NHS
Devon
Clinical Commissioning Group

Annual report and accounts

1 April - 30 June 2022

Contents

Performance report

Performance overview

Introduction

NHS Devon Clinical Commissioning Group (CCG) ceased to exist as a statutory body on 30 June 2022. At this date all CCGs were abolished. Health services are now commissioned by the Integrated Care Board for Devon, the organisational form and functions of which are set out below. This report therefore covers the period from 1 April 2022 to 30 June 2022.

Overview

This section provides information about NHS Devon Clinical Commissioning Group, its purpose and its performance during the period 1 April 2022 – 30 June 2022. The CCG was established on 1 April 2019, from a merger of two previous CCGs, Northern, Eastern and Western Devon CCG and South Devon and Torbay CCG.

Review of the three-month period – working with partners and providers

One Devon

In this period, the CCG worked with its partners across the health and care system to ensure a smooth transition to the new Integrated Care Board for Devon, known as NHS Devon. It made appointments to the Board, including non-executive directors, finalised governance arrangements and ensured all staff and the public were well informed about how the forthcoming changes would affect them.

Through One Devon (the name of the integrated care system for Devon), NHS Devon aims to effect the changes to health and care set out in the NHS Long Term Plan. This is intended to meet the growing challenges of providing community and hospital care and social care when demand is dramatically increasing. Through the Devon Plan – made up of our Integrated Care Strategy and our Five-Year Joint Forward Plan – we will show how we will meet the needs of the local population.

The vision for One Devon is: Equal chances for everyone in Devon to lead long, happy and healthy lives.

With partners, the CCG agreed six strategic objectives for One Devon:

- Collaborate across the system to address quality (safety, effectiveness, experience) and productivity.
- Systematic delivery of the integrated – or joined up – care across Devon.
- A citizen-led approach to health and care. We will adopt a new approach to reduce differences in care across the county and will work with communities to identify priorities and tackle the root causes of problems.
- Working together with children, young people and their families. We want all children and young people in Devon to have the best start in life, grow up in loving and supportive families, and be happy, healthy and safe.
- Invest in a digital Devon: people will only tell their story once, first contact will be digital and more advice and help will be available online. We want to make the most of advances in digital technology to help people stay well, prevent ill-health, and provide care.
- Work together to tackle the physical health inequalities for people with mental illness, learning disabilities and/or autism.

In April 2021, Jane Milligan took up the role of chief executive of the Integrated Care System and the role of Accountable Officer of the CCG.

COVID-19 pandemic

The CCG continued to coordinate the response to COVID-19 to ensure the best possible care for people across Devon. This included preparing for a probable resurgence of cases from the autumn of 2022, and for a new round of vaccinations and boosters. From April, booster vaccinations were delivered within national timeframes to those eligible. During the three months, those living in care homes continued to receive targeted support.

With its partners, the CCG paid particular attention to reducing waiting times for those whose care and treatment was delayed by the COVID-19 pandemic. This included establishing dedicated theatre time for orthopaedic and eye surgery so that planned treatment was not affected by emergencies or surges in demand for care. Addressing this backlog is of the highest priority for NHS Devon and partners.

Equalities

The CCG continued its drive to address health inequalities. In particular, it implemented a range of measures to improve experience among ethnically diverse communities, with Black, Asian and ethnic minority citizens and staff represented at board level and community engagement and involvement making a difference to ethnically diverse communities. Confidence in the COVID-19 vaccination was significantly improved through an outreach programme, which used trusted community representatives as vaccine ambassadors, and resulted in more than 50,000 people from vulnerable communities (including LGBTQ+, migrant workers, gypsy Roma and traveller communities and ethnically diverse groups), receiving their COVID vaccination. (This work was subsequently recognised at national level with the Health Equalities award at the NHS Parliamentary Awards.)

Hospital collaboration formalised

In April 2022, the Royal Devon University Healthcare NHS Foundation Trust was established, bringing together the Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust. With more than 15,000 staff, it is the biggest employer in the county. It provides acute and emergency care, integrated health and social care services and some primary care and specialist community services.

Health and wellbeing

Work continued on a new Health and Wellbeing Centre for Dartmouth, to enable its opening later in 2022 with GPs, health and care staff and the voluntary sector under one roof. The centre will offer multiple services and adopt a multidisciplinary, person-centred approach for the local community.

Type 2 diabetes

Diabetes care continued to take a prominent place, with more than 75,000 people in Devon living with type 2 diabetes. As examples, the Torridge Primary Care Network has a diabetes support nurse working to improve patient care closer to home, to help people with their treatment, reduce the numbers referred to specialist care and improve people's experience.
At the Royal Devon and Exeter Hospital and North Devon District Hospital, a specialist diabetes pharmacist was appointed for 12 months to review diabetic patients and their medications and update care plans. The pharmacist takes part in diabetes ward rounds and works with pharmacists in primary care networks to improve the way people are referred for care.

Investments

Hospital improvements

Work on a £20million state-of-the-art Emergency Department at the Royal Devon and Exeter (RD&E) Hospital has been progressing, with funding from the New Hospital Programme.
The project enables the hospital to expand its clinical services with a first-rate treatment environment. As the RD&E is a teaching hospital, it will also provide high-quality education and training space for future generations of medical students.

It creates eight new resuscitation bays consisting of six adult bays and two dedicated paediatric bays. There will also be a specialist children's department with a paediatric assessment unit providing a child-friendly environment. An area has been designated for seeing and treating those with minor injury and illness, and a new reception area will house a larger waiting room, with natural light.

Under the same initiative, University Hospitals Plymouth NHS Trust is progressing with work on a new emergency care facility, bringing together urgent and emergency care and providing dedicated areas for children, frail people, and those needing same day emergency care. The first phase is due to see the existing Emergency Department replaced by 2024.
Torbay Hospital is building a £15milllion Acute Medicine Unit, due to open in the autumn of 2022. This will double the number of assessment spaces to 52, ensuring patients get timely access to the right care.

Northern Devon Healthcare NHS Trust also continued work on improvements to its hospital facilities, replacing ageing estate and allowing the delivery of new models of care.

Funding for planned care

In the year ended March 2022, health and care partners in Devon received £11.3 million from the national Accelerator Systems Programme (ASP) to spend on three initiatives to reduce waiting times for routine – or planned – operations in Devon, Somerset, Cornwall and Dorset.

Work has continued on the three initiatives identified:

- increasing the number of planned orthopaedic operations at the Nightingale Hospital in Exeter, with ready-made operating theatres and diagnostic services such as CT and MRI scans
- increasing the number of eye operations in Plymouth, with a purpose-built modular ophthalmology unit at Derriford Hospital for eye operations such as cataract removal
- introducing eye operations in community settings

NHS Devon CCG performance rating

There was no new performance rating for Devon CCG in this period of transition to an integrated care system.

In 2021-2022, a simplified annual assessment focused on the CCG's contributions to delivery of the Devon system plan for recovery, with emphasis on the effectiveness of working relationships in the local system.

NHS England noted that the CCG had demonstrated its leadership role in managing the wider system response to COVID-19, fully engaged with Integrated Care System and Integrated Care Partnership developments, maintained engagement with patients and ended the year in a breakeven financial position.

Our purpose and activities

As of July 2022, clinical commissioning groups ceased to exist as statutory bodies and Devon CCG was superseded by the Integrated Care Board for Devon, known as NHS Devon.

The CCG has been responsible for commissioning, or planning and buying, most healthcare services for the 1.2 million people in the local population. Our aim was to improve people's lives, to reduce inequalities in health, and make sure that with our partners in the Integrated Care System we could deliver services for the long term.

We worked with our local communities and partner organisations to improve people's health and wellbeing and make sure they have safe, high quality, local services. We were responsible for commissioning £1.9billion of healthcare services. This does not include dentists, pharmacies or all specialised NHS services, but we had full responsibility for commissioning GP medical services, under authority delegated by NHS England.

The CCG was a membership body made up of all the GP practices in Devon. Full details of the Governing Body are on pages 56 and 57.

Vision, mission and strategic objectives

The vision and values were drawn up with our staff on the creation of a single CCG for Devon.

- **Vision:** Working together for Devon
- **Mission:** Working together to commission the right services that improve lives of those who live in Devon
- **Strategic objectives:** The CCG's strategic objectives were updated in early 2021, with staff helping develop them.

The CCG took joint ownership with its partners and the public for creating sustainable health and care services. Commitment to this has been evidenced by an active role in developing the Integrated Care System for Devon (ICSD), and by extensive discussions with, and involvement of, people using services.

The CCG executive members took corporate and personal accountability for driving and enabling achievement of these objectives through their leadership roles.

Commissioning local services

The CCG assessed the needs and strengths of the local population and communities before designing and buying services to match those needs. It had a statutory duty to do this in an open, transparent and careful manner, ensuring patients and their families had the highest-quality experience of their health care.

To make sure our plans for local services were comprehensive and representative, we talked to clinicians and health professionals, and canvassed patients' views, working with Healthwatch in Plymouth, Torbay and Devon. Details of how we engaged with our communities are set out on page 26.

The CCG had a statutory responsibility to act transparently, proportionately and without discrimination, recognising the responsibilities to consult and engage. The work of the CCG was underpinned by the principles and values set out in the NHS Constitution.

Operational structure and the business environment

The commissioning architecture introduced under the Health and Social Care Act 2012 was designed to place the responsibility for decision-making with clinicians to ensure the focus always remained on the individual patient.

Our CCG commissioned most healthcare services, including:

- Primary care
- Planned hospital care
- Rehabilitation care
- Urgent and emergency care (including out-of-hours care and ambulance services)
- Most community health services
- Maternity and new-born services
- Mental health and learning disability services
- Children's and young people's health services
- Continuing healthcare for people with ongoing health needs

CCGs could commission any service provider that met NHS standards.

The CCG had a statutory responsibility under the NHS Procurement, Patient Choice and Competition Regulations 2013 and the Public Contract Regulations 2015 to secure services that met patients' healthcare needs and improved quality and efficiency.

Opportunities for providing healthcare services continued to be advertised on the Government Contracts Finder website.

CCGs were overseen by NHS England, which ensured that CCGs had the capacity and capability to commission services successfully and to meet their financial responsibilities. NHS England had a duty under the Act to promote the autonomy of local clinical commissioners.

NHS England and local health commissioners had an ongoing duty to involve their patients, carers and the public in decisions about the services they commissioned.

From 1 April 2022 to 30 June 2022 the CCG commissioned its main services from the following key providers:

- Devon Doctors Ltd
- Devon Partnership NHS Trust
- Livewell Southwest Community Interest Company
- Royal Devon University Healthcare NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust
- University Hospitals Plymouth NHS Trust

The CCG was first established with four localities, each with its own clinical representative on the Governing Body: Northern, Eastern, Southern and Western. In the last year, Plymouth worked within its own locality structure.

The CCG's area spanned three local authority areas – Devon County Council, Torbay Council and Plymouth City Council, each with approved Better Care Funds which pool health and social care budgets, and each with a Health and Wellbeing Board.

People in Devon generally live longer than those elsewhere in the country, but there are still variations in life expectancy within the county. Significant levels of deprivation exist within our urban areas with pockets of deprivation both in the towns and deeply rural areas of Devon. The CCG was committed to working with partner organisations to reduce these inequalities.

The business environment involves managing risks – for further details, turn to the 'Risk management arrangements and effectiveness' section on page 68.

Digital strategy

The adoption of new technologies continued to develop at pace during the three months from April to June 2022.

Prominent among these has been work on the Devon and Cornwall Care Record (DCCR), which brings together patient data from a wide range of clinical systems and presents it as a single view.

This means that an approved health and care worker in a GP practice, hospital, hospice or care home can see vital information about a patient they are caring for.

The DCCR will, over time, be expanded in range to include a greater amount of information, including images, radiography, allergies, laboratory results and correspondence, as well as diagnoses, medications, health conditions and procedures.

This will improve decision making and benefit patients in receiving greater continuity of care.

The work is a key part of partnership working across the peninsula, and forms part of the Digital Blueprint agreed by Devon partners.

Digital developments in primary care

Primary care in Devon has continued to develop and mature digitally.

All of Devon's 121 practices offer online and video consultation to their patients and up to this point there was no choice of system for those practices and their patients. The end of our first contract for online consultation systems gave us the opportunity to engage extensively with our practices, patients and stakeholders to determine their requirements for the next generation of system. The conclusion of that work gave practices a choice between two different types of system. These have now been implemented at all 121 practices and are in use with their patients. The systems offer more than just online consultations with SMS text messages – video consultations, patient surveys and other features are now available.

By the end of May 2022, we completed the work to upgrade every practice in Devon to Microsoft Office 365, using the centrally negotiated NHS deal with Microsoft. This provides them with a suite of fit-for-purpose up-to-date software, with both updated traditional office capabilities, but also new useful tools to support the management and running of general practice.

We are building on the foundations already laid for future digital work. A joint project with Plymouth City Council, sponsored by the Department for Digital, Culture, Media and Sport installed fibre-optic connections to 48 GP practice sites in West Devon as part of a larger rollout of superfast connections to public sector buildings in the area. We have now partnered with an organisation which will 'light-up' these fibre connections for us and deliver superfast connections to those GP practices.

Following the launch of a new health apps library with the Organisation for the Review of Care and Health Apps, use by patients has been increasing. Essentially a comparison website for health and care apps, the localised site allows patients to search and download from a wide range of apps and aims to make it quicker and easier for people across Devon to access safe, accredited health and wellbeing apps, making a huge difference to their everyday lives. More than 6,000 page views took place during April 2022.

Use of the NHS App has continued to increase in Devon with 482,688 registrations, accounting for 44% of the patient population over 13.

Primary care developments

Primary care in Devon has continued to implement its five-year strategy. Primary Care Networks are now well established, bringing together GP practices in given areas to work together for the benefit of patients. In each Local Care Partnership, a Primary Care Collaborative Board brings together all the Primary Care Network clinical directors, for discussion about priorities and decision-making.

The vision set out in the strategy is that primary care in Devon will offer each local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.

To do this, we must address a number of challenges. Increasing demand, difficulties in recruitment and retention, and funding that includes estates and IT are areas that need our attention. The strategy therefore outlines five priorities:

1. We will improve patient access to care through innovative technology.
2. We will develop and retain an agile and engaged workforce, with a focus on multi-disciplinary teams to reduce pressures on services and improve outcomes for patients.
3. We will take a population health management approach to improve Devon's health and wellbeing and reduce health inequalities.
4. We will develop Primary Care Networks to provide more joined-up care close to home.
5. We will modernise our estates and infrastructure to support and enhance services.

These five priorities are being built into the Devon Plan, to be executed by the Integrated Care System for Devon.

GP practices in Devon continued to provide large numbers of face-to-face appointments, building on the 4.7 million seen over the previous 12 months.

Winter

With advanced planning under the Integrated Care System for Devon, the system is collaborating more closely than ever to permit timely discharges from hospital, to maintain the flow of patients and relieve pressure on emergency departments and on beds. This work continues year-round, and not just for winter. One Devon will continue the campaign to promote use of the NHS 111 service as an alternative to presentation at hospital emergency departments.

Winter preparedness and delivery of plans remains a standing item on local and Devon A&E delivery boards to underpin strong system working.

Looking ahead – our plans for the remainder of 2022/23

COVID-19 pandemic

A continuing system-wide response to the coronavirus pandemic remains a priority for the Devon healthcare system in the year ahead, with planning for a response to further variants and continued vaccination programmes running alongside strategic planning.

With a rise in COVID-19 cases possible from the autumn, a focus will be on delivering the vaccination programme as required. From April 2022, those in the over 85 age group were offered a further dose. This particularly protects residents in care homes.

The healthcare system as a whole remains focussed on eliminating long delays in treatment, occasioned in large part by the pandemic.

Integrated Care System for Devon – One Devon

The year from 1 April 2022 has seen the biggest change in the healthcare system in Devon since clinical commissioning groups were established in 2012. From 1 July 2022, all the functions of NHS Devon CCG were absorbed into the new Integrated Care Board for Devon, known as NHS Devon. In the remainder of the year, NHS Devon will focus on improving health and social care for the people of Devon, while improving performance of the system.

Digital strengthening

Digital technology has moved more quickly than ever in the past two years, and we will continue to strive for innovation and efficiency.

The Devon and Cornwall Care Record will be an area of great focus, affording the opportunity to improve patient safety and experience as well as aiding decision making.

The safe sharing of data across the system remains a priority.

New provider for NHS 111 and out of hours services

Devon CCG appointed a new provider to run the NHS 111 and GP out of hours services from October 2022, with the aim of giving the people of Devon straightforward round-the-clock access to responsive, safe and high quality care.

Local people in Devon, as users of these services, played a vital role in the process of selecting the new provider.

Following a rigorous, competitive process, the CCG awarded the contract to Practice Plus Group Urgent Care Limited, which currently runs similar services in many other parts of the country. The contract is for three years, with a two-year extension.

Across the country, Practice Plus Group Urgent Care (formerly known as Care UK) answers 1.5million calls a year to NHS 111, and runs out of hours services, urgent treatment centres, minor injuries units, hospitals and general practices. Its NHS 111 service in Bristol was the first to be rated “outstanding” by the Care Quality Commission.

In Devon, it will also run the clinical assessment service, in which clinicians use their expertise to respond to callers, prioritising cases and directing people to the most appropriate services.

Performance summary

A summary and perspective by Jane Milligan, Accountable Officer for NHS Devon CCG:

While we continued to work closely with providers to make improvements against our key targets (including those set out in the NHS Constitution), the period of 1 April to 30 June 2022 remained one of continued challenges.

The CCG continued to perform well on measures of early diagnosis of cancer and cancer survival rates, the range of mental health targets, patient experience and low rates of healthcare acquired infections.

However, performance against the A&E four-hour wait measure was below target although there was good progress in reducing delayed transfers of care. Performance against the 18-week wait target was not recovered, despite progress in orthopaedic and eye surgery.

The Strategic Outcomes Framework (SOF) draws together in one place NHS Constitution and other core performance and finance metrics, outcome goals and transformational challenges, to capture the multi-faceted role of ICSs.

The SOF is updated and released on a quarterly basis, with the SOF published through a range of channels including NHS Futures.

The latest information available where data was published for 54 indicators for the One Devon area, is as follows.

		ICS	MH provider	Provider
Highest performing quartile		14	0	2
Interquartile range		31	0	8
Lowest performing quartile		3	1	2

NHS OF Metric Name	Period	ICS	MH Provider	Provider
S001a: Appointments in general practice	w/e 03/04/2022	160,920		
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	19/06/2022	44.50%		
S008a: Overall size of the waiting list	2022 04	152,834		
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2022 04	14,346		
S010a: Cancer - first treatments	2022 04	638		
S010b: Cancer - urgent referrals seen	2022 04	5,725		
S011a: Cancer - people waiting longer than 62 days	w/e 05/06/2022			838
S012a: Cancer - % meeting faster diagnosis standard	2022 04	80.20%		
S013a: Diagnostic activity levels - Imaging	2022 04	25,319		26,663
S013b: Diagnostic activity levels - Physiological measurement	2022 04	3,095		3,280
S013c: Diagnostic activity levels - Endoscopy	2022 04	2,361		2,541
S014a: Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018	75.40%		
S016a Outpatient - Specialist Advice (including A&G) activity levels	2022 03	30.00%		
S016b: Outpatient - Patieint Initiated Follow-up activity levels		2.27%		
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2022 03			23.70%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03			1,119
S021a: Maternity - % women on continuity of care pathway	2022 02	88.2%		
S022a: Maternity - number of Stillbirths per 1,000 live births	2019	3.43 per 1,000		
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019	1.44 per 1,000		
S026a: Proportion of ED patients who turn up unheralded	2022 05	90.20%		
S029a: Reliance on specialist inpatient care for adults with a learning disability and/or autism	21-22 Q4	38 per 1,000,000		
S030a: Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	21-22 Q4	65.60%		
S031a: Number of personalised care interventions	21-22 Q3	48,894		
S032a: Personal Health Budget	21-22 Q4	8,600		
S033a: Social Prescribing unique patient referrals	21-22 Q4	16,682		
S037a: Patient experience of GP services	2021	87.90%		
S039a: National Patient Safety Alerts not completed by deadline	2022 04			0
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2022 04	0		0
S041a: Clostridium difficile infections	2022 04	28		15
S042a: E. coli blood stream infections	2022 04	71		26
S044a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Apr 2021 - Mar 2022	82.80%		
S044b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Apr 2021 - Mar 2022	9.20%		
S045a: COVID-19 - % adults vaccinated	w/e 12/06/2022	95.70%		
S046a: Population vaccination coverage - MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	21-22 Q2	92.60%		
S047a: Percentage of people aged 65 and over who received a flu vaccination	2022 02	84.40%		
S050a: Cancer - cervical screening coverage, females aged 25-64, attending screening within target period	21-22 Q3	74.40%		
S051a: Number of people supported through the NHS Diabetes Prevention programme	21-22 Q4	46.20%		
[illegible] recommended treatment targets (adults and children)	2020-21	32.90%		
S055a: General Practice Referrals to NHS Digital Weight Management Programme - Crude Rate/100,000 population	21-22 Q4	56.8 per 100,000		
S067a: Leaver rate	2022 02	13.60%		
S068a: Sickness absence (working days lost to sickness)	2022 01	6.51%		
S070a: Number of people working in the NHS who have had a flu vaccination	2022 02		35.4%	69.3%
S073a: Nursing vacancy rate	2021 12			6.7%
S081a: IAPT access (total numbers accessing services)	21-22 Q4	6,500		
S082a: IAPT recovery rate (%)	21-22 Q4	51%		
S083a: Estimated diagnosis rate for people with dementia	2022 05	55%		
S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact)	2022 03	12,140		
S085a: People with severe mental illness receiving a full annual physical health check and follow up interventions	21-22 Q4	3,643		
S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	Jan 2022 - Mar 2022	1		
S087a: Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	2022 03	7.4 per 100,000		
S087b: Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2022 03	6.8 per 100,000		
S088a: Number of women accessing specialist community perinatal mental health services	Apr 2021 - Mar 2022	6.4%		
S089a: Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services	Apr 2021 - Mar 2022	54.3%		
S089b: Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Apr 2021 - Mar 2022	44.2%		

Performance analysis

NHS Constitution targets

The NHS Constitution sets out key targets for NHS organisations. Throughout, 2021-23, many services were affected by the COVID-19 pandemic, resulting in large increases in waiting lists and waiting times in many areas.

Throughout the pandemic, those patients with the greatest clinical need for hospital treatment were prioritised and when pressure on services relaxed, services were restored as quickly and as safely as possible.

However, continuing pressures have resulted in several constitutional performance targets being missed. Despite this, some areas have seen an improvement and there has been significant benefit realised from improvements in technology that have increased the number of patients being able to be treated in a different care setting or in their own homes via telephone or video consultations.

While joint mutual support arrangements were already in place and working well across the Devon system, even closer joint working between organisations has been an important element of the drive for improvement.

The Director of Performance is currently working with Intelligence leads to improve performance reporting, aligned to the national Outcomes Framework domains, which will include performance trajectory monitoring. This will be used in future as the framework to feed all system assurance groups.

Work on the recovery of performance is gathering pace, for example with dedicated theatre space being provided and a programme to tackle the backlog of people whose treatment has been delayed. Benchmarking against comparative systems and providers to identify further improvement opportunities.

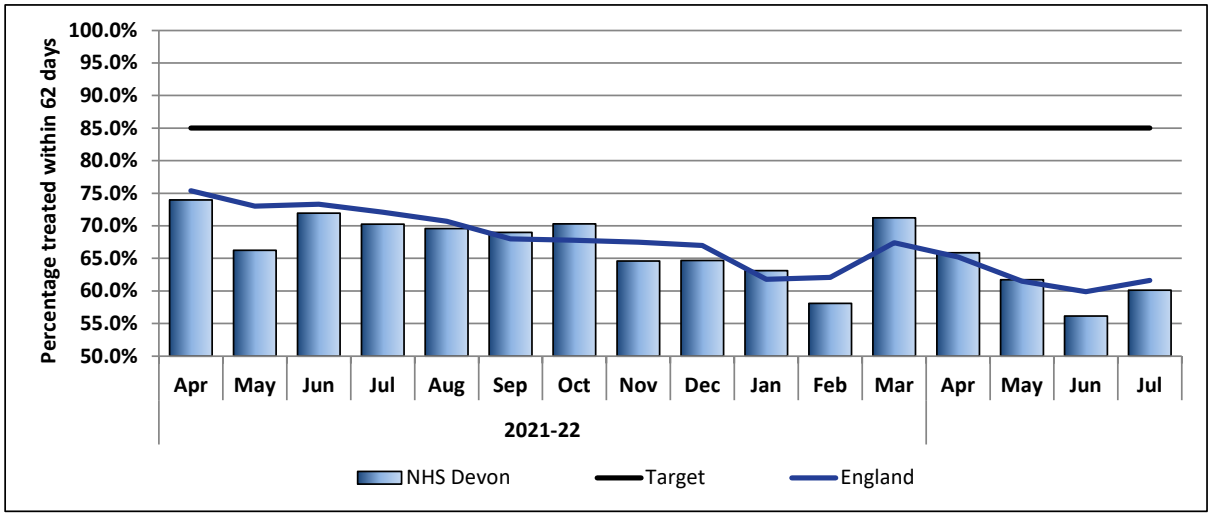
More detail regarding 2020/21 and 2022/23 YTD performance against each of the key national standards is provided below.

