- There were two avoided A&E attendance and one avoided ambulance call out

It also shows how over a period of several months, various alerts prevented hospital admission and GP visits.

Case study – Key worker project

The challenge

Autistic young people 14-25 years old are being admitted to mental health hospitals or being diagnosed with autism in hospital. The number of children, young people, and adults (particularly those aged 18-25) being admitted to mental health beds was identified as a key local issue in 2020.

Systems for supporting children, young people, and families with a learning disability, autism, or both can be complex.

Where they are not joined up, those with a learning disability, autism, or both can fall through the gaps and may struggle to find the help they need at the right time and of a high quality. When crises happen and help is not available locally, children and young people may end up being admitted into a mental health bed that are not always well placed to meet their needs. As a result, there is often a risk of getting stuck and staying in hospital longer than necessary.

Local engagement with children, young people, and families with a learning disability, autism, or both highlighted the following challenges that the Keyworker project was established to address:

- Gaps in early help and preventative services
- Lack of coordination across services
- Transition and preparation for adulthood
- Support for services to understand and make better adjustments to support autistic children
- Mental health crisis and admissions to mental health hospitals

What we did

The original expression of interest submitted to NHSE by the Arden Transforming Care Partnership outlined their desire to use the funding to ‘develop a key worker role which will remain a contact point for autistic people and families to help them to navigate the system and access extra support when they need it.’

We worked collaboratively, using local knowledge and feedback from autistic people, their families, commissioners, people with lived experience and providers, to develop a Keyworker Service. The service identified functions that would offer the following support:

- Navigation and coordination to access the right help at the right time across a complex system.
- Identifying support at home and in the community as an alternative to admission and coordinating care on behalf of the children and young people.
- Act as a champion of autism, supporting everyone involved including colleagues across the system to become autism aware and provide autism friendly services.
- Flexibility and person-centred with an open, revolving door to allow people to return easily to help with de-escalation, avoid crisis and re-admission.
- Promoting independence and empowerment supporting the development of autism profiles that help an autistic person to understand their strengths and areas of support.
- Supporting the voice of autistic people.

The service is hosted by the voluntary sector to ensure close links to the community and facilitate independence from health, education, and social care. The Keyworker roles are not clinical but work closely with therapeutic service.

Who we worked with

Commissioners, providers, and people with lived experience all worked together to develop the project, recruit to the posts, and support the newly appointed team to implement the service. The service meets monthly with people with lived experience to address service challenges and further service developments.

Local multi-disciplinary meetings and admission avoidance meetings address individual challenges and identified needs, attended by the Keyworker service, representing the voice of the child or young person.

Through the project governance, and Learning Disabilities and Autism Governance, service challenges and key emerging themes are escalated and potential gaps in provision are escalated and fed into the wider local autism strategy planning.

The service has been instrumental in supporting the restructuring of the current Autism and Learning Disabilities Admission Avoidance Register (ALDAAR) and ensuring it is a Dynamic Support Register (DSR) providing clarity to all services involved of their functions at varying stages of people's lives where they have been identified of being at risk of crisis.

The outcome

Outcomes are tracked and monitored using the following methods:

- Case studies
- Achievement of 'I' statements developed by people with lived experience that describe what autistic people and families told us was important to them in support of the development of keyworker roles
- Movement on the ALDAAR risk register
- Outcome Star scores

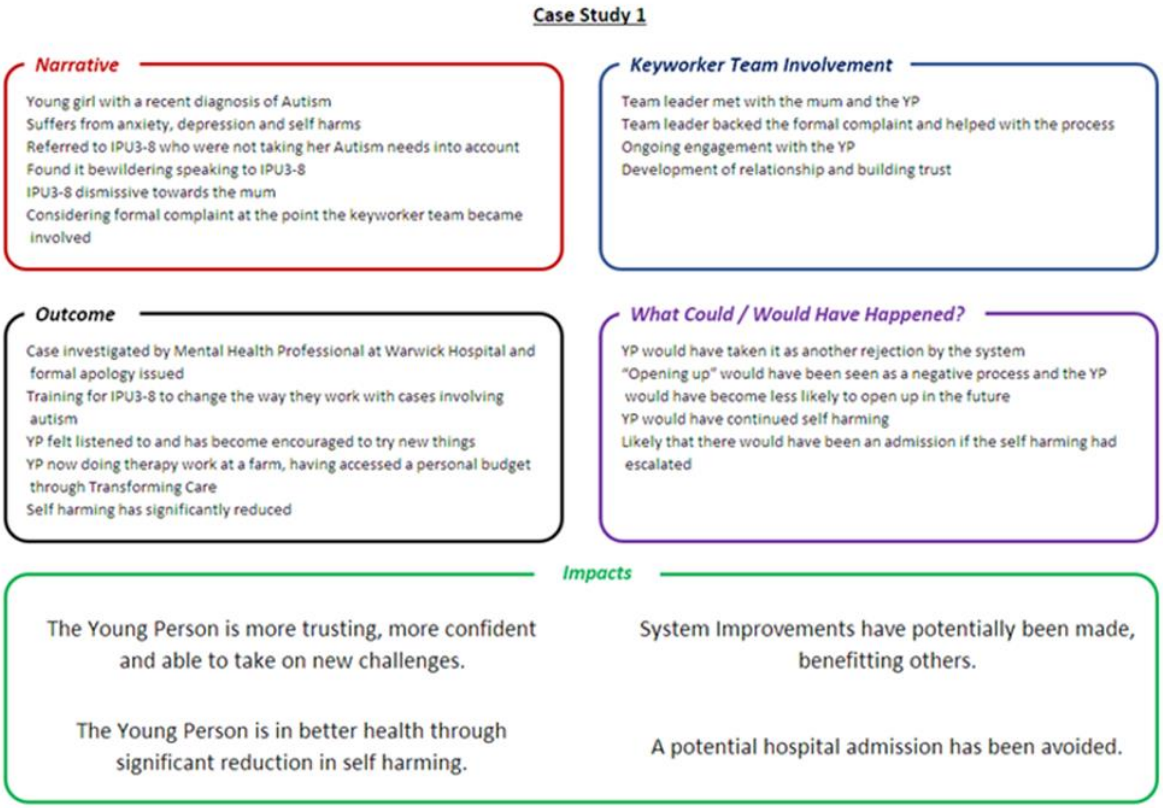
The team is having significant positive impacts on the lives of the young people:

- Hospital admissions have been

prevented
- Prison sentences have been prevented
- The lives of the young people have been saved.

The team is seen by the young people and their families as “their voice” and trusted, sometimes above all others.

“As I say, very early days in my links with key workers; from YP perspective she has engaged with Key worker, values her time/visits and has begun to ask things they could do together (get support) and from a YP that struggles with new relationships, that's a brilliant compliment. YP is happy to go into school with Key worker, but not a parent....and that's a big positive step forward.”



Case study – Severe mental illness

The challenge

People with Severe Mental Illness (SMI) experience complex drivers that lead to significant inequalities, inequity in access to services and inefficiencies.

People with severe mental illness are, on average, **three and a half times more likely to die prematurely than the general population** with estimates of 15-25 years of life lost.

Individuals living with SMI relative to the general population have **double the risk of obesity and diabetes, three times the risk of smoking, hypertension and metabolic syndrome and five times the risk for dyslipidemia.**

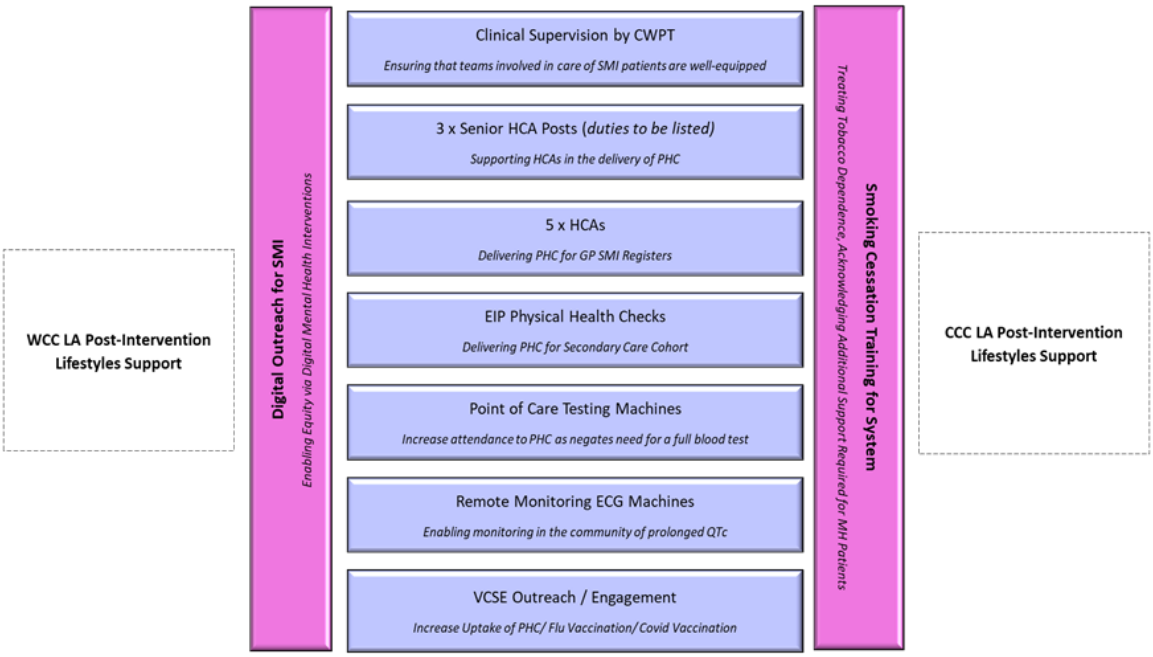
Nearly **half (46% of people with SMI) will have a long-term physical condition yet rates of undiagnosed diabetes are up to 70%** in people with schizophrenia compared with about 25% in the general population .

Individuals living with mental health have **three times more accident and emergency (A&E) attendances and five times more unplanned inpatient admissions** than the general population with **significantly higher length of stays.**

The Long-Term Plan for Mental Health sets out that 60% of people on the GP SMI registers should be receiving a full annual physical health check; progress nationally has been slow, due to the complexity of determinants.

What we did

Coventry and Rugby GP Alliance have been commissioned by the CCG to provide annual health checks for people with SMI, to support primary care in delivery. With a focus on providing consistency across the patch, reducing inequalities associated with rurality, deprivation etc, as well as continuity for the patient, which we know drives down the barriers to access. We have implemented a wide range of initiatives currently ongoing in addition to the HCA model (see below).


WCC LA Post-Intervention Lifestyles Support
Digital Outreach for SMI
Enabling Equity via Digital Mental Health Interventions
Clinical Supervision by CWPT
Ensuring that teams involved in care of SMI patients are well-equipped
3 x Senior HCA Posts (duties to be listed)
Supporting HCAs in the delivery of PHC
5 x HCAs
Delivering PHC for GP SMI Registers
EIP Physical Health Checks
Delivering PHC for Secondary Care Cohort
Point of Care Testing Machines
Increase attendance to PHC as negates need for a full blood test
Remote Monitoring ECG Machines
Enabling monitoring in the community of prolonged QTc
VCSE Outreach / Engagement
Increase Uptake of PHC/ Flu Vaccination/ Covid Vaccination
Smoking Cessation Training for System
Treating Tobacco Dependence, Acknowledging Additional Support Required for MH Patients
CCC LA Post-Intervention Lifestyles Support

This table demonstrates the initiatives in more detail including digital tools, Voluntary, Community and Social Enterprise (VCSE) engagement, different workforce roles, integration across primary and secondary care, with wraparound lifestyles support.

Healthcare for people with SMI and reducing barriers to access is a multi-pronged approach. From our experience, people feel comfortable accessing healthcare services in different ways, and we must tailor our approaches locally in-order to meet this need.

We have been undertaking the VCSE Outreach / Engagement – three of our VCSE partners have spoken with approximately 4.5k people with SMI.

One provider, Grapevine, identified whilst working

with 'Experts by Experience' that "accessing a larger number of people from the Black, Asian and Minority Ethnic (BAME) population was challenging, which raises concerns that the barriers felt by these BAME community are not only different but more deeply felt - also preventing their inclusion and participation in community mental health projects."

As such and acknowledging the disproportionality of BAME populations with a diagnosis, we are carrying out an immediate piece of work which seeks to set up a local BAME Engagement Collaborative – seeking to bring together all of our local BAME community / charitable organisations, with the ask that this is funded collaboratively by our local statutory sector organisations.

We want to ensure that those local voices and communities are being heard in discussions concerning barriers, so that we can work to prevent the risk of perpetuating inequalities for already disadvantaged groups.

Who we worked with

The achievement so far (and any ongoing achievements) have only been possible through collaborative working with our partner organisations – these include, but are not limited to: Voluntary, Community and Social Enterprise, GP Alliance, Coventry and Warwickshire Partnership Trust, Local Authorities, Public Health, Community Pharmacies, Medicines Optimisation Teams.

The outcome

Coventry and Warwickshire increased the delivery of full annual physical health checks by **44% between Quarter 2 and Quarter 3** of 21/22; at the same rate of increase, Coventry and Warwickshire will hit national targets all round by the end of Quarter 1 22/23.

Patient feedback:

"I really appreciate having this check as has been a while that I've seen someone face to face regarding my mental and physical health"

"I have never had this check before, but I definitely wouldn't mind having this check again next year"

"Thank you for everything you have done. I appreciate all your staff and will always thank the NHS"

"You make me feel motivated in getting my life back on track"

"I feel like you care about me and making me a better person"

"I was surprised that I received a call to come in for this check, especially during COVID, but I'm glad that I did come in"

Engaging with our communities and staff about diabetes education and prevention

What we did

As part of the local NHS response to Covid-19, we have continued to engage with community, voluntary and charity organisations by sharing information about the latest situation regarding primary care and hospital services.

All of our face-to-face community engagement activity across Coventry and Warwickshire was postponed due to the pandemic situation, however, we continued to keep in touch with our community groups through virtual meetings and digital communication.

Who we worked with

We currently have 29 fully trained Diabetes Community Champions from Coventry and Warwickshire, these are local people who have an interest in diabetes and are connected in communities, BAME faith centres and charities.

Despite not being able to meet face to face during 2021-22, we adapted our approach and delivered our workshops and community champions training online to a number of people from south Asian communities, the Carers Trust, Foleshill Women's Training, the Equality Inclusion Partnership in Warwickshire and Ekta-Unity group in Coventry, representatives from Grapevine Coventry and Warwickshire, African and Caribbean representative and the Gypsy and Roma project lead. To make it easier for people to access information, we produced videos and information in different languages.

The Champions have been a positive asset in the community throughout the pandemic situation; they have been our eyes, ears and voice at sharing information in different languages and highlighting the latest advice about the COVID-19 Vaccination programme and local diabetes support services in local groups/networks.

The outcome

The CCG and the Lions Club of Coventry Godiva in partnership organised a Diabetes and Health Awareness Event to support local communities. The event took place on Sunday 14th November 2021 and was held at the Ramgharia Gurdwara, Coventry. This partnership event was supported by Diabetes UK, Pharmacy (Warwickshire)

Fitter Futures and Healthcare professionals from the local hospital Trust.

We undertook diabetes health screening for approximately 200 people and held informative/positive conversations with people about diabetes prevention, awareness, nutrition/healthy eating, exercise and portion control.

This event was publicised on BBC Coventry and Warwickshire radio, Radio Panj and the Sikh Channel TV broadcast. In support of National Diabetes Prevention Week 2021, NHS Coventry and Warwickshire Clinical Commissioning Group and Diabetes UK shared information about raising awareness and prevention of Type 2 Diabetes.

Virtual events for staff highlighted important information about recognising the early signs and symptoms of diabetes and understanding what support is available. Top tips to make healthy lifestyle changes and how to

incorporate exercise into daily activity.

Case study: NHS Covid-19 Vaccination Programme - Engaging with communities and seldom heard groups

The challenge

The Health and Social Care system needed to be assured that Black, Asian and Minority Ethnic Groups (BAME), seldom heard and vulnerable groups were aware of the Covid-19 vaccination programme across Coventry and Warwickshire.

What we did

CCG staff undertook a range of engagement and outreach activity, this was a priority to ensure that local people understand the vaccination programme and what this meant to them and that by having the vaccine was the only protection from Coronavirus.

Our aim was to ensure that we had the latest information/guidance available and especially in different languages which helped to support people when they were invited to have the vaccine. We will be promoting the quality and safety of the vaccine and that it will protect immunity by reducing the coronavirus disease which can now be preventable by the vaccination.

We had a wealth of community networks and links already in place and have established links with local people who were already engaged with the work of the NHS and local authorities across the area.

As a system, outreach work has taken place to engage with people from diverse ethnic groups, including seldom heard and vulnerable groups, to support individuals who are due to receive a vaccine who may have questions about the vaccination process and to encourage testing and social distancing.

We reached out to community leaders, faith leaders, volunteers and community influencers. We held more than 40 virtual events, online briefings and Q&A sessions and spoke to thousands of people from a range of communities and voluntary organisations in Coventry and Warwickshire. Meetings and events have taken place with NHS clinicians, public health consultants, vaccinators, pharmacists and community representatives, all to address clinical questions and concerns to reassure.

Who we worked with

Considerations were put in place, knowing that some of our communities do not speak English and required information in their language. Some did have access to a computer, instead they used a mobile phone to access the internet, it was encouraging to see some community groups participate more confidently in vaccination Q&A sessions that were delivered by GPs/clinicians from their culture/background and in their language, this was having a positive impact about their perception of the vaccination. We worked closely with community groups and voluntary organisations, such as:

- The Equality Group in Coventry
- Coventry Refugee and Asylum Seekers
- Gypsy and Traveller Community
- Carriers of Hope, Coventry
- NHS Diabetes Community Champions
- The Roma Project, Coventry
- Syrian Families in Warwickshire

- Midwives across Coventry and Warwickshire
- Foleshill Women's Training
- Lady Godiva
- Positive Youth Foundation
- Coventry University

The outcome

Co-production of a vaccine video

Healthcare clinicians and community members from the African and Caribbean community took part in the production of a video. The aim of this video was to build confidence and trust with the community so that they can relate, get involved and react positively to the vaccination programme by understanding what goes on behind the scenes of a vaccination clinic. To share their positive experience of having the vaccine and the protection that it offers, Dr Una May Olomolaiye, Faith Marara (Nurse) from Engleton House surgery part in the production.

Community and faith leaders Edward St vaccination pop-up

In depth briefings were provided to faith leaders in order that they can disseminate information to their own communities about a one-day vaccination site in Nuneaton as part of the local response to the variant that developed in India and a potential surge in cases in Nuneaton.

Using messages during prayers and social media including Whatsapp and Facebook, the engagement led to 300 vaccinations being delivered in a specific location of concern.

It has been encouraging to see some community groups participate more confidently in vaccination Q&A sessions that were delivered by clinicians from their culture/background and in their language, and the positive impact this had on their perception of the vaccination.

Crucially, the ability to ask direct questions to NHS professionals has helped increase confidence in services across the board beyond the needs of Covid vaccinations and build further trust in the NHS.

The foundations we have created with our communities in Coventry and Warwickshire will be hugely beneficial in helping us achieve our local objective to tackle health inequalities in the future. One of the key outcomes that has been crucial is creating confidence and empowering people with the right information to help them in making a decision to have the vaccination.

The Positive Youth Foundation saw an increase in confidence with young people having their vaccination.

Case study: Elective Accelerator programme

The challenge

The Elective Accelerator programme has delivered real success in supporting the restoration of patient services across Coventry and Warwickshire. This programme brought together the whole System, building on the relationships formed in responding to the pandemic to work together without organisational barriers and find new ways of delivering services.

The key aim of the Programme was to increase the numbers of patients requiring outpatient appointments, surgery or treatments, thereby reducing our waiting lists and helping people to access care in new ways. Through the dedication and hard work of our staff we have developed new ways of working

which led to significant increases in new and follow up appointments at all three of our acute trusts.

What we did

From the start of the Programme on April 1st to its conclusion on July 31st we delivered a 20% increase in new appointments across Coventry and Warwickshire and a 10% increase in follow up appointments. We also increased the number of procedures we undertook, increasing those who do require a hospital stay by 17% and those patients having a treatment on the same day by 25% over the same time period.

The outcome

All this work has meant a reduction in patients who have been waiting to be seen or for treatment across all three of our acute hospitals, particularly for patients who had been waiting for a long time. Our list of patients who had been waiting for 18 weeks reduced by nearly 10% and those who had been waiting for a procedure for over a year reduced by 21%.

Taking place against a difficult backdrop of rising COVID admissions and increasing pressure on health and care organisations across Coventry and Warwickshire, this achievement was only possible because staff from all areas of the system continued to go above and beyond, working together across the system to support patients to access care in ways we never thought possible before the pandemic. This extends to our private hospitals as well, who have also played an essential part in reducing our waiting lists and supporting the programme.

Our Annual General Meeting (AGM)

A virtual AGM was conducted for our patients, staff, stakeholders and members. The AGM was well advertised via email, on our website and on our social media channels which saw an attendance of over 50 people.

Key areas of work that were highlighted focused on local vaccination programme, access to Primary care during the pandemic and the George Elliott Hospital diabetic foot clinic.

The presentation slides from the day are publicly available on our website and the recording has been shared with those that have requested it.

Working with Healthwatch

This year we have continued to work closely with both local Healthwatch organisations in our area. Healthwatch can act independently to gather local intelligence about what people think of local services. Their feedback and information is a key part of our engagement activity and helps us to ensure we have a solid foundation of evidence and insight prior to undertaking any engagement work. We also meet regularly with both Healthwatch organisations to discuss our work.

Case study - improving health and wellbeing for CCG staff through involvement

The challenge

The CCG have committed to workplace wellbeing programme and are working towards silver accreditation with Thrive at Work. The criteria and guidelines promote employee health and wellbeing in areas such as MSK, mental health and healthy lifestyle. The criteria provide a guide as to what steps can be taken and

gives an indication of where we may need to improve, or where we're doing well.

There is free access to an extensive toolkit and resources, including a dedicated Wellbeing Coordinator from Coventry City Council.

There is evidence to show the clear benefits of this wellbeing programme for both employees and employers. Following confirmed certification of Bronze accreditation, the Wellbeing Warriors along with senior management are working towards strengthening the wellbeing work of the CCG further.

What we did

We continue to use the well-established Wellbeing Warriors group which has representation from teams across all bases, including HR and Comms with oversight from the Associate Director of Corporate Affairs and Governance. There is also a Lay member Wellbeing Lead to support the cascade of information to the Governing Body. This ensures that the wellbeing message is on the agenda at all team meetings and is a standing item at our Staff Forum.

We create a wellbeing programme annually based on staff feedback via a staff wellbeing survey which takes place every 6 months and is also tied into national awareness days. Workshops have included:

- Sleep
- Healthy eating cooking demo
- Personal Safety Awareness
- Meditation
- Yoga
- Mental Health
- Suicide Awareness (clinical lead)
- Agile Working
- Know your Finances inc pensions
- Financial health
- Menopause aligned with healthy eating and mental health

These events help to raise awareness of important issues and give staff time out of their day to have a bit of fun and connect to others, particularly important whilst many of us are working from home or much reduced offices.
We produce an informative and fun wellbeing content for the Staff newsletter with a regular section. The regular survey with staff ensures that the Wellbeing warriors' priorities are still in line with staff needs and public affairs including on-going energy costs.
We continue to ensure the wellbeing agenda supports those working at home and in the office with a move towards hybrid working.

