NHS
Shropshire
Clinical Commissioning Group

Annual Report and Accounts
2020/2021

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PERFORMANCE REPORT

Performance overview by Claire Skidmore, Interim Accountable Officer

This year's Annual Report marks the end of a year which has been filled with changes and challenges. In a single year, we have responded to the COVID-19 pandemic, managed our transition to a single Clinical Commissioning Group (CCG) with our neighbours in Telford and Wrekin, and prepared as a shadow Integrated Care System (ICS) board.

The COVID-19 pandemic has presented some of the most significant challenges the NHS has faced, both locally and nationally. As a system, we acted quickly to respond to the emergency, this has been sustained throughout the year and continues into 2021/22.

The pandemic has stretched resources and helped identify places where we can improve. It has also demonstrated where our strengths lie. We have worked closer than ever before with our partners across the NHS, other healthcare providers, local authorities, voluntary and community sector organisations, in a huge collective effort to save lives, protect the NHS, and facilitate a long-term response.

Locally, we have seen our practice membership work together in different ways and settings, using technology to provide online support wherever possible. Our acute and community trusts have adapted ways of work to provide care for our local population to the best of our ability throughout the challenges of the year.

Our CCG staff have worked in a number of settings to support the pandemic, including non-clinical functions which have experienced huge increases in demand, new tasks to support the response and redeployment into clinical settings to provide additional capacity.

Our partners in Shropshire Council have been a key partner in the response throughout, setting up support services and vaccination centres, widening the reach from our hospital, GP and pharmacy-based services. Together, we have ensured a high proportion of local people have received a vaccine.

The commitment of everyone to all our patients and local communities remains outstanding.

Within the context of this exceptional year, we have continued to make improvements to our services.

In December 2020, a new system was introduced across Shropshire, Telford and Wrekin to manage urgent, but not life-threatening health care needs. By calling NHS 111 first, trained staff can now book appointments for patients with the most appropriate service, or refer to the Emergency Department if needed. This has helped to improve the patient experience by helping to ensure people are seen and treated sooner. A survey is planned to assess the patient experience of using NHS 111 First.

Following a community services review in 2017, Shropshire CCG commenced a review and transformation programme, known as Shropshire Care Closer to Home. This aimed to better deliver preventative care and support, with services closer to home. It was underpinned by the principles of

keeping people as well as possible, for as long as possible in their own home or community environment and minimising the need for a hospital admission. The programme has three phases, and our progress is outlined in detail in this report.

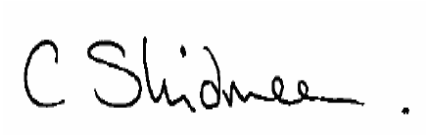
In response to winter pressure in the acute setting, for the last two years a Shrewsbury admission avoidance team has been formed, as we await the full roll out of the Shropshire Care Closer to Home transformations. This service has helped to provide preventative care and support to people where an Emergency Department visit or hospital admission can be avoided. This has helped to reduce some of the pressures on the acute general hospital during the surge in demand in critical winter months.

The national review led by Donna Ockenden, which is reviewing cases of serious and potentially serious concern at the Shrewsbury and Telford Hospitals NHS Trust has requested the CCG provides evidence to the review from the commissioning perspective to enable it to triangulate the information it has already received from families and the Trust. The CCG is cooperating fully with the review and evidence will be shared early in 2021/22.

Our transition to a single CCG for Shropshire, Telford and Wrekin on 1 April 2021 has also been a significant factor this year and represents a key milestone in our future. The move creates a number of opportunities to work more efficiently and effectively, so we can reduce health inequalities and make sure we provide value for money healthcare services when and where they are needed. Staff across both CCGs have worked hard to streamline processes and create a single structure through a complete management of change process.

At the end of this financial year we saw the departure of Dr Julian Povey from his position as Chair of the CCGs, as he returned to full time practice from 1 April 2021 at Pontesbury and Worthen Medical Practice. Mr David Evans, Accountable Officer, also left the CCG to take up a secondment opportunity with NHS Midlands and Lancashire Commissioning Support Unit (MLCSU). Our thanks go to them both for their outstanding contribution to the CCGs throughout, and for leading the organisation through this exceptional year.

The next financial year brings with it a number of challenges, as we emerge from the pandemic and work together to reshape our services. On 1 April 2021 Shropshire, Telford and Wrekin became an ICS, and we are working with our partners across the system to establish new ways of working together for the benefit of our local health and care services.



Mrs Claire Skidmore
Interim Accountable Officer
14 June 2021

Statement of purpose and activities of the CCG

This section of the Annual Report provides summary information on NHS Shropshire CCG – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over 2020/21.

About us

NHS Shropshire Clinical Commissioning Group is a statutory body established under the Health and Social Care Act 2012. It was fully authorised as a CCG on 1 April 2013, with no conditions on its operations. The principal location of our business is at William Farr House, Mytton Oak Road, Shrewsbury SY3 8XL.

The CCG is a membership organisation. During 2020/21, there were 40 GP practices in Shropshire and they are all member practices of the CCG. As local GPs, we have regular contact with patients and know what health services are needed to support our local population.

We are all committed to making a difference by putting patients at the heart of our decision-making and ensuring that every clinician is involved. By striving for the best possible standards, we want patients to be confident that they can access safe and quality care locally.

Shropshire CCG is responsible for designing and purchasing (commissioning) healthcare in the Shropshire area:

- We plan what services are needed to support the health needs of our local population
- We buy services such as mental health, hospital care and community services
- We monitor these services to ensure patients in Shropshire have safe and quality care.

This means we commission services from a range of providers, including:

- Most of our local acute services come from Shrewsbury and Telford Hospital NHS Trust (SaTH)
- Community services from Shropshire Community Health NHS Trust
- Mental health services from Midlands Partnership NHS Foundation Trust (MPFT)
- Out of hours primary care services from Shropshire Community Health NHS Trust and Shropshire Doctors Co-operative (Shropdoc)
- Ambulance services from West Midlands Ambulance Service University NHS Foundation Trust (WMAS).

We also work closely with other organisations including NHS England, which is the organisation that is responsible for buying GP, pharmacy, dental and specialised services in our area and across England, to ensure that health services delivered locally are joined up.

In addition to our statutory duties, we also discharge the responsibility – on behalf of NHS England – for commissioning primary care services in our area.

Our other key local partner is Shropshire Council. We work closely together to commission services that cross social and health boundaries. This is done through the Better Care Fund (BCF) and services where we have developed a joint strategy, for example, mental health services for children and young people. We have also begun to align services across the area, so that social care, self-help support services and health services are located closer to people's homes.

Our mission, values and principles

Our mission

"To have the courage to develop a health system that empowers the delivery of excellent outcomes founded on individual relationships which nurture compassion, respect and dignity."

The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

Our values

Good corporate governance arrangements are critical to achieving the group's objectives.

The values that lie at the heart of the group's work are as follows:

- We will be the type of organisation that listens to and appreciates its staff and members, recognises individual strengths and celebrates successes
- We want teams that are trusting, mutually respectful and have a common purpose
- We want ambitious teams that work in a creative, open and "can-do" way
- We want an air of excitement about our work
- We will be supportive, fostering a no blame culture, ensuring that everyone is knowledgeable and well informed
- We will set out what we intend to do with clarity in order to ensure that we deliver
- We want to break down barriers
- We will be inclusive and delegate responsibilities where we can and be transparent in all our duties and we will go the extra mile for our staff, members and partners.

Our principles

- A continually improving healthcare and patient experience
- To create a 'true' membership organisation
- Financial sustainability
- To influence and lead the development of the local health economy

- To grow the leadership for future organisations.

Population challenges

The activities undertaken by the CCG in 2020/21 were based on the needs of our local population. Key elements of this are set out below:

Shropshire currently has a population of 314,400, which is estimated to grow to 338,843 by 2039. The current Census data tells us that 95.4 per cent of residents described themselves as White English / Welsh / Scottish / Northern Irish / British. Asian or Asian British ethnic groups are next largest in Shropshire, representing one per cent of the population. The number of over-65s living in the county has increased significantly in comparison to the national picture and will continue to do so over the next 10 years. The average age of a Shropshire resident is 43.

The 2011 Census showed 63,400 people aged 65 years and over living in Shropshire. This represents an increase of 23.8 per cent between 2001 and 2011. Shropshire has experienced significantly higher growth in this age group than nationally (10.9 per cent) and regionally (12.6 per cent). In 2001, the over-65s represented 18.1 per cent of the total Shropshire population. This has now risen to 20.7 per cent in 2011, compared to 16.4 per cent for England and Wales. Like many rural areas, the number of people aged 65 and over in Shropshire is expected to continue to rise. It is anticipated that by 2030, one in four people will fall into this age group.

Issues of frailty associated with this group of our population are a significant consideration for the CCG in planning healthcare services for Shropshire residents. It is anticipated that the needs of this group of older people will increase significantly, with the potential for a particular impact on secondary care services.

Rural isolation remains a significant issue for the county and demographic profiles support this. National research highlights that three in 10 people aged 80 or over report feeling lonely. If applied to Shropshire, that would total 1,930 people aged 80 or over. The five most deprived areas in Shropshire are located within the former district wards of Harlescott, Meole Brace, Monkmoor, Battlefield and Heathgates – all in Shrewsbury. Other deprived areas include the Castle, Gobowen, Gatacre and Cambrian in Oswestry; Market Drayton East and Whitchurch North in North Shropshire; and Ludlow Henley, Stokesay, Bridgnorth and Highley in South Shropshire.

In Shropshire, approximately seven per cent of over-65s have dementia; this figure is expected to increase to 7.5 per cent for all people aged 65 and over by 2021. The expected increase in Shropshire is likely to be at a faster pace than the expected increase in England overall. Prevalence estimates for dementia are thought to be more than double the recorded rate in Shropshire. There are different types of dementia. Some are preventable, such as vascular dementia, and some are not, like Alzheimer's.

The risk of developing vascular dementia can be reduced by making healthy lifestyle choices, such as having a healthy diet, maintaining a healthy weight, regular exercise, moderate alcohol intake, not smoking, and controlling blood pressure and diabetes.

Cardiovascular disease (CVD) is the most common cause of death in Shropshire, accounting for around 35 per cent of all deaths annually. Many premature deaths from CVD are preventable as they

are caused by lifestyle risk factors, such as smoking and poor diet. Although Shropshire's rates of CVD are significantly lower than the national figures, males are significantly more likely to die prematurely from CVD than females. Evidence tells us that males who reside in the most deprived areas in Shropshire are significantly more likely to die prematurely than males in the less deprived areas. For females, there is no comparative difference in the same statistics.

Overall, the health of the population in Shropshire is good; both male and female life expectancy is significantly higher than the national average. However, inequalities in health persist in Shropshire.

Shropshire CCG works with Shropshire Council to ensure that we use the most up-to-date population profile data for our area, including the information contained in the local Joint Strategic Needs Assessment, to inform our commissioning decisions and ensure that addressing health inequalities is at the forefront of our decision making.

Working with partners

We continue to build on the strong history of partnership working in Shropshire through the Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP) which at the end of March 2021 was confirmed as a Shadow Integrated Care System (ICS). We are leading on a number of initiatives with partners that are key to delivery of STP/ICS objectives and this will continue to be a key focus for us in 2021/22.

COVID-19

2020/21 has continued to be a very challenging year for the NHS nationally and locally due to the global COVID-19 pandemic. As a result, the normal delivery of services in the NHS ceased for the greater part of the year so that resources could be focused on the NHS fighting the pandemic.

This has resulted in partnership working on a vast scale locally to ensure we had capacity to treat both COVID-19 positive patients and non-positive patients in the safest way possible. We have used our emergency planning model to create a streamlined decision making process across the whole system to ensure that decisions were taken quickly but mitigating risk as much as was possible.

All providers, commissioners, local authority and third sector have been working together to support those suffering from COVID-19 but also to prevent the spread of the virus and to ensure local people were given the accurate and up to date advice on how to keep them and their families safe. The effort has been unprecedented and we would like to acknowledge all those organisations who have taken part and contributed their time, expertise and staff to this monumental effort. At the end of the financial year our attention has now turned to the safe restoration of services to our local populations.

Shropshire Health and Wellbeing Board (HWBB)

Our Chair, Dr Julian Povey and Accountable Officer, David Evans both sit on the HWBB. The two cross-cutting outcomes outlined in the Strategy are:

1. **Reduce health inequalities:** Must be at the core of everything that we do. This is not only about ensuring equal access to health and care services, but also about raising the standards

of health and wellbeing particularly for the most disadvantaged. To do this we need to work with all our partners to address factors such as education, employment and wages, housing and environmental considerations which all have an impact on our health and wellbeing.

2. **Increase healthy life expectancy:** Life expectancy is currently measured in a number of ways, including life expectancy and healthy life expectancy. Measuring **healthy life expectancy** adds a quality of life understanding. According to the Office of National Statistics, Healthy Life Expectancy estimates lifetime spent in "Very good" or "Good" health based on how individuals perceive their general health. While our overall life expectancy has risen significantly over recent decades, the difference between living in good health and living in less good health is broadening. In Shropshire, the difference between healthy life expectancy and life expectancy for men is 15 years and for women it is 18 years. To improve quality of life as we age, we need to ensure that we live well at all stages of life – **start well, live well, age well**. We request that all partners consider how we support our population to achieve and maintain good health and wellbeing through healthy lifestyles, maintaining good mental health and wellbeing, and accessing appropriate services when needed at all stages.

The current Strategy is available on the Shropshire Council website.

The HWBB also forms part of the STP/ICS governance structure to ensure that partnership working is truly at the centre of the delivery of the STP/ICS.

The Chair of the Health and Wellbeing Board has been consulted upon the content of this section of the Annual Report.

Shropshire Council

The Better Care Fund (BCF) continues to be an important focus for our partnership working with Shropshire Council. Switching care from an acute setting to a community setting relies in part on the success of the BCF and we have created programme support to ensure that we have the right skills and capacity to oversee this.

In addition, we continue to work collaboratively on our local neighbourhood working model which forms an important element of the STP/ICS. This work is allowing us to explore – in a more meaningful way – how health and social care services can be delivered in more community settings, closer to people's homes. Ultimately the aim is for services to be more integrated, so we support the whole person and not just a disease.

Health Overview and Scrutiny Committee, Shropshire Council

Our interaction with the Health Overview and Scrutiny Committee has continued to be significant during 2020/21. A number of service redesign projects have been discussed at the Committee, as well as updates on the progress of meeting the COVID-19 challenge.

NHS Telford and Wrekin CCG

We work collaboratively with our neighbours in Telford and Wrekin CCG on several key issues including safeguarding, local maternity services, midwife-led units service review, primary care

working programmes and lead commissioning arrangements with shared providers. We generally work in partnership on procurement programmes and are closely aligned when negotiating contracts with our provider trusts. We have also have a joint contracting function to support our commissioning processes and a joint quality function across both CCGs.

In 2020/21, NHS England and NHS Improvement (NHSE/I) approved a joint application by both CCGs to dissolve the current CCGs and create a single CCG; NHS Shropshire, Telford and Wrekin CCG on 1 April 2021. This has resulted in both CCGs aligning their governing body composition by appointing joint governing body members, adopting Constitutions that align decision making processes and also undertaking a management of change process with both staff groups to create a single staff structure ready for the creation of the new CCG.

NHS Midlands and Lancashire Commissioning Support Unit (MLCSU)

MLCSU currently provides most of our functions through a contract ranging from financial management to human resources and information governance. We continue to work with MLCSU in terms of consistency of services provided.

Emergency Preparedness Resilience and Response (EPRR)

The CCG actively participates in EPRR activities on a local and regional footprint.

2020/21 has been an unprecedented year for the NHS and in particular the principles of EPRR have been front and central in ensuring the correct infrastructure to deal with the COVID-19 pandemic incident has been in place.

Together with Telford and Wrekin CCG, we have led the multi-agency system response to the pandemic, ensuring a responsive, multi-agency approach to a complex, demanding and evolving incident.

We have been guided by the incident management instructions from NHS England (NHSE) and to address both these and the emerging local situation our incident management arrangements were quickly mobilised to manage all aspect of the response. Following mobilisation in February 2020, these structures have remained in place throughout 2020/21 to manage the ongoing response and have been adapted as required.

During 2020/21, NHSE departed from the usual annual EPRR self-assessment process in acknowledgement that organisations were fully engaged in the COVID-19 pandemic response. However, the CCG has maintained its director on call rota 24 hours a day, 365 days a year – not only to support the incident response but to ensure other critical or major incidents and business continuity matters could be addressed in tandem. In addition, the CCGs have participated in an audit of its EPRR approach to the pandemic and have been assigned full assurance.

2020/21 financial position

Due to the COVID-19 pandemic the financial framework in operation during 2020/21 has been very different to previous years. The normal financial regime (including planning and contracting rounds) were paused in March/April 2020 and a temporary financial framework was put into place.

In the first six months of 2020/21, the CCG was given a budget to operate within based on 2019/20 spend with a small uplift, any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first six months of the year the CCG reported a break even position. Block payments to providers were also set at a national level to remove the need for contract negotiations or monitoring in year.

In the second six months of 2020/21, the CCG was again given a budget to operate within based on 2019/20 spend plus a small uplift plus an additional allocation assuming that Non COVID overspends in the first 6 months of the year would continue into the second 6 months. Block payments to providers continued to be set at a national level.

The key difference in the second 6 months was that there would no longer be any additional retrospective top up payments. The CCGs were given system level funds to support COVID expenditure and any growth across the system. There was a clear expectation that organisations and systems would manage within this funding and report a break even position.

The final 2020/21 position (subject to audit) shows Shropshire CCG exiting 2020/21 with a £0.7m surplus against the budget allocated. This surplus will take the cumulative deficit carried into 2021/22 to a total of £123.3m. The transformation and efficiency programme planned for 20-21 has delivered £4.8m, the full programme was not delivered in part due to the COVID-19 pandemic and shift in priority focus for both the organisation and the wider system.

The underlying deficit for the two CCGs combined means that we start the new organisation in 21-22 with an underlying position of £71m deficit.

If we ignore the non recurrent nature of 2020/21, the three main drivers of the 2019-20 and historic deficit therefore continue to be:

Emergency activity (including A&E, non-elective care and ambulance)

Emergency care budgets significantly overspent in 2019-20. The final overspend against plan was £7.6m (11%) in emergency spells of care in hospital, £0.8m (7%) in A&E attendances and £0.3m (2%) in ambulance conveyances.

Individual commissioning (including continuing healthcare and mental health)

Individual Commissioning Costs also significantly increased in 2019/20. The overspend in this area was £12m (28%) over budget. The CCG saw a steep increase in costs particularly in the area of Mental Health, Adult Joint Funded and Adult Fully Funded packages where both numbers and costs of care packages have risen.

Slippage in Quality, Innovation, Productivity and Prevention (QIPP) delivery

For the first time the CCG was able to identify QIPP schemes in the 2019-20 plan to fully meet the QIPP target so that these were in place at the start of the financial year.

Significant progress had been made in year across the schemes identified and the CCG was able to deliver £16m of QIPP against the original target of £19.8m (81%). The remaining 19% slippage contributed to the 2019/20 in year deficit.

During 2020/2021, delivery of QIPP was challenging due to the impact of the pandemic. Block contracts were put in place with our main providers, a number of QIPP projects were suspended and many staff redeployed to other departments.

However, the CCG was able to still deliver £4.8m of savings which were predominantly within the medicines management and individual commissioning teams

As the CCGs come together to become a single commissioning organisation, the focus for both the CCG and the wider system is addressing the underlying financial position.

The current assessment of the underlying financial deficit for the newly combined CCG in 2020/21 is £71m deficit. The system is currently working together to develop a sustainable financial plan that delivers stabilisation during 2021/22 and then improvement through transformation schemes from 2022/23 onwards.

Key issues and risks

We track the progress of our service providers (e.g. local hospitals, community services, primary care practices) against several national outcomes indicators and ensure that patient rights within the NHS Constitution are maintained. Additionally, we have set local priorities against which provider progress is monitored. Performance reports are presented to and scrutinised by every meeting of the Quality and Performance Committees in Common, a sub-committee of the Governing Body and a summary of key issues presented to the Board on a monthly basis. The performance reports can be found on our website.

The key issues and risks include:

- The continued prevalence of COVID-19 and the precautions to manage the pandemic
- Non-achievement of quality-related performance targets, including:
    - Acute hospital trust is rated ‘Inadequate’ by CQC
    - A recent CQC inspection of the Acute Hospital Trust rated services for Children and Young People as ‘Inadequate’.
    - Smoking at time of delivery amongst pregnant mothers
    - Wait times to access diagnostic pathways for our Special Educational Needs and Disability (SEND) community (Shropshire)
    - Annual health checks for patients with learning disabilities.

We work with key providers to improve performance. Risks to sustainable recovery include:

- Workforce capacity – which is a challenge for most of our providers
- The impact on demand of our ageing population
- Culture and attitude to risk – which also impacts on demand.

COVID-19 Expenditure

The CCG spent £25.3m on COVID-19 related costs in 2020/21. The breakdown of this is as follows:

CATEGORY OF SPEND	£
Acute Services	
Recovery Beds	125,158
Payments to Shrewsbury & Telford Hosptials NHS Trust	9,455,000
Payments to Robert Jones & Agnes Hunt NHS Foundation Trust	1,452,000
Mental Health Services	33,717
Section 117 Continuing Health Care	55,265
Community Health Services	
Payments to Shropshire Community Health NHS Trust	1,516,000
Primary Care Services	
General Practice - Community base services	946,163
General Practice - IT	12,315
Hot Sites - Infrastructure	301,075
Hot Sites - Staffing	328,505
Care Home Support (CHAS)	86,000
Phlebotomy	65,254
Other	63,648
Patient Transport	59,835
Running (Corporate) Costs	85,899
Continuing Care Services	
LA commissioned	5,186,376
CCG directly commissioned	5,203,759
Continuing Health Care team	342,359
TOTAL SPEND 2020/21	**25,318,328**

This expenditure was fully funded by HM Treasury through an allocation from NHS England.

The CCG was able to utilise these COVID-19 specific funds to implement a number of COVID-19 specific interventions in order to ensure the safety of our patients and that appropriate care could be delivered across the system during this period of escalation. This included, for example, the re-deployment of staff, delivery of specialist IPC support and advice, delivery of specific Hot Clinics and a COVID-19 Management Service in primary care and designated COVID-19 beds in our community. Via these arrangements the CCG was able to meet the COVID-19 response requirements set out in NHSE guidance but also to meets its Emergency Preparedness, Resilience and response obligations.

EU Exit Funding

The CCG received no funding in 2020/21 in respect of EU exit costs and incurred no expenditure. The EU exit had no impact on the strategic objectives or priority outcomes of the CCG during 2020/21.

Adoption of going concern basis

The CCG's accounts have been prepared on a going concern basis.

The CCG ended the financial year with an in-year surplus of £0.7m and a cumulative deficit position of £123.3m. This is in the context of a temporary financial framework being in operation in 2020/21 due to COVID-19. In the first six months of 2020/21, the CCG was given a budget to operate within and any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first six months of the year the CCG reported a break even position. Further funding was provided for the latter six months of the year which included funding for estimated COVID costs and there was a clear expectation that organisations would manage within this funding and report a break even position.

The ongoing impact of the COVID-19 pandemic has required the CCG to review whether this creates material uncertainty regarding its going concern status. At this time, it is judged that the going concern status of the organisation remains unchanged however it is recognised that there has been a significant impact on how we operate. Our assessment of going concern is made on the basis that Government support is available to the NHS for all COVID-19 related costs and the CCG is fully participating in all financial returns and reviews.

The CCG has taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our third party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of the CCG's aged debt and its continued high achievement against the Better Payment Practice Code.

Although the financial position of the clinical commissioning group indicates some uncertainty over its finances, the Governing Body, having made appropriate enquiries, have reasonable expectations over the continuity of services and the adequacy of resources to continue in operational existence for the foreseeable future (in its merged form with NHS Telford and Wrekin CCG).

As directed by the Group Accounting Manual 2020/21, the Governing Body have prepared the financial statements on a going concern basis as they consider that the services currently provided by the CCG will continue to be provided in the foreseeable future.

On 1 April 2021 the CCG will form one single commissioning group with NHS Telford and Wrekin CCG to become 'NHS Shropshire, Telford and Wrekin Clinical Commissioning Group'. The formation of this new organisation has been approved by both sets of Governing Bodies and NHS England and the services currently provided by the CCG will transfer entirely to the new organisation together with its assets and liabilities.

On this basis, the CCG has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

PERFORMANCE SUMMARY

Performance dashboard

We measure our progress using a performance dashboard that shows up to 12 months' achievements. The Governing Body also receives monthly performance reports.

During 2020/21, performance – and NHS activity generally – has been significantly impacted by the need to deal with the COVID-19 emergency. This has meant reductions in some areas of planned and emergency activity and the cessation of reporting on some key indicators. Consequently, despite performance in some aspects not meeting pre-COVID-19 expectations, the local health system has coped well with the COVID -19 emergency and endeavored to maintain critical services as much as possible particularly in relation to cancer care and other critical conditions. Inevitably, numbers waiting for elective care have increased during the last year and will present a significant backlog to be cleared.

The CCG has not met performance targets in respect of the Accident and Emergency four-hour waiting time standard and ambulance emergency response times. Improvements have however been made against 12-hour admission waits and ambulance handover delays at A&E. The Referral to Treatment (RTT) target for waiting times for elective treatment was not achieved by the CCG or the local hospitals as a result of elective capacity being severely constrained by the need to cope with emergency COVID-19 demand.

Work has commenced with our service providers to identify how normal services can be restored and numbers waiting reduced as quickly as is possible whilst still maintaining an ability to respond to any future resurgence of COVID-19 demand.

Standard	Performance
Referral to Treatment (RTT) for non-urgent consultant-led services: Incomplete patients to start treatment within a maximum of 18 weeks from referral	At the end of January 2021, we achieved 60.6 per cent. This was made up of 59 per cent achievement at Shrewsbury and Telford Hospital NHS Trust (SaTH), 60.0 per cent at Robert Jones and Agnes Hunt Orthopaedic Hospital (RJAH), 94 per cent at Shropshire Community Health NHS Trust and 68 per cent at all other providers. Performance was impacted particularly at SaTH by the impact of COVID-19 and the loss of capacity for elective care and at RJAH by a pause in the elective admissions to allow staff to be seconded to SaTH to assist in critical care at the height of the COVID-19 surge. In addition, staff have been seconded to assist in the delivery of a successful local COVID-19 vaccination programme.
Number of 52-week RTT	At the end of January, published figures showed 1,956

pathways (incompletes): Zero tolerance of over 52-week waits	Shropshire patients had been waiting over 52 weeks for treatment. Waiting list backlogs will be addressed taking full account of clinical priority to recover the numbers waiting.
Diagnostic waiting times: Patients waiting for a diagnostic test should have been waiting fewer than six weeks from referral	Waiting times for diagnostic tests have not been achieved regularly throughout the year and were at 43.2 per cent in January. This again is due to the impact of COVID-19 and has been particularly felt in diagnostic endoscopy procedures which were impacted by a loss of physical capacity at SaTH. Endoscopy capacity is now being restored and additional Imaging capacity has been secured for the local health system to assist with the reduction in the waiting list backlog. Together these are beginning to make some headway in reducing the accrued backlog of patients waiting and the six-week target is expected to be achieved during Q2 2021/22.
A&E waits: Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department	Work has continued throughout the year when the opportunity presented at SaTH, to improve processes around A&E. COVID-19 impacted A&E performance in terms of the need to introduce social distancing into operational procedures and in changing the nature of the case mix being treated. Performance at SaTH remained a significant challenge throughout the year, with 66 per cent of A&E attendances waiting under four hours in February 2021. Improvement plans at SaTH are focused around improving patient flow and processes in the hospital to achieve quicker progress through A&E and earlier discharge, to reduce ambulance conveyances by developing alternate options other than A&E and implementing national recommendations around Same Day Emergency Care.
Cancer waiting times: First outpatient appointment for patients referred urgently with suspected cancer by a GP	Performance against the range of cancer targets has held up reasonably well in a difficult year due to loss of treatment capacity arising from the impact of COVID-19. This has been layered on top of existing underlying challenges in staffing capacity for a number of tumour types. Throughout the COVID-19 emergency, the focus has been on maximising the level of cancer services that could be maintained. Particular issues were experienced in relation to breast cancer 14-day standards due to a need to make physical changes to the waiting areas for treatment. This has been completed early in the new year, and an improvement in performance in this metric is now being seen. Figures for the end of January 2021 are shown below.
Category 1 ambulance calls: Category 1 calls to have an average emergency response within seven minutes and reach 90 per cent of calls within 15 minutes	The performance in the CCG has not achieved the targets locally during 2020/21 in call category 1. For calls in categories 2 and 3, the performance deteriorated in the second part of the year as activity volumes recovered from the initial drop in the first months of the COVID-19 pandemic. Category 4 calls achieved the standard in all months. The CCG has struggled for several years to reach the performance standards for category 1 and 2 calls but has generally fared better for categories 3 and 4.

	The contrast with the relative performance for Telford and Wrekin CCG indicates some of the difficulties experienced by a rural area.
Mental health and primary care indicators	Many of the indicators relevant to these aspects have been suspended during the pandemic. The CCG has improved performance in achieving annual health checks for people with a learning disability and dementia assessment rates have held up reasonably well during the pandemic. Numbers of people presenting to the improving access to psychological therapies (IAPT) services decreased markedly during the pandemic, but the expectation is that these will increase substantially over the coming year and that it will be priority aspect for the CCG recovery planning.

NHS Shropshire Clinical Commissioning Group

		Q1			Q2			Q3			Q4		
		2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21
KPI	Title	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	NHS Constitution and related indicators												
EB3	18-week waits: see IAF 129a	75.2%	64.8%	53.3%	48.2%	49.1%	55.8%	60.3%	62.7%	61.9%	60.6%	59.3%	59.6%
EB4	Diagnostic waits: see IAF 133a	65.8%	74.8%	65.4%	58.4%	56.8%	51.8%	44.5%	39.7%	41.0%	43.2%	37.0%	23.9%
EB6	CWT - 2-week cancer waits	85.9%	96.7%	96.6%	98.1%	96.1%	90.0%	89.6%	86.8%	88.3%	84.8%	84.5%	83.8%
EB7	2-week breast waits	80.0%	100%	100%	92.0%	93.8%	56.3%	30.2%	17.9%	12.1%	17.4%	11.9%	17.5%
EB8	CWT - 31 days to cancer treatment	96.3%	97.8%	99.3%	96.2%	97.4%	97.2%	98.8%	99.0%	95.9%	97.3%	94.3%	93.8%
EB9	CWT - 31 days to treatment (surgery)	97.3%	100%	86.7%	100%	93.3%	88.0%	87.9%	84.6%	83.3%	71.0%	86.4%	74.2%
EB10	CWT - 31 days to treatment (drugs)	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98.7%
EB11	CWT - 31 days to treatment (radiotherapy)	97.7%	98.2%	97.3%	93.3%	97.4%	95.6%	95.1%	100%	100%	98.3%	95.7%	98.5%
EB12	62-day CWT: see IAF 122b	68.0%	69.7%	70.3%	86.7%	80.2%	80.0%	86.9%	78.8%	65.4%	83.3%	69.8%	60.0%
EB13	CWT - 62 days to treatment after referral from screening	80.0%	n/a	0.0%	100%	0.0%	100%	0.0%	100%	66.7%	100%	83.3%	60.0%
	CWT - 62 days to treatment after consultant upgrade	86.1%	81.0%	86.8%	88.2%	94.1%	81.3%	88.6%	87.8%	90.9%	79.3%	93.3%	73.2%
EAS1	Dementia rates - see IAF 126a	67.4%	66.0%	65.0%	65.2%	64.4%	64.4%	63.9%	63.4%	63.1%	62.5%	62.3%	63.2%
EH10	Routine Eating Disorders - seen within 4 weeks	91.3%			93.9%			97.4%			100%		
EH11	Urgent Eating Disorders - seen within 1 week	100%			100%			100%			90.9%		

PERFORMANCE ANALYSIS

Primary care

The CCG commissions primary care services under delegated authority from NHS England and has a memorandum of understanding with NHS England which sets out roles and responsibilities and ensures robust contracts and support are provided to our GP practices.

As part of the preparation for the new organisation, the primary care team has become part of the Partnerships Directorate. The team is led by an Associate Directorate of Primary Care, with three primary care partnership managers acting as the first point of contact for individual practices and Primary Care Networks (PCN). The newly-structured team also includes leads for workforce, estates and contracts, with project and administration support across all work streams. Linked to the team is the newly-established Training Hub, which will lead and coordinate the delivery of training and development initiatives.

The CCG has 40 GP practices across three localities (North Shropshire South Shropshire, Shrewsbury and Atcham), which are all linked to one of four PCNs:

- North Shropshire PCN

- Shrewsbury PCN
- South West Shropshire PCN
- South East Shropshire PCN.

One of the main areas of focus for PCNs during 2020/21 has been the introduction of the Enhanced Health in Care Homes (EHCH) requirements of the PCN Directed Enhanced Service (DES), which came into effect from 1 October 2020. The existing Care Homes Advanced Scheme (CHAS) was enhanced ahead of this date to recognise the additional support needs in care homes linked to the COVID-19 pandemic, and a wraparound support team known as CCHEST has been put in place to support the PCNs in the delivery of the EHCH.

The medicines management team has supported PCNs with the introduction of the requirements of structured education reviews. PCNs used protected learning time and peer review sessions to start to develop work around early cancer diagnosis and learning disability.

General practice has continued to prioritise learning disability annual health checks through the pandemic in line with the national guidance to reduce health inequalities and proactively engage those at greatest risk of poor health. In spite of the challenges of COVID-19, practices exceeded the annual target of at least 67 per cent of people on the learning disability registers receiving an annual health check before the end of March 2021 by reaching a total of 77 per cent – a real achievement.

We have continued to support PCNs to develop their workforce plans to progress recruitment into new roles that are part of the Additional Roles Reimbursement Scheme. Clinical Pharmacists, Social Prescribing Link Workers and First Contact Physiotherapists have been the main roles to be recruited to this year, with plans progressing around the recruitment of Mental Health Practitioners.

The rollout of the COVID-19 vaccination programme from December 2020 became the main priority and focus for PCNs in the latter part of the year, with general practice playing a vital role in this roll out. Our thanks go to all practices for their huge efforts and hard work in relation to this.

General practice has continued to be accessible to patients during the pandemic, with appointments offered remotely where possible but face-to-face when needed. The use of online and video consultations has increased rapidly to meet new ways of working.

The CCG has continued to support practices and PCNs in accessing all available funding and support from regional and national development schemes, including the offer of continued support via the NHS England time for care team, GP Forward View funding and PCN development funding. One specific area of success has been in rolling out the GP/GPN Fellowship Programme which provides support and development for newly-qualified General Practitioners and General Practice Nurses. The COVID-19 pandemic has impacted on practice capacity to be able to maximise uptake of support offers during this financial year, however where offers have been available these opportunities have been shared.

The extended access service, offering clinical appointments to patients in the evenings and at weekends, has continued this year. Some capacity has been repurposed to support the COVID-19 vaccination programme in the latter part of the year.