	2021-22					
KPI	Target	ICS Devon	RDU	UHP	TSDFT	England
Referral to treatment - Percentage treated within 18 weeks - Incomplete Pathways	92%	56.3%	53.8%	63.8%	58.3%	65.4%
Number of over-52-week waiters (as at December)	0	13562	7411	3062	3177	N/A
Diagnostic waiting times - Percentage treated within 6 weeks	99%	63.3%	53.8%	74.1%	65.2%	75.0%
Accident and emergency percentage seen within four hours (acute only)	85%	62.3%	67..56%	N/A	50.5%	57.9%
Accident and emergency percentage seen within four hours (All)	95%	74.5%	73.9%	N/A	67.3%	68.3%
Cancer - Percentage treated within 2 weeks	93%	71.8%	71.0%	84.2%	58.3%	82.1%
Cancer - Percentage treated within 62 days - urgent referral to first definitive treatment	85%	67.8%	66.4%	69.9%	66.4%	68.8%

	2022-23 YTD (April -July)					
KPI	Target	CS Devo	RDU	UHP	TSDFT	England
Referral to treatment - Percentage treated within 18 weeks - Incomplete Pathways	92%	52.6%	52.4%	58.7%	50.7%	62.1%
Number of over-52-week waiters (as at December)	0	15459	8192	3196	4741	N/A
Diagnostic waiting times - Percentage treated within 6 weeks	99%	63.7%	53.5%	81.0%	68.3%	72.6%
Accident and emergency percentage seen within four hours (acute only)	85%	48.4%	54.0%		37.0%	51.4%
Accident and emergency percentage seen within four hours (All)	95%	65.4%	63.0%		57.8%	64.3%
Cancer - Percentage treated within 2 weeks	93%	72.0%	79.0%	82.6%	46.8%	79.5%
Cancer - Percentage treated within 62 days - urgent referral to first definitive treatment	85%	60.9%	58.8%	65.0%	58.9%	62.0%

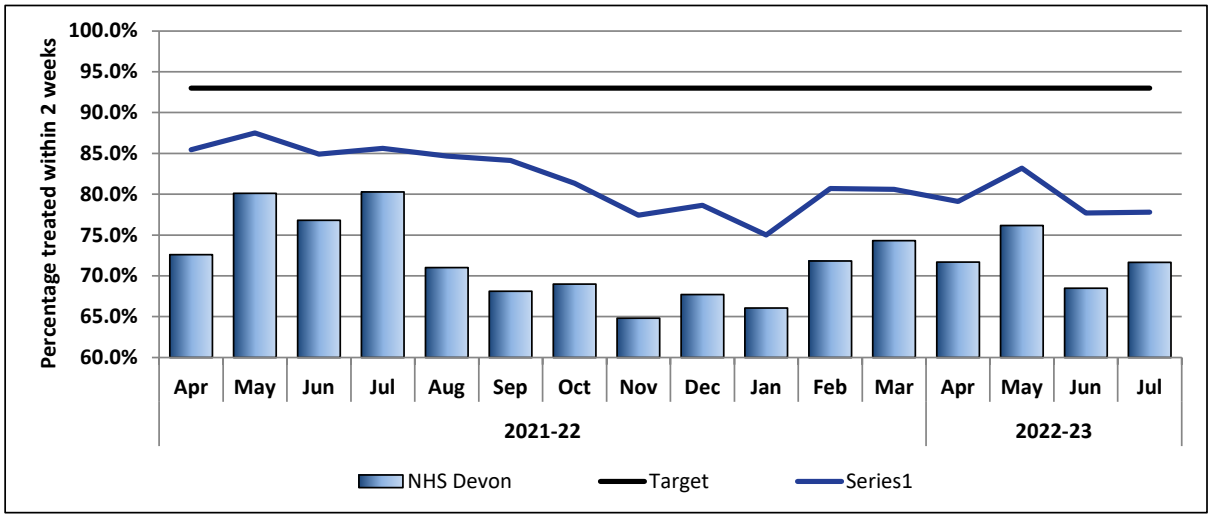
Cancer - percentage treated within 62 days - urgent referral to first definitive treatment

Throughout the pandemic, cancer services remained active and although it remains under the national target, the ICS position has remained close to the national average for the majority of the year. As of July 2022, the ICS saw 60.1% within 62 days – slightly below the national average of 61.6%.



Cancer – percentage seen within 2 weeks – urgent referral to first seen

The ICS performance remained below the national 93% target throughout 2021-22 and 2022-23. Staffing levels were a significant challenge, with Covid-related absence and self-isolation requirements having an impact. Providers are following national guidance to enable urgent cancer services to continue through the pandemic, aided by the mutual support process led by the Cancer Alliance.



Other cancer targets

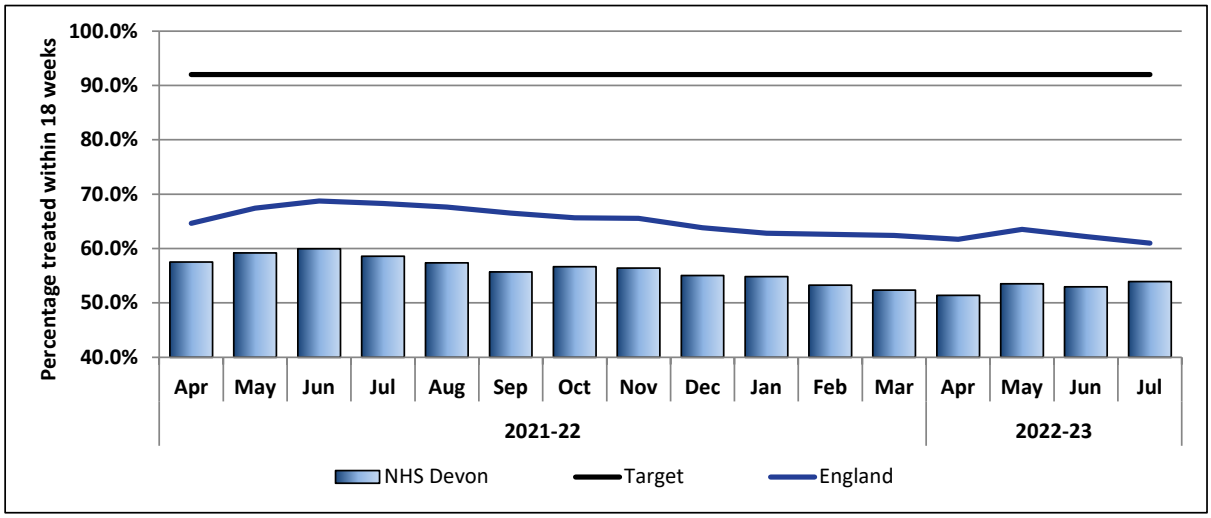
Performance was poor against other cancer waiting times targets with two of the seven standards. The ICS continues to work closely with providers to review cancer pathways and identify opportunities for reducing delays. Cancer breaches are reviewed on an individual basis so that lessons learned can be applied to ensure future improvement.

Description	Target	2021	Q1	Q2	Q3	Q4	2022	Q1	2023 YTD (July)
Cancer - seen within 2 weeks - urgent referral to first seen	93%	82%	76.4%	73.1%	67.1%	71.1%	71.5%	72.1%	71.2%
Seen within 2 weeks - referral of any patients with breast symptoms	93%	64%	22.5%	46.4%	31.1%	42.5%	34.4%	54.2%	50.7%
Cancer - treated within 62 days - urgent referral to first definitive treatment	85%	77%	71.2%	69.6%	66.3%	64.5%	67.4%	61.1%	60.8%
Cancer - treated within 62 days - referral from NHS Cancer Screening Programme	90%	82%	71.1%	61.5%	70.2%	70.4%	67.3%	67.0%	65.0%
Cancer - treated within 62 days - consultant upgrade	85%	84%	78.1%	76.1%	74.9%	76.6%	76.9%	70.5%	71.2%
Cancer - treated within 31 days - decision to treat to first definitive treatment	96%	98%	96.6%	94.7%	93.8%	93.8%	94.7%	92.7%	92.7%
Cancer - receiving subsequent treatment within 31 days – surgery	94%	91%	88.3%	88.2%	85.3%	83.0%	86.5%	82.5%	82.6%
Cancer - receiving subsequent treatment within 31 days – drug	98%	100%	99.7%	99.3%	99.4%	99%	99.4%	99.7%	99.6%
Cancer - percentage receiving subsequent treatment within 31 days – radiotherapy	94%	97%	98.9%	98.3%	98.6%	98%	98.5%	97.4%	97.6%

KEY	
GREEN: PERFORMING	on or above target
AMBER: AT RISK	5% below target
RED: UNDERPERFORMING	More than 5% below target

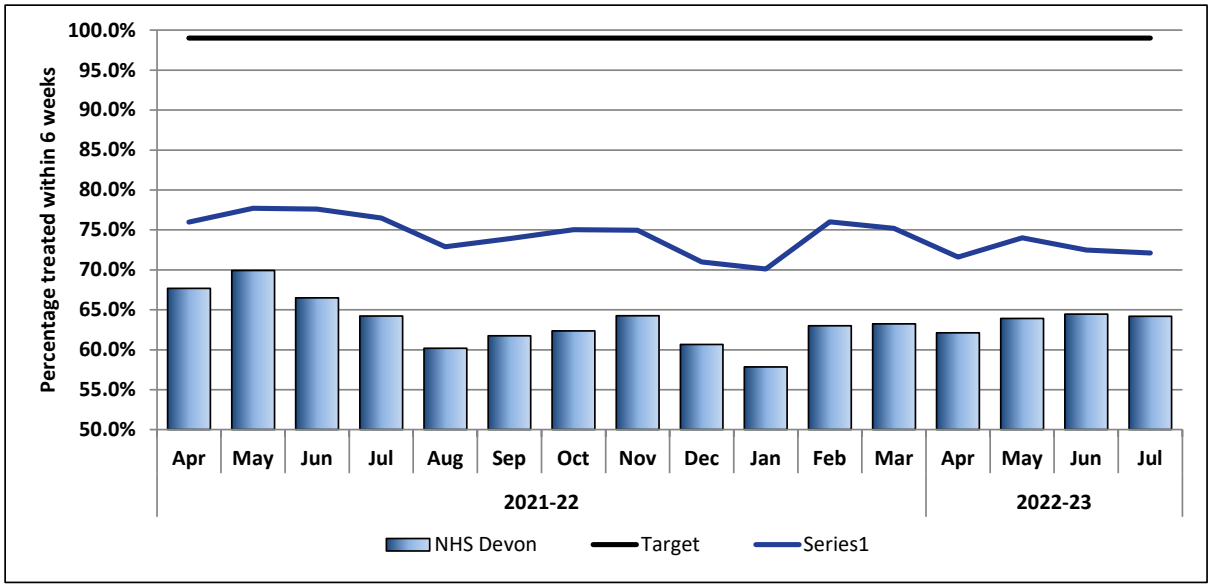
18-Week referral to treatment (RTT)

Due to many hospital services being suspended or reduced during the Covid-19 pandemic, waiting times for treatment have escalated and although the majority of services were quickly restored, they have been at a reduced level. As at July 2022, the ICS saw 53.9% of patients within 18 weeks compared to a national average of 61% and over one-year waits increased from 124,332 in April 2022 to 162,614 patients by July 2022. However, patients continue to be prioritised by clinical need and system-wide plans are being developed to address the backlog of long patients and to reduce the overall size of the waiting list.



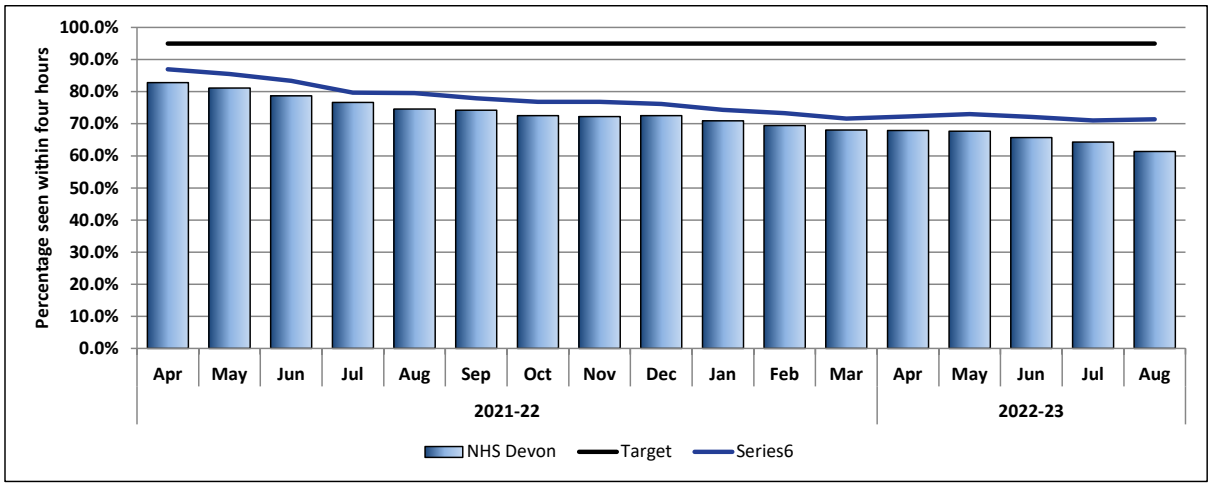
6-Week diagnostic waits

Diagnostics services were also reduced during the pandemic to support the Covid-19 response. Providers have now increased diagnostic testing and performance rates remain low at 64.2% as at July 2022 within 6 weeks below the national average of 72%. Main pressure areas continue to be imaging (mainly CTs and MRIs), endoscopies and echocardiograms.



A&E 4-hour waits

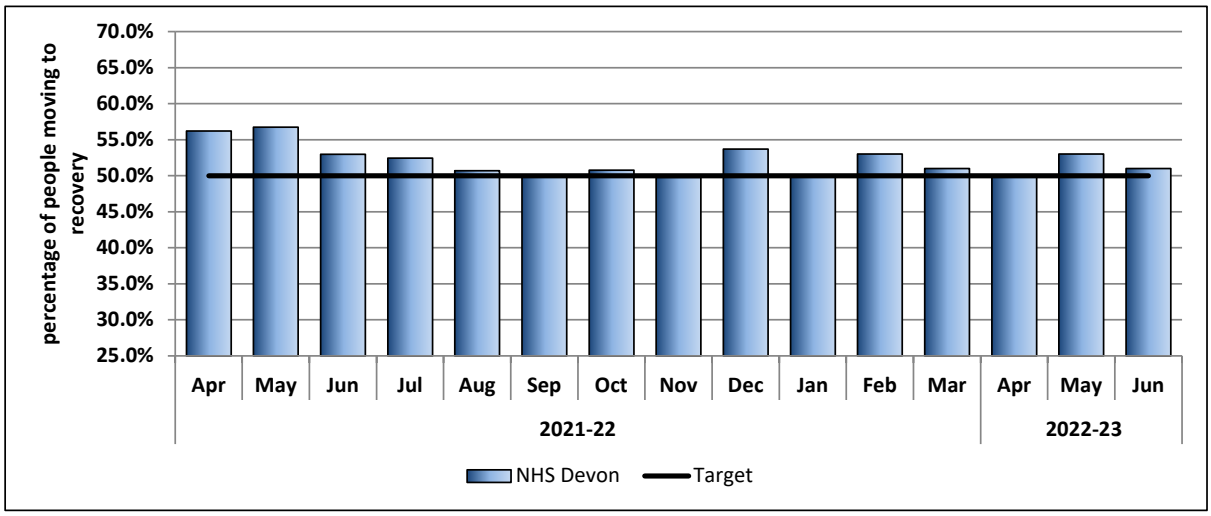
A&E performance was below the 95% target at ICS level during 2021/22 and 2022-23 with all providers in Devon struggling to meet this target, reflecting the deteriorating national position.



Mental health - improving access to psychological therapies (IAPT) access and recovery rate

The IAPT recovery rate is linked to the profile of the patients accessing treatment. Those patients with lower level needs often have a higher recovery rate than the more complex cases.

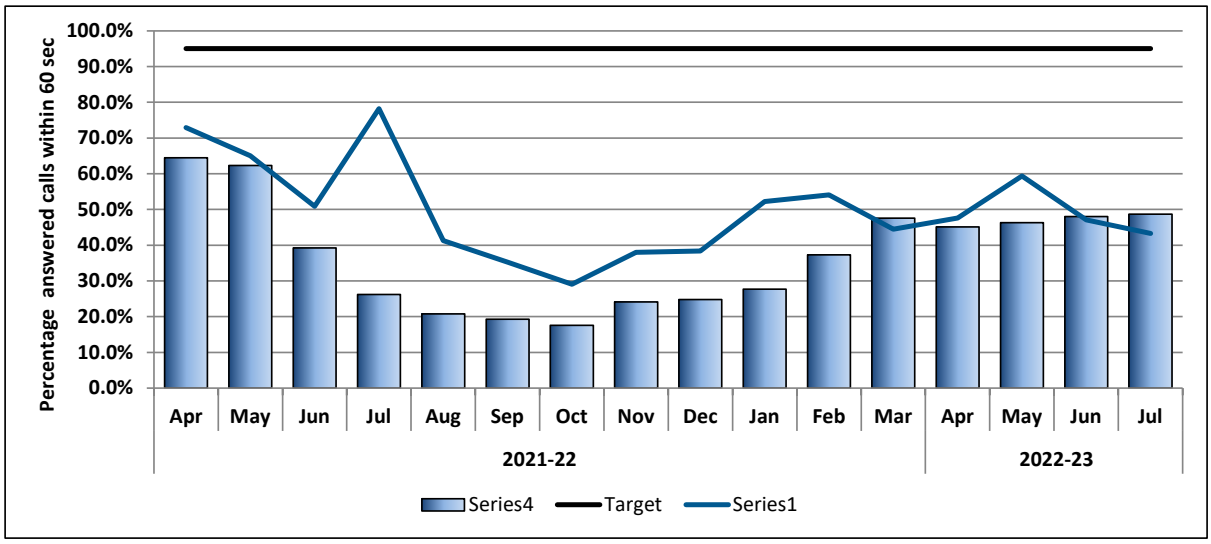
The ICS has performed well against this target in 2021/22 and 2022/23 YTD, achieving the 50% threshold throughout.



NHS 111

A new provider of the NHS 111 service will be in place from 1 October 2022 following an extensive procurement, and the Devon system has confidence that performance will improve.

Performance against the non-emergency calls being answered in 60 seconds measure saw a significant decrease from 64% in April to 43.3% in July 2022, reflecting the national position. The Think 111 campaign resulted in an increased volume of calls with a consequent reduction in calls meeting the target, although this should reduce the level of emergency department attendances.



Performance monitoring

The ICS continued to closely monitor performance against a large range of performance and quality standards. Regular detailed reports, dashboards and analysis are reviewed by the Governing Body and supporting committees, whilst a monthly system performance group chaired by the ICS and attended by providers and regulators assessed the latest performance information and reviewed exception reports and action plans to improve performance where required. Work was carried out to integrate reporting of population outcome measures (the 'health of the population'), performance, quality and finance, which will provide a more rounded view of system outcomes.

Environmental matters

Sustainable development (environmental matters)

Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012). We acknowledge this responsibility to our patients, local

communities and the environment by working hard to minimise our carbon footprint. Along with a number of public sector organisations in Devon, the Governing Body declared a climate emergency in 2019 and the CCG was represented at the Devon Climate Emergency Response Group.

An Environmental Policy was approved by the Governing Body in January 2020. The policy sets out our commitment to maintain and improve the economic and social wellbeing of staff and the health of the population by contributing towards sustainability. The policy now links to the system wide ICS Green Plan which will be in place from April 2022.

NHS England/Improvement asked that all ICSs have a system-wide Green Plan by April 2022. Our inaugural Green Plan is a high level, strategic 'living' document and as the ICS develops the areas of focus of the Green Plan will be developed. Sustainability will be embedded as business as usual.

The ICS Green Plan concentrates on the following areas:

- Workforce and system leadership
- Sustainable models of care
- Digital transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation

.The CCG continued to make significant reductions in its carbon footprint, for example, in reduced travel by staff. One Devon must decrease its carbon footprint by approximately 15% a year, year on year, if it is to achieve the national target of 80% reduction by 2028-2032.

Climate Change Act target

In order to embed sustainability within our business it is important to explain where sustainability features in our process and procedures.

Providers are required under contract to take all reasonable steps to minimise adverse impact on the environment, to maintain a sustainable development plan and to demonstrate progress on climate change adaptation, mitigation and sustainable development, including performance against carbon reduction management plans.

The Emergency, Preparedness Resilience Response (EPRR) responsibilities require the CCG to not only assure itself that the services it has commissioned for the population of Devon have plans in place to respond to and recover from emergencies, but that it also has its own plans in place. NHS England has a process in place to check this is the case, requiring NHS commissioners and service providers to complete an annual self-assessment.

Improving quality

Quality assurance and continuous improvement

CCG Functions:

The CCG continued to undertake statutory and non-statutory functions. Quality systems and assurance processes that enable this include:

- Statutory safeguarding, quality and equality assurance (see 1.3)
- Ongoing implementation of Better Births through the Local Maternity and Neonatal System, including the recommendations from the Ockenden Report
- Continued provision of continuing healthcare services for those with ongoing needs, ensuring that people can access the care that they need in a timely way
- Monitoring of patient safety serious incidents
- Learning from deaths
- Medical examiners
- Infection prevention and control; antimicrobial resistance; healthcare acquired infections
- Independent Investigations (including mental health homicides)
- Regulation 28 reports
- Judicial reviews
- Controlled drugs assurance and oversight
- Complaints
- Whistleblowing and Freedom to Speak Up
- Review of provider quality accounts

CCG Functions - Devon's 'Harm Profile'

CCG quality assurance continued to be sought through local and national data sources, CCG processes, including serious incidents, complaints and concerns, plus on-going CCG COVID-19 groups, intelligence and relationships with system partners.

In light of the challenge COVID-19 brought to Devon's health and social care system, some providers continued to experience enhanced monitoring and assurance by the CCG and have CQC action plans in place to address ongoing concerns around quality and safety.

The Devon System remains extremely challenged, in urgent, elective, community and primary care. Multiple factors have contributed to this position of increased risk, including sustained urgent care activity leading to pressures in Emergency Departments and a further stepping down of some planned procedures.

Risks continued to be captured on the CCG risk register (and updated monthly), but also on CCG team provider risk registers.

Moving forward as an integrated care system, to bring together different parts of the health and care system in Devon and to work cohesively as a system, the Devon Integrated Care Board System Quality and Performance Group provides a single

framework of governance that enables and supports Local Care Partnerships collaboratively to drive improvement to quality, delivery and outcomes.

Experience: Patient, family and carer feedback enables the system to embed experience of care at the centre of improvement and transformation programmes including coproduction with people with lived experience of certain conditions or circumstances.

CCG figures showed an overall increase in patient experience queries and reports. Feedback largely reflected a return towards normal services after the impact on services during the first and second wave of COVID-19. Continuing Health Care remains a theme within patient experience.

Safety: The CCG continued to support the commissioning of patient safety incident investigations, and these include arrangements for regional or national escalation as appropriate, ensuring compliance with national patient safety alerts, supporting safety improvement programmes and identifying patient safety specialists. In doing so, we have been preparing for changes to the national serious incident reporting system, due to take place in 2022. The Integrated Care Board will have oversight of the processes.

Effectiveness: The CCG continued to ensure effectiveness through processes that include the monitoring of national clinical audits, provider's compliance with NICE health and care guidance, quality standards and technology appraisals and Getting it Right First Time reports.

CCG Functions - Transformation and Quality Improvement:

Local transformation and improvement priorities continued to reflect Devon's commitment to keep quality at the heart of commissioned services. These are embedded within the NHS Long Term Plan programmes (eg maternity, learning disabilities and autism, screening programmes, continuing healthcare, personal health budgets, infection prevention and control, digital transformation programmes, clinical pathways).

CCG Functions - Safeguarding:

The CCG safeguarding team delivered the statutory functions as directed within the Care Act 2014, the Children Act 1989 and 2004, the Health of Children in Care 2015 and the counter terrorism strategy including Prevent and the Mental Capacity Act 2005.

Consideration is also given to other statutory legislation linked to safeguarding which includes child sexual exploitation, domestic abuse, female genital mutilation and modern slavery. The CCG also worked to the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019. Safeguarding was always a high priority.

The CCG ensured it had robust arrangements to provide strong leadership, vision and direction for safeguarding. The CCG had clear and accessible policies in line with relevant legislation, statutory guidance and best practice. The CCG had a clear line of

accountability for safeguarding in that an Accountable Officer and Executive Lead for Safeguarding was in place. Designated health professional roles were in place as outlined in the Intercollegiate Guidance and additional safeguarding nurse capacity was implemented to support the CCG in its role as a delegated commissioner for primary care medical services. The team also expanded its expertise and capacity to improve the health response in Devon to interpersonal trauma and serious violence.

The integrated safeguarding team supported both health providers and multi-agency partners working at a local, strategic and national level on safeguarding issues that had an impact on the health and wellbeing of children, young people and adults. The CCG worked in partnership with the police and local authorities to share the responsibility for arrangements that safeguard and promote the welfare of children and adults in Devon. It took an active strategic leadership role, supporting and engaging others and implementing local and national learning, including from serious child safeguarding incidents, safeguarding adult reviews and domestic homicide reviews. The safeguarding team worked in collaboration with commissioned providers to gain assurance over the meeting of statutory responsibilities. There was regular reporting and assurance through the Safeguarding Steering Group and quarterly reports to the Quality Assurance Committee.

CCG Functions - Developing Quality Governance:

Quality and Governance arrangements moving forward:

The ICS has developed six strategic ambitions to enable delivery of the overarching ICS vision. There is a golden thread of quality embedded within each of these strategic ambitions. These threads are:

- “We will deliver safe care and we will embrace an open and learning culture, ensuring we continually improve”
- “We will respond to people’s needs by striving for the highest standards of quality, proactively reducing health inequalities”.

The ICS is committed to providing the highest quality services for patients. It is therefore essential we continually improve the quality of our services by engaging with and listening to service users and carers, staff and key stakeholders in order to meet their needs and expectations. Furthermore, continued strengthening of system-wide partnership working is imperative to promote population health across Devon.

Our Quality Strategy is set around our quality priorities and is shaped by the healthcare definition of quality, namely patient safety, clinical effectiveness and patient experience. ‘You will receive safe person-centred care that is prevention and recovery focused and accessible in your local community’.

