NHS
Shropshire, Telford and Wrekin

Annual Report and Accounts

Months 4 - 12
2022/23

Contents

PERFORMANCE REPORT

Statement from Simon Whitehouse, Accountable Officer NHS Shropshire, Telford and Wrekin

Over the last 12 months, the NHS has faced and responded to significant challenges both nationally and across Shropshire, Telford and Wrekin. I would therefore like to start this annual report by recognising the tireless and continued efforts of all colleagues working in health and care across the system, in adapting and responding to these challenges in difficult circumstances. I recognise the efforts and contributions that colleagues have made to improve local services and to respond to the local challenges. I strongly believe that we have finished the year in a stronger place as a system than we started it and that is down to our staff and partners. In recognising that I am also clear that there is much still to do and that our collective drive to improve performance in a number of areas is unrelenting.

Since the last annual report, the structure and focus of the organisation has changed significantly. At the end of June 2022 we closed down Shropshire, Telford and Wrekin CCG and on 1 July 2022 NHS Shropshire, Telford and Wrekin was founded as one of forty-two integrated care boards across the NHS in England. Although our mission to improve outcomes for local people and to deliver the best possible healthcare to our residents hasn't fundamentally changed, we now have a renewed energy towards working in collaboration and partnership with other local public sector organisations. Our collective focus as an integrated care system is aligned to the four main principles –

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

Collaborating with partners across Shropshire, Telford and Wrekin we have a collective drive to tackle some of our complex challenges, including:

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

The difficult circumstances we have faced over this winter and the associated responses have given us a strong platform to build upon with our partner organisations. There are many examples of where collaboration and integrated working is starting to show demonstrable benefit in our performance. However, I reiterate the point that I made at the start, that there is a lot still to do.

Before we draw this year to a close, we kicked off our 'Big Health and Wellbeing Conversation', offering people across Shropshire, Telford and Wrekin the opportunity to input into our future plans. I am strongly encouraged that the voices that we hear through this process, along with the foundations of

collaborative working that we have built will stand us in good stead as an organisation to bring a patient-centred approach to improving the health and wellbeing of local people.

Simon Whitehouse

Accountable Officer

29th June 2023

Performance Overview

Statement of purpose and activities of the ICB

This section of the Annual Report provides summary information on NHS Shropshire, Telford and Wrekin – its purpose, key risks to the achievement of the organisation's objectives and how the organisation has performed over the period 1st July 2022 to 31st March 2023.

About us

NHS Shropshire, Telford and Wrekin was created on 1st July 2022 and is responsible for planning and buying a wide range of health and care services for the whole of Shropshire, Telford and Wrekin. These include GP and primary care services, hospital care, community healthcare and mental health services. The principal location of the organisation is Halesfield 6, Telford, TF7 4BF.

An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in a geographical area.

Nationally, the expectation is that an ICB will:

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

We also have a duty to monitor these services to ensure they provide a high level of care and are value for money. We are clinically-led and work closely with the 51 GP practices across the county. This means we can have closer links to our patients so we can develop more personalised local health services.

A governance structure chart is included on page 113 of this report.

Our mission statement and priorities

What we want to achieve as an ICS:

Together as one, we want to transform the health and care across Shropshire, Telford & Wrekin by:

- Providing a greater emphasis on prevention and self-care
- Helping people to stay at home with the right support with fewer people needing to go into hospital
- Giving people better health information and making sure everyone gets the same high quality care
- Utilising developing technologies to fuel innovation, supporting people to stay independent and manage their conditions
- Attracting, developing and retaining world class staff

- Involving and engaging our staff, local partners, carers, the voluntary sector and residents in the planning and shaping of future services
- Developing an environmentally friendly health and care system

NHS Shropshire, Telford and Wrekin is currently developing a Joint Forward Plan for the next five years based upon the Integrated Care Strategy, which will include its mission statement and strategic objectives. This Plan is due to be published on or around 30th June 2023.

Population challenges

We work across the 1,347 square miles of Shropshire, Telford and Wrekin, serving around 500,000 people.

The NHS Shropshire, Telford and Wrekin is responsible for buying NHS services for local people. In our area, we have:

- Two acute hospitals, less than 20 miles apart in Telford and Shrewsbury. These are run by one acute trust, the Shrewsbury and Telford NHS Trust (SaTH)
- A specialist orthopaedic hospital, the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH), which provides elective orthopaedic surgery in the northwest of the county
- A community trust, the Shropshire Community Health Trust
- A mental health trust, Midlands Partnership NHS Foundation Trust (who covers Shropshire and Staffordshire)
- An ambulance service, the West Midlands Ambulance Service University NHS Foundation Trust

Within our area, we have two unitary authorities – Shropshire Council and Telford & Wrekin Council. Shropshire Council covers 1,234 square miles, including 91.7% of the ceremonial county of Shropshire. This incorporates a number of towns, including Shrewsbury, Oswestry and Ludlow, but no major cities. The area covered by Shropshire Council has a population of around 320,000 people.

The rest of the area is covered by Telford & Wrekin Council. Around 185,000 live in this borough with around 165,000 living in Telford itself – making it the largest town that we cover.

Being on the Welsh-English border, we provide some hospital services for people from the Welsh health system who live outside of Shropshire or Telford and Wrekin. Some residents in mid-Wales rely on our services particularly at the two acute hospitals, the Royal Shrewsbury and the Princess Royal Hospitals, and RJAH.

In Shropshire, Telford and Wrekin, there are particular population challenges in meeting the demand for health and social care services.