Key achievements this year include:

- Regular communication with practices to support them and address queries in relation to the ongoing challenges linked to COVID-19
- Involvement in the design and management of the COVID staff testing programme for general practice staff
- Involvement in the STP-wide vaccination workforce group, enabling over 300 practice staff, CCG staff and locums to join the STP workforce
- Continuation of progress against identified priorities to address inequalities, for example delivery of learning disability health checks
- Collaborative working with our neighbour Telford and Wrekin CCG to engage 13 newly-qualified GPs and three newly-qualified GPNs supported on the NHSE/I funded Fellowship Programme across the Shropshire, Telford and Wrekin footprint
- Seven GP mentors supported to deliver mentoring sessions to colleagues
- Funding for newly-appointed GP First 5s leads
- Collaborative working with Telford and Wrekin CCG to provide support to PCNs to recruit over 60 new members of staff across the seven PCNs in Shropshire, Telford and Wrekin
- An enhanced Training Hub across the Shropshire, Telford and Wrekin footprint has enabled a number of training programmes to be delivered included continuing professional development (CPD) for around 240 general practice nurses.

A range of significant primary care estate projects have been realised during 2020/21 in addition to significant progress in the development work on major capital projects. The largest project saw the completion of a new facility for Riverside Medical Practice as part of the wider Tannery Development in Shrewsbury, delivered in partnership with Shropshire Council. A range of smaller but vital improvement projects have taken place in several practices utilising Improvement Grant monies.

Work towards creating new primary care facilities in Shifnal and Whitchurch has taken major strides, with expected completion of one of these schemes in 2021/22.

Primary care has taken a lead role in the establishment of a range of services in response to the COVID-19 pandemic, including the pulse oximetry at home service and the COVID-19 virtual ward.

The work of the primary care team is mainly overseen by the CCGs' Primary Care Commissioning Committee (PCCC) in common which receives regular updates on the key priorities. A Primary Care Risk Register ensures that identified risks are monitored and mitigated and this is overseen on a quarterly basis by PCCC.

National Diabetes Prevention Programme (NDPP)

The National Diabetes Prevention Programme is an NHSE/I commissioned scheme. When people are identified as being at risk of developing type two diabetes, they are referred into this nine-month lifestyle change management programme. Evidence from across England has shown this programme has reduced the risk of people going on to develop diabetes.

From April 2020, a new provider commenced delivery of this service. This new programme includes an online option for people who prefer it or cannot attend a local venue. As with many other services,

the pandemic has significantly reduced the number of referrals into the service, however, in March 2021 referrals started to return to previous levels.

Commissioning

Integrated urgent and emergency care – NHS 111 First

In December 2020, a new system was introduced for people in Shropshire, Telford and Wrekin who have an urgent, but not serious or life-threatening, health care need. Anyone needing urgent care is asked to contact NHS 111 first to ensure they get the right help in the right place at the right time. The service, staffed by trained health advisers, can now book the caller a time slot for the most appropriate service, such as a GP, Minor Injury Units, Urgent Treatment Centres, or, if needed, A&E (Emergency Department) at the Royal Shrewsbury Hospital (RSH) or the Princess Royal Hospital (PRH) in Telford.

Booked appointments through NHS 111 have been introduced in England to help keep people safe and reduce the pressure on hospitals and staff. The new system will help the NHS manage the flow of patients when capacity in waiting rooms is much smaller than before the pandemic, to maintain distancing and reduce the risk of infection. This will also improve the patient experience as people will be seen and treated more quickly.

It is too early to be definitive about the impact of this development, particularly given it is not possible to compare activity this year with last because of COVID-19, but the early signs are encouraging. Data indicates that NHS 111 first is reducing the number of patients who self-present to A&E and increasing the uptake of booked appointments into urgent treatment centres and general practice via 111. A patient survey is planned to assess patient experience of using NHS 111 First.

Reducing delayed discharges

Although we are one of the best performing areas for delayed discharges, the extreme pressure on acute beds from the pandemic, and particularly in the second surge in the winter, sharpened our focus this winter on further improving our discharge processes to support effective flow through the acute hospitals. In December, January and February we carried out four Multi-Agency Discharge Events (MADE) to improve our processes even further. The outcome of these events included:

- Improving the number of discharges before midday
- Enhancing the number of patients who access care directly through our new and improving the Same Day Emergency Care process rather than going into A&E first
- Improving our Frailty Assessment at the front door of the hospitals so that we can avoid unnecessary admissions
- Increasing the number of patients who are discharged on the day they become medically fit for discharge.

Early on in the pandemic, the system also worked together to develop a COVID-19 discharge pathway. It was clinically developed based on national guidance, requirements and evidence and

covers patients discharged from an acute hospital to a supported pathway in a community hospital, care home or in domiciliary care.

Same Day Emergency Care – Royal Shrewsbury Hospital

In December 2020, the Royal Shrewsbury Hospital opened a new modular build Same Day Emergency Care Unit which will significantly improve their ability to safely assess, treat and discharge more patients on the same day as they attend the hospital. This unit provides a better patient experience with much improved facilities and speedier discharge, frees-up much needed acute beds through reduced admissions and improve staff retention and recruitment with better working environment and the ability to deliver better outcomes for patients.

Out of hospital transformation

System changes

During the year, some major changes have contributed to shifts in how the system operates including the response to COVID-19 and the impact it has had on services, patients, and staff, which meant more than ever working together as one cohesive system as a combined force with the same aims and objectives. Work also continued to align commissioning with NHS Telford and Wrekin CCG to become one integrated strategic commissioning organisation that would span the whole Shropshire, Telford and Wrekin footprint.

As the system, its structure has been redefined to take into account:

- The ongoing shift towards strategic commissioning and alignment between Shropshire, Telford and Wrekin
- COVID-19 response and the reducing, stopping and restarting of services
- Development, management and delivery of a range of system transformation programmes
- Development and delivery of system Long Term Plan priorities
- Winter planning, performance and business as usual
- Planned service development projects
- System improvement plans.

This restructuring of the system saw the development and establishing of three Programme Boards who would be accountable for all of this work associated with their areas. These groups are:

- Acute and Specialist Care Programme Board
- Community and Place Based Care Programme Board
- Mental Health, Autism and Learning Disabilities Programme Board.

As described, as COVID-19 took hold in the UK, resources were pulled into crisis response roles and therefore the decision was made to pause all transformation programmes in March 2020. In September 2020, it was agreed to re-start the transformation across the system but with the need to

revisit the scope, aims, objectives and anticipated outcomes. This work would be governed by a new system structure and programme boards.

Shropshire Care Closer to Home and Telford and Wrekin Integrated Place Programme have become the operational arms of this Community and Place Based Care Programme Board.

Shropshire Care Closer to Home

In 2017, following a community services review, Shropshire CCG commenced a large-scale review and transformation of community-based services with a view to making the necessary changes to the overall system that are required to better deliver preventative care and support, and services closer to home. This was underpinned by the principles of keeping people as well as possible, for as long as possible in their own home or community environment and minimising the need for a hospital admission. This supports the delivery of the NHS Long Term Plan, which advocates collaborative whole system solutions, as well as locally supporting the Hospital Transformation Programme (formerly Future Fit model).

Due to the scale of this programme of transformation known as Shropshire Care Closer to Home, it was broken down into three core phases, the detail and progress of which is outlined below. As this was originally aimed at reaching all people in Shropshire aged 65 and over, there was also a Phase 4, which was the future expansion of these services to become all-age.

Phase 1 – Frailty assessment and intervention

The frailty intervention team (FIT) is a small integrated health and social care team from Shrewsbury and Telford Hospital NHS Trust, Shropshire Community Health NHS Trust and Shropshire Council. Together they to ensure anyone aged 75 and over who arrives via the A&E department is assessed quickly for frailty, treated or stabilised, and discharged or transferred safely back to their own homes or to another appropriate place of care based on their individual needs. This helps to ensure that people are in the best environment for them and their care needs, helping to make a better and quicker recovery, and avoiding an unnecessary admission into hospital.

In 2020/21, FIT continued to run five days a week at both sites with recognition from the Acute Frailty Network of the service as exemplary, and was held as a beacon of excellence in leading other national Trust in the development of similar kinds of services and teams. NHS England also commissioned the production of a film clip entitled ‘Roy’s Story’ which demonstrates how this team and service works, and some of the impact that it has for people.

Further into 2020, it became necessary to broaden the remit of these teams and assist with admitted general patients as part of managing and dealing with the impact of COVID-19 and the unprecedented demands that this placed on the general hospital. This temporary change in use was made possible by the decline in numbers of individuals coming into A&E during the period that the team would ordinarily work with and support.

Phase 2 – Case management

Following two years of involvement and engagement, and co-design with a wide range of stakeholders including service users, carers, general public, health and social care professionals and the voluntary and care sector, this new model of care was approved in August 2018. A model of care that would see the development of locally available community-based integrated teams who would work with systems that identified people's needs earlier, enabling them to develop and provide holistic proactive preventative care plans wrapped around the unique needs of the individual.

In 2019/20, the CCG piloted Case Management in eight demonstrator site locations, with monitoring and capturing of positive impact and outcomes achieved through these locally available integrated teams. This pilot feedback was also supplemented by information gathered at a Case Manager workshop where we could hear first-hand the strengths and weaknesses, and a number of anonymised case studies, enabling us to make any necessary improving or finessing prior to wider rollout.

With that further refining work complete, and evidence of positive impact, in January 2020, the CCG approved a proposed expansion and rollout strategy for Case Management to be implemented across the whole county over the year, in two key steps:

Step 1 – April / May 2020

Expand the existing eight demonstrator sites to work with an additional practice each, so that the teams are working with a total of 16 practices and their patients aged 65 and over.

Step 2 – November 2020

Transition teams to work from five Wellbeing Hubs, and work with patients aged 65 and over spanning the whole Shropshire county, and including all practices. The preference is that these Wellbeing Hubs are aligned with the PCN geography to ensure that the integrated teams are locally available to that area and group of practices. It was agreed that the North PCN should in fact have two Wellbeing Hubs to reflect the South, due to the geographical spread of that North Shropshire area. These Wellbeing Hub locations would be:

- North East
- North West
- Central/Shrewsbury
- South East
- South West.

When COVID-19 began to take hold in the UK early 2020, the majority of the health and social care workforce were pulled back into crisis response roles as part the response to the pandemic. In March 2020, the decision was then made to pause all transformation programmes including this one, and so the pilots were stood down and the rollout and implementation plan shelved.

In September 2020, the decision was made to re-start all transformation programmes but would need to be managed through a newly-established system structure (as described below) and that all programmes would need to be re-scoped and revisited to ensure they remained relevant; taking into

account the impact of COVID-19 and the changing health and social care needs of the local population.

A new rollout and implementation plan for Case Management is currently under review and development, which may also require some modifications to the version of the model agreed in 2018.

Phase 3 – Community-based semi-acute services

In 2019/20, Phase 3 models of care including a community rapid response team were approved by the CCG and a robust impact assessment was undertaken with all provider and partner organisations in the system, to determine any potential unintended risk or negative impact on existing services and pathways once they were implemented.

The outcomes of that impact assessment exercise were considered by the CCG Clinical Commissioning Committee in March 2020 and agreed in principle as a new range of services that would benefit the Shropshire population, and health and social care system, and discussions commended on how best to proceed with the procurement and implementation of these new community-based services.

As above however, the decision was also made in March 2020 to pause all transformation programmes and therefore this did not progress during the year whilst the system dealt with COVID-19.

With transformation programmes now re-started, this forms part of the re-scoping, review and development being undertaken via the Community and Place Based Care Programme Board on how best to proceed; including looking at options for combining these new semi-acute community services with case management to become one combined service model that reaches people at various levels of acuity near to where they live.

Ageing Well Strategy

A public, patient and stakeholder workshop around the Shropshire Ageing Well Strategy took place in February 2020. The session concluded with an exercise where everyone contributed to suggestions for strategic recommendations on what future health and social care services in Shropshire need to look like to be sustainable, and appropriately matched to predicted needs and changes in demand over the coming years.

The outcome report was due to be shared once finalised, with strategic recommendations agreed in readiness for Public Health publishing the final Shropshire Joint Strategic Needs Assessment (JSNA) document, a wealth of information that would also be vital in the work being planned to review Shropshire community bed provision planned 2020/21.

The impact of COVID-19 however meant that this piece of work and the finalising of the JSNA was halted, as was the community bed review. It is anticipated that further work will be required with Public Health colleagues to revisit this JSNA in order to take into account and capture the impact of COVID-19 and health and social care landscape that has changed significantly as a result.

Shrewsbury admission avoidance team

Winter 2018/19 demonstrated significant pressures in the acute setting. Medical bed capacity was on occasion insufficient for demand, and the CCG received reports of corridor waits and ambulance handover delays which cause concern from a patient safety and quality of care perspective.

In November 2020, the CCG launched a discrete admission avoidance team, as an interim “rescue” measure, pending full roll out of the Care Closer to Home work in the Shrewsbury locality lead by the local authority. The service was achieving an 85 per cent admission avoidance rate based on referrals with ongoing work across the system to increase the service to 24/7.

This service was commissioned once again over the core winter months of 2020/21 to help provide preventative care and supported to people where an A&E visit or hospital admission could be prevented, and this helped to take some of the demand pressures from the acute general hospital through the critical winter months of surge demand.

Neurology

The neurology service delivered at SaTH has been challenged for many years, primarily due to workforce limitations. These challenges led to patients experiencing long waits to see a consultant, which in turn led to the decision to close new referrals. Following a system agreement that the local service cannot be reopened in its current form, the CCG has been working with SaTH and The Royal Wolverhampton NHS Trust (RWT) to develop a sustainable neurology service across Shropshire, Telford and Wrekin.

During 2020/21, COVID-19 has had and continues to have a significant impact on the implementation of the neurology service. During this period, the CCG has been working with the trusts in the development of the transfer of the neurology service from SaTH to RWT. This transfer is scheduled for early 2021/22.

Mental health

A Mental Health Learning Disability and Autism Programme Board has been established to oversee the delivery of key priorities for mental health and the aspirations of the NHS Long Term Plan.

The Programme Board has direct oversight of the Transforming Care Programme (now known as the LD&A programme), ensuring a coordinated approach across the whole agenda, increasing the focus on reasonable adjustments and the importance of mental wellbeing for all.

Through increased community and earlier intervention, fewer people need to go into hospital for their care associated with their learning disability and/or mental health needs. For those people who do need to go into hospital, a plan of care and treatment to support a robust and safe discharge is delivered through a multiagency approach. A stay in hospital is appropriate for the individual’s needs and not due to other social, environmental or housing factors.

Despite the focus on the pandemic, we have continued to develop services across the Shropshire, Telford and Wrekin area in line with the Mental Health Long Term Plan.

- Specialist perinatal mental health services are now in place to support women and their partners where they have mental health issues associated with their pregnancy – referrals from a midwife or GP
- Increased support in the community to support people living with dementia to reduce the need to go into hospital
- Increased support into employment for people with severe mental health issues – referrals from mental health services
- A dedicated team is in place to support people with a learning disability and or autism to live successfully in the community
- Increased the numbers of professionals working to support people with severe mental illness.

The health and social care system has worked in a far more integrated way reducing barriers between services during this pandemic so that we are better able to support individuals.

We now have a 24/7 mental health helpline in place:

- Urgent Helpline (0808 196 4501 option 1 – under-18s; option 2 – over-18s)
- Expanded Crisis Home Treatment for adults and extended service for children and young people (CYP) to 24/7 in line with adults.

We have extended support out of hours with for individuals in emotional distress and struggling to cope or need somebody to talk within the voluntary sector.

- Calmer Café No 1 by Shropshire MIND (01743 368647 manager.shropshiremind@gmail.com)
- Put in place a pilot for and extend offer for CYP from Beam – support for children and young people – further detail in CYP section
- We have increased access to psychological services for people who are feeling depressed and/or anxious through Improving Access to Psychological Therapies (IAPT).

These areas of improvement are all part of supporting people in crisis with the right care, at the right place. Making sure people can navigate a simplified urgent care system to meet both physical and mental health needs.

Continued focus on increasing the delivery of Severe Mental Illness (SMI) – annual physical and mental health reviews. The uptake has been positive, which has enabled both primary care teams and secondary mental health services to work together. COVID-19 has required different approaches, but with the use of digital engagement, this work has continued for these vulnerable groups.

Key achievements / areas of work

The membership, through all Locality Committees, has considered key areas of CCG work to ensure that clinical voices are embedded in the decision-making processes. Some of the areas of work presented or discussed at the Locality Committees over the last 12 months include:

- Improving Access to Psychological Therapies (IAPT)
- Specialist perinatal mental health services

- BeeU Service development of the autism spectrum disorder (ASD) pathway
- The development plan for community mental health transformation, which will take place over the next three years.

Cancer

Improving cancer pathways continues to be a priority and is at the heart of the STP's approach to recovery of cancer services. Key actions have been undertaken during the last 12 months include:

- The Strategic Cancer Board has been re-established in the latter half of 2021 and will focus on a review of the Cancer Strategy
- Investment has been secured for time-specific projects, including:
    - Supporting primary care with the undertaking of cancer care reviews (CCR)
    - Developing the principles of Rapid Diagnostic Centres – focusing on non-specific symptoms pathway and pathways with challenged performance
- A living well video has been developed for patients to hear other patients' experiences, which continues to be available on SaTH's website. Face-to-face sessions were paused due to COVID-19, but sessions were developed virtually. Initial feedback has been positive, further sessions are planned and evaluation is to be undertaken.

The implementation of Living Well Passports has continued. Positive feedback has been received from both staff and patients, who feel it has given them back some control. Work will continue to evaluate.

Children and young people (CYP)

CYP Mental Health Long Term Plan update

The Shropshire, Telford and Wrekin Transformation Plan for Children and Young People's Mental Health and Wellbeing has been refreshed in 2021. This report details an update since 2020, areas where improvements have been made and where services and plans are being developed to meet the actions.

Areas of improvement include:

- Increase in early intervention mental health via programme such as Anna Freud across the county schools, the mental health trailblazer in school service
- Improved communications and understanding of what is available around mental health on both council websites
- There are no waits for mental health services over 18 weeks. Children and young people referred to BeeU Access are triaged within one week and contacted by service within four weeks, but usually within two weeks. The only pathways that have CYP waiting over 18 weeks is ASD diagnosis

- Shropshire's recent Special Educational Needs and Disability (SEND) inspection concluded in a written statement of action. One of the areas of concern is 'Significant waiting times for large numbers of children and young people on the ASD and attention deficit hyperactivity disorder (ADHD) diagnostic pathways'. An ASD diagnostic team within Midlands Partnership NHS Foundation Trust (MPFT) has been in place since September 2020. When they started there were more than 300 on the waiting list across the county, they are now working through this list and all CYP will have started their assessment by the end of April 2021. It is then envisaged that all CYP will start their assessments within 12 weeks of referral – as per National Institute for Health and Care Excellence (NICE) guidance
- All children and young people in crisis are triaged within four hours and seen by the crisis homecare team within 72 hours. This meets the national target
- Since January 2021, a 24/7 crisis care for children and young people ran by MPFT has been in place with increased funding from mental health transition monies.

Areas still under development:

- Place-based neurodevelopmental pathways are being developed across the system to include pre-diagnosis, diagnosis and post diagnosis support
- The positive behaviour support (PBS) plan is an evidence-based model that improves outcomes for children and young people. The elements within the PBS include functional and sensory assessments, leading to personalised PBS plans. A joint paper and plan has been developed and will be vital in initially supporting children with learning disabilities.

Community physical health update

Shropshire Community Health NHS Trust delivers most of the children and young people community services, which include:

- CYP therapies
- Child Development Centres
- Wheelchair services
- Children community nursing service
- Paediatric psychology
- Community paediatricians
- 0-19 healthy child programme.

The services were reduced during COVID-19, but nothing was stood down. All children were assessed and given a risk rating to decide what level and type of service they required. They offered many children virtual consultations via 'attend anywhere' and will continue to offer this service where appropriate in future service provision.

During 2020/21, a number of service reviews began. Findings will be published during 2021, these will include new pathways that have been co-produced across the system and with support from children and young people, their parents and carers. These include:

- Speech and language therapy
- Special school nursing.

SEND (Special Educational Needs and Disability)

SEND work across the STP at a place-based level and there are two SEND plans owned by each of the local authorities.

A joint SEND Inspection by the Care Quality Commission (CQC) and Ofsted took place in Shropshire across health, social care and education between 27 and 31 January 2020.

The final letter was published on 6 May 2020 and identified many strengths, including the positive education outcomes for Shropshire children and young people with an Education, Health and Care Plan (EHCP) that attend mainstream schools and colleges.

A number of concerns were identified by the inspection and, as a result of these findings and, in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, the Chief Inspector determined that the Shropshire 'local area' was required to produce a Written Statement of Action (WSoA).

Shropshire Council, Shropshire CCG and the Parent and Carer Council (PACC) have worked together to develop this co-produced WSoA that identifies the actions that will be taken by all partners to secure timely improvement, as well as providing an indication of what difference we expect these actions to make to our children and young people with SEND and their families. This will ensure that SEND is a priority for everybody and that all partners recognise the importance of SEND.

The full WSOA is available online.

Learning from COVID-19

The SEND COVID-19 operational group was very successful in bringing different partners together across the system. They were able to develop solutions to problems together very quickly and easily. An example is offering fit mask testing to support workers in educational settings and parents with a child with aerosol generating procedure (AGP) from community health services. The group carried out a strengths, weaknesses, opportunities and threats (SWOT) analysis. The wider CYP tactical group looked over and agreed many of the SWOTs were the same across the CYP economy. This piece of work has been taken forward by the new system governance plan for CYP.

The main elements which the group felt were invaluable were:

- Improved communications across organisations
- Reduction to barriers across organisations
- The offer of different types of service (e.g. virtual support where clients want, yet still offering face-to-face where needed or required). This offer will stay after COVID-19, and grow where the evidence and patients feedback dictates
- Data sharing has improved during COVID-19, and examples of weekly huddles with social care and MPFT to discuss CYP with complex needs has been invaluable and this will stay post-COVID-19. Work to improve data sharing post COVID-19 is underway.

System governance

During 2020/21, a children and young people STP/ICS workstream has been developed. The key elements are:

- The development of a recovery, restoration and 'new normal' governance structure within the STP/ICS has highlighted a need for a stronger CYP voice within our system
- The foundations of a healthy and fulfilled adult life are laid in childhood and adolescence
- There are some excellent examples locally of partnership working to support improved outcomes for CYP
- There are many components and services that are interdependent and explicitly linked to each other underpinning successful outcomes for the CYP and their families
- An initial group met in June 2020, led by Jane Povey (SCHT Medical Director and STP Clinical lead), to discuss appetite, benefits and barriers. The group has met monthly since October 2020
- It is proposed a CYP pathway group will pull together and co-ordinate the elements of the CYP service across the STP/ICS
- Short, medium and long-term actions have been developed to demonstrate commitment to getting this right.

The aims of the group are to:

- Work in partnership with CYP and their families to develop shared outcomes
- Lead and improve partnership working across the system
- Lead and inspire local partnerships to deliver an integrated approach across the wider system to ensure families experience a joined up offer of provision
- Make best use of available resources preventing duplication and silo working
- Be the voice and advocate for CYP and their families across the STP/ICS
- Build upon community capacity and assets whilst reflecting local issues and needs which will inform service delivery
- Use innovative approaches to identify health and wellbeing needs in order to target interventions and prevent needs from escalating across the system
- Share information effectively and efficiently with partner agencies
- Develop an approach that supports the ethos of 'getting the right help at the right time', while taking into account the need for place-based adaptations
- Develop a CYP's strategy setting out our agreed partnership priorities for the next three years.

Future work for 2021/22

There are plans in place to develop a partnership with CYP and their families across the STP/ICS with senior leadership, with the aim to support the delivery of CYP transformation as recognised in the NHS Long Term Plan.

Medicines optimisation

Medicines optimisation looks at the value that medicines offer, making sure they are clinically-effective (that they improve outcomes for the person taking them) and cost-effective (that they represent good use of NHS resources). It is about ensuring that people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team (shared decision-making).

The goal of medicines optimisation is to help patients:

- Improve their outcomes
- Take their medicines correctly
- Avoid taking unnecessary medicines
- Reduce waste of medicines
- Improve medicine safety.

Our medicines management team works closely with patients and members of the public, clinicians, commissioners and managers to help achieve these goals. Here is some background information and details about some of the things that we have done during 2020/21.

COVID-19 response

The medicines optimisation team have had a key role to play in the COVID-19 response. In the first wave, the team supported the 'hot sites' set up at the Shrewsbury Town Football Ground and Telford International Centre to assess patients showing COVID-19 symptoms and provide access to medicines. During the pandemic, they provided guidance on both the appropriate symptomatic treatment of patients who had not been admitted to hospital and helped to ensure that patients could continue to receive their regular medical treatment safely (including drug monitoring, providing advice on when this could be safely delayed and when it was essential it continued), particularly for vulnerable patients who were shielding.

Since December, many of the team have been supporting the COVID-19 vaccination programme both strategically in the oversight and governance of the local vaccine programme and practically in care homes, GP-led vaccine sites and the larger vaccine centres. The programme needs significant input from pharmacy to ensure the safe and effective storage and use of the vaccine, and this has been achieved through collaboration across all sectors from the CCG, hospital pharmacy teams and community pharmacy providers.

Medicines optimisation clinical projects

Despite the impacts of COVID-19, the team has seen a number of key achievements in clinical projects during 2020/21:

- **Wound care.** The team fully established a Wound Care Steering group which has enabled an STP/ICS approach to wound care management. The group has successfully reviewed the wound care management formulary for use across the local health economy and established

several key documents to support wound care management including the debridement pathway and patient wound care passport. An audit was also conducted with community nursing teams to identify key areas for improvement and education support.

- **Respiratory.** Working with clinicians in SaTH and Shropshire Community Health NHS Trust information and guidance was developed to support patients and clinicians with COPD to manage infective exacerbations (rescue pack guidance) and prevent further decline which may lead to hospital admission. This was particularly important during COVID-19 to keep patients out of hospital and reduce the need for GP practice visits
- **Pain management.** The team supported practices across Shropshire, Telford and Wrekin to review their patients prescribed high doses of opioids (>120mg morphine or equivalent strength doses of other opioids). Opiates are generally not a suitable treatment for chronic (long-term) non-cancer pain. The NICE guidance NG59 for the management of low back pain and sciatica in over-16s advises against the use of opioids for chronic back pain. Patients should not be prescribed >120mg morphine or equivalent/day since the risk of harm increases substantially at higher doses. Any patients taking over this dose should be reviewed as the risks of harm outweigh the benefits of use. Through the provision of guidance for clinicians and two educational workshops targeting the approach to reviewing opioids in primary care, the Medicines Management Team has enabled a steady reduction of the percentage of high dose opioid prescribing.

The Prescription Ordering Department (POD)

The POD teams in Shropshire, Telford and Wrekin experienced an unprecedented increase in workload due to the COVID-19 pandemic. In order to prevent virus transmission, paper requests directly through practices were restricted heavily, meaning that more patients utilised the POD service than ever before.

The email facility was brought in to help relieve the incoming calls and to provide more accessibility to the POD service for patients. During 2020, 67k email requests have been processed for Shropshire, and 20k for Telford. This, in addition to more than 393k calls for Shropshire and 300k for Telford, has meant that the team have processed more than 750k repeat prescriptions to patients – approximately a 30 per cent increase on the previous year.

Whilst the majority of cost-saving interventions recording was halted due to the increase in call volumes, the team still managed to deliver more than £2m worth of savings to the local health economy by reducing medicines wastage and preventing unnecessary medication ordering.

Medicines optimisation in care homes

The care home medicines optimisation team collaboratively work with care homes, GP practices, community pharmacies and the local authorities to provide support, education and guidance to ensure safe and effective use of medicines and to support the delivery of quality, personalised and safe care. The team works collaboratively with the wider multidisciplinary teams supporting each patient, providing polypharmacy medication reviews, adherence advice, guidance in swallowing difficulties and advice on safe and effective medicines use, as well as a rolling training programme for

care home staff. Much of the work has had to be done remotely due to COVID restrictions, but the team reviewed the medication of 3,000 care home residents and made 3,600 interventions improving quality and safety of prescribing, reducing waste, and reducing potential hospital admissions.

The Transfer of Care Around Medicines (TCAM) Project in care homes has been set up over the last year to support discharges from local hospital trusts into care homes across the locality. Shropshire was the first CCG nationally to offer a dedicated care home TCAM service accessing specialist elderly care pharmacist reviews, which has now been extended to discharges to Telford and Wrekin care homes. The project ensures that a patient admitted to the care home directly from a local hospital is receiving the right medicines and all changes have been safely managed, reducing the risks of another hospital admission. The team, working collaboratively with medicines management teams in the West Midlands and with the West Midlands Care Home Pharmacy Network have also supported development of a Midlands Regional Medicines Reconciliation Policy.

Proxy Ordering in Care Homes is currently being implemented in care homes, practices and community pharmacies to digitalise and improve efficiencies with medication ordering. The project aims to improve medicines safety with a more efficient and auditable process.

Medicines formulary

Scriptswitch Shropshire

Scriptswitch, since its inception in Shropshire in 2015, has been continually developing to ensure that safety and savings messages remain current, strengthening engagement with practices. This year has been no exception, with savings of £424,000 exceeding the planned target figure. Information and safety messages have been updated which has been key to respond to COVID-19 developments. More than 9,000 messages are already logged onto the system with weekly updates. Additional improvements include the integration and roll out of the Eclipse system support tool within Scriptswitch to alert practices to high risk prescribing. This has had positive feedback and will, moving forward, become an integral safety system within GP practices.

Formulary and medication switches

Cost-effective medication switches across Shropshire, Telford and Wrekin were impacted by redeployment due to COVID-19 but still exceeded planned target figures. Formulary decisions, medication changes, tags, warnings etc are now fed through to Optimise Rx, Scriptswitch and netFormulary to ensure that all systems are updated with new information. This will connect all systems with the work undertaken on the ground to produce savings through medication switches.

Encouraging self-care

During 2020/21, our work on encouraging self-care and reducing prescribing in GP practices was impacted by the coronavirus outbreak priorities. Our public engagement remained high, with several press releases and social media campaigns throughout the year. Our focus shifted to social media campaigns rather than place-based campaigns to ensure we reached our patients during lockdown.

Press releases we have released include ‘What is the difference between hay fever and coronavirus’ and ‘The importance of self-care during the national restrictions’.

Drugs of limited clinical value

For several years, we have been working on reducing the prescribing of medicines considered to be of low clinical effectiveness, medicines which have more cost-effective alternatives and medicines which are deemed to be low priority for funding by the NHS. Despite the COVID-19 pandemic, we have seen further reductions in this area this year – particularly with bath and shower preparations for dry and pruritic skin conditions, as collaborative working with dermatology, primary care clinicians, community pharmacies and within our own team (POD staff, care home, project lead and locality pharmacy technicians) has made the implementation of, and the adherence to, our Joint Commissioning Policy a real success.

Antimicrobial resistance

We continue to support the UK's five-year national action plan 2019-24 which includes tackling antimicrobial resistance (AMR) and optimising the use of antimicrobials in humans. Antibiotic prescribing data is monitored closely both locally and nationally. Despite the additional challenges faced by health professionals managing patients with infections during the pandemic, the Shropshire, Telford and Wrekin CCGs have remained both below the national target and England's median for total antibiotic prescribing volume and use of broad-spectrum antibiotics.

Early in 2020, the medicines management team at Shropshire CCG hosted a TARGET Train the Trainer Workshop which develops accredited TARGET trainers to train and facilitate the development of an antimicrobial stewardship plan within primary care. This was attended by GPs, advanced nurse practitioners, practice nurses, practice and care home pharmacists and technicians. It was a really positive session and promoted discussion and sharing of best practice in antimicrobial prescribing and stewardship. A number of those who attended managed to deliver their own workshop before the pandemic hit.

During world antimicrobial awareness week in November 2020, we targeted health and social care workers undertaking a digital campaign focusing on urinary tract infections (UTIs) which are commonplace and frequently result in an antibiotic being prescribed. The campaign centred on publishing digital 'thank you' notes with links to key messages, resources and training to support appropriate management of UTIs.

Improving patient safety

The medicines management team work with all local providers in order to promote the safe use of medicines. This includes conducting audits of the prescribing and monitoring of potentially High Risk Drugs, providing advice and guidance on appropriate use of medicines, cascading drug warnings and safety information to providers, and promoting and sharing learning from reported medication incidents.

Working collaboratively with our local hospitals and community provider

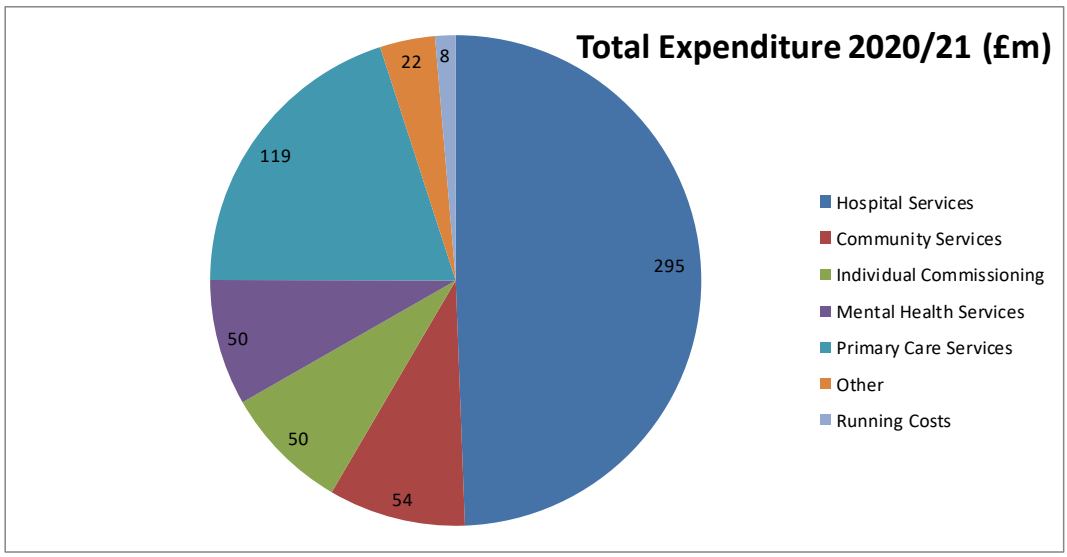
The medicines management team works closely with local trusts and specialist services in order to ensure that the treatment provided is evidence-based, following recommended clinical guidelines and is also cost-effective. This helps to ensure that the healthcare services commissioned for our population are cohesive across all settings and make best use of medicines. This has been achieved

by the introduction of a new netFormulary for the prescribing of medication and the use of Blueteq, which is a computer system designed to support clinical decision making.

Finance

In 2020/21 the CCG received a total allocation of £597.1m to spend on the healthcare of its residents. Total expenditure against this allocation was £596.4m and a breakdown of this by expenditure type is shown in the chart below:

NHS Shropshire Expenditure 2020/21 (£596.4m)



Further analysis of expenditure, by type, can be found within the Annual Accounts on page 151-154 of this report.

An analysis of the Statement of Financial Position, detailing movements in assets and liability balances, can be found within the Annual Accounts on pages 141 of this report.

Performance against financial targets can be found in Note 19 of the accounts, (page 165 of this report).

Quality, Innovation, Productivity and Prevention (QIPP)

QIPP stands for Quality, Innovation, Productivity and Prevention. It is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS.

In order to fund increases in activity, demography and any additional cost pressures the CCG will need to deliver recurrent QIPP plans year on year.

During 2020/2021, delivery of QIPP was challenging due to the impact of the pandemic. Block contracts were put in place with our main providers, a number of QIPP projects were suspended and many staff redeployed to other departments.

However, the CCG was able to still deliver £4.8m of savings which were predominantly within the medicines management and individual commissioning teams.