This Quality Strategy has been developed in order to support those ambitions. The strategy supports the ICS improvement journey.

Quality is defined in line with the National Quality Board (NQB) definition of quality: a shared single view of quality:

High-quality, personalised and equitable care for all, now and into the future. High quality personalised and equitable care for all. Ensure and be assured that systems supporting the delivery of care are:

- **Safe** - delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.
- **Effective** - informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit.
- Shaped to give a **positive experience**
- **Responsive and personalised** - shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable.
- **Caring** - delivered with compassion, dignity and mutual respect.
- **Well-led** - driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.

- Sustainably-resourced - focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment.
  Quality care is also equitable - everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

Governance will be supported by three main bodies:

1. Quality Committee (Non-Executive group)

The committee was established to contribute to the overall delivery of the ICP's objectives to create opportunities for the benefit of local residents, to support Health and Wellbeing, to bring care closer to home and to improve and transform services by providing oversight and providing NHS Devon with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022.

The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee will provide regular assurance updates to NHS Devon in relation to activities and items within its remit.

2. Devon Integrated Care System Executive Quality and Oversight Group

The Group will support a single framework of governance that enables and supports Local Care Partnerships collaboratively to drive improvement to quality, delivery and outcomes and has been established in accordance with the Devon Integrated Care Board (ICB) Constitution

The Quality and Oversight Group's purpose to scrutinise the robustness of, and provide assurance to the ICB, that there are effective quality governance systems in place across the Devon ICS, through the routine review of quality outcomes and intelligence data provided through the work and assurance output of the system delivery groups, including ICB statutory and mandatory functions, (including but not limited to: safeguarding of children and Adults, Infection Prevention and Control, mortality and learning from death reviews, Continuing Health Care Services, local maternity services).

3. Devon Integrated Care System Quality and Performance Group.

The Devon Integrated Care System Quality and Performance Group will provide a single framework of governance that enables and supports Local Care Partnerships collaboratively to drive improvement to quality, delivery and outcomes and provides clear line of sight on performance and risk at system level. To do this it will systematically bring together different parts of the health and care system in Devon to work cohesively as a system to meet the following aims:

- To seek positive assurance that statutory duties are being met, concerns and risk are addressed, and improvement plans are having the desired effect
- To seek confidence in the ongoing improvement of care quality, drawing on timely diagnosis, insight and learning. This includes confident that inequalities and unwarranted variation are being met
- Ensure timely insight and intelligence sharing into opportunities for learning and improvement.
- Identify issues that need to be addressed and escalated.

The Quality and Performance Group is required to meet the 'core' arrangements expected in each system as outlined in NHS England ICS Design Framework (Report template - NHSI website (england.nhs.uk)) and is aligned to the NQB publications for Integrated Care Systems (NHS England » NQB publications for Integrated Care Systems)

CCG Functions - The Quality, Equality Impact Assessment (QEIA):

The QEIA process continued to be a key tool for Devon during 2021- 2022. The process was simplified and used to assess the impact of services being stepped down during the pandemic, but the QEIA panel recommenced and continued to ensure the robustness of impact assessments through a panel consisting of member organisations across the Devon health and care system, led by the CCG.

The purpose of the QEIA process is to ensure all proposed changes to services, policies, and processes within Devon have been robustly and openly challenged regarding the effect they will have on the population of Devon, regarding their quality, equality, and experience. The impact identified (which can be either positive, negative, or neutral) is captured and used for the risk and action planning of the proposed service, policy, or process change.

Providers within Devon have their own QEIA processes that they manage internally. In addition, there was the Devon Clinical Commissioning Group QEIA process and panel that had an open invitation for all providers to be involved and participate as panel members. The CCG panel included key identified roles within the CCG, (communication and engagement, patient experience, equality and diversity, commissioning, and contracting), lay members and Healthwatch.

The majority of QEIAs reviewed within the panel concerned internal service, policy and process changes, with only a small proportion concerning provider organisations.

Ahead of the establishment of the new ICS for Devon, the QEIA process was reviewed to ensure oversight of all QEIAs within the system, a platform to share learning, and continuing management of QEIAs within NHS Devon. The new process considered the following:

- The number of QEIAs completed across the system
- How the outcomes/learning is identified from all QEIAs and shared
- Theme analysis of all QEIAs to see if specific groups of patients are being impacted by process and policy changes
- How NHS Devon gains assurance on QEIA processes within the system
- Resource required to manage the potentially increasing number of QEIAs that will come to panel

Involving people and communities

NHS Devon CCG had an exceptional record on community and patient involvement to take forward and develop in the Integrated Care System for Devon.

Our strategic approach to communications and engagement is to:

- Involve people in planning services and listening to them before we make decisions that have an impact on them
- Communicate the decisions we make as effectively as we can
- Work in partnership on the way services are developed and planned and on the way in which care is commissioned to continue to drive engagement for quality improvement.

Our engagement platforms

The CCG developed many platforms for engagement. These will be reviewed by One Devon and adapted as required.

Devon Virtual Voices – our citizens' panel

The CCG established an online panel in 2019. Devon Virtual Voices has more than 1,700 volunteer members willing to provide views and feedback on NHS services and priorities.

Panel members represent all the various sectors of the community including gender, ethnicity, age, postcode (geography/deprivation), disability, carers and parent or guardian.

Building on the great success of the Devon Virtual Voices citizens panel there has been a move to create a more collaborative and two-way online engagement community, so the CCG has invested in a new online engagement platform.

The new platform will be the central point for all ICS online engagement and consultation and will host the new and refreshed Citizens' Panel in 2022. It will look to strengthen our engagement practice even further and with added functionality such as translation options it will increase our engagement reach to the people and communities of Devon.

Healthwatch in Devon, Plymouth and Torbay

Healthwatch organisations that have come together across Torbay, Plymouth and Devon worked closely with us through at a strategic and operational level during the three-month period.

Healthwatch listen to what local residents say about the healthcare services they use and make sure they are heard by the people in charge who have the power to improve services for you. The more people share their ideas, experiences and concerns about their NHS and social care, the more services can understand what works, what doesn't and what people want from care in the future.

Healthwatch also provides specially commissioned engagement work as required by the CCG.

Patient Participation Groups (PPGs)

The CCG is committed to supporting a Devon-wide PPG network, and the contribution of PPG members will continue to be valued by One Devon.

An agreement with Healthwatch in Devon, Plymouth and Torbay offers all PPGs in Devon the opportunity to join the Assist network which offers a range of opportunities to influence and improve health and social care. Assist is currently a 100-group strong network, spanning the county.

Joint Engagement Forum (JEF)

The JEF is chaired by Devon County Council's adult social care team. The group is multi-agency and brings together a number of community leaders who cover a diverse section of Devon.

The JEF meets quarterly and takes the form of a multi-part meeting with which varies throughout the event to enable the most relevant people to attend for particular agenda items.

The business of the JEF usually consists of:

- A round-up of the last quarter's engagement activity to help make links and share insights between change projects
- A question-and-answer forum with health and social care managers
- A discussion to enable to inform the input the JEF representative makes on the next Health and Wellbeing Board
- Space to reflect on the development of ways in which service users and carers are meaningfully involved in health and social care.

The JEF is supported by Living Options Devon as holders of the Devon Engagement Service Contract and by Devon County Council's Involvement Team, with attendance that varies meeting to meeting, by participation officers from NHS Devon CCG.

Living Options Devon

Living Options Devon is a specialist engagement organisation that hosts the Devon Engagement Service, providing a central point of contact for local authorities and organisations to engage with particular community groups.

Living Options support and encourage people to take part in surveys, meetings, and focus groups on health and social care related topics. This makes sure their voice is heard and they influence the development and delivery of services.

The Devon Engagement Service helps the CCG reach a diverse audience, including:

- The general public across Devon and those in a particular geographical area.
- People who use a particular service including specialist services that require a social care assessment and those who use condition-specific services.
- People with characteristics protected by the Equality Act who may use particular services as well as asylum seekers and refugees; economically challenged; travellers; rurally isolated.
- People who care for others receiving health and social care support.

Ensuring people have a voice

Reaching seldom heard groups

The CCG actively sought the views of a diverse range of people, recognising that for some people who can be excluded or are disadvantaged, it can be hard to get their voice heard. This work will continue with One Devon.

In developing plans for health and care services it worked with groups including:

- Hikmat Devon Community Interest Company
- Devon Parent Carer Voice
- Devon Senior Voice
- Intercom Trust
- Proud 2 Be
- The Carers Forum
- The Autism Involvement Group

The CCG worked closely with:

- local authority partners on the Special Educational Needs and Disability (SEND) agenda.
- providers who work specifically with disadvantaged groups, eg Devon Partnership NHS Trust, Shekinah Mission (homeless outreach services)

Reducing health inequality

How the CCG has discharged its duty under Section 14 T

The CCG worked closely with other organisations in the health, social care and voluntary sectors to reduce inequalities for the population of Devon and the impact of these inequalities on their health.

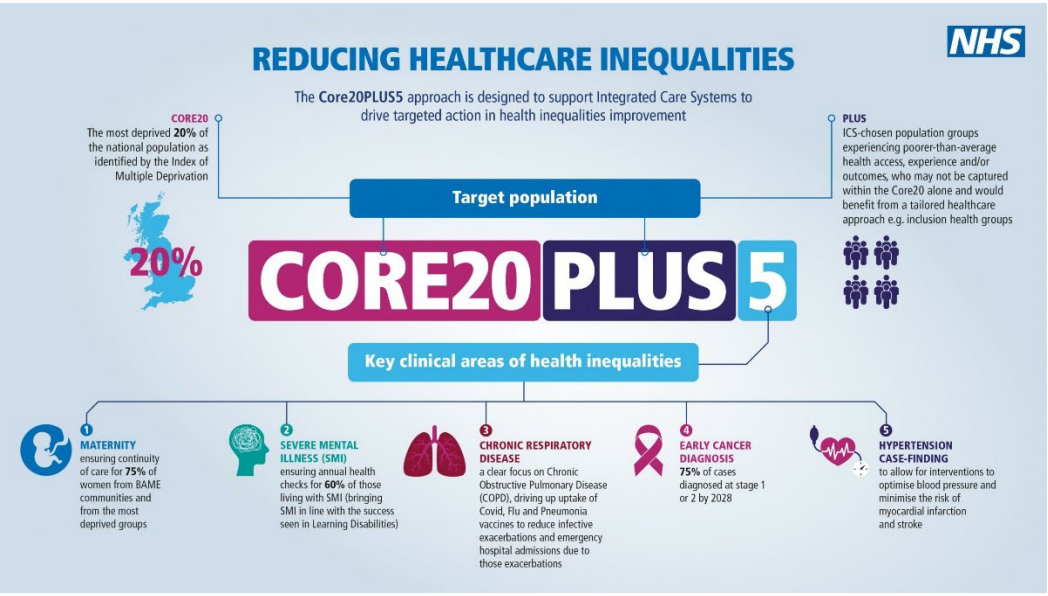
The Health Inequalities (HI) programme adapted to meet both the requirements of the evolving national health inequalities agenda and the needs of the Devon population as we gathered greater insight into health inequalities within Devon. The COVID-19 pandemic continued to exacerbate existing health inequalities within Devon, putting into stark focus the importance of the system working collaboratively to address the wider determinants of health such as access to safe, stable and fit-for-purpose housing, employment and education.

Work still in progress is to address the quality and completeness of our data across all parts of the healthcare system.

Our cross-system partner, the health inequalities executive leadership group, has overseen delivery of our work plan, meeting on a regular basis to monitor progress and share good practice and successes.

The “CORE20PLUS5” framework gave the CCG focus to its programme. This national framework gives emphasis to inclusion of health groups known to be at greatest risk of unacceptable differences in access to and experience of health services and support, and at risk of poorer health outcomes. It also allows identification of other priority groups at both local and whole-Devon perspectives.

CORE20PLUS5 gives emphasis to five clinical areas known to be areas of health inequality, again allowing for locally determined priorities.



Through a number of funding bids and business cases, the CCG secured approximately £600,000 of regional and national funding to further work across a number of topics areas. This was invested in whole-Devon activities and in work within specific communities.

Whole-Devon workstreams which continue:

- Long Term Plan funding for 2.5 years for the treatment of tobacco dependence in those admitted to our acute hospitals, and women and their partners using our maternity services
- Through a voluntary sector-led test of change project, provided additional support, advice and signposting to 1,108 of our patients waiting for extended periods for planned care
- Achieving national Digital Inclusion Pioneer status for Devon, we have secured both funding, and specialist support from NHSX to better understand the digital inequalities experienced by those living in our most rural communities. This work will inform the development of a Digital Inclusion Strategy for Devon, ensuring that we consider the needs of those less confident, or practically able, to interact with our services and support using digital channels
- Short-term capacity funding to increase the resourcing of the Health Inequalities programme

In addition to these focused pieces of work we have invested in, we have continued working to develop the processes and culture by which health inequalities will become a consideration in everything we do. We are working across the system to ensure that we have robust mechanisms for identifying potential impact on health inequalities as we restore services following the pandemic, described below:

- Working with service providers to improve the quality of data collection
- Developing ways to join together data from a number of different sources to give a more holistic picture of health need
- Use of The Equality Delivery System tool to measure CCG performance on equality issues
- Feedback from patients through our CCG mechanisms, social media, and other media
- The Devon-wide Equality Co-operative, a forum set up to ensure a system-wide oversight of equality issues
- Regular reporting to the Quality Assurance Committee of the CCG (patient and public equality, diversity and inclusion information)
- Regular reporting to the Remuneration Committee of the CCG (workforce equality and diversity information)
- The CCG's Quality Assurance Framework
- CCG presence at Devon County Council's Joint Engagement Forum where representatives of people with protected characteristics share experience and inform commissioning developments
- Accessing to Devon County Council's Equality Reference Group (which includes members with specific protected characteristics) as a source of user experience information
- Producing an annual equality report to give assurance to our Governing Body

Revisions to our Quality and Equality Impact Assessment (QEIA) toolset are now well under way. The revised toolkit will be launched in early 2022/23, with enhancements that:

- Support our Quality Committee in offering informed, supportive, challenge to any change
- Introduces an approach that allows for greater narrative in assessing the impact of any change on people with protected characteristics where limited quantitative data is available
- Supports QEIA authors in better understanding the barriers to access, experience and outcome experienced by each group
- Describes the types of proven interventions that can be implemented to mitigate or eliminate any potential negative impact of a change, and enhance access, experience and outcomes.

The greatest risk to our programme remains a lack of good quality data relating to the protected characteristics of our population and patients. There is consensus across all system partners about the importance of addressing the issue of quality and completeness of data.

We are working to create access to the full data and the required business intelligence support that allows us to:

- Refer to a baseline, up-to-date, picture of the composition of the population of Devon, particularly in relation to ethnicity
- Routinely identify the characteristics of the people who are, and importantly are not, connecting with our services to identify who may be disproportionately represented and/or underrepresented in our activity data
- Target our efforts to those experiencing unacceptable differences in access, experience and outcomes
- Be confident in understanding the impact we are having on access, experience and outcomes for those experiencing health inequalities.

In light of the challenge that the lack of good quality data relating to our population and patients present us, we have promoted a “do the right thing” culture within the programme to encourage positive action while we continue to address the underlying issue of data. We carry this “can do” attitude into 2022/23 and the Integrated Care System for Devon.

Equality, diversity and inclusion

The CCG has put great emphasis on equality, diversity and inclusion. Its work to improve the experience of healthcare among its diverse population and staff has been nationally recognised (see the review of activity, below).

Legal duties and national standards

The CCG has a responsibility to meet a range of legal duties and standards that support equality for people who are identified as having a particular protected characteristic under the Equality Act. These characteristics are:

- Age
- Sex

- Ethnicity
- Disability
- Religion and belief
- Sexual orientation
- Gender reassignment
- Marriage and civil partnership
- Maternity and pregnancy

In addition, the CCG has identified other groups of people with characteristics that contribute towards inequality in health, and these are:

- Rough sleepers (especially in relation to mental health services)
- Rural populations
- People in contact with the justice system
- Veterans and the armed forces and their families
- People affected by specific conditions or risk factors:
    - Cancer
    - Smoking
    - Learning disabilities and autism
    - Diabetes
    - Respiratory disease
    - Obesity
    - Drug and alcohol use

The duties and responsibilities include:

- The Equality Act 2010
- The Public Sector Equality Duty (PSED)
- Human Rights Act
- The Children Act
- The Workforce Race Equality Standard (WRES)
- Equality Delivery System 2 (EDS2)
- Internal equality reporting requirements

In addition, the CCG has to assure itself and the public that the organisations it commissions are meeting these requirements plus some additional standards imposed on the acute Trusts these are:

- The Sexual Orientation Monitoring Standard (SOMS)
- The Workforce Disability Equality Standard (WDES)
- The Accessible Information Standard (AIS)

Activity from 1 April to 30 June 2022

Protecting Elective Care - Public

Despite the best efforts of the four trusts, dealing with the pandemic adversely affected the amount of planned care the NHS has been able to provide resulting in longer waiting times for many patients. The CCG wants to work with local people to develop plans to tackle the waiting lists. Working with Healthwatch, the CCG invited patients on waiting lists to share their experiences and thoughts about how best to approach the issue through a series of workshops.

The key things that people on waiting lists told us:

1. Waiting for elective treatment has a significant impact on participants' physical and mental health but it was felt that better communication about waiting times was needed and would reduce anxiety and uncertainty.
2. Participants were overwhelmingly in favour of addressing waiting times as quickly as possible, rather than waiting for a Devon-wide solution.
3. Participants saw the benefits of moving elective care to a dedicated facility shared between Trusts, however, there were concerns about patients being required to travel longer distances, and the length of time it may take this solution to be enacted.
4. Participants agreed that a combined approach would be beneficial to suit the needs of different areas, eg urban vs rural, and the needs of patients who may require more complex treatment. When deciding where to have treatment, the three most important considerations for participants were: **the speed at which they could be seen, who would be providing their treatment, and distance from home.**

This insight will go on to inform the Planned Care strategy and future commissioning around in and out of hospital services.

Protecting Elective Care – Staff

The CCG sought to work with NHS staff to develop plans to tackle the waiting lists.

It was vital that all NHS staff members were given the opportunity to be part of this engagement process, so we undertook two CCG led focus groups and supported locally led engagement sessions across NHS trust/provider sites. A total of 37 staff expressed an interest in the CCG led focus groups with 20 staff members attending across the two, comprising of clinical leads, orthopaedic and ophthalmic surgeons, urology leads, operational leads, commissioners, and support staff.

We learnt that staff were directly dealing with the impact of long waits on patients, they urged the system to invest in the current workforce who would be able to tackle the backlog with the adequate support in place. They stated their support for a shared on-site approach, which would support the key piece of feedback of supporting the maintenance of a good work/life balance.

This insight will go onto inform future commissioning around in and out of hospital services.

Equality, Diversity and Inclusion – 'What would you like to tell One Devon?'

Over the summer One Devon Senior leads, involvement and equality, diversity and inclusion staff attended the number of cultural events to understand the experiences and needs of our diverse communities in Devon. The purpose of our attendance was to show the community that our senior leadership teams champion inclusion and show our system commitment to supporting our ethnically diverse, faith and belief communities and LGBTQ+ communities and staff in Devon. Additionally, these events were a fantastic opportunity to engage with the public around the needs and experiences of diverse patients and staff in Devon.

During these events we involved LGBTQ+ communities and ethnically diverse, faith and belief communities about their experiences of health and care needs and how our services could be more inclusive through asking the question "What do you want us to know?" We had 234 people responding through the various channels available, giving us valuable feedback about their experiences of health and care, their perceptions of felling like second class citizens when accessing services and how we can better support people to access the services they need.

This insight will go onto inform and help develop the One Devon EDI strategy.

As a part of our system-wide Pride and disability pride month celebrations, One Devon has sought out feedback from LGBTQ+ staff and staff with disabilities to hear about their experiences and ideas for change. LGBTQ+ staff and staff with disabilities across the ICS were invited to attend bespoke sessions to talk about their experiences, any feedback they may have and ask the system EDI leads any questions they may have about our EDI work. A total of 33 people attended the sessions and provide feedback about their experiences at work where they feel a lack of awareness of the needs of people with disabilities or who identify as LGBTQ+, the support they do or don't receive and how people from these groups need more allies and representation at senior level.

This insight will go onto inform and help develop the One Devon EDI strategy.

Other work includes:

- Setting out a clear EDI strategy for 2022/23
- Increasing support and collaboration with the BAME staff Network
- Overhauling recruitment practices across Devon.
- Building stronger relationships with diverse communities as part of the vaccination outreach programme
- Diversifying recruitment panels for leadership appointments
- New EDI and OD group to oversee system cultural development programme and the overhaul of recruitment

Vaccine outreach programme

The Devon health and social care system has a Health Inequalities Cell to ensure that all eligible citizens are offered the COVID-19 vaccine and supported to take it up – the

standard means of delivering the vaccine being not easily accessible for all communities

Detailed work continues to support specific communities including:

- Ethnic minority communities
- People experiencing homelessness
- Migrant workers
- Illegal immigrants and refugees
- The Gypsy, Roma and traveller communities
- People with learning disabilities, neurodiversity and mental illness
- The LGBTQ+ community

Insight, engagement, and involvement is used to inform the vaccination programme.

We continue to work closely with our partners across the health and care system, the voluntary and community sector and community leaders to develop vaccine outreach plans, refining these as we move through the differing cohorts.

Outreach clinics have included

- Local mosques
- Food processing factory with large numbers of migrant workers
- Bespoke sessions for people with learning disabilities
- Bespoke sessions for people experiencing homelessness
- Bespoke sessions for asylum seekers and undocumented migrants in partnership with the Red Cross
- Mobile vaccination Unit targeting areas of deprivation
- Partnership working with the Chinese association to deliver vaccines for the communities in Plymouth and Exeter

Monitoring of inequalities

This has been supported through:

- Staff risk assessments (with a focus on risk assessment for staff from a minority ethnic community)
- Contributions to the development of a southwest workforce strategy.
- Establishment of a CCG staff equality group to address equality issues affecting those employed by the CCG.
- The preparation of an annual equality report to give assurance to our Governing Body
- CCG attendance at Devon County Council's Joint Engagement Forum where representatives of people with protected characteristics share experience and inform commissioning developments
- Continued working through the Devon-wide Equality Co-operative, a forum set up to ensure a system-wide oversight of equality issues

- Regular reporting to the Quality Assurance Committee of the CCG (patient and public equality, diversity and inclusion information)
- Regular reporting to the Remuneration Committee of the CCG (workforce equality and diversity information)
- Use of The Equality Delivery System tool to measure CCG performance on equality issues

Governance of EDI and system working in Devon

The CCG established clear lines of reporting between the various groups working on EDI related projects within the CCG and across the system.

The CCG worked on EDI as a key member of the wider Equality Co-operative. This enables the health and care system in Devon to address issues common to all members of the health and social care community. Many members of the co-operative also attend the South West Inclusion Network which enables them to learn from and share with EDI leads beyond Devon.

EDI and the CCG workforce

We undertook work to better understand the diversity of our workforce using the staff survey data.

The Rainbow badge scheme continued at the CCG, supporting a number of staff to be a point of contact and listening ear for people from the LGBT+ community.

The CCG completed a Workforce Race Equality Standard report and a gender pay gap report, published on its website.

Prevention Programme

While the impact of the COVID-19 pandemic was challenging in the preceding periods, the CCG adapted where possible to ensure prevention remained an area of focus within the Devon system.

It continued to target investment from its prevention fund to support both whole-Devon and place-based interventions. The period from April to June 2022 saw the CCG:

- Continue proactive community work to reduce rates of infections within the community setting with our **Community Infection Management Service** (CIMS). Supporting COVID-19 work in care homes was a key focus.

The CIMS team continued with several community-facing projects. These included:

  - Scoping the areas supported and creating networks and relationships from scratch
  - Supporting a Devon-wide infection control champions project in care homes
  - Remote COVID-19 education sessions for care home staff

  - The purchase and modification of an infection prevention and control handbook designed for education of care home staff
  - Creating supportive relationships with primary care
  - A trial of an Infection Prevention and Control (IPC) audit tool for primary care
  - Supporting with IPC considerations in new builds
  - Investigating community-associated *C. difficile* and *E. coli* cases
  - Input into non-COVID outbreaks, such as flu and norovirus

- Develop new, and expanded existing, physical activity schemes in some of our most deprived communities. This has included establishing new walking groups for mid-life and older adults with type-2 diabetes, depression and anxiety, alongside those at risk of frailty, with 60% of new participants reporting themselves as previously "inactive". We have also adapted to support those at home to stay active during COVID-19 restrictions.

- Connect approximately 1,000 people living with obesity who also have a diagnosis of diabetes, hypertension or both to the 12-week NHS Digital Weight Management Programme, and online behavioural and lifestyle programmes.

- Provide the first year of two-year's investment to support our Local Care Partnerships in putting in place interventions that will improve people's independence, life experience and morbidity through the prevention of falls. In turn, this will reduce demands on other parts of the system, such as our urgent community response; urgent and emergency care; and rehabilitation and equipment services.

Investing in **Mental Health** remains a priority for prevention, with suicide prevention an area of particular focus.

- We have adapted our approach to targeting those bereaved by suicide to reflect COVID-19 restrictions, launching an online version of our suicide bereavement training offer to staff working with people who lead complex lives. Their success is being built on and some 1,750 sessions will be available during 2022-23.

- Training staff have delivered a suite of suicide related courses to staff across our mental health and community services providers.

	Suicide Prevention Training	**Post Ligature Physical Healthcare Management**	**Suicide Response and Safety Planning Training**
Devon Partnership NHS Trust (DPT)	90% completion rate (3,053 staff)	37% of eligible clinicians (256 staff)	41% of eligible clinicians (375 staff)
Livewell Southwest		Being delivered March – November 2022	Commencing March 2022

Devon Partnership Trust reports that since August 2020, there have been no inpatient suicides.