Who we worked with

We have worked closely with a number of other local organisations to take part in this initiative:

- Coventry City Council provided free access to an extensive toolkit and resources.
- Staff In Mind team at Coventry and Warwickshire Partnership NHS Trust also provided us with resources and support for our wellbeing sessions and led on the Suicide awareness session
- Grounds Works and the local Community Police Team have also supported us to implement a healthier workplace.
- Fay Goodman, Lady Samurai talking about self-defence.

The outcome

The latest staff wellbeing survey (Jan 2022) showed:

Of the 80 respondents:

- Two thirds rate their physical health and mental health as good-excellent
- Over half have established a good working routine
- Three quarters believe that the CCG has taken positive action on supporting health and wellbeing
- Almost all are non-smokers/vapers
- Over two thirds drink within the weekly guidelines
- Two thirds eat less than 5 fruit/veg a day
- Almost all are physically active
- Almost half said they have made changes to improve lifestyle behaviours as a result of CCG wellbeing activity

System Wide Health Needs Assessment

A big thank you to all those who completed the Health Need Assessment survey in August and September. This survey was done system wide across Coventry and Warwickshire with all workforces in health and social care.

We received over 800 anonymous responses to the survey and currently the system wide Health and Wellbeing sub-group are reviewing all responses collectively and individually as organisations to gain a better understanding on what information, resources and support our workforce need to feel physically and mentally well.

What you respondents say?

It has been great to hear that a majority of you felt that the organisation you worked for has taken positive action on your health and wellbeing. Majority of you also reported feeling a sense of accomplishment from what you do at work and there were opportunities for you to develop and progress within the organisation.

There are some areas that you have expressed the need for support, additional information, or training. These included:

- Weight loss initiatives
- Improving your sleep
- NHS health checks
- Additionally, it appears that a number of you are not aware of the Health and Wellbeing offers available to you.

The past two years has been a difficult period for all, and this is reflected in the survey responses where a number of you have mentioned that covid has affected your mental health and physical wellbeing.

What next?

We have taken on board the outcome of the health needs assessment and what you have reported. Over the next few months, we will be preparing support covering the above areas, keep a look out for additional information and training sessions being put forward through the ICS to help improve your mental and physical health.

We will continue to promote healthy behaviours within the workplace and give staff opportunities to lead and be involved in health and wellbeing initiatives.

We will also continue to ensure that this Programme is inclusive to all our staff and consideration is given to this for each event/campaign.
As we work towards a hybrid approach

and welcome staff back into offices on a flexible basis, we will continue to tune into the needs of our workforce to ensure they are happy, safe, and healthy.

Internal communications

Following the measures introduced into Internal communications to support staff working from home, these channels are now well established.
This led to finding digital ways to maintain staff wellbeing and keep the sense of community going throughout the organization while supporting transition. It has been important to develop new and digital links with our staff.

A variety of initiatives have been put in place over the past year. The newly branded Coventry and Warwickshire CCG newsletter moved to bi-weekly on a Monday and a Friday and hosts a range of operational, HR, IT and wellbeing information for staff. In addition, we have also hosted online Christmas quizzes to offer informal and social engagement with staff.

Day in the life of…

Running in tandem with these webinars has been a series of informal discussions, where a member of staff talks about their role, and gives a bit of background as to who they are, and their career path which has brought them to the CCG. These “Day in the life of…” sessions have offered a chance to get to know staff members, learn about other aspects of the CCG and start conversations.

Following these weekly sessions, a number of important topics have been highlighted in the workplace such as but not limited to, mental health, anxiety, bereavement and post-natal depression. We actively encourage and have had participants from various senior, junior, and diverse roles across the organisation.

Staff Briefing

Our staff briefing led by Accountable Officer supported by the Executive team took place every fortnightly on Microsoft Teams. This has ensured that staff remain in view of current priorities and challenges within the organization and across the system as the approach to the pandemic fluctuates. This virtual briefing is recorded for those staff not able to attend and staff are encouraged to ask questions with the opportunity to submit questions anonymously via virtual comment box at any time. Staff briefing is well attended with approximately 180-200 staff attending each session.

Viva Insights

Viva Insights is a function available on Microsoft Teams to all CCG staff that enables and supports a work life balance. The function allows staff to set up their core working hours, set up focus time, allows reflection, to send praise to team members and more.
To support the promotion of this function a quick user guide has been designed and shred with all staff along with an online session showcasing the function. Due to popular demand with over 40 staff attending the first section, a second session has been arranged for the coming weeks.

Staff Forum

The Staff Forum was a monthly meeting where representatives of each team come together to discuss opportunities and challenges facing the staff. The Forum has a rotating Chair, so that members were offered the opportunity to lead the meetings should they wish to for experience and development.

The Forum had standing agenda items for health and wellbeing, HR, estates, health and safety and communications and engagement, which ensure staff concerns and feedback are incorporated throughout the organisation.

We asked staff, via the Staff Forum, to volunteer for reviewing HR policies and process. This group was involved in reviewing and revising the HR policies and processes across the organisation to ensure they are fit for purpose, maintain organisational standards, support staff and teams and reduce duplication and confusion. These policies often have significant impact on staff once approved, so having staff involved in their development is vitally important.

The Forum also considered the results of the NHS Staff Survey which our staff are asked to take part in. This is a national survey so that we can get staff's views on what it is like to work for the CCG, which informs local improvements in staff experience and wellbeing. The Forum is also involved in additional ad-hoc surveys depending on service and team needs, for example Wellbeing, Consultation, Communications etc.

Staff Survey

The CCG took part in the National NHS Staff Survey in 2021-22. The survey ran from September – November and we received a 64% response rate.

Reducing Inequality

In this section we demonstrate how we have achieved compliance with the Equality Act 2010 and our duty to reduce inequalities under section 14T of the Health & Social Care Act 2012.

The Equality Act has two broad aspects. Firstly, it prohibits discrimination, harassment, and victimisation against people with one or more of the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage or civil partnership

The Public Sector Equality Duty (PSED) places an obligation on public bodies including the CCG to be proactive in improving equality for people with one or more protected characteristics. It aims to help public authorities avoid discriminatory practices and integrate equality into core business. The PSED (Section 149 of the Equality Act 2010) imposes a duty on public authorities in the exercise of their functions to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic

and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The second part of the Act relates to a specific duty that requires the CCG to publish information showing how we are complying with the PSED when taking decisions and making policies including the impact of policies on both employees and the public, by:

- Preparing and publishing one or more equality objectives
- Publishing information to demonstrate compliance with the PSED including information relating to employees and other persons affected by the CCGs policies and practices who share a relevant protected characteristic.

Our response to the Equality Act

The CCG committed to making sure that equality and inclusion is a priority when planning and commissioning local healthcare, and tackling inequalities is one of our key priorities. To help us do this, we work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs.

To help us achieve this, we have an ongoing programme of equality work, covering all our functions. This is quality assured by the Clinical Quality Governance committee and encompasses the following:

Equality training

All staff undertook Equality, Diversity, and Inclusion training to equip them with the knowledge to give due consideration to Equality, Diversity and Inclusion in all that they do.

Equality Impact Assessments

All policies, strategies, service redesign and newly commissioned services undergo an equality impact assessment. This ensures careful consideration is given to how the change may affect our staff or the local population, particularly in relation to people with protected characteristics. The assessments also help to identify any action we can take to reduce or remove any negative impacts.

Engagement

We have a strong commitment to engagement, and we understand the need to reach out to communities and individuals whose voice may be otherwise unheard.

We have a robust process to record all our engagement activity, ensuring we identify and address priorities or and gaps. We continually engage with the communities we serve to ensure that their views inform our plans and the delivery of services. Examples of this can be found in the case studies within this report.

The Equality Delivery System

The main purpose of the equality delivery system is to help NHS organisations, in discussion with local partners, including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010.

We have worked hard throughout the period to address equality and health inequality across all our commissioning activity to empower our staff and to ensure the best outcomes for all the communities we serve. Many examples of the approaches we have taken are set out within this report.

Equality Objectives
The CCG committed to achieving its equality objectives through a variety of routes, such as patient involvement, stakeholder, and staff engagement.

Our equality objectives were:

1. To further develop our existing relationships with patients and communities and to continue to improve health, transform care and make the best use of our resources.
2. To enhance our engagement work with seldom heard groups, health champions and those with protected characteristics.
3. To further reduce health inequalities by continuing to improve fair and equitable access to healthcare services.
4. To improve and influence parity of esteem for mental health services across the NHS.
5. To maintain a positive workforce culture and empower staff to make considerations for and respond to patients' and communities' needs.

These priorities have been central to our activity throughout the period and there are many examples of the progress we have made within this report. We will more fully set out our progress in our EDS report.

We will review our organisational equality objectives at the earliest opportunity within the Transition process to ensure the new organisation has clear and focused objectives to deliver the greatest benefit to our staff and our communities.

Belonging in the NHS
Our Equality, Diversity & Inclusion sub-group race priorities are aligned to the Regional Race strategy and the High Impact actions: to improve Black, Asian and minority ethnic representation through:

- Recruitment practices at entry-levels i.e., direct from education and community. We are simplifying application processes We have offered 120 Kickstart places that have had a high conversion rate to employment and apprenticeships. Our promotion of nursing and support to nursing careers will target under-represented groups; Our Black, Asian and minority ethnic representation in Bands 1-4 has increased.
- Talent - We are reviewing talent and promotion practices, from a leadership lens and participating in the scope for growth pilot to support this. We have had an increase in senior manager and board representation, and our medical workforce remains above Trust total and local population levels
- We have committed to develop a system-wide race network and will ensure active engagement through active race networks. We recognise the power of networks to influence and make proactive change and will therefore be supporting their ongoing development.

- We have appointed a system Equality, Diversity & Inclusion to support the implementation of Equality, Diversity & Inclusion actions
- We are working with the Leadership Academy to develop and ICS-wide leadership inclusion pilot programme
- With our system race & disability equality dashboard in place, we will now agree ICS system targets.
- We will develop plans to promote equality across all protected characteristics focussing on Disability and LGBTQ+ in 2022/3
- Following our system International Women's Day event, we have committed to developing a system women's network

The Duty to Involve Patients and the Public

As commissioners, we recognised the important connections between engagement, consultation, equality, and health inequalities. It was therefore important for us to ensure that our decision making, particularly when it is likely to impact on patients, carers, and our local communities, is informed by equality analysis and inclusive engagement. We are committed to reducing health inequalities and ensuring that in meeting our duties to engage and consult we work closely with our partners, including the voluntary sector, to hear the 'voices' of protected characteristic and other vulnerable groups.

Employment

We aim to ensure that all of our staff operate in a working environment within which they can excel, develop and do not experience discrimination, harassment and victimisation. We have equality assessed and put in place a broad range of workplace policies to ensure that we are fully inclusive, and staff flourish in achieving their potential without fear of discrimination.

We were also proud to have two active staff led groups, namely Staff Forum, Wellbeing Warriors and the Equality, Diversity and Inclusion Network. These groups do amazing work, championing staff wellbeing across our diverse workforce. They take focused action to promote equality, particularly across minority groups.

Workforce Race Equality Standard (2020/21)

The Workforce Race Equality Standard (WRES) requires NHS organisations to demonstrate progress against nine indicators of workforce equality.

We are fully committed to inclusive workplaces that are free from discrimination where all staff can thrive, and flourish based on their diverse talent. This is evidenced through our organisational values - enacted through our behaviours at all levels, robust recruitment processes; proactive support for team working and wellbeing in the workplace; and active awareness of equality and inclusion requirements embedded within our workplace practices.

We will continue to meet all ED&I reporting requirements as an ICB in accordance with the annual reporting cycle.

Equality Strategy

The CCG has an Equality, Inclusion and Human Rights Strategy setting out the CCG's approach to promoting Equality and Diversity which has guided our work. This strategy will be reviewed during the process transitioning to an Integrated Care Board to ensure we have a clear strategy to integrate quality and diversity across several key areas. We are looking forward to involving staff, stakeholders, and our communities in the development of our new strategy.

Reducing Health Inequalities

Various case studies within this report show how we have worked to reduce health inequalities. Going forward, the Coventry and Warwickshire Health Inequalities Strategic Plan 2022-27 sets out the plan for reducing health inequalities in Coventry and Warwickshire as the Integrated Care System, taking account of the delivery of key elements of the NHS Long Term Plan and the NHS five priority actions for reducing health inequalities.

The overarching aim of the strategic plan is to set out how the health and care sector will directly influence and deliver improvements in health outcomes, and reduce health inequalities experienced by the local population. We will do this by:

- Embedding action to tackle inequalities at both strategic and operational levels as part of our core work
- Recognising that health inequalities can only be reduced by a system-wide approach to population health – and using our influence to achieve positive alignment with strategies and activities linked to the wider determinants of health
- Identifying specifically how the NHS can contribute, in terms of health service delivery and working in partnership with the wider system.

The five priority areas in the NHS Operating Plan have been mapped against our activity and ambitions for reducing health inequalities. These are:

1) Restore NHS services inclusively – we will do this using a Population Health Management (PHM) approach which is a way of working preventatively to help frontline teams understand current health and care needs and predict what local people will need in the future. Population Health Management particularly focuses on wider determinants that influence health and wellbeing outcomes, including housing, employment and education
2) Mitigate against digital exclusion - we support the inclusion of digital skills and the resourcing of a digital inclusion programme as a key enabler in the strategy. This could be strengthened by additional innovation and resources to maximise digital inclusion, access and aspiration.
3) Ensure datasets are complete and timely, understanding barriers to capturing accurate ethnicity data and include regular reporting of inequalities data.
4) Accelerate preventative programmes for example, continuing our long-term conditions work programme and embed and sustain the Thrive at

Work workplace wellbeing programme in the business sector.

5) Strengthen leadership and accountability Create ‘Inequalities Senior Responsible Owner’ roles in each core system organisation and maintain System-wide Health inequalities Task Group.

The infographics on the next two pages show the inequality in life expectancy in Coventry and Warwickshire and the key priorities and focus areas.

Figure 1: A brief overview of inequality in life expectancy in Coventry and Warwickshire.

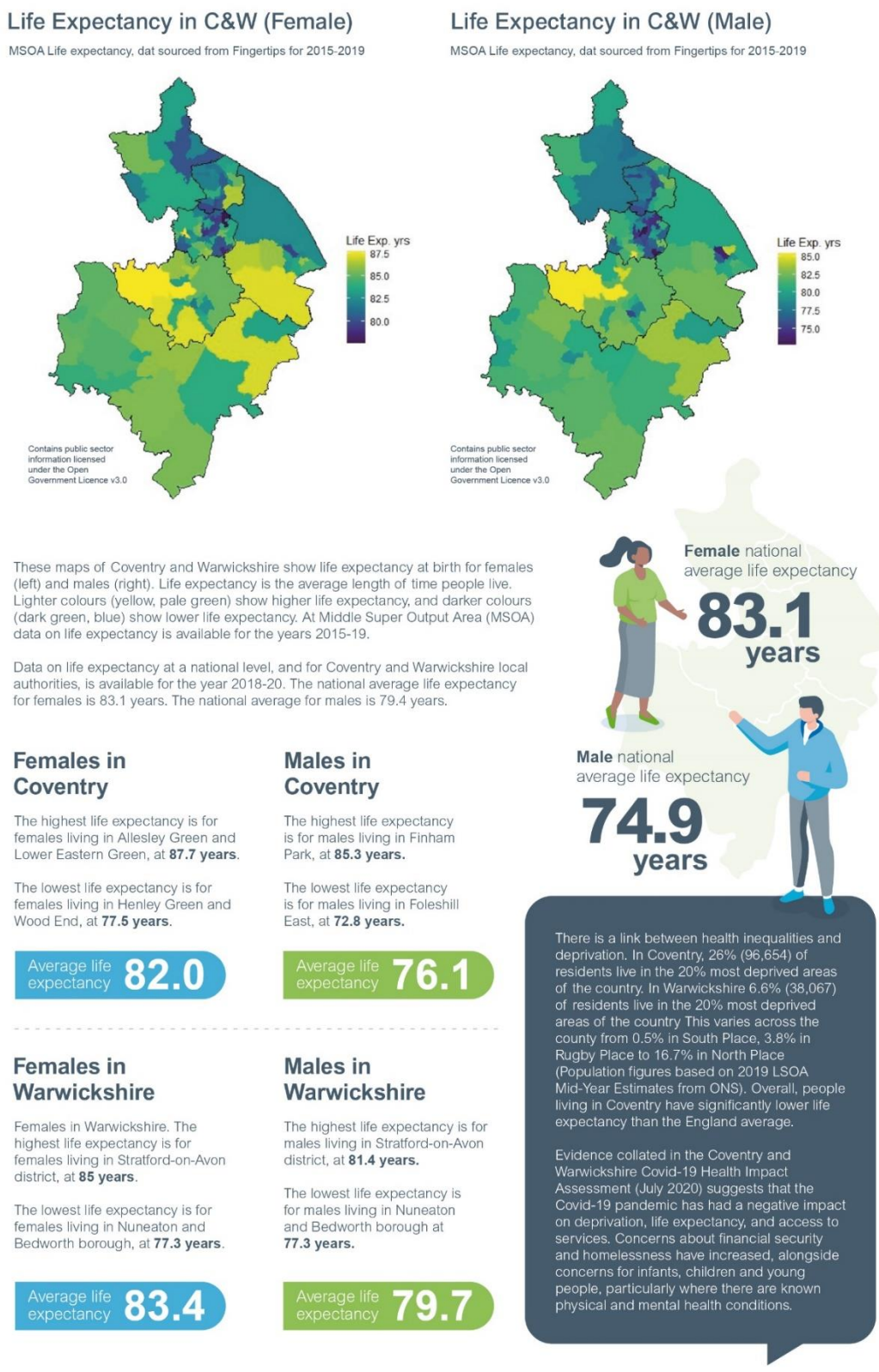


Figure 2: Coventry and Warwickshire's delivery 'plan on a page'.

Improving Quality

How we have achieved our duty to improve quality under section 14R of the Health and Social Care Act 2012

Quality continued to be a golden thread that runs through all we do as a CCG. We expect the delivery of health and care to be consistently safe, effective, personalised and delivered in a way that is well-led, sustainable and addresses inequalities. This means that it consistently enables equality of access, positive experiences, and outcomes for our local population.
The CCG approach was based on three pillars of quality as a means of monitoring services. These include patient safety, clinical effectiveness and patient and carer experience. Nationally, over the last year Clinical Quality Review meetings used by CCGs to hold providers to account, were stood down to allow all NHS staff to respond to the unprecedented challenge associated with the COVID 19 Pandemic. However, preparation for the roll out of National Contract and quality schedules mean the quality team have continued to monitor and triangulate a variety of sources to ensure robust quality monitoring of health and care services, to identify areas of concern. These included serious incidents, complaints, national and local monitoring, clinical outcomes, local intelligence, quality indicators and open an honest dialogue with providers. Where the outcomes were not as expected, the CCG Quality Assurance Framework (QAF) provided a standardised and responsive approach to managing our quality surveillance processes. It supported the assessment of risk and ensured timely investigation, robust action and appropriate support was implemented. Work has been undertaken to prepare for the transition of the CCG to Integrated Care Board (ICB). As part of this a System Quality Group has been implemented in order to start planning and preparation for a system approach to quality.

Incident monitoring of services

The CCG robustly reviews the Serious Incident investigations which each Provider undertake where a patient has suffered harm. The CCG ensure that Providers have taken appropriate, timely actions and ensure that lessons learnt are embedded to reduce the risk of further incidents.
The CCG's Quality Team has an internal assurance process which provides additional analysis and a risk rating process to effectively inform appropriate actions. The process allows for a consistent approach to quality monitoring and highlights early identification of themes and trends.

Safeguarding

The CCG team have worked in conjunction with the Safeguarding Adults Board/Partnership and Children's Partnerships to improve the quality, safety, and efficiency around safeguarding in Primary care and the health system. Using GP funding scheme, most practices in Coventry and Rugby now have Children's Safeguarding Co-ordinators working within them, with practices hosting monthly vulnerable family meetings. There has been a significant uptake by practices in South Warwickshire to attend the voluntary programme, based on the Coventry and Rugby safeguarding coordinator's model. This has now been expanded to now have a rolling Adult

Safeguarding Scheme for Coventry and Rugby Practices to assist with compliance with Care Act (2014) requirement.

The Safeguarding scheme has continued to invest in the Identification and Referral to Improve Safety (IRIS) programme. This programme provides training for Practices to identify and support from Advocate Educators for victims of domestic abuse. In Coventry, most of the GP Practices have signed up to the scheme, with 400 referrals since its inception in June 2018 (2 annually pre-2018). Warwickshire have effectively embedded the IRIS model over the past seven years and have revised the service to streamline support to all health providers. Primary care support remains constant but with a change of title from IRIS Advocate Educators to Domestic abuse advisors for health.
The CCG's safeguarding team have embraced the new way of working to ensure statutory duties are delivered, utilising virtual technology to facilitate safeguarding partnership meetings and training delivery.

NHS England: West Midlands Trauma Vanguard (positive Pathways) September 2021- March 2024:

In August 2021, Coventry and Warwickshire CCG was awarded Vanguard status for the West Midlands via the NHS England Framework for Integrated Care. The Framework developed, named by the children and young people (CYP) as **Positive Pathways**, has been developed in collaboration with young people from across Coventry and Warwickshire as a response to the NHS England/NHS Improvement Long Term Plan (LTP) commitment to provide additional support for the most vulnerable CYP in four targeted areas in our Coventry and Warwickshire system for 10-18 year olds: CYP open to the Youth Justice Team, CYP open to Edge of Care, CYP returning to the community from the Secure estate and CYP who have a school attendance of less than 50%. This funding enables the development of innovative working practices and collaborations that stretch across traditional agency boundaries, promotes genuine integration and co-production. A system trauma mobilisation plan has been developed underpinned by a Trauma Needs Analysis, and is moving at pace to co-produce services from a range of statutory and voluntary agencies (Youth workers, Speech and Language and Occupational Therapy in Youth Justice Teams), developing and curating a universal and targeted Children and Young People's Social Prescribing offer called Positive Pathway that is accessible across the ISC. The ICB Project team are developing robust qualitative and quantitative data sets to capture the efficacy of these new interventions and will share the learning to influence future commissioning intentions. In addition, a suite of asynchronous trauma training assets is in production that will be endorsed by the safeguarding partnership and used across the system to achieve cultural and organisational change, with the aim of developing and enhancing service delivery that promotes safeguarding, seeks to prevent re-traumatisation and enables children and young people who have been disempowered to have their voices heard.

Health Transitions: Post 18 years old Health access App:

Utilising funds from NHS England Safeguarding monies, the CCG have worked in partnership with a partner CCG who have developed a looked after children's leaving care app to revise its

content and bespoke it to assist Coventry and Warwickshire young people to improve their health seeking behaviour. The CCG have commissioned the developer and it will go live and be launched in March 2022.