During 2021/22 the Shropshire healthcare system will introduce an Intelligent Fixed Payment (IFP) System, a financial framework between the health partners who are performance managed within the Shropshire and Telford and Wrekin Integrated Care System (ICS), so that rather than using activity and price to determine contract income, the CCG resource limit will be allocated between system organisations based on net expenditure levels.

The four IFP partners will attempt to improve the system financial position over a number of years by working together and individually on improving the cost effectiveness of the health services provided. The system financial position will be the main measure of financial success although individual organisational financial reporting will remain the bedrock of financial governance arrangements.

As part of the development of the system financial sustainability plan, the aim is that in 2021/22 all system organisations will work to deliver a 3% efficiency target. For the combined CCGs this equates to a £13.5m efficiency target.

Due to the IFP arrangements in place, the CCG will need to deliver this target from its non system expenditure portfolio.

SUSTAINABLE DEVELOPMENT

As an NHS organisation and spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities.

By making the most of social, environmental and economic assets, we can improve health both in the immediate and long-term, even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint. We plan to develop a Sustainability Policy during 2021/22, as the pandemic prevented this work to be undertaken during 2020/21 as a newly-created CCG across the whole of Shropshire, Telford and Wrekin which will set out several key objectives. We have also appointed a board level Sustainability Champion.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34 per cent (from a 1990 baseline). This is equivalent to a 28 per cent reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28 per

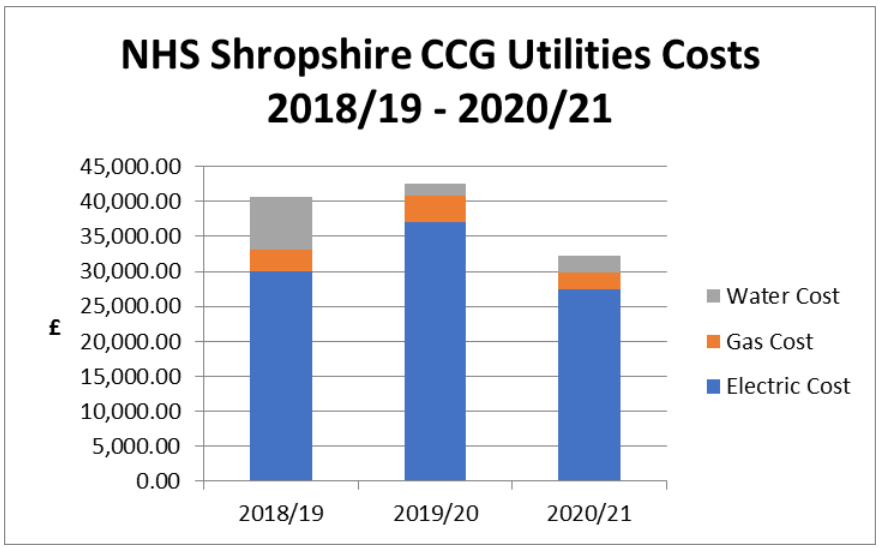
cent by using 2013/14 as the baseline year. More information on these measures is available on the Greener NHS website.

Energy

The graph below shows there has been a reduction in water costs, gas and electricity costs during 2020/21.

This is partly due to the CCG staff working from their homes for significant periods during 2020/21 whilst the country was subject to national lockdowns to combat COVID-19 pandemic, although the impact is less on energy costs as some staff still had to base themselves at the CCG's headquarters during these periods and so the buildings continued to require heat/ light and water.

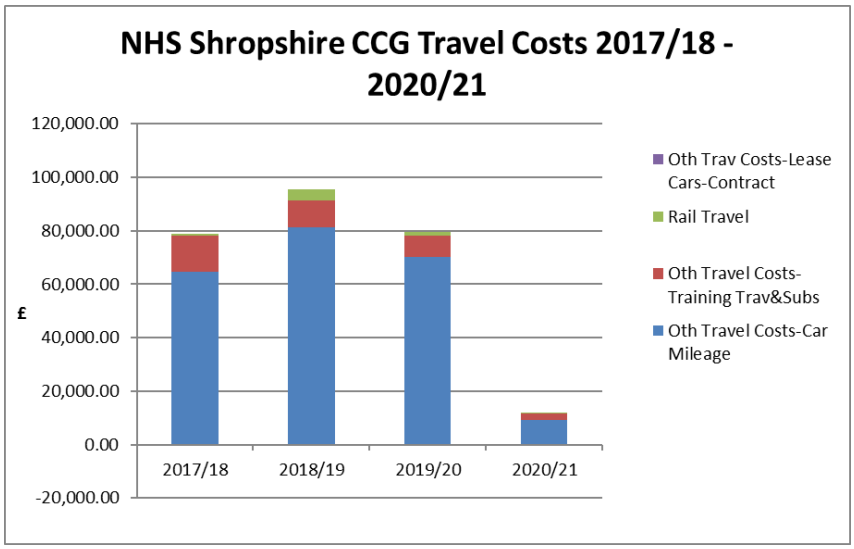
Following the transition to a single CCG from April 2021/22, staff based at William Farr House will, during quarter 1, be relocated to a smaller building where we will utilise hot desk/ agile working to utilise the space more effectively but reducing our footprint and our associated costs.



Travel

The graph below shows a very significant reduction in the amount of travel costs incurred by the CCG during 2020/21. This is due wholly to CCG staff working and meeting virtually to comply with the legal requirements to combat the COVID-19 pandemic.

This position demonstrates the contribution that virtual working has had and can continue to have on the sustainability of the CCG. The new single CCG is currently developing an agile working policy to implement in the first half of 2021/22 which will encourage staff to work from other bases including their homes using virtual technology so that some of these significant gains can be retained.



Improve quality – Care Quality Commission

The CQC gathers data from across the system into one place so professionals and the public can easily compare the performance of health and care services over a range of measures. Read more on the CQC website.

MONITORING THE QUALITY OF SERVICES

Improving the quality of services

Quality assurance principals and processes

The CCG holds the following statutory responsibilities for quality under the Health and Social Care Act, 2012:

- Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services and outcomes related to effectiveness, safety and the experience of the patient
- CCGs must work to ensure that health services are provided in an integrated way, particularly when integration would improve the quality of health services, reduce inequalities in access and reduce inequalities in outcomes
- CCGs have a duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.

As a CCG, we remain responsible for securing comprehensive services within the financial resources available to meet the needs of our population of Shropshire, Telford and Wrekin, and in doing so we must continue to assure ourselves of the quality of the services we commission during the transition arrangements to the new quality governance framework and the anticipated statutory functions of the developing Integrated Care System (ICS) arrangements.

Quality concerns and risks are reported to our monthly CCG Quality and Performance Committees in Common. The quality team holds its own risk register which is updated as required and reviewed on a quarterly basis. Any high risk is included within the corporate risk register.

The highest quality risk during 2020/21 continues to be with Shrewsbury and Telford Hospital NHS Trust (SaTH) which has a history of challenges. In the main these relate to workforce provision; A&E performance; and the pace of maternity services transformation which is at present under external scrutiny from the Ockenden Review of historic cases. Some progress has been made, with the CQC retracting regulatory conditions relating to maternity services during 2020/21. The first Ockenden report has been published in December 2022 and the trust is responding to the requirements of the findings.

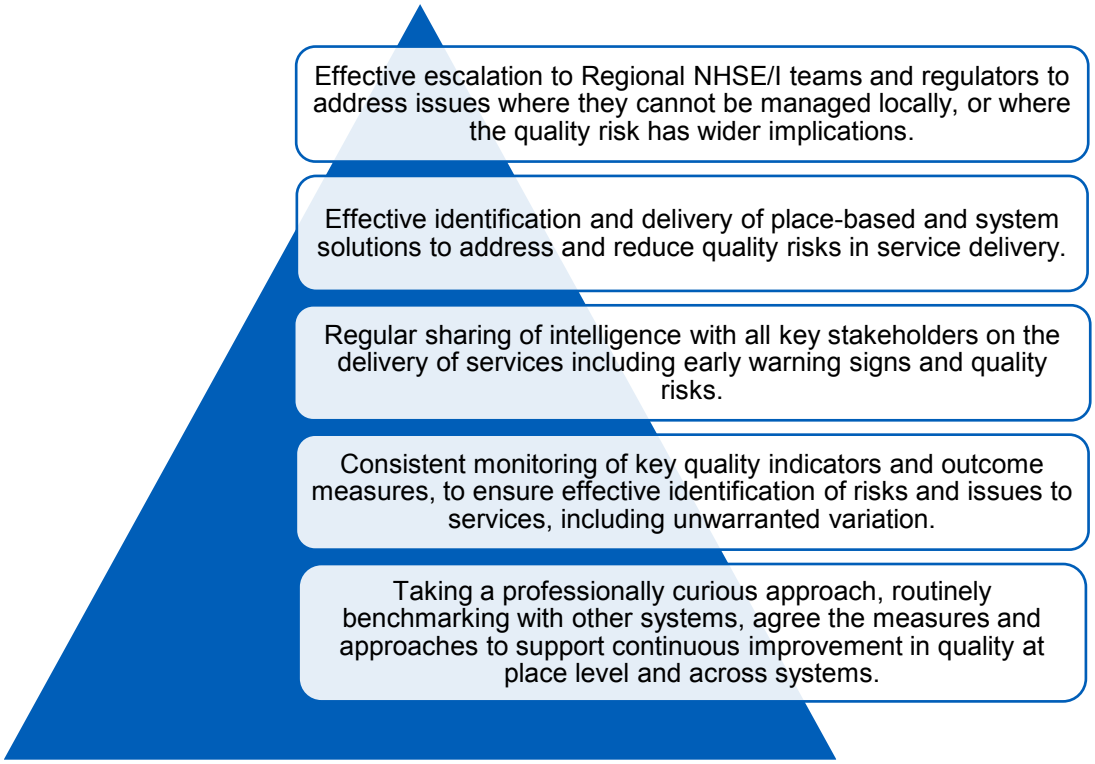
A more recent quality concern at SaTH was highlighted in the 2021 CQC inspection report into Children and Young people presenting with a mental health or learning disability. This group often present with complex health needs or social circumstances and we are working closely as a system to address the improvements needed to support our young people.

Ensuring quality in care homes and the domiciliary care home sector is equally challenging and complex. We have an important and increased role in supporting providers to deliver high quality services and improvement plans, in order to contribute to the sustainability of out of hospital care, and to keep these vulnerable groups safe.

Since the COVID-19 pandemic, we have strengthened our infection prevention and control (IPC) measures working in partnership with local authority Public Health colleagues. We work in partnership to deliver proactive and reactive IPC measures – through training, advice and other direct support, as well as maintaining an oversight role where infection outbreaks occur. Through this approach, we have fully delivered the Chief Nursing Office for England's professional mandate to actively support these care settings and protect vulnerable service-users.

ICS Quality Strategy

2021/22 will be a period of change for our system as the organisation of healthcare changes. Working as an ICS will enable us to adopt a more strategic quality assurance function through establishing robust quality governance arrangements at system level to manage quality risks and inform ongoing improvement activities, including:



Over the next two years, we are leading work through the development of a system Quality Strategy, in collaboration with our partners, which reflects the changing priorities of the new single CCG organisation from April 2021 and the plans for an ICS from April 2022. The Quality Strategy describes improved opportunity for co-production of quality improvements and partnership working at both organisational and system level, with service users and patient representatives, and enables us to ensure that improving quality is at the heart of everything we do.

The priority areas we have identified within our Quality Strategy include strengthening our system approaches to:

- **Infection prevention and control**, preventing avoidable healthcare-associated infections and building on the good work undertaken as part of the COVID-19 pandemic across our county
- **Maternity transformation** and improvement priorities
- **Learning from deaths**, including the new requirements of the LeDeR programme (learning from lives and deaths – people with a learning disability and autistic people)
- **Patient experience**, with a prime focus of co-production as a principle of shared working.

Taking a transformational approach and adopting a single shared accountability framework will enable us to demonstrate over time:

- Improved quality and safety of services for individual service users
- Better outcomes and better service user experience for our population
- Our health care system will be safe and sustainable.

Safeguarding

The safeguarding team (Designated Nurses for Children and Looked After Children, Designated Lead Professional for Adults, Named GPs) continue to offer advice, guidance, support and training across the health economy to professionals including dentists, pharmacists and GPs. As part of the development of a single CCG organisation, we have strengthened the leadership capacity and organisation of our safeguarding team. We remain as committed as ever as an equal partner within the safeguarding partnership board arrangements for both local authorities in Shropshire, Telford and Wrekin, leading and contributing to key strategic and operational workstreams.

Some of the key safeguarding risks have been:

- Reduced contact with children and vulnerable adults due to more remote working within health, social care and education since the advent of lockdown measures
- An increase in harm to babies under 12 months old, with parental stress cited as the significant factor
- Reduced training opportunities within provider organisations, due to the diversion to frontline service delivery.

Our key safeguarding activities during 2020/21 included:

- Working closely with our local authority partners to assess levels of risk and prioritise and respond to these changing needs
- Developing and implementing our training and support offer to GP practices
- Maintaining our quality monitoring of, and improvement approach to all of our providers
- Working directly with hospital trusts to review and advise on best practice approaches to assure safeguarding is robust and resilient
- Maintaining a strong focus on attending to the health requirements for Looked After Children.

As well as continuing the above areas of activity, for 2021/22 we will be maintaining a focus on:

- Enacting any changes in requirements for adult safeguarding statutory legislation, including the awaited changes to Mental Capacity Act / Deprivation of Liberty Safeguards (MCA/DOLs) and Liberty Protection Safeguards when these are published
- The Telford Independent Inquiry Child Sexual Exploitation/Abuse (IICSEA) is yet to conclude and we continue to contribute to this process.

ENGAGING PEOPLE AND COMMUNITIES

As a commissioning organisation, we have a legal duty under the National Health Service Act 2006 (as amended) to involve the public in the commissioning of services for NHS patients ("the public involvement duty"). For NHS Shropshire CCG, this duty is outlined in Section 14Z2 of the Act. To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:

a) the planning of services
b) the development and consideration of proposals for changes, which if implemented, would have an impact on services
c) decisions which, when implemented, would have an impact on services.

In meeting our statutory duty to involve, we recognise the importance and value of patient and public engagement to develop and deliver whole-scale system change through new models of service provision. The success of these models of care will be dependent in the way we interact and empower patients and the public to be involved in their own health care.

Governance and assurance

The CCG exists to set health care outcomes for the people of Shropshire, ensuring services reflect the needs of the population and holding providers to account for the delivery of safe, high quality, value for money services that improve population health, within budgetary limitations.

Our commitment

Local people can influence health and social care services across the county. This helps us to make better, more informed decisions about the services which are needed by all of our diverse local communities.

This commitment is embedded in our Constitution which sets out how it will make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting commissioning arrangements. It is available on our website.

Our priorities

- To make health and care services available when and where they are needed
- To work together with our partners to achieve the best results
- To deliver value for money and improve productivity
- To commission high quality, safe services which improve health outcomes.

Our Communications and Engagement Strategy, which can be found on our website, demonstrates how we will include patients, the public and stakeholders in our decision making to continually improve services. It also outlines how we will adhere to our statutory responsibilities to carry out effective consultation and engagement and is aligned to our equalities work programme to ensure that we work with our whole population and groups who may be underrepresented. It sets out our

principles on how we will involve and engage with patients and the public and the value that the CCG has on involvement. We have an action plan that sits with the strategy that sets out the practical actions we will undertake to deliver our strategic priorities.

The CCG has a number of committees where patient involvement is key:

- Audit Committee – Lay Member Chair
- Remuneration Committee – two Lay Members attend and one is Chair
- Primary Care Commissioning Committee – Lay Member Chair
- Quality and Performance Committee – Lay Member Chair
- Finance Committee – Lay Member
- Joint Individual Funding Committee – Lay Member Chair
- Joint Individual Funding Appeal Panel – Lay Member
- Strategic Commissioning Committee – Lay Member Chair.

The 40 member GP practices of the CCG have individual Patient Participation or Practice Patient Groups (PPGs) that work with their respective practices on issues affecting the local residents of that practice. Representatives from the PPGs meet monthly, and give feedback to the CCG on issues affecting patients and the public.

NHS England Patient and Public Engagement (PPE) Assurance Rating

Every year, NHS England conducts a review of how CCGs across the country engage with local patients and public. This forms part of the Integrated Assurance Framework by which CCGs are assessed.

The last assessment for 2019/20 was rated as ‘Green’.

Impact of participation

Throughout the year, we have undertaken a number of engagement and involvement activities where patients and the public have helped to shape decisions and services and also examples of where the CCG has acted upon feedback and experiences. Some examples are highlighted below.

You said, we did…

Patient feedback	Actions to address	Change
The local Dementia Champions are trying to work with a local practice on behalf of clients but there is a problem now they are working from home and not the practice office as they are not able to send information	The Patient Engagement Lead contacted the primary care team to highlight this feedback.	Primary care worked with the Dementia Champions and the practice. A new nhs.uk account has been set up so that information can be sent securely. This will be rolled out to

to a personal email address. Worried about the time it is taking to sort stuff out.		the other Dementia Champions.
The STP communication and engagement team wanted feedback on a letter that was part of a toolkit for healthcare professionals to use when talking about advanced care planning.	The local patient groups had shared the draft letter with its members and collected feedback from them.	Following the patient's feedback, they have acted on their suggestion and will not include the letter and have agreed that they need to have a face-to-face conversation with the patient.

Review of phlebotomy services

Background

As of September 2020, there were 508,613 people registered with GPs in Shropshire, Telford and Wrekin. The number of blood tests completed is in excess of 650,000 – which roughly equates to 1.3 blood tests for every person, every year. The CCGs worked together to review the service.

As a result of the COVID-19 pandemic, a number of short-term interventions were put in place to maintain service access. This work revealed some outstanding issues and variations in service provision that raised the profile and provided a mandate for a system-wide review.

This case for change has been captured in the completion of an equality impact assessment.

Aim and objectives of engagement

To ensure the views of service users underpin the new commissioned model of phlebotomy.

Key stakeholders were identified including patients; carers, general public, Healthwatch Shropshire and Healthwatch Telford and Wrekin, general practice, phlebotomists, clinicians, service providers and the Joint Health Overview and Scrutiny Committee (JHOSC) of Shropshire Council and Telford and Wrekin Council.

An Engagement Task and Finish Group was established, which included representation from clinicians, managers, Healthwatch, patients and commissioners to help develop the Communication and Engagement Plan. The Communication and Engagement Plan was shared with the JHOSC.

Engagement approach

There is a wealth of public health data from the Joint Strategic Needs Assessment that helped identifies the key areas for any targeted engagement. The engagement work targeted representation from:

- Protected characteristics (including people with a learning disability and mental health conditions)

- Rurality
- In the first and second most deprived decile.

Initially, there was a review of existing data which was gathered from stakeholders, public, service users and carers over the last six months, including from Patient Advice and Liaison Services (PALS) and Complaints, Friends and Family Test, plus intelligence from Healthwatch and feedback from patient groups.

An online survey was developed to form the basis of the engagement. There were a number of multiple choice options to enable analysis and options for free text. In addition, patients could choose to complete the Equality Monitoring form which provides further data and helps the CCGs to monitor the reach into the seldom-heard and protected characteristics groups.

Alongside the online survey, we promoted the offer of paper surveys to be posted out to people who were not able to access digital technology. These were sent back via a Freepost address and collected safely by the team. Those that were not comfortable receiving paper copies, were invited to telephone the CCGs where a call handler was able to complete the online survey on their behalf.

The CCGs also introduced the use of a QR (Quick Response) code, which could be used by smart phones, by scanning the code which took them directly to the online survey.

The survey was open for four weeks initially. The Engagement Task and Finish Group reviewed the data that had been collected during this period. Following discussion, it was agreed to extend the survey for another three weeks to enable more targeted promotion to elicit further views.

In addition to the survey, a number of focus groups were established to enable a free discussion around the phlebotomy service. People who used the service on a regular basis were targeted, including a local respiratory group and diabetes support group. A checklist was developed to ensure consistent information. Whilst there will be limitations in the analysis that can be completed, this will provide qualitative information to the final report. However, where this is normally done in a face-to-face manner, they were conducted virtually due to the COVID-19 limitations.

Running alongside the public engagement, surveys were designed to gain the views of the providers who use and/or refer into the service. It included GPs, senior nurses, healthcare assistants, primary care practice managers, consultants and allied health professionals. A focus group was also held with phlebotomists.

Communication

A comprehensive promotional programme was developed to ensure effective communication including a press release, social media, posters, website and newsletter copy, and targeted emails to support groups.

Feedback

Following the period of engagement, a report was written and will be presented to the Steering Group so that they have information to be able to develop the options for the phlebotomy service.

Encouraging uptake of the COVID-19 vaccine

In December 2020, the national rollout of the COVID-19 vaccination started with the creation of various vaccination centres across the county. Although take-up of the vaccination has increased over the months, data and feedback showed that there were communities where uptake was very low.

A system-wide equalities group including the CCG, local authorities, community leaders, health professionals and equality and inclusion leads came together to share information and facilitate engagement on increasing uptake.

A communications and engagement plan was developed and following feedback and agreement with communities and community leaders a number of toolkits were developed to help address some of the concerns, worries and questions that had been fed back.

- We have been working with local businesses with a high proportion of Eastern European employees to circulate key messages about the COVID-19 vaccine to their workforces and we are organising on site engagement sessions and/or vaccination sessions where appropriate.
- Engaged with the two main organisations supporting Eastern Europeans living in Shropshire, Telford and Wrekin. Questions were submitted by members of the communities and community leaders have participated in Q&A videos with clinicians and recorded talking about their experience of having the vaccine. These have been shared with through the community communication channels.
- Information and videos in different languages have been produced with clinicians and have been shared through social media and across the ICS.
- We have worked with community leaders and faith leaders to gather insight, create resources and channel key messages about the vaccination programme.

In addition to this using guidance from national sources we have adapted information for people with learning disabilities and those with sensory impairment. Our toolkits include:

- Care sector toolkit
- Bulgarian Language toolkit
- Businesses toolkit
- Eastern European Communities Toolkit
- COVID-19 toolkit for seldom-heard groups
- COVID-19video for seldom heard groups
- Large print version of COVID-19 information.

The Equalities Group continues to meet, to look at data, feed back and work with local communities.

Single strategic commissioning organisation

The NHS is undergoing a major transformation following the publication of the NHS Long Term Plan and future vision of integrated care systems.

Following a decision to have one strategic commissioning organisation within the Shropshire, Telford and Wrekin Sustainability and Transformation Partnership (STP), the CCGs developed a Communication and Engagement Plan, to aid with the transition to a single strategic commissioning organisation. The plan is available on our website.

During 2019/20, the first engagement event was held with stakeholders in Shrewsbury and was well attended.

During 2020/21, there has been continual engagement with the Governing Body, GP practice membership, executive team and staff. In addition a further two stakeholder events have been held, supported by NHS Midlands and Lancashire Commissioning Support Unit.

The second event held in December 2020 invited patients, carers, Patient Participation Group members, support organisations, Healthwatch Shropshire and Healthwatch Telford and Wrekin to attend a virtual event.

Using pre-recorded videos and breakout rooms, delegates were invited to take part in small, facilitated discussions following videos notes were made by the facilitators. Following this session, delegates were then invited to move into a larger meeting with other delegates to take part in a question and answer session. After the event, a feedback report was produced by MLCSU. The report was shared with the directors of the CCGs to provide responses to the questions raised to feedback to participants.

In March 2021, delegates who had already attended the first and second events were invited to a virtual event where they could listen to presentations from directors on the patients' voice, structure and implementation and partnership working.

Engagement using technology

During the COVID-19 pandemic, the CCGs have not been able to engage in the normal way by having face-to-face meetings or drop-in events. As organisations started to become aware of and use technology, there were more opportunities to join in conversations virtually with established groups.

Although this was challenging at first, it has highlighted that by increasing the use of technology, we can reach further into our communities.

Patient feedback and relevant data

We use a number of differently sourced pieces of information to help triangulate our understanding of patient experience of the health services we commission.

The primary data source we use for population health is the Joint Strategic Needs Assessment (JSNA) – a statutory process undertaken by Shropshire Council to inform the development of priorities across the county.

The process brings together and explores a wide range of data, performance information and intelligence to identify those issues where the county is doing well and also those which remain a challenge and where more needs to be done.

This data is used by CCG commissioners to begin service redesign projects and to help determine what services we need for our local population. The communications and engagement team also consider this information when stakeholder mapping for specific engagement and consultation projects.

The JSNA is not one single document – individual parts of the JSNA can be found on Shropshire Council's facts and figures webpage.

In addition to this, the CCGs also have the following information on specific services:

- Complaints and PALS queries made to the CCGs and to its providers which can highlight trends
- Quality and commissioning teams also gather information from quality and contracting meetings with our providers on patient experience and quality issues
- Surveys of GP patients and other services we commission
- NHS Friends and Family test outcomes by provider
- Information received via Healthwatch Shropshire and CQC reports.

How we reach diverse and potentially excluded groups

When identifying stakeholders for engagement, we are sure to seek out the 'seldom-heard'. We look at the nine protected characteristics outlined in the Equalities Act 2010, plus carers, people who suffer from a mental health problem or addiction and those who are socioeconomically deprived.

To support development of commissioning plans and decision making, it is essential that engagement and communication methods consider the needs of people with a protected characteristic and enables them to participate. An example of how practical engagement delivery is designed to meet the needs of our diverse population is the engagement that was done for the review of the phlebotomy service. It was established from current data that most patients at some time will have had blood taken for analysis and therefore we needed an approach that met the needs of our population.

Using active members of the communities, we targeted emails to groups within our ethnic communities. Patients who accessed support for substance misuse were offered the opportunity to join a focus group. Patients whose first language is Polish were also offered the opportunity to attend a focus group supported by a local translator.

These examples undertaken in the year have enabled progress to be achieved in line with our equalities objective 1, where we are 'Improving lives of local people and patients'.

Working with partner organisations

Throughout the county, there is a myriad of patients groups and voluntary organisations supporting people. It has been difficult to visit the groups during the COVID-19 pandemic, but we continue to send out regular updates on the pandemic to the groups known to us as well as a number of engagement opportunities.

Examples include:

- Virtual meetings with Shropshire Patient Group and Healthwatch Shropshire keeping them updated with the progress on the pandemic
- Members from both Shropshire Patient Group and Telford Patients First Group being part of the Engagement Task and Finish Group for the phlebotomy service review
- Drop-in to the 'virtual' monthly meetings with the local respiratory and diabetes groups to discuss their experience of using the phlebotomy services.

How we involve patients and the public

Our engagement with patients and the public is vital to our work. We use a range of communications channels to communicate to keep patients and the public informed such as:

- News releases
- Website
- Newspaper columns
- Radio adverts
- Website updates
- Posters and leaflets in GP practices and community venues
- Social media, for example Facebook and Twitter
- Sending event attendees reports of the outcomes
- For some projects, newsletters and direct communication
- Individual phone calls and emails to people who have been involved
- The Shropshire Patient Group help communicate messages to individual Patient Participation Groups.

Enabling and supporting those patients and the public who wish to get involved

For patients and members of the public who have an interest in being actively involved with the CCG, they are offered informal discussions to find their area of interest.

For those patients who prefer to sit on a working group or steering group as part of a procurement or service redesign process, they will be offered an initial briefing together with ongoing support at those meetings, until they feel comfortable to attend on their own.

The CCG's reading group has been supported and involved in checking any documents the CCG produces that will be public-facing.

Learning and best practice

During our experience of engaging, involving and consulting with patients, carers and the general public in 2020, we have made contact with a number of groups and individuals which will help future engagement. The CCGs' communication and engagement staff also have a more detailed understanding of the processes and delivery methods that work with different groups of people to illicit a response that can be used to design improved engagement in the future.

Future plans

The coming year will continue to bring new opportunities for the communication and engagement team. Our priorities will focus on:

- Engaging and informing patients, as we move to a single strategic commissioning organisation
- Working with Healthwatch Shropshire and Healthwatch Telford and Wrekin to ensure that local residents are fully engaged with Shropshire, Telford and Wrekin's transformation of health and care services
- More integrated working with our communication and engagement colleagues across our Strategic Transformation Partnership (STP) area to share knowledge and expertise
- Supporting neighbourhood initiatives to build local networks as a key enabler for the CCG's self-care and management of long term conditions projects
- Enhancing our relationships with seldom-heard groups that make up the nine protected characteristics in our area and building new ones
- Delivering engagement forums, workshops, focus groups, commissioning intentions events and the CCG's Annual General Meeting.

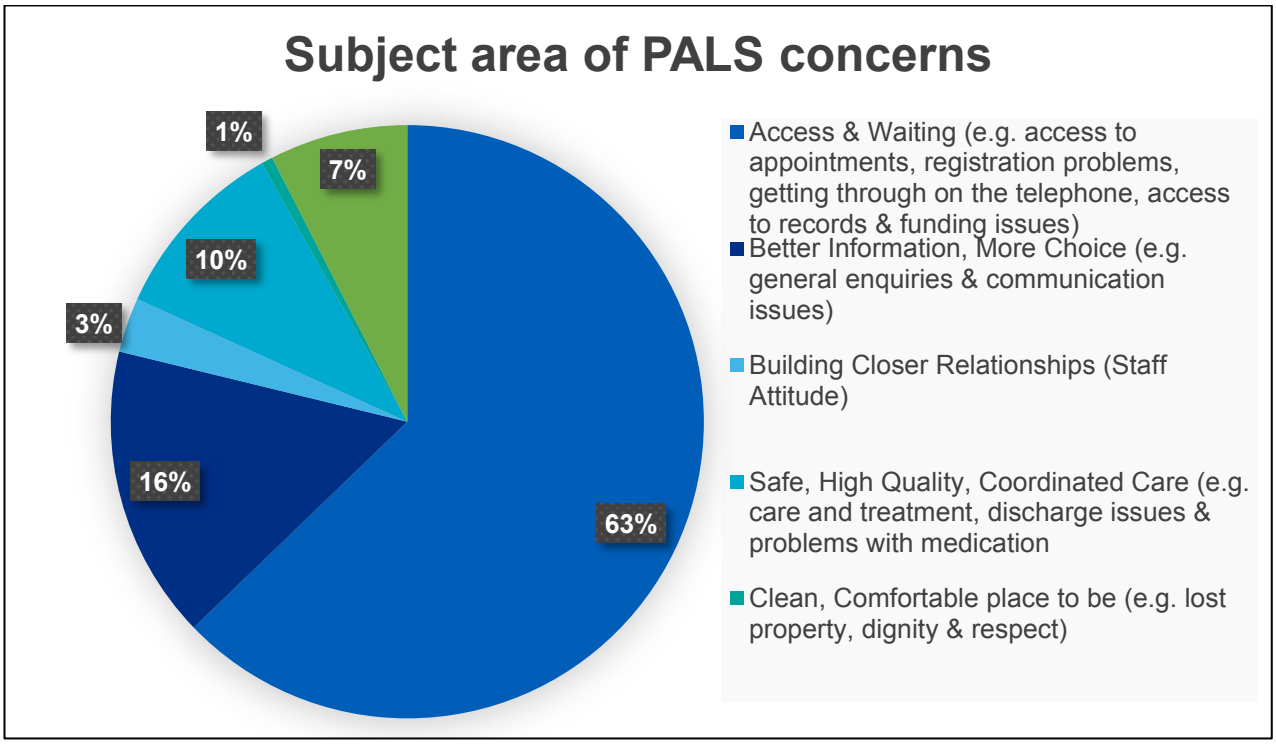
Patient Advice and Liaison Services (PALS)

PALS is integral to Shropshire CCG's commitment to working closely with patients and staff to improve services. It is an informal and impartial way to resolve the concerns of patients, relatives, carers, and members of the public.

The service is intermediary and a useful source of information, often signposting people to the healthcare they need. All enquiries received through PALS are recorded on a database and used to improve services.

During 2020/21, 637 contacts were received through PALS. This is a significant increase on the 340 enquiries received in 2019/20, and is largely as a result of COVID-related concerns.

The chart below illustrates the 'domains of patient experience' that the PALS enquiries received during 2020/21 related to.



More than half the queries received related to COVID-19. These ranged from queries about getting tested, to concerns about infection prevention and control, and shielding letters. During the last four months of the financial year, in the region of 200 contacts have related to the COVID-19 vaccination programme.

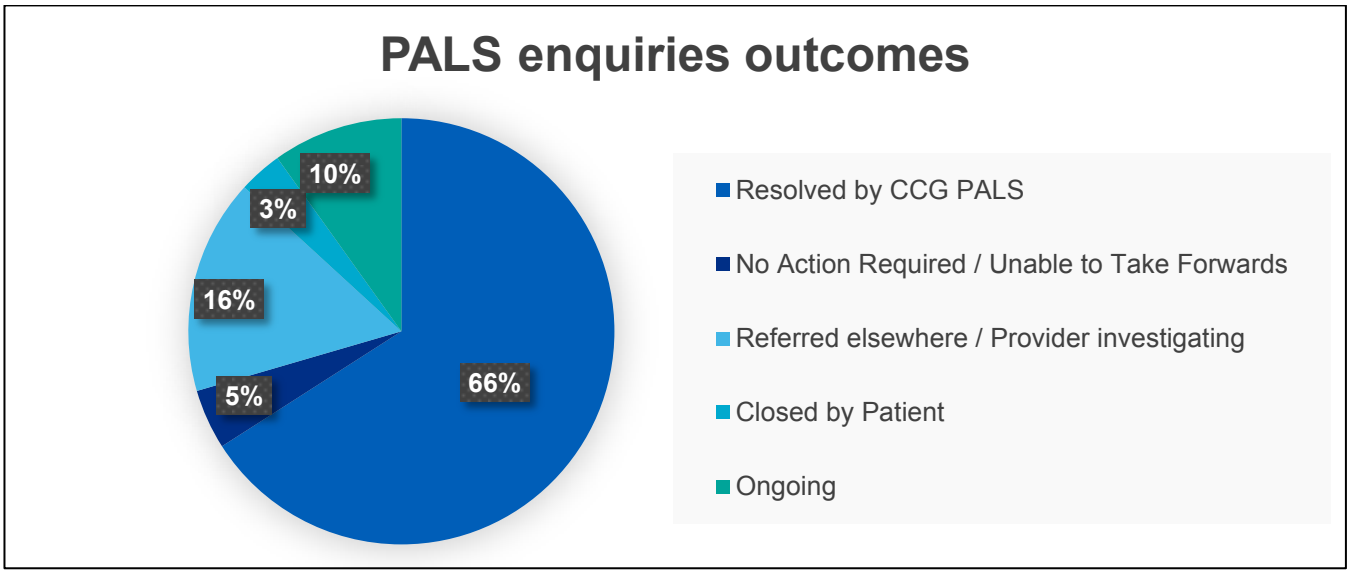
The majority of primary care enquiries concerned GP practices, largely about access to services including COVID-19 and flu vaccines in addition to queries about options for registering as a new patient.

For hospital services, the highest percentage of queries were about access to appointments and included delays with dates for surgery and routine review appointments. The vast majority of delays were caused by the impact of COVID-19.

Nearly half of the enquiries about CCG services related to the Prescription Ordering Department. These included callers having problems getting through to the service, due to the surge in demand from patients who were no longer able to submit their prescription request in person at their GP practice due to COVID-19 restrictions.

The remaining queries covered ambulance, community, mental health and out of hours/111 services, with no more than a dozen enquiries for each of these services.