An “Early Intervention Self Harm” service continues to run, having been commissioned as a two-year pilot aiming to provide early interventions to support young people aged 11-18 who are self-harming. During the first six months, 70 young people had been referred to the service, with 54 of these going to receive additional support. Practitioners and school staff described the service as “reassuring” and said it had had a positive on the happiness of the young people who had received support.

Domestic violence and abuse and health inequalities experienced by people with complex needs were amplified by the pandemic and this trajectory of harm and ‘need’ is likely to continue. Our Whole Systems for Whole People work gathered pace.

Our continued investment in social prescribing is to develop the resilience of local communities in meeting the needs of their population.

There are a wide range of programmes identifying with the social prescribing label across the Devon footprint. This work includes link workers, community connectors, wellbeing advisors and community navigators; all of whom connect people to community groups and help the individual develop skills, friendships and resilience to aid their wellbeing.

All 31 Primary Care Networks of GP practices in Devon have at least one social prescriber, 18 of them being managed by the voluntary sector. This is helping ensure PCN based link workers are well placed to connect people to resources in their communities as well as learn from the voluntary sector experience via a network of peer support.

Overall, there are now 66 social prescribers operating in the county, with each prescriber having an average caseload of 250 people. Social prescribers have about six to 12 contacts with a patient over a three-month period. This means that approximately 16,500 people are currently receiving some form of social prescription offer in Devon.

2022/23 will see us retain focus on the prevention of community acquired infections and long-term conditions, with specific attention to atrial fibrillation, cardiovascular disease and diabetes. We will support our acute services to provide patients with ready access to smoking cessation support and alcohol care.

We will work with our four localities to provide support to those at risk of falls and fractures, and those considered frail, within their communities. We will work hand-in-hand with the Devon Health Inequalities programme to ensure our services are meeting the needs of those experiencing health inequalities within Devon.

Developing the Population Health Management approach

Population Health Management (PHM) was introduced by the CCG and will underpin the work of the Integrated Care System for Devon, One Devon. It aims to improve the physical and mental health and wellbeing of people, while reducing health inequalities within and across a defined population. It requires action to reduce the occurrence of ill-health, including addressing wider determinants of health, and action to slow the progression, in individuals, of existing conditions.

PHM involves a partnership approach across the NHS and other public services including social services, public health, schools, voluntary sector, housing associations and, importantly, the public. To maximise its impact, all partners work more closely together to improve overall population health. The approach is underpinned by a patient-level population data set and is enabled by data analytics. Taking a data-driven approach to planning drives a more targeted approach to both care design and care management.

In Devon, PHM is enabling commissioners to better understand current, and predict future, health and care demand and commission more integrated and sustainable services, thereby making better use of public resources. PHM is enabling healthcare providers to identify people who are at risk of ill-health and develop proactive interventions to prevent or delay the onset of long-term conditions and slow the progression of frailty.

The expected outcomes and benefits from implementing PHM in Devon include:

- Increasingly evidence-based decisions that inform the most efficient allocation of resources to prevent illness, improve care and lower costs.
- Financial improvement and improved health outcomes through prevention, early detection and intervention.
- Better monitoring and evaluation of the impact of interventions to improve outcomes or reduce inequalities, and upscaling to maximise benefits.
- Through participation of partners, the opportunity of data linkage across organisations and staff capacity building.

Progress made

To implement Population Health Management successfully and enable our Integrated Care System (ICS) to thrive, Devon system partners have been focusing on the following three areas:

- Developing the infrastructure to ensure the basic building blocks of population health management are in place.
- Building the workforce capacity and capability to embed PHM at all levels of our system
- Using PHM tools and techniques to inform the development of new models of care and proactive interventions to improve health outcomes, reduce inequalities and reduce costs.

Our system's involvement in Wave 2 of NHS England's Population Health Management Development Programme has enabled the CCG and our partners to begin developing the technical capabilities and infrastructure needed to deliver PHM. In the remainder of 2022/23, we will be focusing on developing a local programme to support wider spread and adoption.

Using PHM to address health inequalities

In Devon, the PHM programme will be used as a way to enhance the system's capability in addressing inequalities. The programme has been deliberately designed to involve NHS organisations and local authorities in all localities across the Devon system. While there have been multiple initiatives across the system, adopting a PHM approach will provide a more consistent framework for tackling inequalities.

Developing enhanced data sharing and analysis will provide intelligence to inform actions that can be taken at each level from direct support to vulnerable individuals, local integrated service provision in the least intensive setting, to system prioritisation and leadership.

Health and wellbeing strategy

The CCG contribution to the delivery of the Joint Health and Wellbeing Strategy

Devon CCG covered three top tier local authorities and associated Health and Wellbeing Boards (HWBs) in Plymouth, Devon and Torbay.

HWBs have identified a vision and key priorities within their Joint Health and Wellbeing Strategies (JHWBS).

CCG representatives on the Health and Wellbeing Boards work with the Boards on an ongoing basis to ensure the priorities are being addressed. Some examples of joint working are:

- Implementation of the PHM Action Learning Sets in both Northern and Eastern localities - the aim of the PHM programme is to provide targeted interventions based upon population data to reduce health inequalities. The East Devon PCN's projects are focusing on working age males linked to loneliness, self-harm, and suicide. The Northern PCN projects are focusing on the improvement of wellbeing and to de-medicalise, where appropriate, the management of people with non-functional chronic pain.
- The Northern and Eastern LCPs are promoting, through partnership work, annual health checks for people with learning disabilities, autism and mental health disorders.
- The Eastern Local Care Partnership has a specific prevention focus on children and young people's mental health; the work programme includes the collation of safety plans and identifying how professionals and organisations can use these most effectively as well as transition planning.
- Both Northern and Eastern LCPs are establishing Healthy Ageing Boards. The Health Ageing North Devon Board aims to establish an integrated model of care and support for older people living with frailty. The multi-organisation board

produces monthly reports on its activities: OND Healthy Ageing North Devon (HAND) Report – April 2023

Plymouth	Devon	Torbay
JHWBS Vision Statements		
To be one of Europe's most vibrant waterfront cities where an outstanding quality of life is enjoyed by everyone.	***Health outcomes and health equality in Devon will be amongst the best in the world and will be achieved by Devon's communities, businesses and organisations working in partnership.***	***To create a healthy Torbay where individuals and communities can thrive***
JHWBS Priorities		
Delivering solutions and creating environments which address the wider determinants of health and wellbeing and make healthy choices available.	Create opportunities for all-inclusive economic growth, education and social mobility	Working together, at scale, to promote good health and wellbeing and prevent illness
Reducing health and wellbeing inequalities and the burden of chronic diseases in the city.	Healthy, safe and strong communities creating conditions for good health and wellbeing where we live, work and learn	Enable children to have the best start in life and address the inequalities in their outcomes
Delivering the best health, wellbeing and social outcomes for all people, and reducing and mitigating the impact of poverty, especially child poverty.	Focus on mental health building good emotional health and wellbeing, happiness and resilience	Build emotional resilience in children and young people
Helping ensure that children, young people and adults feel safe and confident in their communities, with all people treated with dignity and respect.	Maintain good health for all supporting people to stay as healthy as possible for as long as possible	Create places where people can live healthy and happy lives
Building strong and safe communities in good quality neighbourhoods with decent		Support those who are at risk of harm and living complex lives, addressing the

homes for all, health-promoting natural and built environments, community facilities and public spaces and accessible local services, alongside supporting restoration of natural habitats and ecosystems.		underlying factors that increase vulnerability
Enabling people of all ages to play an active role in their community and engage with arts and culture and other activities to promote social cohesion and good mental health and wellbeing.		Enable people to age well
Providing a safe, efficient, accessible and health-enabling transport network which supports freedom of movement and active travel and promotes low carbon lifestyles that are beneficial to physical and mental health.		Promote good mental health
Providing vibrant, effective and modern education settings that enable children and young people to develop as active citizens in the community and enjoy a good quality of life in a dynamic and modern economy, and delivering quality lifelong learning which is available to everyone and can be tailored to quality employment and social opportunities.		
Ensuring people get the right care from the right		

people at the right time to improve their health, wellbeing and social outcomes.		
Making Plymouth a centre of clinical excellence and innovation to benefit the sustainability and growth of the medical and health care sectors in the city and to create education and employment opportunities.		

Common areas of priority among the strategies include:

- Common vision around reducing health inequalities and addressing wider determinants of health
- Enabling children to have the best start in life
- Promoting good mental health across the life course
- Creating good education and employment opportunities to improve social mobility
- A focus on living well, encouraging health lifestyles and prevention
- Maintaining independence and good health into older age

Some examples of how the CCG has contributed to the delivery of some of the priorities identified in JHWBS through its commissioning activity this year include:

- Development of an extensive programme to address health inequalities working with partners to address differences in access and outcome by ethnicity, deprivation and other factors
- Continuing to promote annual health checks for people with learning disabilities, autism and/or mental health disorders, to prevent ill health and reduce inequalities
- Improving children and young people's access to school-based mental health support and NHS funded community mental health services
- Encouraging healthy lifestyles by actively developing and commissioning initiatives to support smoking cessation, improve alcohol care and prevent diabetes

Shared Aspirations

Devon's NHS organisations, together with Devon County, Plymouth City and Torbay Councils, and Livewell Southwest have a single vision and shared aspirations for health and care in Devon over next ten years.

Vision agreed by all partners:

"Equal chances for everyone in Devon to lead long, happy and healthy lives"

Work is currently being undertaken to develop a single 'Devon Plan' which will be a description of the actions we will collectively take to address the challenges that health and care services in Devon face and deliver our vision. The 'Devon Plan' will encompass our system's Long Term Plan which was developed in 2019 to respond to national and local priorities including those identified within Joint Health and Wellbeing Strategies (JHWBS).

At its core, the Devon Plan has six ambitions, with an aim to shape services around the needs and preferences of the Devon population, while improving outcomes, tackling health inequalities unwarranted variation, being financially sustainable and a great place to work.

The common areas of priority within the Joint Health and Wellbeing Strategies are reflected within our ambitions and to close working and full participation of CCG representatives in local HWBs.

The Devon Plan ambitions include:

Ambition 1: Effective and efficient care

- Collaborate across the system to address safety, effectiveness, experience and productivity.
- Health and care organisations will work together to provide the best possible services. They will use Devon taxpayer's money to deliver value for the population by reducing waste, tackling unwarranted clinical variation and improving productivity everywhere.

Ambition 2: Integrated Care Model

- Systematic delivery of the integrated care model across Devon.
- There will be a shift to out of hospital care through enhanced Primary Care Networks, community (including mental health), social care and voluntary and community services. This will reduce the growth in acute urgent care, improve access to primary care and enable more people to be cared for at home.

Ambition 3: People-led Change

- A citizens-led approach to health and care.
- A new approach will be adopted to reduce variations in outcomes, gaps in life expectancy and health inequalities across Devon. There will be a shared way of working with people and communities to identify priorities and tackle the root causes of problems such as substance misuse, domestic abuse and sexual violence, homelessness and mental ill-health. Information and intelligence across services will be used to target resources in the most effective way.

Ambition 4: Children and young people

- Invest in children and young people: to have the best start in life, be ready for school, be physically and emotionally well and develop resilience throughout childhood and on into adulthood.
- All children and young people in Devon will have the best start in life, grow up in loving and supportive families, and be happy, healthy and safe. Children, young people, their families and carers and communities will have access to a personalised, sustainable and coordinated system of care and support which

meets needs early and improves their quality of life so that they can live well throughout life and make the most of the choices and opportunities available to them.

Ambition 5: Digital Devon

- Invest in a digital Devon: only tell your story once, first contact will be digital, self-care, digital connectivity
- Digital advances are continually creating possibilities for preventing ill health and improving care and treatment and modernising the way we work. Adopting a 'digital first' approach across the whole system will deliver transformational benefits of developments in technology, robotics, artificial intelligence, wearables, analytics changing experiences of and access to care for individuals; enabling efficiencies for staff; and allowing advances in quality and safety; and improving productivity.

Ambition 6: Equally well in Devon

- Work together to tackle the physical health inequalities for people with mental illness, learning disabilities and/or autism.
- The physical health of some people with mental illness, learning disabilities, and/or autism is significantly worse than the health of Devon's population as a whole. Health and care providers, commissioners, professional bodies, service user and carer organisations, and charities in Devon are committed to working together to bring about equal physical health for all.

Financial review

In line with the requirements of NHS England, the CCG produced a balanced position for the period covering 1 April to 30 June 2022.

The CCG worked within a financial framework that was put in place to meet the challenges of the COVID-19 pandemic. The CCG received a fixed funding envelope to cover the Devon Integrated Care System (ICS), including primary medical care funding and funding for COVID related costs.

The CCG worked in conjunction with partner NHS organisations (listed below) to agree the distribution of the ICS's fixed funding allocation. Each of the partners listed received an allocation for normal business, as well as an allocation for COVID related expenditure:

- NHS Devon CCG
- University Hospitals Plymouth NHS Trust
- Royal Devon University Healthcare NHS Foundation Trust
- Northern Devon Healthcare NHS Trust
- Torbay and South Devon NHS Foundation Trust
- Devon Partnership NHS Trust

Devon CCG's reported position for the period ended 30 June 2022 against its revenue resource limit is set out below:

Financial Summary	Period ended 30 June 2022 £ million
Revenue resource limit	596.32
Total net operating cost for the financial year	596.32
(Overspend) / Underspend	0

The CCG had purchased no capital items for the period ended 30 June 2022, in line with its capital resource limit.

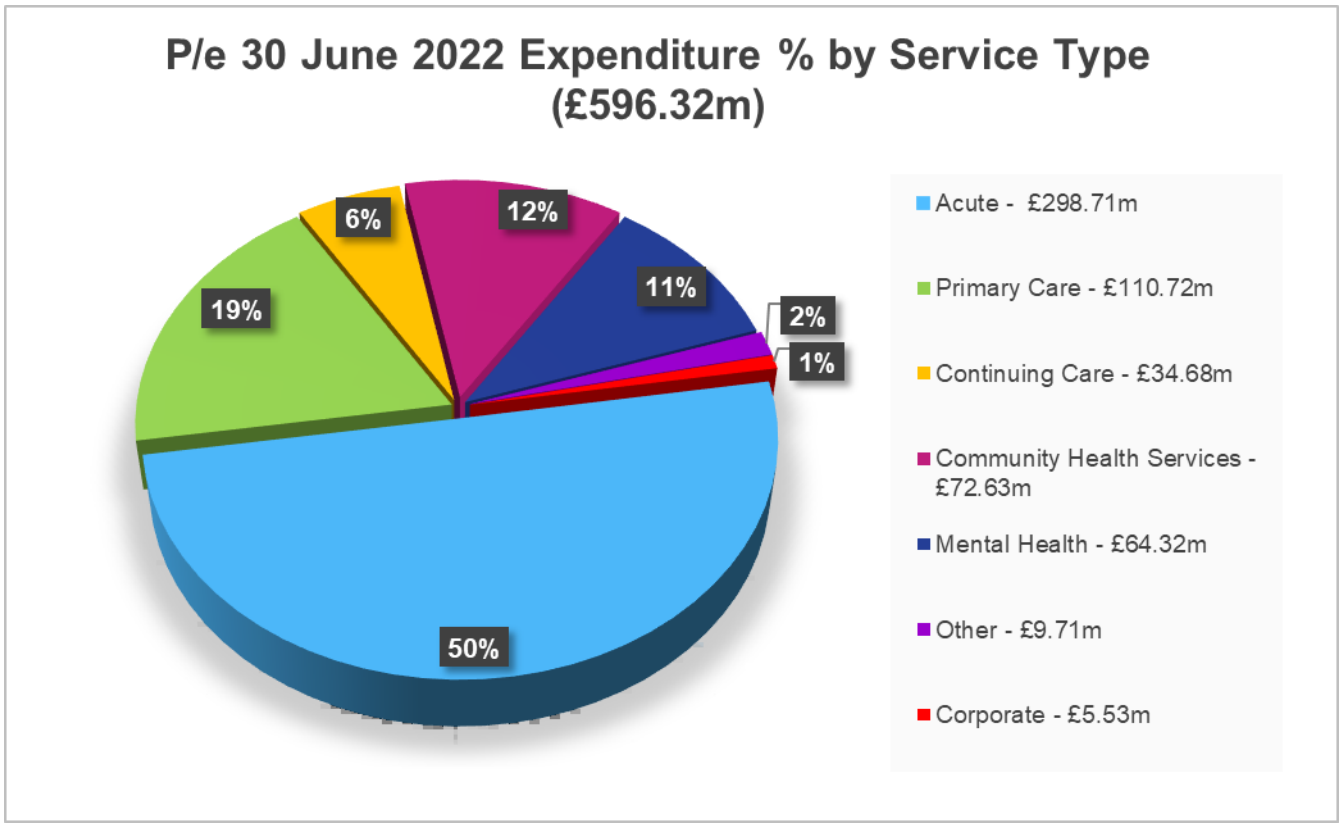
The CCG also managed to meet the following other financial duties:

- Running costs contained within the agreed allocation – for the CCG this was achieved with reported expenditure of £5.53 million against £5.53 million funding allocated
- Compliance with the Better Payment Practice Code

How the CCG funds were spent in the period ended 30 June 2022

The CCG was responsible to its members and the public in relation to how it allocated and spent taxpayers' money in each financial year.

For the period ended 30 June 2022 the CCG budget spend was allocated in the following proportions, which largely reflects historical levels of expenditure, trends in current demand but also the impact of the pandemic. The pie chart below shows the annual expenditure by service type which includes contract and non-contractual expenditure with NHS providers, independent providers, local authorities and the voluntary sector, and shows the running costs for the CCG:



Explanation of going-concern basis

The Governing Body is required to assess, at the time of preparing the financial statements, whether the entity is a going concern. In other words, will the entity continue to operate for the foreseeable future?

From 1 July 2022 NHS Devon Integrated Care Board will take on the statutory commissioning functions, assets and liabilities of NHS Devon CCG. The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern.

Indicators of an uncertain future would include the failure to achieve one or more statutory financial duties – for example, the breach of the resource limit.

The period ended 30 June 2022 resulted in a balanced position for Devon CCG. With the need to ensure that health services continue to meet the needs of the population and to support the achievement of national performance targets, the plan for the remaining nine months of the financial year indicates a very challenging period.

The 2022/23 plan will have an impact on the cash flow of the CCG and going forward the NHS Devon Integrated Care Board. However, overall cash is managed at an NHS England level. Therefore, if the total cash used by NHS England does not breach its cash limit, set by Treasury and the Department of Health and Social Care, NHS England will have the flexibility to provide cash support to CCGs when needed.

With the above in mind, the Governing Body of Devon CCG has prepared these financial statements on a going concern basis. This is effectively in relation to its

intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

Name of external auditor, plus costs

The CCG used the services of KPMG LLP as its external auditor and paid £58,597 (£70,316 including VAT) for the three-month period ended 30 June 2022 ((£73,246 (£87,895 including VAT) for 2021/22)). In 2021/22 there is an additional payment of £8,500 (£10,200 including VAT) for 2020/21's audit fee that wasn't accounted for in the 2020/21 accounts.

Basis of accounting

The financial statements contained within this report have been prepared in accordance with the direction given by NHS England under the National Health Service Act 2006 (as amended) and in a format instructed by the Department of Health and Social Care with the approval of HM Treasury.

The accounts present our results for, and financial position to, the period ended 30 June 2022. They have been prepared under International Financial Reporting Standards (IFRS) using the accounting policies shown in the notes to the accounts, in accordance with the 2022/23 Group Accounting Manual (GAM) issued by the Department of Health and Social Care. They comprise a Statement of Financial Position, Statement of Comprehensive Net Expenditure, a Statement of Cash Flows, and a Statement of Changes in Taxpayers' Equity, all with related notes.

Losses and 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, and special notation in the accounts to draw them to the attention of Parliament. They are divided into different categories including cash losses, bad debts, extracontractual payments and compensation.

For the period ended 30 June 2022 there were no losses and special payments, there were three ex-gratia payments coming to a total of £8,360.80 during 2021/22.

2022/23 Financial Outlook

From 1 July 2022 NHS Devon ICB will be a new statutory organisation which will take on the commissioning functions, assets and liabilities of NHS Devon CCG. The NHS confirmed that the financial arrangements for the remaining nine months of 2022/23 will continue to support a system-based approach to planning and delivery. The plans are based on the outcome of capacity and service planning reviews, together with the prioritisation of investments and disinvestments in accordance with the NHS Long Term Plan, the strategic plan for NHS Devon ICB, as well as the wider One Devon vision.

The ICB received recurrent base growth funding in 2022/23 of 3.1% which equates to £61.9m. For running costs, the allocation growth was approximately 0.7% which equates to broadly £0.2m.

The efficiency requirement this amount of growth creates is a challenging £36.5m which when you set aside the landscape for providers and the investments required, is in excess of 1.4% for other areas of planned expenditure.

The remainder of 2022/23 will be a very challenging period, reducing the waiting times, maximising recovery opportunities, driving system efficiency and reinvesting in less expensive, innovative and more effective integrated care models.

Managing our financial risks

The financial position of the ICB needs to be assured through the continued development of safe and deliverable savings programmes across the health community.

One Devon is committed to working collaboratively. The 2022/23 ICB plan carries a level of risk, some of which has been contained with partners organisations, through the approach to financial principles and collaborative working but importantly the translation of the financial framework set as part of national planning assumptions.

The plan is dependent on the on-going evaluation and mitigation of a number of broad financial risks through 2022/23:

- Although the Living with COVID plan is in effect, the arrangements for returning to business-as-usual presents both challenge and opportunity from a financial management perspective. We must ensure the system receives adequate resources to cover the additional costs incurred, due to the crisis, in line with the additional resource commitments for the NHS made by the Government, for example the Elective Recovery Fund. We will fully assess changes to the cost of commissioned services, both positive and negative, because of the adjustments to service delivery models required through the pandemic that can and should be retained for the foreseeable future.
- Funding provider contracts and commitments into 2022/23 and managing in-year financial risk. This will be particularly challenging given the level of system savings required.
- Managing within the running costs allowance which has been capped for a number of years. There is a risk of unforeseen staffing pressures due to workforce requirements of the ICB and system working.

The ICB must also play an active role in the mitigation of risk to the overall system position, supporting providers in the delivery of their challenging cost reduction plans through delivering a level of demand management which will support a step change and support a transformational approach to the capacity within the provider sector.

The ICB will only achieve its objectives through effective collaboration with its partners. It continues to work closely with local authorities, primary care services and local hospitals to improve the outcomes and experience of patients. The organisation seeks

the involvement of service-users and members of the public to enhance its understanding of the health needs and experience of the local population.

In addition to those outlined above, there are other risks because of the environment the ICB operates in, with NHS funding principally voted by Parliament. As such, it is reliant on the elected government for its income largely dependent on priorities at the time of voting.

It is not possible for the ICB to mitigate all the risks it faces. Risk is managed within the organisation using a risk register. Risks are scored against the likelihood of occurrence, the potential impact, and the strength of the risk controls in place. Responsibility for managing each risk is assigned to an appropriate individual. The risk register is reviewed periodically by the Audit Committee, the Senior Leadership Team and the Governing Body to ensure that appropriate controls are in place.

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

The Governing Body had responsibility for ensuring that the CCG had appropriate arrangements in place to manage its functions economically, efficiently and effectively. The Governing Body made sure that the CCG operated within the corporate governance framework (i.e. its standing orders, scheme of delegations and standing financial instructions) and established an Audit Committee to assist the Governing Body in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control, and a Finance and Performance Committee to provide a performance framework that proactively manages the CCG's financial and performance agendas.

The Quality Assurance Committee had in place a quality assurance process which measures quality against the 5 domains of the Care Quality Commission. In addition, there are Quality, equality, inclusion assessments (QEIA) and local key performance indicators in relation to quality and performance.

The Audit Committee provided assurance to the Governing Body that an appropriate system of internal control was in place to ensure that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities.

The CCG had a procurement policy to help ensure quality and value for money, helping it commission the right services to improve the lives of people in Devon.

The CCG made full use of internal and external audit functions to confirm controls were operating effectively, to provide independent assurance and advise on areas of

improvement. Audit report findings were discussed in detail at Audit Committee and summarised in the Head of Internal Audit Opinion Statement.

The Chief Finance Officer provided routine financial performance reports to the CCG's Finance and Performance Committee, as well as Governing Body, including performance against the organisation's statutory financial duties.

For the period ended 30 June 2022, NHS England continued the financial regime, introduced in 2020/21 due to COVID, that CCGs were required to follow. Funding included adjustments for inflation, efficiency requirements and policy priorities, as well as an allocation for COVID.

The CCG produced a plan in line with NHSE's guidance and was able to deliver a balanced position for the period covering 1 April to 30 June 2022.

It is not possible for the CCG to mitigate all the risks it faces. Risk is managed within the organisation using a risk register. Risks are scored against the likelihood of occurrence, the potential impact, and the strength of the risk controls in place. Responsibility for managing each risk is assigned to an appropriate individual. The risk register is reviewed periodically by the Audit Committee, the Senior Leadership Team and the Governing Body to ensure that appropriate controls are in place.

Jane Milligan
Accountable Officer
NHS Devon Clinical Commissioning Group
June 2022

Accountability report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April to 30 June 2022, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

CCGs were clinically led membership organisations made up of general practice. The members of the CCG took responsibility for determining the governing arrangements for the CCG, including arrangements for clinical leadership which are set out in the CCG's constitution.

Governing Body disclosures

The declaration of interests register included all interests declared by Governing Body members, employees and members of committees or subcommittees (including committees and subcommittees of the Governing Body). It was published on our website.

In accordance with the CCG's constitution and section 140 of The National Health Service Act 2006, the CCG's accountable officer must be informed of any interest which may lead to a conflict with the interests of the CCG and the public in relation to a decision to be made by the CCG, and that needs to be included in the Register within 28 days of the individual becoming aware of the potential for a conflict. If required, the register is updated regularly (at no more than three-monthly intervals).