Primary Care Responsibilities to Looked after Children Guidance (#RADAR):

Children in Care (CiC)/Looked after Children (LAC) are likely to have suffered some form of abuse and harm, and the outset to the exit from care, Primary Care needs to be aware of the child's health needs and how it can respond to address unmet need, be alert to the risk of their vulnerability and proactive information sharing with other agencies. The guidance introduces the #RADAR approach to meeting these vulnerable children's health needs:

- Registration at Practice
- Access records
- Dedicated GP
- Assessment of health needs
- Review of health care plan and referral to meet any of health needs to promote the health needs of children in care.

Nursing and quality

Local Maternity and Neonatal Services

The Coventry and Warwickshire Local Maternity and Neonatal Services (LMNS) was set up to specifically to develop and implement a plan to transform and sustain improvements in maternity and neonatal services. This forms part of the response to the Ockenden reports, to continuously improve the safety of maternity care by learning from incidents and sharing this learning through the LMNS. The core aim is to optimise health outcomes for mothers and babies through the provision of high quality and safe services.

During the final quarter 2021/2022 the LMNS continued to work in collaboration with partner organisations and stakeholders, with full representation from across the system. In the light of the Ockendon 2 report published March 2022 the LMNS terms of reference are being refreshed, with objectives strengthened and ensuring that all the workstreams are fully functional. The provider dashboard has been updated to ensure focused agendas are implemented on a regular basis with "Quality and Safety Deep Dive" helping to deliver our "Better Births" plan.

Saving babies lives audits for quarter four, 2021-2022 has been completed, and all five elements have been implemented. This covers the reduction in smoking during pregnancy, risk assessment and surveillance of fetal growth restriction, raising awareness for reduced fetal movements, effective fetal monitoring during labour and reducing pre-term births.

The LMNS continues its monthly reviews of the compliance data dashboard, with a quarterly deep dive. Through the dashboard we are able to monitor any areas of concerns and where there may be growing trends as well of identifies areas of good practice. The dashboard was revised in the final quarter of 2021/2022 to encapsulate further health and wellbeing aspects and ensure the key data is available in one place.

Work continues with key drivers and

achievements includes the development of co-production of the Equity and Equality Strategy Action Plan with our Maternity Voice Partnership (MVP) This was submitted in September 2022 to address inequalities within the remit of the LMNS work to ensure pregnant women and their families are heard.

Insight visits to each of the providers have now been organised. The purpose of the visits is to provide assurance against the seven IEAs from the Ockenden report. The Insight Visit Team will use an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations are embedded in practice.

The LMNS continues to fund a range of projects across the organisations including the expansion of pre-term clinics, Quantitative Fetal Fibronectin testing and neonatal unit psychologist support provision across the LMNS.

Nursing case study – Leave no doubt

Coventry and Warwickshire CCG in partnership with both Coventry and Warwickshire safeguarding partnerships hosted a conference which was carefully designed to cover some of the most important and sensitive issues surrounding the choices an individual makes, or which may be made on their behalf, when making decisions about their treatment and death. Coventry and Warwickshire Clinical Commissioning group launched a campaign in 2021 entitled ‘Leave no doubt’ in partnership with ‘Compassion in dying’ to raise the awareness of Advance decisions, Advance care planning, Mental Capacity Assessments and Best Interest decisions.

As part of this ongoing campaign everyone is encouraged, whilst they are fit and well, to plan and document their choices and decisions on their treatment and intervention should their life suddenly change. The National experts joined us in presenting at this conference along with many local experts in attendance. Other aspects of the campaign included a poster on the back of multiple buses running across Coventry and Warwickshire for 8 weeks, dissemination of posters and resources form ‘Compassion in dying’ ,and a number of workstreams with our providers and service users. These events and workstreams form part of an ongoing agenda as the CCG transitions to an Integrated Care Board (ICB) on 1 July 2022.

Listening to patients and carers

We are keen to hear feedback from patients, carers and the public about what works well and what can be improved. This feedback takes a number of forms:

The CCG review all comments and complaints about local healthcare services and ensure any themes and trends are highlighted and lessons are learned to strive to improve the services provided to the community.

The CCG monitor how providers manage complaints and any themes and trends identified via their Patient Advice and Liaison Service (PALS).

The CCG triangulates patient experience information with other quality measures to give assurance of the high quality of

care of the services the CCG commissions.

The CCG's Quality Team work closely with the Patient Engagement Team liaising with patients and carers in order to capture what works well, and what works not so well, to endeavour to continually improve services.

When and where appropriate the CCG will approach patients, carers and relatives to capture their experience for learning and sharing as a patient story.

Continuing Healthcare

The Continuing Healthcare Team support a number of clinical functions including discharging patients from hospital, fast track discharge for end of life patients and assessing needs for long term care. The team comprises of clinical and non-clinical staff working together as a care system to assess patients and secure care for those eligible for NHS funding. Working in collaboration with Local Authorities to secure community providers to offer at home and care home placements to meet a wide range of needs.

Restoration of all services from the ongoing effects of the Pandemic has required flexibility and tenacity. Coupled with the CCG's merger in 2021 and the planning for the creation of the ICB in July 22 has been challenging, however, the service has continued to remain safe, effective and has delivered on all key performance and statutory responsibilities:

- NHSE/I Key Performance Indicators
- Completion of significant backlogs related to Court of Protection, Appeals, CHC Reviews
- Projects have included improving patient flow, earlier decisions for long term care needs and supporting new pathways for Stroke patients and home based support
- Alignment of CHC processes (administration and clinical) across the newly merged CCGs from April 2021
- Significant work in contracting to commission additional capacity, assuring provider contracts (589), joint collaborative working with system partners to design and create additional capacity in specialist areas as long term mental health rehabilitation.
- CHC has plans in place to continue to commission safe, quality and value for money service

CHC continues to provide a safe service and there are robust plans in place for continued delivery with associated workforce development as a key priority for the coming year.

Mental Health and Children and Young People in Crisis

This year has seen a push to reduce the number of children and young people (CYP) with mental health or emotional wellbeing issues on our Paediatric wards. This work across all aspects of health and social care has seen the number of children on these wards more than halved, and the average length of time spent on the wards once medically fit for discharge significantly reduced.

The dashboard and the escalation model developed across Coventry and

Warwickshire are both seen as regional best practice and are being adopted by other systems across the Midlands.

Improving infection control in healthcare settings

The Infection Prevention and Control (IPC) team have continued to work across the system collaboratively with local Public Health, Local Authorities and UKHSA to provide a system wide response to Infection control across Coventry and Warwickshire.

The restoration of healthcare associated infections threshold (HCAIs) was reintroduced in July 2021 and further expanded to include the mandatory reporting of other organisms previously reported for surveillance purposes.

The challenges around target reductions particularly Clostridium difficile (C.diff) continue across the systemwide largely due to the impact of the pandemic. The team continue to deliver training across all care homes and have introduced an educational and resource module with an associated accreditation for the homes.

The scheme called “Say no to Infection” encourages the provider to raise infection control standards throughout the home and promotes the development of IPC Champions for who can act as role models for other staff. Work to progress this has continued and feedback from providers remains positive.

Care Homes Quality Assurance

Quarter 1 has seen the quality assurance team supporting quality providers come to full strength with an additional post supporting mental health, learning disability and autism providers across Coventry and Warwickshire.

Face to face quality assurance visits with our colleagues from the Local Authorities are back to pre-covid levels and work to develop updated models of assurance that benefit from the lessons learnt during the pandemic are underway.

Learning Disability and Autism Programme

As part of the system sustainability plan for Learning Disability and Autism, a Coventry and Warwickshire Partnership Trust Executive was appointed as Senior Responsible Officer (SRO) to oversee the operational performance of the Learning Disabilities and Autism Programme. Additional resource has also been enacted to ensure closer system working on admission prevention and effective discharges for autistic people and people with a learning disability in hospital.

We continue to involve people with lived experience of Learning Disabilities and/or Autism across the programme to ensure that each aspect is co-produced. This plays a key part in the work we are undertaking in 2022 – 2023 to set a new, shared vision to ensure a good life for people with a Learning Disability and/or Autism.

Coventry and Warwickshire system partners have approved a Joint All Age Strategy for Autistic People, with annual implementation plans. A system Autism Partnership Board has been developed in Q1, which will oversee delivery of this strategy across the system.

We are undertaking evaluations of our community forensic and intensive support services, which have expanded to include support to autistic people. We are also continuing to commission and implement admission avoidance schemes, which are being evaluated to understand their impact in 2022. Our Dynamic Support Register continues to drive our activity keeping people safe in the community, using a clinically driven process and the clinical tool developed by the national exemplar – Cheshire and Wirral Partnership Foundation Trust. This has enabled us to signpost and support people appropriately when they are at risk of admission to hospital. Alongside this work, we have also strengthened the gatekeeping function for inpatient Mental Health beds to assure all admission avoidance options have been explored prior to admitting somebody to an inpatient bed.

We have carried out Safe and Wellbeing reviews for all people with a Learning Disability and/or Autism in a hospital setting to ensure that they receive safe and effective treatment that promotes wellbeing. Findings have been presented to the ICB's Clinical Quality and Governance Committee and the system Learning Disability and Autism Executive Board. A recommendation is being taken forward to establish a quarterly Safe and Wellbeing Oversight Panel to ensure learning is taken forward to improve the lives of autistic people and of people with a learning disability.

The Coventry and Warwickshire LeDeR annual report 2021 – 2022 has been completed. The report shows the progress towards translating learning to action that has been made through collaboration of health and social care colleagues across the local system. It also outlines the plan to do more to highlight and recognise the best practice that is evident in our local area, whilst striving to further improve provision for people with learning disabilities and autistic people, to reduce inequalities and enable people to live full and healthy lives.

We continued to deliver positive performance for Learning Disability Annual Health Checks, and in Quarter 1 there were 410 Annual Health Checks (AHCs) delivered, compared to 280 in the corresponding quarter of 2021/22. This puts us 277 annual health checks ahead of our Q1 target of 183.

Improving Health Outcomes for People with Learning Disabilities and/or Autism

We have continued to support GP practices to develop sustainable, high-quality approaches to the delivery of annual health checks for patients with learning disabilities. The aim of these checks is to identify undetected health conditions early, ensure the appropriateness of ongoing treatments and promote general health. Working with dedicated nurses and experts by experience, we have improved information, advice and access. This has included embedding the use of co-produced, easy read materials.
Between 1st April - 30th June 2022, 410 annual health checks were delivered across our region, compared to 280 in the corresponding quarter of 2021/22.

Collaborative working across the system has ensured that there has been a high level of uptake of COVID vaccination for people with a Learning Disability.

This was achieved through a range of creative approaches including specialist clinics, the application of a range of

reasonable adjustments, and close monitoring of uptake data.

We have been working with system-wide colleagues to promote the importance of reasonable adjustments, to build the foundations for the future national roll out of the Reasonable Adjustment Flag. We have participated in pilot activity to support the development of local and national systems to support this.

Our local Learning from Lives and Deaths (LeDeR) programme is continuing to find areas of learning, opportunities to improve, and examples of excellent practice.

We have strengthened our local approach to LeDeR through the employment of dedicated reviewers, and as of January 2022, the programme was expanded to review the deaths of autistic people, as well as people with a learning disability or a diagnosis of both. We have implemented a range of actions in response to learning including a programme of carers education sessions on key topics, highlighting and addressing commissioning needs for specific services, promotion of the use of hospital passports and the dissemination of resources to improve application of the Mental Capacity Act. LeDeR is also highlighting areas of excellent practice and high quality, co-ordinated care examples.

Palliative and End of Life Care

The CCG team continued to work closely and supported partners across the system to drive forward improvements in Palliative and End of Life Care.

The ongoing work reflects the national priorities outlined in the NHS Long Term Plan and Ambitions for Palliative and End of Life Care (PEoLC) national framework for local action 2021 – 2026.

The aim is to ensure the needs of people of all ages who are living with dying, death and bereavement, their families, carers and communities, receive personalised care at end of life resulting in a better experience, tailored around what really matters to the person, and more sustainable NHS services.

https://acpopc.csp.org.uk/system/files/documents/2021-05/FINAL_Ambitions-for-Palliative-and-End-of-Life-Care_2nd_edition.pdf

This ambitious and transformative approach to palliative and end of life care over the next five years is to ensure sustainable, responsive, personalised palliative and end of life care for all, irrespective of age, area or setting.

Coventry and Warwickshire were successful in being chosen as one of five early adopters, across the seven regions as part of the NHSE 'Getting to Outstanding programme'. The key deliverables for the six-month project are:

- Fully establish the system wide End of Life Care infrastructure and local leadership
- To agree an overarching end of life care strategy for our local system
- To begin the development of Collaborative commissioning model with our local Hospice market to support our strategic intentions.
- To raise the awareness and profile of end of life and palliative care issues and strategic priorities across our local system

This will form the foundations for our local system commitment to developing an all age, system wide End of Life and Palliative Care Strategy in Coventry and Warwickshire.

This ambitious and transformative approach to palliative and end of life care over the next five years is to ensure sustainable, responsive, personalised palliative and end of life care for all, irrespective of age, area or setting.

Research Quality

Research and innovation are important priorities for CWCCG in carrying out its statutory duty to "promote research and innovation and the use of research evidence in decision making". The CCG achieves this through building and sustaining a research culture through Leadership, partnerships, use of evidence and professional education and development.

The CCG has continued to support research activity and the successful attainment of research funding through its role as host organisation, particularly for Government funded research through the National institute of health research (NIHR). Primary care has been the main area of research activity through Warwick University. The Care Companion project which aimed to develop a web resource for carers to access information and advice received a funding contribution from South Warwickshire CCG.

The CCG also hosts three GP research champions who have a role of supporting the research agenda in primary care. The CCG have also undertaken the role of providing mentorship and support for the Clinical academic Research nurse undertaking a PhD to raise the profile of clinical academic careers across the nursing profession.

A significant amount of research activity is ongoing including work around Stillbirth, Atrial fibrillation, Obstructive sleep apnea, telephone access to primary care for older adults, and the involvement of black and ethnic minority

groups in research.

Over the next three years with the transfer to the ICS focus will be commissioners clearly specifying the research questions that the local health economy need answers to and work that is important locally.

NHS England CCG Oversight Framework

The NHS Oversight Framework, which outlines the joint approach taken to organisational performance monitoring by NHS England and NHS Improvement, was in place in April-June 2022.

The Oversight Framework covers a number of metrics that encompasses five priority areas. These are:

- Quality, access and outcomes (including restoration of elective and cancer services, mental health, emergency care etc);
- Preventing ill health and reducing inequalities (including vaccination and screening, long term conditions and reducing inequalities);
- Leadership and Capability;
- People;
- Finance and the use of resources.

Following the implementation of the Framework, NHSE/I have allocated Trusts and Systems to one of four segments. A Segmentation decision indicates the scale and general nature of support needs, from no specific support (Segment 1) to a requirement for mandated intensive support (Segment 4). In November 2021, Coventry & Warwickshire CCG was allocated to Segment 3 and so will be required to work collaboratively with NHSE/I to undertake a diagnostic stocktake to identify the key drivers of the concerns that need to be resolved.

As we move into becoming an Integrated Care Board, with wider System accountability for performance, the Oversight Framework will be used as the basis for performance assurance across all providers. This will ensure the ICB is not only monitoring to ensure patients are receiving the best outcomes in a timely manner, but also finance, quality, governance and public and patient involvement, to demonstrate the System is meeting its statutory duties.

The Board will also ensure, through the monitoring of the Framework, that improvements are made and transformation projects tracked with the aim of maximising positive outcomes. Given the challenges around the historical nationally set targets and the impact of covid, local trajectories and priorities with the tracking of improvements will be key.

A number of System wide boards have already been implemented to drive these improvements such as the Elective Care Delivery Board, the Cancer Board and the Financial Advisory Board which are attended by all partners of the System. These Boards also monitor the progress against the NHS long term plan and the annual targets and aspirations.

NHS Constitution Targets

The CCG is committed to meeting the requirements outlined within the NHS Constitution and taking action to make improvements where performance is below expectations. These indicators are reported to and monitored through the CCG's Governing Body and its committees.

Due to the continued impact of Coronavirus/COVID-19, Q1 of 2022-23 has seen sustained challenges to people's physical and mental health, and resultant extraordinary pressures on the

NHS and Social Care. This has been compounded by the efforts of the vaccine programme by all delivery pillars (particularly Primary Care), who have delivered over 2 million vaccines to Coventry and Warwickshire residents since the start of the vaccine programme in December 2020.

The NHS has had to continue to adapt to the changing landscape of delivering healthcare, to both meet the needs of patients and minimising the risks of operating within the pandemic. Maintaining COVID safe pathways has remained essential to protect both patients and staff, and to ensure the safe delivery of services. During 1 April – 30 June 2022, the main focus has been on restoration, after a year of reduced activity which saw Cancer and clinically urgent cases prioritised. During the COVID response, elective care waiting lists grew, and every effort has been made to restore these pathways and activity. This has involved all aspects of the System, including looking at how services can be delivered differently and utilising the Independent Sector to support local Acute trusts.

NHS England have been supportive of the programmes of work to increase activity over and above that achieved in 2019-20, pre-pandemic. During 1 April – 30 June 2022, Coventry and Warwickshire built on restoration work which commenced in 2021-22, including projects to support additional theatre sessions, more specialties using Patient Initiated Follow Ups (PIFU), expansion of Advice and Guidance and exploration of digital innovation.

This continues to be delivered against a backdrop of residents and staff recovering from personal losses as a result of the pandemic, the ongoing impact on society and mental health challenges as a result of the events of the previous two years. Staff in primary care, the community and Acute trusts particularly have been delivering under very pressured conditions, with little break.

The delivery of the COVID-19 vaccination programme has been essential for protection of our population, giving the ability for life to open up and to reduce the stresses on hospital and primary care services. Another key step in this was the introduction of an outpatient clinic, delivering neutralising monoclonal antibodies (nMABs) to patients to allow them to stay in their own homes while being treated for the effects of COVID-19.

The overall performance of Coventry and Warwickshire CCG was exceedingly challenged through 2021-22, and this was carried through into Q1 of 2022-23. This is due to the increase in patients waiting for interventions following the reduced capacity during the pandemic. Performance deteriorated further as referrals increased, and patients waiting the longest were prioritised. The result of this has been a reduction in the longest waiters, but an overall growth in the waiting list. The waiting list has continued to grow, however since achieving zero 104 week waits at our System providers, we are now looking to eliminate all patients waiting longer than 78 weeks for treatment.

The CCG's principal aim is always to achieve the best outcomes for our patients, and working to innovate at a fast pace to support our population. However, we do have to also focus on finance and making sure each Coventry and Warwickshire pound spent is used to bring maximum benefit.

2021-22 arrangements were supported by additional government funding to reflect the on-going impact of COVID-19. 2022-23 represents a critical period for recovery of NHS services and finances. ICSs are expected to work across their partner organisations to produce plans that consider alignment between CCGs and providers, and between activity, workforce and finances.

As we rise to the challenge of restoring services, meeting the new care demands and reducing the care back logs that are a direct consequence of the pandemic, we know that it has also taken its toll on our people. By supporting staff recovery, their health and wellbeing and improving workforce supply we can restore services in a sustainable way.

The pandemic has shone a brighter light on health inequalities. We will need to take further steps to develop population health management approaches that address inequalities in access, experience and outcomes, working with local partners across health, social care, and beyond.

To achieve these goals, while restoring services and recovering backlogs, will require us to do things differently, accelerating delivery against and redoubling our commitment to strategic goals we all agreed in the Long-Term Plan (LTP).

Work progressed well through 2021-22, and into Q1 2022-23, to reshape the local System into a full Integrated Care System. Providers and the CCG worked together to make this national reorganisation effective for our population and improve health outcomes. Primary Care Networks continue to be a key part of delivering this plan, working at Place with health and social care providers to address health inequalities at a local level.

Key Performance Indicators (KPIs) have adapted into Q1 of 2022/23, in line with the new Operational Standard which have been designed to support recovery and be reflective of the position of the NHS nationally, due to the impact of COVID-19. This has re-prioritised standards to ensure effective emergency care services, focus on provision for cancer and clinically urgent cases, and priority on maintaining safe access to primary care. There have also been developments of how we measure key standards, such as the introduction of closer monitoring of patients waiting more than 78 weeks for routine treatment, as the waiting list has grown.

Key KPIs for 2022-23 include closer monitoring of the backlog of elective care cases, ensuring patients are treated in the right place at the right time and helping people manage their mental health following the last two, very difficult, years of the pandemic.

As a System, the coming year will be focussed on embedding processes into the Integrated Care System and developing further the services introduced to best manage the effects of the COVID-19 pandemic, but which now suit the changing lifestyles of our population. This includes virtual appointments where appropriate, improved discharge pathways and delivery of healthcare programmes, such as vaccination, closer to patient's homes.

Performance has been less than the NHS Constitutional standard across most metrics, both locally and nationally, due to the ongoing impacts of the pandemic. However, we have seen areas of improvement in:

- Referral to Treatment (RTT) – There has been an in-year improvement in the number of patients waiting over 104 weeks and 52 weeks for treatment and also the percentage seen within 18 weeks has increased.
- Diagnostics Wait Times – The CCG is currently one of the best performing CCGs in England against the percentage of diagnostics that take place within 6 weeks of referral.
- Annual Health Checks for patients with a Severe Mental Illness – while the CCG is performing significantly below the national standard, there have been significant improvements made in-year, and the CCG expects to continue this improvement throughout 2022-23.

Achievements against the NHS Constitution for Quarter 1 (1 April – 30 June 2022) are outlined in the sections below, as are the actions that have been taken during this period. Unless otherwise stated the indicator is at CCG level.

Cancer waiting times

Cancer waits – 2 weeks wait	Target	Q1 22/23
Maximum 2-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	83.2%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	88.9%
Cancer waits – 31 days wait	**Target**	**Q1 22/23**
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	96%	95.1%
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	91.8%
Maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	98%	99.5%
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	90.5%
Cancer waits – 62 days wait	**Target**	**Q1 22/23**
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	85%	54.7%
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	69.4%
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	85%	74.0%

Referral to Treatment Times (RTT) – Incomplete

Referral to treatment (RTT) waiting times for non-urgent	Target	Q1 22/23
RTT- Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	61.9%

Diagnostic Waiting Times

Diagnostic waiting times	Target	Q1 22/23
Diagnostic tests - patients waiting no longer than 6 weeks from referral	<1%	8.4%

A&E Waiting Times

A&E waiting times	Target	Q1 22/23
A&E waits - Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	70.4%

Improving Access to Psychological Therapies (IAPT)

IAPT	Target	May-22
IAPT 6 weeks - Finished Treatment:	75%	90.0%
IAPT 18 weeks - Finished Treatment:	95%	100.0%
IAPT Access Rate (annualised):	25%	18.6%
IAPT Recovery Rate:	50%	50.0%

Activity Figures

Point of Delivery	2020-21	2021-22	22-23 Forecast from Q1	% Change from 2019/20 (pre-pandemic)
GP Referrals	120,276	185,558	192,836	-6%
A&E Attendances	263,094	382,908	426,792	6%
Electives (Planned Admissions)	92,945	126,631	139,500	3%
Non-Electives (Emergency Admissions)	107,842	121,912	148,880	31%
First Outpatient Attendances	367,980	493,104	632,080	28%

*1st Outpatient Attendances: AQP figures now included -not previously reported

Financial Performance

CCGs have several financial duties under the National Health Service Act 2006 (as amended). NHS Coventry and Warwickshire CCG's performance against these financial duties during 1 April – 30 June 2022 is shown in the table below:

	2021-22 Target £000	2021-22 Performance £000	2021-22 Duty Achieved Yes/No	Notes
STATUTORY DUTIES				
Expenditure not to exceed income	457,591	457,591	YES	Income has not exceeded expenditure for the financial year.
Capital resource use does not exceed the amount specified in Directions	n/a	n/a	n/a	The CCG has achieved the capital resource target.
Revenue resource use does not exceed the amount specified in Directions	455,592	455,592	YES	The CCG has achieved its Statutory Duties
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	n/a	n/a	n/a	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	n/a	n/a	n/a	
Revenue administration resource use does not exceed the amount specified in Directions	4,655	4,655	YES	The CCG has remained within the running cost allocation target.
NON-STATUTORY DUTIES				
Better Payment Practice Code - NHS	95.00%	99.98%	YES	The CCG has also achieved its Non-Statutory Duties in 21/22, exceeding the 95% target for NHS and Non-NHS payment of invoices.
Better Payment Practice Code - Non-NHS	95.00%	99.32%	YES	
Efficiency of cash - closing bank balance to be no greater than 1.25% of monthly drawdown	1,615	15	YES	Month end cash balance was managed below the statutory target.