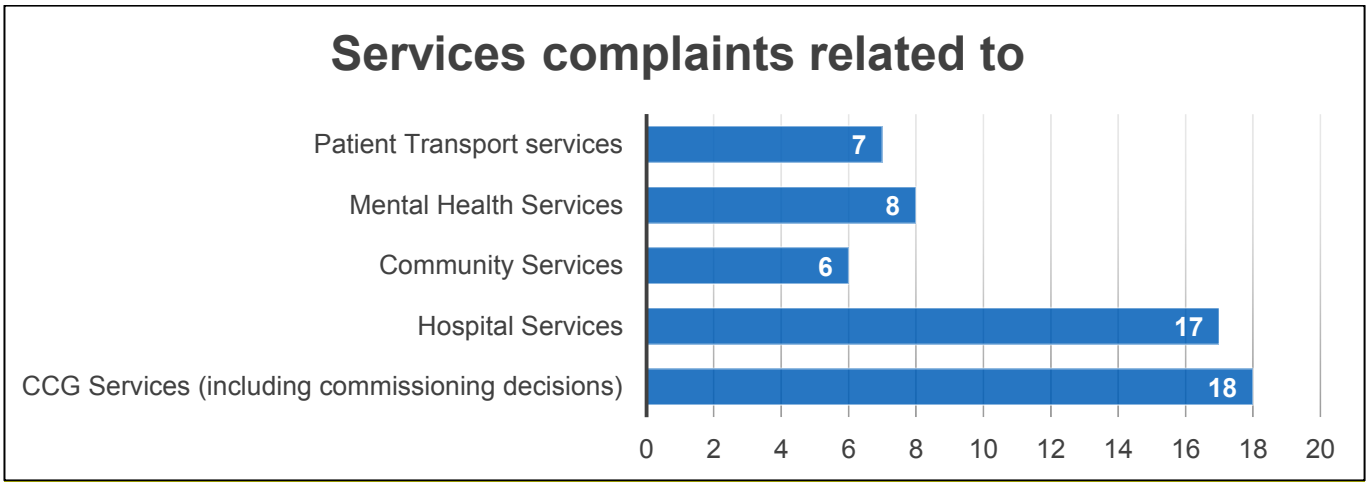
The chart below shows what happened with the queries and concerns received by PALS, noting that a relatively small percentage were referred to other organisations whilst the vast majority were resolved within the CCG.



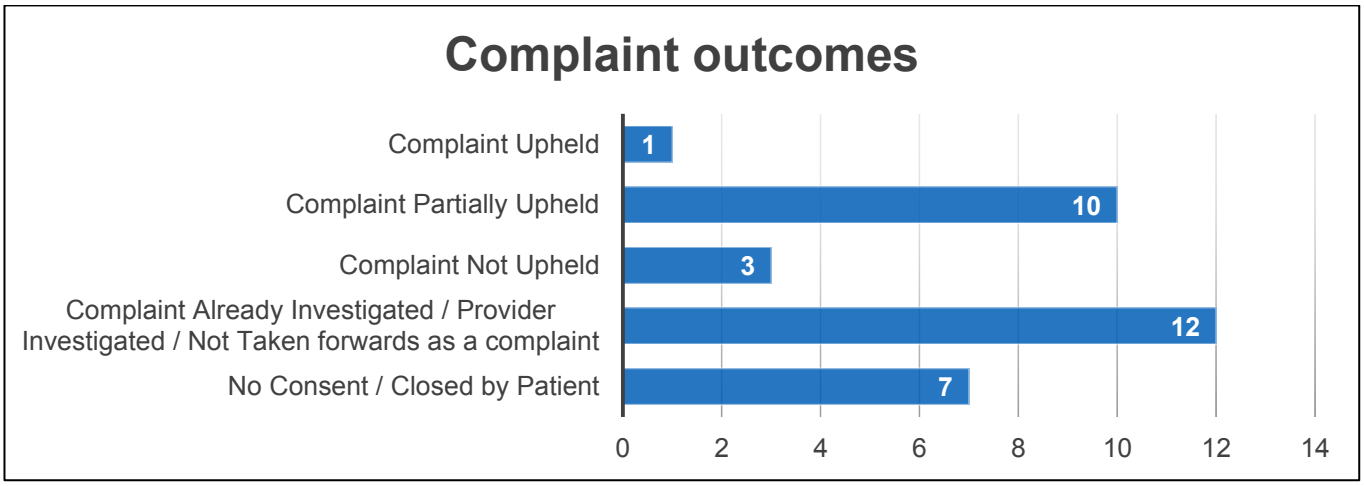
Complaints

During 2020/21, Shropshire CCG received 56 complaints – a significant decrease on the 127 complaints received the previous year. This is thought to be partly due to resolution of concerns informally through PALS (hence the increase in those types of cases) and partly due to the public's awareness of the challenges faced as a result of the COVID-19 pandemic.

As shown in the graph below, in addition to complaints made about the CCG itself, many of the complaints relate to providers of services commissioned by the CCG.



Of the 56 complaints received, 24 are ongoing. The graph below shows the outcomes for complaints where the process has been completed during 2020/21:



Ombudsman

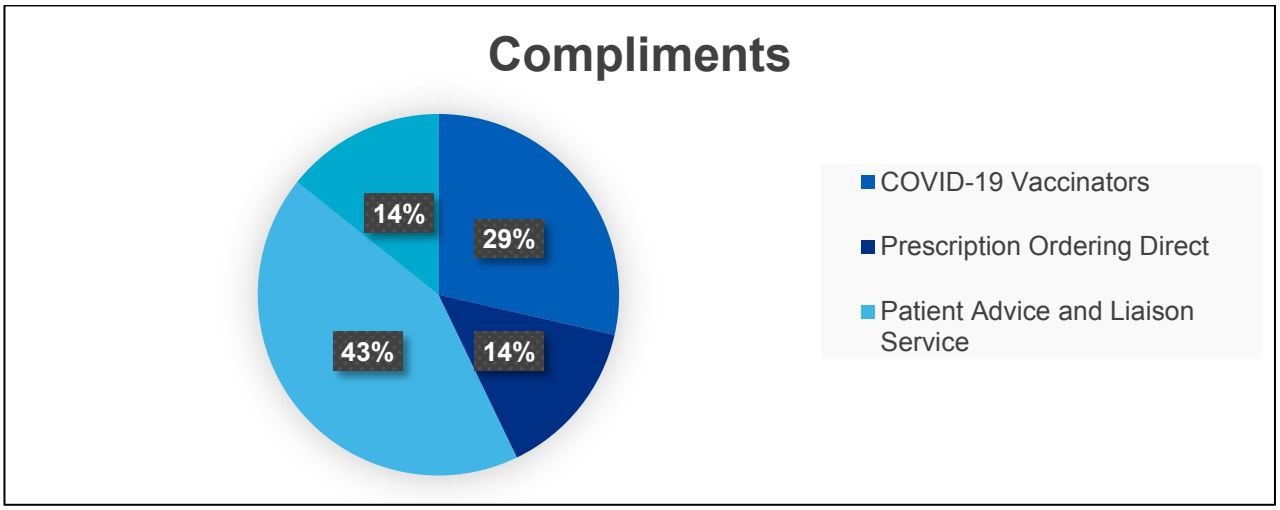
The public have the right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) for review if they are not satisfied with the CCG's response. There was only one Shropshire CCG case investigated by the PHSO of a complaint made to a caring organisation during 2020/21. This involved the care of a patient provided by a company that no longer exists, but at the time had been commissioned by the CCG. The complaint was partially upheld by the Ombudsman but because the company was no longer trading the Ombudsman sent the report to the CCG for noting as the recommendations could no longer be enacted.

MP letters

During 2020/21, Shropshire CCG received 41 letters or emails from local Members of Parliament (MPs) relating to the healthcare of constituents. More than half of these cases were related to COVID-19, including queries and concerns about personal protective equipment (PPE), testing, shielding letters and vaccinations.

Compliments

In addition to dealing with complaints, concerns and enquiries, the CCG also receives positive feedback in the form of compliments. Other than the COVID-19 vaccinators, the other services in the chart below are the areas within the CCG where there is regular contact with members of the public.



An important part of the complaints and PALS process is that lessons are learned and improvements made to services based on feedback received from individuals. Below are examples of where changes have been made to services following patients providing feedback to the CCG:

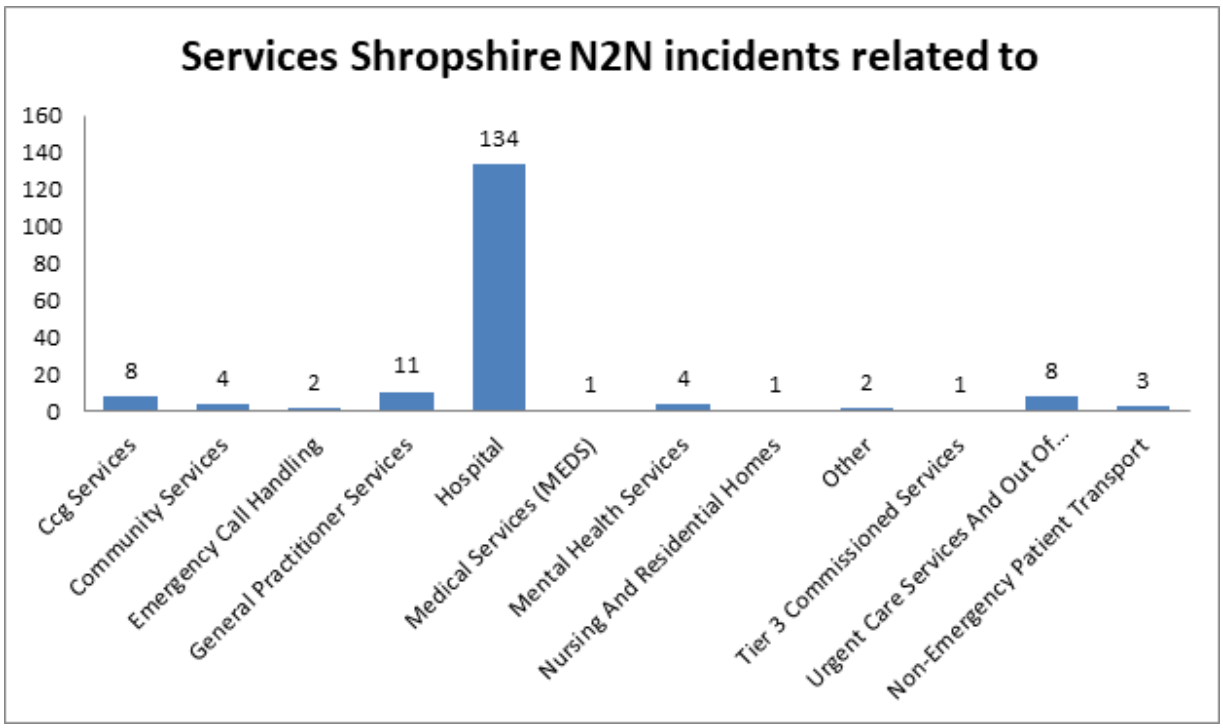
- Following the emergence of COVID-19, the Prescription Ordering Department (POD) service experienced a six-fold increase in the number of calls received. This resulted in long delays for patients trying to order their medication. Staff from other parts of the CCG were redeployed and trained to help deal with calls. In addition, an email address was created so patients had an alternative method for placing an order. This helped ensure that the most urgent requests were dealt with promptly, and gave patients greater flexibility in how they could order their medication.
- A patient complained about their experience in A&E, where they were left alone in a bay for two hours despite alarms sounding due to their rapid pulse and low blood pressure. The hospital apologised for the patient's experience and provided details of changes made as a result including an increased level of senior staff present to support staff and patients. Additional regularly documented patient safety checks have been put in place to identify and rectify concerns without delay.
- Concerns were raised by residents about a recovery house (for people with mental health needs who have left hospital) about the quality of care provided. The concerns were investigated and an action plan was developed involving residents, staff and the CCG. This resulted in a more focussed approach to supporting residents' needs, their recovery and development.

NHS to NHS concerns

This process gives NHS organisations the opportunity to identify and feedback where there are concerns relating to patient care delivered by NHS commissioned healthcare providers. It also allows the CCG to identify any trends relating to specific areas or departments, and to take appropriate actions as required.

During 2020/21, Shropshire CCG received a total of 179 NHS to NHS concerns.

The table below illustrates a breakdown of the areas these concerns related to:



Below are examples where the incidents raised have led to improvements in services:

- Discharge issues about SaTH have led to work being commenced on a trust-wide thematic review. A task and finish group has also been set up with local health and social care providers, to see how improvements can be made. Updates to documentation have already been made as part of this work
- A GP practice has changed their process so that calls relating to a request for complex wound management will be put through to a practice nurse to ensure the services can be delivered
- It has been agreed that when a consultant is adding an addendum to a report, this must be telephoned through to the relevant clinical team for awareness.

EQUALITY, DIVERSITY AND HUMAN RIGHTS REPORT

We believe that equality and inclusion include addressing health inequalities and should be embedded into all commissioning activity. It is our overriding aim to provide equality of opportunity to all our patients, their families and carers, and to proactively attempt to eliminate discrimination of any kind to the services we commission (buy).

We are keen to involve local people in the continuing development and monitoring of this aim to ensure that we commission the right health care services, provide well-trained staff to deliver and ensure our providers meet the equality duties set out in the Equality Act 2010.

Under the Equality Act 2010 and the Public Sector General Equality Duty, organisations must publish sufficient information to demonstrate that, in the exercise of its functions, it has a due regard to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a relevant protected characteristic and those who do not.

To help monitor how the NHS was working towards these functions, the NHS Equality Delivery System (EDS2) was launched in November 2013. It is a toolkit designed to help NHS organisations and staff review their performance for people with characteristics protected by the Equality Act 2010 and identify how improvements may be made.

The nine protected characteristics are as follows:

1. Age
2. Disability
3. Gender re-assignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race including nationality and ethnic origin
7. Religion or belief
8. Sex
9. Sexual orientation.

EDS2 can also be applied to people from other disadvantaged groups who may experience difficulties in accessing NHS services, including people who are homeless or live in poverty, those who are long-term unemployed, people in stigmatised occupations, drug users, and people with limited family or social networks or who are geographically isolated.

Organisations score themselves against the four main goals. More information on the scoring mechanisms is available on NHS England's website.

The results of the CCG assessment can be found on our website.

We have continued to rate ourselves as 'developing' across most goals. We recognise that to progress from this level, we need to understand the needs of individuals accessing healthcare services and ensure we can evidence how we have acted to promote equalities.

We utilise some key processes to help us understand in more detail how different groups access healthcare. A key source of information is the Joint Strategic Needs Assessment (JSNA) for the resident population of the CCG, which analyses the health needs of the population of the area. The JSNA informs and guides commissioning of health, wellbeing and social care services to improve health and wellbeing and reduce inequalities. The JSNA informs the Joint Health and Wellbeing Strategy.

The JSNA is available on Shropshire Council's website.

We utilise the standard NHS Contract which places a requirement on providers to ensure that they consider the needs of individuals in the delivery of their services, including disability access and equity of access. Providers who bid for NHS services through our procurement processes are required to demonstrate compliance with the Equality Act 2010 and the Human Rights Act 1998. We expect providers to clearly demonstrate the ability to make reasonable adjustments when accessing their services. This is monitored as part of the contract monitoring process. To improve our developing rating, we intend to work more with providers on their recording and reporting of protected characteristics.

We have made targeted efforts to engage with groups who make up, some or all, the nine protected characteristics this year, particularly but not exclusively around COVID-19. These include:

- The Polish community has received information in Polish to share with patients about the spread of COVID-19
- The Shropshire, Telford and Wrekin Equality, Diversity and Inclusion Group has worked with the STP to help develop information about the COVID vaccine
- A COVID-19 vaccination communications toolkit has been sent to groups in the ethnic communities and supporting the nine protected characteristics. This includes posters in various languages and videos
- The CCGs' new Joint Governing Bodies now have a jointly-appointed Patient and Public Involvement Lay Member for Equality, Diversity and Inclusion
- As part of ensuring we are hearing our population's views of their needs, we continued to engage with pregnant women and new mothers as part of redesigning future services for the midwife-led units and the local maternity services (LMS) as a whole. To enable new mothers and their partners to attend, we continue to facilitate meetings where young children can come along and play, whilst the parents take part in discussions. With the help of our local authority and community health trust partners, we also identified several groups for parents and toddlers in specific areas where transport was an issue and visited the groups to talk with the members. Shropshire, Telford and Wrekin Maternity Voices Partnership continues to use social media to enable a wider group of women, partners and families to get involved. In addition, several face-to-face groups have also been established locally. It had been identified the previous year that we needed to improve engagement with local Asian women's support group, the local Polish community and the local traveller community where discussions took place with women and their partners around maternity experiences and redesign of maternity services.
- We continue to record equality monitoring data as part of our complaints function. From this monitoring, we have deduced that most complainants are White British and heterosexual, which would require us to explore why other groups are not utilising the complaint process. Further work will be done with groups representing the nine protected characteristics during 2020/21.
- We continue to ensure we are reinforcing the Accessible Information Standard via a staff policy to help ensure that those people suffering from a visual or sensory impairment are able to specify how we will communicate with them about their medical treatment. The policy is available on our website.

As we transition into a single CCG on 1 April 2021, we will continue to build on our aim to make strong links with those groups that make up the nine protected characteristics and other groups include people suffering from mental health problems and substance misuse.

We require all provider contracts to contain equality and diversity clauses, notably as per Service Condition 13 of the NHS Contract. This applies to all the nine protected characteristics.

Compliance with this service condition is monitored as part of routine quality monitoring of each contract. Under Service Condition 13, providers must comply with equality legislation. That is, they must not discriminate on grounds of protected characteristics, must provide assistance and make reasonable adjustments where service users, carers and legal guardians do not speak English, or where they have communication difficulties. They must also provide a plan to show compliance with the legislation.

Quality monitoring of patient experience reports from providers is also undertaken to identify themes and trends, and ensure actions are put in place.

We normally record equality monitoring data as part of the complaints function but this has been delayed due to the capacity issues arising from redeployment of staff due to COVID-19. We plan to resume this recording for the new financial year 2021/22.

Under the EDS2 Equality performance toolkit, we are required to set our self-equality objectives at least every four years. Our objectives are:

- To improve lives of local people and patients
- Inclusive leadership and a representative and supported workforce.

Workplace Race Equality Standard requires us to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Our current workforce representativeness of ethnicity is 2.04 per cent as shown below. This can be compared to an ethnic minority percentage of 2.01 per cent in the Shropshire population. Population information is based upon JSNA information on Shropshire Council's website.

Shropshire CCG percentage of staff by pay band and ethnicity as at 31 March 2020 (collected annually in July for previous year)

Pay band	White	BME	Unknown / Not Stated	Average total
Apprentice	0	0	0	0
Band 2	1.53%	0	0	100.00%
Band 3	20.40%	0	1.02%	100.00%
Band 4	8.67%	0	0	100.00%
Band 5	12.24%	0.51%	1.02%	100.00%
Band 6	12.75%	0	0	100.00%

Band 7	8.69%	0.51%	0.51%	100.00%
Band 8 - Range A	8.18%	0.51%	0.51%	100.00%
Band 8 - Range B	3.57%	0	0	100.00%
Band 8 - Range C	2.04%	0	0	100.00%
Band 8 - Range D	1.02%	0	0	100.00%
Band 9	1.02%	0	0	100.00%
Very Senior Managers (VSM)	13.77%	0.51%	1.02%	100.00%
Grand total	**93.88**	**2.04%**	**4.08%**	**100.00%**

Our self-certification statements can be found on our website.

Based upon our analysis of its Workforce Race Equality Standard (WRES) data, we have identified key actions which can be found in our action plan on our website.

We undertook a full data cleanse of the ethnicity information we hold on all our staff and Board members in February 2018, so both actions have now been completed.

We recognise that unfair discrimination is unacceptable and, in this respect, we have made a statement of policy on equal opportunities in employment through our Equality and Diversity Policy. This ensures that no potential or actual employee receives less favourable treatment on the grounds of age, disability, sex, sexual orientation, race colour, nationality, religion or belief, national or ethnic origins, gender reassignment, pregnancy or maternity, marriage or civil partnership, or trade union membership.

In our policy on equal opportunities, we recognise that everyone in the organisation has a role in ensuring fairness towards people with any disability. Emphasis will be placed on the individual's ability, rather than disability, and we will endeavour to support disabled employees and prospective employees in the workplace with reasonable adjustments.

We remain committed to ensuring that staff receive up-to-date and relevant equalities and inclusion training, which is described in the Equality and Inclusion Report above. This is further supported by our Equalities and Diversity Policy, which sets out our vision that all employees should follow.

HEALTH AND WELLBEING STRATEGY

Health and Wellbeing Boards are an important feature of the reforms brought about by the Health and Social Care Act 2012.

The Health and Wellbeing Board acts to ensure that key leaders from the health and care system work together to improve the health and wellbeing of its residents. Health and Wellbeing Board members collaborate to understand their local community's needs, agree priorities and work together to plan how best to deliver services as well as promoting integrated working among local providers.

The Health and Wellbeing Boards receive regular updates from the CCG about programme of work designed to deliver against the priorities within the strategies.

Shropshire Health and Wellbeing Board

Shropshire Health and Wellbeing Strategy is due to be refreshed in 2021.

The current priorities are:

- Prevention and self-care promotion
- Promoting independence at home
- Promoting easy to access to access and joined up care.

With the three development projects of: mental health, healthy weight and diabetes prevention and Carers. During 2021, Shropshire CCG received reports in relation to the Shropshire Care Closer to Home Programme which aimed to provide joined up care in patient homes following a case management approach as well as a report on the Better Care Fund, and the schemes of work funded through this to assist in achieving the aims of the Health and Wellbeing Board.

Other reports have detailed the CCG leadership in the restore and recovery phases of the local response to the pandemic, updates relating to the mental health transformation around trauma informed care and how the system was responding to the increased demands of winter pressures through joined-up schemes and plans.

REDUCING HEALTH INEQUALITIES

The CCG has a duty under Section 14T of the Health and Social Care Act 2012 to reduce inequalities. This will be discharged during the planning and redesign of services through the use of equality impact assessments. The duty to deliver services with due regard to reducing inequalities forms part of the standard NHS Contract with all providers.

The impact of COVID-19 has been particularly detrimental on people living in areas of greatest deprivation, on people from ethnic communities, older people, men, those who are obese and who have other long-term health conditions, people with a learning disability and other inclusion health groups, those with a severe mental illness and those in certain occupations. [1]

The local and national response to the impact of COVID-19 in the first few months of 2020 was planned and delivered as an emergency response to the pandemic.

As part of this, Shropshire CCG worked with service providers to complete equality impact assessments to identify sectors of the community that may be impacted upon by immediate stepping down of services and consider how these could be addressed. An example of this is the work undertaken to identify high-risk, vulnerable patients who required ongoing primary care services. Primary care and community nurses from Shropshire Community Health NHS Trust worked in collaboration to deliver essential services such as home visiting for urgent needs.

In August 2020, there was national guidance shared that CCGs need to address the health inequalities that had widened over the pandemic by developing and implementing an eight-point plan:

Protect the most vulnerable from COVID	**Restore NHS services inclusively**	**Digitally-enabled care pathways**	**Accelerate preventative programmes for at-risk groups**
Support those who suffer mental ill-health	**Strengthen leadership and accountability**	**Ensure datasets are complete and timely**	**Collaborate locally in planning and delivering action**

Working with partners across the system, Telford and Wrekin CCG and Shropshire CCG have begun working across these eight areas, and will continue to do so across the forthcoming year.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

The below tables indicate an assessment of the work being carried out across the eight areas.

Achievements

Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Collaboration and delivery with voluntary community and social enterprise (VCSE) on a robust support offer for clinically extremely vulnerable (CEV) and other vulnerable groups Established robust system links with care sector and	Cancer and maternity care and support plans Restored Diagnostics Restored Immunisations Cancer Living Well (LW) passports Individual services across providers have used clinical information available to	System has developed at pace digitally-enabled pathways in primary care Telephone appointments Digital outpatients Digital cancer appointments Online	Social prescribing Healthy weight strategies Blood pressure at home monitoring Health checks for people with learning disabilities Food insecurity	24/7 access line Crisis support Sanctuary Suicide prevention Bereavement offer TogetherAll online support Social prescribin	All key organisations have named board level health inequalities lead	Provider organisations commenced work on importance of ethnicity data collection COVID expansion funding used to support primary care with	SEND Board Integrated place partnerships (SHIPP and TWIPP) Joint delivery of local vaccination programme Vaccinati

businesses Joint working primary care and Shropshire Community Health NHS Trust identification and targeting of CEV patients including care home residents	target those at higher risk Some organisations have commenced monitoring of health inequalities data	mental health support Worked with local Healthwatch to review impact of switch to digital	programmes Children and young people mental health support through schools Trauma informed work	g Delivery with VCSE		ethnicity data coding Available data being used to assist with COVID vaccination	ng the homeless Delivery with VCSE

Areas outstanding for 2021/22

Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Continuation of activities to date Prioritisation of COVID vaccination programme	Routine and coordinated data collection across the system	Review impacts on accessibility regarding digital pathways including reviewing recommendations of Healthwatch survey on digital inclusion Cross-system methodology for data collection and analysis	Community development at place Continue roll out of trauma informed work Developing diabetes population health management programme	Implementation of non-clinical approaches to supporting people in crisis Primary care local enhanced service Access to psychological therapies and support	Regular reporting on progress to identify areas for further intervention either at an individual provider level or as a system	Continuation of progress to date to improve collection of ethnicity data to assist with service planning and monitoring	Implement agreed ICS principles Coordination of data collection and reporting Create whole system understanding of inequalities and local response Transformation plans Continued delivery of place-based priorities Population

							health management – decision support unit

Plans for delivering outstanding commitments. Delivery through:

Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Continuation of targeted vaccination, including engagement with ethnic minorities and other at-risk groups Vaccination Delivery and Inequalities Group	Develop and implement system monitoring and evaluation of outcomes To be led by CCG performance team	Develop consistent approach to evaluate impact of change of delivery mode Digital Enablement Group (includes clinical input) and Business Intelligence (BI) Group	To embed agreed principles in all restorative and transformation planning Two Place Boards (SHIPP and TWIPP) Programme boards for six big ticket items	Mental health transformation plans Dual diagnosis steering group Primary care / PCNs Voluntary sector is a key partner Learning disability and autism and local maternity system programme boards	Requirement to report to ICS Board progress across the key eight Embed key eight in all six key focus areas	To form part of regular reporting to ICS board as part of action against the key eight	Health and Wellbeing Strategies Place partnerships PCNs Transformation programmes Six big ticket items

Key learning to date

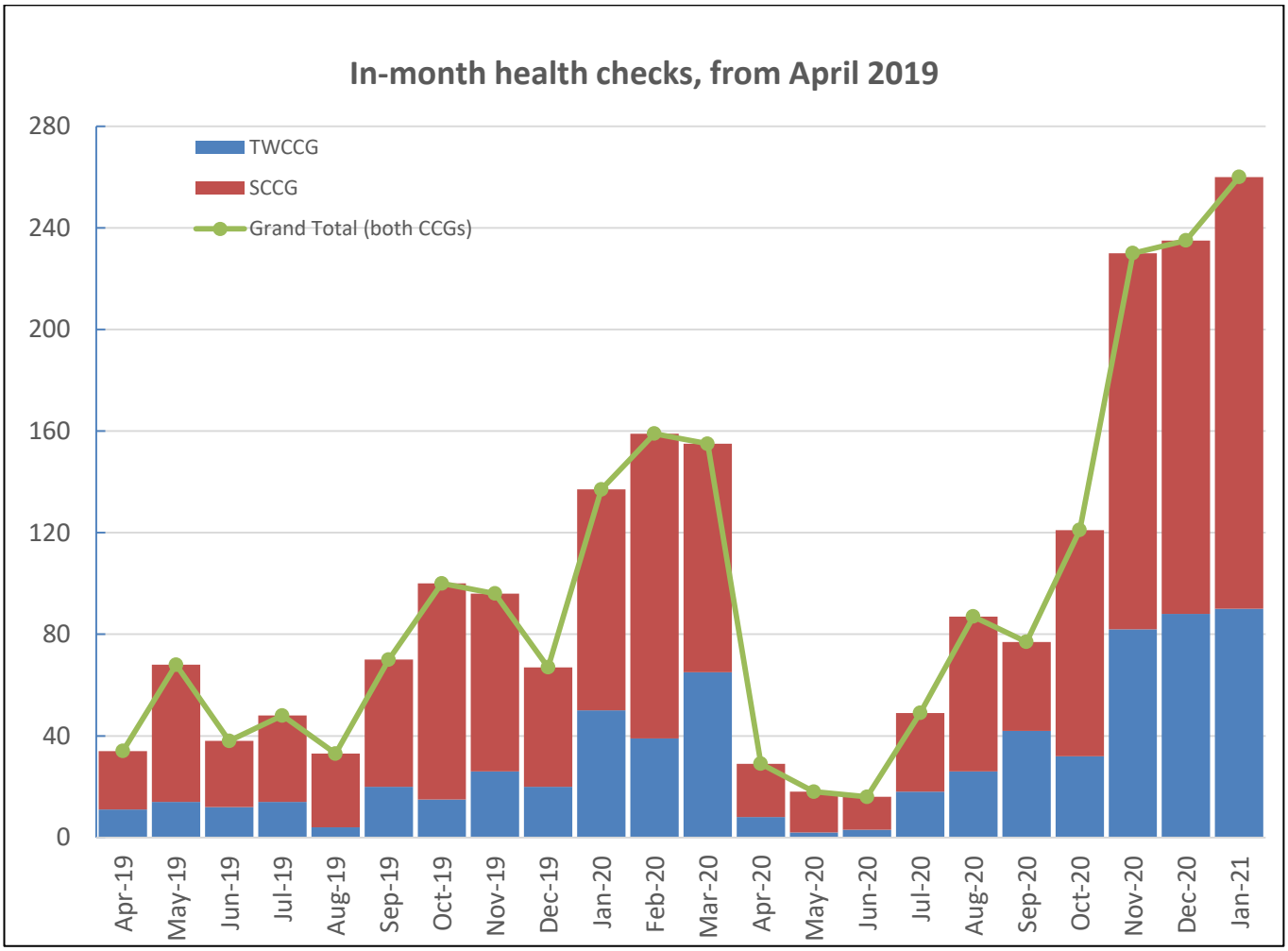
Protect the most vulnerable from COVID	Restore NHS services inclusively	Digitally-enabled care pathways	Accelerate preventative programmes for at-risk groups	Support those who suffer mental ill-health	Strengthen leadership and accountability	Ensure datasets are complete and timely	Collaborate locally in planning and delivering action
Regular public communication is vital Combining datasets gives a powerful understanding of vulnerable people (beyond CEV)	The need to bring together the clinical prioritisation that has guided the system restore with data on health inequalities	Mixed review of digital appointments Positive feedback on digital appointments for cancer Key learning in the Healthwatch report	Programmes can adapt to deliver digital approaches with consideration of accessibility and loneliness	Significant rise in access to vol sector mental health phone lines and sanctuary, significant increase in suicidal ideation Increase in children and young people self-harm	Aware system has dispersed leadership across population health management Inequalities SRO with separate task and finish group Equalities, Diversity and Inclusion (EDI) Group Workforce EDI Group Vaccination Inequalities Group Digital Enablement Group and that there needs to be a refocus on core leadership	Communication across organisations is at the core of developing this work	Collectively Shropshire, Telford and Wrekin can support residents, service users, vulnerable and reduce inequalities so much better than as individual organisations Vital that we work with the VCSE as equal partners in planning and delivery

Example of actions to address under health inequalities eight-point plan

Prioritising physical health checks for those with learning disabilities

Shropshire CCG has prioritised the physical health checks of those individuals with learning disabilities. This is important, as we know individuals with learning disabilities are at higher risk of physical health conditions which can be identified through regular health checks.

The chart below demonstrates the number of health checks achieved by primary care each month since 2019, and demonstrates the increase achieved through a targeted approach of prioritising this work in primary care. This is an excellent achievement, as primary care dealt with the different ways of working to manage the demands of the vaccination programme as well as delivering services in a COVID-19-safe way.



COVID-19 vaccine equalities activity

As a member of the system vaccine equalities group, we have been supporting the system's work to increase the uptake of the COVID-19 vaccination amongst different groups within our communities. Working with the equality, diversity and inclusion leads, partners, community leaders and the communities themselves, we have mapped our groups and the organisations able to help facilitate engagement and share information.

We have developed communications and engagement plans supported by toolkits addressing the specific concerns and questions raised by our diverse population, bringing together national and locally developed resources with the support of local healthcare providers and community representatives. The individual toolkits are specifically tailored to support the engagement with the different groups identified as being more vaccine hesitant.

By talking to our communities, we continue to gain a better understanding of the appropriate channels for reaching those who are seldom-heard and their needs, involving individuals trusted and respected by them. This work is being supported with local data to help target resource and activity to where it is most needed.

Engaging the support of a range of clinicians and staff of different ethnicities, we have produced short films to share factual information about COVID-19 vaccination with our communities and facilitated opportunities for our seldom-heard communities to put their questions to local clinicians and recorded these sessions for wider dissemination.

We have also engaged the support of our different communities to share their experiences of having the vaccine in different languages. To increase the diversity of our media spokespeople, we have organised media training for more of our staff to better represent our diverse population. These individuals have been at the fore of our media activity to encourage vaccine uptake amongst different ethnic minorities.

We continue to reach out to our local communities, working with system partners, through our community leaders and communications channels to monitor and respond to their questions and concerns. This includes providing factual information to counter concerns about the Oxford AstraZeneca vaccine through trusted individuals, sharing key messages about receiving the vaccine during Ramadan, a question and answer event for social care workers to address specific concerns, including in relation to fertility and pregnancy, and a programme of vaccination community engagement activity and pop-up services.

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ACCOUNTABILITY REPORT

Corporate Governance Report

Members Report

Shropshire CCG is a membership organisation composed of the 40 GP practices located within the geographical area of Shropshire Unitary Council. When the members of the group meet to conduct business as the CCG, this is known as the CCG Membership Forum. The CCG also has three Locality Forums that are used to engage on a regular basis with member practices. Each member practice will nominate one GP representative to represent the practice in all matters considered at the Membership or Locality Forum, and if necessary, exercise a vote. The Member Forum delegates the majority of decision making to the CCG Governing Body and this is outlined in the CCG Constitution.