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- Roles and responsibilities held within member practices
- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG
- Shareholdings (more than five percent) of companies in the field of health and social care
- A position of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care
- Any connection with a voluntary or other organisation contracting for NHS services
- Research funding/grants that may be received by the individual or any organisation in which they have an interest or role

Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG.

Member practices

NHS Devon CCG comprised 121 member practices across the identified localities, all grouped into primary care networks. Each primary care network has a clinical director. The clinical locality leaders were represented on the CCG Board.

**Note: Mewstone and Beacon PCNs are within the Plymouth locality, but also have a footprint within the West locality.*

East locality	
Primary Care Network	Practice name
Nexus	Mount Pleasant
	Heavitree
	South Lawn
	ISCA
	Hill Barton
TASC	Axminster Medical Practice
	Seaton and Colyton Medical Practice
	Townsend House Medical Centre
Outer Exeter	Cranbrook Medical Centre
	Ide Lane Surgery
	Pinhoe and Broadclyst Medical Practice
	Topsham Surgery and Glasshouse Medical Centre
	Westbank Practice
Honiton/Ottery/ Sid Valley (HOSMS)	Honiton Surgery
	Coleridge Medical Centre
	Sid Valley Practice

Exeter West	Foxhayes Practice
	St Thomas Medical Group
Exeter City	Barnfield Hill Surgery
	Clocktower Surgery
	Southernhay House Surgery
	St Leonards Practice
	Whipton Surgery
	Wonford Green Surgery
WEB	Claremont Medical Practice
	Rolle Medical Partnership
	Imperial Surgery
	Haldon House Surgery
	Woodbury Surgery
	Budleigh Salterton Medical Practice
	Raleigh Surgery
Culm Valley	Bramblehaies Surgery
	Blackdown Practice
	College Surgery
	Sampford Peverell Surgery
	Wyndham House Surgery
Tiverton	Amicus Health
	Castle Place
Mid Devon Healthcare	Bow Medical Practice
	Cheriton Bishop and Teign Valley Practice
	Mid Devon Medical Practice
	Redlands Primary Care
	Wallingbrook Health Group
North Dartmoor	Chagford Health Centre
	Blake House Surgery (Black Torrington)
	Moretonhampstead Health Centre
	Okehampton Medical Centre

North locality	
Network	Practice name
Torridge	Bideford Medical Centre
	Castle Gardens Surgery
	Hartland Surgery
	Northam Surgery
	Wooda Surgery
	Torrington Health Centre
Barnstaple Alliance	Brannams Medical Centre
	Fremington Medical Centre
	Litchdon Medical Centre
	Queens Medical Centre
Coast and Country	Ruby Country Medical Group
	Bradworthy Surgery
North Devon Coastal	Caen Medical Centre
	South Molton Medical Centre
	Lynton Health Centre
	Combe Coastal

West locality	
Network	Practice name
West Devon	Abbey Surgery
	Tavyside Health Centre
	Yelverton Surgery
Beacon Medical Group *	*Beacon Medical Group*
Mewstone *	*Wembury Surgery*
	Dean Cross Surgery
	Church View Surgery
	Yealm Medical Centre

Plymouth	
Network	Practice name
Beacon Medical Group*	Beacon Medical Group
Drake Medical	North Road West MC
	Roborough Surgery
	Knowle House Surgery

Alliance Limited	Wycliffe Surgery
	Lisson Grove and Woolwell Medical Centre
Mayflower	Mayflower Medical Group
Waterside Health Network	Devonport Health Centre
	St Levan Surgery
	Adelaide Surgery
	West Hoe Surgery
	Stoke Surgery
	Peverell Park Surgery and University Medical Centre
	St Neots Surgery
Mewstone*	Wembury Surgery
	Dean Cross Surgery
	Church View Surgery
	Yealm Medical Centre
Sound	Budshead Medical Practice
	Elm Surgery
	Friary House Surgery
	Oakside Surgery
	Southway Surgery
Pathfields Medical Group	Pathfields
	Beaumont Villa Surgery

South locality	
Network	Practice name
Baywide	Compass House Medical Centres
	Pembroke House Surgery
	Chilcote Surgery
Torquay	Southover Medical Practice
	Brunel Medical Practice
	Chelston Hall Surgery
	Croft Hall Medical Practice
Newton West	Albany Surgery Newton Abbot
	Bovey Tracey and Chudleigh Medical Practice
	Kingskerswell and Ipplepen Medical Practice
	Ashburton Surgery

South Dartmoor and Totnes	Buckfastleigh Medical Centre
	Catherine House Surgery
	Leatside Surgery
	South Brent Health Centre
Paignton and Brixham	Mayfield Medical Centre
	Corner Place Surgery
	Old Farm Surgery
The Coastal Network	Channel View Medical Practice
	Teign Estuary Medical Group
	Dawlish Medical Group (known as Barton Surgery)
Templer Care Network	Buckland Surgery
	Cricketfield Surgery
	Devon Square Surgery
	Kingsteignton Medical Practice
South Hams	Dartmouth Medical Practice
	Modbury Health Centre
	Chillington Health Centre
	Redfern Health Centre
	Norton Brook Medical Centre

Composition of Governing Body

The Governing Body ensured that the CCG operated effectively and efficiently, with good governance. The Governing Body, in line with the CCG constitution, most recently had 19 voting members, of which 12 were men and 7 women. Our lay members had a clear statutory role in acting as an independent and expert voice on the board.

Dr Paul Johnson[r]
Clinical chair

Jane Milligan
Chief Executive

Nick Ball**[r]
Vice chair; Non-executive lay member, Governance and probity

Simon Tapley
Deputy accountable officer

Dr Simon Kerr
Clinical representative, eastern locality

Dr Shelagh McCormick[r]
Clinical representative, western locality

Dr David Greenwell
Clinical representative, southern locality

Dr John Womersley
Clinical representative, northern locality

Darryn Allcorn**

Chief Nurse

John Dowell
Chief Finance Officer

Andrew Millward
Director of Communications, HR, Governance and IT

Jo Turl
Director of commissioning – out of hospital

John Finn
Director of commissioning – in hospital

Dr Nick Kennedy**[r]
Non-executive lay Member - Secondary care doctor

Gaynor Appleby[r]
Non-executive lay member, Allied healthcare

Graham Turner**[r]
Non-executive lay member, finance and remuneration

Judy Hargadon**[r]
Non-executive lay member, primary care and prevention

Glynis Atherton[r]
Non-executive lay member,
quality assurance

Alison Davis*
Non-executive lay member,
Independent social worker

*non-voting member
**member of Audit Committee
[r] member of Remuneration Committee

The above represents the membership of the Governing Body as of 30 June 2022.

The CCG Governing Body regularly invited the following individuals to attend any or all of its meetings as attendees who are non-voting:

Local authority representatives, specifically Public Health in accordance with Section 14W of the NHS Act. Within the CCG local geography, this representation would be from Devon County Council, Plymouth City Council and Torbay Council as described in section 2.2 of the CCG's constitution.

The Governing Body followed the Nolan Principles of Public Life in all that it did, and had a declaration of interests register, which was scrupulously maintained and openly shared. Governing Body meetings were held in public and the CCG endeavoured to manage the majority of its clinical commissioning decision-making in public. From the start, the Governing Body put the patient at the centre of its decision making. Its meetings began with a patient story, usually presented by one of our clinical members, and at the end of most meetings members reflect on the difference their decision making might have made to that patient.

Register of Interests

The declaration of interests register for decision making Governing Body members, employees and members of committees or subcommittees (including committees and subcommittees of the Board). It was published on our website.

In accordance with the CCGs constitution and section 140 of The National Health Service Act 2006, the CCGs accountable officer must be informed of any interest which may lead to a conflict with the interests of the CCG and the public in relation to a decision to be made by the CCG, and that needs to be included in the Register within 28 days of the individual becoming aware of the potential for a conflict. If required, the register is updated regularly (at no more than three-monthly intervals).

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- Roles and responsibilities held within member practices

- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG
- Shareholdings (more than five percent) of companies in the field of health and social care
- A position of authority in an organisation (eg, charity or voluntary organisation) in the field of health and social care
- Any connection with a voluntary or other organisation contracting for NHS services
- Research funding/grants that may be received by the individual or any organisation in which they have an interest or role
- Any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgement or actions in their role within the CCG.

Personal data related incidents

During the three months from 1 April 2022 to 30 June 2022 the CCG recorded no personal data related incidents to be reported to the Information Commissioner's Office.

Modern Slavery Act

Devon CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015. It is committed to ensuring that there is no use of modern slavery in its supply chain, and work on this will be redoubled once resources allow CCG personnel to return to their substantive posts from their redeployment into the COVID-19 response.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Jane Milligan to be the Accountable Officer of Devon Clinical Commissioning Group.

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

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and

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

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

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

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

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

This section includes information on how the CCG ensured that the organisation ran safely and effectively and that we made the best use of the resources available. It includes

- A Corporate Governance report which explains how our governance structures operate and how they support the achievement of the CCG's objectives
- A Remuneration report (to follow) and Staff report which gives information about our staff and how they are paid
- A Parliamentary Accountability and Audit report which some organisations are required to produce to give disclosures on statutory requirements.

Annual governance statement

Introduction and context

NHS Devon Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2019 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2022, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

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

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

Governance arrangements and effectiveness

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

The CCG's membership comprises 121 member practices, working together within 31 primary care networks across Devon. A full list of member practices is included in the Members' Report at page 52.

The membership and attendance record for the Governing Body and its committees are detailed at appendix 1. The Governing Body met twice in public between 1 April and 30 June 2022.

The Governing Body has six committees reporting to it. This includes three statutory committees of the Governing Body, as outlined in the constitution, and an additional three committees, namely Quality Assurance Committee, Finance and Performance Committee and Commissioning Committee.

The Governing Body committees have each undertaken an annual effectiveness review. These reviews will focus on what good practice could be transitioned into the Integrated Care Board and details presented at the shadow committees and the ICB Board during quarter 1.

Audit Committee – Statutory Requirement	
Chair	Chair Nick Ball, Non-Executive Director/Lay Member, Conflict of Interests Guardian
Terms of Reference	Approved July 2021
Purpose	The purpose of the Audit Committee is to assist the CCG in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide evidence-based assurance to the Governing Body that an appropriate system of internal control is in place to ensure that: • Business is conducted in accordance with the law and proper standards • Public money is safeguarded and properly accounted for • Financial statements are prepared in a timely fashion, and give a true and fair view of the financial position of the CCG for the period in question • Affairs are managed to secure economic, efficient and effective use of resources • Reasonable steps are taken to prevent and detect fraud lead by the Chief Finance Officer and other irregularities Governing

	bodies can – if they choose – nominate a 'subset' of the Audit Committee to act as the Auditor Panel. If a subset is used, there must be at least three Members with a majority who are independent and non-executive Members of the Governing Body. (HFMA briefing December 2015)

Remuneration and Strategic Workforce Committee – Statutory Requirement	
Chair	Chair Graham Turner, Non-Executive Director/Lay Member, Chair Finance and Performance Committee
Terms of Reference	Approved July 2021
Purpose	The purposes of the Remuneration and Strategic Workforce Committee are to: Part 1 - Make recommendations to the governing body on determinations about pay and remuneration for Very Senior Manager (VSM) employees of the clinical commissioning group and people who provide services to the clinical commissioning group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme. Part 2 - Provide assurance and oversight of strategic people management and organisational development identifying key issues and risks requiring discussion or decision by the Governing Body. The Remuneration and Strategic Workforce Committee has clear delegations for decision making which are set out in the Scheme of Reservation and Delegation.

Primary Care Commissioning Committee – Statutory requirement	
Chair	Judy Hargadon, Non-Executive Director/Lay Member, Chair Primary Care Commissioning Committee
Terms of Reference	Approved March 2021

Purpose	The Committee has been established in accordance with the above statutory provisions to enable the members to make decisions on the review, planning and procurement of primary care services in Devon, under delegated authority from NHS England. In performing its role, the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Devon CCG, which will sit alongside the delegation and terms of reference. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. The specific obligations of the CCG with respect to the delegated functions are set out in section 6 and schedule 2 of the Delegation Agreement and include: Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts including: a) the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach / remedial notices, and removing a contract); b) Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services"); c) Local incentive schemes as an alternative to the national Quality Outcomes Framework (QOF) (including the design of such schemes); d) 'Discretionary' payments (e.g., returner/retainer schemes); e) Commissioning urgent care for out of area registered patients. Planning the primary medical services provider landscape in Devon, including considering and taking decisions in relation to: a) The establishment of new GP practices (including branch surgeries) in the area, and the closure of GP Practices. b) Approving practice mergers. c) Managing GP practices providing inadequate standards of patient care, ensuring patients receive appropriate care. d) The procurement of new Primary Medical Services Contracts.

	e) Dispersing the lists of GP practices. f) Agreeing variations to the boundaries of GP practices; and g) Co-ordinating and carrying out the process of list cleansing in relation to GP practices. Decisions in relation to the management of poorly performing GP Practices including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list). Decisions in relation to the Premises Costs Directions Functions. The CCG will also carry out the following activities: • To plan, including needs assessment, primary care services in Devon. • To undertake reviews of primary care services in Devon. • To co-ordinate a common approach to the commissioning of primary care services generally. • To manage the budget for commissioning of primary care services in Devon. The Primary Care Operational Group will review operational contractual issues impacting on primary care delivery working within approved frameworks and decision-making authority from the Primary Care Commissioning Committee. This includes operational decisions pertaining to the Devon CCG primary medical care commissioning budget and making strategic recommendations to PCCC. The Primary Care Commissioning Committee is accountable for the management of the Devon CCG primary medical care commissioning budget. A finance report on the financial position of the budget will be submitted to PCCC monthly to inform strategic decision-making.

Finance and Performance Committee	
Chair	Graham Turner, Non-Executive Director/Lay Member, Chair Finance and Performance Committee

Terms of Reference	January 2021
Purpose	The Finance and Performance Committee is the overarching finance assurance committee. To provide assurance that the commissioning of services is evidence based, in line with the strategic objectives of the CCG, and inclusive of national and local requirements. Oversee CCG performance against statutory duties and legislation for financial governance, escalating any issues considered to impact on the commissioning of services. To provide assurance to the Governing Body and Audit Committee that the CCG is achieving the commissioning, financial and performance elements of its plan. This is to be achieved through judgement, scrutiny, and independent and objective review. To have oversight of budget, financial plans and any financial recovery plans. Review and approve finance and performance reports prior to submission to the Governing Body. To objectively assess and assure the Governing Body that the internal business support services are operating effectively, are responsive to the business need and offer value for money. Oversee care pathways and services that support the financial plans and vision of the CCG. Consider clinical quality and safety in all commissioned services and make recommendations to the Quality and Assurance Committee or Governing Body as appropriate. Ensure a clear escalation process, including appropriate trigger points, is in place to enable the committee to respond when the CCG is under financial pressure. The committee will meet jointly with the Quality Assurance Committee on a regular basis, as determined in the corporate calendar, to ensure that there are robust and functioning systems in place to commission safe, economical and effective treatment and care for patients, and that the experiences of patients are cost effective and positive.

Quality Assurance Committee	
Chair	Glynis Atherton, Non-Executive Director/Lay Member, Chair Quality Assurance Committee
Terms of Reference	Approved February 2021
Purpose	To quality assure, in an oversight role, the delivery of quality standards within commissioned services and to influence prioritisation of those services commissioned within the context of Devon's strategic plan and NHS long term plan. The Quality Assurance Committee will oversee performance against constitutional standards and statutory duties as well as legislation for clinical governance and escalate to the Governing Body, through the Committee Chair, any issues of concern considered to impact on the commissioning of high quality, safe care. It is the responsibility of the committee to make recommendations to the Governing Body of the CCG on determinations about the assurances received surrounding quality issues for the CCG.

Commissioning Committee	
Chair	Dr Claire Hooper, Strategic Clinical Advisor (Planned Care)
Terms of Reference	Approved February 2021
Purpose	The purpose of the Committee is to - • Ensure the CCG fulfils the functions, duties and responsibilities as set out in the CCG's Constitution in relation to its commissioning function • Co-ordinate operational aspects of the organisation to ensure that the CCG meets its strategic and operational objectives • Ensure that there is clinical input to commissioning decisions.

UK Corporate Governance Code

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

We report our corporate governance arrangements by drawing on 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 therefore intended to demonstrate the CCG's compliance with the principles set out in the Code.

Discharge of Statutory Functions

In light of the recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislature and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions. Responsibility for each duty and power is clearly outlined in the CCG's scheme of reservation and delegation, within the financial limits policy delegations are allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties. The financial risks in relation to financial sustainability are clearly visible on the assurance framework and corporate risk register. Controls and assurances are reviewed and updated at each monthly Finance and Performance Committee and reported through to the Governing Body no less than four times a year.

Risk management arrangements and effectiveness

The CCG is committed to a strategy that minimises risks to the organisation, staff and patients and stakeholders through a comprehensive system of internal controls, while providing maximum potential for flexibility, innovation and best practice in delivery of its strategic objectives. The CCG works to all applicable legislation and NHS guidance, and where risk forms a part of the CCG's work, this is assessed and recorded on the risk register.

The CCG has a comprehensive approach to risk management which has been assessed by internal audit as significant. The CCG maintains a risk register for all identified risks which are linked to the relevant element of the CCG's Corporate Objectives. A 5 x 5 risk scoring matrix is consistently applied to all risks, and the impact and likelihood of all risks are regularly assessed. This ensures that risks across different functions (e.g. finance, patient safety, data security) are objectively rated and compared on a single register.

All risks recorded on the register are assigned to one of the CCG's directors, a risk owner who is a senior officer within the CCG and are supported by a directorate risk coordinator. A risk assurance checklist is used to ensure that all identified risks are consistently scored in terms of likelihood and impact, and that the controls, assurances, and action plans are recorded. All risks are reviewed at least quarterly, and the length of time a risk has remained at its current risk score is reported. The CCG corporate risk register is reviewed by each of the CCG's committees, either in full or as relevant to the remit of that committee.

The Governing Body has discussed and agreed the CCG's risk appetite. The CCG will ensure high quality, with very limited tolerance of risk regarding patient and public safety. The CCG is eager to be innovative and to choose options offering potentially higher business rewards regarding finance, capacity and capability risks. The CCG is willing to consider all potential delivery options regarding patient and public safety risks.

The CCG uses team risk registers to record risks identified from directorate /team /individual work plans. This includes risks that have been removed from the corporate risk register for regular review to ensure that the risks remain in view. Team risks can be escalated to the Corporate Risk Register should the risk change in line with the risk appetite.

The CCG's risk appetite can be summarised as follows:

The Governing Body of NHS Devon CCG recognises that risk is a natural part of health and social care provision. The CCG will manage and mitigate risk whenever possible, to optimise patient safety. Whenever possible, we will look to take calculated risks where the potential results outweigh the costs.

Risk management is thoroughly embedded in the activity of the CCG, with members of staff engaged as risk owners or risk coordinators.

Risk is an agenda item on all Governing Body assurance committees, any new risk identified through these committees is recorded and appropriate action taken.

Quality and equality impact assessments are integrated into the CCG's core business and form a part of all policies and reports presented to CGG committees and the Governing Body for approval.

The CCG has an incident reporting module through the nursing and quality team and the governance team, where all staff are encouraged to record any incidents arising within the CCG or that relate to the CCG's commissioning work.

ASW Assurance provides an independent counter-fraud service to the CCG. No significant matters of concern have been identified and no investigations have been undertaken.

Capacity to Handle Risk

All CCG staff are involved in risk management – the Executive Director with accountability has responsibility to approve risks onto the CCG corporate risk register and board assurance framework; senior managers as risk-owners with responsibility for ensuring that risks are operationally managed, and, administrative staff as risk-coordinators with responsibility for recording and updating controls, assurances and action plans on the CCG's bespoke corporate risk register.

Guidance on risk management and frequency of training is contained in the CCG's risk management framework policy. The CCG has a risk and governance manager to support the Board Secretary and to provide support to the executive team, training and guidance to the risk coordinators and all other staff members. The Governing Body is assured risk management is effective within the CCG by the Audit Committee. The

Audit Committee receives regular reports on risk and the Audit Committee Chair includes the discussion and papers in the chairs report to Governing Body.

The use of team risk registers has further strengthened risk management within the CCG by providing a tool for teams/directorates to record and review operational risks identified from directorate /team /individual work plans. This includes risks that have been removed from the corporate risk register on being approved by the responsible Executive these risks are transferred to the Team Risk Register for regular review to ensure that the risks remain in view. Team risks to be escalated to the Corporate Risk Register require Executive approval, as does any recommended change in risk score. Risks escalated to the corporate risk register will result in a risk score change in line with the risk appetite.

Risk Assessment

Risks may be identified at all levels across the CCG, with each being assigned a risk-owner to oversee day-to-day activities, and an executive director to oversee effective management of the risk. Risks are aligned with the CCG's corporate objectives, with an expectation that all parts of the operational plan will have some element of risk associated with them.

Risks are graded according to a standard scoring 5 x 5 matrix, taking account of the CCG's risk appetite. Risks are presented to the relevant committee, the board assurance framework is presented and discussed by the Audit Committee and approved by the Governing Body and included in reports to the executive team.

All relevant risks and their controls are considered during internal audits. The CCG identified 1 new risk and closed a total of 1 risk during the April, May and June of 2022, to give a total of 31 open risks remaining as at 1 July 2022.

All these risks are reported regularly to the Accountable Officer's Strategic Leadership Team and assurance sought from the Audit Committee prior to a summary being presented to the Governing Body through the Audit Chair's report. Each risk is assigned to a committee of the Governing Body where these committees discuss those risks at each meeting and present their findings to the Governing Body through each committee chair's reports. The CCG's Governing Body papers can be found on the CCG's website.

1 risk was opened during the 1 April and 30 June 2022. Risks contained within the board assurance framework at 31 March 2022 will be reviewed as part of transition from CCG to Integrated Care Board and transferred, where appropriate, to the relevant risk register managed by the Board.

Other sources of assurance

Control Issues

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks

being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The CCG allocates all risks to a named executive director, and a risk owner (who is a senior manager), both of which are supported by a directorate risk coordinator. In addition, a member of the governance team holds a CCG wide overview and coordinates compliance with the Risk Management Framework Policy. All risks are reviewed at least quarterly, with high risks being reviewed no less than monthly. The CCG's corporate risk register is reviewed by the Governance Body and Audit Committee on a quarterly basis, with the corporate risk register being reviewed by each of the Governing Body committees, either in full or as relevant to the remit of that committee each time that it meets. The CCG's risk register is reviewed by each of the CCG's Governing Body committees, either in full or as relevant to the remit of that committee. An annual audit of the risk management process is completed by the CCG's internal auditors, who undertake a review of the CCG's Risk Management arrangements and ensure controls are robustly designed and, in the main, are operating as intended.

Team level risk registers has further supported the management of risk within the CCG by providing a tool to record and monitor operational risk which does not require escalation to the corporate risk register but does ensure executives are aware of risk within their portfolios.

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 systems of internal control related to risk management are monitored by the governance team to ensure regular reviews of risk are carried out and reporting any breaches should they occur. The corporate risk reports for Governing Body, Audit Committee, Quality Assurance Committee, Finance and Performance Committee, Commissioning Committee, Strategic Leadership Team and Primary Care Committee are produced by the governance team. During 1 April – 30 June 2022 no breaches of the policy have been identified.

Annual audit of conflicts of interest management

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

The overall objective of this audit was to evaluate the design and operation of the CCG's arrangements and controls for managing conflicts of interest and gifts and hospitality, ensuring compliance with NHS England's managing conflicts of interest statutory guidance for CCGs.

The following specific objectives were covered by this audit:

- The CCG has clear governance arrangements in place to manage conflicts of interest
- Registers for declarations of interest, gifts and hospitality, and procurement decisions are appropriately maintained:
- Clear decisions are made and appropriately documented where senior staff and GB / committee members declare any conflicts:
- Robust procedures are in place to manage breaches of the conflict of interest policy
- CCG registers reconcile to ABPI datasets

As part of the audit consideration was given to the impact of COVID-19 and/or any recovery/restoration or transformation changes to processes or procedures in place for the above areas.

Based on the findings of the audit of conflict of interests completed in quarter 3 2021/2022 the CCG was awarded significant assurance that the controls established by the CCG to manage conflicts of interest, and gifts and hospitality, are appropriately designed and are operating effectively. The CCG's arrangements comply with NHS England's updated statutory guidance for managing conflicts of interest.

We consider that the arrangements and controls established by the CCG to manage conflicts of interest, and gifts and hospitality, are appropriately designed and in the majority of cases, operated as intended.

Data Quality

The Governing Body, in addition to its committees and sub-committees (working groups), receives information provided by the CCG business intelligence team that is sourced from national mandatory returns and NHS Digital information. This data is subject to data quality checks from providers prior to submission, from NHS Digital as part of the national collation process and from the CCG as part of its data management processes. Information is also sourced directly from local providers and this is validated by the CCG business intelligence team on receipt, as well as against national information/guidance when that becomes available. The committee effectiveness reviews undertaken during 2022/23 do not raise any concerns around quality of data.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The Data Security and Protection Toolkit (DSPT) submission date for 2021/22 was 30 June 2022. The Data Protection Officer (DPO), following approval from both the Senior

Information Risk Owner (SIRO) and Caldicott Guardian, submitted its full 2021/2022 submission in June 2022 as ‘Standards Met’.

The CCG records all risks relating to data security on a risk register and has taken steps to ensure that all data is held securely, as mandated by the UK Data Protection Act and NHS requirements. This includes the risk identified due to the increase in home-working and shared working premises with non-CCG individuals.