Sustainable Development

The CCG continued to drive sustainability improvements on both a day-to-day basis and at a strategic level. All members of our organisation are reminded to think about the environmental impact of all they do – whether it be printing documents through to travelling to meetings. Increasing use of video conferencing has helped to prevent unnecessary journeys.

The CCG operated out of shared buildings with several other organisations using the same facilities. This means that information on CCG use of energy, water, carbon footprint or waste and recycling is not available for reporting purposes.

Primary Care Estate

Ensuring that we have a general practice estate portfolio which is able to meet the needs of the growing population of Coventry and Warwickshire is a key strategic aim for the CCG. The portfolio needs to be modern and efficient, as well as being suitably located to match the main areas of population growth across our geography. Sustainable development is, and will remain, an important consideration for the CCG when commissioning new GP premises developments or agreeing support for GP premises improvements. The CCG encourages compliance with Health Building Notes which provide best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities, including on the main issues relating to sustainability and energy efficiency that should be addressed throughout a building's life. Relevant development schemes are required to use the BREEAM Healthcare methodology to demonstrate that they are built with sustainability in mind.

Emergency Preparedness, Resilience and Response (EPRR)

Coventry and Warwickshire CCG continued to be an active partner in both NHS and multi-agency Emergency Planning, Resilience, Response (EPRR) across Coventry and Warwickshire and the wider West Midlands and is a member of the Local Health Resilience Partnership. The CCG was classed as a category 2 responder under the Civil Contingencies Act (CCA 2005) however the transition to an ICS in July 2022 saw this newly formed body become a Cat 1 responder under the CCA, which requires a clear set of duties required under the CCA are undertaken. The CCG is ready to ensure this transition into a Cat 1 responder and its required duties are in place and actioned prior to the July completion.

Coventry and Warwickshire CCG regularly reviewed and made improvements to its EPRR plans and documents, ensuring its major incident plan is current and is exercised in accordance with the current NHSEI EPRR Framework (2015) whilst awaiting the latest 2022 version. The results were reported to the CCG's Clinical Quality and Governance Committee. The CCG also participated in multi-agency partner/s exercises and, along with the Trusts EPRR planners it provides an on-call Incident management training for all on call Health Directors/Managers across Coventry and Warwickshire.

The CCG has an out of hours on call system, whereupon a CCG Director (and admin if required) was on call providing support to all Health partners across Coventry and Warwickshire 24/7, with out of hours being classed as 5pm – 8am and weekends/Bank holidays. This is maintained and facilitated by the CCG Resilience team utilising the Pageone telecommunications system.

Coventry and Warwickshire CCG undertook the 2021 NHSEI EPRR Core standards process during the Pandemic response. The CCG assessed itself as fully compliant for this process and submitted this full compliance along with the Coventry and Warwickshire providers.

NHSEI undertook a full check and challenge process across the West Midlands on all submissions and due to concerns around delivery of the Mass discharge plans during current pressures due to Covid response, NHSEI asked a large majority of those who submitted full compliance to review and accept a 'Substantial submission' (80-90% compliance) with a view to supporting and improving these areas once a new normal way of EPRR working returns (cessation of major Covid responses). Upon review and consultation this was accepted by Coventry and Warwickshire's Accountable Emergency Officer (AEO) and submitted a 'Substantial' return for the 2021 Core standards.

The 2022 Core standards process is expected in July 2022 when the CCG has transitioned to an ICB.

Coventry and Warwickshire CCG continued to take a lead role in the Pandemic response, which reduced to a level 3 classed incident. This continued to involve all staff in a variety of roles in a variety of locations, including working from home. The CCG led on numerous response phases during the Pandemic such as the Vaccination programme, the Covid 19 Testing programme and supporting the GP responses and continues to support all UK Health Security Agency (UKHSA) and Local Resilience Forum (LRF) partners also. The CCG continued to staff and maintain an Incident Control Centre (since March 2020), which returned back to 5 days a week after being at 7day staffing for a long period.

The CCG is also playing a major part in planning for the 2022 Commonwealth games, with daily reports and calls with NHSEI beginning in July 2022.

ACCOUNTABILITY REPORT

Accountability Report

This statement has been prepared in accordance with the requirements set out in the Department of Health's Group Accounting Manual 2022-23.

Phil Johns

Chief Executive , Integrated Care Board

Previously Accountable Officer, NHS Coventry and Warwickshire Clinical Commissioning Group

13 July 2023

Corporate Governance Report

The Corporate Governance Report comprises the Members' Report which contains details of our CCG membership practices, membership of the Governing Body and committees and information on the register of interests. It also contains the Statement of Accountable Officer's Responsibilities and the Governance Statement.

Members Report

The CCG was a membership organisation comprised of 120 Practices. The Membership is divided into 19 Primary Care Networks split across Coventry, Rugby, South Warwickshire, and Warwickshire North. The Networks are represented on the Governing Body by elected Clinical Leads. The Clinical Leads engage with their members to ensure that members' views are represented in Governing Body meetings. The Member Practices of the CCG are listed below:

Coventry - 50 Practices over 8 Primary Care Networks	
Code	**Practice**
M84012	Park Leys Medical Practice
M86008	The Gables Medicentre
M86018	Moseley Avenue Surgery
M86021	Springfield Medical Practice
M86039	Allesley Village Surgery
M86622	Govind Health Centre
M86605	Limbrick Wood
M86006	Jubilee Healthcare
M86010	Forrest Medical Centre
M86019	Westwood Medical Centre
M86034	Woodside Medical Centre
M86030	Kensington Road Surgery
M86009	Engleton House Surgery
M86004	Allesley Park Medical Centre
M86029	Broomfield Park Medical Centre
M86624	Coventry GP Group of Practices
M86003	Sky Blue Medical Group
M86038	Bredon Avenue Surgery
M86037	Quinton Park Medical Centre
M86005	Hillfields - Dr Sani
M86012	Priory Gate Practice
M86617	Hillfields- Dr Bano
M86016	Godiva Group of Practices
M86045	Paradise Medical Centre
M86041	Clay Lane Medical Practice
Y00060	Anchor Centre
Y00996	The Meridian
Y04965	ATP at Foleshill
M86028	Central Medical Centre
M86048	Windmill Surgery

M86002	Longford Primary Care Centre
M86612	George Eliot Medical Centre
M86007	Phoenix Family Care
M86044	Park House Surgery
M86627	Stoke Aldermoor Medical Centre
M86638	Woodway Medical Centre
M86015	Kenyon Medical Centres
M86017	Mansfield Medical Centre
M86001	Willenhall Primary Care Centre 1
M86033	Willenhall Oak Surgery
M86046	Copsewood Medical Centre
M86014	The Forum Health Centre
M86020	Wood End Health Centre
M86035	Henley Green Medical Centre
M86040	Walsgrave Health Centre
Y00140	Torcross Medical Centre
M86027	Cheylesmore Surgery
M86032	Holbrooks Health Team
M86610	St Georges Road Surgery
M86633	Edgwick Medical Centre

Rugby - 12 Practices over 1 Primary Care Network	
Code	**Practice**
M84065	Beech Tree Medical Practice
M84067	Bennfield Medical Centre
M84616	Brookside Surgery
M84023	Central Surgery
M84020	Clifton Road Surgery
M84046	Dunchurch Surgery
M84050	Market Quarter Medical Practice
M84031	Revel Surgery
M84035	Westside Medical Centre
M84004	Whitehall Medical Practice
M84016	Wolston Surgery
Y06218	Brownsover Surgery

South Warwickshire – 32 Practices over 7 Primary Care Networks	
Code	**Practice**
M84049	Alcester Health Centre
M84069	Budbrooke Medical Centre
M84024	Henley in Arden Medical Centre
M84620	Lapworth Surgery
M84047	Tanworth in Arden medical Centre
M84060	The Arrow Surgery
M84002	The Pool Medical Centre
M84044	Harbury Surgery
M84062	Kineton Surgery
M84026	Southam Surgery
M84629	St Wulstan Surgery
M84009	Fenny Compton Surgery
M84017	Clarendon Lodge
M84029	Cubbington
M84040	Sherbourne
M84032	Waterside
M84015	Croft Medical Centre
M84059	Spa Medical Centre
M84070	Warwick Gates Family Health Centre
M84064	Whitnash Medical Centre
M84014	Bridge House Medical Centre
M84018	Bidford on Avon Health Centre
M84021	Rother House medical Centre
M84043	Trinity Court Surgery
M84030	Hastings House
M84066	Meon Medical Centre
M84025	Shipston Medical Centre
M84036	Abbey Medical Centre
M84010	Avonside Health Centre
M84028	Priory Medical Centre
M84013	The Castle Medical Centre
M84063	Chase Meadow Health Centre

Warwickshire North – 25 Practices over 5 Primary Care Networks	
Code	**Practice**
M84003	Arbury Medical Centre
M84005	Chapel End Surgery
M84022	Manor Court Surgery
M84037	The Grange Medical Centre
M84055	Stockingford Medical Centre
Y04969	Camp Hill GP Led Health Centre
M84006	Pear Tree Surgery
M84007	Dordon and Polesworth Group
M84042	Hazelwood Group Practice
Y04884	Satis House Medical Practice
M84008	Spring Hill Medical Centre
M84019	Atherstone Surgery
M84612	Station Street Surgery
M84615	Chancery Lane Surgery
M84011	Bedworth Health Centre
M84034	Whitestone Surgery
M84061	Bulkington Surgery
M84609	Woodlands Surgery
M84618	Rugby Road Surgery
M84627	The Old Cole House Surgery
M84001	Red Roofs Surgery
M84041	Riversley Road Surgery
M84051	Old Mill Surgery
M84621	Queens Road Surgery
Y04882	The Chaucers Surgery
Y07274	St Nicholas Medical Centre

Composition of Governing Body

During 1 April to 30 June 2022, the CCG was led by Dr Sarah Raistrick as Chair and Phil Johns as Accountable Officer. The Chairs and Accountable Officers were supported by the CCG Governing Body and Executive Team.

Membership of the Governing Body, established in accordance with statutory requirements, is detailed below. The Annual report was signed on behalf of NHS Coventry and Warwickshire ICB by Phil Johns who became Chief Executive on 1 July 2022.

Role	Name
Chair	Sarah Raistrick
Accountable Officer	Phil Johns
Interim Chief Finance Officer	Adrian Stokes
Chief Nursing Officer	Jo Galloway
Lay Member – Governance and Audit	Richard Percival
Lay Member	Ghulam Vohra
Lay Member	Zubair Khan
Practice Member (Coventry)	Deepika Yadav
Practice Member (Rugby)	Jonathan Menon
Practice Member (South Warwickshire)	Sukhi Dhesi
Practice Member (Warwickshire North)	Arshad Khan
Secondary Care Consultant	Colette Marshall
Registered Nurse	Elaine Strachan-Hall
Chief Officer Performance and Delivery (non-voting)	Ali Cartwright
Public Health Representative (Coventry) (non-voting)	Dr Allison Duggal

Public Health Representative (Warwickshire) (non-voting)	Shade Agboola

Committees, including Audit Committee

The CCG established six committees to support the Governing Body in setting and monitoring the overall strategic direction of the CCG. The committees are responsible for reporting to the Governing Body on the most important areas of our business.

Committee	Role
Audit Committee	The Audit Committee played a crucial role in the governance of the CCG, reporting on the relevance and rigour of the underlying structures and processes and on the assurances that the Governing Body receives and scrutinising the risks and controls of the CCG, whilst also maintaining a focus on finance and financial management. Members of the Audit Committee during the period included: Ghulam Vohra, Richard Percival and Elaine Strachan-Hall. Full membership of the Committee can be found in Appendix 1.
Remuneration Committee	This committee made decisions on the process for remuneration and appointment of Governing Body Members. Details of the membership of the Remuneration Committee are included in the Remuneration Report on page 112.
Clinical Quality and Governance Committee	This committee reviewed and monitored matters relating to the safety and quality of commissioned services, safeguarding, incident reporting, public involvement and consultation, equality, corporate governance, and information governance.
Finance and Performance Committee	This committee scrutinised, monitored, and challenged commissioning, finance and performance risks and issues throughout the period.
Individual Funding Request Panel	The panel made formal decisions on individual funding requests from patients on behalf of the CCG.

Committee	Role
Primary Care Commissioning Committee	The membership for this Committee is drawn from both the CCG and NHS England and includes representatives from our Member practices and considered issues and performance relating to commissioning of Primary Care (GP) services.

Register of Interests

A conflict of interest occurs:

- Where an individual's ability to exercise judgement or act in one role is or could be impaired or otherwise influenced by his/her involvement in another role/relationship. The individual does not need to exploit his/her position or obtain an actual benefit, financial or otherwise.
- Where there is a potential for competing interests and/or a perception of impaired judgement or undue influence.

Conflicts can arise from:

- Indirect financial interest.
- Non-financial interest i.e., kudos/reputation
- Professional/personal relationships with others.
- Conflicts of loyalty may also arise e.g., in respect of an organisation of which the individual is a member or has an affiliation.

The CCG ensures that all member practices and all individuals who hold positions of authority or who can make, or influence decisions are in a position whereby:

- It is clear to everyone from the outset that they have this interest through the Public Register of Interest.
- Systems and processes ensure that at any time in discussions or proceedings where an individual feels that their interest maybe relevant, they have a mechanism for declaring this so that any comments they make are fully understood by all others to be within that context.
- Where this conflict could have a material interest on any decision or process, the individual will play no part in influencing or making the relevant decision. This will be absolutely essential in instances where the individual or interest they represent may derive financial gain from the decision.

Declared interests are recorded in the CCG's Register of Interests which is published on their website.

Personal Data Related Incidents

The CCG submitted a satisfactory level of compliance (Standards Met) with the Data Security and Protection Toolkit assessment by 31 March 2022.

During the period 1 April – 30 June 2022 there have been no serious incidents relating to data security breaches.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

NHS Coventry and Warwickshire CCG fully support the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2022 is published on our website.

Statement of Accountable Officer's Responsibilities

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

NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Coventry and Warwickshire CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the CCG 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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction).
- For safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money.
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)).
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Ernst and Young LLP auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

To the best of my knowledge and belief I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money, and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Phil Johns

Chief Executive, Integrated Care Board

Previously Accountable Officer, NHS Coventry and Warwickshire Clinical Commissioning Group

13 July 2023

Governance Statement

Introduction and context

NHS Coventry and Warwickshire Clinical Commissioning Group (CCG) was a corporate body established by NHS England on 1 April 2021 under the National Health Service Act 2006 (as amended) following the merger of NHS Coventry and Rugby CCG, NHS South Warwickshire CCG and NHS Warwickshire North CCG.

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, in particular, 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.

Between 1 April 2022 and 30 June 2022, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The systems in place as described in this Governance Statement have been in place for the whole of the period.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Accountable Officer Appointment Letter. I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

UK Corporate Governance Code

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

This Governance Statement is intended to demonstrate how the CCG has had regard to the principles set out in the Code considered appropriate for CCGs for the period 1 April 2022-30 June 2022.

The CCG Governance Framework

The governance framework that the CCG has established is set out in the Constitution. The Constitution emphasises the importance of good governance and states that the CCG will at all times, observe generally accepted principles of good governance. These include:

- Adopting CCG values that include standards of propriety in relation to the stewardship of public funds, impartiality, integrity and objectivity
- The Good Governance Standard for Public Services;
- the standards of behaviour published by the Committee on

Standards in Public Life (1995) known as the 'Nolan Principles';
- the seven key principles of the NHS Constitution;
- relevant legislation including such as the Equality Act 2010; and
- the standards set out in the Professional Standard Authority's guidance 'Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England'.

Governance Arrangements and Effectiveness

The main function of the Governing Body was to ensure that the CCG had made appropriate arrangements for exercising its functions effectively, efficiently and economically and complies with generally accepted principles of good governance as are relevant to it. Details of how this has been achieved are set out in this governance statement.

The Scheme of Delegation sets out the responsibilities reserved for the Membership and those delegated to the Governing Body.

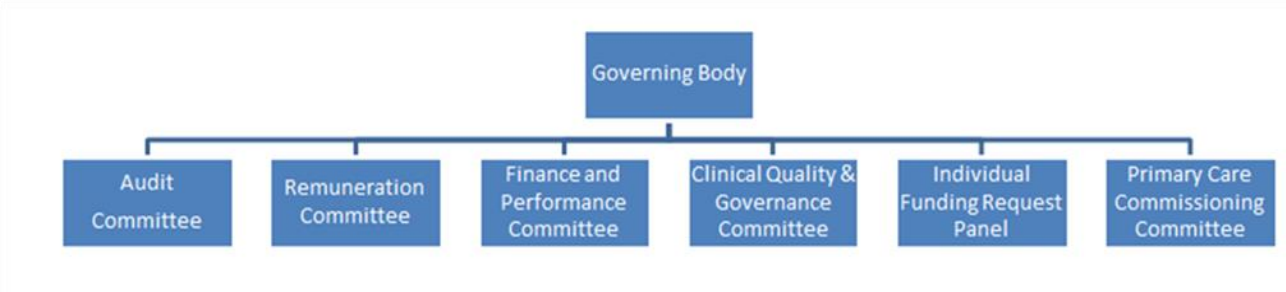
The prime financial policies were part of the CCG's control environment for managing the CCG's financial affairs. These policies contribute to good corporate governance, internal control and the management of risk. They also enable sound administration, reduce the risk of irregularities and support the commissioning and delivery of effective, efficient and economical services. Importantly, they also support me, as Accountable Officer, to effectively discharge my responsibilities.

The CCG had in place a Managing Conflicts of Interest Policy which complies with revised statutory guidance for CCGs published by NHS England in July 2017.

This policy ensured that conflicts of interest were managed in a way that cannot undermine the probity and accountability of the organisation. Any breaches of this policy are published on the CCG's website. During the period, there have been no breaches of the Conflicts of Interest Policy.

The CCG maintained a Register of Interests and a Register of Procurement Decisions which are published on the CCG website.

The CCG had a Gifts and Hospitality Policy which provides guidance to all member practices, staff and Governing Body members on the receipt of gifts and hospitality. The CCG maintained gifts and hospitality and commercial sponsorship registers which have been reviewed by the Audit Committee and are published on the CCG website.



Governing Body and Committee Structure

The CCG had six committees that report to the Governing Body. Membership of the Governing Body and the committees is detailed in the Members Report.

The Governing Body has an ongoing role in reviewing the governance arrangements to ensure that the CCG continued to reflect the principles of good governance. The Governing Body meets in public and publishes its Board papers, agenda and minutes on the CCG's website.

The Governing Body consisted of a Chair, who is a GP, 4 GPs representing the 4 Places of the CCG, Accountable Officer, Chief Finance Officer, Registered Nurse, Secondary Care Specialist and three Lay Members. Coventry City Council and Warwickshire County Council's Directors of Public Health also attend the Governing Body.

From April – June 2022 there have been no changes to the Governing Body membership.

In accordance with the Constitution, the Governing Body is required to meet on a regular basis, at least six times per year (and no more than two months apart).

From 1 April to 30 June 2022, the Governing Body held two meetings in public. These have been held virtually.

The agendas for the Governing Body meetings have been focused on the key areas of Quality and Safety; Strategy and Planning; Performance, Finance and Governance.

During April to June 2022, the Governing Body held one development session focussing on key developments for the CCG. The sessions were aimed at ensuring that members are equipped to deal with challenges that the CCG faces.

Committees of the Governing Body

The Governing Body is supported in fulfilling its duties by six Committees that have been formally established and given delegated authority to act on its behalf. Outlined below is a summary of the role of each committee and the contribution they made during the year to date. The full Terms of Reference of the Committees are contained within the CCG's Constitution which is published on the CCG's website at

https://coventrywarwickshireccg.nhs.uk/.

Attendance at the committees was recorded in the minutes of each meeting and appeared in the Members' Report of the Annual Report. Any declarations of any conflicts of interest were made at the start of each meeting. Each committee reported to the Governing Body highlighting matters which needed attention and summarising the work undertaken.

The committee arrangements were kept under regular review and all changes to Committee remit or terms of reference have been incorporated within our Constitution or Governance Handbook as applicable.

Audit Committee

The Audit Committee played a crucial role in the governance of the CCG. It was chaired by the Lay Member for Audit and Governance, and reports on the relevance and rigour of the underlying structures and processes in place. The committee monitored the assurances that the Governing Body received and scrutinised the risks and controls of the CCG, whilst maintaining a focus on finance and financial management. In undertaking this role, the Committee received reports and updates from our Internal and External Auditors, the Local Counter-Fraud Officer and Security Management Lead.

The Committee could, where required, request legal and other independent professional advice.

During April to June 2022, the Committee has met twice to: approve the Annual Report and Accounts for the predecessor CCG (including the governance statement) for 2021-22; approve the letter of representation for 2021-22; receive the external audit ISA 260 reports for 2021-22; receive the Section 30 reports for 2021-22; receive the Head of Internal Audit's Opinions for 2021-22; receive individual internal audit reports and progress reports from our internal and external auditors and the Commissioning Support Unit Service Auditor report; review the Assurance Framework; review the gifts and hospitality register; review losses, compensations and write-offs.

Finance and Performance Committee

The Finance and Performance Committee was chaired by a Lay Member. The Committee scrutinised, monitored and challenged on commissioning, finance and performance issues. In undertaking this role, the Committee; scrutinised reports on financial performance and risks; key performance indicators; progress against recovery action plans and reviews commissioning plans and policies.

The work of the Committee has included: oversight of the CCG's performance in relation to the agreed financial plan; review of performance against the NHS Constitution and other standards; recommendations to the Governing Body when appropriate and review of commissioning policies.