The member practices are outlined below:

Practice Name	Address
Albrighton Medical Practice	Shaw Lane, Albrighton, Wolverhampton, WV7 3DT
Alveley Medical Practice	Village Road, Alveley, Bridgnorth, WV15 6NG
The Beeches Medical Practice	1 Beeches Road, Bayston Hill, Shrewsbury, SY3 0PF
Belvidere Medical Practice	23 Belvidere Road, Shrewsbury, SY2 5LS
Bishop's Castle Medical Practice	Schoolhouse Lane, Bishop's Castle, SY9 5BP
Bridgnorth Medical Practice	Northgate Health Centre, Northgate, Bridgnorth, WV16 4EN
Broseley Medical Centre	Bridgnorth Road, Broseley, TF12 5EL
Brown Clee Medical Practice	Ditton Priors, Bridgnorth, WV16 6SS
Cambrian Surgery	Oswestry Health Centre, Thomas Savin Road, Oswestry, SY11 1GA
The Caxton Surgery	Oswald Road, Oswestry, SY11 1RD
Churchmere Medical Group	Trimpley Street, Ellesmere, SY12 0DB
Church Stretton Medical Practice	Easthope Road, Church Stretton, SY6 6BL

Claremont Bank Surgery	Claremont Bank, Shrewsbury, SY1 1RL
Cleobury Mortimer Medical Centre	Vaughan Road, Cleobury Mortimer, Kidderminster, Worcestershire, DY14 8DB
Clive Surgery	20 High Street, Clive, Shrewsbury, SY4 5PS
Craven Arms Medical Practice	20 Shrewsbury Rd, Craven Arms, SY7 9PY
Dodington Surgery	29 Dodington, Whitchurch, SY13 1EN
Highley Medical Centre	Bridgnorth Road, Highley, Bridgnorth, WV16 6HG
Hodnet Medical Centre	18 Drayton Road, Hodnet, Market Drayton, TF9 3NF
Knockin Medical Centre	Knockin, Oswestry, SY10 8HL
Marden Medical Practice	25 Sutton Road, Shrewsbury, SY2 6DL
Market Drayton Medical Practice	Market Drayton Primary Care Centre, Maer Lane, Market Drayton, TF9 3AL
Marysville Medical Practice	Brook Street, Belle Vue, Shrewsbury, SY3 7QR
The Meadows Medical Practice (Clun and Knighton)	Penybont Road, Knighton, Powys, LD7 1HB
Much Wenlock and Cressage Medical Practice	Kingsway Lodge, Much Wenlock, TF13 6BL
Mytton Oak Surgery	Racecourse Lane, Shrewsbury, SY3 5LZ
Plas Ffynnon Medical Centre	Middleton Road, Oswestry, SY11 2RB
Pontesbury Medical Practice	Hall Bank, Pontesbury, Shrewsbury, SY5 0RF
Portcullis Surgery	Portcullis Road, Ludlow, SY8 1GT
Prescott Surgery	Baschurch, Shrewsbury, SY4 2DR
Radbrook Green Surgery	Bank Farm Road, Shrewsbury, SY3 6DU
Riverside Medical Practice	Roushill, Shrewsbury, SY1 1PQ
Severn Fields Medical Practice	Severn Fields Health Village, Sundorne Road, Shrewsbury SY1 4RQ
Shawbury Medical Practice	Poynton Road, Shawbury, SY4 4JS
Shifnal and Priorslee Medical Practice	Shrewsbury Road, Shifnal, TF11 8AJ

South Hermitage Surgery	South Hermitage, Belle Vue, Shrewsbury, SY3 7JS
Station Drive Surgery	Station Drive, Ludlow, SY8 2AB
Wem and Prees Medical Practice (Wem Site)	New Street, Wem, Shrewsbury, SY4 5AF
Westbury Medical Centre	Westbury, Shrewsbury, SY5 9QX
Worthen Medical Practice	Village Hall, Worthen, Shrewsbury, SY5 9HT

The CCG Governing Body discharges the day-to-day decision making for the CCG as a whole and is made up of a number of different clinical and non-clinical professionals, lay members, and patient representatives.

CCG Governing Body composition during 2020/21 changed during the year. This was due to the Governing Bodies of Shropshire CCG and Telford and Wrekin CCG agreeing to appoint joint Governing Body members from 1 August 2020, in order to allow greater alignment of governance structures in preparation for the creation of a single CCG for Shropshire, Telford and Wrekin:

CCG Governing Body Member	Role
Dr Julian Povey (voting)	GP Chair
Dr Stephen James (voting) to 31 July 2020	GP Member
Dr John Pepper (voting)	GP Member
Dr Finola Lynch (voting) to 30 April 2020	GP Member
Dr Priya George (voting) to 31 July 2020	GP Member
Mr Kevin Morris (voting) to 31 July 2020	Practice Representative
Dr Deborah Shepherd (voting) to 31 July 2020	Locality Chair (Shrewsbury and Atcham)
Dr Michael Matthee (voting) to 31 July 2020	Joint Locality Chair (North Shropshire)
Dr Katie Lewis (voting) to 31 July 2020	Joint Locality Chair (North Shropshire)
Dr Matthew Bird (voting)	Locality Chair (South Shropshire)
Dr Alan Leaman (voting) to 31 July 2020	Secondary Doctor Member
Dr Martin Allen (voting) from 1 August 2020	Secondary Doctor Member
Mrs Julie McCabe (voting) from 1 August 2020 to 31 January 2021	Registered Nurse Member

Mr Keith Timmis (voting)	Lay Member – Governance
Mrs Sarah Porter (voting) to 31 July 2020	Lay Member – Transformation
Mr Meredith Vivian (voting)	Lay Member – Patient and Public Involvement (PPI)
Dr Colin Stanford (voting) to 31 July 2020	Lay Member
Mr Gary Turner (voting) from 1 August 2020 to 30 August 2020	Lay Member – Primary Care
Mrs Donna MacArthur (voting) from 1 October 2020	Lay Member – Primary Care
Mr David Evans (voting)	Accountable Officer
Mrs Claire Skidmore (voting)	Executive Director of Finance
Professor Steven Trenchard (voting)	Interim Executive Director of Transformation
Mrs Zena Young (voting)	Executive Director of Nursing and Quality
Miss Alison Smith (non-voting)	Director of Corporate Affairs
Dr Julie Davies (non-voting)	Director of Performance
Mrs Sam Tilley (non-voting)	Director of Planning
Ms Claire Parker (non-voting)	Director of Partnerships
Dr Deborah Sheppard (non-voting)	Interim Medical Director
Mr Ash Ahmed (non-voting) from 1 August 2020	Associate Lay Member PPI – Equality Diversity and Inclusion
Dr Stephen James (non-voting) from 1 August 2020	Interim Chief Clinical Information Officer
Ms Rachael Robinson	Observer – Shropshire Council
Ms Lynn Cawley	Observer – Healthwatch Shropshire

Committee(s) including Audit Committee

So that the CCG Governing Body can provide strategic direction to the CCG and to assure itself of the CCG's internal control infrastructure, it has established a number of committees to undertake specific roles within the governance structure. A diagram showing the governance structure and explaining the role of each committee can be found in the Annual Governance Statement later in this report.

The Audit Committee has been meeting as committees in common with the Audit Committee of Telford and Wrekin CCG in preparation for the transition to a single CCG in April 2021.

Composition of the Audit Committee:

- Mr Geoff Braden (Chair) – Lay Member Governance
- Mr Meredith Vivian – Lay Member Patient and Public Involvement
- Mrs Donna MacArthur – Lay Member Primary Care
- Mr Ash Ahmed – Associate Lay Member Patient and Public Involvement – Equality, Diversity and Inclusion.

The role of each CCG Governing Body committee, composition and attendance is detailed in the Annual Governance Statement which forms part of this Annual Report.

Conflicts of interest declared by our CCG Governing Body members and other committees where membership is different can be found on our website.

Information Governance (IG) incidents

Shropshire CCG has reported a total of five incidents during 20/20/21. The scoring for IG breaches changed from 0-2 to Reportable or Non reportable, All of these incidents were graded as non-reportable - very low risk and therefore not reported to the Information Commissioner's Office (ICO).

Statement of disclosure to auditors

Each individual who is a member of the Membership Body at the time the Members' report is approved confirms that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Modern slavery

Shropshire 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.

Statement of Accountable Officer's responsibilities

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

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health and Social Care have been followed, and disclose and explain any material departures in the financial statements
- Prepare the financial statements on a going concern basis.

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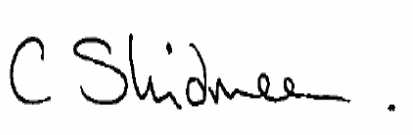
To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my CCG Accountable Officer Appointment Letter.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information
- The Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.



Claire Skidmore,
Interim Accountable Officer
14 June 2021

NHS Shropshire Clinical Commissioning Group

GOVERNANCE STATEMENT

Introduction and context

NHS Shropshire CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The CCG'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 4 April 2016, the CCG was subject to legal directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006. This remains the case in 2020/21. Prior to that, during January 2016, Shropshire CCG had been placed into the 'Special Measures' regime, in order to provide a structured approach for the CCG to improve its performance, whilst remaining accountable for its functions. These 'Special Measures' also remain in place.

The framework associated with Legal Directions and Special Measures continues to provide assurance that any agreed action plans are effective and are being achieved.

Special Measures focused on:

- Agreement of a control total for the CCG's forecast outturn in 2016/17, 2017/18, 2018/19 and 2019/20
- Production of a Financial Recovery Plan to achieve the control total
- Recruitment of a substantive Executive Team.

Legal Directions focused on:

- All senior CCG appointments
- The production and implementation of a Financial Recovery Plan.

The full 'directions' issued by NHS England can be found on NHS England's website.

As an initial step in 2016/17, the CCG was required as part of its Legal Directions and Special Measures to complete a capacity and capability review and develop an associated implementation plan. These actions were completed to NHS England's satisfaction and have provided the platform for further improvements in the CCG's infrastructure to support its sustainability.

We have continued to work hard over the past year to build on the steps made since legal directions were placed on us and to reach our aspiration to achieve financial balance. We do this whilst maintaining high quality services for patients and to subsequently move out of Legal Directions and Special Measures.

Whilst we still face considerable financial challenges, some of the specific actions completed over the past year include:

- The CCG has reviewed and updated its Constitution to reflect improvements in the way it operates in accordance with the latest NHS England guidance and to streamline decision making processes between with Telford and Wrekin CCG in preparation for the creation of a single CCG from 1 April 2021
- The CCG has developed a Financial Plan in preparation for the creation of a single CCG, but also continues to work with system partners to develop a system Financial Plan in preparation for the development of an Integrated Care System (ICS) in 2022
- The CCG continues to develop a number of key commissioning plans including a review of midwifery units and the development of Shropshire Care Closer to Home, although implementation over the year has been delayed due to the COVID-19 pandemic and the need for a particular focus on the restoration of services.

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 CCG Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the CCG 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.

Shropshire CCG is a clinically-led membership organisation made up of GP practices within the geographical area of Shropshire and which is also coterminous with Shropshire Council. The CCG was established under the Health and Social Care Act 2012 and is a statutory body which has the function of commissioning services for the purposes of the health service in England. The members of the CCG are responsible for determining the governing arrangements of the organisation, which they are required to set out in the CCG's Constitution which can be found on our website.

The year 2020/21 has seen an unprecedented emergency response from the NHS to the COVID-19 global pandemic. The impact on the CCG has also been unprecedented, in that staff and resources have been redeployed to support frontline services. The governance processes

for the CCG have, in line with national guidance, also had to be changed temporarily to fit this emergency situation, with some committees of the Governing Body and membership stood down or meeting less frequently, agendas streamlined and risk management processes focusing on the CCG Board Assurance Framework and system Gold Command emergency response. The CCG undertook these changes to ensure that its focus and resources were reserved to meet the challenges from COVID-19 during 2020/21.

In addition to the response to COVID-19, in August 2020 Shropshire CCG realigned its committees and the composition of the Governing Body in closer alignment with those of Telford and Wrekin CCG in order to create more aligned decision making processes in preparation for the transition into a single CCG from 1 April 2021. Consequently, the following pages reflect the final structure adopted, but also outline the changes made to membership of the old and new committees and the Governing Body.

The membership of the CCG is made up of 40 practices which are outlined in the Constitution. When the members of the group meet to conduct business as a group, this is known as the CCG Membership Forum. Each member of the group has nominated one practice representative to represent the practice in all matters, and vote on behalf of the practice at Membership Forum meetings. The group has reserved some decisions to itself to make through the mechanism of Membership Forum which is outlined in the Scheme of Reservation and Delegation that forms part of the Governance Handbook.

The Membership Forum has not met during the year, but has transacted one decision reserved to it virtually online of adopting a new Constitution for the new single CCG from 1 April 2021.

The CCG also has three Locality Forums, which meet regularly to conduct business that informs and supports the work of the CCG. These were amended from August 2020 to Forums from Committees following the realignment of the Governing Body composition and Joint and Committees in Common with Telford and Wrekin CCG.

Each member practice has nominated a GP and practice manager to represent the practice in all matters considered at the Locality Committee and vote on decisions, when required. The majority of decision making is delegated to the CCG Governing Body. The Locality Forums have met six times over the year.

The North Locality membership and attendance is set out below:

Name	Title	Medical Practice	Attendance
Dr A Booth	General Practitioner	Baschurch	5 of 6
Mr Nicolas Storey (moved to Plas Ffynnon from September 2020 meeting)	Practice Manager	Baschurch	1 of 2
Mr Gary Turner (started attending September 2020, stopped attending November 2020)	Practice Manager	Baschurch	1 of 2

Dr T W Lyttle	General Practitioner	Churchmere Medical Group	3 of 6
Ms Jenny Davies	Practice Manager	Churchmere Medical Group	4 of 6
Dr A Schur	General Practitioner	Clive	4 of 6
Mrs Zoe Bishop	Practice Manager	Clive	0 of 6
Dr J Mehta	General Practitioner	Hodnet	4 of 6
Mrs Rosemary Mehta	Practice Manager	Hodnet	3 of 6
Dr J Davies	General Practitioner	Knockin	5 of 6
Mrs Mary Herbert	Practice Manager	Knockin	3 of 6
Dr Michael Matthee (Co-Chair) to 31 July 2020	General Practitioner	Market Drayton	6 of 6
Mrs Michele Matthee	Practice Manager	Market Drayton	6 of 6
Dr S Eslava	General Practitioner	Oswestry - Cambrian	4 of 6
Mr Kevin Morris / Ms Nicola James	Practice Manager	Oswestry - Cambrian	5 of 6
Dr S Lachowicz	General Practitioner	Oswestry - Caxton	3 of 6
Mr James Bradbury	Practice Manager	Oswestry - Caxton	6 of 6
Dr Y Vibhishanan	General Practitioner	Oswestry - Plas Ffynnon	2 of 6
Ms Sarah Williams (stopped attending July 2020)	Practice Manager	Oswestry - Plas Ffynnon	0 of 2
Mr Nicolas Storey (started attending for practice from September 2020)	Practice Manager	Oswestry - Plas Ffynnon	3 of 4
Dr A C W Clark	General Practitioner	Shawbury	3 of 6
Ms Kirsty Arkinstall	Practice Manager	Shawbury	2 of 6
Dr C Rogers	General Practitioner	Wem and Prees	4 of 6
Ms Caroline Morris	Practice Manager	Wem and Prees	4 of 6
Dr K Lewis (Co-Chair) to 31 July 2020 Chair from 1 August 2020	General Practitioner	Westbury	6 of 6

Mrs Helen Bowkett	Practice Manager	Westbury	0 of 6
Dr R Clayton / Dr A Rogers	General Practitioner	Whitchurch – Dodington	4 of 6
Mrs Elaine Ashley	Practice Manager	Whitchurch – Dodington	4 of 6

The Shrewsbury and Atcham Locality membership and attendance is set out below:

Name	Title	Medical Practice	Attendance
Dr D Shepherd (Chair) To 31 July 2020	General Practitioner	Locum GP	0 of 1
Dr J Pepper (stopped attending November 2020)	General Practitioner	Belvidere	2 of 3
Dr B Teelucksingh / Dr K Leach (started attending January 2021)	General Practitioner	Belvidere	3 of 3
Ms Caroline Davis	Practice Manager	Belvidere	6 of 6
Dr M Fallon	General Practitioner	Claremont Bank	1 of 6
Ms Jane Read	Practice Manager	Claremont Bank	4 of 6
Dr E Baines (Chair) From 1 August 2020	General Practitioner	Marden	5 of 6
Mrs Zoe George	Practice Manager	Marden	6 of 6
Dr J Visick	General Practitioner	Marysville	4 of 6
Mrs Izzy Culliss	Practice Manager	Marysville	5 of 6
Dr S Watton	General Practitioner	Mytton Oak	4 of 6
Mr Adrian Kirsop (stopped attending September 2020)	Practice Manager	Mytton Oak	2 of 2
Ms Susan Lewis	Practice Manager	Mytton Oak	3 of 4
Dr R Bland	General Practitioner	Pontesbury	2 of 6
Ms Heather Brown	Practice Manager	Pontesbury	5 of 6
Dr C Hart / Dr H Bale	General Practitioner	Radbrook Green	5 of 6
Ms Angela Treherne	Practice Manager	Radbrook Green	1 of 6

Dr P Rwezaura	General Practitioner	Riverside	0 of 6
Ms Tracy Willocks (stopped attending January 2021)	Practice Manager	Riverside	3 of 4
Ms Amanda Lloyd (started attending February 2021)	Practice Manager	Riverside	1 of 2
Dr D Martin	General Practitioner	Severn Fields	0 of 6
Mr Tim Bellett (moved to The Beeches from March 2021 meeting)	Practice Manager	Severn Fields	1 of 5
Ms S Griffiths (started attending from March 2021)	Practice Manager	Severn Fields	1 of 1
Dr L Davis	General Practitioner	South Hermitage	5 of 6
Mrs Caroline Brown	Practice Manager	South Hermitage	5 of 6
Dr E Jutsum	General Practitioner	The Beeches, Bayston Hill	5 of 6
Ms Kim Richards (stopped attending February 2021)	Practice Manager	The Beeches, Bayston Hill	4 of 5
Mr Tim Bellett (started attending for practice from March 2021)	Practice Manager	The Beeches, Bayston Hill	1 of 1
Dr K McCormack	General Practitioner	Worthen	6 of 6
Ms Cheryl Brierley	Practice Manager	Worthen	0 of 6

The South Shropshire Locality membership and attendance is set out below:

Name	Title	Medical Practice	Attendance
Dr Matthew Bird (Chair)	General Practitioner	Albrighton	6 of 6
Ms Val Eastup	Practice Manager	Albrighton	5 of 6
Dr D Abbotts	General Practitioner	Alveley	0 of 6
Mrs Lindsey Clark	Practice Manager	Alveley	1 of 6
Dr A Penney / Dr P Gardner	General Practitioner	Bishops Castle	5 of 6
Ms Sarah Bevan	Practice Manager	Bishops Castle	0 of 6
Dr G Potter	General Practitioner	Bridgnorth	5 of 6

Mrs Sandra Sutton (stopped attending February 2021)	Practice Manager	Bridgnorth	4 of 5
Ms Dude Newell (started attending March 2021)	Practice Manager	Bridgnorth	1 of 1
Dr M Babu	General Practitioner	Broseley	6 of 6
Ms Nina Wakenell	Practice Manager	Broseley	4 of 6
Dr W Bassett	General Practitioner	Brown Clee	6 of 6
Ms Vicki Brassington	Practice Manager	Brown Clee	0 of 6
Dr A Chamberlain	General Practitioner	Church Stretton	4 of 6
Ms Emma Kay	Practice Manager	Church Stretton	6 of 6
Dr P Thompson	General Practitioner	Cleobury Mortimer	4 of 6
Mr Mark Dodds	Practice Manager	Cleobury Mortimer	3 of 6
Dr J Bennett	General Practitioner	Clun	3 of 6
Mr Peter Allen	Practice Manager	Clun	6 of 6
Dr D Appleby / Dr M Carter	General Practitioner	Craven Arms	4 of 6
Mrs Susan Mellor-Palmer	Practice Manager	Craven Arms	6 of 6
Dr S Allen	General Practitioner	Highley	3 of 6
Mr S Consul	Practice Manager	Highley	6 of 6
Dr C Beanland / Dr C Targett	General Practitioner	Ludlow – Portcullis	6 of 6
Mrs Rachel Shields	Practice Manager	Ludlow – Portcullis	6 of 6
Dr G Cook	General Practitioner	Ludlow – Station Drive	5 of 6
Ms Jodie Billinge	Practice Manager	Ludlow – Station Drive	1 of 6
Dr J Wentel	General Practitioner	Much Wenlock and Cressage	5 of 6
Mrs Sarah Hope / Ms M Jones	Practice Manager	Much Wenlock and Cressage	5 of 6
Dr R Shore / Dr P Leigh	General Practitioner	Shifnal and Priorslee	1 of 6
Ms Louise Linning (stopped	Practice Manager	Shifnal and Priorslee	0 of 4

attending January 2021)			
Ms Hayley Breese (started attending February 2021)	Practice Manager	Shifnal and Priorslee	0 of 2

Key achievements / areas of work

The membership, through all three Locality Forums, has considered key areas of CCG work to ensure that clinical voices are embedded in the decision-making processes. Some of the areas of work presented or discussed at the Locality Forums over the last 12 months include:

- Advanced care planning in care homes
- COVID-19 restoration programme
- Community matrons
- Shropshire Recovery Partnership
- Shropshire respiratory service
- Pathology
- Integrated care record
- Mental health
- Phlebotomy review
- Admission avoidance
- Public Health nursing
- New maternity IT system.

Localities continue to review their locality plans, and to use Locality Assurance Frameworks to raise and track responses to issues and concerns identified.

As set out in the Constitution, the CCG has delegated the majority of its decision making to the CCG Governing Body and has specific functions conferred on it by section 25 in the 2012 Act.

The composition of the CCG Governing Body is made up of GP/Primary Healthcare Professional Board members drawn from the CCG membership and from the membership of Telford and Wrekin CCG, jointly appointed executive officers, other clinical representation and lay members. The full composition is outlined in full within the Constitution.

CCG Governing Body met six times during the year in total. From 1 August 2020, the CCG appointed, jointly with Telford and Wrekin CCG, new Governing Body members to align decision making processes in preparation for the creation of a single CCG across Shropshire, Telford and Wrekin. The names of members and their attendance are listed below in tables showing membership prior to 1 August 2020 when the composition changed and post 1 August 2020:

Names of Governing Body members Up to 31 July 2020	Board Role	Meetings attended during 2020/21
Dr Julian Povey (voting)	Chair	2 of 2
Mr David Evans (voting)	Accountable Officer	2 of 2
Dr Finola Lynch (voting)	GP Member to 30 April 2020	2 of 2
Dr Stephen James (voting)	GP Member to 31 July 2020	2 of 2
Dr John Pepper (voting)	GP Member to 31 July 2020	1 of 2
Dr Priya George (voting)	GP Member to 31 July 2020	1 of 2
Professor Steven Trenchard (voting)	Interim Executive Director of Transformation	2 of 2
Mr Kevin Morris (voting)	Practice Representative to 31 July 2020	2 of 2
Dr Deborah Shepherd (voting)	Locality Chair (Shrewsbury and Atcham) to 31 July 2020	2 of 2
Mrs Claire Skidmore (voting)	Executive Director of Finance	2 of 2
Dr Julie Davies (non-voting)	Director of Performance	2 of 2
Mrs Samantha Tilley (non-voting)	Director of Planning	2 of 2
Mrs Zena Young (voting)	Executive Director of Nursing and Quality	2 of 2
Miss Alison Smith (non-voting)	Director of Corporate Affairs	2 of 2
Ms Claire Parker (non-voting) from 1 April 2020	Director of Partnerships	2 of 2
Mrs Nicky Wilde (non-voting)	Director of Primary Care to November 2020	2 of 2
Mrs Gail Fortes-Mayer (non-voting)	Director of Planning and Contracting to November 2020	2 of 2
Mr Keith Timmis (voting)	Lay Member for Governance	2 of 2
Mrs Sarah Porter (voting)	Lay Member for Transformation to 31 July 2020	2 of 2
Mr Meredith Vivian (voting)	Lay Member for Public and Patient Involvement (PPI) to 31 July 2020	2 of 2
Dr Alan Leaman (voting)	Secondary Care Consultant to 31 July 2020	2 of 2
Dr Matthew Bird (voting)	Locality Chair (South) to 31 July 2020	2 of 2

Dr Michael Matthee (voting)	Joint Locality Chair (North) to 31 July 2020	2 of 2
Dr Katie Lewis	Joint Locality Chair (North) to 31 July 2020	
Dr Colin Stanford (voting)	Lay Member to 31 July 2020	1 of 2
Ms Rachel Robinson / Ms Jo Robbins (non-voting)	Observer – Shropshire Council to 31 July 2020	2 of 2
Ms Lynn Cawley (non-voting)	Observer – Healthwatch Shropshire to 31 July 2020	2 of 2

Names of Governing Body members From 1 August 2020	Board Role	Meetings attended during 2020/21
Dr Julian Povey (voting) from 1 August 2020	Joint GP Chair	4 of 4
Dr Rachael Bryceland (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Dr Michael Matthee (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Dr John Pepper (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Dr Adam Pringle (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Mrs Fiona Smith (voting) from 1 August 2020	Joint GP/Healthcare Professional Member	4 of 4
Mrs Julie McCabe (voting) from 1 August 2020 to 31 January 2021	Joint Registered Nurse	2 of 3
Dr Martin Allen (voting) from 1 August 2020	Secondary Doctor Member	3 of 4
Mr Geoff Braden (voting) For Telford and Wrekin CCG	Lay Member - Governance	4 of 4
Mr Keith Timmis (voting)	Lay Member - Governance	4 of 4
Mr Meredith Vivian (voting) from 1 August 2020	Lay Member – Patient Public Involvement	4 of 4
Mr Gary Turner (voting) from 1 August to 30 September	Lay Member – Primary Care	1 of 1

2020		
Mrs Donna MacArthur (voting) from 1 October 2020	Lay Member – Primary Care	3 of 3
Mr David Evans (voting)	Accountable Officer	4 of 4
Mrs Claire Skidmore (voting)	Executive Director of Finance	4 of 4
Mrs Zena Young (voting)	Executive Director of Nursing and Quality	4 of 4
Professor Steven Trenchard (voting)	Interim Executive Director of Transformation	4 of 4
Ms Claire Parker (non-voting)	Director of Partnerships	4 of 4
Miss Alison Smith (non-voting)	Director of Corporate Affairs	4 of 4
Dr Julie Davies (non-voting)	Director of Performance	4 of 4
Mrs Sam Tilley (non-voting)	Director of Planning	4 of 4
Dr Deborah Shepherd (non-voting) from 1 August 2020	Interim Medical Director	4 of 4
Mr Ash Ahmed (non-voting) from 1 August 2020	Associate Lay Member PPI – Equality Diversity and Inclusion	3 of 4
Dr Stephen James (non-voting) from 1 August 2020	Interim Chief Clinical Information Officer	4 of 4
Rachel Robinson (non-voting)	Director of Public Health for Shropshire	3 of 4
Liz Noakes (non-voting)	Director of Public Health for Telford and Wrekin	3 of 4
Lynn Cawley (non-voting)	Chief Officer – Healthwatch Shropshire	4 of 4
Paul Shirley (non-voting) to 11 November 2020	Chief Officer – Healthwatch Telford and Wrekin	2 0f 2

The CCG Governing Body has appointed the following committees:

Audit Committee

The Audit Committee provides assurance to the CCG Governing Body that the organisation's overall internal control / governance system operates in an adequate and effective way. The committee's work focuses not only on financial controls, but also risk management and quality governance controls.

During 2020/21, the CCG also agreed to the Audit Committee meeting with the Audit Committee of NHS Telford and Wrekin CCG as Committees in Common to transact business common to

both CCGs. The Audit Committee has retained its meeting schedule during COVID-19 but reduced its agenda items to focus on key areas of governance assurance.

It has met a total of eight times during 2020/21 which is included in the attendance table below.

Names of Audit Committee members Up to 1 August 2020	Meetings attended during 2020/21
Mr Keith Timmis (Chair)	2 of 2
Mrs Sarah Porter	2 of 2
Mr Meredith Vivian	1 of 2

Names of Audit Committee members After 1 August 2020	Meetings attended during 2020/21
Mr Keith Timmis (Chair)	6
Mr Meredith Vivian	6
Mrs Donna MacArthur	6
Mr Ash Ahmed	6

The highlighted areas of the Audit Committee's reports are as follows:

- Assurance gained from and further development of the Board Assurance Framework (BAF) and Executive Risk Register
- Assurance gained from overseeing the development and recommendation of corporate and human resource policies
- Assurance gained from overseeing the continued development and self-certification of the CCG against the Information Governance (IG) toolkit
- Assurance on quality process for triangulating information to monitor provider quality and ensuring high standards of safeguarding
- Assurance on the CCG's emergency planning and business continuity processes
- Assurance on the counter fraud measures in place and on continuing work around preventing and addressing fraud
- Assurance on financial systems of Midlands and Lancashire CSU
- Assurance gained from Internal / External Audit reports
- Assurance on quality systems employed by the CCG
- Assurance on processes in place to manage conflicts of interest, gifts, hospitality and sponsorship and procurement decisions taken.

The Audit Committee undertakes an annual self-assessment of its own effectiveness to help inform its own programme of work and the Annual Report it presents to the CCG Governing Body annually.

Remuneration Committee

The Remuneration Committee recommends to the Board appropriate salaries, payments and terms and conditions of employment.

During 2020/21, the CCG also agreed to the Remuneration Committee meeting with the Remuneration committee of Telford and Wrekin CCG as Committees in Common to transact business common to both CCGs. The Remuneration Committee has met three times separately and six times in common as required during COVID-19.

Names of Remuneration Committee Members Up to 1 August 2020	Meetings attended during 2020/21
Mr Keith Timmis	3 of 4
Mrs Sarah Porter	3 of 4
Mr Meredith Vivian	3 of 4
Dr Julian Povey	1 of 4
Mr David Evans	1 of 4
Dr Alan Leaman	1 of 1

Names of Remuneration Committee Members From 1 August 2020	Meetings attended during 2020/21
Mrs Donna MacArthur (Chair)	5 of 5
Mr Keith Timmis	6 of 6
Mr Meredith Vivian	6 of 6

The highlighted areas of the committee's reports are as follows:

- Review and recommendation on remuneration policies
- Review of continuous service audit action implementation
- Review of performance related remuneration for Very Senior Managers (VSM) and policy development.

Finance and Performance Committee (F&P)

The Finance and Performance Committee oversaw and provided assurance on the financial and service delivery of commissioned services. The committee has met twice during 2020/21. The Finance and Performance Committee reduced its meeting schedule during COVID-19 to bi-monthly.

Names of Finance and Performance members	Meetings attended during 2020/21
Ms Sarah Porter – Lay Member Transformation	2
Mr Keith Timmis – Lay Member Governance for Shropshire CCG	1
Dr Mike Matthee – Joint GP / Healthcare Professional	1

The highlighted areas of the committee's reports are as follows:

- Review of Continuing Healthcare (CHC) Plan
- STP finance update
- Finance and Contracting Report including QIPP update
- Performance Report.

Finance Committee

The Finance and Performance Committee ceased on 31 July 2020 and was replaced by the Finance Committee operating from 1 August 2020.

The Finance Committee oversees and provides assurance on the financial delivery of commissioned services. During the remainder of 2020/21, Shropshire CCG agreed to the Finance Committee meeting with the Finance committee of Telford and Wrekin CCG as Committees in Common to transact business common to both CCGs. The Committees in Common have met five times during 2020/21 which is included in the attendance table below.

Names of Finance Committee members	Meetings attended during 2020/21
Mr Keith Timmis – Lay Member Governance for Shropshire CCG	5
Mr Geoff Braden – Lay Member Governance for Telford and Wrekin CCG	5
Mr Ash Ahmed – Joint Lay Member PPI	5
Dr Mike Matthee – Joint GP / Healthcare Professional	5
Dr Martin Allen – Joint Secondary Care Doctor Governing Body Member	4

The highlighted areas of the committee's reports are as follows:

- STP finance update
- Finance Report – Month 5/8/9/10/11
- Value for money and QIPP update – Month 5/8/9/10/11
- Finance Strategy update
- 2021/22 Plan update
- Update on development of the 2021/22 position and Medium-Term Financial Strategy (MTFS)
- Governing Body Assurance Framework and key messages to Governing Body
- Review of Continuing Healthcare (CHC) Action Plan
- Minutes of PPQ meeting.

Quality Committee

The Quality Committee oversaw and provided assurance on quality of commissioned services. The Quality Committee reduced its meeting schedule during COVID-19 to bi-monthly. The committee has met twice during 2020/21 which is included in the attendance table below.

Names of Quality Committee members	Meetings attended during 2020/21 as at 31 July 2020
Meredith Vivian	2
Keith Timmis	2
Zena Young	2
Claire Parker	2
Sarah Porter	1
Julie Davies	2
Alan Leaman	2
Deborah Shepherd	2
Priya George	2
Helen Bayley	2
Lynn Cawley, Healthwatch Shropshire	1

The highlighted areas of the committee's reports are as follows:

- Provider Exception Report

- Shrewsbury and Telford NHS Hospital Trust Oversight and Assurance Group (SOAG) update
- SEND
- Maternity services and maternity metrics
- Infection prevention and control
- Support to care homes
- Safeguarding Supervision Policy
- Quarter 4 Insight Report
- CQC Improvement Plan
- Quality oversight during COVID-19
- LeDeR (learning from lives and deaths – people with a learning disability and autistic people) Annual Report
- Suicides and unexpected deaths
- Safeguarding Annual Report.

Quality and Performance Committee (Q&P)

The Quality Committee ceased on 31 July 2020 and was replaced by the Quality and Performance Committee operating from 1 August 2020. The Quality and Performance Committee oversees and provides assurance on the quality of commissioned services. During the remainder of 2020/21, the CCG agreed to the Quality and Performance Committee meeting with the Quality and Performance committee of NHS Telford and Wrekin CCG as Committees in Common to transact business common to both CCGs. The Committees in Common have met seven times during 2020/21 which is included in the attendance table below.

Names of Q&P members	Meetings attended during 2020/21
Meredith Vivian	6
Geoff Braden	0
Keith Timmis	7 (including chairing the meeting in September 2020)
Rachel Bryceland	6
Dr Martin Allen	6
Julie McCabe	4 of 5

The highlighted areas of the committee's reports are as follows:

- Quality and Performance Exception Reports
- Update on care home work
- Patient Experience Insight Reports

- Shrewsbury and Telford NHS Hospital Trust Oversight and Assurance Group (SOAG) update
- SEND update
- Neurodevelopmental pathway update
- Attention deficit hyperactivity disorder (ADHD) procurement update
- High intensity user service update
- Continuing Healthcare (CHC) update
- QIPP Board update
- Safeguarding and Looked After Children update reports
- CCG Quality Strategy Report to include Operational Plan
- Infection prevention and control report
- Maternity update
- Serious incidents update
- Ulysses update
- Quarterly Primary Care Quality Report
- CHC update
- Learning disability health checks
- LeDeR update
- Learning disabilities update
- Breast cancer two-week wait performance report
- Healthwatch updates
- Policies and information for approval.

Clinical Commissioning Committee (CCC)

The Clinical Commissioning Committee is responsible for providing assurance to the Governing Body that the CCG is commissioning services in line with the needs of the local population and strategic objectives of the CCG. The Clinical Commissioning Committee reduced its meeting schedule during COVID-19 to bi-monthly. The Committee has met three times during 2020/21 which is included in the attendance table below.

Names of Clinical Commissioning Committee members	Meetings attended during 2020/21
Mrs Sarah Porter (Chair)	3
Mr Meredith Vivian	3
Dr Alan Leaman	3
Dr Julie Davies	3
Mr Kevin Morris	3

Mrs Claire Skidmore	3
Mr Steve Trenchard	3
Mrs Zena Young	3
Dr John Pepper	3
Dr Deborah Shepherd	2
Dr Matthew Bird	2
Dr Julian Povey	2
Mrs Nicky Wilde	1
Dr Steve James	2
Mrs Rachel Robinson	1
Mrs Sam Tilley	1

The highlighted areas of the committee's reports are as follows:

- Review and approval of Macmillan end of life bid
- Position update on COVID 19 / demand and capacity
- Position update on pathway and service changes
- Restoration of services and transformation work updates on musculo-skeletal services, Care Closer to Home and respiratory
- Capacity and modelling update position report
- Restoration and recovery update position report
- Review and approval of the Learning Disability Strategy Development and Improvement Plan.

The Joint Strategic Commissioning Committee (JSCC)

The Clinical Commissioning Committee ceased on 31 July 2020 and was replaced by the Joint Strategic Committee operating from 1 August 2020. The Joint Strategic Commissioning Committee oversees and provides assurance on the commissioning of services and has delegated decision making from both the Governing Body of Shropshire CCG and Telford and Wrekin CCG to make binding decisions on their behalf. The Joint Committee has met seven times during 2020/21 which is included in the attendance table below.