As a result of continued improvements for safer working, the CCG has further embedded staff training and, as with previous years, the CCG continues to use the NHS Digital and e-Learning for Health Data Security Awareness training modules via the Electronic Staff Record portal and this continues to form part of the annual mandatory training for all staff. Face-to-face training with teams takes place to give all staff the opportunity to raise questions specific to their roles. The CCG regularly reviews its processes in relation to fair processing, subject access requests, incident reporting and investigation, and updates its Privacy Notice at least every six months, this now includes a section on Covid-19. The Internal Incidents portal available via the icon on every staff member’s desktop permits direct and quick access to Datix for the reporting of incidents, breaches and near misses. It provides a consistent approach for all staff for reporting whether that be data protection or for example, health and safety. The ongoing reviews and staff engagement ensured awareness surrounding information risk culture throughout the organisation. The CCG continues to work with its member practices via their Data Protection Officers, Devon Local Medical Committee, providers, community interest company and Local Authorities.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established a data protection framework and have data protection processes and procedures in line with the DSPT.

In addition to staff training the CCG has implemented a staff information governance handbook as a reference guide to ensure staff are aware of their data protection roles and responsibilities.

The CCG routinely reports any untoward incidents involving personal data to its Data Protection Steering Group which meets every two months and reports are produced for the Audit Committee. No CCG incidents were required to be reported to the Information Commissioner’s Office.

The Secretary of State released a Control of Patient Information Notice covering the purposes of sharing information in response to the COVID-19 pandemic. This Notice has subsequently been extended to 30 June 2022 as the pandemic continues. In accordance with the Notice, COVID-19 data, such as data privacy impact assessments, are recorded separately from business-as-usual CCG records. Preparations for the upcoming Covid-19 Response Inquiry have begun with the appointment of an Inquiry Lead while we await the Terms of Reference – it should be noted this Inquiry will cover

all aspects of the pandemic response such as Education, and not focused solely on just the Health Service.

The Health and Social Care Act 2012 provides NHS Digital with powers to collect personal confidential information. However, the Act does not provide for onward disclosure of identifiable data from NHS Digital. Nationally, a solution was agreed – through a network of Data Services for Commissioners Regional Offices (DSCRO) and supported locally by in house Safe Havens and Controlled Environment for Finance – where only named staff can control access to identifiable data in line with S251. During October 2015, the Health and Social Care (Safety and Quality) Act 2015: Duty to Share Information introduced a new legal duty in which health and adult social care bodies share information where this will facilitate the care of an individual. The CCG has been working with all appropriate bodies to ensure that this is in place and that personal data will only be processed where it is:

- Lawful, fair, and transparent
- Limited to a specified, explicit and legitimate purpose
- Use of minimal data to achieve its purpose
- Accurate and kept up-to-date
- Retained no longer than necessary
- Secured appropriately

The CCG is registered with the ICO ref no: ZA517803

Business Critical Models

An appropriate framework and environment are in place, in line with best practice recommendations of the 2013 MacPherson review, to provide quality assurance of business-critical models – including service planning and provision, budget-setting and allocations. This framework is informed by the role of the Audit Committee and the internal audit programme to review systems of internal control to identify areas for improvement

Third party assurances

As part of its annual plan, the Audit Committee has a rolling programme to gain assurance in respect of the third-party providers to which CCG functions are outsourced.

The Committee reviewed the effectiveness of the controls in relation to our locally outsourced functions, which are NHS Shared Business Services (Finance and Accounting), NHS Digital (General Practitioners payment), NHS Business Services Authority (Prescription and dental payments), Delt (IT services), SW Commissioning Support Unit, Payroll Services and Electronic Staff Records (ESR); these assurances are summarised in the Head of Internal Audit Opinion on page 77.

The CCG's contracting team seeks assurance from providers in relation to all contractual requirements, annually or more often, as required.

Control Issues

The CCG has kept its objectives and priorities under review, in line with national guidance.

The CCG continues to maintain its governance processes with the Governing Body taking on some of the activities of the assurance committees.

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

The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to manage its functions economically, efficiently and effectively. The Governing Body makes sure that the CCG operates within the corporate governance framework (i.e. its standing orders, scheme of delegations and standing financial instructions) and has established an Audit Committee to assist the Governing Body in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control, and a Finance and Performance Committee to provide a performance framework that proactively manages the CCG's financial and performance agendas.

The Quality Assurance Committee have in place a quality assurance process which measures quality against the five domains of the Care Quality Commission. In addition, there are Quality, equality, inclusion assessments (QEIA) and local key performance indicators in relation to quality and performance.

The Audit Committee provides assurance to the Governing Body that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities

The CCG has a procurement policy that seeks to be an effective way to help ensure quality and value for money requirements are achieved; helping the CCG commission the right services to improve the lives of those who live in Devon.

The CCG makes full use of internal and external audit functions to confirm controls are operating effectively, to provide independent assurance and advise on areas of improvement. Audit report findings are discussed in detail at Audit Committee and summarised in the Head of Internal Audit Opinion Statement.

Delegation of functions

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

The CCG's Governing Body may also have functions delegated to it by the membership of the CCG. These are set out in the articles of the constitution, scheme of reservation and delegation or the standing orders.

The Governing Body undertakes some of its work through its committees. Each committee has terms of reference, which have been formally approved by the Governing Body. Committee chairs present summaries, through their Chair's report, of the key business conducted at their meetings at subsequent meetings of the Governing Body held in public.

Value for money is assured through procurements which follow national and NHS guidelines. The appropriate legal and professional procurement advice is sought at all times which keeps the appropriate focus on patient safety quality and care as well as value for money.

Led by the Audit Committee, a risk-based audit plan is developed and detailed scrutiny and checking of systems and procedures are undertaken by internal audit and counter fraud services. At a more strategic level external audit also check and provide assurance on a number of key areas as well as the annual accounts.

The Governing Body receive reports from the finance team at each meeting and have devolved detailed scrutiny of all finance issues through the finance and performance committee.

Compliance with NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

NHS Devon CCG reported their compliance against the NHS England Core Standards for EPRR to the Governing Body during Q3 on 25 November 2021. NHS Devon CCG was assessed as Fully Compliant.

Counter fraud arrangements

ASW Assurance and their accredited Counter Fraud Specialists provide an independent counter-fraud service to the CCG. No significant matters of concern have been identified.

The Audit Committee receives regular reports from the Counter Fraud team and provides assurance to the Governing Body that an appropriate system of internal control is in place to ensure reasonable steps are taken to prevent and detect fraud and other irregularities.

Head of Internal Audit Opinion

The purpose of the opinion is to contribute to the assurances available to the Accountable Officer and the Board of the NHS Devon ICB which underpin the assessment of the effectiveness of NHS Devon CCG's system of internal control. This opinion will in turn assist the Accountable Officer and the Board of NHS Devon ICB in the completion of NHS Devon CCG's Annual Governance Statement for the period April to June 2022. The opinion does not imply that Internal Audit reviewed all risks and assurances relating to NHS Devon CCG.

The opinion is derived from the risk-based internal audit work that was undertaken for the period April to June 2022 that took into consideration the strategies, objectives and risks of NHS Devon CCG, the expectations of senior management, the Governing Body and other stakeholders during that period, agreed by management and approved by the Audit Committee. The Opinion concludes on the NHS Devon CCG's governance and control arrangements during the period April to June 2022. This approach provides a reasonable level of assurance, subject to the inherent limitations described in the Opinion.

As such, it is one component that the NHS Devon ICB Accountable Officer and Board takes into account in making NHS Devon CCG's Annual Governance Statement.

This opinion is provided by Internal Audit, externally assessed as compliant with Public Sector Internal Audit Standards.

This opinion should be read in the context of NHS Devon CCG's operating arrangements during the period April to June 2022. Due to changes nationally for the inception date for ICBs, CCGs continued to be statutory bodies for the first three months of 2022/2023. In line with guidance from NHS England and NHS Improvement Internal Auditors are required to prepare a Head of Internal Audit Opinion for the CCG covering this period.

During this period NHS Devon CCG was not only required to continue "normal" operations but was also in the process of preparing the establishment and transition to the NHS Devon ICB, on the 1st July, within the wider Integrated Care System "One Devon".

The basis for forming my opinion takes into consideration the context and oversight of NHS Devon CCG set out above, and the following:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.
2. An assessment of individual opinions arising from risk-based audit assignments that have been reported during the period April to June 2022. This assessment has taken account of the relative scope and materiality of these areas and management's progress in respect of addressing control weaknesses.
3. Any reliance that is being placed upon third party assurances.

The assurances provided from the work undertaken, which together support this opinion, are set out below including any limitations in scope of work on account of the Covid-19 pandemic and/or any subsequent restoration and transformation changes and NHS Devon CCG's transition to the NHS Devon ICB.

My overall Opinion is that:

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. Some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. Weaknesses in the design and/or inconsistent application of controls, which put the achievement of particular objectives at risk, are appropriately managed**. This opinion is provided except for the area of the Board Assurance Framework as it was not maintained, and the Governing Body did not receive the Board Assurance Framework during the period April to June 2022.**

The table below details the audit and assurance work completed relating to NHS Devon CCG's Corporate Governance arrangements.

Area of Audit and Level of Assurance Given

Due Diligence Part 2	Significant
NHS Devon CCG Oversight Governance Arrangements Months 1 to 3 2022/2023	Satisfactory - Risk Management Arrangements, Gifts and Hospitality and Conflicts of Interest, Quality and Third Party Assurance
NHS Devon CCG Oversight Governance Arrangements Months 1 to 3 2022/2023	Satisfactory - Financial Systems Controls
Performance Management	Satisfactory
Primary Care Commissioning	Satisfactory
NHS Devon CCG Oversight Governance Arrangements Months 1 to 3 2022/2023	Satisfactory - Information Governance and Planning and Commissioning Stakeholder Engagement

The internal audit review of Performance Management resulted in a "satisfactory" assurance rating. It was noted that the CCG's performance reporting processes enabled performance measures which related to the delivery of healthcare services to be regularly reported in a timely manner and that the Integrated Quality and Performance Report (IQPR) was regularly reported and monitored within the CCG's governance structure, with work underway to ensure that the report remained aligned to system priorities following the CCG's transition to an Integrated Care Board. However, it was considered that there were opportunities for the Business Intelligence team to enhance their monitoring of performance reporting compliance as although quality assurance measures had been implemented, quality checks were not recorded. The

increased use of Microsoft Power BI was also recommended as this would improve the promptness of performance reporting.

Third party assurances

NHS England has stated that there will not be separate service auditor reports for the period April to June 2022. However, a request has been made to key suppliers such as NHS SBS to provide "bridging letters" for the period to confirm consistent operation of controls. At the time of writing this draft opinion this has not yet been received. Once received this will be included in the final opinion.

Review of the effectiveness of governance, risk management and internal control

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

Conclusion

In line with the HIAO I can confirm that no significant internal control issues have been identified and that the CCG's risk management arrangements are appropriately designed and are operating as intended in respect of the management and monitoring of strategic and corporate level risks.

Jane Milligan
Accountable Officer
NHS Devon Clinical Commissioning Group

Remuneration and staff report

Remuneration Report

Remuneration Committee

The Remuneration Committee fulfils the remuneration committee functions required by statute, principally to determine remuneration, fees and allowances payable to CCG staff, and make recommendations to the governing body. As well as this, the committee deals with remuneration and terms of service in relation to the governing body and the executive team.

The remuneration committee consists of both executive members and lay members of the governing body. The quorum constitutes of a minimum of four members to include a non-executive director, the Director of Finance, and either a director of commissioning or clinical representative. The committee is advised by the associate director of human resources and organisational development and, where required, the chair and the accountable officer of the CCG.

Policy on the remuneration of senior managers

Some senior managers were on the NHS Agenda for Change framework, while others were in line with the Department of Health and Social Care Pay Framework for very senior managers.

The remuneration of senior managers was reviewed annually in conjunction with advice and guidance received from NHS Partners and the Department of Health and Social Care and included review of the assessment of performance during the relevant financial period including achievement of specific performance targets.

All governing body members had contracts of employment with the CCG, with appropriate notice periods built into each contract. This is in line with guidance received from the Department of Health and Social Care and HM Revenue and Customs.

Redundancy clauses in each contract matched the provisions in the Agenda for Change contract of employment.

Senior manager performance related pay.

Devon CCG does not have performance related pay.

Senior manager remuneration (including salary and pension entitlements) April-June 2022 (subject to audit)

Name and Title	Note	Apr-Jun 2022					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£0	£	£000	£000	£000	£000
Nigel Acheson Chief Medical Officer	1	30-35	0			15-17.5	45-50
Darryn Allcorn Chief Nurse		30-35	0			10-12.5	45-50
Gaynor Appleby Independent Non Executive Director Allied Healthcare	2	0-5	0			0	0-5
Glynis Atherton Independent Non Executive Director Quality Assurance	3	0-5	0			0	0-5
Nick Ball Vice Chair; Independent Non Executive Director Governance and Probity	4	5-10	0			0	5-10
Alison Davis Associate Non-Executive Lay Member, Independent Social Worker	5	0-5	0			0	0-5
John Dowell Chief Finance Officer		30-35	0			0	30-35
John Finn Director of In Hospital Commissioning	6	25-30	100			10-12.5	40-45
David Greenwell Clinical Representative, Southern Locality	7	5-10	0			5-7.5	10-15
Judith Hargadon Independent Non Executive Director Primary Care and Prevention		0-5	0			0	0-5
Paul Johnson Clinical Chair	8	30-35	0			10-12.5	40-45
Nick Kennedy Independent Non Executive Director - Secondary care doctor	9	10-15	0			0	10-15
Simon Kerr Clinical Representative, Eastern Locality	10	15-20	0			0	15-20
Shelagh McCormick Clinical Representative, Western Locality	11	20-25	0			5-7.5	25-30
Jane Milligan Chief Executive Officer		45-50	100			10-12.5	55-60
Andrew Millward Director of Communications, HR, Governance and IT	12	15-20	0			12.5-15	25-30
Paul Renshaw Director of Workforce Strategy	13	30-35	200			7.5-10	40-45

Simon Tapley Deputy Accountable Officer		35-40	0			12.5-15	45-50
Jo Turl Executive Director of Out of Hospital Commissioning	14	30-35	0			7.5-10	35-40
Graham Turner Independent Non Executive Director Finance and Remuneration	15	0-5	0			0	0-5
John Womersley Clinical Representative, Northern Locality	16	20-25	0			0	20-25

Notes:

1 Nigel Acheson began his role on 18th April 2022
2 Gaynor Appleby finished role on 30th June 2022
3 Glynis Atherton finished role on 30th June 2022
4 Nick Ball finished role on 30th June 2022
5 Alison Davis finished role on 30th June 2022
6 John Finn finished role on 30th June 2022
7 David Greenwell finished role on 30th June 2022
8 Paul Johnson finished role on 30th June 2022
9 Nick Kennedy finished role on 30th June 2022
10 Simon Kerr finished role on 30th June 2022
11 Shelagh McCormick finished role on 30th June 2022
12 Andrew Millward is also Systems Director of Communications and Engagement, only CCG Director of Communications and HR salary disclosed which is 50%
13 Paul Renshaw began role on 1st April 2022
14 Jo Turl finished role on 30th June 2022
15 Graham Turner finished role on 30th June 2022
16 John Womersley finished role on 30th June 2022

Additional governing body members and attendees not receiving remuneration from Devon CCG

Steve Brown is Director of Public Health - Devon County Council. No payments are made for attendance.
Ruth Harrell is Director of Public Health, Plymouth City Council. No payments are made for attendance.
Lincoln Sargeant is Director of Public Health, Torbay Council. No payments are made for attendance.

Senior manager remuneration (including salary and pension entitlements) 2021/22 (audited)

Name and Title	Note	2021/22

		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£0	£	£000	£000	£000	£000
Alison Davis Non Executive Director		5-10				0	5-10
Andrew Millward Chief Communications, IT and People Officer	1	65-70				27.5-30	95-100
Charlotte Burrows Lay Member - Patient and Public Involvement	2	5-10				0	5-10
Darryn Allcorn Nursing Chief Nursing Officer		130-135				35-37.5	165-170
David Greenwell Clinical representative (southern)		25-30				5-7.5	30-35
Gaynor Appleby Lay Member - Allied Healthcare		10-15				0	10-15
Glynis Atherton Lay Member - Assuring Quality of Services		10-15				0	10-15
Graham Turner Lay Member - Finance and Remuneration		10-15				0	10-15
James Wooldridge Associate Non Executive Director	3	0-5				0	0-5
Jane Milligan Accountable Officer	4	190-195	1,000			257.5-260	445-450
Jayne Carroll Interim Chief Operating Officer	5	20-25				57.5-60	75-80
Jo Turl Executive Director of Out of Hospital commissioning		120-125				30-32.5	150-155
John Dowell Chief Finance Officer		130-135				0-2.5	130-135
John Finn Executive Director of In Hospital commissioning	6	125-130				92.5-95	215-220
John Womersley Clinical representative (Northern)		85-90				0	85-90
Judith Hargadon Lay Member - Primary Care and Prevention		10-15				0	10-15
Nick Ball Lay Member - Audit and Assurance		25-30				0	25-30
Nick Kennedy Secondary care doctor		55-60				0	55-60
Paul Johnson Clinical Chair		135-140	100			7.5-10	140-145
Shelagh McCormick Clinical representative (Western)		85-90				25-27.5	110-115

Simon Kerr Clinical representative (Eastern)		60-65				22.5-25	85-90
Simon Tapley Deputy Accountable Officer		140-145				32.5-35	175-180

Note

1. Andrew Milward is also Systems Director of Communications and Engagement, only CCG Director of Communications and HR salary disclosed which is 50%
2. Charlotte Burrows finished role on 30th November 2021
3. James Wooldridge finished role on 12th October 2021
4. Jane Milligan began role on 1st April 2021. The pension related benefits have been calculated using the mid-point of the 2020/21 pension bands.
5. Jayne Carroll finished role on 31st May 2021
6. John Finn began role on 27th January 2021

Additional governing body members and attendees not receiving remuneration from Devon CCG are as follows

Steve Brown is a director of Public Health for Devon County Council and is a co-opted member. No payments are made for attendance.

Ruth Harrell is a Director of Public Health for Plymouth and is a co-opted member. No payments are made for attendance.

Lincoln Sargeant is a director of Public Health for Torbay and is a co-opted member. No payments are made for attendance.

Taxable expenses

No expenses, other than reimbursement of those actually incurred and in support of training and development of Senior Managers, have been paid.

Expenses, all of which relate to mileage claims and relocation costs, give rise to a tax liability and have been disclosed separately as benefits in kind. The tax liability arises as either the rate per mile reimbursed by the CCG exceeds that allowed as a tax-free amount by HMRC, or the total annual amount paid by the CCG exceeds that allowed as a tax-free amount by HMRC respectively.

Pension benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

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

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

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

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

Pension benefits relate to the total employment with Devon CCG even if the member has a split role but are pro rata to time spent in senior management position.

Pension benefits – April-June 2022 (subject to audit)

Name and Title	(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 30 June 2022 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 1 April 2022 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 30 June 2022 £000	(h) Employer's contribution to stakeholder pension £000
Nigel Acheson Chief Medical Officer	0-2.5	0-2.5	70-75	140-145	1418	17	1448	0
Darryn Allcorn Chief Nurse	0-2.5	0	45-50	95-100	805	8	825	0
John Dowell Chief Finance officer	0	0-2.5	60-65	100-105	1168	0	0	0
John Finn Director of In Hospital Commissioning	0-2.5	0	25-30	0-5	419	7	434	0
David Greenwell Clinical Representative, Southern Locality	0-2.5	0	10-15	20-25	210	5	217	0
Paul Johnson Clinical Chair	0-2.5	0	30-35	65-70	558	15	597	0
Shelagh McCormick Clinical Representative, Western Locality	0-2.5	0	15-20	35-40	378	7	393	0
Jane Milligan Chief Executive Officer	0-2.5	0	65-70	145-150	1332	9	1358	0
Andrew Millward Director of Communications, HR, Governance and IT	0-2.5	0	50-55	125-130	1160	12	1186	0
Paul Renshaw Director of Workforce Strategy	0-2.5	0-2.5	15-20	0-5	203	3	212	0

Simon Tapley Deputy Accountable Officer	0-2.5	0	55-60	115-120	982	10	1005	0
Jo Turl Executive Director of Out of Hospital Commissioning	0-2.5	0	35-40	60-65	497	3	508	0

NHS Business Services Authority (NHS BSA) only provide information as at 31 March each year. With the ICB commencing 1 July 2022, figures had to be re-calculated on a pro rata basis to 30 June 2022. This was determined to be the best available approach given NHS BSA information was only available for 31 March 2022 and 31 March 2023.

No CETV will be shown for pensioners or senior managers over NPA. Age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 Scheme.

• Lay members do not receive pensionable remuneration; there are no entries in respect of pensions for lay members.
• Only members with an NHS pension have been included.
• Pension benefits have not been included for those who are currently drawing their NHS pension.

Pension benefits - 2021/22 (audited)

Name and Title	(a) Real Increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2021	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2022	(h) Employer's contribution to stakeholder pension
	£0	£0	£0	£0	£0	£0	£0	£0
Andrew Millward Chief Communications, IT and People Officer	2.5-5	0	50-55	125-130	1,093	41	1,160	0
Darryn Allcorn Nursing Director/ Chief Nursing Officer	2.5-5	0-2.5	45-50	95-100	751	32	805	0
David Greenwell Clinical representative (southern)	0-2.5	0	10-15	20-25	197	7	210	0
Jane Milligan Accountable Officer	12.5-15	30-32.5	65-70	145-150	1,015	284	1,332	0

Jayne Carroll Interim Chief Operating Officer	2.5-5	0	35-40	90-95	722	56	790	0
Jo Turl Executive Director of Out of Hospital commissioning	0-2.5	0-2.5	30-35	60-65	460	18	497	0
John Dowell Chief Finance Officer	0-2.5	0	65-70	100-105	1,125	18	1,168	0
John Finn Executive Director of In Hospital commissioning	5-7.5	0	25-30	0-5	370	29	419	0
Paul Johnson Clinical Chair	0-2.5	0	30-35	65-70	529	2	558	0
Shelagh McCormick Clinical representative (Western)	0-2.5	0-2.5	15-20	35-40	338	25	378	0
Simon Kerr Clinical representative (Eastern)	0-2.5	0-2.5	20-25	45-50	424	28	463	0
Simon Tapley Deputy Accountable Officer	2.5-5	0	55-60	115-120	924	33	982	0

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

There was no early retirement through ill health during April – June 2022/23, or during 2021/22.

Payments to past directors

There were no awards made to past senior managers in-year.

Pay multiples

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	2.6%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	0.4%	N/A

Reporting bodies are required to disclose annual percentage changes in remuneration of the highest paid director and employees.

The highest paid director's salary has increased by 2.6% in 2022/23 to £197,500 (2021/22, £192,500). This salary is in line with the executive salary scale for Integrated Care Boards and the 2022/23 increase based on the independent national pay review body's recommendation for senior pay.

The average salary for employees as a whole has increased by 0.4% in 2022/23 to £50,042 (2021/22, £49,823). This is calculated for 2022/23 (Apr-Jun) from a total annualised salary of £29,775,072 for a total number of staff of 595 (2021/22, £28,747,613 for 577)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the 25th percentile, median (50th percentile) and 75th percentile of remuneration of the organisation's workforce.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Apr – June 2022	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	26,282	41,659	56,164
Salary component of total remuneration (£)	26,282	41,659	56,164

Pay ratio information	7.51	4.74	3.52
2021/22			
Total remuneration (£)	24,882	42,121	63,862
Salary component of total remuneration (£)	24,882	42,121	63,862
Pay ratio information	7.74	4.57	3.01

The banded annual remuneration of the highest paid director in Devon CCG in the reporting period 1 April - 30 June 2022 was £197,500 (2021/22, £192,500).

Firstly, this was 7.51 times (2021/22, 7.74) the 25th percentile of remuneration of the workforce, which was £26,282 (2021/22, £24,882). Secondly, this was 4.74 times (2021/22, 4.57) the median remuneration of the workforce, which was £41,659 (2021/22, £42,121). Finally, this was 3.52 times (2021/22, 3.01) the 75th percentile of remuneration of the workforce, which was £56,164 (2021/22, £63,862).

During the reporting period April – June 2022, no employees received remuneration in excess of the highest-paid director/member (2021/22: 0). Remuneration ranged from £14,923 to £196,650 (2021-22, £13,943 to £190,000).

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

Staff Report

The CCG has put great value on strength and commitment of its workforce which exhibits an effective range of skills, abilities and experience across all of our functions. It has continued to support and develop its workforce to ensure the CCG was responsive and adaptable to the changing political environment. This will continue in the Integrated Care System for Devon.

Number of senior managers

As of 30 June 2022, the Governing Body had a total of 19 members, of which 12 are men and 7 are women

Staff numbers and costs

The average number of CCG staff employed by staff grouping over the three-month period is presented below

	Permanent	**Other**	**Total**

Average number of full-time equivalent staff	461.20	41.25	502.45

Staff composition

The following table describes the staff composition in terms of banding, contract type and gender as of 30 June 2022.