Clinical Quality and Governance Committee

The Clinical Quality and Governance Committee was chaired by a Lay Member. The Chair reviewed and scrutinised matters relating to the safety and quality of commissioned and in-house services, safeguarding, incident reporting, public involvement and consultation, equality, corporate governance and information governance. The Committee sought to provide assurance to the Governing Body that commissioned and in-house services are being delivered to the right quality and in a safe manner, ensuring that quality sits at the heart of everything the CCG does. The work undertaken by the Committee has included: patient quality and safety assurance in provider trusts; never events; mortality rates; emergency planning activities; patient feedback; safeguarding updates and reconfirmation of responsibilities; reports from external bodies; complaints; review of the Information Governance policies and

compliance; regular review of the corporate risk register.

Remuneration Committee

The Remuneration Committee was chaired by a Lay Member and made recommendations to the Governing Body on determinations about the remuneration, payment for additional responsibilities, other benefits and conditions of service of the senior management team, including clinical leads.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee (PCCC) was the corporate decision-making body for the management of the delegated functions and the exercise of delegated powers for the geographical area covered by the CCG. The Committee was chaired by a Lay Member.

Individual Funding Request Panel

The Individual Funding Request (IFR) panel considered requests for funding for treatments, therapies, drugs and equipment not routinely funded by the CCG or covered by current contractual arrangements. The panel followed the IFR policy guidance to arrive at consistent and informed decisions based on whether exceptionality has been demonstrated for each case considered. The panel also identified potential service developments where a request was clearly not exceptional but relates to a cohort of patients.

Joint and Collaborative Commissioning Arrangements

In addition to the formal committees of the Governing Body, the CCG had a number of joint and collaborative commissioning arrangements in place with local CCGs and the local authority. Collaborative commissioning arrangements were in place for the period, the main ones of which were with NHS Sandwell and West Birmingham CCG and Warwickshire County Council and Coventry City Council. There are also formal arrangements in place for working with other partner organisations.

Discharge of Statutory Functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation. In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations.

As a result, I can confirm that the CCG was clear about the legislative requirements associated with each of the statutory functions for which it was responsible, including any restrictions on delegation of those functions.

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

Risk Management Arrangements and Effectiveness

The CCG had a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives.

Risk management within the CCG was underpinned by four interlocking systems of internal control namely the:

- Assurance Framework.
- Corporate Risk Register.
- Committees of the Governing Body
- Governance Statement.

The Risk Management Policy sets out the CCG's approach to the strategic management of risk and the supporting infrastructure which enables informed management decisions in the identification, assessment, treatment and monitoring of the risk environment. The policy promotes:

- A systematic, consistent and coordinated approach to the management of risk across all of its activities.
- The integration of risk management into all key business processes of the CCG.
- The development of a positive risk management culture across the organisation.
- The development of safe working practices aimed at the reduction and elimination of risk, as far as is reasonably practicable.
- Awareness of risk and its management through the promotion of a programme of communication, education and training; and
- Continuous improvement through self-assessment

The risk registers and other systems of internal control are an evolutionary process designed to identify and prioritise the risks to the delivery of aims and objectives, evaluate the likelihood of those risks occurring and the impact should they be realised, and to manage them efficiency, effectively and economically.

The risk registers were reviewed and updated regularly by risk owners. The Corporate Risk Register is reviewed by the Audit Committee, Clinical Quality and Governance Committee, Finance and Performance Committee, Primary Care Commissioning Committee and by the Executive Team. All lower-level risks are included on departmental and project risk registers for monitoring and escalation to the Corporate Risk Register where applicable. All staff and stakeholders are encouraged to identify risk.

The Assurance Framework was designed to provide the CCG with a comprehensive method for the effective and focused management of the principal risks to meeting the corporate objectives. The Assurance Framework is reviewed quarterly by the Audit Committee and the Governing Body.

Control measures were in place to ensure that all the CCG's obligations under equality, diversity and human rights legislation are complied with. For example, all CCG policies were required to have undertaken impact assessment screening or a full assessment as part of core business.

A risk management process was in place to identify and manage information risks. This consists of proactive risk assessments on key information assets, investigation of information-related

incidents and review of information related complaints.

The CCG's risk appetite, as defined in the Risk Management Policy, stated that the Governing Body will, where necessary, tolerate overall levels of risk that are classified as 12 or lower (scored using the risk matrix contained within the policy on a basis of likelihood and consequence) where action is not cost effective or reasonably practicable. The Governing Body would not normally accept levels of risk scored at 15 or above and therefore ensures that plans are put into place to lower the level of risk whenever an extreme risk has been identified.

CCG staff received training on risk management in a number of ways. It is included as part of the statutory and mandatory training and, in addition to this, awareness raising of the Risk Management Policy is incorporated in the induction process for new starters. The CCG also has a Health and Safety Group to ensure that an incidents or risks associated to the physical environment are considered and mitigated.

The Audit Committee has a specific responsibility to maintain oversight and scrutiny of the risk management arrangements as part of its portfolio to review all systems of internal control and governance across the totality of the CCG functions.

The Accountable Officer has overall responsibility for risk management and reviewing its effectiveness.

Capacity to Handle Risk

The capacity of the CCG to handle risk was achieved through the delegated responsibilities in place as defined in the CCG's Risk Management Policy. The Risk Management Policy set out the CCG's approach to risk and the accountability arrangements, including the responsibilities of the Governing Body and its Committees, Executive Directors, specialist leads, contractors and individual employees. The Scheme of Delegation sets out individuals' authority to act.

Appropriate risk management training, information and support was given to all staff as part of their induction to enable them to undertake their work safely and regular updates are also provided. Additional training has been provided in specific areas including fire safety; infection control; moving and handling; and first aid.

Risk Assessment

Risks have been documented in the Corporate Risk Register and these, together with the Assurance Framework, show the mitigations and controls in place to prevent disruption of the CCG's achieving its objectives.

Where gaps were identified in either the assurance or the controls, Governing Body members required that further action be taken to mitigate the risks. Furthermore, all papers presented to the Governing Body or a Committee include a section that highlights the risks associated with the information being presented and where appropriate this is cross referenced to the Corporate Risk Register and/or the Assurance Framework.

The key risks to achieving our objectives have been:

Transforming Care Programme achieving the planned trajectory. If the ICB is unable to provide the necessary support to those with a Learning Disability and/or Autism in the community, then there is a risk that more people with a Learning Disability and/or Autism will be admitted to hospital or the that number of people in hospital will not reduce, resulting

in significantly adverse impacts on the quality of life for these people and their families.

Mitigations to manage this risk included:

- Increased operational capacity for delivery of effective discharge and admission avoidance.
- Intensive Support Team and Community Forensic Service being established on recurrent basis to support all-age people with learning disabilities and/or autism
- Local Government Association peer review in early 2021, discharge assurance process under review, weekly system discharge planning and admission avoidance meeting, Root Cause Analyses for all admissions,
- 21/22 Operational plan and 3-year road map, system wide governance arrangements,

Urgent and Emergency Care
If there is a demand and capacity deficit across urgent and emergency care services, there is a risk that patients will not be seen in the right care setting within the right timeframes, leading to increased ambulance handover delays, resulting in patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services and capacity being compromised for new presenting patients.

Mitigations to manage this risk included:

- Local Urgent Care Boards at Place to manage demand and capacity.
- Daily Medically Fit for Discharge meetings with providers and Local Authorities.
- Plans in place for surge capacity.
- Delivery monitored through contracting meetings.

Elective Care Recovery
If the system is not able to align its elective recovery programme to the national recovery proposals, there is a risk that patients will not be seen in the right care setting within the right timeframes, resulting in patients receiving sub-optimal care, a poorer patient experience, the system incurring more costs for these services, would not receive the associated funding through the Elective Recovery Fund (ERF) and capacity being compromised for new presenting patients.

Mitigations to manage this risk included:

- System Elective Care Board in place including all partners across the system to support elective recovery.
- System-wide theatre productivity group in place to share best practice and learning.
- Effective use of digital and AI platforms system-wide to focus on ‘digital first’ opportunities.
- Weekly escalation meetings with overall system review of waiting lists and mutual aid/transfer of priority patients as needed to support equitable delivery of priority patients and reduction of the longest waits across the system.

Cancer
If we do not utilise our capacity and manage our cancer referrals effectively there is a risk that patients will continue to wait longer for both diagnosis and treatment. Resulting in failure of key cancer standards and sub-optimal pathways for our patients with variation across our ICS for both access and inequalities potentially.

Mitigations to manage this risk include:

- Ensuring screening programmes are effective and delivering within timescales.

- Engaging with Public Health and target key populations across the area.
- Review of pathways and alignment to best practice.
- System-wide oversight including at Coventry and Warwickshire Cancer Board.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivered 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 achieved this through the range of policies that it has in place (including the Incident Policy, the Health and Safety Policy and the Risk Management Policy) which are also supported by operating procedures and the reporting arrangements through the governance structure from the committees to the Governing Body, as already outlined in this document. In addition, the CCG has sought independent assurance through the provision of internal audit reviews.

The Assurance Framework is the key document for the Governing Body in ensuring that all principal risks are controlled and there is sufficient evidence of this to support this Governance Statement.

The Assurance Framework is aligned to the CCG's strategic objectives and additional information regarding the sources of assurance and risk ratings are also included in it.

Procedures are in place to ensure that all incidents are reported and investigated in accordance with Department of Health guidelines. Some staff undertook additional training that was required for specific areas of their work.

Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (originally published in June 2016 and updated in 2017) required CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England published a template audit framework.

This ensured the triangulation of data and that feedback trends identified are considered at a senior level within the organisation, with action being taken where necessary.

During the period, the CCG's internal Auditors found that the CCG had a Conflicts of Interest Policy in place and declarations made and have been recorded and managed within the Governing Body and Committee meetings held.

Data Quality

The CCG was reliant on other organisations to provide a large proportion of the data that it reports to the Governing Body. The CCG assured itself through robust challenge by Chief Officers and Executive Directors within the CCG and by scrutiny at committees and the Governing Body on the accuracy and reliability of the data presented.

Information Governance

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

We placed high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.

We established an information governance management framework and we have developed information governance processes and procedures in line with the DSP toolkit.

We have ensured all staff undertake annual Data Security Awareness training to ensure that our staff are aware of their information governance roles and responsibilities. We also have in place information risk assessment and management procedures and will continue to embed an information risk culture throughout the organisation.

We have an annual work plan to enable us to systematically review our compliance and gather evidence for the DSP Toolkit. In addition, the CCG's DSP Toolkit evidence was last audited during February 2022.

The General Data Protection Regulation (GDPR) came into effect on 25 May 2018. Organisations are required to comply with the GDPR and demonstrate compliance. The CCG has undertaken a programme of work to ensure compliance with GDPR and the Data Protection Act 2018 through a review of each of the CCG's functions against the new requirements. Compliance is demonstrated through the DSP Toolkit.

During the period 1 April to 30 June 2022, the CCG has not identified any serious lapses in Data Security. Risks to data security were assessed and monitored by the CCG's Information Governance Steering Group. Risks to data security were included in the Corporate Risk Register as necessary which is reviewed by committees of the Governing Body and escalated as appropriate.

Whistleblowing

The CCG committed to the principle of public accountability. The CCG investigated genuine and reasonable concerns expressed by employees relating to malpractice within the CCG and ensured that employees are not discriminated against or suffered a detriment as a result of making such a disclosure, as laid down by the Public Interest Disclosure Act 1998 (PIDA).

The CCG had a Whistleblowing Policy in place which aims to encourage employees to feel confident in raising serious concerns regarding the practice of the CCG; provide avenues for employees to raise those concerns and receive feedback on any action taken; ensure that

employees receive a response to their concerns; and reassure employees that they will be protected from possible reprisals, subsequent discrimination, victimisation or disadvantage if they have a reasonable belief that they have made any disclosure in good faith.

The CCG also had a number of Freedom to speak up representatives including Freedom to Speak Up Guardians who staff can speak to about any concerns they may have.

Business Critical Models

The Macpherson report, issued in March 2013, emphasised the importance of strong leadership which values and expects effective challenge, a clear governance framework and time for quality assurance of business-critical models. The review recommendations highlighted best practice which should apply across organisations, in particular, the responsibility of the Governing Body in ensuring that an appropriate framework and processes are in place.

Whilst the review did not specifically cover the NHS, its principles and recommendations can be translated to a number of the CCG's business critical functions such as procurement of services, major transformation programmes and associated QIPP schemes. Within the CCG the principles of the Macpherson Report recommendations have been adopted and applied to the strategic planning process; all QIPP schemes had executive sponsors, clinical leads and robust programme management.

Third party assurances

Many of the CCG's operational activities were undertaken by Arden and GEM Commissioning Support Unit (AGCSU). This is covered by service specifications for each area.

Whilst the operational activities are undertaken by AGCSU in many areas, the responsibility and accountability rests with the CCG and therefore no authority is delegated to AGCSU. The CCG seeks to gain assurance on the AGCSU systems and process through the Service Auditor Reports which are undertaken by the NHS England Internal Audit provider and provided to the CCG and reported through the CCG Audit Committee. No concerns were raised in the Service Auditor Report.

NHS Shared Business Services provides Finance and Accounting Services to a number of organisations across the country. The CCG received a Service Auditor Report in respect to Shared Business Services. No concerns were raised in the most recent report.

Control Issues

The CCG declared the risks outlined in the risk assessment above in its Month 1-3 Governance Statement return to NHS England and we continue to manage these risks through the control framework set out in this Governance Statement. The significant risks declared by the CCG are:

- Risk of not meeting the transforming care trajectory.
- Demand and capacity deficit in urgent and emergency care.
- Elective care recovery.
- Cancer waiting times.

These have been identified as the principal risks as the impacts:

- Could have a material impact on the accounts
- Could prevent the CCG from achieving its objective

- Could prevent the CCG from achieving NHS Constitution targets.

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

Each member of the Governing Body was aware of their responsibility to spend public money effectively and this is emphasised in the CCG's Constitution which sets out that NHS resources should be used effectively and efficiently. This message has also been communicated throughout the organisation so that all staff are aware of their responsibility. We have reviewed our contracts in order to ensure that we are commissioning high quality and efficient services that provide value for money.

The CCG's Internal Auditors have continued their programme of work to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas including those identified in the Assurance Framework. All Internal Audit Reports have been reported to the Audit Committee throughout the year and will be reflected in the Head of Internal Audit's annual opinion which is included in this annual report.

The Finance and Performance Committee has provided scrutiny on the overall financial management of the CCG. This has included the assessment of the financial planning of the organisation and the assumptions used for modelling and contracting. Additionally, the Committee has monitored delivery against financial plans and contracts, including the position on running costs, and progress on QIPP efficiency savings within the regular reports. In turn the Committee has provided updates to the CCG's Governing Body on a bi-monthly basis. Minutes of the Governing Body demonstrate the Governing Body's detailed scrutiny of these reports.

Delegation of functions

The CCG was the co-ordinating Commissioner for University Hospitals Coventry and Warwickshire NHS Trust (UHCW), George Eliot Hospital NHS Trust (GEH), South Warwickshire NHS Foundation Trust (SWFT) and Coventry and Warwickshire Partnership NHS Trust (CWPT) and has 'Associate Commissioner' arrangements in place for other contracts under a 'collaborative commissioning agreement' which set out the CCG's responsibilities and those delegated to the co-ordinating commissioner. The largest contracts to which this relates includes, Heart of England NHS Foundation Trust and the West Midlands Ambulance Service NHS Trust.

Many of the CCG's operational activities were undertaken by Arden and GEM Commissioning Support Unit (AGCSU). Services delivered by AGCSU are covered by service specifications for each area and during the year the CCG has been reviewing the service specifications to ensure that they are strengthened and more clearly define the respective responsibilities of the CCG and the AGCSU.

Whilst the operational activities are undertaken by AGCSU in many areas, the responsibility and accountability rests with the CCG and therefore no authority is delegated to the AGCSU.

The CCG sought to gain assurance on the AGCSU systems and process through the Service Auditor Report which is undertaken by the NHS England Internal Audit provider and provided to the CCG and reported through the CCG Audit Committee.

Counter Fraud Arrangements

The CCG procured the services of an Anti-Fraud Specialist who has worked with the CCG through the period to address any issues of potential fraud or related concerns. Regular updates on anti-fraud activity and any recommendations for implementation are presented to the Audit Committee.

The Local Counter Fraud Specialist has supported the Chief Finance Officer, the Executive lead for counter fraud work, and the CCG in the interpretation of the NHS Counter Fraud Authority's national counter fraud standards and has worked to help ensure compliance with them, as well as maintaining an effective deterrence against economic crime. Compliance against these standards is reviewed annually by the Audit Committee.
The Local Counter Fraud Specialist has also sought to maintain and increase staff awareness of how fraud could occur and encouraged anyone with concerns to report them via any of the reporting routes available to staff.

The Local Counter Fraud Specialist has supported the Chief Finance Officer, the Executive lead for counter fraud work, and the CCG in the interpretation of the NHS Counter Fraud Authority's national counter fraud standards and has worked to help ensure compliance with them, as well as maintaining an effective deterrence against economic crime. Compliance against these standards was reviewed annually by the Audit Committee.
The Local Counter Fraud Specialist has also sought to maintain and increase staff awareness of how fraud could occur and encouraged anyone with concerns to report them via any of the reporting routes available to staff.

Head of Internal Audit's Opinion

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

My overall opinion is: Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

Area of Audit	Level of Assurance Given
Board Assurance Framework	Full Assurance
Financial Systems	Significant Assurance
Due Diligence	Significant Assurance

Reviews in other areas that were not full audits: Conflicts of Interest, Data Security and Protection Toolkit

Transition to Integrated Care Board
As part of the assurance mechanism in relation to the due diligence process, a Scrutiny Panel meeting was held on 9 May 2022, chaired by the Accountable Officer and attended by Workstream and Approval Leads as necessary. Internal Audit was asked to attend this meeting to provide assurance from an internal audit perspective.

It was Internal Audits view, the scrutiny process, and the assurance provided by participants was rigorous and robust. The process demonstrated that the CCG is on track to complete the planned activities within the allotted timeframe. The panel asked a series of questions and received appropriate assurance from the managers presenting their workstreams.

Internal Audit have attended these meetings to provide independent scrutiny of the go live project to ensure that Shared Business Services and the CCG are working together to ensure the financial systems and new ledger is ready on time for the Integrated Care Board. As at the last meeting attended 14th June 2022. The project management stream and project overall are on amber. This is due to the cutover plan not having been issued in full by SBS yet and will be the same for all CCGs and will not prevent the CCG from going live.

Governing Body Assurance Framework
Internal Audit have reviewed the latest Governing Body Assurance Framework presented to the 18 May 2022 Governing Body and reviewed this to confirm that it is designed and operating effectively.

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

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

Our Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed. Furthermore, through the review of the Assurance Framework and the Corporate Risk Register by the Audit Committee, Clinical Quality and Governance Committee, Finance and Performance Committee and Primary Care Commissioning Committee I am assured of the effectiveness of the systems of internal control and that plans to address weaknesses to ensure continuous improvement within the system are in place.

The Audit Committee received regular reports on the assurance outcomes of assessments undertaken by the CCG's Internal Auditors and also monitored the implementation of recommendations from Internal Audit Action Plans.

The Finance and Performance Committee monitored delivery against operational plans and received regular finance and performance reports, investigating variance from plan and agreeing rectification plans.

The Clinical Quality and Governance Committee scrutinised reports regarding the quality, safety and patient experience of commissioned and in-house services and the governance arrangements of the CCG, including information governance, incidents, complaints and business continuity. The Committee monitored progress and related action plans as appropriate.

Executives, Directors, and senior managers of the CCG had specific responsibilities for reviewing risks and controls for which they are responsible and maintaining internal control systems.

Additionally, my review of effectiveness is informed in a number of ways:

- The work programme of Internal Audit and in particular their opinion on the system of internal control and the Assurance Framework.
- The CCG's Relationship Manager in AGCSU has provided me with assurance that effective control organisation in respect of the work it undertakes for the CCG;
- Assurance of the controls and operation for services provided by the Arden and GEM Commissioning Support Service via Service Auditor Reports

- Personal involvement in the Governing Body and Committees.
- Reviews with NHSE;
- The NHS Counter Fraud Specialist's reports to the Audit Committee.
- External reviews of the CCG's main provider organisations.
- External Audit Annual Audit Letter.
- Internal and External Audit reports.
- Data Security and Protection Toolkit assurance.

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

Conclusion

As Accountable Officer, and based on the review process above, I can confirm that this Governance Statement is a fair, balanced and understandable reflection of the actual controls position at the year-to-date position. Control issues have been set out in this Governance Statement and there have been clear plans in place throughout the period 1 April – 30 June 2022 to address the areas of concern.

Phil Johns
Chief Executive, Integrated Care Board
Previously Accountable Officer,
NHS Coventry and Warwickshire
Clinical Commissioning Group
13 July 2023

Remuneration and Staff Report

The Remuneration Report sets out the organisation's remuneration policy for directors and senior managers.

The CCG had a Remuneration Committee which met once during 1 April – 30 June 2022. Membership has included:

- Ghulam Vohra, Chair
- Zubair Khan, Lay Member
- Deepika Yadav, Practice Member, Coventry Place
- Colette Marshall, Secondary Care Consultant

Policy on the remuneration of senior managers

A senior manager is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the organisation '.

There are no amounts where any money or other assets reported in the single total figure table in the remuneration report of for the period 1 April – 30 June 2022 the subject of a recovery of amount paid or the withholding of any sum for any reason in the current financial year.

All senior managers' remuneration was agreed in line with national guidance on either:

- **Agenda for Change** – where senior appointments are recruited in line with NHS Agenda for Change terms and conditions of service, the remuneration for the role will be in line with the nationally agreed process and in line with local job matching processes for Agenda for Change. Except for the Lay Members, elected clinicians, the Secondary Care Consultant and the Chief Officer, all senior appointments within the CCG are appointed in line with this.
- **Very Senior Managers (VSM) Pay –** where an individual is appointed under the VSM recruitment process, this is followed as per national guidance.
- **Medical appointments –** for those Governing Body members who are elected clinicians, including the Clinical Chair, remuneration was agreed prior to the CCG's authorisation on an agreed hourly rate, in line with other local and regional CCGs, this is then subject to annual review in line with published national guidance. The remuneration for the secondary care doctor is in line with national guidance.
- **Lay Members** – Lay Members' remuneration has been in line with historic Non-Executive Directors remuneration in predecessor organisations. This is subject to annual review and is benchmarked against other Lay Members and Non- Executive posts in similar sized NHS organisations.

Staff with remuneration higher than that of the Prime Minister

From 1 April to 30 June 2022 there were 17 (9 in 2021-22) employees of the CCG who received remuneration, calculated on an annualised, full time equivalent basis, more than the Prime Minister's annual salary of £150,000.

For this same period there was a number of part time staff whose annualised salaries are included in salaries over £150,000.

Senior manager remuneration (including salary and pension entitlements) (Audited)

1 April – 30 June 2022

The following table reflects the salary related benefits to the CCG during the period 1 April – 30 June 2022.