Names of Joint Strategic Commissioning Committee members	Meetings attended during 2020/21
Mr Ash Ahmed (Chair)	6
Mrs Donna MacArthur	3 of 4

Ms Julie McCabe (last attended Jan 2021)	4
Mr Geoff Braden	2
Mrs Fiona Smith	7
Dr John Pepper	6
Mr David Evans	2
Mrs Claire Skidmore	7
Mrs Zena Young	5
Mr Steve Trenchard	5
Attendees:	
Dr Julian Povey	5
Mrs Claire Parker	6
Mrs Sam Tilley	5
Dr Julie Davies	5
Dr Deborah Shepherd	4
Ms Alison Smith	1
Ms Michelle Davies / Mrs Tanya Miles – Shropshire Council	5
Cllr Andrew Burford – Telford and Wrekin Council	3
Mr Jonathan Rowe – Telford and Wrekin Council	4

The highlighted areas of the committee's reports are as follows:

- Autism spectrum disorder pathways
- NHSE/I Restoration and Recovery
- NHS 111 Demand and Dispositions
- COVID recovery updates
- Deep vein thrombosis pathways
- ICS Transformation Programme Board updates
- CCG Procurement Strategy
- Breast Cancer Improvement Plan.

Primary Care Commissioning Committee

This committee oversees the commissioning of primary care under delegated decision making authority from NHS England. It was a committee introduced in April 2015 following amendments to the CCG Constitution. The Primary Care Commissioning Committee stood down its meetings during COVID-19 from March to August 2020. From 1 August 2020, the CCG agreed to the Primary Care Commissioning Committee meeting with the Primary Care Commissioning Committee of Telford and Wrekin CCG as Committees in Common to transact business common to both CCGs. The committee met three times during the year.

Due to COVID-19, the CCG stood down its Primary Care Commissioning Committee during the period 1 April 2020 to 31 July 2020.

Names of Primary Care Commissioning Committee members Up to 31 July 2020	Meetings attended during 2020/21
Dr Colin Stanford	0
Mr Keith Timmis	0
Mrs Sarah Porter	0
Mr Meredith Vivian	0
Mr David Evans	0
Dr Julian Povey	0
Mrs Claire Skidmore	0
Dr Alan Leaman	0
Mrs Nicky Wilde	0
Mrs Zena Young	0
Mrs Sam Tilley	0
Miss Alison Smith	0
Professor Steve Trenchard	0
Dr Deborah Shepherd	0
Mr Kevin Morris	0
Dr Stephen James	0
Dr Finola Lynch	0

Three PCCC in Common meetings took place in the period 1 August 2020 to 3 February 2021. These were scheduled meetings which took place in October and December 2020, and

February 2021. Two extraordinary meetings were called in November 2020 and February 2021 which are not included in these figures.

Names of Primary Care Commissioning Committee members From 1 August 2020	Meetings attended during 2020/21
Donna Macarthur from 1 October 2020	2 of 2
Meredith Vivian	3
Colin Stanford to 31 February 2021	2 of 2
Andy Watts	2
David Evans	0
Claire Skidmore	3
Steve Trenchard	1
Zena Young	2
Claire Parker	2
Attendees:	
Dr Julian Povey	3
Dr Adam Pringle	3
Dr Deborah Shepherd	2
Julie Davies	0
Nicky Wilde to 3 November 2020	1
Vanessa Barrett, Healthwatch Shropshire	3
Paul Shirley, Healthwatch Telford and Wrekin to 30 October 2020	1
Barry Parnaby, Healthwatch Telford and Wrekin from 1 February 2021	1

The highlighted areas of the committee's reports are as follows:

- Primary care performance reporting: financial performance reporting, quality and performance monitoring, quarterly assurance and primary care information technology.
- In addition, the Primary Care Committee has overseen the development and implementation of the following during 2020/21:
- Review of Terms of Reference
- Finance update

- Quality Report
- Pharmacy workforce model
- PCN Report
- Primary Care Strategy delivery
- Court Street boundary change
- Shropcom business case – Dawley
- GP patient survey
- Risk Register
- Pontesbury/Worthen merger application
- Annual Electronic Declaration (eDEC)
- Quality Outcomes Framework
- Churchmere/Dodington merger proposal
- Primary care quarterly Quality Report.

Joint Individual Funding Committee

In August 2020, the CCG Governing Body created a Joint Individual Funding Committee with Telford and Wrekin CCG. The Joint Committee approves commissioning decisions for individual funding requests on behalf of the group. Due to COVID-19, it has not met during the year.

Names of Joint Individual Funding Committee members	Meetings attended during 2020/21
Ash Ahmed (Chair)	0
Dr Adam Pringle	0
Dr Mike Matthee	0
Rachael Robinson	0
Liz Noakes	0
Michele Rowland-Jones	0

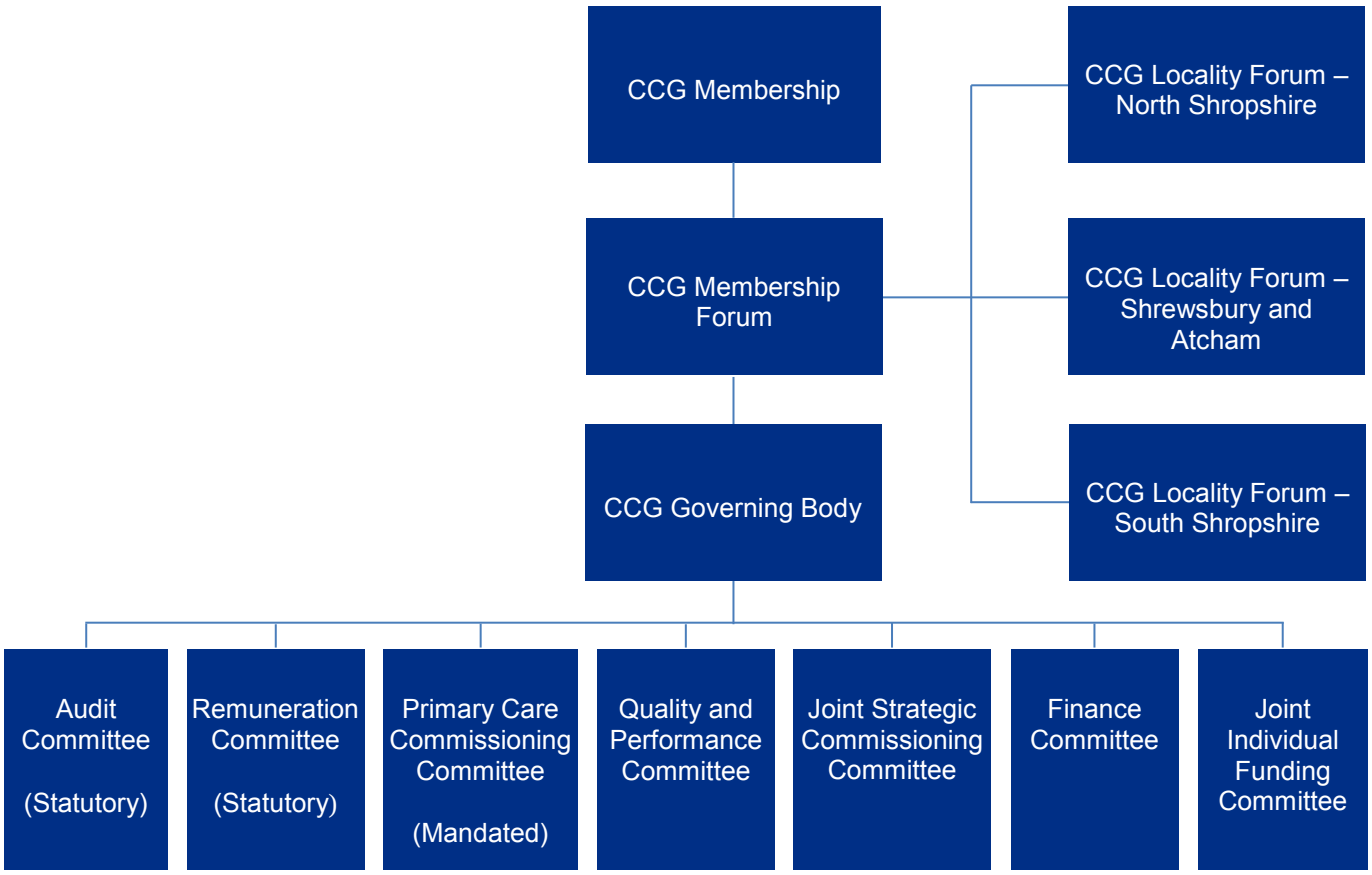
The committee has not met since its creation on 1 August 2020 due to COVID-19.

Membership of the committees and sub-committees of the CCG Governing Body is outlined in respective terms of reference which are included in the CCG's Constitution and Governance Handbook. Attendance at these meeting is recorded in the minutes of each meeting.

The CCG has reflected on its own effectiveness and performance as part the monthly assurance checkpoints undertaken by NHS England for all CCGs during 2020/21. The outcomes of these are reported to the CCG Governing Body and Practice Forum by the Chief Officer and published on the CCG's website as a year-end statement.

The CCG Governing Body has also been working with an organisational development partner to help facilitate discussions and agreement with Telford and Wrekin CCG Governing Body on the transition to a single strategic commissioner across the whole county, part of which is to develop strong governance processes to address the forthcoming changes in commissioning and to contribute to making 20 per cent savings to the CCG's running costs as directed by NHS England and NHS Improvement. The CCG Governing Body also receives regular reporting from committees via Chair Reports and for those committees with delegated decision making an Annual Report that seeks to summarise that committee's effectiveness in discharging its duties.

The governance structure for the CCG from 1 August 2020 as described in the CCG's Constitution is shown in the diagram below:



UK Corporate Governance Code

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

We are committed to ensuring that we have in place structures that will effectively manage risks to a level that is in line with our key aims as set out in our Constitution. Some of these risks are internal and will be controlled by our internal controls and the internal control system. Others are external and arise due to unpredictable changes in the economic, business, political, technological and financial environment.

The following information outlines the normal risk management practice the CCG follows, but due to the COVID-19 pandemic, the CCG Governing Body agreed to focus its attention during 2020/21 on the Board Assurance Framework, to assist it in both navigating a very challenging environment but to also conserve valuable staff resources.

Preventing and deterring risk

We work to prevent risks from developing in the first instance, by making sure that employees are aware of their own areas of work and develop processes and procedures that help to eliminate any risks. This also includes providing appropriate mandatory and specialist training where required. We also provide communications and advice about issues related to fraud risk and who to contact should any employees have concerns. However, there are always risks inherent to programmes of work which need to be identified and managed.

Identification of risk

We identify our significant risks from the following sources:

- The investigation of incidents, claims and complaints
- Concerns raised by stakeholders, patients and staff
- Expertise of directors and managers
- Issues raised by CCG committees and groups
- External organisation reports and inspections
- External and internal audits and surveys
- Carrying out risk analyses or relevant assessment work.

Analysing the risk

The following factors are taken into account when the risk is analysed:

- The full extent of the consequences of the risk
- The likelihood of the risk occurring
- Any means by which the risk is currently controlled or mitigated
- How we will be assured that the risk is being adequately managed.

Developing further mitigating controls / accepting the risk

Following analysis of the risk, the relevant lead manager, in conjunction with other interested parties, will consider the circumstances identified and decide whether further mitigating controls are necessary. This may mean seeking advice from more senior CCG employees.

Monitoring the risk

Through the processes described in the policy below, all identified significant risks are monitored to ensure:

- The level of risk that we are prepared to accept in the pursuit of our strategic objectives is acceptable to the organisation and our stakeholders (risk appetite, described as 'Post Mitigation Assessment of Risk Level' on the CCG Assurance Framework)
- The risk is communicated to all relevant parties
- That identified systems of internal control are working effectively, reducing risk to an accepted level
- Identified assurances have been received by the Governing Body.

We see risks and potential risks in a positive way – as a tool for learning and developing and making sure that processes and procedures are in place to mitigate any such risks developing in the future. Employees are encouraged to report any potential risks in their directorate and where appropriate, for these to be added to the Corporate Risk Register. It is the responsibility of the appropriate director to raise this risk within the executive team to identify any mitigating actions or to consider whether the risk is significant enough to be included in the Governing Body Assurance Framework.

Work with patients and public – either through formal routes like complaints, PALS, Healthwatch or our patient advisory group, or informally through other patient groups; helps to identify other potential risks. Where these are identified, they are passed to the appropriate lead manager or director for consideration or follow-up with the patients or public to get a greater understanding of the issue.

Capacity to handle risk

Our Governing Body, Finance Committee, Quality and Performance Committee and Audit Committee in particular, consider organisational risks at each of their meetings, thereby demonstrating senior level ownership of the risk management process across the organisation. However, each of the Governing Body Committees will also review the Corporate Risks periodically. Risks are also regularly reviewed and highlighted at weekly Executive Team meetings.

Our Risk Management Policy defines the structures, processes, roles and responsibilities that support the effective management of risks of all kinds to a level that is in line with our key aims as set out in the CCG constitution. In doing so, we use the framework to take all reasonably practicable steps in the management of risks: in commissioned services, associated with staff, associated with visitors, with regard to organisational reputation, organisational assets and any other issue, as an integral part of our management processes.

Each Executive Director and Director takes responsibility for risks associated with their work portfolio and ensures that their Directorate Risk Registers reflect these risks and feed into the overall Corporate Risk Register and ultimately the Governing Body Board Assurance Framework (BAF).

There is a process for escalating the risk onto the BAF when appropriate. Staff in directorates are encouraged to raise any potential risks with their director in order to make sure directorate Risk Registers are up to date and reflect real, time-sensitive risks. The CCG has continued to utilise an Issues Log to complement the BAF and ensure that where risks are realised there continues to be focus on mitigation and resolution and that the Governing Body has oversight of this.

The Director of Corporate Affairs has oversight of the Governing Body Board Assurance Framework and Issues Log as well as the Corporate Risk Register and Issues Log. They are therefore responsible for ensuring these documents are kept up to date through working with executive directors to review their respective risk areas and update them accordingly.

Risk assessment

During 2015/16 and 2016/17, we identified deteriorations in our financial position, exposing control weaknesses within the organisation. This has had a significant impact on the delivery of key system objectives and has resulted in us failing to remain within our financial allocation. As a result of the significant financial and operational challenges facing the CCG, we have been subject to NHS England Legal Directions since April 2016 and continue to be subject to a formal monitoring and oversight process with NHS England. We were able to reach the financial control total set by NHS England in 2016/17. However, this has not been the case for 2017/18, 2018/19, 2019/20 and 2020/21. The CCG continues to operate in a challenging financial environment and manage a number of organisational risks.

The Governing Body Assurance Framework (BAF) is a key document and considered in detail at the Governing Body and Audit Committee. It is updated on a regular basis and directors are held to account for the assessments made in it. Each of the risks that are included in the BAF is

regularly reviewed and key controls and key assurances identified and monitored. Where any gaps in controls or assurances are identified, then mitigating actions are identified and taken to make sure the risk is appropriately managed.

In November 2020, the CCG together with Telford and Wrekin CCG agreed to create a joint interim Board Assurance Framework in order to support the newly-appointed joint governing body members on both Governing Bodies to focus on the strategic risks facing both CCGs during a pandemic situation. A summary of the major risks identified in this interim joint Board Assurance Framework is set out below and the actions being taken to mitigate the risks. The major risks to the CCG have been reviewed and revised where necessary every quarter and then presented to Audit Committees in Common and the CCG Governing Bodies.

Description of joint Interim major risks added to the Board Assurance Framework during 2020/21	Existing controls	Further actions
Underlying financial position is currently a 9.8 per cent deficit (compared to recurrent allocation): There is a risk that the CCGs fail to deliver their financial plans for 2020/21 and that the underlying position going forward significantly deteriorates.	Detailed 2020/21 financial year to date and forecast reporting in place. QIPP Programme Board meeting monthly to monitor delivery of savings and action plans. Constitution / Prime Financial policies etc in place and communicated across organisation. Regular budget meetings with budget holders and both budget manager handbook and regular training programme in place.	CCG Financial Strategy accepted by NHSE/I for authorisation process and signed off by Finance Committee in January 2021. The strategy will now be updated going forward in line with the development of the System Financial Plan. Update on this to be taken to April Finance Committee. System Long Term Financial Sustainability Plan to be updated by 31 March 2021, to include implementation plans from programme boards to address priorities and inclusion of COVID-19 recovery trajectories. Awaiting detailed planning guidance for 2021/22 and plans and budgets to be developed in line with this for reporting to Board in March/ May 2021. Continuing Healthcare (CHC) Action Plan in place and discussed with CFO and AO. Action plan is progressing and CHC team are reviewing QIPP plans for 2021/22 although the COVID-19 pandemic is still posting a risk. The recent internal audit report notes progress and evaluation scheduled for April 2021.
Quality and Safety: If the CCGs fail to commission safe, quality, services for their populations then there is a risk	1. CCG attendance at all providers quality and contract monthly meetings. RAP in key areas of concern including emergency departments, maternity,	Continue to monitor workforce plans and risks at provider Certified Quantitative Risk Management (CQRM). 2, 3, 6, 7, 8, 9 – undertake themed reviews for both individual providers and system quality concerns and issues.

that patients will come to harm, that regulatory action or commissioning decisions will result in closure of services, with our population having to access services out of county, and a risk of adverse publicity.	ophthalmology, diagnostics, neurology, cancer waits, referral to treatment, mental health, Looked After Children. 2. Monthly Serious Incident Review Group (SIRG) for each provider. 3. Monthly internal CCG SIRG. 4. Quality visit schedules for all providers, primary care and care homes Currently on hold due to COVID pandemic. 5. Infection prevention and control (IPC) health economy meetings and attendance at IPC committees and outbreak meetings. 6. NHSE/I Oversight and Assurance process in place with agreed support. 7. Regular monitoring re workforce including mandatory training, supervision, sickness, absence and vacancy rates for all providers. 8. CCG Quality Strategy and associated delivery programme.	Maintain a schedule of quality assurance visits, with triangulation of data from a variety of sources, including increased inclusion of patient experience elements. Further develop the maternity metrics dashboard by May 2021. Evidence to support maternity Clinical Negligence Scheme for Trusts (CNST) submission to be reviewed and validated by CCG by July 2021. Implement / embed a system-wide approach to quality improvements – Quality Surveillance Group, Patient Safety Group, Medicines Safety Group, which aligns to NHSE requirements (when published) to allow shared view of quality and appropriate escalation both within and external to system. By May 2021.
NHS Constitution Performance Targets: There is a risk that the CCGs fail to meet the NHS Constitution performance targets consistently.	CCG attendance at: Monthly Planned Care Working Groups – temporarily stood down due to COVID. Fortnightly Urgent and Emergency Care (UEC) Delivery Group. Fortnightly SaTH Cancer Performance meeting. Monthly provider contract meetings – temporarily stood	Team staffing update – did not recruit to Deputy post – looking for interim while go out to external add in March. Analysts in post now and one performance assurance manager in post for elective and cancer. Agree key elements of A&E improvement plan at UEC Delivery Group by end March (delayed due to COVID wave 3). Working across system to get single performance framework and single reporting through system PMO delayed due to COVID wave 3. MLCSU supporting integrated performance reporting from March until system

	down due to COVID.	solution in place. Maximising use of all available system capacity for cancer and urgent elective care through to the end of March 2021 and beyond as required. Performance assurance manager doing deep dives into performance by tumour site to support delivery of 62-day referral to treatment. Already supported recovery in two-week breast cancer. Minimal improvement in referral to treatment times this year due to COVID, so mitigation is not sufficient to improve overall risk score this financial year – listed mitigation should slightly improve A&E performance and help maintain cancer performance and deliver required improvement in two-week measure by year-end.
COVID 19 Emergency Preparedness Resilience and Response (EPRR): There is a risk that the CCGs fail to manage with partner organisations the local health system response to COVID-19 second wave.	Gold Command Silver Command COVID-19 workstream Task and Finish Groups	Full programme in place to address all elements of COVID-19 response. System incident response structure in place and operational. Continued system approach to managing the incident as it evolves. Ongoing demand and capacity work to track impact in real time and inform decision making. Continued evaluation of surge planning. Ongoing discussions across region regarding mutual aid as well as with the Independent sector. Memorandum of Understanding in place to support re-deployment of staff. Prevalence rates now declining significantly and hospital admissions also continuing to decline. De-escalation plan in place and enacted relating to exit from third COVID wave.
Restoration of health services following COVID-19 third wave: There is a risk that the CCGs fail to take account of best practice and learning during COVID 19 response in the planning for future health needs.	Gold Command Silver Command COVID-19 workstream Task and Finish Groups System Transformation Delivery Group System Planning and Performance Group Use of Microsoft Teams as repository for all COVID-19 related information	Commitment via Gold and Silver Command to embrace new ways of working and where possible encourage the implementation of innovative ideas and solutions. Learning outputs presented to Silver and Gold as and when appropriate. Full debrief will be carried out following stepping down of incident response as part of usual EPRR process. System Improvement Plan developed and in implementation stage. To be addressed as part of single strategic commissioner organisational development work as well as through programme to develop the ICS. Prioritisation of critical tasks at height of pandemic will inevitably mean that change will

		focus on the immediate and necessary tasks to manage patient care and learning will be captured as a reflective piece at a later date. De-escalation plan enacted and repatriation of staff taking place and/or planned. Modelling work underway for restoration of services alongside mapping of staff resource required for delivery. Likely that restoration will present significant capacity issues.
Patient and public involvement: There is a risk that the CCGs fail to involve patients and the public in planning commissioning arrangements, in development and consideration of proposals to change existing services or to cease existing services.	Communications and Engagement (C&E) Strategies. C&E teams working jointly across both CCGs providing expertise in planning and delivery. Reports to Governing bodies/Committees require section completing on patient involvement. Decisions at STP level on restore of services require equality and engagement plans to be completed. Presence of Healthwatch for both areas at Governing body meetings/JSCC and Quality Committees. Joint Lay Member for PPI and Joint Associate Lay Member for PPI – Equalities, Diversity and Inclusion in place on Governing Bodies to act as specific check and balance. Patient engagement events delivered January 2020, December 2020 and March 2021 as per single strategic commissioner C&E Plan. Interim Director of C&E appointed for ICS/CCG to provide strategic direction and development whilst recruitment of substantive role is undertaken.	Draft communications strategy submitted to NHSE/I by 25 January 2021 deadline, no further comments received. Further final version to be submitted 31 March 2021. Management of Change (MOC) for staff due to complete in March 2021. Band 7 vacancy now filled, Admin role still awaiting MOC to be finalised before any external recruitment can begin. Interim ICS/CCG Director of C&E will lead piece of work to review STP team work coming over to CCG team. Recruiting to an ICS/CCG Director of Communications and Engagement.

Single strategic commissioner: There is a risk that the CCGs fail to provide system leadership and the delivery of system transformation.	ICS Shadow Board Chief Executives Group STP Programme Boards CCG Directors weekly meeting Commissioning Strategy Operating Model Project plans for delivering required changes Agreement from system to have single leadership model for ICS and CCG	Recruitment of a single Accountable Officer for CCG and STP by March 2021. PMO programme management website to be updated with comprehensive project plans for all STP priorities by November 2020. Full ICS Development Plan finalised. Development of appropriate accountability framework that accommodate whole system and place-based commissioning.
Population needs: There is a risk that the CCGs fail to understand their populations needs that contribute to health inequalities across the county.	Population Health Management (PHM) portfolio priority for Director of Planning. Partnerships and relationships developing with key stakeholders. JSNA for Shropshire, Telford and Wrekin. Health inequalities system strategy overseen by Director of Partnerships and feeds into governance of Care Closer to Home Programme Board. Links with patient, parent and carer groups to embed specific groups i.e. SEND, children's, mental health into strategies.	MLCSU Strategy Unit undertaking system review of BI capacity and capability to provide recommendations on future system model for BI including PHM. 2 x PHM posts in new CCG structure, each to be a joint post with our two local authorities Engagement strategies being developed with the SCCtH and TWIPP boards. Joint posts with local authority to develop partnership and place based working to deliver the needs of the population. Assurance. PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Funding requirement linked to output of the MLCSU Strategy Unit review.
ICS development: There is a risk that the CCGs fail to support and lead the development of ICS/ICP which then compromises the capacity and capability of a new single CCG in the future.	CCG AO is interim ICS Lead Director.	ICS Plan to gain authorisation has been developed. Checkpoint meetings with NHSE/I. Monitoring through the ICS Shadow Board.

Sustainable services: If CCGs fail to maintain sustainable acute services within the county, there is a risk that patients will have to receive healthcare outside of the county. There is a risk of clinical safety associated with longer travel times. There is a risk of adverse publicity.	1. Current contract and quality monitoring arrangements including: CQRM (including workforce reports) QA visits SI reporting and meetings monthly Monitoring of NHS to NHS concerns. Staff survey. Friends and Family Test. Patient experiences and stories. 2. Fortnightly ED/ SaTH Assurance call with Exec / SMT leads. 3. Monthly Shrewsbury and Telford NHS Hospital Trust Oversight and Assurance Group (SOAG) meetings to drive system approach to support in relieving the pressure at the front and back door of SaTH. 4. During COVID, the quality team have been working with the Trust's quality team, joining Exemplar visits. 5. Informal drop-in / ad-hoc visits take place as required based on horizon scanning of soft intelligence, data, SIs, NHS to NHS concerns, complaints etc.	Robust monitoring of workforce modelling – recruitment and retention plans. The People Board continues to identify and plan for the workforce gaps across the STP footprint. The CCG is an active part of this process. Escalate to NHSE/I, Board, PSG, as appropriate. Ongoing Local QSG in development to ensure a system approach to quality and demand issues by May 2021. System Planning and Performance Group now in place. Continue to attend SOAG and gain assurances required in relation to all ED concerns. Ongoing. Both CCGs, via the current control mechanisms, will continue to robustly encourage SaTH to make improvements across the trust to achieve improvements on all quality key indicators. Continue with enhanced monitoring and surveillance as per quality assurance framework. Oversight of quality management processes at the Trust continues via CQRM. Agree system quality matrix, Triangulation with CQC and NHS Improvement. Continuously review the assurance calls template/ data capture to provide assurances that the Emergency Departments are providing safe care and are appropriately staffed. Continue to support and challenge implementation of CQC action plans. The CCG is working closely with the Trust, NHSE/I, emergency care improvement support team (ECIST) and partners to provide support and challenge in driving forward the measures required to improve. The CCGs continues to offer direct support to SATH's safeguarding governance and operational processes. This has involved embedding the CCG named nurse for adult safeguarding within the Trust and this work is progressing positively. All actions ongoing.
EU Exit:	1. CCG attendance at all regional and national	System EU Exit Lead in place and organisation integrated care communities in place to receive

There is a risk that the CCGs fail to manage the impact of EU Exit on the adequacy of patient care.	pharmacy leads briefings. 2. National planning and stockpile of medicines to ensure supply over first stages of EU Exit. 3. National shortage supply protocols implemented. 4. Medicines team will support practices with information and to respond to shortages. 5. Prescription Ordering Department can be utilised to shorten prescribing duration to ensure stock is equitable distributed. 6. Financial impact on NCSO and Cat M price changes are monitored monthly. 7.System EU Exit Lead identified. 8. Engagement with NHSE/I on EU Exit planning. 9. System procurement and supply chain Task and Finish Group in place.	communications and directives from NHSE/I. System Procurement and Supply Chain Task and Finish Group meeting regularly and providing updated to Silver Command twice a week as well as a weekly SitRep. System will continue to monitor the position as it develops and request input / flag issues as required. No issues experienced locally and minimal nationally. Daily EU Exit SitReps now stood down at weekends for CCGs.

Other sources of assurance

Internal Control Framework

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place under review for the year 2020/21 and up to the date of approval of the annual report and accounts.

The system utilised by the CCG is designed to identify and prioritise 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. There is appropriate monitoring of risks and the courses of action being employed to mitigate them.

Our Risk Management Policy defines our commitment to ensuring that the CCG has in place structures that will effectively manage risks of all kinds, in-line with aims set out in our Constitution. We will take all reasonable steps to manage risks in commissioned services, staff, visitors, reputation, organisational assets and any other issue as an integral part of our management processes.

The following control mechanisms are in place:

- Constitution
- Risk management
- Security management
- Counter Fraud Annual Plan
- Internal Audit Annual Plan
- Performance monitoring of CCG providers and the CCG itself
- IG toolkit submission
- Incident and serious incident reporting
- Quality and financial reporting
- Contract / quality performance monitoring arrangements with providers
- Policies and procedures
- Risk assessments
- Governance reporting between Board and its committees / sub-committees
- Safeguarding Annual Report
- Emergency and Business Continuity Planning / core standards
- External regulator reports on providers.

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 CCG has carried out its annual internal audit of conflicts of interest and the audit provided significant assurance, with no recommendations for further action.

There have been no breaches of the Conflicts of Interest Policy which require reporting to the Audit Committee.

Data quality

The Board relies on the data quality elements in its contracts with providers, that requires them to quality assure their data prior to submission. The CCG also uses NHS Midlands and Lancashire Commissioning Support Unit for provider information performance, quality and finance and therefore the CCG's contract with MLCSU outlines information reporting

expectations. The data sources used by MLCSU is the national UNIFY system and SUS data which is verified via the contracting process with providers.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. Shropshire CCG is compliant with the standards set out in the IG Toolkit for 2020/21.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed processes and procedures in line with the IG toolkit. We have ensured all staff undertake annual IG training and provide a staff IG handbook to ensure everyone is aware of their roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We have reported a total of five incidents during 20/20/21. The scoring for IG breaches changed from 0-2 to Reportable or Non reportable, All of these incidents were graded as non-reportable - very low risk and therefore not reported to the Information Commissioner's Office (ICO). We have developed an Information asset register which enables the CCG to identify high-risk assets through data flow mapping and the CCG ensures that an information risk culture is embedded throughout the organisation.

The CCG receives an IG service from NHS Midlands and Lancashire CSU. This enables us to receive a full specialised service which as a small organisation we could no reproduce in-house. A work programme has been undertaken by MLCSU in order to ensure that the CCG is compliant against General Data Protection Regulations. As part of this the CCG's information has been audited, staff training has been delivered and the CCG has a nominated data protection officer.

During 2021/22, the CCG will continue to move towards having a fully embedded information risk culture throughout the organisation and retaining its IG compliance in preparation for transition to an ICS in 2022.

Business critical models

The CCG relies on centrally provided NHS business planning models, to help it plan future strategy. The CCG has no business critical models that it would be required to be shared with the Analytical Oversight Committee.

Third party assurances

Third party assurances are received annually from MLCSU for particular financial functions which are part of a Service Level Agreement. Processes are in place to ensure that the CSU Internal Audit function shares its own audit findings of these functions with the CCG's internal auditor who includes a precis of the findings in the Head of Internal Audit Opinion which is part of this statement. There have been no limited findings from last year's reports which would require remedial action.

Raising Concerns – Whistleblowing

The CCG has a policy in place to support staff to raise concerns (sometimes referred to as whistleblowing). There have been no concerns raised by staff during the year 2020/21. The Audit Committee gets an annual report on any concerns raised and action taken protecting anonymity where required. The new single CCG has appointed a Speak Up Guardian at Board level to support staff to raise concerns under the policy moving forward.

Control issues

The significant control issues that have materialised during 2020/21 that would require reporting in this Annual Governance Statement are as follows:

1. Financial Deficit

Due to the COVID-19 pandemic, the financial regime for 2020-21 has been very different to any normal year. In the first six months of 2020/21, the CCG was given a budget to operate within based on 2019/20 spend with a small uplift, any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first six months of the year the CCG reported a break even position. In the second six months of 2020/21, the CCG was again given a budget to operate within based on 2019/20 spend plus a small uplift plus an additional allocation assuming that Non COVID overspends in the first six months of the year would continue into the second six months. The CCGs were also given system level funds to support COVID expenditure and any growth across the system. There was a clear expectation that organisations and systems would manage within this funding and report a break even position.

The CCG has ended the year with a £0.7m surplus against the budget allocated. This surplus will take the cumulative deficit carried into 2021/22 to a total of £123.3m.

As the CCGs come together to become a single commissioning organisation, the focus for both the CCG and the wider system is addressing the underlying financial position. The current assessment of the underlying financial deficit for the newly combined CCG in 2020/21 is £71m deficit. The system is currently working together to develop a sustainable financial plan that delivers stabilisation during 2021/22 and then improvement through transformation schemes from 2022/23 onwards.

Running costs are expected to exceed its resource limit this year due to non-recurrent costs relating to the development of a single commissioner. In working towards the creation of a single strategic commissioning organisation with Telford and Wrekin CCG, a new staffing structure has been implemented and is in the final stages of the management of change process so that for 2021/22, the CCG is intending to operate within its new lower running cost allocation. In addition, the CCG has all but eliminated the use of interim staff.

2. Quality issues at local providers

The CCG continues to work with the trust to manage significant performance and quality issues in year in relation to its acute provider, which is in special measures for quality, particularly relating to ED, maternity care and more recently care of children and young people presenting with mental health conditions, and is assessed as inadequate for leadership at organisational level, which includes quality governance concerns.

The CCG has a range of inputs to the provider to aid improvement and will be implementing revised system quality governance arrangements during the next reporting period, including strengthening the role of our Local Maternity and Neonatal System (LMNS) to have oversight of perinatal mortality and safety.

A&E performance continues to be poor, with associated issues relating to 12-hour breaches and ambulance delays over one hour. These have been made worse by additional pressures of the COVID-19 pandemic including the reduced bed base as a result of infection, prevention and control and cohorting challenges. Also as a result of the pandemic, the local cancer and 18-week referral to treatment performance has been affected. The CCG now has a number of patients waiting longer than 52 weeks, which prior to the pandemic was zero. The CCG is working with all providers to ensure patients waiting are kept under regular clinical review and clinically prioritised at a system level. Detailed improvement plans are being worked on with providers in preparation for the end of the pandemic and the start of the recovery period and these will be reported through the CCG's Quality and Performance Committee and the emerging ICS governance structure to ensure a more coordinated approach to performance. The work around performance continues to be supported by NHSE/I.

3. COVID-19 pandemic

A further significant control issue is that the impact of the continuing COVID-19 pandemic. A national emergency was declared in March 2020, which has required the NHS as a whole to respond on a scale not seen since the Second World War and which is still in place.

The CCG in partnership with Telford and Wrekin CCG and other key stakeholders continues to lead the local health resilience partnership (LHRP) response to the emergency across Shropshire, Telford and Wrekin. Some clinical staff continue to be redeployed to frontline services to support the significant challenge that COVID-19 has had. Non-clinical CCG staff also continue to be redeployed into identified critical services or have been trained to provide back-up to these services to cover any staff shortages. The CCG has led on the restoration of services following the first national lockdown.

4. Continuing Healthcare (CHC)

The impact of COVID-19 has meant that the Continuing Healthcare service was suspended on 19 March 2020 which resulted in a large backlog of referrals. The CCG has started to address this backlog with a resulting one-third decrease in the backlog since September 2020 – but this remains a high risk.

The CCG had forecast an overspend on jointly-funded children CHC cases, but this has been revised down from £6.6m to £4m due to focused efforts on forecasting methodology and analysis of expected growth as compared to actual growth.

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

The Finance Committee and Quality and Performance Committee gives detailed consideration to the CCG's financial and performance issues to provide the CCG Board with assurance that all issues are being appropriately managed and escalated where necessary. This includes the determination of key financial assumptions to underpin the CCG's medium-term financial strategy and scrutiny of monthly financial reporting including delivery of Quality, Innovation, Productivity and Prevention (QIPP) schemes through the Programme Management Sub-committee, performance against central management costs and efficiency controls. Both committees report to the Governing Body via a Chair's exception report on a monthly basis. The Governing Body in addition receives summary financial reporting at each meeting.