Pay grade	Contract	Female	Male	Headcount	%	FTE
Band 2	Permanent	0	0	0	0.00%	0
	Other	7	4	11	1.88%	11
Band 3	Permanent	80	12	92	15.70%	83.26
	Other	3	1	4	0.68%	3.8
Band 4	Permanent	48	8	56	9.56%	51.37
	Other	4	1	5	0.85%	4.76
Band 5	Permanent	54	9	63	10.75%	57.49
	Other	0	0	0	0.00%	0
Band 6	Permanent	28	8	36	6.14%	34.22
	Other	3	0	3	0.51%	2
Band 7	Permanent	51	26	77	13.14%	72.03
	Other	3	3	6	1.02%	5.24
Band 8A	Permanent	49	22	71	12.12%	64.93
	Other	3	2	5	0.85%	3.57
Band 8B	Permanent	28	9	37	6.31%	34.18
	Other	2	0	2	0.34%	2
Band 8C	Permanent	21	14	35	5.97%	34.4
	Other	3	0	3	0.51%	3
	Permanent	4	5	9	1.54%	9

Band 8D	Other	0	0	0	0.00%	0
Band 9	Permanent	7	9	16	2.73%	15.81
	Other	0	0	0	0.00%	0
Other	Permanent	21	15	36	6.14%	16.19
	Other	8	11	19	3.24%	7.4
Grand Total		**427**	**159**	**586**	**100.00%**	**515.65**

**Note: Where staff have more than one role across different bands or categories their headcount is duplicated. Figures exclude Non-Executive Directors/ Lay Governing Body Members.*

Directors and Senior CCG managers*

Pay grade	Contract	Female	Male	Headcount	FTE
VSM	Permanent	2	6	8	8
	Other	1	1	2	1.8
Band 9	Permanent	5	7	12	12
	Other	0	0	0	0
Total		**8**	**14**	**22**	**21.8**

**Note: Figures above do not include those staff hosted by the CCG who are employed as part of the Integrated Care System.*

The below table illustrates our distribution of staff by gender identity as of 30 June 2022.

Gender	Headcount	FTE
Staff who identify as female	427	370.38
Staff who identify as male	159	145.27
Grand Total	**586**	**515.65**

The table below illustrates our employee distribution relating to staff group as of 30 June 2022.

Staff Group	Headcount	FTE
Administration and Estates Staff	459	428.41
Healthcare assistants and other support staff	3	2.80
Medical and Dental	41	10.40
Nursing, Midwifery and Health Visiting Staff	41	38.17
Scientific, Therapeutic and Technical Staff	42	35.88
Grand Total	**586**	**515.65**

Sickness absence data

Staff absence figures are included in the NHS sickness absence rates report published on the NHS Digital website.

Staff turnover percentages

Staff turnover figures for the CCG are included in the NHS workforce statistics reported on the NHS Digital website

Staff Costs

The table below sets out the breakdown of employee benefits for the period ending 30 June 2022.

2021/22	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Salaries and wages	6,093	5,375	718	3,132	**2,964**	168	2,961	2,411	550
Social security costs	664	664	-	424	424	-	240	240	-
Employer Contributions to NHS Pension scheme	1,055	1,055	-	777	777	-	278	278	-
Other pension costs	2	2	-	2	2	-	-	-	-
Apprenticeship Levy	26	26	-	26	26	-	-	-	-
Termination benefits	-	-	-	-	-	-	-	-	-
Gross employee benefits expenditure	**7,840**	7,122	**718**	**4,361**	4,193	168	3,479	2,929	**550**
Less recoveries in respect of employee benefits	(116)	(116)	-	(116)	(116)	-	-	-	-
Net admin employee benefits including capitalised costs	7,724	7,006	**718**	4,245	4,077	168	3,479	2,929	**550**
Less: employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	7,724	7,006	718	4,245	4,077	168	3,479	2,929	**550**

Staff engagement percentages

The CCG is committed to involving and communicating with staff across a range of matters. This is through a variety of channels such as our weekly staff bulletin and monthly briefings, as well as:

- the Staff Partnership forum
- an annual staff awards event
- the promotion of health and wellbeing, including a monthly newsletter
- a new and improved induction programme

In 2021 the NHS Staff Survey engagement score for the CCG was 7.1 out of 10.

Staff policies

The CCG has a range of human resources policies in place to ensure clear, fair and transparent practices that cover all aspects of the CCG. All policies are approved by the Staff Partnership Forum and Executive and are available to all staff on our intranet.

Equalities issues are incorporated into policies covering all aspects of human resources to ensure that individuals are treated equally and fairly, and that decisions on recruitment, selection, training, promotion and career management are based solely on objectives and job-related criteria. The CCG's aims are to promote diversity and equality of opportunity and provide an inclusive The CCG has a range of human resources policies in place to ensure clear, fair and transparent practices that cover all

aspects of the CCG. All policies are approved by the Staff Partnership Forum and Executive and are available to all staff on our intranet.

Equalities issues are incorporated into policies covering all aspects of human resources to ensure that individuals are treated equally and fairly, and that decisions on recruitment, selection, training, promotion and career management are based solely on objectives and job-related criteria. The CCG's aims are to promote diversity and equality of opportunity and provide an inclusive working environment in which all staff feel valued and supported.

We are an accredited "Disability Confident" employer, which ensures all applicants who have declared that they have a disability are guaranteed an interview if they meet the essential requirements of the person specification of a role. The Recruitment policy and process outlines the requirements for recruiting managers to make reasonable adjustments for candidates with disabilities and this is reinforced through recruitment training courses run for all staff who are required to sit on recruitment panels.

All staff with a declared disability or who become disabled during their employment will have access to appropriate training courses, and career development opportunities, and access to promotional opportunities. Reasonable adjustments are made to support these people with accessing and benefitting from these opportunities.

All our policies that relate to the continued employment and training of staff with disabilities have been equality impact assessed to ensure they are not detrimental to any staff with protected characteristics, including persons with disabilities. All policies are developed in line with Agenda for Change Terms and Conditions where applicable.

The CCG also recently employed a System Equality Diversity and Inclusion Lead, a post which will focus specifically on equality and diversity policies and initiatives within the CCG and the Devon system as a whole.

The CCG also has a staff Equality, Diversity & Inclusion Group which influences and leads change projects within the staff base to increase knowledge and visibility of EDI issues, create a more diverse workforce and improve overall staff wellbeing and satisfaction.

In addition, the CCG continues to monitor providers compliance with the workforce race equality standard.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 took effect on 1 April 2017, this means that NHS employers are now required to publish certain information on trade union officials and facility time on their website and within annual reports.

The information provided below is for the relevant period of 1 April 2022 to 30 June 2022. It captures details of employee's time spent on duties carried out for a trade union or as a union learning representative, for example, attending meetings, accompanying

an employee to disciplinary or grievance hearing etc. It also applies to, if applicable, training received, and duties carried out under the Health and Safety at Work Act 1974.

It is important to note that the CCG's formal consultation mechanism is through the Staff Partnership Forum. Representatives of the forum are staff members who are not required to be part of a Trade Union or indeed be a representative of a Trade Union and therefore this information does not reflect staff time spent on forum duties.

Table 1: the number of trade union representatives in your organisation

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

Table 2: the percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	0
51-99%	0
100%	0

Table 3: the amount spent on facility time

First column	Figures
Provide the total cost of facility time	0
Provide the total pay bill	£7,332,888
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time/total pay bill) x 100	0

Table 4: the percentage of paid facility time spent on paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period/total paid facility time hours) x 100	0

Other employee matters

Staff health and wellbeing

We are committed to the health and wellbeing of our staff through preventive and promotional support through our staff-led health and wellbeing programme which aims to:

- create and encourage an ongoing dialogue across the organisation to improve staff health and wellbeing
- raise awareness and provide useful information and resources

- organise staff events and workshops that encourage colleagues to improve their health and wellbeing
- link initiatives back to our own colleagues and values by sharing personal and team stories

A Wellbeing Guardian has been appointed from the CCG's Board and Health and Wellbeing Champions continue to develop and implement the health and wellbeing programme.

Expenditure on consultancy

During the period ending 30 June 2022 the CCG had a credit of £0.159m on external consultancy costs which was made up of £0.037m period spend against a prior period VAT credits of £0.196m (£1.646m in 2021/22).

Off-payroll engagements

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as at 30 June 2022 for more than £245* per day:

	Number
Number of existing engagements as of 30 June 2022	5
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

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

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022 for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	6
Of which:	
No. not subject to off-payroll legislation[2]	
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	6
the number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

[2] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2022 and 30 June 2022:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period[1]	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on payroll and off-payroll engagements. [2]	19

Exit packages, including special (non-contractual) payments

Exit packages are agreements made in year for payments to employees on termination of employment. These include the additional costs where the CCG has agreed early retirements. Exit packages agreed and paid from 1 April to 30 June 2022 are below.

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS terms and conditions handbook, NHS pension Scheme and NHS standard contract where applicable. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Devon CCG has agreed early retirements, the additional costs are met by the NHS Devon CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	**£000s**
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**0**	**0**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval**	**0**	**0**
TOTAL	**0**	**0**

Parliamentary Accountability and Audit Report

NHS Devon CCG is not required to produce a Parliamentary Accountability and Audit Report. Included, as notes, are disclosures on contingencies (see page 51) and special payments (see page 46). An audit certificate and report are also included on page X.

Annual accounts

Contents

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

	Note	Period ending 30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(116)	(1,044)
Other operating income	2	(4,533)	(23,715)
Total operating income		**(4,649)**	**(24,759)**
Staff costs	4	7,840	30,448
Purchase of goods and services	5	592,912	2,551,918
Depreciation and impairment charges	5	176	717
Other Operating Expenditure	5	33	591
Total operating expenditure		**600,961**	**2,583,674**
Net Operating Expenditure		**596,312**	**2,558,915**
Other gains and losses	8	-	350
Finance expense	9	5	-
Net expenditure for the Period/Year		**596,317**	**2,559,265**
Other gain and losses		-	-
Total Net Expenditure for the Financial Period/Year		**596,317**	**2,559,265**
Comprehensive Expenditure for the Period/Year		**596,317**	**2,559,265**

NHS Devon CCG ceased 30 June 2022 with NHS Devon ICB taking on the commissioning functions from 1 July 2022 therefore the current accounts period only covers 3 months 1 April 2022 to 30 June 2022. These figures are not comparable to the 12 month comparators covering the period 1 April 2021 to 31 March 2022.

The notes on the following pages form part of this statement

Statement of Financial Position as at 30 June 2022

	Note	Period ending 30 June 2022 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	10	559	619
Right-of-use Assets	11	2,267	-
Intangible assets	12	225	244
Other financial assets	15	-	-
Total non-current assets		**3,051**	863
Current assets:			
Inventories	13	896	896
Trade and other receivables	14	8,866	8,095
Cash and cash equivalents	16	731	424
Total current assets		**10,493**	9,415
Total assets		**13,544**	10,278
Current liabilities			
Trade and other payables	17	(134,884)	(164,503)
Lease liabilities	11	(463)	-
Borrowings	19	(2,489)	(1,780)
Provisions	20	-	-
Total current liabilities		**(137,836)**	(166,283)
Total Assets less Current Liabilities		**(124,292)**	(156,005)
Non-current liabilities			
Other financial liabilities	18	-	(72)
Lease liabilities	11	(1,854)	-
Total non-current liabilities		**(1,854)**	(72)
Assets less Liabilities		**(126,146)**	(156,077)
Financed by Taxpayers' Equity			
General fund		(126,146)	(156,077)
Total taxpayers' equity:		**(126,146)**	(156,077)

The notes on the following pages form part of this statement

The financial statements on the following pages were approved by the Governing Body on 6 September 2023 and signed on its behalf by:

Jane Milligan
Accountable Officer

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

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Period ending 30 June 2022		
Balance at 01 April 2022	(156,077)	**(156,077)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-
Adjusted balance 1 April 2022	**(156,077)**	**(156,077)**
Changes in NHS CCG taxpayers' equity for Period ending 30 June 2022		
Net expenditure for the financial period	(596,317)	**(596,317)**
Net Recognised NHS CCG Expenditure for the Financial year	**(596,317)**	**(596,317)**
Net funding	626,248	**626,248**
Balance at 30 June 2022	**(126,146)**	**(126,146)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22		
Balance at 01 April 2021	(136,878)	(136,878)
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-
Adjusted balance 1 April 2021	**(136,878)**	**(136,878)**
Changes in NHS CCG taxpayers' equity for 2021-22		
Net expenditure for the financial year	(2,559,265)	(2,559,265)
Net Recognised NHS CCG Expenditure for the Financial Year	**(2,559,265)**	**(2,559,265)**
Net funding	2,540,066	2,540,066
Balance at 31 March 2022	**(156,077)**	**(156,077)**

The notes on the following pages from part of this statement

Statement of Cash Flows for the period ended 30 June 2022

	Note	Period ending 30 June 2022 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(596,389)	(2,559,278)
Depreciation and amortisation	5	176	717
Interest paid	9	5	0
Other Gains & Losses	8	-	350
(Increase)/decrease in inventories	13	-	(148)
(Increase)/decrease in trade & other receivables	14	(771)	10,425
Increase/(decrease) in trade & other payables	17	(29,619)	15,661
Net Cash Inflow (Outflow) from Operating Activities		**(626,598)**	(2,532,273)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment	10	-	(319)
(Payments) for intangible assets	12	-	(244)
Net Cash Inflow (Outflow) from Investing Activities		-	(563)
Net Cash Inflow (Outflow) before Financing		**(626,598)**	(2,532,836)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		626,248	2,540,066
Repayment of lease liabilities	11	(52)	-
Net Cash Inflow (Outflow) from Financing Activities		**626,196**	2,540,066
Net Increase (Decrease) in Cash & Cash Equivalents	16	**(402)**	7,230
Cash & Cash Equivalents at the Beginning of the Financial Period/ Year		**(1,356)**	(8,586)
Transfer from other public bodies under absorption		0	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period/Year		**(1,758)**	(1,356)

The notes on the following pages form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups (CCGs) shall meet the accounting requirements of the Group Accounting Manual (GAM) 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 (IFRS) to the extent that they are meaningful and appropriate to Clinical Commissioning Groups (CCGs), 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

Management is required to assess, at the time of preparing the financial statements, the entity's ability to continue as a going concern. The accounting concept of a going concern refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. If an organisation is a going concern it is expected to operate for the foreseeable future, usually 12 months from the date the final accounts have been approved by the Governing Body (in this case 12 months from the end of June 2022). An organisation that was not a going concern would prepare its accounts on a different basis, reflecting their value on the winding up of the entity. Consequently, assets are more likely to be recorded at a much lower break-up value and medium and long-term liabilities would become short-term liabilities.

The Health and Social Care Bill was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICBs) across England and abolished CCGs. ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

The Department of Health and Social Care Group Accounting Manual 2022-23 states that for non-trading entities in the public sector, the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision of that service in published documents, is normally sufficient evidence of going concern. The 2022-23 Annual Report for the period ended 30 June 2022 will discuss and review the CCGs future service plans and aims for their local populations.

With the above in mind the accounts of Devon CCG have been prepared these financial statements on a going-concern basis. This is effectively in relation to the organisations intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

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 **Joint arrangements**

Arrangements over which the CCG 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 CCG is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The CCG has entered into five arrangements, four of which has been assessed as joint operations.

The first of which is a joint operation under a Section 75 agreement with Plymouth City Council (PCC) to form the Plymouth Integrated Fund to manage Health and Social Care spending for the population of Plymouth. There are two elements to the integrated fund being 1) pooled funds (including the Plymouth Better Care Fund (BCF)) and 2) aligned funds where they cannot be managed within the pool but can be aligned for inclusion in the risk share arrangements. Under the section 75 agreement the CCG is the host to the pooled element of the fund however PCC remain lead commissioner for their element of spend within the pool. Under a joint operation each entity accounts for its share of the arrangement.

The second of which is a joint operation under a Section 75 agreement with Devon County Council (DCC) to form the Devon BCF. DCC are host to the fund and the CCG is lead commissioner to some of the funds elements. The net cost of the Devon BCF is reported within purchase of goods and services. Under a joint operation each entity accounts for its share of the arrangement.

The third arrangement is with Torbay Council for the Joint Community Equipment Store and the fourth concerns the Better Care Fund with Torbay Council.

The arrangement for Torbay is hosted by the CCG. The CCG accounts for its share of the income and expenditure arising from the activities of the arrangements, identified in accordance with the pooled budget agreements.

If the CCG is involved in a joint venture, the parties that have joint control have rights to the net assets of the arrangement. This must involve a separate vehicle and will need to account for their interest as an investment. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The CCG has entered into a joint venture with Plymouth City Council for the provision of IT services through the company DELT Shared Services (DELT). DELT commenced providing services on 1 September 2014. No IT assets transferred from the CCG to DELT. Existing IT assets remain on the CCG's fixed asset register with the exception of GPIT assets which remain on the NHS England's fixed asset register.

The CCG holds a shareholding interest in DELT in respect of 1 A ordinary Share with a nominal total value of £1 being 50% of the total shareholding and 30 B ordinary shares with a total nominal value of £30 being 30% of the total shareholding. This shareholding is held within the CCG's fixed asset register but due to the immaterial value is not visible in the annual accounts.

The CCG has considered the materiality of DELT as an entity and has concluded that the value falls below a materiality threshold and therefore group accounts have not been prepared.

1.4 **Revenue**

The CCG receives its main funding through a resource allocation from NHS England. This is drawn down and credited to the general fund.

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 CCG will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The CCG 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 CCG to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the CCGs 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.

Other income the CCG receives is pass-through funds from organisations, for example from NHS England, as well as refunds for drugs the CCG purchased during the year.

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

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

Payment terms are standard reflecting cross government principles.

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

1.5 **Employee Benefits**

1.5.1 **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.

1.5.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment.

Some employees have joined the National Employment Savings Trust (NEST) pension scheme which is a defined contribution scheme and was set up by the government. The contributions the employee makes, along with the level of growth from the investments, will determine the size of the pension available on retirement.

1.6 **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.

1.7 **Grants Payable**

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

1.8 **Property, Plant & Equipment**

1.8.1 **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 CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.8.2 **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.

1.8.3 **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.

1.9 **Intangible Assets**

1.9.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG'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 CCG;
- 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.

1.9.2 **Measurement**

Notes to the financial statements

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

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

1.9.3 **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 CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG 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 CCG checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 **Leases**

A lease is a contract, or part of a contract, that conveys the right to use an asset for a period of time in exchange for consideration. The CCG assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 **The CCG 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% (3.51%) is applied for leases commencing, transitioning or being remeasured in the 2022 (2023) 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.

1.11 **Inventories**

Inventories are valued at the lower of cost and net realisable value. The CCG's share of the inventory in the Better Care Fund with Devon County Council is disclosed in note 13.

1.12 **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 CCG's cash management.

1.13 **Provisions**

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG 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 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 3.20% (2021-22: 0.70%) 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 3.51% (2021-22: 0.95%) 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 3.00% (2021-22: 0.66%) 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 CCG 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.

1.14 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the CCG 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 CCG. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the CCG is disclosed in Note 20.

1.15 **Non-clinical Risk Pooling**

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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.

1.16 **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 CCG, 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 CCG. 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.

1.17 **Financial Assets**

Financial assets are recognised when the CCG 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.

1.17.1 **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.

1.17.2 **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.

1.17.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

The CCG has no embedded derivatives that are required to be accounted for separately.

The CCG's only financial assets are trade receivables and cash and cash equivalents which are disclosed in note 22.2. Trade receivables are recognised at the consideration agreed at the date of the transaction and the cash and cash equivalents are recognised at face value.

1.17.4 **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 CCG recognises a loss allowance representing the expected credit losses on the financial asset.

The CCG 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 CCG 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 CCG 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.

1.18 **Financial Liabilities**

Notes to the financial statements

Financial liabilities are recognised on the statement of financial position when the CCG 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.

1.18.1 **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.

1.18.2 **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 CCG's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. The CCG has no embedded derivatives that are required to be accounted for separately.

1.18.3 **Other Financial Liabilities**

The CCG's other financial liabilities are trade payables and loans with external bodies. These are disclosed in note 22.3. Trade payables are recognised at the consideration agreed at the date of the transactions. Loans with external bodies is a technical overdraft with the bank due to the CCG meeting its obligation to pay general practitioners, at the start of the month, while ensuring the bank account balance is within 1.25% of the CCG's June's funding. Loans with external bodies is recognised as the full value of the BACs run processed.

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.

1.19 **Value Added Tax**

Most of the activities of the CCG 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.

1.20 **Foreign Currencies**

The CCG'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. No significant foreign currency transactions occurred during the year.

1.21 **Third Party Assets**

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

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

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

1.22.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the CCG's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Apart from the accounting treatment of the better care fund budgets mentioned in 1.3 above and those involving estimations (see below), management has made no other critical accounting judgements in the process of applying the CCG's accounting policies that have would have a significant effect on the amounts recognised in the financial statements:

1.22.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial period.

Estimation techniques are used to ensure that the correct levels of income and expenditure relating to current year are included through the inclusion of accruals. These are based on known commitments and local knowledge. Historically the difference between the estimated accruals and actual cost have not been material and it is expected to follow suit this year. The accruals will be carried forward into the period 1 July 2022 to 31 March 2023 and matched against the actual costs incurred within the ICB.

For the main acute contracts the period end forecasts are based on the 3 month effect of the financial framework put in place in 2022/23.

Regarding prescribing costs, the CCG relies on the Business Services Authority's (BSA) forecasting methodology applied to primary care prescribing as well as local factors that fall outside of the national model. Due to the timing of published data the year end position includes an estimate for both May and June's prescribing costs.

Other estimates and judgements made in applying the CCG's accounting policies relate to the valuation of Property, Plant and Equipment and Intangibles. The nature of the assumptions and carrying value of the assets and liabilities are detailed in note 10 and 12 respectively.

1.23 **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 asset.

Impact assessment

The CCG 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 taxpayers' equity 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.

Notes to the financial statements

As of 1 April 2022, the group recognised £2.364m or right-of-use assets and lease liabilities of £2.364m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was an £nil impact to tax payers' equity.

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	(2,580)
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	25
Operating lease commitments discounted used weighted average IBR	(2,555)
Less: Short term leases (including those with <12 months at application date)	11
Less: Variable payments not included in the valuation of the lease liabilities	180
Lease liability at 1 April 2022	**(2,364)**

1.24 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standard and Interpretation to be applied for the period ended 30 June 2022.

- IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted. This standard will apply to companies that write insurance contracts and as such would have no effect on the CCG's/ICB's financial position.

2 Other Operating Revenue

	Period ending 30 June 2022 Total £'000	2021-22 Total £'000
Income from sale of goods and services (contracts)		
Recoveries in respect of employee benefits	**116**	1,044
Total Income from sale of goods and services	**116**	**1,044**
Other operating income		
Non cash apprenticeship training grants revenue	**17**	58
Other non contract revenue	**4,516**	23,657
Total Other operating income	**4,533**	**23,715**
Total Operating Income	**4,649**	**24,759**

The main CCG funding is not included in this note. Revenue received from NHS England is drawn down directly into the bank account of the CCG and credited to the General Fund.

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

The CCG receives income as part of the joint arrangements with its partner organisations. Income also includes reimbursments for cost of drugs that the CCG purchased during the year.

4 Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		Period ending 30 June 2022
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	5,375	718	6,093
Social security costs	664	-	664
Employer Contributions to NHS Pension scheme	1,055	-	1,055
Other pension costs	2	-	2
Apprenticeship Levy	26	-	26
Gross employee benefits expenditure	7,122	718	7,840
Less recoveries in respect of employee benefits (note 4.1.2)	(116)	-	(116)
Total - Net admin employee benefits including capitalised costs	7,006	718	7,724
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	7,006	718	7,724

4.1.1 Employee benefits

	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	21,506	2,263	23,769
Social security costs	2,343	-	2,343
Employer Contributions to NHS Pension scheme	4,249	-	4,249
Other pension costs	5	-	5
Apprenticeship Levy	82	-	82
Gross employee benefits expenditure	28,185	2,263	30,448
Less recoveries in respect of employee benefits (note 4.1.2)	(1,044)	-	(1,044)
Total - Net admin employee benefits including capitalised costs	27,141	2,263	29,404
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	27,141	2,263	29,404

4.1.2 Recoveries in respect of employee benefits

	Period ending 30 June 2022			2021-22
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(116)	-	(116)	(1,044)
Total recoveries in respect of employee benefits	(116)	-	(116)	(1,044)

The comparators (2021-22) in note 4.1.1 and 4.1.2 above have been restated to disclose the Recoveries In Respect of Employee Benefits which were previous netted off within Salaries and Wages.

4.2 Average number of people employed

	Period ending 30 June 2022			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**461.20**	**41.25**	**502.45**	**439.08**	**38.62**	**477.80**
Of the above: **Number of whole time equivalent people engaged on capital projects**	-	-	-	-	-	-

4.3 Staff Annual Leave Accrual Balances	Period ending 30 June 2022			2021-22		
	Total £000s	Permanent Staff £000s	Temp/Agency £000s	Total £000s	Permanent £000s	Temp/Agency £000s
	(2)	(2)	-	(524)	(524)	-

4.4 Exit packages agreed in the financial year

There were no agreed exit packages in the period ended 30 June 2022 or for the year ended 31 March 2022.

4.5 Pension costs

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

5 Operating expenses

	Period ending 30 June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	199	477
Services from foundation trusts	269,425	914,088
Services from other NHS trusts	146,017	790,546
Purchase of healthcare from non-NHS bodies	57,645	362,847
Purchase of social care	10,418	44,413
Prescribing costs	53,218	208,957
GPMS/APMS and PCTMS	53,290	213,729
Supplies and services – clinical	166	651
Supplies and services – general	633	2,977
Consultancy services	(159)	1,646
Establishment	1,314	7,500
Transport	51	61
Premises	346	2,309
Audit fees	70	98
Other non statutory audit expenditure		
- Internal audit services	-	-
- Other services	-	12
Other professional fees	119	936
Legal fees	85	360
Education, training and conferences	58	253
Non cash apprenticeship training grants	17	58
Total Purchase of goods and services	**592,912**	**2,551,918**
Depreciation and impairment charges		
Depreciation	157	716
Amortisation	19	1
Total Depreciation and impairment charges	**176**	**717**
Other Operating Expenditure		
Chair and Non Executive Members	92	310
Grants to Other bodies	-	1,022
Clinical negligence	-	1
Expected credit loss on receivables	(67)	(895)
Other expenditure	8	153
Total Other Operating Expenditure	**33**	**591**
Total operating expenditure	**593,121**	**2,553,226**

In accordance with SI 2008 no.489, The Companies Regulations 2008, the contract the CCG has with the external auditors, KPMG UK LLP, has a limitation on their liability set at £5m.
The external audit fee, payable to KPMG UK LLP, was estimated at the time of producing the accounts at £58,596.80 plus VAT totalling £70,316.16 for the period ended 30 June 2022 (£73,246 plus VAT totalling £87,895 for 2021/22). Included in the 2021/22 audit fee is £10,500 which relates to additional costs for the 2020/21 audit.