Name	Title	Note	Col A	Col B	Col C	Col D	Col E	Col F
			Salary	Expense payments (Taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	TOTAL
			(bands of £5,000)	to nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
			£000	£	£000	£000	£000	£000
Dr Sarah Raistrick	Chair	Note 1	25-30	0	0	0	0	25-30
Phil Johns	Accountable Officer	Note 3	40-45	3	0	0	0-2.5	45-50
Adrian Stokes	Chief Finance Officer	Note 2	35-40	0	0	0	0	35-40
Jo Galloway	Chief Nursing Officer		25-30	0	0	0	7.5-10	35-40
Alison Cartwright	Director of Contracting		25-30	0	0	0	7.5-10	35-40
Dr Jonathan Menon	Practice Member	Note 1	10-15	0	0	0	0	10-15
Dr Sukhi Dhesi	Practice Member	Note 1	10-15	0	0	0	0	10-15
Dr Deepika Yadav	Practice Member		10-15	0	0	0	0	10-15
Dr Arshad Khan	Practice Member	Note 1	10-15	0	0	0	0	10-15

Elaine Strathan-Hall	Registered Nurse	Note 1	5-10	0	0	0	0	5-10
Colette Marshall	Secondary Care Specialist	Note 1	5-10	0	0	0	0	5-10
Richard Percival	Lay Member, Governance and Audit and Conflicts of Interest Guardian	Note 1	0-5	0	0	0	0	0-5
Zubair Khan	Lay Member	Note 1	0-5	0	0	0	0	0-5
Ghulam Vohra	Lay Member	Note 1	0-5	0	0	0	0	0-5

Notes to Table

Note 1: Lay members do not receive pensionable remuneration. The following are not in the NHS Pension Scheme in respect of their CCG service: E Strachan-Hall, S Dhesi, S Raistrick, J Menon, A Khan

Note 2: Adrian Stokes on secondment from UHCW.

Note 3: Expenses payment related to lease car.

The following table reflects the salary related benefits to the CCG during the period 1 April 2021– 30 March 2022.

			2021-22						
			Col A	Col B	Col C	Col D	Col E		Col F
Name	Note	Title	Salary (bands of £5,000)	Expense payments (Taxable) to nearest £100	Performance Pay and Bonuses (Bands of £5,000)	Long Term Performance Pay and Bonuses (Bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Payments for Loss of office (bands of £5000)	TOTAL(bands of £5,000)
Raistrick S	note 11	Chair	110-115	0	0	0	0	0	110-115
Johns P	note 1	Accountable Officer	165-170	0	0	0	72.5-75	0	240-245
A Stokes	note 2	Chief Finance Officer	150-155	0	0	0	0	0	150-155
Galloway JL		Chief Nursing Officer	105-110	0	0	0	15-17.5	0	120-125
Northcote JM	note 3	Chief Strategy and Primary Care officer	45-50	0	0	0	12.5-15	0	60-65
Khan M	note 11	Lay Member (Inclusion Champion)	10-15	0	0	0	0	0	10-15
Percival R	note 11	Lay Member Audit	10-15	0	0	0	0	0	10-15
Menon J	note 11	Practice member	45-50	0	0	0	0	0	45-50
Staveley I	note 7 &11	Practice member	10-15	0	0	0	0	0	15-20

Dhesi S	note 11	Clinical Vice Chair and Practice Member	45-50	0	0	0	0	0	45-50
Yadav D		Practice member	50-55	0	0	0	42.5-45	0	95-100
Khan A	note 8 & 11	Practice member	5-10	0	0	0	0	0	5-10
Strachan-Hall E	note 11	Registered Nurse	20-25	0	0	0	0	0	20-25
Timperley J	note 5	Secondary Care Specialist	5-10	0	0	0	0	0	5-10
Hargrave AL	note 4	Director of Strategy and Engagement	65-70	0	0	0	50-52.5	0	115-120
Cartwright AJ		Director of Contracting	110-115	0	0	0	72.5-75	0	185-190
Marshall C	note 10	Secondary Care Specialist	15-20	0	0	0	0	0	15-20
Vohra G	note 11	Lay Member	10-15	0	0	0	0	0	10-15
Harkness AN	note 6	Chief Transformation Officer	35-40	1	0	0	62.5-65	105-110	205-210
Bartholomew RCA	note 9	Chief Nursing Officer	55-60	0	0	0	40-42.5	0	95-100

The Greenbury calculations have been provided centrally by the Greenbury team in relation to the members identified above. The table above shows all Governing Body Members and Directors who receive pensions funded by the CCG.

Notes to Table 2021-22
Note 1: P Johns became Accountable Officer for NHS Coventry and Warwickshire CCG from 1 April 2021
Note 2: A Stokes became Chief Finance Officer for NHS Coventry and Warwickshire CCG from 1 April 2021
Note 3: J Northcote left 31 August 2021
Note 4: A Hargrave left 31 October 2021

Note 5: J Timperley left 31 July 2021
Note 6: A Harkness was Chief Transformation Officer for the period 1 April to 1 August 2021
Note 7: I Staveley left 30 November 2021
Note 8: A Khan started 1 February 2022
Note 9: R Bartholomew acted as Chief Nursing Officer from 1 October 2021 to 31 March 2022 and opted out of pension scheme 1 February 2022.
Note 10: C Marshall started 16 September 2021
Note 11: Lay members do not receive pensionable remuneration (R Percival, G Vohra and Z Khan). The following are not in the NHS Pension Scheme in respect of their CCG service: E Strachan Hall, S Dhesi, S Raistricks, I Staveley, A khan, J Menon, J Timperely.
Note 12: Expense payments (taxable) include any benefits attributable to mileage reimbursements above the HMRC tax free rate.

Pension benefits as of (Audited) 1 April – 30 June 2022

The following table reflects the pension related benefits to the CCG during the period 1 April – 30 June 2022. The table below shows all Governing Body Members and Senior Managers who receive pensions funded by the CCG.

Name	Title	Note	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 30 June 2022 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 30th June 2022 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1st April 2022 (bands of £1,000) £000	(f) Real increase in Cash Equivalent Transfer Value (bands of £1,000) £000	(g) Cash Equivalent Transfer Value at 30th June 2022 (bands of £1,000) £000	(h) Employer's contribution to stakeholder pension £000
Sarah Raistrick	Chair	Note 1								
Phil Johns	Accountable Officer		0-2.5		50-55	95-100	889.28	1.91	876.68	
Adrian Stokes	Chief Finance Officer	Note 2								
Jo Galloway	Chief Nursing Officer		0-2.5	0-2.5	50-55	115-120	1,087.66	11.99	1,078.84	
Alison Cartwright	Director of Contracting		0-2.5	0-2.5	45-50	95-100	900.91	9.80	894.56	
Dr Jonathan Menon	Practice Member	Note 1								
Dr Sukhi Dhesi	Practice Member	Note 1								
Dr Deepika Yadav	Practice Member		0-2.5		20-25	40-45	354.52		348.01	
Dr Arshad Khan	Practice Member	Note 1								

Elaine Strathan-Hall	Registered Nurse	Note 1								
Colette Marshall	Secondary Care Specialist	Note 1								
Richard Percival	Lay Member, Governance and Audit and Conflicts of Interest Guardian	Note 1								
Zubair Khan	Lay Member	Note 1								
Ghulam Vohra	Lay Member	Note 1								

The Greenbury calculations have been provided centrally by the Greenbury team in relation to the members identified above. The table above shows all Governing Body Members and Directors who receive pensions funded by the CCG.

Notes to Table:

Note 1: Lay members do not receive pensionable remuneration. The following are not in the NHS Pension Scheme in respect of their CCG service: E Strachan-Hall, S Dhesi, S Raistrick, J Menon, A Khan.

Notes 2: Adrian Stokes on secondment from UHCW.

GAD Actuarial Factors

NHS Pensions are using the most recent set of actuarial factors produced by the Government Actuary's Department (GAD) with effect from 31 March 2016, in calculating Senior Managers' pension benefits as at 31 March 2022.

Cash Equivalent Transfer Values (Audited)

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 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. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation; the value of any benefits transferred from another scheme or arrangement and uses common market valuation factors for the start and end of the period.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

McCloud

The NHS continues not to make any adjustment to the pension and lump sum data in order to consider the impact of the McCloud judgement (an ongoing legal case in relation to age discrimination benefits) as there is uncertainty on how the affected benefits would be adjusted within the new NHS 2015 Scheme once the legal proceedings are completed.

As a consequence, the benefits and corresponding CETV do not allow for any potential adjustment in relation to the McCloud judgement.

Real Increase in Pension and Lump Sum

The calculation of the real increase (or decrease) in the pension and lump sum reflects pensionable earnings within the financial year, compared with pension calculated from pensionable earnings in the previous year, each year taken in isolation. The calculation also takes account of changes in value as a result of inflation, as measured by the annual increase in public sector pensions under the provisions of the Pensions (Increase) Act 1971. There was no increase in public sector pensions from April 2016 and no inflation adjustment has, therefore, been made to the opening figures for the year. Note that any increase in lump sum for those employees who have transferred to the 2015 NHS Pension Scheme relates to solely to changes in salary and not to accrued service. This is explained below.

Changes to the NHS Pension Scheme

The new NHS Pension Scheme went live on 1st April 2015. Most staff transferred into this new scheme on that date although some staff will move over on a phased basis over a period of 6 years. One of the key differences from the existing scheme is that there is no automatic lump sum in the new scheme benefits retain a final salary link, so they are still calculated based on their current total pensionable pay despite the fact they have now moved to the 2015 scheme. So, although their membership cannot increase any further, if their pensionable pay increases, as will their pre 2015 pension benefits.

(Fair Pay) Pay multiples (Audited)

A senior manager is defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the organisation'.

There are no amounts where any money or other assets reported in the single total figure table in the remuneration report for the period 1 April – 30 June 2022, the subject of a recovery of amount paid or the withholding of any sum for any reason in the current financial year:

Percentage change in remuneration of highest paid director (Audited)

The percentage change from the previous financial year in respect of the highest paid director and the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole is illustrated below :-

	% change from previous year	Salary and allowances 22/23	Salary and allowances 21/22	% change from previous year	Performance pay and bonuses 22/23	Performance pay and bonuses 21/22
The percentage change from the previous financial year in respect of the highest paid director	10.46%	185,759	168,172	0.00%	-	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-15.25%	65,887	77,744	0.00%	-	-

The % change in the highest paid director between 22/23 and 21/22 reflects the additional responsibilities due to transition to an ICS and the cost of living increase.

The % change in the salary and allowances between 22/23 and 21/22 are due to the value of remuneration decreasing but WTE increasing and agency costs reduced.

Compensation on Early Retirement or for Fair Pay (Audited)

There was 1 payment totalling £1k made for loss of office (1 payment for £107k in 21/22)

Payments to Past members (Audited)

There were no payments to past directors during the period 1 April – 30 June 2022 (none for 21/22).

Pension Liabilities

The CCG's treatment of Pension Liabilities is outlined in on page 152 of the Financial Statements and the Pension Entitlement of Senior Managers on page 119.

Pay Ratio (Audited)

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

The banded remuneration of the highest paid director/member in Coventry and Warwickshire CCG in the three months to 30 June 2022-23 £186k (21/22 was £168k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Ill Health Retirement

During the period 1 April 2022 – 30 June 2023, there have been no ill health retirements from the CCG (none for 21/22).

Staff Report

Number of senior managers

At 30 June 2022, the CCG employed 4 Senior Managers (including Governing Body Members), (5 in 21/22).

Staff numbers and costs (Audited)

We employed 366 individuals (including Senior Managers) (364 in 21/22) who are engaged in areas such as commissioning, quality, governance, strategy, and primary care development. Employee numbers, costs and gender composition is outlined in the table from page 125.

The CCG buys in the majority of our support services from Arden and Greater East Midlands Commissioning Support Unit (AGCSU).

Pay ratio

2022/23	25th Percentile Pay Ratio	Median Pay Ratio	75th Percentile Pay Ratio
All staff remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	25,755.99	38,835.11	63,861.96
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	25,755.99	38,835.11	63,861.96
2021/22	**25th Percentile Pay Ratio**	**Median Pay Ratio**	**75th Percentile Pay Ratio**
All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	24,882.00	35,487.72	63,159.58
salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	24,882.00	35,487.72	62,955.64

During the reporting period 2022-23, nil employees received remuneration in excess of the highest-paid director/member (2021-22: nil). Remuneration ranged from £0 to £185k (2021-22: £0-£222k).

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

The increase in the pay ratios between years reflects the reduction of remuneration, but WTE increasing and agency costs reducing in 2022-23.

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

In 2022-23 Nil (2021-22 Nil) employees received remuneration in excess of the highest-paid member of the Governing Body.

	25th percentile Total Remuneration ratio	25th percentile salary ratio	Median Total Remuneration ratio	Median salary ratio	75 percentile Total Remuneration ratio	75 percentile salary ratio
22-23	3.61:1	3.61:1	2.39:1	2.39:1	1.45:1	1.45:1
21-22	3.38:1	3.38:1	2.37:1	2.37:1	1.34:1	1.34:1

Staff Composition

We employed 302 individuals (including Senior Managers) between April 22-June 22 who are engaged in areas such as commissioning, quality, governance, strategy, and primary care development.

Staff Composition			
Pay scale	**Gender**	**Permanent/Fixed Term staff (WTE)***	**Bank Staff (Headcount)**
Band 2	Female	2.52	
	Male	1	
Band 3	Female	26.68	1
	Male	8.92	1
Band 4	Female	43.86	
	Male	11.18	
Band 5	Female	39.98	1
	Male	9.18	
Band 6	Female	24.94	
	Male	3.3	
Band 7	Female	23.26	1
	Male	8	
Band 8a	Female	24.32	1
	Male	3	
Band 8b	Female	26.43	
	Male	7.8	
Band 8c	Female	15.1	
	Male	4	
Band 8d	Female	6	
	Male	2	
Band 9	Female	3.56	
	Male	3.14	
GP Members	Female	0	
	Male	0.11	
Other and Non Agenda for change (including Very Senior Managers)	Female	2.48	1
	Male	1.6	
Grand Total		302.36	6

Sickness absence

During the period 1 April to 30 June 2022 the rolling 12 month average percentage recorded in Quarter 1 was 5.62% and the average monthly sickness rate was 4.08%

Long Term absence (absence of over 28 calendar days) was 2.79% in April 2022 and reduced to 1.85% in June 2022. Short term absence was 1.97% in April 2022 and reduced to 1.45% in June 2022.

There were 10 cases in Coventry and Warwickshire CCG linked to COVID-19 during this period, all short-term.

All long term and repetitive short term absences were dealt with under the Absence Management Policy and all employees who had periods of sickness absence had return to work interviews in line with policy.

Staff Turnover

The Coventry and Warwickshire CCG monthly average headcount turnover percentage during this period was 2.01%.

The number of leavers during this period has been 22, and there have been 21 staff join the CCG during the same period.

Our turnover report includes all defined in the civil service, although it does not consider anyone who has retired and returned, nor who is on external secondment.

We have had 1 individual retire and return during this period, and externally seconded staff remain employed by the CCG so are captured in the figures as staff in post, not leavers.

Staff Policies

To ensure that staff do not experience discrimination, harassment and victimisation we ensure equality is integrated across all our employment practices and have a range of policies including:

- Harassment and Bullying at Work Policy.
- Managing Sickness Absence Policy.
- Recruitment and Selection Policy.
- Equality and Diversity Policy.

The CCG also has a Whistleblowing Policy and promotes effective procedures to ensure that concerned members of staff have the means through which to voice their concerns including a number of Freedom to Speak Up Champions.

Equality impact assessments have been carried out on all relevant policies and we have monitored the impact of the implementation of our workforce policies on our staff to ensure that we are proactively identifying and addressing any inequalities.

We value diversity and aim to support protected groups and recognise that in order to remove the barriers experienced by disabled people. We guarantee to offer an interview to disabled candidates who meet the minimum person specification for a job.

Provisions are in place to ensure that disabled staff are supported to keep them in employment by making.

reasonable adjustments to workstations, patterns of working or other adaptions as necessary, and ensuring appropriate training opportunities to facilitate career development and promotion.

Staff Survey

The CCG last participated in the 2021 National Staff Survey. The data collection took place in October/November 2021 and this was undertaken by Quality Health.

The CCG response rate was 63.8% compared to 67.1% for the 17 CCGs that contracted Quality Health to run the Staff Survey for them.

The latest staff wellbeing survey (Jan 2022) showed:

Of the 80 respondents:

- Two thirds rate their physical health and mental health as good-excellent
- Over half have established a good working routine
- Three quarters believe that the CCG has taken positive action on supporting health and wellbeing
- Almost all are non-smokers/vapers
- Over two thirds drink within the weekly guidelines
- Two thirds eat less than 5 fruit/veg a day
- Almost all are physically active
- Almost half said they have made changes to improve lifestyle behaviours as a result of CCG wellbeing activity

Expenditure on Consultancy

During April-June 2022 the CCG has incurred £13,050 on consultancy expenditure.

KR Business Excellence Ltd £13,050

The Trade Union (Facility Time Publication Requirements) Regulations 2017

The Trade Union (Facility Time Publication Requirements) Regulations 2017 put into effect the provision in the Trade Union Act 2016 whereby certain public-sector employers are expected to report annually on use of facility time provided to trade union officials as follows:

The CCG did not have any employees who were relevant union officials during the period 1 April – 30 June 2022.

Parliamentary Accountability and Audit Report

NHS Coventry and Warwickshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements. An audit certificate and report are also included at Appendix 2.

Off Payroll Engagements

Off Payroll Engagement disclosures are not applicable to this report as they relate to a six month period.

Exit Packages, including special (non-contractual payments) (Audited)

Exit packages agreed in the financial year

	2022-23 Compulsory redundancies Number	£	2022-23 Other agreed departures Number	£	Three months to 2022-23 Total Number	£
Less than £10,000	-	-	1	1,148	1	1,148
Total	**-**	**-**	**1**	**1,148**	**1**	**1,148**

All payments are bases on redundancy calculation received by the Pensions Agency

Exit Packages agreed in 21/22

	2021-22 Compulsory redundancies Number	£	2021-22 Other agreed departures Number	£	2021-22 Total Number	£
Less than £10,000	-	-	1	2,525	1	2,525
£10,001 to £25,000	-	-	1	15,938	1	15,938
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	1	106,667	-	-	1	106,667
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**106,667**	**2**	**18,463**	**3**	**125,130**

Below amounts consist of only 1 element per person were:

£2,569
£15,938
£106,667

£106,667 Payment is based on redundancy calculation received by pensions

No other payments made to this individual, including long term bonus
No discretion exercised

Appendix 1: Membership and Attendance at the Governing Body and Committee Meetings

Name	Governing Body **(Meeting held in Public)**	Primary Care Commissioning Committee **(Meeting held in Public)**	Audit	Finance and Performance	Clinical Quality and Governance	Remuneration	Individual Funding Request Panel
Number of meetings	**2**	**1**	**2**	4	**3**	**1**	**2**
Governing Body Members							
Dr Sarah Raistrick	2 out of 2				3 out of 3		
Mr Phil Johns	2 out of 2	0 out of 1				0 out of 1	
Mr Adrian Stokes	2 out of 2	0 out of 1	1 out of 2	2 out of 4			
Dr Colette Marshall	2 out of 2				2 out of 3	1 out of 1	
Ms Jo Galloway	2 out of 2	0 out of 1		0 out of 4	2 out of 3		
Dr Deepika Yadav	2 out of 2	1 out of 1				0 out of 1	
Elaine Strachan-Hall	1 out of 2		2 out of 2		1 out of 3		
Ghulam Vohra	2 out of 2	1 out of 1	1 out of 2	4 out of 4	2 out of 3	1 out of 1	
Zubair Khan	2 out of 2	1 out of 1		3 out of 4	2 out of 3	0 out of 1	
Dr Sukhi Dhesi	2 out of 2	1 out of 1		4 out of 4	3 out of 3		
Dr Arshad Khan	2 out of 2						
Jonathan Menon	2 out of 2			3 out of 4	3 out of 3		
Mr Richard Percival	2 out of 2		2 out of 2	2 out of 4			2 out of
Others							
Ali Cartwright	6 out of 8	6 out of 6		12 out of 12			
Anita Wilson Other	2 out of 2		1 out of 2		3 out of 3		
Dr Allison Duggal (or deputy)	1 out of 2						
Dr Shade Agboola (or deputy)	0 out of 2						

Appendix 2: Audit Report

The CCG's External Auditors are Ernst and Young LLP. Their report to the Members of NHS Coventry and Warwickshire CCG can be found in this Appendix.

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS COVENTRY AND WARWICKSHIRE CLINICAL COMMISSIONNING GROUP

Opinion

We have audited the financial statements of NHS Coventry and Warwickshire Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 2022 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 the related notes 1 to 23, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the Accounts Direction issued by NHS England with the approval of the Secretary of State.

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Coventry and Warwickshire Clinical Commissioning Group as at 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. 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 the Comptroller and Auditor General's AGN01 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.

Emphasis of Matter – Transition to an Integrated Care Board

We draw attention to Note 21 - Events After the Reporting Period, which describes the Clinical Commissioning Group's transition into the NHS Coventry & Warwickshire Integrated Care Board from the 1 July 2022. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCG's, or the successor body's, ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

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 course of 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 themselves. 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.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2022 to 2023; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) 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 issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the three-month period ended 30 June 2022.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 94 and 95, the Accountable Officer is responsible for the preparation of the financial statements and 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. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

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 the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibility 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022 and other legislation governing NHS CCGs, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

- We understood how NHS Coventry and Warwickshire Clinical Commissioning Group is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. This includes appropriate oversight of those charged with governance, a culture of honesty and ethical behaviour and placing an emphasis on fraud prevention, to reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment.

- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy, testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. We also assessed the susceptibility of the CCG's financial statements to material misstatement in relation to the risk of fraud in expenditure recognition, specifically those entries and adjustments that over or under state expenditure accruals and prepayments balances at the period end.

- Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance

and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

- We addressed our fraud risk related to the overstatement/understatement of expenditure accruals and prepayments by undertaking testing to gain assurance over the completeness, existence and valuation of a sample of manual accruals raised outside the purchase order system and prepayments. We checked that criteria for recognition had been met and the estimate of the value was supportable with reference to underlying evidence. We also performed sample testing of expenditure cut-off and unrecorded liabilities to ensure that transactions had been recorded in the correct financial year.

- We addressed our fraud risks related to management override through implementation of a journal entry testing strategy, assessing accounting estimates for evidence of management bias and evaluating the business rationale for significant unusual transactions. This included testing postings in the general ledger that fell outside of the standard transaction process flow.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in January 2023 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria 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 three-month period ended 30 June 2022.

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 form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice does not require us to refer to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resource if we are satisfied that proper arrangements are in place.

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.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have issued our Auditor's Annual Report for the 3-month period ended 30 June 2022. We have completed our work on the value for money arrangements and will report the outcome of our work in our commentary on those arrangements within the Auditor's Annual Report.

Until we have completed these procedures, we are unable to certify that we have completed the audit of the accounts in accordance with the requirements of the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General.

Use of our report

This report is made solely to the members of the Governing Body of NHS Coventry and Warwickshire Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Hayley Clark
Ernst & Young LLP

Hayley Clark (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Birmingham
Date: 13 July 2023

Appendix 3: The Primary Financial Statements and Notes to the accounts

These accounts for the period ending 30 June 2022 have been prepared by the CCG under Schedule 17 of Schedule 1A of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of Treasury, directed.

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Foreward to the Financial Statements

NHS Coventry and Warwickshire Clinical Commissioning Group (CCG) was licensed from 1 April 2021. It's predecessor organisations were NHS Coventry Rugby CCG , NHS Warwickshire North CCG and NHS South Warwickshire CCG . The CCG was licensed under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

These accounts for the period ending 30 June 2022 have been prepared by the CCG under Schedule 17 of Schedule 1A of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of Treasury, directed.