The internal audit plan also provides reports to Audit Committee throughout the year on financial systems and financial management provided by the CCG and supported by MLCSU. Outcomes from these internal audit reviews are detailed in the Head of Internal Audit Opinion.

Delegation of functions

The CCG has a Scheme of Reservation and Delegation that sets out delegated areas of responsibility and authority and clearly defined limits that properly reflect roles and responsibilities.

It is underpinned by a comprehensive system of internal control, including budgetary control measures and ensures that there are sufficient safeguards and management mechanisms in place to maintain high standards in terms of effective, efficient and economic operation of the group. The scheme captures the decision-making roles of the CCG Accountable Officer, Directors, Governing Body and Committees, and is linked to the terms of reference of each committee.

The Audit Committee maintains an oversight of delegated functions and responsibilities to ensure that resources are used efficiently and economically and that there are effective processes in place to guard against fraudulent usage.

The CCG, in accordance with its Constitution, reviews its Scheme of Reservation and Delegation annually. Amendments to the overarching Scheme of Reservation and Delegation are taken to the Governing Body in the first instance and any material changes must be approved by the CCG's Membership Forum. The CCG remains accountable for all of its functions, including those that it has delegated.

Counter fraud arrangements

Counter fraud arrangements are contracted by the CCG from CW Audit Services who provide the services of an Accredited Counter Fraud Specialist, contracted to undertake counter fraud work proportionate to the CCG's identified risks.

The CCG Audit Committee receives a report from the Counter Fraud Specialist against each of the Standards for Commissioners at least annually and there is executive support and direction for a proportionate proactive work plan to address identified risks.

The Executive Director of Finance, who is a member of the CCG Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption and oversees that appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations.

Head of Internal Audit (HOIA) opinion

The purpose of my annual HOIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement.

My **overall** opinion is that:

Moderate assurance can be given as weaknesses in the design, and/or inconsistent application of some controls, put the achievement of aspects of some of the organisation's objectives at risk in some of the areas reviewed.

The **basis for forming my opinion** is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes
2. An assessment of the range of individual opinions arising from risk based audit assignments, contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses
3. Any reliance that is being placed upon third party assurances.

The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes

I have reviewed the overall arrangements the Governing Body has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Governing Body has identified the principal risks to achieving its objectives, the identification of controls in operation to mitigate against these risks and the degree to which the organisation has received assurances that these risks are being effectively managed. I have approached this by examining the Assurance Framework documents that you have in place and also by giving consideration to the wider reporting to the Governing Body that informs the Governing Body's assessment of the effectiveness of the organisation's system of internal control. The CCG have created a joint BAF with Telford and Wrekin CCG which should help establish controls and risk management in the new commissioning organisation. Whilst broader control arrangements were in place the BAF was not always fully updated and we have raised a recommendation to address this.

It is my view that an Assurance Framework has been established which is designed and is broadly operating to meet the requirements of the 2020/21 Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

The system of internal control based on internal audit work undertaken

My opinion also takes into account the range of individual opinions arising from the risk-based audit assignments that have been reported throughout the year. A revised internal audit plan for 2020/21 was developed to provide you with independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas. To achieve this, our internal audit plan was divided into two broad categories: work on the financial systems that underpin your financial processing and reporting and then broader risk focused work driven essentially by principal risk areas that you had identified in your Assurance Framework.

The assurance levels provided for all assurance reviews undertaken is summarised below:

Full Assurance	▪ Financial Systems (Payroll)
Significant Assurance	▪ Financial Governance (COVID-19) ▪ Financial Systems (Debtors, Ledger and Accounts Payable*) ▪ Conflicts of Interest Management ▪ Primary Care Commissioning (Finance)
Moderate Assurance	• Continuing Healthcare

- Data Protection and Security Toolkit (the CCG plan to submit in June 2020 – Moderate Confidence based on DPST guidance)
- Board Assurance Framework – Level A – with recommendations for improvement including to keep updated
- Governance Arrangements – COVID-19 in support of the Head of Internal Audit Opinion
- Organisational Preparedness – Committees of the Board Effectiveness.

*accounts payable opinion was updated in March 2021 following resolution of key items.

Details of the reviews were Moderate Assurance was provided are set out below:

Moderate assurance reviews

Continuing Healthcare (December 2020)

The CHC service had been subject to a highly challenging period of change resulting from the national COVID-19 response, with the CHC process suspended on 19 March 2020. Consequently, this had resulted in a large backlog of referrals because whilst the assessment process was suspended the referral process continued. The CHC process was reintroduced from 1 September 2020, with the CCG dealing with service recovery at the time of the review (December 2020) and taking positive action to reduce the backlog of referrals, which had reduced by nearly one third since the beginning of September 2020 (493 as at 31 August 2020 to 337 as at 26 October 20). The team should be commended for their efforts during this period.

There was clear evidence that the CCG had worked closely with the local authority to deal with service disruption and had responded quickly to national guidance during this time. In addition,

the CCG continued to work towards Management of Change requirements to put in place a uniform service / systems approach across both Shropshire CCG and Telford and Wrekin CCG, taking into account team capacity requirements and the use of Trusted Assessors.

However, processing of deferred assessments remained a significant challenge for the CHC team, and whilst there was clear evidence of good progress being made with backlog assessments reducing, it was noted that it was important that timely processing of deferred cases as well as 'business as usual' referrals from September 2020 remained a risk based focus for the CCG and the CHC team.

Whilst a price costing framework was not yet in place, there was clear evidence of CCG and local authority working together collaboratively for commissioning options during the COVID-19 period up to 31 August 2020. The intention was that these arrangements would continue to develop and become formal going forward during the service recovery period. A 'Spot Purchase Care Home Contract 2020/21' was agreed in November 2020, and was due to be rolled out to providers.

Agreement of joint-funded children CHC cases required action to ensure cases were completed on a needs basis and to provide additional stability to financial forecasts. The need to focus on implementation on this area had been highlighted previously, however it is recognised it takes two parties to agree. At the time of our review, the annual NHSE allocated budget was £67.3m with a forecast outturn as at Month 6 of £73.9m, resulting in a forecast overspend of £6.6m for individual commissioning. We were subsequently advised that the CCG has reduced the forecast overspend by approximately £4m due to some focused efforts on the forecasting methodology and analysis of expected growth compared to actual growth.

The Healthcheck showed overall rating improvement in both Performance Reporting and Broadcare, with overall ratings for other aspects of the service remaining unchanged from the previous position with the majority of areas assessed as "Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe".

Other

COVID-19 governance

In order to help issue the Head of Internal Audit Opinion without extensive limitations in this extraordinary year, an additional high-level review of the governance around some of the key controls was undertaken. The review was designed to help provide the required assurance for the organisation whilst minimising inputs from key staff who are likely to be actively engaged in managing the impacts of the pandemic, it did not therefore provide an assurance level for each area considered.

The CCG has responded well to the challenge of achieving governance during the pandemic. We noted the development and implementation of a robust incident management structure with Telford and Wrekin CCG which has been subject to internal review and revision during the course of the pandemic – particularly in light of the second wave. We were advised by the Director of Planning on 11 February 2021 that there have been no significant weaknesses specific to the CCG for which we would need to be made aware of with regard to the response.

We noted a clear process was established to support the completion of staff risk assessments in order to ensure that appropriate mitigations were put in place for staff who are unable to work from home during the pandemic and for those identified as 'at-risk'.

We noted that appropriate governance arrangements were maintained during the course of the pandemic with regular meetings of the Governing Body and Committees of the Board continuing to be held for the period reviewed, with key areas being reported on at each meeting. SitRep arrangements were also considered to be appropriate.

We confirmed as part of our Financial Governance review completed in July that no changes were made to the CCG's Standing Financial Instructions, Scheme of Delegation/Delegated limits and this was reported to the Audit Committee in June 2020. Our review noted a paper on 'Review of Governance Arrangements in Response to COVID-19' was presented to the Governing Body meetings of both Shropshire CCG and Telford and Wrekin CCG in May 2020. The paper proposed the stepping down a number of committees to a different regularity and to move to virtual meetings in response to COVID-19. Governing Body meetings were to remain as bi-monthly but with a reduced agenda focussing on assurance from committees, COVID-19 response updates, Governing Body Assurance Framework and strategic or investment decisions that need to be made in the period. The proposed interim arrangements were agreed at the May Governing Body meetings and in July, following a further update paper presented to both meetings it was agreed for governance arrangements to be reverted back from August.

Financial position

There is an underlying significant system deficit both at the CCG and its main provider SaTH. The CCG services a rural area that has an ageing population and care services are challenged financially in part due to this. This position is recognised in the STP in their System Operational Plan of April 2019 which will support the development of the Integrated Care System.

The financial position in 2020/21 for both Telford and Wrekin CCG and Shropshire CCG is particularly complicated with significant non recurrent funds received to operate a break even process during Months 1-6 and significant system non recurrent pass through allocations in Months 7-12. The CCGs (Shropshire CCG and Telford and Wrekin CCG) reported that the underlying position reported to the system was calculated at Month 7 as a £78m underlying deficit (2019/20: £65.3m) which mostly related to Shropshire CCG. It was reported that if this was adjusted for prescribing and individual commissioning Month 8 FOT improvements, the joint position showed a £74.3m underlying deficit. The underlying position was still being reviewed both internally and in discussions at a system level with providers. There was particular focus on whether all COVID spend is non-recurrent.

Following up of actions arising from our work

All recommendations and agreed actions are uploaded to a central web-based database as and when reports are finalised. Management is then required to update the status against agreed actions. This is a self-assessment and is supplemented by our independent follow-up reviews where this is deemed necessary, for example, following the issue of a limited or moderate assurance report.

The Audit Committee is proactive in monitoring actions and during the year there has been good progress in relation to implementing recommendations that the Audit Committee are responsible for overseeing. Challenging areas remain despite previous actions taken for example in relation to Continuing Healthcare, system affordability and quality.

Reliance on third party assurances

At the time of providing this opinion, we have not received third party assurances in relation to outsourced services provided by NHS Shared Business Services and NHS Midlands and Lancashire Commissioning Support Unit. I therefore reserve the right to revise my overall opinion in the event that these reviews identify any significant control failings that would impact on the CCG.

There are a number of significant and persistent quality challenges that the system has struggled to see significant traction and sustained improvement in. These challenges have included amongst others A&E, referral to treatment, cancer waiting times and lack of staff in key areas at the main provider. COVID-19 has compounded issues further as the system looks to restoration. As at May 2019, we followed up our review of SI (provider oversight) which had previously identified concerns with the process at the CCG and noted that there were still issues at that time with the production of RCA by providers and the review of these by the CCG.

On 8 April 2020, the CQC published their report on Shrewsbury and Telford Hospital NHS Trust (SaTH). The 'inadequate' rating was assessed as remaining in place with no assessment areas improving and two areas rated by CQC worse than the last inspection. The first part of the Ockenden Report (Maternity Services) has been issued which highlights local actions for learning and immediate and essential actions. The second report is expected next year. The CCG have advised (November 2020) that the CQC have confirmed to SaTH that sustained improvements have resulted in the two S31 conditions relating to maternity services being lifted and reporting requirements reduced. The future single commissioning organisation will have plenty to focus on as part of system reconfiguration.

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:

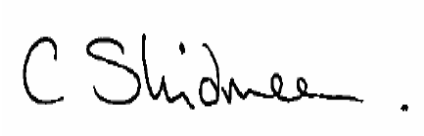
- The Governing Body

- The Audit Committee
- The Finance Committee
- The Quality and Performance Committee
- Internal audit
- Other explicit review / assurance mechanisms.

This has been a challenging year for the CCG; leading the system response to the COVID 19 pandemic, preparing the CCG for its transition into a newly-created CCG on 1 April 2021, addressing the significant financial issues across our system and the continuing quality challenges of some of our providers. I have put in place a series of actions to address these issues which are discussed in more detail in the body of the Annual Report.

Conclusion

The Head of Internal Audit Opinion contained within this report sets out an overview of the control issues we have faced which are also set against a number of external, ongoing challenges within the environment in which we commission services. These challenges continue to be evident in 2020/21 coupled with those posed by the need to respond to the COVID 19 pandemic. However, during the year, good progress has been made to address these challenges. This Annual Report highlights many of our achievements during this period and our Internal audit opinion reflects the efforts by CCG staff to make the required improvements. Despite this progress, significant issues still remain and Shropshire CCG will continue to build on the work we have commenced to address these ongoing challenges. In doing so we will continue to utilise the assurance methods available to us which are outlined above, but will strive to enhance and build on these foundations.



Claire Skidmore,
Interim Accountable Officer
14 June 2021

REMUNERATION AND STAFF REPORT

Remuneration Report

Remuneration Committee

The Remuneration Committee was established by Shropshire CCG to recommend approval of the remuneration and terms of service for the Executive Directors, other staff employed with Very Senior Manager (VSM) pay terms, and the conditions and lay appointments to the CCG Board.

The composition and responsibilities of the CCG's Remuneration Committee can be found in the Governance Statement.

Policy on the remuneration of senior managers

The remuneration of the Accountable Officer Executive Directors and Directors serving on our Governing Body is determined by the Governing Body on the recommendation of Remuneration Committee, with reference to recognised national NHS pay scales and benchmarking with other CCGs. The very senior manager (VSM) pay framework is used for the Accountable Officer and Executive Directors/Director. The Remuneration Committee also recommends for determination by the Governing Body the remuneration of the GP practice members of our Governing Body. The rates payable are determined locally.

NHS Midlands and Lancashire Commissioning Support Unit provide independent advice and support to the CCG and the Remuneration Committee in relation to employment and remuneration matters.

Remuneration report tables – pension and salary (subject to audit)
Salary and Pension Benefits 2020/21

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Ahmed *	Ash	Lay Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Allen *	Martin	Secondary doctor member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Bird	Matthew	Locality Chair	01/04/20 to 31/07/20	10-15	-	-	-	(5)-(7.5)	0-5
Braden *	Geoff	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	0-5	-	-	-	-	0-5
Bryceland	Rachel	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	(72.5)-(75)	(60)-(65)
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	32.5-35	100-105
Evans *	David	Accountable Officer - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	90-95	-	-	-	-	90-95
Fortes-Mayer	Gail	Interim Director	01/04/20 to 31/10/20	55-60	-	-	-	112.5-115	170-175
George	Priya	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	2.5-5	5-10
James *	Stephen	GP Governing Body Member	01/04/20 to 31/07/20	15-20	200	-	-	-	15-20
James *	Stephen	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	35-40	-	-	-	-	35-40
Leaman *	Alan	Secondary Care Clinical Member	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	01/04/20 to 30/04/20	0-5	-	-	-	0-2.5	5-10
Macarthur *	Donna	Lay Member - Joint post with Telford & Wrekin CCG	12/10/20 to 31/03/21	0-5	-	-	-	-	0-5
Matthee *	Michael	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	-	10-15
Matthee *	Michael	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	-	5-10
McCabe *	Julie	Nurse Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/01/21	0-5	-	-	-	-	0-5
Morris	Kevin	Practice Representative	01/04/20 to 31/07/20	15-20	-	-	-	27.5-30	45-50
Parker	Claire	Director of Partnerships - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	(0)-(2.5)	65-70
Pepper	John	GP Governing Body Member	01/04/20 to 31/07/20	5-10	-	-	-	15-17.5	25-30
Pepper	John	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	20-22.5	30-35
Porter *	Sarah	Lay Member - Transformation	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Povey *	Julian	Chair (Clinical)	01/04/20 to 31/07/20	30-35	-	-	-	-	30-35
Povey *	Julian	Chair (Clinical) - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	35-40	-	-	-	-	35-40
Pringle	Adam	GP Governing Body Member - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	2.5-5	15-20
Shepherd	Deborah	Medical Director	01/04/20 to 31/07/20	20-25	-	-	-	7.5-10	30-35
Shepherd	Deborah	Medical Director - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	25-30	-	-	-	7.5-10	35-40
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	80-85	-	-	-	60-62.5	140-145
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	55-57.5	120-125
Smith *	Fiona (Danella)	Practice Representative - joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	10-15	-	-	-	-	10-15
Stanford *	Colin	Lay Member	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	65-70	-	-	-	37.5-40	105-110
Timmis *	Keith (Andrew)	Lay Member - Governance & Audit	01/04/20 to 31/07/20	0-5	-	-	-	-	0-5
Timmis *	Keith (Andrew)	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	5-10	-	-	-	-	5-10
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	75-80	-	-	-	(7.5)-(10)	65-70
Turner *	Gary	Lay Member - Joint post with Telford & Wrekin CCG	01/08/20 to 18/09/20	0-5	-	-	-	-	0-5
Vivian *	Meredith	Lay Member - Patient & Public Involvement	01/04/20 to 31/07/20	5-10	-	-	-	-	5-10
Vivian *	Meredith	Lay Member - Patient & Public Involvement - Joint post with Telford & Wrekin CCG	01/08/20 to 31/03/21	5-10	-	-	-	-	5-10
Wilde	Nicola	Interim Director	01/04/20 to 31/10/20	55-60	-	-	-	47.5-50	105-110
Young	Zena	Executive Director of Quality - Joint post with Telford & Wrekin CCG	01/04/20 to 31/03/21	70-75	-	-	-	170-172.5	245-250

* Not in the NHS Pension scheme in this employment

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Note on exit packages

The following Board Members received the following redundancy payments in 2020/21 due to a restructuring of the Governing Body in preparation for the creation of a single commissioning organisation on 1st April 2021:

G Fortes-Mayer	£160k
K Morris	£8k
J Pepper	£2k
J Povey	£47k
N Wilde	£153k

These payments are not included in the values disclosed in these tables and exclude any applicable employers NI costs. Details of exit packages (including employers NI costs), are disclosed in Note 4.3 of the annual accounts.

Explanation of Joint Arrangements with Telford & Wrekin CCG

During 2020/21 Shropshire CCG and Telford & Wrekin CCG undertook a management of change process in preparation for the creation of one single commissioning organisation with effect from 1st April 2021. Part of this process was the formulation of a joint Governing Body and all Director roles became joint posts across the 2 CCGs with effect from 1st April 2020. The remaining Governing Body roles became joint points with effect from 1st August 2020.

The total cost of remuneration across both CCGs is shown below. This is in respect of the period of joint working only (where applicable):

SURNAME	FIRST NAME	POST	TOTAL REMUNERATION (Bands of £5,000)
Ahmed	Ash	Lay Member - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Allen	Martin	Secondary doctor member - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Braden	Geoff	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Bryceland	Rachel	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	20-25
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	105-110
Evans	David	Accountable Officer - Joint post with Telford & Wrekin CCG	145-150
James	Stephen	Interim Chief Clinical Information Officer - Joint post with Telford & Wrekin CCG	55-60
Macarthur	Donna	Lay Member - Joint post with Telford & Wrekin CCG wef 01/10/20	0-5
Matthee	Michael	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
McCabe	Julie	Nurse Member - Joint post with Telford & Wrekin CCG 01/08/20-31/01/21	0-5
Parker	Claire	Director of Partnerships - Joint post with Telford & Wrekin CCG	100-105
Pepper	John	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
Povey	Julian	Chair (Clinical) - Joint post with Telford & Wrekin CCG wef 01/08/20	60-65
Pringle	Adam	GP Governing Body Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
Shepherd	Deborah	Medical Director - Joint post with Telford & Wrekin CCG wef 01/08/20	45-50
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	130-135
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	105-110
Smith	Fiona (Danella)	GP/Healthcare Professional Member - Joint post with Telford & Wrekin CCG wef 01/08/20	15-20
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	105-110
Timmis	Keith (Andrew)	Lay Member - Governance & Audit - Joint post with Telford & Wrekin CCG wef 01/08/20	5-10
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	120-125
Turner	Gary	Lay Member - Joint post with Telford & Wrekin CCG 01/08/20-30/08/20	0-5
Vivian	Meredith	Lay Member - Patient & Public Involvement - Joint post with Telford & Wrekin CCG wef 01/08/20	10-15
Young	Zena	Executive Director of Quality - Joint post with Telford & Wrekin CCG	115-120

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Salary and Pension Benefits 2019/20 (subject to audit)

Surname	Forename	Title	Appointment Details	Salary (bands of £5,000)	Expenses payments (taxable) (rounded to the nearest £100) £	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related Benefits (bands of £2,500)	Total (bands of £5,000)
Bird	Matthew	Locality Chair - South	01/04/19 to 31/03/20	20-25	-	-	-	217.5-220	240-245
Clarke	Dawn	Executive Nurse Director	01/04/19 to 31/05/19	10-15	-	-	-	10-12.5	25-30
Davies	Julie	Director of Performance & Delivery	01/04/19 to 31/12/19	70-75	900	-	-	55-57.5	130-135
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	300	-	-	7.5-10	20-25
Evans	David	Accountable Officer - Joint post with Telford & Wrekin CCG	01/10/19 to 31/03/20	35-40	-	-	-	0-2.5	35-40
Fortes-Mayer	Gail	Director of Contracting & Planning	01/04/19 to 31/12/19	70-75	-	-	-	112.5-115	185-190
Fortes-Mayer	Gail	Interim Director	01/01/20 to 31/03/20	20-25	-	-	-	37.5-40	60-65
Morris	Christine	Executive Nurse Director - Joint post with Telford & Wrekin CCG	01/06/19 to 31/12/19	30-35	-	-	-	27.5-30	60-65
Morris	Christine	Interim Executive Director of Quality - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	-	-	-	10-12.5	25-30
George	Priya	GP Member	01/04/19 to 31/03/20	20-25	-	-	-	0-2.5	20-25
James *	Stephen	GP Governing Body Member/Clinical Chief Information Officer	01/04/19 to 31/03/20	55-60	600	-	-	0-2.5	55-60
Leaman *	Alan	Secondary Care Clinical Member	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Lewis *	Katy	Joint Locality Chair - North	01/04/19 to 31/03/20	20-25	-	-	-	0-2.5	20-25
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	01/04/19 to 31/03/20	55-60	-	-	-	52.5-55	55-60
Matthee	Michael	Joint Locality Chair - North	01/04/19 to 31/03/20	25-30	-	-	-	0-2.5	25-30
Morris	Kevin	Practice Representative	01/04/19 to 31/03/20	50-55	-	-	-	27.5-30	50-55
Pepper	John	GP Governing Body Member	01/04/19 to 31/03/20	20-25	-	-	-	0-2.5	20-25
Porter *	Sarah	Lay Member - Transformation	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Povey *	Julian	Chair (Clinical)	01/04/19 to 31/03/20	105-110	900	-	-	0-2.5	105-110
Shepherd	Deborah	Locality Chair - Shrewsbury & Atcham	01/04/19 to 31/03/20	60-65	-	-	-	40-42.5	60-65
Skidmore	Claire	Chief Finance Officer & Deputy Accountable Officer	01/04/19 to 31/12/19	85-90	-	-	-	65-67.5	155-160
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	15-20	-	-	-	10-12.5	25-30
Smith	Alison	Director of Corporate Affairs - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	-	-	-	2.5-5	15-20
Sokolov	Jessica	Medical Director	01/04/19 to 31/12/19	75-80	-	-	-	25-27.5	100-105
Sokolov	Jessica	Executive Director of Transformation - Joint post with Telford & Wrekin CCG	01/01/20 to 15/03/20	15-20	-	-	-	2.5-5	20-25
Stout	David	Interim Accountable Officer	01/04/19 to 30/09/19	70-75	1,500	-	-	0-2.5	70-75
Tilley	Samantha	Director of Corporate Affairs	01/04/19 to 31/12/19	70-75	800	-	-	120-122.5	195-200
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	01/01/20 to 31/03/20	10-15	300	-	-	20-22.5	30-35
Timmis *	Keith (Andrew)	Lay Member - Performance	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CCG	16/03/20 to 31/03/20	0-5	-	-	-	0-2.5	0-5
Vivian *	Meredith	Lay Member - Patient & Public Involvement	01/04/19 to 31/03/20	15-20	-	-	-	0-2.5	15-20
Wilde	Nicola	Director of Primary Care	01/04/19 to 31/12/19	70-75	800	-	-	97.5-100	170-175
Wilde	Nicola	Interim Director	01/01/20 to 31/03/20	20-25	300	-	-	32.5-35	55-60
					-				

* Not in the NHS Pension scheme in this employment

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Pension benefits

Please note that the Cash Equivalent Transfer Value was calculated by NHS Pensions Agency

Salary and Pension Benefits 2020/21

Surname	Forename		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021 £'000	Cash Equivalent Transfer Value at 1 April 2020 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Bird	Matthew	Locality Chair	(0)-(2.5)	(0)-(2.5)	10-15	35-40	218	211	3	0
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG	2.5-5	0-2.5	25-30	40-45	442	388	47	0
Fortes-Mayer	Gail	Interim Director	5-7.5	5-7.5	45-50	65-70	719	618	91	0
George	Priya	GP Governing Body Member	0-2.5	(0)-(2.5)	0-5	10-15	73	69	3	0
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	0-2.5	(0)-(2.5)	15-20	35-40	272	262	5	0
Morris	Kevin	Practice Representative	0-2.5	(0)-(2.5)	15-20	40-45	392	359	27	0
Pepper	John	GP Governing Body Member	0-2.5	5-7.5	10-15	25-30	239	182	54	0
Pepper	John	GP Governing Body Member - Joint post with Telford & Wrekin CCG								
Shepherd	Deborah	Medical Director	0-2.5	(0)-(2.5)	10-15	25-30	265	241	20	0
Shepherd	Deborah	Medical Director - Joint post with Telford & Wrekin CCG								
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG	2.5-5	5-7.5	40-45	90-95	644	565	70	0
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG	2.5-5	0-2.5	30-35	65-70	534	476	50	0
Wilde	Nicola	Interim Director	0-2.5	0-2.5	30-35	60-65	628	571	47	0

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Salary and Pension Benefits 2019/20

Surname	Forename		Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020 £'000	Cash Equivalent Transfer Value at 1 April 2019 £'000	Real increase in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Bird	Matthew	Locality Chair - South	7.5-10	25-27.5	10-15	35-40	211	47	163	0
Clarke #	Dawn	Executive Nurse Director	0-2.5	0-2.5	25-30	75-80	-	-	-	0
Davies	Julie	Director of Performance & Delivery	2.5-5	0-2.5	20-25	35-40	388	289	92	0
Davies	Julie	Director of Performance - Joint post with Telford & Wrekin CCG								
Fortes-Mayer	Gail	Director of Contracting & Planning	5-7.5	5-7.5	40-45	60-65	618	432	175	0
Fortes-Mayer	Gail	Interim Director								
Parker	Claire	Director of Partnerships - Joint post with Telford & Wrekin CCG	0-2.5	0-2.5	0-5	0-5	0	0	0	0
George	Priya	GP Member	0-2.5	7.5-10	0-5	10-15	69	52	16	0
James *	Stephen	GP Governing Body Member/Clinical Chief Information Officer	-	-	-	-	-		-	0
Leaman *	Alan	Secondary Care Clinical Member	-	-	-	-	-	-	-	0
Lewis *	Katy	Joint Locality Chair - North	-	-	-	-	-	-	-	0
Lynch	Finola	GP Governing Body Member/Deputy Clinical Chair	2.5-5	0-2.5	15-20	35-40	262	191	67	0
Matthee *	Michael	Joint Locality Chair - North	-	-	-	-	-	-	-	0
Morris	Kevin	Practice Representative	0-2.5	0-2.5	15-20	40-45	359	296	56	0
Pepper	John	GP Governing Body Member	0-2.5	0-2.5	5-10	20-25	182	173	4	0
Porter *	Sarah	Lay Member - Transformation	-	-	-	-	-	-	-	0
Povey *	Julian	Chair (Clinical)	-	-	-	-	-	-	-	0
Shepherd	Deborah	Locality Chair - Shrewsbury & Atcham	0-2.5	0-2.5	10-15	25-30	241	183	53	0
Skidmore	Claire	Chief Finance Officer & Deputy Accountable Officer	2.5-5	0-2.5	35-40	80-85	565	424	131	0
Skidmore	Claire	Executive Director of Finance - Joint post with Telford & Wrekin CCG								
Sokolov	Jessica	Medical Director	0-2.5	0-2.5	10-15	25-30	238	187	46	0
Sokolov	Jessica	Executive Director of Transformation - Joint post with Telford & Wrekin CCG								
Stout	David	Interim Accountable Officer	0-2.5	0-2.5	50-55	150-155	1,177	1,181	0	0
Tilley	Samantha	Director of Corporate Affairs	7.5-10	10-12.5	25-30	60-65	476	300	169	0
Tilley	Samantha	Director of Planning - Joint post with Telford & Wrekin CCG								
Timmis *	Keith (Andrew	Lay Member - Performance	-	-	-	-	-	-	-	0
Trenchard	Steven	Interim Executive Director of Transformation - Joint post with Telford & Wrekin CC	0-2.5	0-2.5	0-5	0-5	0	0	0	0
Vivian *	Meredith	Lay Member - Patient & Public Involvement	-	-	-	-	-	-	-	0
Wilde	Nicola	Director of Primary Care	5-7.5	5-7.5	25-30	60-65	571	399	162	0
Wilde	Nicola	Interim Director								

* Not in the NHS Pension scheme in this employment
# Pension has now been taken so CETV figures are no longer applicable

Compensation on early retirement or for loss of office (subject to audit)

Shropshire CCG does not have any to report during 2020/21, (nil in 2019/20).

Payment to past members (subject to audit)

Shropshire CCG does not have any to report during 2020/21, (nil in 2019/20).

Pay multiples (subject to audit)

The CCG is required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The remuneration of the highest paid member of the Governing Body in the CCG in the financial year 2020-21 was £148,500, (2019-20, £149,000). This was 4.48 times (2019-20, 4.58) the median remuneration of the workforce, which was £33,176 (2019-20, £32,525). The movement in the ratio compared to 2019-20 is due to a one-off payment of relocation costs received in 2019-20.

In 2020/21, 0 employees (2019-20, 1) received remuneration in excess of the highest paid member of the CCG Governing Body. Remuneration ranged from £19k to £149k, (2019/20, £15k to £167k).

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

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Staff Report (subject to audit)

The CCG has employed a headcount of 161 staff during 2020/21. This is equivalent to 129.04 WTE.

Staff Analysis by Gender as at 31.03.21 (Headcount)

Staff Analysis by Gender (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

	Headcount by Gender			% by Gender	
Staff Grouping	**Female**	**Male**	**Totals**	**Female**	**Male**
Governing Body	10	11	**21**	47.6%	52.4%
Other Senior Management (Band 8C+)	9	4	**13**	69.2%	30.8%
All Other Employees	101	26	**127**	79.5%	20.5%
Grand Total	**120**	**41**	**161**	**74.53%**	**25.47%**

Staff Analysis by Gender as at 31.03.21 (FTE)

Staff Analysis by Gender (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

	FTE by Gender			% by Gender	
Staff Grouping	**Female**	**Male**	**Totals**	**Female**	**Male**
Governing Body	3.50	1.40	**4.90**	71.4%	28.6%
Other Senior Management (Band 8C+)	6.84	2.10	**8.93**	76.5%	23.5%
All Other Employees	89.29	25.91	**115.20**	77.5%	22.5%
Grand Total	**99.63**	**29.40**	**129.04**	**77.21%**	**22.79%**

*Unknown Gender pertains to Governing Body Members without an entry in the CCG Electronic Staff Record

Staff composition by pay band

Staff Analysis by Band as at 31.03.21 (Headcount)

Senior Staff Analysis by Band (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	1
Band 3	38
Band 4	12
Band 5	19
Band 6	20
Band 7	17
Band 8 - Range A	13
Band 8 - Range B	7
Band 8 - Range C	4
Band 8 - Range D	2
Band 9	2
Medical	15
VSM	11
Gov Body (off payroll)	0
Grand Total	**161**

Staff Analysis by Band as at 31.03.21 – (FTE)

Senior Staff Analysis by Band (based on staffing at 31.03.2021 - Extracted from ESR 19.04.2021)

Pay Band	FTE
Apprentice	0.00
Band 1	0.00
Band 2	0.60
Band 3	34.00
Band 4	10.57
Band 5	17.63
Band 6	17.69
Band 7	15.40
Band 8 - Range A	12.71
Band 8 - Range B	6.60
Band 8 - Range C	3.80
Band 8 - Range D	2.00
Band 9	2.00

Medical	2.84
VSM	3.19
Gov Body (off payroll)	0.00
Grand Total	**129.04**

Redeployment of staff for COVID work

The following categories of CCG staff were redeployed for COVID work during 2020/21:

1.00wte Band 8C (Administrative/managerial support) – duration 2.5 months

1.00wte Band 8B (Administrative/managerial support) – duration four months

1.80wte Band 7 (Administrative/managerial support) – duration 3.5 months

These were short-term redeployments and the average duration was 3.4 months.

Employee benefits (subject to audit)

Shropshire Clinical Commissioning Group - Annual Accounts 2020-21

Employee benefits and staff numbers

Employee benefits 2020-21

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	5,548	423	**5,971**
Social security costs	561	-	**561**
Employer Contributions to NHS Pension scheme	1,036	-	**1,036**
Other pension costs	-	-	**-**
Apprenticeship Levy	16	-	**16**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	203	-	**203**
Gross employee benefits expenditure	7,363	423	**7,786**
Less recoveries in respect of employee benefits	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	7,363	423	**7,786**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	7,363	423	**7,786**

The costs above include £428k for COVID-19 related costs.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20 & 2020/21, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in the accounts and further detail explaining the reason for this increase can be found in Note 4.5 of the accounts.

Employee benefits 2019-20

	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	5,595	976	6,570
Social security costs	561	-	561
Employer Contributions to NHS Pension scheme	1,045	-	1,045
Other pension costs	-	-	-
Apprenticeship Levy	15	-	15
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	7,215	976	8,190
Less recoveries in respect of employee benefits	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	7,215	976	8,190
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	7,215	976	8,190

Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2020/21, (nil in 2019/20).

Sickness absence data

The sickness absence data for the CCG in 2020 was whole time equivalent (WTE) days available of 33940.44 and WTE days lost to sickness absence of 1633.3 and average working days lost per employee was 10.83 which was managed through the absence management policy.

Staff sickness absence 2020	2020 Number
Total Days Lost	1633.30
Total Staff Years	150.85
Average Working Days Lost	10.83

Staff turnover 2020-21

The staff turnover rate for 2020-21 has been calculated by dividing the total FTE Leavers in-year by the average FTE staff in post during the year. The CCG's total FTE leavers in year was 35.14. The CCG's average FTE staff in post during the year was 143.39. The CCG staff turnover rate for the year was 24.51%

CCG staff turnover 2020-21	2020-21 Number
Average FTE Employed 2020-21	143.39
Total FTE Leavers 2020-21	35.14
Turnover Rate	24.51%

Other employee matters

The CCG recognises that discrimination and victimisation is unacceptable and that it is in the interests of the organisation and its employees to utilise the skills of the total workforce. It is the aim of the organisation to ensure that no employee or job applicant receives less favourable facilities or treatment (either directly or indirectly) in recruitment training/career progression or employment on grounds of age, disability, gender/gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion or belief, sex, or sexual orientation.

To support this commitment and to ensure we comply with both the Equality Act 2010 and the Human Rights Act 1998, the CCG requires all of its staff to undertake regular mandatory training on equality, diversity and human rights and to comply with our Equal Opportunities Policy.