6.1 Better Payment Practice Code

Measure of compliance	Period ending 30 June 2022 Number	Period ending 30 June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	13,255	149,970	46,423	662,684
Total Non-NHS Trade invoices paid within target	13,191	143,273	46,088	640,451
Percentage of Non-NHS Trade invoices paid within target	**99.52%**	**95.53%**	**99.28%**	**96.65%**
NHS Payables				
Total NHS Trade invoices Paid in the Year	293	427,070	1,028	1,672,619
Total NHS Trade invoices Paid within target	286	426,628	1,003	1,666,322
Percentage of NHS Trade invoices paid within target	**97.61%**	**99.90%**	**97.57%**	**99.74%**

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.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	Period ending 30 June 2022 £'000	2021-22 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	-	-

7 Income Generation Activities

The CCG undertakes income generation activities with an aim of achieving profit, which is then used in commissioning healthcare services. None of these activities had a full cost which exceeded £1m or was otherwise material.

8 Other Gains & Losses

	Period ending 30 June 2022 £'000	2021-22 £'000
(Gain) / Loss on disposal of property, plant and equipment assets other than by sale	-	350
Total	-	350

There were no gains or losses in the period ending 30 June 2022. In 2021/22 there was a loss of £350k as a result of disposing of assets no longer in use held by the CCG and used by Livewell Southwest as well as the CCG moving out of Crown Yealm House.

9 Finance costs

	Period ending 30 June 2022 £'000	2021-22 £'000
Interest		
Interest on obligations under finance leases	5	-
Total interest	5	-

10 Property, plant and equipment

Period ending 30 June 2022	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2022	-	4	3,736	74	3,814
Additions purchased	-	-	-	-	-
Additions donated	-	-	-	-	-
Additions government granted	-	-	-	-	-
Additions leased	-	-	-	-	-
Reclassifications	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-
Disposals other than by sale	-	-	(2,525)	-	(2,525)
Upward revaluation gains	-	-	-	-	-
Impairments charged	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-
Cost/Valuation at 30 June 2022	-	4	1,211	74	1,289
Depreciation 01 April 2022	-	4	3,125	66	3,195
Reclassifications	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-
Disposals other than by sale	-	-	(2,525)	-	(2,525)
Upward revaluation gains	-	-	-	-	-
Impairments charged	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Charged during the year	-	-	58	2	60
Transfer (to)/from other public sector body	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-
Depreciation at 30 June 2022	-	4	658	68	730
Net Book Value at 30 June 2022	-	-	553	6	559
Purchased	-	-	553	6	559
Donated	-	-	-	-	-
Government Granted	-	-	-	-	-
Total at 30 June 2022	-	-	553	6	559
Asset financing:					
Owned	-	-	553	6	559
Total at 30 June 2022	-	-	553	6	559

Revaluation Reserve Balance for Property, Plant & Equipment

	Buildings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-	-
Revaluation gains	-	-	-	-	-
Impairments	-	-	-	-	-
Release to general fund	-	-	-	-	-
Other movements	-	-	-	-	-
Balance at 30 June 2022	-	-	-	-	-

Assets that have been disposed of are no longer in used and have been fully depreciated.

10 Property, plant and equipment cont'd

10.1 Cost or valuation of fully depreciated assets

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

	Period ending 30 June 2022 £'000	2021-22 £'000
Plant & machinery	4	4
Information technology	53	2,408
Total	**57**	**2,412**

10.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	5
Furniture & fittings	1	2

11 Leases Right-of-use assets

Period ending 30 June 2022	Land £'000	Buildings excluding dwellings £'000	Furniture & fittings £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Cost or valuation at 01 April 2022	-	-	-	-	-
IFRS 16 Transition Adjustment	-	2,364	-	2,364	886
Addition of Assets under Construction & Payments on Account	-	-	-	-	-
Additions	-	-	-	-	-
Reclassifications	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-
Lease remeasurement	-	-	-	-	-
Modifications	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-
Cost/Valuation at 30 June 2022	-	2,364	-	2,364	886
Depreciation 01 April 2022	-	-	-	-	-
Charged during the year	-	97	-	97	44
Reclassifications	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-
Impairments charged	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Disposals on expiry of lease term	-	-	-	-	-
Derecognition for early terminations	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-
Depreciation at 30 June 2022	-	97	-	97	44
Net Book Value at 30 June 2022	-	2,267	-	2,267	842
NBV by counterparty					
Leased from DHSC					-
Leased from the NHS England Group					-
Leased from NHS Providers					-
Leased from Executive Agencies					-
Leased from Non-Departmental Public Bodies					-
Leased from other group bodies					842
Net Book Value at 30 June 2022					842

Revaluation Reserve Balance for Right-of-use-assets

	Land £'000	Buildings £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2022	-	-	-	-
Revaluation gains	-	-	-	-
Impairments	-	-	-	-
Release to general fund	-	-	-	-
Other movements	-	-	-	-
Balance at 30 June 2022	-	-	-	-

11 Leases Right-of-use assets cont'd

11.1 Lease liabilities

	Period ending 30 June 2022 £'000	2021-22 £'000
Liabilities at 1 April 2022	-	-
IFRS 16 Transition Adjustment	2,364	-
Addition of Assets under Construction & Payments on Account	-	-
Additions	-	-
Reclassifications	-	-
Interest expense relating to lease liabilities	5	-
Repayment of lease liabilities (capital and interest)	(52)	-
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	-	-
Other	-	-
Lease liabilities at 30 June 2022	**2,317**	-

11.2 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Period ending 30 June 2022 £'000	Of which: leased from DHSC group bodies £'000	2021-22 £'000	Of which: leased from DHSC group bodies £'000
Within one year	(482)	(173)	-	-
Between one and five years	(1,534)	(691)	-	-
After five years	(364)	-	-	-
	(2,380)	(864)	-	-
Effect of discounting	63	19	-	-
Included in:				
Current lease liabilities	(463)	(166)	-	-
Non-current lease liabilities	(1,854)	(679)	-	-
Total	**(2,317)**	(845)	-	-
Balance by counterparty				
Leased from DHSC		-		-
Leased from the NHS England Group		-		-
Leased from NHS Providers		-		-
Leased from Executive Agencies		-		-
Leased from Non-Departmental Public Bodies		-		-
Leased from other group bodies		(845)		-
Balance as at 30 June 2022		(845)		-

11.3 Amounts recognised in Statement of Comprehensive Net Expenditure

	Period ending 30 June 2022 £'000
Depreciation expense on right-of-use assets	97
Interest expense on lease liabilities	5
Expense relating to variable lease payments not included in the measurement of the lease liability	7

11.4 Amounts recognised in Statement of Cash Flows

	Period ending 30 June 2022 £'000
Total cash outflow on leases under IFRS 16	(52)
Total cash outflow for lease payments not included within the measurement of lease liabilities	(7)

The CCG 's leases relate to the organisations offices. County Hall (Exeter), Pomona House (Torquay) and The Stone Barn (South Molton).

The CCG has committed itself to two additional leases commencing later in 2022/23 totalling £305k. In additional, irrecoverable VAT is not included in the measurement of leases and so the CCG has an estimated £191k of future VAT payments related to the leases disclosed above.

12 Intangible non-current assets

Period ending 30 June 2022	Computer Software: Purchased £'000	Development Expenditure (internally generated) £'000	Total £'000
Cost or valuation at 01 April 2022	499	67	566
Additions purchased	-	-	-
Disposals other than by sale	(255)	(67)	(322)
Upward revaluation gains	-	-	-
Cost / Valuation At 30 June 2022	**244**	**-**	**244**
Amortisation 01 April 2022	255	67	322
Disposals other than by sale	(255)	(67)	(322)
Charged during the year	19	-	19
Amortisation At 30 June 2022	**19**	**(0)**	**19**
Net Book Value at 30 June 2022	**225**	**0**	**225**
Purchased	225	-	225
Donated	-	-	-
Government Granted	-	-	-
Total at 30 June 2022	**225**	**-**	**225**

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £'000	Development Expenditure (internally generated) £'000	Total £'000
Balance at 01 April 2022	-	-	-
Revaluation gains	-	-	-
Impairments	-	-	-
Release to general fund	-	-	-
Other movements	-	-	-
Balance at 30 June 2022	-	-	-

Assets that have been disposed of are no longer in use and have been fully amortised.

12 Intangible non-current assets cont'd

12.1 Cost or valuation of fully amortised assets

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

	Period ending 30 June 2022 £'000	2021-22 £'000
Computer software: purchased	-	254
Development expenditure	-	67
Total	**-**	**321**

12.2 Economic lives

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

13 Inventories

	Drugs £'000	Consumables £'000	Other £'000	Total £'000
Balance at 01 April 2022	-	824	72	**896**
Additions	-	-	-	-
Inventories recognised as an expense in the period	-	-	-	-
Balance at 30 June 2022	**-**	**824**	**72**	**896**

Inventories relate to the CCG's share of inventories held within the Devon Better Care Fund managed by Devon County Council as host of the pooled fund.

14.1 Trade and other receivables

	Current Period ending 30 June 2022 £'000	Non-current Period ending 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	980	-	2,986	-
NHS accrued income	585	-	5	-
Non-NHS and Other WGA receivables: Revenue	3,764	-	2,126	-
Non-NHS and Other WGA prepayments	2,887	-	1,758	-
Non-NHS and Other WGA accrued income	664	-	1,149	-
Expected credit loss allowance-receivables	(729)	-	(796)	-
VAT	710	-	866	-
Other receivables and accruals	5	-	1	-
Total Trade & other receivables	**8,866**	**-**	**8,095**	**-**
Total current and non current	**8,866**		**8,095**	
As at 30 June 2022 there were no non-current trade and other receivables (none as at 31 March 2022).			-	
There are no prepaid pensions contributions as at 30 June 2022 (none as at 31 March 2022).			-	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to CCG's to commission services, no credit scoring of them is considered necessary.

14.2 Receivables past their due date but not impaired

	Period ending 30 June 2022 DHSC Group Bodies £'000	Period ending 30 June 2022 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	76	306	518	1,809
By three to six months	153	1	-	-
By more than six months	20	10	28	10
Total	**249**	**317**	**546**	**1,819**

£175k of the amount above has subsequently been recovered post year end as at the end of July 2022.
The CCG did not hold any collateral against receivables outstanding at 30 June 2022.
Receivables past their due date are stated at the consideration agreed at the date of the transaction and the carrying amount and terms have not been renegotiated.

14.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2022	(796)	-	**(796)**
Other changes	67	-	**67**
Total	**(729)**	**-**	**(729)**

Other changes include income received relating to brought forward credit loss.

15 Other financial assets

15.1 Non-Current: capital analysis

The CCG holds a shareholding interest in DELT in respect of 1 A ordinary Share with a nominal total value of £1 being 50% of the total shareholding and 30 B ordinary shares with a total nominal value of £30 being 30% of the total shareholding. Due to the immaterial value it is not visible in the annual accounts.

16 Cash and cash equivalents

	Period ending 30 June 2022 £'000	2021-22 £'000
Balance at 01 April 2022	(1,356)	(8,586)
Net change in year	(402)	7,230
Balance at 30 June 2022	**(1,758)**	**(1,356)**
Made up of:		
Cash with the Government Banking Service (GBS)	730	423
Cash in hand	1	1
Cash and cash equivalents as in statement of financial position	**731**	**424**
Bank overdraft: Government Banking Service	(2,489)	(1,780)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**(2,489)**	**(1,780)**
Balance at 30 June 2022	**(1,758)**	**(1,356)**
Patients' money held by the clinical commissioning group, not included above	-	-

The CCG is in a technical overdraft which is partly due to the requirement for the CCG to pay general practices at the start of the month. The bank is in credit (Cash with the Government Banking Service) while the BACS payment is in progress (Bank overdraft: Government Banking Services). NHS England funds are deposited into the CCG account on the day the general practices payments leave the account.

17 Trade and other payables	Current Period ending 30 June 2022 £'000	Non-current Period ending 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS payables: Revenue	1,687	-	6,449	-
NHS accruals	17,108	-	21,294	-
Non-NHS and Other WGA payables: Revenue	9,514	-	19,947	-
Non-NHS and Other WGA accruals	71,110	-	71,558	-
Non-NHS and Other WGA deferred income	-	-	50	-
Social security costs	387	-	341	-
Tax	305	-	297	-
Other payables and accruals	34,773	-	44,567	-
Total Trade & Other Payables	**134,884**	-	**164,503**	-
Total current and non-current	**134,884**		**164,503**	

Other payables and accruals include those for Primary Care, Placements, Acute Care and Community Services that are not part of Whole Government Accounts (WGA), as well as outstanding pension contributions.

18 Other financial liabilities	Current Period ending 30 June 2022 £'000	Non-current Period ending 30 June 2022 £'000	Current 2020-21 £'000	Non-current 2021-22 £'000
Embedded derivatives at fair value through the statement of	-	-	-	-
Financial liabilities carried at fair value through profit and loss	-	-	-	-
Amortised cost	-	-	-	72
Total	-	-	-	**72**
Total current and non-current	-		**72**	

Amortised cost is operating lease costs amortised on a straight line basis. Balance was not required on the application of IFRS16 from 1 April 2022.

19 Borrowings	Current Period ending 30 June 2022 £'000	Non-current Period ending 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Bank overdrafts:				
· Government banking service	2,489	-	1,780	-
· Commercial banks	-	-	-	-
Total overdrafts	**2,489**	-	**1,780**	-
Total Borrowings	**2,489**	-	**1,780**	-
Total current and non-current	**2,489**		**1,780**	

The CCG is in a technical overdraft which is partly due to the requirement for the CCG to pay general practices at the start of the month. The bank is in credit while the BACS payment is in progress. NHS England funds are deposited into the CCG account on the day the general practices payments leave the account.

19.1 Repayment of principal falling due

	Department of Health Period ending 30 June 2022 £'000	Other Period ending 30 June 2022 £'000	Total Period ending 30 June 2022 £'000
Within one year	-	2,489	2,489
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Total	-	**2,489**	**2,489**

	Department of Health 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Within one year	-	1,780	1,780
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Total	-	**1,780**	**1,780**

20 Provisions

£ nil is included in the provisions of NHS Resolution as at 30 June 2022 (£ nil 31 March 2022) in respect of liabilities to third parties.

21 Contingencies

Under the Accounts direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare contingent liability accounted for by NHS England on behalf of this CCG as at 30 June 2022 is £ nil (£96k 31 March 2022).

22 Financial instruments

Financial instruments are disclosed at fair value. Due to the short term nature of the transactions, fair value for cash is recognised at its sterling value; trade receivables, trade payables, other financial assets and liabilities are stated at the consideration agreed at the date of the transaction, hence the carrying value is considered to be a reasonable approximation to fair value.

22.1 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 CCG 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 CCG 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 CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

22.1.1 Currency risk

The CCG is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The CCG has no overseas operations. The CCG therefore has low exposure to currency rate fluctuations.

22.1.2 Interest rate risk

The CCG 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 CCG therefore has low exposure to interest rate fluctuations.

22.1.3 Credit risk

Because the majority of the CCG and revenue comes parliamentary funding, CCG 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.

22.1.4 Liquidity risk

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

22.1.5 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.

22 Financial instruments cont'd

22.2 Financial assets

	Financial Assets measured at amortised cost Period ending 30 June 2022 £'000	Equity instruments designated at FVOCI Period ending 30 June 2022 £'000	Total Period ending 30 June 2022 £'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	1,211	-	1,211	2,504	-	2,504
Trade and other receivables with other DHSC group bodies	504	-	504	865	-	865
Trade and other receivables with external bodies	4,284	-	4,284	2,899	-	2,899
Cash and cash equivalents	731	-	731	424	-	424
Total	6,730	-	6,730	6,692	-	6,692

22.3 Financial liabilities

	Financial Liabilities measured at amortised cost Period ending 30 June 2022 £'000	Other Period ending 30 June 2022 £'000	Total Period ending 30 June 2022 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000	Other 2021-22 £'000	Total 2021-22 £'000
Loans with external bodies	2,489		2,489	1,780		1,780
Trade and other payables with NHSE bodies	410	-	410	244	-	244
Trade and other payables with other DHSC group bodies	19,695	-	19,695	32,306	-	32,306
Trade and other payables with external bodies	116,405	-	116,405	131,265	-	131,265
Other financial liabilities	-	-	-	72	-	72
Total	138,999	-	138,999	165,667	-	165,667

Loans with external bodies are the outstanding payments yet to leave the bank account and has resulted in a technical overdraft.

22.4 Maturity of financial liabilities

	Payable to DHSC Period ending 30 June 2022 £'000	Payable to Other bodies Period ending 30 June 2022 £'000	Total Period ending 30 June 2022 £'000	Payable to DHSC 2021-22 £'000	Payable to Other bodies 2021-22 £'000	Total 2021-22 £'000
In one year or less	19,426	117,719	137,145	32,550	133,117	165,667
In more than one year but not more than two years	167	208	375	-	-	-
In more than two years but not more than five years	512	607	1,119	-	-	-
In more than five years	-	360	360	-	-	-
Total	20,105	118,894	138,999	32,550	133,117	165,667

23 Operating segments

The CCG consider they have only one segment, commissioning of healthcare services.

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioning of Healthcare Services	600,966	(4,649)	**596,317**	13,544	(139,690)	**(126,146)**

Wherever possible the CCG manages resources and commissioning on a locality basis. Whilst this covers gross expenditure, which is reported using segmental analysis, this is not sufficient to necessitate a full reanalysis of the CCG's spend within these accounts.

24 Joint arrangements - interests in joint operations

24.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY Period ending 30 June 2022				Amounts recognised in Entities books ONLY 2021-22			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Devon Better Care Fund	Devon County Council	Provision of integrated care	896	-	8,842	16,146	896	-	28,267	61,126
Plymouth Integrated Fund	Plymouth City Council	Provision of integrated care	-	-	3,164	42,242	-	-	12,657	185,578
Joint Community Equipment Store	Torbay Council	Provision of community equipment	-	-	-	213	-	-	-	754
Better Care Fund Torbay	Torbay Council	Provision of integrated care services	-	-	-	3,280	-	-	-	12,417

24.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

Name of entity	Description of principal activities	Basis for treatment eg materiality
DELT Shared Services Ltd	IT Services	Materiality

25 Related party transactions

Period ending 30 June 2022

During the year, apart from the following transactions none of the Department of Health Ministers, leadership or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Devon CCG.

Details of related party transactions are as follows:

	Period ending 30 June 2022 Payments to Related Party £'000	Period ending 30 June 2022 Receipts from Related Party £'000	Period ending 30 June 2022 Amounts owed to Related Party £'000	Period ending 30 June 2022 Amounts due from Related Party £'000
DELT SHARED SERVICES LTD	1,506	-	-	-
DEVON COUNTY COUNCIL	15,976	(136)	1,825	(33)
DEVON DOCTORS LTD	5,255	-	-	-
PLYMOUTH CITY COUNCIL	8,614	(3,286)	243	(3,286)
TORBAY COUNCIL	476	(115)	-	(107)

The CCG has responsibility for GP primary care commissioning and therefore management of the payments made to GP surgeries payable under the Primary Medical Services (PMS) and General Medical Services (GMS) contracts. As such some of the GP Governing Body members and senior management will be partners within GP practices that receive payments from the CCG for medical services rendered. These payments have not been disclosed as the medical contract, including the financial payments are predominantly agreed at a national level.

The majority of the GP members of the Governing Body and GP senior management, who are also GP partners at practices, will have a voting share of Devon Doctors Ltd. Devon Doctors Ltd is a social enterprise organisation that provide out-of-hours GP care.

The Department of Health and Social Care is regarded as a related party. During the year, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant transactions for the CCG were with the following:

Devon Partnership NHS Trust
Leeds Teaching Hospitals NHS Trust
NHS England
NHS Property Services Ltd
North Bristol NHS Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon University Healthcare NHS Foundation Trust
South Western Ambulance NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Plymouth NHS Trust

In addition, the CCG has had a number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions have been with Torbay Council, Devon County Council and Plymouth County Council, details of which are included above.

25 Related party transactions

2021-22

During the year, apart from the following transactions none of the Department of Health Ministers, leadership or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Devon CCG.

Details of related party transactions are as follows:

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
DELT SHARED SERVICES LTD	8,664	(407)	179	(407)
DEVON COUNTY COUNCIL	154,688	(2,246)	882	(166)
DEVON DOCTORS LTD	22,782	(206)	1,532	(32)
PLYMOUTH CITY COUNCIL	65,674	(13,729)	209	(1,718)
TORBAY COUNCIL	14,966	(463)	41	(39)

The CCG has responsibility for GP primary care commissioning and therefore management of the payments made to GP surgeries payable under the Primary Medical Services (PMS) and General Medical Services (GMS) contracts. As such some of the GP Governing Body members and senior management will be partners within GP practices that receive payments from the CCG for medical services rendered. These payments have not been disclosed as the medical contract, including the financial payments are predominantly agreed at a national level.

The majority of the GP members of the Governing Body and GP senior management, who are also GP partners at practices, will have a voting share of Devon Doctors Ltd. Devon Doctors Ltd is a social enterprise organisation that provide out-of-hours GP care.

The Department of Health and Social Care is regarded as a related party. During the year, the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant transactions for the CCG were with the following:

Devon Partnership NHS Trust
NHS England
NHS Property Services Ltd
North Bristol NHS Trust
Northern Devon Healthcare NHS Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon University Healthcare NHS Foundation Trust
South Western Ambulance NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Plymouth NHS Trust

In addition, the CCG has had a number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions have been with Torbay Council, Devon County Council and Plymouth County Council, details of which are included above.

The Payments to Related Party figures above have been restated, as shown, from the original disclosures in 2021/22 as a number of duplicate entries were incorrectly included in the report used.
Original disclosure were as follows; Delt Shared Services Ltd £9.170m, Devon County Council £164.115m, Devon Doctor Ltd £35.791m, Plymouth City Council £84.878m and Torbay Council £14.966m.
There is no effect on the 2022/23 accounts.

28 Events after the end of the reporting period

28.1 Establishment of Integrated Care Boards (ICBs)
From 1 July 2022 NHS Devon ICB will be a new statutory organisation which will take on the commissioning functions, assets and liabilities of NHS Devon CCG. The summary of assets and liabilities to be transferred are stated in the Statement of financial position on page 2 of these accounts.

28.2 Financial Statements
The financial statements were approved by the Governing Body and authorised for issue on 6 September 2023.

The above mentioned post balance sheet events have no material effect on the accounts for the period ended 30 June 2022.

27 Financial performance targets
NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	Period ending 30 June 2022 Target	Period ending 30 June 2022 Performance	2021-22 Target	2021-22 Performance	Period ending 30 June 2022 Duty	2021-22 Duty
	£'000	£'000	£'000	£'000	Achieved?	Achieved?
Expenditure not to exceed income	600,888	600,888	2,589,688	2,584,413	Y	Y
Capital resource use does not exceed the amount specified in Directions	-	-	389	389	Y	Y
Revenue resource use does not exceed the amount specified in Directions	686,317	686,317	2,564,540	2,559,265	Y	Y
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	n/a	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-	n/a	n/a
Revenue administration resource use does not exceed the amount specified in Directions	6,634	6,634	23,720	21,337	Y	Y

The CCG met the requirement for spend not to exceed the capital and overall revenue resources received during the year. The CCG's overall expenditure matched the income and revenue resource received during the year resulting in a balanced position (surplus of £5.275m in 2021/22).

The comparators (2021-22) in the above Financial Performance Target note have been restated to include the Recoveries in Respect of Employee Benefits, disclosed in note 4, which were previous netted off within Salaries and Wages.

Summary of Programme and Administration, Income and Expenditure

	Period ending 30 June 2022 £000	2021-22 £000
Programme Expenditure	595,290	2,561,706
Administration Expenditure	5,676	22,318
Total Expenditure	**600,888**	2,584,024
Programme Income	(4,507)	(23,778)
Administration Income	(142)	(981)
Total Income	**(4,648)**	(24,759)
Total Net Expenditure for the financial period	**686,317**	2,559,265
Revenue Resource Limit (RRL)	**686,317**	2,564,540
Surplus/(Deficit)	**(0)**	5,275
Surplus/(Deficit) % of Revenue Resource Limit	**(0.00%)**	0.21%

Jane Milligan

Accountable Officer

6 September 2023

Independent auditor's report

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS DEVON INTEGRATED CARE BOARD IN RESPECT OF NHS DEVON CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Devon Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 2022 which comprise of the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 30 June 2022 and of its income and expenditure for the three month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 June 2022 as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Services Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG and NHS Devon Integrated Care Board ("the ICB") in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 22 to the financial statements which explains that on 1 July 2022, NHS Devon CCG was dissolved, and its services transferred to NHS Devon Integrated Care Board. Under the continuation of service principle the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in respect of this matter.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis as the CCG has been dissolved and its services transferred to another public sector entity, the ICB, and the Accountable Officer has not been informed by the relevant national body of the intention to cease the services previously provided by the CCG. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the CCG and transferred to the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and

- we have not identified and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the services provided by the CCG will continue to be provided by the successor body.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee of the successor ICB and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Risk and Audit Committee minutes of the CCG and the ICB.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We did not identify any additional fraud risks

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual postings to cash, unusual postings to expenditure, and journals that move expenditure between programme and administrative expenditure.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board of the CCG and ICB (as required by auditing standards) and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on pages 59 and 60, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the CCG or dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

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

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on pages 59 and 60, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently, and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency, and effectiveness in the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

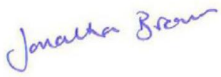
We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Devon Integrated Care Board in respect of NHS Devon CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, 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 of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Devon CCG for the three-month period ended 30 June 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square,
Bristol,
BS1 4BE
7 September 2023