The National Health Service Act 2006 (as amended) requires clinical commissioning groups to prepare their Annual Report and Accounts in accordance with the directions issued by NHS England.

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The Primary Statements:

Notes to the Accounts

Coventry and Warwickshire CCG - Annual Accounts 2022-23

Statement of Comprehensive Net Expenditure for the period ended 30 June 2022

	Note	Three Months 2022-23 £'000	Twelve Months 2021-22 £'000
Income from sale of goods and services	2	(2,005)	(2,085)
Total operating income		**(2,005)**	(2,085)
Staff costs	3	5,336	22,950
Purchase of goods and services	4	451,843	1,857,789
Depreciation and impairment charges	4	244	286
Provision expense	4	-	1,459
Other Operating Expenditure	4	168	1,169
Total operating expenditure		**457,591**	**1,883,654**
Net Operating Expenditure		**455,586**	**1,881,569**
Finance expense	6	6	217
Net expenditure for the period		**455,592**	**1,881,787**
Net (Gain)/Loss on Transfer by Absorption	7	-	114,815
Total Net Expenditure for the Financial period		**455,592**	**1,996,602**
Comprehensive Expenditure for the period		**455,592**	**1,996,602**

Total net revenue expenditure for the period (before transfers) of £455,592k is funded by in-year revenue resource allocations from NHS England totalling £455,592k. This represented a break even position for the three months to 30 June 2022 reported in note 22 (financial performance targets).

The revenue resource allocation is accounted for by crediting the General Fund, but this funding is only drawn down from NHS England and accounted for, to meet payments as they fall due. The total funding credited to the General Fund during the period was therefore less than the revenue resource allocation and totalled £451,378k (see Statement of Changes in Taxpayers Equity on page 141).

Coventry and Warwickshire CCG - Annual Accounts 2022-23

Statement of Financial Position as at 30 June 2022

	Note	Three Months 2022-23 £'000	Twelve Months 2021-22 £'000
Non-current assets:			
Property, plant and equipment	8	579	649
Right-of-use Assets	9	2,255	-
Total non-current assets		2,834	649
Current assets:			
Trade and other receivables	10.1	5,063	7,618
Cash and cash equivalents	11	17	527
Total current assets		**5,080**	8,145
Total current assets		**5,080**	8,145
Total assets		**7,914**	8,794
Current liabilities			
Trade and other payables	12	(144,510)	(143,610)
Lease liabilities	13	(706)	
Provisions	14	(5,532)	(5,532)
Total current liabilities		**(150,748)**	(149,142)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(142,834)**	(140,348)
Non-current liabilities			
Lease liabilities	13	(1,728)	-
Provisions	14	(3,143)	(3,143)
Total non-current liabilities		**(4,872)**	**(3,143)**
Assets less Liabilities		**(147,705)**	(143,492)
Financed by Taxpayers' Equity			
General fund		(147,705)	(143,492)
Total taxpayers' equity:		**(147,705)**	(143,492)

The financial statements on pages 139 to 166 were approved by the ICB Board on 13th July 2023 and signed on its behalf by:

Chief Accountable Officer
Phil Johns

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Statement of Changes In Taxpayers Equity for the year ended 30 June 2022

	General fund £'000
Balance at 01 April 2022	(143,492)
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(143,492)**
Changes in taxpayers' equity for 2022-23	
Net operating expenditure for the financial period	(455,592)
Total revaluations against revaluation reserve	**(455,592)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial period	**(455,592)**
Net funding (note 1)	451,378
Balance at 30 June 2022	**(147,705)**

Note 1 The Net funding 22/23 above includes an amount of £13k relating to Expenditure incurred in respect of support for Covid Vaccination sites during the year. As advised by NHSE these entries are not included in the CCGs Cash drawings report for the Year.

Balance at 01 April 2021	0
Adjusted NHS Clinical Commissioning Group balance at 1 April 2021	**0**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22	
Net operating expenditure for the financial year	(1,881,787)
Total revaluations against revaluation reserve	**(1,881,787)**
Transfers by absorption to (from) other bodies (note 7)	(114,815)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(1,996,602)**
Net funding	1,853,110
Balance at 31 March 2022	**(143,492)**

Coventry and Warwickshire CCG - Annual Accounts 2022-23

Statement of Cash Flows for the period ended 30 June 2022

	Note	**Three Months 2022-23 £'000**	Twelve Months 2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(455,592)	(1,881,787)
Depreciation and amortisation	4	244	286
Finance Costs		0	0
Unwinding of Discounts		0	217
(Increase)/decrease in trade & other receivables	10.1	2,555	(478)
Increase/(decrease) in trade & other payables	12	1,170	27,294
Provisions utilised	14	0	(735)
Increase/(decrease) in provisions	14	0	2,577
Net Cash Inflow (Outflow) from Operating Activities		**(451,623)**	**(1,852,626)**
Cash Flows from Investing Activities			
Interest paid / received		6	0
(Payments) for property, plant and equipment		(270)	(31)
Net Cash Inflow (Outflow) from Investing Activities		**(264)**	**(31)**
Net Cash Inflow (Outflow) before Financing		**(451,888)**	**(1,852,657)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		451,378	1,853,110
Net Cash Inflow (Outflow) from Financing Activities		**451,378**	**1,853,110**
Net Increase (Decrease) in Cash & Cash Equivalents		**(510)**	**453**
Cash & Cash Equivalents at the Beginning of the Financial period		**527**	**74**
Transfers by absorption to (from) other bodies		**0**	**0**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial period	**11**	**17**	**527**

Coventry and Warwickshire CCG - Annual Accounts 2022-23

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 2022-23 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, in accordance with the definition as set out in Section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual 2022/23, which outlines the interpretation of IAS1 'Presentation of Financial Statements' as 'anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents'.
For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision (funding allocation) for that service in published documents, is normally sufficient evidence of going concern.

DHSC group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

In carrying out its assessment, the Governing Body has taken into account the following key considerations:

The Health and Social Care Act

The Health and Social care act was given Royal Assent on 28 April 2022. The Act allows for the establishment of Integrated Care Boards (ICB) across England and will abolish Clinical Commissioning Groups (CCG). ICBs will take on the commissioning functions of CCGs and therefore all CCG functions, assets and liabilities will transfer to an ICB.

NHS contracting and payment framework during 2022/23

The CCG has been given a resource allocation for the three months to 30 June 2022 based on a share of the full year allocation. The financial regime for CCGs during this period still reflects some of the funding arrangements put in place during the covid pandemic. Allocations have been set for CCGs and the system which include a top up allocation at a level to enable all organisations within the system to breakeven, albeit at a lower level than in previous years.

As a result, the CCG reported a breakeven position as shown in Note 22 – Financial Performance Targets.

2022/23 to 2023/24 Indicative financial planning

In January 2022 the CCG was notified of its full year allocation for 2022/23. This allocation is an update from the 5 year allocations notified in February 2019 and reflects the fact that NHS England have continued to fund CCGs at a higher level than previously notified; the “top up” funding issued in 2020/21 has been built into the recurrent allocation to enable CCG’s and providers within the health system to achieve breakeven. The CCG has submitted a draft plan to NHS England that shows an in year breakeven position.

As in previous years, the CCG will be permitted to draw down sufficient cash from NHS England to meet expenditure levels even if these exceed the resource allocation issued.
As previously stated, the CCG has been notified formally of the level of allocations it will receive from the Department of Health, through NHS England, for both 2022/23 and 2023/24. The table below sets out the allocations for 2022/23, 2023/24 and 2024/25 as set out in the table below.

CCG/ICB Notified Funding	2022/23 000	2023/24 000	2024/25 000
CCG/ICB Recurrent Allocation	£1,752,383	£1,983,692	£2,026,055

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. It remains the case that the Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2022/23 and CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the Coventry & Warwickshire Integrated Care Board, rather than NHS Coventry & Warwickshire CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, is not considered to impact on going concern. Our considerations cover the period 12 months beyond the date of authorisation of issue of these financial statements. Taking into account the information summarised above, the Board have a reasonable expectation that the CCG (and the successor commissioning organisation) will have adequate resources to continue in operational existence for the foreseeable future.

1.2 **Accounting Convention**

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

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

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

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Arrangements over which the clinical commissioning group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the clinical commissioning group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its

The CCG has joint operation where it is a party to the Coventry Better Care Fund established under Section 75 of the NHS Act 2006 and Warwicksl Better Care Fund .
The CCG also is party to the Young People's Mental Health and Well-being Services established under Section 75 of the NHS Act 2006. The fund has been established to further the integration of young people's Mental Health Services in Warwickshire
Note 17 to the accounts provide details of its share of, assets, liabilities, income and expenses in its own accounts
A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 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.
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.

The CCG is a party to the Coventry Better Care Fund established under Section 75 of the NHS Act 2006 and Warwickshire
Better Care Fund . The funds have been established to further the integration of health and social care services in Coventry and Warwickshire. The funds are hosted by Coventry City Council (CCC) and Warwickshire County Council respectively (WCC).
The CCG also is party to the Young People's Mental Health and Well-being Services established under Section 75 of the NHS Act 2006. The fund has been established to further the integration of young people's Mental Health Services in Warwickshire.

The CCG is party to a Section 75 of NHS Act 2006 with Coventry City Council in relation to the Provision of Public Health Support.
Note 18 to the accounts provide details of its share of, assets, liabilities, income and expenses in its own accounts

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group (note 16).

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

1.8 **Employee Benefits**

1.8.1 **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.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

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

1.09 **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.

1.10 **Grants Payable**

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

1.11 **Property, Plant & Equipment**

1.11.1 **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

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.

1.11.2 **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.

1.11.3 **Subsequent Expenditure**

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

1.12 **Intangible Assets**

1.12.1 **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.

1.12.2 **Measurement**

Intangible assets acquired separately are intially 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.

1.12.3 **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

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.

1.13 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration. The clinical commissioning group assesses whether a contract is or contains a lease, at inception of the contract.

1.13.1 **The Clinical Commissioning Group as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning or being remeasured in the 2022 calendar year under IFRS 16.
Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.14 **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.

1.15 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.47% (2020-21: -0.02%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.70% (2020-21: 0.18%) 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 0.95% (2020-21 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 0.66% (2020-21: 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.

1.16 **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.

1.17 **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.

1.18 **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.

1.19 **Contingent liabilities and contingent assets**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.20 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

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

1.20.1 **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.

1.20.2 **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.

1.20.3 **Financial assets at fair value through profit and loss**

Financial assets measured 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.

1.20.4 **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.

1.21 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

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

1.22 **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.

1.23 **Foreign Currencies**
The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.24 **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.

1.25 **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).

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

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

In assessing critical judgements the CCG has had to consider its accounting treatment for the Better Care Funds for Coventry and Warwickshire and Warwickshire Young people's Mental Health and Well Services .Under IFRS 11 'Joint Arrangements', 'Joint Control' exists where "decisions about the relevant activities require the unanimous consent of the parties sharing control". As the Fund is run by a Partnership Board the initial assumption is that all such transactions should be accounted for as a 'Joint Operation'. Consideration has also been made to the underlying substance of the commissioning transactions in the Pool. This has also resulted in the conclusion that a Joint Commissioning arrangement is in place so that each Pool partner accounts for their share of expenditure and balances with the end provider (net accounting would apply between partners).

Otherwise there are no critical judgements, apart from those involving estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have any significant effect on the amounts recognised in the financial statements.

Key Sources of Estimation Uncertainty
The following is the key estimation 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:
Prescribing liabilities:
NHS England actions monthly cash charges to the CCG for prescribing contracts. These are issued approximately 6 weeks in arrears. The CCG uses information provided by the NHS Business Authority as part of the estimate for the full year expenditure. In 2022-23 the accrual was £23,624k (2021-22 £23,562k).

CHC/S117 Estimates
The CCG accrues for the outstanding liabilities in relations to individual packages of care as per the available CCG records. Given the volume of packages and shared funding arrangements with other agencies, it is possible that not every liability has been captured. Any missing expenditure will not be material to the accounts and will be covered in the year identified. The CCG has included a 2.5% contingency to reflect that packages may be added retrospectively after the year-end date.

1.27 **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.

1.28 **Adoption of new standards**
On 1 April 2022, the clinical commissioning group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.
Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.
In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use

Impact assessment

The clinical commissioning group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the group recognised £2.4m of right-of-use assets and lease liabilities of £2.4m . The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an immatrial impact to tax payers' equity.

The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.
The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	2,452
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	(23)
Operating lease commitments discounted used weighted average IBR	2,429
Lease liability at 1 April 2022	**2,429**

1.29 **New and revised IFRS Standards in issue but not yet effective**

- IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted.
- The new and revised IFRS standards in issue but not yet effective, have no potential impact on the ICB

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2 Other Operating Revenue

	Three months to 2022-23 Admin £'000	Three months to 2022-23 Programme £'000	Three months to 2022-23 Total £'000	Twelve months 2021-22 Admin £'000	Twelve months 2021-22 Programme £'000	Twelve months 2021-22 Total £'000
Income from sale of goods and services (contracts)						
Non-patient care services to other bodies	25	1,354	**1,379**	**389**	809	1,198
Other Contract income	-	627	**627**	**199**	688	887
Total Income from sale of goods and services	**25**	**1,980**	**2,005**	**588**	**1,497**	**2,085**
Total Operating Income	**25**	**1,980**	**2,005**	**588**	**1,497**	**2,085**

2.1 Disaggregation of revenue

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

	Three months to 2022-23 Non-patient care services to other bodies	Three months to 2022-23 Other Contract income	Twelve months 2021-22 Non-patient care services to other bodies	Twelve months 2021-22 Other Contract income
	£'000	£'000	£'000	£'000
Source of Revenue				
NHS	1,059	-	790	81
Non NHS	320	627	408	806
Total	**1,379**	**627**	**1,198**	**887**

	Three months to 2022-23 Non-patient care services to other bodies	Three months to 2022-23 Other Contract income	Twelve months 2021-22 Non-patient care services to other bodies	Twelve months 2021-22 Other Contract income
	£'000	£'000	£'000	£'000
Timing of Revenue				
Point in time	321	627	-	-
Over time	1,058	-	1,198	887
Total	**1,379**	**627**	**1,198**	**887**

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

3 Employee benefits and staff numbers

3.1.1 Employee benefits

	Three months to 2022-23			Twelve Months 2021-22		
	Total Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	**3,336**	**1,011**	**4,347**	13,413	4,447	17,860
Social security costs	**372**	**-**	**372**	1,398		1,398
Employer Contributions to NHS Pension scheme	**604**	**-**	**604**	2,413		2,413
Apprenticeship Levy	**13**	**-**	**13**	56		56
Termination benefits	**-**	**-**	**-**	1,224		1,224
Gross employee benefits expenditure	4,325	1,011	5,336	18,503	4,447	22,950
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	4,325	1,011	5,336	18,503	4,447	22,950
Less: Employee costs capitalised	**-**	**-**	**-**	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	4,325	1,011	5,336	18,503	4,447	22,950

3.2 Average number of people employed

	2022-23			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**315.01**	**68.43**	**383.44**	303.43	67.78	371.21

3.3 Exit packages agreed in the financial year

	2022-23 Compulsory redundancies		2022-23 Other agreed departures		Three months to 2022-23 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	1,148	1	1,148
Total	**-**	**-**	**1**	**1,148**	**1**	**1,148**

Analysis of Other Agreed Departures

	2022-23 Other agreed departures		2021-22 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	1	1,148	2	18,463
Total	**1**	**1,148**	**2**	**18,463**

There were no Departures where special payments have been made in 22/23 or 21/22.

Ill Health retirements
There were no ill Health retirements during the 22/23 or 21/22.

3.4 Pension costs

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

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

3.4.1 Accounting valuation

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

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

3.4.2 Full actuarial (funding) valuation

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

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

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

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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4. Operating expenses

	Three months to 2022-23 Total £'000	Twelve Months 2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,483	11,684
Services from foundation trusts	88,869	353,709
Services from other NHS trusts	209,527	883,486
Purchase of healthcare from non-NHS bodies	52,742	206,456
Purchase of social care	6,155	21,987
Prescribing costs	36,908	149,024
Pharmaceutical services	339	1,383
General Ophthalmic services	187	729
GPMS/APMS and PCTMS	43,325	168,033
Supplies and services – general	8,864	50,449
Consultancy services	13	84
Establishment	627	6,071
Transport	-	-
Premises	518	2,987
Audit fees *	51	236
Other non statutory audit expenditure		
· Internal audit services **	-	
· Other services	-	
Other professional fees	96	1,225
Legal fees	90	194
Education, training and conferences	52	52
Total Purchase of goods and services	**451,843**	**1,857,789**
Depreciation and impairment charges		
Depreciation	244	286
Total Depreciation and impairment charges	**244**	**286**
Provision expense		
Provisions	-	1,459
Total Provision expense	**-**	**1,459**
Other Operating Expenditure		
Chair and Non Executive Members	72	166
Grants to Other bodies	71	283
Research and development (excluding staff costs)	25	720
Expected credit loss on receivables	-	-
Other expenditure	-	-
Total Other Operating Expenditure	**168**	**1,169**
Total operating expenditure	**452,255**	**1,860,704**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

* The total fees paid to External Auditors in relation to the CCG audit is £224,400. So far £51,000 has been recognised in CCG accounts as shown above. However due to the timing of and agreement of fees £173400 amount has been paid by the ICB

** Internal Audit Fees £18,600 included within services from foundation trusts

5 Better Payment Practice Code

Measure of compliance	**2022-23 Number**	**2022-23 £'000**	2021-22 **Number**	2021-22 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	16,268	112,305	59,373	393,508
Total Non-NHS Trade Invoices paid within target	16,135	111,540	58,254	387,834
Percentage of Non-NHS Trade invoices paid within target	**99.18%**	**99.32%**	**98.12%**	**98.56%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	179	287,059	2,539	1,295,911
Total NHS Trade Invoices Paid within target	178	287,012	2,513	1,295,477
Percentage of NHS Trade Invoices paid within target	**99.44%**	**99.98%**	**98.98%**	**99.97%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.
The target percentage to be reached is 95% (for three months in 2022-23 and full twelve months in 21/22). The CCG achieved this across all measures for 22/23 and 21/22.

6 Finance costs

	2022-23	2021-22
Interest	**£'000**	**£'000**
Interest on lesase liabilities	6	0
Total interest	6	-
Provisions: unwinding of discount	-	218
Total finance costs	**-**	**218**

7. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

The CCG received the following balances on1 April 2021, from the three predecessor CCG's: Coventry Rugby CCG , Warwickshire North CCG and South Warwickshire CCG

	Coventry Rugby CCG 2021-22 £'000	Warwickshire North CCG 2021-22 £'000	South Warwickshire CCG 2021-22 £'000	TOTAL 2021-22 £'000
Transfer of property plant and equipment	212	143	83	438
Transfer of intangibles	-			
Transfer of cash and cash equivalents	32	20	22	74
Transfer of receivables	3,148	772	3,220	7,140
Transfer of payables	(54,889)	(26,273)	(34,689)	(115,851)
Transfer of provisions	(2,238)	(600)	(3,778)	(6,616)
Net loss on transfers by absorption	**(53,735)**	**(25,938)**	**(35,142)**	**(114,815)**

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8 Property, plant and equipment

2022-23	Information technology £'000	Total £'000
Cost or valuation at 01 April 2022	861	861
		-
Additions purchased	(0)	(0)
Disposals other than by sale	-	-
Cost/Valuation at 30 June 2022	**861**	**861**
Depreciation 01 April 2022	212	212
		-
Disposals other than by sale	-	-
Charged during the year	70	70
Depreciation at 30 June 2022	**282**	**282**
Net Book Value at 30 June 2022	**579**	**579**
Purchased	579	579
Total at 30 June 2022	**579**	**579**
Asset financing:		
Owned	579	579
Total at 30 June 2022	**579**	**579**

8.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was £ nil (21/22 £Nil)

8.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	5	5

9 Lease - Right of Use Assets

2022-23	Buildings excluding dwellings £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-	-
IFRS 16 Transition Adjustment	2,417	11	2,429
			-
Cost/Valuation at 30 June 2022	**2,417**	**11**	**2,429**
Depreciation 01 April 2022	-	-	-
Charged during the year	173	1	174
Depreciation at 30 June 2022	**173**	**1**	**174**
			-
Net Book Value at 30 June 2022	**2,245**	**10**	**2,255**

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10.1 Trade and other receivables

	Three Months to Current 2022-23 £'000	Twelve Months Current 2021-22 £'000
NHS receivables: Revenue	294	2,555
NHS prepayments	-	-
NHS accrued income	1,045	618
Non-NHS and Other WGA receivables: Revenue	427	856
Non-NHS and Other WGA prepayments	692	260
Non-NHS and Other WGA accrued income	791	1,149
Expected credit loss allowance-receivables	(15)	(15)
VAT	1,809	2,194
Other receivables and accruals	20	0
Total Trade & other receivables	**5,063**	**7,618**
Total current and non current	**5,063**	**7,618**

10.2 Receivables past their due date but not impaired	Three Months to 2022-23 DHSC Group Bodies £'000	Three Months to 2022-23 Non DHSC Group Bodies £'000	Twelve Months 2021-22 DHSC Group Bodies £'000	Twelve Months 2021-22 Non DHSC Group Bodies £'000
By up to three months	9	54	13	171
By three to six months	-	79	-	-
By more than six months	-	-	-	-
Total	**9**	**133**	**13**	**171**

10.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 01 April 2022	**0**	**0**
Transfer (to)/from other public sector body	**(15)**	**(15)**
Lifetime expected credit loss on credit impaired financial assets	0	**0**
Lifetime expected credit losses on trade and other receivables-Stage 2	0	**0**
Lifetime expected credit losses on trade and other receivables-Stage 3	0	**0**
Amounts written off	0	**0**
Other changes	0	**0**
Allowance for credit losses at 30 June 2022	(15)	**(15)**

11 Cash and cash equivalents

	Three Months to 2022-23 £'000	Twelve Months 2021-22 £'000
Balance at 01 April 2022	527	74
Net change in year	(510)	453
Balance at 30 June 2022	**17**	**527**
Made up of:		
Cash with the Government Banking Service	16	525
Cash in hand	2	2
Cash and cash equivalents as in statement of financial position	**17**	**527**
Balance at 30 June 2022	**17**	**527**

The CCG achieved its cash target for 2022/23 with a cleared Cash balance at 30 June 2022 of £597k (21/22 £525k).
The CCGs cash target is notionally 1.25% of June 2022 cash drawdown £1,513k (21/22 £1,615k).

12 Trade and other payables

	Three Months to Current 2022-23 £'000	Twelve Months Current 2021-22 £'000
NHS payables: Revenue	1,346	1,541
NHS payables: Capital	-	-
NHS accruals	25,558	8,463
Non-NHS and Other WGA payables: Revenue	18,353	30,338
Non-NHS and Other WGA payables: Capital	210	481
Non-NHS and Other WGA accruals	92,093	94,015
Non-NHS and Other WGA deferred income	3,371	3,652
Social security costs	232	214
Tax	180	187
Payments received on account	-	-
Other payables and accruals	3,167	4,720
Total Trade & Other Payables	**144,510**	**143,610**
Total current	**144,510**	**143,610**

Other payables include £1,413k outstanding pension contributions at 30 June 2022 (21/22 £1,578k).