We are committed to communicating and engaging with staff on a consistent and frequent basis, through one-to-ones, team meetings, staff consultation events, CCG staff briefings, staff newsletters. We are part of our regional Joint Staff Consultative Committee (JSCC), which provides a forum for Trade Union staff representatives to meet and contribute to service change and development and for issues to be discussed. During the COVID-19 pandemic when the

majority of our staff have been working from home, we have run weekly “huddle” meetings via Microsoft Teams. These are hosted by the Accountable Officer and Directors and all staff to share information, receive updates on key areas of development with the pandemic and other priority areas. These huddles have also been shared with Telford and Wrekin CCG as a way of bringing together the two CCGs in preparation for the transition to a single CCG in April 2021.

The CCG has a recruitment policy which is based on NHS best practice and we use the recruitment service of NHS Midlands and Lancashire Commissioning Support Unit to ensure that recruitment is carried out robustly and transparently in line with our policy and there is a clear audit trail of recruitment decisions and employee checks. The CCG has a Training and Development Policy which seeks to ensure that all staff have an equal opportunity and access to training and development that their role requires through identification with their managers in appraisals and regular one-to-one meetings.

Employees with a disability

Employing people with a disability is important for any organisation providing services for the public, as they need to reflect the many and varied experiences of the public they serve. In the provision of health services, it is perhaps even more important, as people with disabilities make up a significant proportion of the population, and those with long-term medical conditions use the services of the NHS. The CCG’s commitment to people with disabilities includes:

- People with disabilities who meet the minimum criteria for a job vacancy are guaranteed an interview
- The adjustments that people with disabilities might require to take up a job or continue working in a job are proactively considered
- The CCG’s mandatory equality and diversity training includes awareness of a range of issues impacting on people with disabilities.

Trade union facility time

Relevant union officials

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

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0

1-50%	0
51-99%	0
100%	0

Percentage of pay bill spent on facility time

Percentage of pay bill	Figures
Provide the total cost of facility time	0
Provide the total pay bill	0
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

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

Expenditure on consultancy

Shropshire CCG spent £14k on consultancy services in 2020/21. The majority of this related to payments to a consultancy firm to review continuing care costs.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012 Clinical Commissioning Groups must publish information on their highly paid and/or senior off-payroll engagements.

The table below shows the existing arrangements as of 31 March 2021:

Off-payroll engagements longer than six months

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

Shropshire CCG can confirm that 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.

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

New off-payroll engagements

For all new off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency	0

review	

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 2020 and 31 March 2021:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	19

Exit packages and severance payments (subject to audit)

Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
Less than £10,000	2	12,070	1	5,750	3	17,820
£10,001 to £25,000	-	-	4	60,385	4	60,385
£25,001 to £50,000	2	80,953	3	100,828	5	181,781
£50,001 to £100,000	-	-	1	62,001	1	62,001
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	2	348,293	-	-	2	348,293
Over £200,001	-	-	-	-	-	-
Total	**6**	**441,316**	**9**	**228,964**	**15**	**670,280**

Compulsory redundancies include £370k paid to Board members as disclosed in the salary and pension benefits information on page 124.

Analysis of Other Agreed Departures

	2020-21 Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	9	228,964
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	**9**	**228,964**

These tables report the number and value of exit packages agreed in the financial year.

The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms & Conditions of Service Handbook and a Mutually Agreed Resignation Scheme (MARS)

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

Health and safety

The CCG takes health and safety of its employees very seriously and we have a policy in place to help ensure staff carry out their functions in a safe way. The policy requires staff to report health and safety incidents via an electronic system, which are then investigated, and action taken to help mitigate incidents reoccurring.

During 2020/21 due to the COVID-19 pandemic, the majority of CCG staff have been working from home, but with a small number of staff having to work in the office environment due to the nature of the roles they undertake. In order to ensure that the safety of staff was paramount during this time, we have assessed the risk to all staff having to work from the office and put protocols for mask-wearing, social distancing and cleaning processes in place to allow them to do this safely. Some staff identified as having a greater risk have been either redeployed or provided with equipment to allow them to work from home. We have also developed a home workstation assessment checklist for all staff working from home to ensure they are working in an environment that is supporting their health and wellbeing.

There were no health and safety incidents reported in the year.

Statement as to disclosure to auditors

Everyone who is a member of the Membership Body at the time the Members Report is approved confirms:

So far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and, that the member has taken all steps that they ought to have as a member in order to make them self-aware of any relevant audit information and to establish that the CCG's auditor is aware of the information.

Parliamentary Accountability and Audit Report

Shropshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this Annual Report at note 22. An audit certificate will be received from our auditors following submission of the Annual Accounts.

Fraud

The CCG adheres to the standards set by NHS Protect, in order to combat economic crime within the NHS. The CCG complies with the NHS Protect AntiFraud Manual, and best practice guidance from the Chartered Institute of Public Finance and Accountancy and the Institute of Counter Fraud Specialists.

The CCG employed the services of assurance provider CW Audit Services during 2020/21 to provide its local counter fraud specialists. The CCG does not tolerate economic crime, the CCG has an Anti-Fraud Bribery and Corruption Response Policy in place which is designed to make all staff aware of their responsibilities should they suspect offences being committed.

When economic crime is suspected it is fully investigated in line with legislation, with appropriate action taken, which can result in criminal, disciplinary and civil sanctions being applied. This work is monitored by the Audit Committee as a standing agenda item at each meeting.

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AUDIT REPORT

External audit fees, work and independence

The CCG's External Auditors are Grant Thornton UK LLP, Colmore Plaza, 20, Colmore Circus, Birmingham B4 6AT. The contract value was £55k excl VAT. The contract included the core audit work of the financial statements and work to reach a conclusion on the economy, efficiency and effectiveness in the CCG's use of resources (Value for Money conclusion).

Annual Accounts/ the financial statements and notes

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The Primary Statements:

Notes to the Accounts:

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

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(0)	-
Other operating income	2	(926)	(1,251)
Total operating income		**(926)**	**(1,251)**
Staff costs	4	7,786	8,190
Purchase of goods and services	5	587,810	514,911
Depreciation and impairment charges	5	-	-
Provision expense	5	1,636	599
Other Operating Expenditure	5	127	861
Total operating expenditure		**597,359**	**524,562**
Net Operating Expenditure		**596,434**	**523,311**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**596,434**	**523,311**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**596,434**	**523,311**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**596,434**	**523,311**

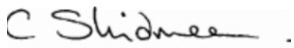
The CCG's planned in-year deficit was £12.8m, and has concluded the year with a surplus of £0.7m.
The cumulative deficit is £123m, following the application of the cumulative deficit brought forward from previous years of £124 million. The External Auditors have made a referral to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 in this respect.

The Clinical Commissioning Group has a residual cash balance of £128k on 31 March 2021 that is within the tolerance required by NHS England. This balance can be seen in the Statement of Cash Flows.

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment		-	-
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		-	-
Current assets:			
Inventories		-	-
Trade and other receivables	9	4,056	1,807
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	10	128	37
Total current assets		**4,184**	1,845
Non-current assets held for sale		-	-
Total current assets		**4,184**	1,845
Total assets		**4,184**	1,845
Current liabilities			
Trade and other payables	11	(52,490)	(36,646)
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	12	(1,837)	(599)
Total current liabilities		**(54,327)**	(37,245)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(50,143)**	(35,400)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions		-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(50,143)**	(35,400)
Financed by Taxpayers' Equity			
General fund		(50,143)	(35,400)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(50,143)**	(35,400)

The financial statements on pages 139 to 166 were approved by the Governing Body on 9 June and signed on its behalf by:



Claire Skidmore
Interim Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(35,400)	-	-	**(35,400)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(35,400)**	**-**	**-**	**(35,400)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(596,434)	-	-	**(596,434)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total revaluations against revaluation reserve		**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(596,434)**	**-**	**-**	**(596,434)**
Net funding	581,690	-	-	**581,690**
Balance at 31 March 2021	**(50,143)**	**-**	**-**	**(50,143)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(27,540)	-	-	**(27,540)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	**-**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2019	**(27,540)**	**-**	**-**	**(27,540)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating costs for the financial year	(523,311)	-	-	(523,311)
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(523,311)**	**-**	**-**	**(523,311)**
Net funding	515,451	-	-	515,451
Balance at 31 March 2020	**(35,400)**	**-**	**-**	**(35,400)**

Statement of Cash Flows for the year ended
31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(596,434)	(523,311)
Depreciation and amortisation		-	-
Impairments and reversals		-	-
Non-cash movements arising on application of new accounting standards		-	-
Movement due to transfer by Modified Absorption		-	-
Other gains (losses) on foreign exchange		-	-
Donated assets received credited to revenue but non-cash		-	-
Government granted assets received credited to revenue but non-cash		-	-
Interest paid		-	-
Release of PFI deferred credit		-	-
Other Gains & Losses		-	-
Finance Costs		-	-
Unwinding of Discounts		-	-
(Increase)/decrease in inventories		-	-
(Increase)/decrease in trade & other receivables	9	(2,249)	1,879
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	11	15,844	5,331
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	12	(398)	-
Increase/(decrease) in provisions	12	1,636	599
Net Cash Inflow (Outflow) from Operating Activities		**(581,600)**	(515,502)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		-	-
(Payments) for intangible assets		-	-
(Payments) for investments with the Department of Health		-	-
(Payments) for other financial assets		-	-
(Payments) for financial assets (LIFT)		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Proceeds from disposal of investments with the Department of Health		-	-
Proceeds from disposal of other financial assets		-	-
Proceeds from disposal of financial assets (LIFT)		-	-
Non-cash movements arising on application of new accounting standards		-	-
Loans made in respect of LIFT		-	-
Loans repaid in respect of LIFT		-	-
Rental revenue		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	-
Net Cash Inflow (Outflow) before Financing		**(581,600)**	(515,502)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		581,690	515,451
Other loans received		-	-
Other loans repaid		-	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-	-
Capital grants and other capital receipts		-	-
Capital receipts surrendered		-	-
Non-cash movements arising on application of new accounting standards		-	-
Net Cash Inflow (Outflow) from Financing Activities		**581,690**	515,451
		90	(51)
Cash & Cash Equivalents at the Beginning of the Financial Year	10	37	88
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**128**	37

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.

The CCG ended the financial year with an in-year surplus of £0.7m and a cumulative deficit position of £123.3m. This is in the context of a temporary financial framework being in operation in 2020/21 due to COVID-19. In the first 6 months of 2020/21, the CCG was given a budget to operate within and any variances from this budget for either COVID or non COVID expenditure were then funded retrospectively so that for the first 6 months of the year the CCG reported a break even position. Further funding was provided for the latter 6 months of the year which included funding for estimated COVID costs and there was a clear expectation that organisations would manage within this funding and report a break even position.

The ongoing impact of the COVID-19 pandemic has required the CCG to review whether this creates material uncertainty regarding its going concern status. At this time, it is judged that the going concern status of the organisation remains unchanged however it is recognised that there has been a significant impact on how we operate. Our assessment of going concern is made on the basis that Government support is available to the NHS for all COVID-19 related costs and the CCG is fully participating in all financial returns and reviews.

The CCG have taken steps to maintain business continuity for the finance function during this time in order that payments and collection of debt are not materially impacted. These steps include securing remote access to financial systems for all finance staff and budget holders, and working with our 3rd party providers (Midlands & Lancashire CSU and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of the CCG's aged debt and its continued high achievement against the Better Payment Practice Code.

Although the financial position of the clinical commissioning group indicates some uncertainty over its finances, the Governing Body, having made appropriate enquiries, have reasonable expectations over the continuity of services and the adequacy of resources to continue in operational existence for the foreseeable future (in its merged form with Telford and Wrekin CCG). As directed by the Group Accounting Manual 2020/21, the Governing Body have prepared the financial statements on a going concern basis as they consider that the services currently provided by the CCG will continue to be provided in the foreseeable future.

On 1st April 2021 the CCG will form one single commissioning group with Telford & Wrekin CCG to become 'Shropshire, Telford and Wrekin Clinical Commissioning Group'. The formation of this new organisation has been approved by both sets of Governing Bodies and NHS England and the services currently provided by the CCG will transfer entirely to the new organisation together with its assets and liabilities.

On this basis, the CCG has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

1.2 Accounting Convention

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

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

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

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

1.4 Pooled Budgets

The clinical commissioning group entered into a pooled budget arrangement with Shropshire Council under a Section 75 (NHS Act 2006) partnership agreement. This was for the purpose of commissioning health and social care services under the Better Care Fund (BCF). The host Partner for the agreement is Shropshire Council.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

Notes to the financial statements

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

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

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

1.9 **Property, Plant & Equipment**

Recognition

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

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

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Notes to the financial statements

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **Depreciation, Amortisation & Impairments**

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

1.10 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Notes to the financial statements

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

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

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

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

Notes to the financial statements

1.16 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 **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.

1.16.2 **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.

The CCG did not hold any such assets as at 31st March 2021.

1.16.3 **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 did not hold any such assets as at 31st March 2021.

1.16.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 **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.

The CCG did not take financial guarantee contracts during 2020/21.

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

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

The CCG did not hold any financial liabilities at fair value through profit and loss during 2020/21.

1.17.3 **Other Financial Liabilities**

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

1.18 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Losses & Special Payments**

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

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

Notes to the financial statements

1.20 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.20.1 **Critical accounting judgements in applying accounting policies**
Apart from those involving estimations (see below), management has made no critical judgements in the process of applying the clinical commissioning group's accounting policies that have a significant effect on the amounts recognised in the financial statements.

1.20.2 **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 year.

Provisions: Estimates used to calculate potential provisions are based on expert advice from solicitors and other external professional agents combined with the experience of CCG managers. The redundancy provision is based on the number of staff deemed at risk following a management of change process and the estimated costs have been calculated using an average cost for all staff. The actual costs will vary dependant upon the grade of staff and their number of years service but an average cost is deemed appropriate given the uncertainity at this point in time.
The continuing health care provision reflects the cost of appeals outstanding as at 31st March 2021. The cost has been calculated using an average weekly rate and assumes that all of the appeals will be successful.

Accruals - Continuing Health Care (CHC): The value of expected claims for CHC is estimated based on the number of days a patient has spent in a care home, multiplied by the daily charge of that provider. An estimate of future patients (accounting for expected growth), that are not yet in the CCG's CHC database is also made based on the number of days in a given month multiplied by the average monthly cost of existing patients included in the database.

Accruals - **Prescribing:** The CCG recognises the cost of drug prescribing based on data received from the NHS Business Services Authority (NHSBSA). Reports are received on a monthly basis, but reflect charges up to the end of February only. March costs are estimated using historical levels of expenditure. The NHSBSA uses a methodology for forecasting prescribing expenditure that is based on national averages and does not necessarily reflect local issues. Therefore consideration is given to the use of local knowledge to determine the appropriate level of expenditure to be included in the accounts. This review is undertaken and full disclosure of any proposed adjustments shared with the auditors.

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

1.22 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM. Work carried out to date has identified that the CCG currently has 1 operating lease which will be re-classified as finance leases. This is the lease for office accommodation which will commence in early May 2021 with Shropshire Local Authority. Current calculations estimate that this would have the effect on the Statement of Financial Position of increasing non-current assets by £90k and increasing financial liabilities by £90k. The current estimated impact on expenditure is an annual increase of £91k representing depreciation and interest costs and guidance is awaited from NHSE/I regarding the funding of this.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. The impact on the CCG has not yet been assessed.

2 Other Operating Revenue

	2020-21 Total £'000	2019-20 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	-
Non-patient care services to other bodies	-	-
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	0	-
Recoveries in respect of employee benefits	-	-
Total Income from sale of goods and services	**0**	**-**
Other operating income		
Rental revenue from finance leases	-	-
Rental revenue from operating leases	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-
Receipt of donations (capital/cash)	-	-
Receipt of Government grants for capital acquisitions	-	-
Continuing Health Care risk pool contributions	-	-
Non cash apprenticeship training grants revenue	-	-
Other non contract revenue	926	1,251
Total Other operating income	**926**	**1,251**
Total Operating Income	**926**	**1,251**

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

3. Contract Revenue

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

The CCG did not receive any income in 2020/21 from the sale of goods and services (contracts), (nil in 2019/20).

3.2 Transaction price to remaining contract performance obligations

The CCG did not have any contract revenue in 2020/21 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date, (nil in 2019/20).

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2020-21

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	5,548	423	**5,971**
Social security costs	561	-	**561**
Employer Contributions to NHS Pension scheme	1,036	-	**1,036**
Other pension costs	-	-	**-**
Apprenticeship Levy	16	-	**16**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	203	-	**203**
Gross employee benefits expenditure	7,363	423	**7,786**
Less recoveries in respect of employee benefits (note 4.1.3)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	7,363	423	**7,786**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	7,363	423	**7,786**

The costs above include £428k for COVID-19 related costs.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20 & 2020/21, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.5.

4.1.2 Employee benefits 2019-20

	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	5,595	976	6,570
Social security costs	561	-	561
Employer Contributions to NHS Pension scheme	1,045	-	1,045
Other pension costs	-	-	-
Apprenticeship Levy	15	-	15
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	**-**	**-**	**-**
Gross employee benefits expenditure	7,215	976	8,190
Less recoveries in respect of employee benefits (note 4.1.3)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	7,215	976	8,190
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	7,215	976	8,190

4.1.3 Recoveries in respect of employee benefits

The CCG has made no recoveries in respect of employee benefits in 2020/21, (nil in 2019/20).

4.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**144.70**	**4.38**	**149.08**	153.73	12.28	166.01
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	-	-	-

4.3 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		**2020-21 Other agreed departures**		**2020-21 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	2	12,070	1	5,750	3	17,820
£10,001 to £25,000	-	-	4	60,385	4	60,385
£25,001 to £50,000	2	80,953	3	100,828	5	181,781
£50,001 to £100,000	-	-	1	62,001	1	62,001
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	2	348,293	-	-	2	348,293
Over £200,001	-	-	-	-	-	-
Total	**6**	**441,316**	**9**	**228,964**	**15**	**670,280**

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	2020-21 Departures where special payments have been made		2019-20 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

4.4 Analysis of Other Agreed Departures

	2020-21 Other agreed departures		2019-20 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	9	228,964	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**9**	**228,964**	**-**	**-**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms & Conditions of Service Handbook and a Mutually Agreed Resignation Scheme (MARS)

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

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

4.5 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5. Operating expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,467	2,989
Services from foundation trusts	94,455	90,473
Services from other NHS trusts	275,978	229,730
Provider Sustainability Fund	-	-
Services from Other WGA bodies	(2)	2
Purchase of healthcare from non-NHS bodies	93,735	78,120
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	52,700	52,182
Pharmaceutical services	-	-
General Ophthalmic services	263	392
GPMS/APMS and PCTMS	52,085	47,581
Supplies and services – clinical	1,222	1,121
Supplies and services – general	9,880	8,638
Consultancy services	14	85
Establishment	1,787	2,068
Transport	107	95
Premises	1,043	653
Audit fees	66	72
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	10	12
Other professional fees	854	640
Legal fees	131	35
Education, training and conferences	13	24
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**587,810**	**514,911**
Depreciation and impairment charges		
Depreciation	-	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**-**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	1,636	599
Total Provision expense	**1,636**	**599**
Other Operating Expenditure		
Chair and Non Executive Members	504	574
Grants to Other bodies	182	183
Clinical negligence	-	-
Research & development (excluding staff costs)	-	-
Expected credit loss on receivables	(559)	104
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	-	-
Total Other Operating Expenditure	**127**	**861**
Total operating expenditure	**589,573**	**516,372**

The above includes expenditure dealt with under the pooled budget arrangement for the Better Care Fund as set out in Note 16.

COVID-19 costs included in the above figures total £25,319k. The majority of these costs fall under Services from other NHS Trusts and Purchase of Healthcare from non-NHS bodies. COVID-19 pay costs are shown in Note 4.1.

Health care expenditure includes (£112k) representing a reduction in the assessment of partially completed spells. In line with latest NHSE guidance, partially completed spells have been settled in full in 2020/21.

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £30k in 2020/21, (included within other professional fees).

External Audit Fees are inclusive of VAT. The auditor's liability for external audit work carried out for the financial year 2020/21 is limited to £2 million.

6.1 Better Payment Practice Code

Measure of compliance	**2020-21 Number**	**2020-21 £'000**	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	27,355	154,522	26,945	144,119
Total Non-NHS Trade Invoices paid within target	27,081	151,522	26,539	141,855
Percentage of Non-NHS Trade invoices paid within target	**99.00%**	**98.06%**	98.49%	98.43%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,144	381,531	3,266	325,894
Total NHS Trade Invoices Paid within target	1,125	381,403	3,215	325,327
Percentage of NHS Trade Invoices paid within target	**98.34%**	**99.97%**	98.44%	99.83%

The Better Payment Practice Code requires the clinical commissioning group to pay valid invoices by their due date or within 30 days of receipt of the invoices, whichever is the later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2020-21 £'000**	2019-20 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7. Net gain/(loss) on transfer by absorption

Shropshire CCG does not have any to report in 2020/21 or any reported during 2019/20.

8. Operating Leases

8.1 As lessee

8.1.1 Payments recognised as an expense

	2020-21				2019-20			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	-	333	5	**338**	-	253	6	258
Contingent rents	-	-	-	**-**	-	-	-	-
Sub-lease payments	-	-	-	**-**	-	-	-	-
Total	**-**	**333**	**5**	**338**	-	253	6	258

Buildings lease payments relate to expenditure with NHS Property Services Ltd for the rental of office accommodation (£118k), and void & subsidy costs (£215k).
Other lease payments relate to photocopier rental costs.

8.1.2 Future minimum lease payments

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

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for this arrangement. Similarly, the current lease for printer/photocopier is under review and a new lease has not yet been signed.

8.2 As lessor

The clinical commissioning group does not have any leasing arrangements as a lessor.

9 Trade and other receivables	Current 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	2,837	-	656	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	7	-	-	-
NHS accrued income	747	-	651	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	126	-	642	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	122	-	138	-
Non-NHS and Other WGA accrued income	103	-	92	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(3)	-	(562)	-
VAT	117	-	188	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	1	-	2	-
Total Trade & other receivables	**4,056**	**-**	1,807	**-**
Total current and non current	**4,056**		1,807	

9.1 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	2,688	93	410	1
By three to six months	-	2	-	1
By more than six months	145	31	-	-
Total	**2,833**	**126**	410	2

9.2 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2020	(562)	-	**(562)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(3)	-	**(3)**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	562	-	**562**
Total	**(3)**	**-**	**(3)**

10 Cash and cash equivalents

	2020-21	2019-20
	£'000	£'000
Balance at 01 April 2020	37	88
Net change in year	90	(51)
Balance at 31 March 2021	**128**	37
Made up of:		
Cash with the Government Banking Service	128	37
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**128**	37
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	-
Balance at 31 March 2021	**128**	37

11 Trade and other payables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	5,640	-	3,045	-
NHS payables: Capital	-	-	-	-
NHS accruals	2,534	-	2,735	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	7,085	-	5,914	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	25,798	-	18,304	-
Non-NHS and Other WGA deferred income	7	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	75	-	92	-
VAT	-	-	-	-
Tax	63	-	77	-
Payments received on account	-	-	-	-
Other payables and accruals	11,288	-	6,477	-
Total Trade & Other Payables	**52,490**	**-**	36,646	**-**
Total current and non-current	**52,490**		36,646	

NHS payables includes £1,329k in respect of an invoice received from Shrewsbury & Telford Hospitals NHS Trust for the settlement of partially completed spells and this has been paid in April 2021. In line with latest NHSE guidance, partially completed spells have been settled in full in 2020/21 and the remaining liability with other providers was settled in cash in March 2021, (the liability in respect of partially completed spells in 2019/20 was £1,824k).

The increase in 2020/21 of other payables relates to an increase in continuing health care accruals. This is due to a rise in activity in 2020/21 and also a delay in the receipt of invoices. Other payables also includes £591k outstanding pension contributions at 31 March 2021, (£472k in 2019/20).

12 Provisions

	Current 2020-21 £'000	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	118	-	190	-
Redundancy	651	-	209	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	47	-	-	-
Continuing care	642	-	200	-
Other	380	-	-	-
Total	**1,837**	**-**	599	**-**
Total current and non-current	**1,837**		599	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2020	**-**	**-**	**190**	**209**	**-**	**-**	**-**	**200**	**-**	**599**
Arising during the year	-	-	118	651	-	-	47	442	380	**1,637**
Utilised during the year	-	-	(189)	(209)	-	-	-	-	-	**(398)**
Reversed unused	-	-	(1)	-	-	-	-	-	-	**(1)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**118**	**651**	**-**	**-**	**47**	**642**	**380**	**1,837**
Expected timing of cash flows:										
Within one year	-	-	118	651	-	-	47	642	380	**1,837**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**118**	**651**	**-**	**-**	**47**	**642**	**380**	**1,837**

The restructuring provision reflects the estimated costs in relocating office accommodation and is expected to be settled in the first half of 2021/22.

The creation of one single commissioning organisation in Shropshire, Telford & Wrekin with effect from 1st April 2021 has involved a restructuring of roles & responsibilities and has had an impact on the associated staffing. The majority of this management of change work has been completed during 2020/21 but as at 31st March 2021 some staff were still awaiting an outcome. The redundancy provision reflects the estimated impact of this and it is expected that the process will be concluded early in the new financial year.

The legal claims provision relates to ongoing legal cases outstanding at 31/03/2021, with the estimated costs to conclusion provided by the CCG's legal advisors. The CCG has no claims currently lodged with NHS Resolution.

A continuing care provision has been created which reflects the estimated cost of continuing care appeals currently awaiting processing. The provision is based on the number of appeals outstanding at the 31st March 2021 and these are expected to be processed within the new financial year.

Other provisions include £285k in relation to ring-fenced funding received in 2020/21 which may need to be repaid in 2021/22, £59k in relation to a claim against the CCG for lost revenue and £36k in relation to an industrial tribunal case which is ongoing and is expected to be concluded during 2021/22.

13 Contingencies

The CCG has no contingent assets or liabilities to disclose.

14 Financial instruments

14.1 Financial risk management

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

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

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

14.1.1 Currency risk

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

14.1.2 Interest rate risk

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

14.1.3 Credit risk

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

14.1.4 Liquidity risk

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

14.1.5 Financial Instruments

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

14 Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	1,961		1,961
Trade and other receivables with other DHSC group bodies	1,723		1,723
Trade and other receivables with external bodies	130		130
Other financial assets	-		-
Cash and cash equivalents	128		128
Total at 31 March 2021	**3,942**	**-**	**3,942**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	1,037		**1,037**
Trade and other payables with other DHSC group bodies	16,223		**16,223**
Trade and other payables with external bodies	35,086		**35,086**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2021	**52,346**	**-**	**52,346**

15 Operating segments

As stated in IFRS8, the "Chief Operating Decision Maker" is responsible for allocating resources to and assessing the performance of the operating segments of an entity. At Shropshire Clinical Commissioning Group this function is performed by the Governing Body. The clinical commissioning group considers it has a single operating segment; commissioning of healthcare services. Hence finance and performance information is reported to the Governing Body as one segment. These Statements are produced in accordance with this position.

16 Joint arrangements - interests in joint operations

			Amounts recognised in Entities books ONLY 2020-21				Amounts recognised in Entities books ONLY 2019-20			
Name of arrangement	**Parties to the arrangement**	**Description of principal activities**	**Assets £'000**	**Liabilities £'000**	**Income £'000**	**Expenditure £'000**	Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better Care Fund pooled budget	Shropshire CCG & Shropshire LA	Commissioning of health & social care services under the Better Care Fund	0	0	0	22,083	0	0	0	21,555

The total value of this pool for 2020/21 is £44m, £22m of this being the CCG's contribution (£22m for 2019/20).

A summary of the schemes relating to this expenditure is given below:

	2020-21 £'000	2019-20 £'000
Assistive Technologies	1,713	1,613
Care navigation/Co-ordination	1,844	1,843
Carers Services	0	0
Enablers for Integration	3,906	3,666
Healthcare Services to Care Homes	163	140
Integrated Care Planning	2,992	2,992
Intermediate Care Services	3,377	3,233
Personalised Healthcare at Home	309	289
L A Schemes	7,779	7,779
Total	**22,083**	21,555

The CCG is party to the Shropshire Better Care Fund Pooled Budget established under Section 75 of the NHS Act 2006. The other party to the Section 75 Agreement is Shropshire Local Authority.

The CCG's total contribution to the Fund in 2020/21 was £22 million. The partners determine the nature of the programmes of work making up the Fund and in particular whether joint control is in operation for each programme for the purposes of IFRS 11.

17 Related party transactions

During 2020/21 the following Governing Body members and key members of management declared interests with other organisations that have undertaken material transactions with the clinical commissioning group:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Keith Timmis Lay member - Wife is an archivist for Shropshire Council	15,891	117	2,439	34
Mr Colin Stanford - Lay Member - Clinical Champion of Osteoarthritis Keele University	20	0	0	0
Dr Adam Pringle - Joint Vice Clinical Chair and GP member - sessional work for Shropshire Doctors Co-Operative Ltd	636	0	109	0

The Department of Health and Social Care is regarded as a related party. During the year the clinical commissioning group has had material transactions with entities for which the Department is regarded as the parent Department. These include:

NHS England
NHS Business Services Authority
NHS Property Services Limited
NHS Midlands & Lancashire CSU
Shrewsbury & Telford Hospitals NHS Trust
Shropshire Community Health NHS Trust
University Hospital of North Midlands NHS Foundation Trust

In addition, the clinical commissioning group has had a number of transactions with other government departments and other central and local government bodies. The majority of these transactions have been with Shropshire Council (disclosed in the section above), and Welsh Government Bodies.

Payments were also made to GP practices in 2020/21 in respect of GMS/PMS/APMS and enhanced services. Some of the general practitioners within these practices are also members of the clinical commissioning group's governing body.

18 Events after the end of the reporting period

On 1st April 2021 Shropshire CCG joined with Telford & Wrekin CCG to create one single commissioning organisation, (Shropshire, Telford & Wrekin CCG). All of the services, assets and liabilities from both CCGs were transferred to the new organisation.

19 Financial performance targets

The clinical commissioning group have a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	2020-21 Target	**2020-21 Performance**	2019-20 Target	2019-20 e
	£'000	**£'000**	£'000	£'000
Expenditure not to exceed income	598,019	597,359	477,276	524,562
Capital resource use does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use does not exceed the amount specified in Directions	597,093	596,434	476,025	523,311
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	6,224	8,040	6,955	7,157

The excess of expenditure above the revenue resource limit has occurred in the following context:

NHS England set the CCG an in-year control total of break-even and the CCG is reporting an outturn of £0.7m surplus The CCG brought forward a deficit of £124m and therefore the cumulative outturn is £123.3m deficit.

It should be noted that a report to the Secretary of State under section 30 of the Local Audit and Accountability Act has been issued for the breach of financial duties, i.e. failure to contain expenditure within the Revenue Resource Limit.

20 Analysis of charitable reserves

	2020-21	2019-20
	£'000	£'000
Unrestricted funds	-	-
Restricted funds	1	1
Endowment funds	-	-
Total	**1**	**1**

The clinical commissioning group holds a charitable donation of £1k for use towards staff welfare.

21 Losses and special payments

21.1 Losses

The clinical commissioning group did not record any cases of losses in 2020/21 (nil in 2019/20).

21.2 Special payments

The clinical commissioning group has made no special payments in 2020/21 (nil in 2019/20).

Independent auditor's report to the members of the Governing Body of NHS Shropshire, Telford & Wrekin CCG in respect of NHS Shropshire CCG

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of NHS Shropshire CCG (the 'CCG') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of matter – Demise of the organisation

In forming our opinion on the financial statements, which is not modified, we draw attention to note 1.1 to the financial statements, which indicates that NHS Shropshire CCG merged with NHS Telford & Wrekin CCG to become NHS Shropshire, Telford & Wrekin CCG on 1st April 2021. The services provided by Shropshire CCG transferred entirely to NHS Shropshire, Telford & Wrekin CCG, together with its assets and liabilities.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the CCG's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the CCG's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the CCG. In doing so we have had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the CCG and the CCG's disclosures over the going concern period.

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

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

The responsibilities of the Accountable Officer with respect to going concern are described in the 'Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

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

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

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

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

Basis for qualified opinion on regularity

The CCG reported administration expenditure of £8.040 million against a target of £6.155 million in its financial statements for the year ending 31 March 2021. The CCG thereby breached its duty under the National Health Service Act 2006, as amended by paragraph 223J (3) of Section 27 of the Health and Social Care Act 2021, to ensure that revenue resource use in a financial year which is attributable to administration does not exceed the amount specified by direction of NHS England.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of the above matters except on 14 June 2021 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the CCG's breach of its administration resource limit.

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

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 76 to 77, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the CCG's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit Committee, concerning the CCG's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - journal entries that altered the CCG's financial performance for the year; and
  - potential management bias in determining accounting estimates.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on significant journals at the end of the financial year which impacted on the CCG's financial performance;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of accruals;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in expenditure recognition, and the significant accounting estimates related to prescribing accruals, continuing healthcare accruals, and provisions. On 14 June 2021 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to the CCG's breach of its administration resource limit.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the CCG operates
  - understanding of the legal and regulatory requirements specific to the CCG including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the CCG's operations, including the nature of its operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the CCG's control environment, including the policies and procedures implemented by the CCG to ensure compliance with the requirements of the financial reporting framework.

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

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except on 14 June 2021 we identified a significant weakness in how the CCG plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the CCG's failure to develop plans during 2020/21 to address NHS Shropshire, Telford & Wrekin CCG's predicted deficit for 2021/22 and to achieve the efficiency target set for it by NHS England. We recommended that NHS Shropshire, Telford & Wrekin CCG reconsider its planned expenditure and the deliverability of its savings schemes and amends its financial plan as necessary to deliver a balanced financial position.

Our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the CCG's arrangements in our Auditor's Annual Report. If we identify any further significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Shropshire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the members of the Governing Body of NHS Shropshire, Telford & Wrekin CCG, as a body, in respect of NHS Shropshire CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of NHS Shropshire, Telford & Wrekin CCG those matters we are required to state to them in an auditor's report, in respect of NHS Shropshire CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than NHS Shropshire, Telford & Wrekin CCG and NHS Shropshire CCG, and the members of the Governing Bodies of both CCG's, as bodies, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner

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

Birmingham

14 June 2021

Independent auditor's report to the members of the Governing Body of Shropshire, Telford and Wrekin CCG in respect of Shropshire CCG

In our auditor's report issued on 14 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate in respect of Shropshire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we had completed our work on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements of Shropshire CCG

In our auditor's report for the year ended 31 March 2021 issued on 14 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

Matter on which we are required to report by exception – the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except on 14 June 2021 we identified a significant weakness in how the CCG plans and manages its resources to ensure it can continue to deliver its services. This was in relation to the CCG's failure to develop plans during 2020/21 to address NHS Shropshire, Telford & Wrekin CCG's predicted deficit for 2021/22 and to achieve the efficiency target set for it by NHS England. We recommended that NHS Shropshire, Telford & Wrekin CCG reconsider its planned expenditure and the deliverability of its savings schemes and amends its financial plan as necessary to deliver a balanced financial position.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these

arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the CCG plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the CCG ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the CCG uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the CCG has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Shropshire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of Shropshire, Telford and Wrekin CCG, as a body, in respect of Shropshire CCG, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of Shropshire, Telford and Wrekin CCG those matters we are required to state to them in an audit certificate, in respect of Shropshire CCG and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than Shropshire, Telford and Wrekin CCG and Shropshire CCG, and the members of the Governing Bodies of both CCG's, as bodies, for our audit work, for this report, or for the opinions we have formed.

M C Stocks

Mark Stocks, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Birmingham

17 September 2021