13 Lease Liabilities

	Three Months to 2022-23 £'000	Twelve Months 2021-22 £'000
Lease liabilities at 01 April 2022	0	0
IFRS 16 Transition Adjustment	2,428	0
Interest expense relating to lease liabilities	6	0
Lease liabilities at 30 June 2022	**2,434**	**-**

13.1 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Three Months to 2022-23 £'000	Twelve Months 2021-22 £'000
Within one year	707	-
Between one and five years	1,767	-
After five years	-	-
Balance at 30 June 2022	**2,474**	**-**
Effect of discounting	(40)	-
Included in:		
Current lease liabilities	706	-
Non-current lease liabilities	1,728	-
Balance at 30 June 2022	**2,434**	**-**

13.2 Amounts recognised in Statement of Comprehensive Net Expenditure

	Three Months to 2022-23	Twelve Months 2021-22
Depreciation expense on right-of-use assets	174	0
Interest expense on lease liabilities	6	0
Total	**179**	**-**

13.3 Amounts recognised in Statement of Cash Flows

	Three Months to 2022-23 £'000	Twelve Months 2021-22 £'000
Total cash outflow on leases under IFRS 16	-	-
Total cash outflow for lease payments not included within the measurement of lease liabilit	-	-
Total cash inflows from sale and leaseback transactions	-	-

14 Provisions

	Three months to Current 2022-23 £'000	Three months to Non-current 2022-23 £'000	Twelve Months Current 2021-22 £'000	Twelve Months Non-current 2021-22 £'000
Restructuring	2,802	-	2,802	-
Continuing care	2,730	3,143	2,730	3,143
Total	**5,532**	**3,143**	**5,532**	**3,143**
Total current and non-current	**8,676**		**8,676**	

	Restructuring £'000	Continuing Care £'000	Total £'000
Balance at 01 April 2022	**2,802**	**5,873**	**8,676**
Arising during the year	-	-	**-**
Utilised during the year	-	-	**-**
Unwinding of discount	-	-	**-**
Balance at 30 June 2022	**2,802**	**5,873**	**8,676**
Expected timing of cash flows:			
Within one year	2,802	2,730	**5,532**
Between one and five years	-	3,143	**3,143**
Balance at 30 June 2022	**2,802**	**5,873**	**8,676**

CHC provision

The CCG has provided for retrospective Continuing Healthcare (CHC) eligibility claims submitted. The provision reflects these cases and valid claims against the provision during the year. With the response to Covid-19 it has been anticipated there may be additional claims to be made, given the priority has been off assessments and reviews during the financial year. This has been reflected in the provision.

Restructure provision

The CCG has provided for a Restructure Provision this year, due to the transfer to the new Coventry and Warwickshire Integrated Care Board and following from the previous merger of the previous CCGs.

15 Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

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

15.1.3 Credit risk

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

15.1.4 Liquidity risk

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

15.1.5 Financial Instruments

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

15 Financial instruments cont'd

15.2 Financial assets

	Three months to			Twelve Months		
	Financial Assets measured at amortised cost 2022-23 £'000	Equity Instruments designated at FVOCI 2022-23 £'000	Total 2022-23 £'000	Financial Assets measured at amortised cost 2021-22 £'000	Equity Instruments designated at FVOCI 2021-22 £'000	Total 2021-22 £'000
Trade and other receivables with NHSE bodies	390		390	2,554		2,554
Trade and other receivables with other DHSC group bodies	1,727		1,727	1,768		1,768
Trade and other receivables with external bodies	461		461	856		856
Cash and cash equivalents	17		17	527		527
Total at 30 June 2022	**2,595**	**-**	**2,595**	**5,705**	**-**	**5,705**

15.3 Financial liabilities

	Three months to			Twelve Months		
	Financial Liabilities measured at amortised cost 2022-23 £'000	Other 2022-23 £'000	Total 2022-23 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Trade and other payables with NHSE bodies	674		**674**	155		**155**
Trade and other payables with other DHSC group bodies	26,348		**26,348**	11,670		**11,670**
Trade and other payables with external bodies	118,684		**118,684**	127,733		**127,733**
Total at 30 June 2022	**145,706**	**-**	**145,706**	**139,558**	**-**	**139,558**

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16 Operating segments

In accordance with IFRS 8 the CCG recognises Operating Segments as outlined below. These fall within the definition of a recognisable segment :

• that engages in activities from which it may earn revenues and incur expenses (including revenue and expenses generated internally)

• whose operating results are regularly reviewed by the entity's "chief operating decision maker" to make decisions about resource allocation to the segment and assess its performance, and

• for which discrete financial information is available.

	3 Months to 30 June 2022						12 Months to 31 March 2022					
	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Acute	236,882	(32)	236,850				1,011,150	(133)	1,011,017			
Mental Health & Learning Disabilities	39,335	0	39,335				156,527	0	156,527			
Community Health	37,990	(263)	37,727				160,841	(351)	160,490			
Continuing Healthcare	41,831	0	41,831				166,722	0	166,722			
GP Prescribing and Primary Care	44,123	(195)	43,928				185,974	(549)	185,425			
Delegated Co- Commissioning	41,032	0	41,032				159,054	0	159,054			
Clinical Support	11,724	(1,490)	10,234				24,506	(464)	24,042			
Running Cost Allowance	4,680	(25)	4,655				19,098	(588)	18,510			
Assets liabilities	0	0	0	7,914	(155,620)	(147,706)	0	0	0	8,794	(152,286)	(143,492)
				0	0					0	0	
Total	457,597	(2,005)	455,592	7,914	(155,620)	(147,706)	1,883,872	(2,085)	1,881,787	8,794	(152,286)	(143,492)

Revenue resource Limit (excluding deficit b/f from 2021/22)	455,592	1,881,813
Operating Surplus (See Note 22)	0	26

16.1 Reconciliation between Operating Segments and SoCNE

There are no differences between Total net expenditure reported for operating segments and Total net expenditure per the Statement of Comprehensive Net Expenditure

16.2 Reconciliation between Operating Segments and SoFP

There are no differences between Total assets reported for operating segments and Total assets per Statement of Financial Position

There are no differences between Total liabilities reported for operating segments and Total Liabilities per Statement of Financial Position

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17 Joint arrangements - interests in joint operations

17.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2022-23				Amounts recognised in Entities books ONLY 2021-22			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Coventry Better Care fund	CCC ,CWCCG,	The funds have been established to further the integration of health and social care services in Coventry and Warwickshire.	2,277	1,081	-	2,827	157	3,184	-	19,865
Warwickshire Better Care fund	WCC , CWCCG	The funds have been established to further the integration of health and social care services in Coventry and Warwickshire.	3,952	9,201	6,869	10,723	633	9,320	65,907	84,073
Young People's Mental Health and Well-being Services	WCC , CWCCG	The CCG is party to the Young People's Mental Health and Well-being Services established under Section 75 of the NHS Act 2006. The fund has been established to further the integration of young people's Mental Health Services in Warwickshire.	-	-	944	944	-	-	3,592	3,592
Mental Health & well being	WCC , CWCCG	The CCG is also party to a Mental Health and Well-being Services established under Section 75 of the NHS Act 2006.	-	-	-	-	-	-	-	3,000

17.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

There are no Interests in entities not accounted for under IFRS 10 or IFRS 11

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18 Pooled budgets

Better Care Fund Section 75 Agreement

	2022/23 Coventry Pool Budget Better Care Fund			2022/23 Warwickshire Pool Budget Better Care fund		
	Coventry and Warwickshire CCG £'000	Coventry City Council £'000	Total £'000	Coventry and Warwickshire CCG £'000	Warwickshire County Council £'000	Total £'000
Contributions to the fund	17,169	16,913	34,082	10,696	5,064	15,760
Expenditure on Service provision	(14,077)	(15,607)	(29,684)	(6,878)	(8,883)	(15,761)
Total Surplus/(deficit)	3,092	1,306	4,398	3,818	(3,819)	(1)
Use of balance						
Surplus retained		2,071	2,071			
Care Act carry forward		(75)	(75)			
Net balance		1,996	1,996			

The carry forward includes £5m development fund CCC are carrying forward on behalf of the CCG.

	2021/22 Coventry Pool Budget Better Care Fund			2021/22 Warwickshire Pool Budget Better Care fund		
	Coventry and Warwickshire CCG £'000	Coventry City Council £'000	Total £'000	Coventry and Warwickshire CCG £'000	Warwickshire County Council £'000	Total £'000
Contributions to the fund	76,583	57,005	133,588	43,302	19,862	63,164
Expenditure on Service provision	(56,718)	(54,033)	(110,751)	(26,005)	(32,897)	(58,902)
Total Surplus/(deficit)	19,865	2,972	22,837	17,296	(13,035)	4,261
Use of balance						
Surplus retained		16,411	16,411			
Care Act carry forward		6,426	6,426			
Net balance		22,837	22,837			

Young People's Mental Health and Well-being Services Section 75 Agreement

The CCG is party to the Young People's Mental Health and Well-being Services established under Section 75 of the NHS Act 2006. The fund has been established to further the the integration of young people's Mental Health Services in Warwickshire.

2022/23 Warwickshire Pool Budget

	Coventry and Warwickshire CCG **£000**	Warwickshire County Council £000	Total £000
Contributions to the fund	920	190	1,110
Expenditure on service provision	(920)	(190)	(1,110)
Total surplus/(deficit)	**0**	**0**	**0**

2021/22 Warwickshire Pool Budget

	Coventry and Warwickshire CCG £000	Warwickshire County Council £000	Total £000
Contributions to the fund	3,592	860	4,452
Expenditure on service provision	(3,592)	(860)	(4,452)
Total surplus/(deficit)	**0**	**(0)**	**(0)**

The S75 Young Peoples Mental Health and Well being Pooled Budget was effective from 1st August 2017.

The CCG is also party to a Mental Health and Well-being Services established under Section 75 of the NHS Act 2006.

2022/23	Coventry and Warwickshire CCG **£'000**	Coventry City Council **£'000**	Total **£'000**	2021/22	Coventry and Warwickshire CCG **£'000**	Coventry City Council **£'000**	Total **£'000**
Contributions to the fund	0	0	0	Contributions to the fund	3,000	0	3,000
Expenditure on Service provision	0	0	0	Expenditure on Service prov	0	0	0
Total Surplus/(deficit)	**0**	**0**	**0**	Total Surplus/(deficit)	**(3,000)**	**0**	**3,000**

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19 Related party transactions

Coventry and Warwickshire CCG is a corporate body established by order of the Secretary of State for Health.
During the year the following Board Members or members of the key management staff or parties related to them have undertaken transactions with Coventry and Warwickshire CCG.

	2022-23 Payments to Related Party £ 000	2022-23 Receipts from Related Party £ 000	2022-23 Amounts owed to Related Party £ 000	2022-23 Amounts due from Related Party £ 000	2021-22 Payments to Related Party £ 000	2021-22 Receipts from Related Party £ 000	2021-22 Amounts owed to Related Party £ 000	2021-22 Amounts due from Related Party £ 000
S Raistricks - GP Alliance members	**1,407**	**0**	**0**	**0**	**8,044**	**0**	**0**	**0**
S Raistrick- Dr Sharma and Partners	**203**	**0**	**0**	**0**	**778**	**0**	**0**	**0**
S Dhesi -Croft Medical Centre (includes Lisle Court Medical centre)	**445**	**0**	**0**	**0**	**1,961**	**0**	**0**	**0**
J Menon -Brookside surgery	**179**	**0**	**0**	**0**	**1,085**	**0**	**0**	**0**

There were no amounts due from these interests and no receipts in year.

A. Stokes was employed by University Hospitals Coventry and Warwickshire NHS Trust for the period to 30 June 2022 . Transactions with that organisation are disclosed below

19.1. The following Delegated Primary Care Practices had transactions in the year with the CCG

As a result of the Delegated Primary Care arrangements for 3 months to 30 June 2022, the following practices had transactions with Coventry and Warwickshire CCG that are disclosed under GMS/PMS and prescribing expenditure within Note 5 of the accounts.

In Addition to the Above the CCG made payments to other member GP Practices with are deemed related parties on account of contracted Co-Commissioning Arrangements

	2022-23 Payments to Related Party £000	2022-23 Amounts owed to Related Party £000	2021-22 Payments to Related Party £000	2021-22 Amounts owed to Related Party £000
DR K RAI & PARTNER	141	-	643	-
P HORN & PARTNERS	598	-	3,157	-
DR S LYALL & PARTNERS	307	-	1,277	-
DR J V C MOHAN & PARTNERS	485	-	1,982	-
DR E W COWAN & PARTNERS	493	-	1,970	-
DR G SANI GUSAU	184	-	697	-
DR A FELTBOWER & PARTNERS	305	-	1,192	-
DR A EZZAT & PARTNERS	210	-	868	-
DR B BODALIA & PARTNERS	300	-	1,219	-
DR K THOMSON & PARTNERS	642	-	2,513	-
DR C RHODES & PARTNERS	343	-	1,379	-
DRS BEAUMONT & PAI	288	-	1,121	-
DR DE SOUZA & PARTNERS	692	-	3,763	-
DR PS KENYON & PARTNERS	426	-	1,750	-
STONEY STANTON MEDICAL CENTRE	589	-	3,168	-
DR B KHARA & PARTNERS	292	-	1,300	-
DR KEATING & PARTNERS	336	-	1,410	-
DR A KUKREJA & PARTNERS	138	-	555	-
WOOD END HEALTH CENTRE	227	-	994	-
DR J MAC PHERSON & PARTNERS	279	-	1,120	-
DR MOTTRAM & PARTNERS	318	-	1,494	-
DR A KHAN COVENTRY	103	-	403	-
DR DURR & PARTNERS	486	-	1,927	-
DR COCKERILL & PARTNER	184	-	765	-
DR HOLTON & PARTNERS	364	-	1,513	-
DR MEH WALLACE & PARTNER	147	-	545	-
DR COOPER & PARTNERS COVENTRY	412	-	1,572	-
DR HARKNESS & PARTNERS	256	-	971	-
DR DOSANJ	110	-	520	-
ALLESLEY VILLAGE SURGERY	102	-	430	-
DR WHEATLEY & I MACDONALD	150	-	586	-
DR K EL-KASHOTY	271	-	1,149	-
DR JM PATEL & PARTNERS	121	-	477	-
DR D MISTRY & PARTNERS	221	-	924	-
DR T KAZMI & DR TEWARY	155	-	700	-
DR S KATTI & PARTNERS	249	-	1,059	-
DR SK DHILLON	114	-	440	-
DR DADHANIA	65	-	249	-
DR MM SINGH	104	-	1,207	-
DR R BANO	129	-	509	-
DR M GARALA	93	-	354	-
DR SIHOTA & PARTNERS	305	-	1,178	-
DR P AGGARWAL	159	-	638	-
DR MISHRA & MISRA	155	-	601	-
DR P PATEL	187	-	778	-
DR JM BOOKER	66	-	286	-
WHITEHALL MEDICAL PRACTICE	433	-	1,758	-
SCHOOL STREET SURGERY	155	-	768	-
CLIFTON ROAD SURGERY	433	-	1,741	-
CENTRAL SURGERY RUGBY	569	-	2,350	-
BARR LANE SURGERY	298	-	1,616	-
WESTSIDE MEDICAL CENTRE	313	-	1,338	-
DUNCHURCH SURGERY	257	-	1,056	-
MARKET QUARTER MEDICAL PRACTICE	282	-	1,072	-
WHITEHALL ROAD SURGERY	197	-	720	-
BENNFIELD SURGERY	269	-	1,082	-
THE ATHERSTONE SURGERY	550	-	2,573	-
ARBURY MEDICAL PRACTICE	306	-	1,174	-
CHANCERY LANE PRACTICE	197	-	794	-
DRS AK CHAUDHURI & M MOTALA SURGERY	133	-	584	-
DR SS SINGH & PARTNERS	654	-	2,903	-
GRANGE MEDICAL PRACTICE	362	-	1,484	-
HAZELWOOD GROUP PRACTICE	364	-	1,605	-
MALLING HEALTH	79	-	447	-
MALLING HEALTHCARE AT SATIS HOUSE	63	-	365	-
MALLING HEALTHCARE AT THE CHAUCERS	57	-	351	-
MANOR COURT SURGERY	271	-	1,080	-
NORTHUMBERLAND ROAD PRACTICE	74	-	326	-
OLD COLE HOUSE PRACTICE	124	-	536	-
OLD MILL PRACTICE	367	-	1,484	-
PEAR TREE SURGERY	385	-	1,833	-
QUEENS ROAD PRACTICE	78	-	318	-
RED ROOFS PRACTICE	507	-	2,138	-
RIVERSLEY ROAD PRACTICE	195	-	759	-
RUGBY ROAD PRACTICE	116	-	507	-
SCHOOL ROAD PRACTICE	200	-	799	-
SPRING HILL MEDICAL CENTRE	303	-	1,303	-
WHITESTONE SURGERY	124	-	581	-
ABBEY MEDICAL CENTER KENILWORTH	431	-	1,786	-
AVONSIDE HEALTH CENTRE	327	-	1,340	-
BRIDGE HOUSE MEDICAL CENTRE	293	-	1,289	-
BIDFORD ON AVON HEALTH CENTRE	563	-	2,865	-
BUDBROOKE MEDICAL CENTRE	207	-	1,162	-
WATERSIDE MEDICAL CENTRE LEAMINGTON SPA	371	-	1,550	-
CUBBINGTON ROAD SURGERY	212	-	885	-
FENNY COMPTON SURGERY	263	-	1,411	-
HARBURY SURGERY	220	-	1,192	-
HASTINGS HOUSE	531	-	2,475	-
HENLEY IN ARDEN MEDICAL CENTRE	262	-	1,026	-
KINETON SURGERY	274	-	1,574	-
NEW DISPENSARY	224	-	950	-
POOL MEDICAL CENTRE	225	-	985	-
ALCESTER HEALTH CENTRE	205	2	893	-
PRIORY MEDICAL CENTRE	597	-	2,539	-
ROTHER HOUSE MEDICAL CENTRE	580	-	2,363	-
SHERBOURNE MEDICAL CENTRE	299	-	1,219	-
SHIPSTON MEDICAL CENTRE	472	-	2,363	-
SOUTHAM SURGERY	246	-	1,106	-
SPA MEDICAL CENTRE	127	-	516	-
TANWORTH IN ARDEN MEDICAL PRACTICE	247	-	1,310	-
TRINITY COURT SURGERY	736	-	3,251	-
WARWICK GATE FAMILY HEALTH CENTRE	288	-	1,130	-
WHITNASH MEDICAL CENTRE	167	-	743	-
SOUTH WARWICKSHIRE GP LTD	2,649	-	4,915	-
DORDON AND POLESWORTH GROUP (LONG STREET) SURGERY	469	-	1,825	-
WOODLANDS SURGERY (NEWTOWN ROAD)	128	-	565	-
STATION STREET SURGERY	135	-	546	-
CASTLE MEDICAL CENTRE	369	-	1,576	-
THE ARROW SURGERY	221	-	964	-
CLARENDON LODGE	377	-	1,662	-
MEON MEDICAL CENTRE	257	-	1,395	-
ST WULFSTAN SURGERY	265	-	1,000	-
LAPWORTH SURGERY	117	-	649	-
ANCHOR CENTRE	41	-	-	-
MERIDIAN CENTRE	264	-	-	-
PARTNERING HEALTH LTD	1	-	-	-
CITY OF COVENTRY HEALTH CENTRE	2	-	-	-
BROAD LANE SURGERY	1	-	-	-
MALLING HEALTH AT FOLESHILL	380	-	-	-
BROWNSOVER MEDICAL PRACTICE	245	-	-	-

The Department of Health is regarded as a related party. During the year Coventry & Warwickshire CCG has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below.

	2022-23 Payments to Related Party £000	2022-23 Receipts from Related Party £000	2022-23 Amounts owed to Related Party £000	2022-23 Amounts due from Related Party £000	2021-22 Payments to Related Party £000	2021-22 Receipts from Related Party £000	2021-22 Amounts owed to Related Party £000	2021-22 Amounts due from Related Party £000
University Hospitals Coventry and Warwickshire NHS Trust	108,807	0	12,427	72	516,120	0	516	0
Coventry & Warwickshire Partnership NHS Trust	48,402	0	656	0	190,532	0	920	16
South Warwickshire NHS Foundation Trust	67,737	0	1,594	591	287,259	0	788	502

Additionally the CCG had significant but non-material transactions with the following related parties:

West Midlands Ambulance Service NHS Foundation Trust
George Eliot Hospital NHS Trust

Where our payments to them represented more than 1% but less than 10% of their total income.
Organisations where more than 10% of their income came from Coventry and Warwickshire CCG have been reported separately as material transactions

The CCG had no material transactions with Central Government departments other than those with the Department of Health which are detailed below.
The CCG engaged in significant material transactions with the following local authorities

	2022-23 Payments to Related Party £000	2022-23 Receipts from Related Party £000	2022-23 Amounts owed to Related Party £000	2022-23 Amounts due from Related Party £000	2021-22 Payments to Related Party £000	2021-22 Receipts from Related Party £000	2021-22 Amounts owed to Related Party £000	2021-22 Amounts due from Related Party £000
Coventry City Council	5,937	44	1,081	164	30,645	0	3,185	156
Warwickshire County Council	6,854	263	9,201	616	29,566	0	9,320	633

Payments in respect of Better Care fund included above are treated net in line with Expenditure treatment

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20 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2022-23 Number	**Total Value of Cases 2022-23 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Administrative write-offs	0	0	0	0
Total	-	-	-	-

Compensation and Special payments

There were no Compensation or special payments during the period (21/22 Nil)

21 Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups were abolished and the functions, assets and liabilities of NHS Coventry & Warwickshire CCG were transfered to NHS Coventry & Warwickshire Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements as the services of the clinical commissioning groups continue to be provided using the same assets by another public sector entity.

22 Financial performance targets

The CCG has a number of financial duties under the NHS Act 2006 (as amended). The CCG's performance against those duties in 2022-23 was as follows:

	2022-23 £000 Target	**2022-23 £000 Performance**	**2022-23 Duty Achieved Yes/No**	2021-22 **£000** Target	2021-22 **£000** Performance
Expenditure not to exceed income	457,597	457,591	YES	1,884,394	1,883,654
Capital resource use does not exceed the amount specified in Directions	-	(0)	YES	496	496
Revenue resource use does not exceed the amount specified in Directions	455,592	455,592	YES	1,881,813	1,881,787
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	n/a	n/a	n/a	n/a	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	n/a	n/a	n/a	n/a	n/a
Revenue administration resource use does not exceed the amount specified in Directions	4,655	4,655	YES	18,521	18,510

23. External Audit Limitation to liability

In accordance with SI 2008 no.489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the CCG must disclose the principal terms of the limitation of the auditors liability. This is detailed as follows:
- For all defaults resulting in direct loss or damage to the property of the other party - £2m limit.
- In respect of all other defaults, claims, losses or damages arising from breach of contract, misrepresentation, tort, breach of statutory duty or otherwise - not exceed the greater of the sum of £2m or a sum equivalent to 125% of the contract charges paid or payable to the supplier in the relevant year of the contract.