These include:

- Telford and Wrekin has a large, younger urban population with some rural areas. Telford is ranked among the 30% most deprived populations in England. Telford and Wrekin is home to around 185,000 people with the fastest growing population being aged 65+. This older

group is growing at one of the fastest rates in the country.

- Shropshire covers a large rural population with problems of physical isolation and low population density (0.96 people per hectare compared to 4.09 in England) and has a mix of rural and urban aging populations. Shropshire has a population of approximately 320,000 people and a higher percentage of older people than the national average. (2021 Census). Shropshire, Telford & Wrekin has one of the least ethnically diverse populations in England: the lowest black and minority ethnic groups population levels across Midlands and East with 95.9% of the population identified as 'White British/Irish' (2011 Census).

- In Shropshire the population of people aged over 65 has increased by 25% in just 10 years. Over 44% of residents are over the age of 50 and around 23% of Shropshire's population are aged 65+, this compares with a West Midlands and England figure of 18% (2011 Census).

- The number of people with dementia or mobility issues which mean they are unable to manage at least one activity on their own is expected to rise significantly with the increase in the elderly population. Between 2017 and 2035 the number of people aged 65+ with dementia is expected to increase by 80%. Those people who are aged 65+ and unable to manage at least one activity on their own is projected to increase by 63%. Demand for services is shifting with greater need for services to support frailer people in the community with home-based health and wellbeing self-management and building resilience.

- Long-term conditions are on the rise due to changing lifestyles. This means we need to move the emphasis away from services that support short-term, episodic illness and infections towards earlier intervention to improve health and deliver sustained community based continued support.

- Along with an ageing population Shropshire, Telford & Wrekin has the third lowest fertility rates across Midlands and East (ONS Statistics: Gov.uk data June 2016).

Working with partners

NHS Shropshire, Telford and Wrekin forms part of the Shropshire, Telford and Wrekin Integrated Care System (ICS). An integrated care system (or ICS) is a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. Each ICS includes an integrated care board (as described above) and an integrated care partnership (as described below).

In its first year of operation NHS Shropshire, Telford and Wrekin has been seeking to support the ICS to identify how partnership working will be further embedded across all partners and then to identify how the ICS needs to be structured and the ongoing support role the ICB will need to take to ensure that integration of services by all partners continues to be a key deliverable. It is expected that this focus will continue in 2023/24.

Shropshire, Telford and Wrekin ICS includes the following healthcare providers:

- The Shrewsbury and Telford Hospital NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

- Shropshire Community Health NHS Trust
- Midlands Partnership NHS Foundation Trust
- West Midlands Ambulance Service Foundation Trust
- 51 GP practices across eight Primary Care Networks.

There are also two local authorities within our ICS:

- Shropshire Council
- Telford & Wrekin Council

There is also involvement from our local voluntary community and social enterprise sector in Shropshire and Telford and Wrekin.

You can find out more about the ICS here: Home - STWICS

An integrated care partnership (or ICP) is a statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

In our area our ICP is known as the Shropshire, Telford and Wrekin Integrated Care Partnership. You can find out more on the partnership's webpage:

Integrated Care Partnership (ICP) Meetings - STWICS

Shropshire Council and Telford and Wrekin Council's Health and Wellbeing Boards (HWBB)

Our Chief Executive Officer, Simon Whitehouse, sits on the Health and Wellbeing Boards (HWBBs) of both local authorities and is co-chair for both Health and Well Being Boards. The HWBBs also form part of the ICS governance structure to ensure that partnership working is truly at the centre of the delivery of the ICS.

Both HWBBs have a Health and Wellbeing Strategy in place and this underpins the development work on the Joint Forward Plan.

Shropshire Council and Telford and Wrekin Council

The Better Care Fund (BCF) continues to be an important focus for our partnership working with Shropshire Council and Telford & Wrekin 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 ICS. This work allows 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 can support the whole person and not just a disease.

Joint Health Overview and Scrutiny Committee of Shropshire Council and Telford and Wrekin Council

Our interaction with the Joint Health Overview and Scrutiny Committee has continued during 2022/23. A number of areas have been discussed at the committee including:

- Maternity services and the Ockenden Review
- Winter Preparedness
- Updates from the Prevention, Primary Care, Urgent and Emergency Care and discharge task and finish group
- Interim Integrated Care Strategy
- Musculoskeletal Transformation Update
- Proposed changes to renal dialysis services
- Primary Care Review proposals

Consultation with Health and Wellbeing Boards

The ICB has consulted each lead officer of the relevant Health and Wellbeing Boards in preparing the review of their contribution to the delivery of the joint Health and Wellbeing Strategy for Shropshire and the joint Health and Wellbeing Strategy for Telford and Wrekin.

NHS Midlands and Lancashire Commissioning Support Unit

Midlands and Lancashire Commissioning Support Unit (MLCSU) provided a number of services through a contract ranging from financial management to human resources and information governance (IG). We continue to work with MLCSU in this period in terms of consistency of services provided.

2022/23 financial position

Due to the transition from a CCG to an ICB on 1st July 2022 there has been a requirement to produce two sets of financial reports to reflect the three month period of the CCG to its termination date of 30th June 2022, and a nine month period of the ICB from 1st July 2022 to 31st March 2023.

	CCG Three months to 30th June 2022			ICB Nine months to 31st March 2023			Full twelve month period		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Allocation	245,171	245,171	0	773,543	773,543	0	**1,018,714**	**1,018,714**	**0**
Expenditure	(246,562)	(245,171)	1,391	(783,895)	(795,060)	(11,165)	**(1,030,457)**	**(1,040,231)**	**(9,774)**
System Affordability Gap	0	0	0	13,936	0	(13,936)	**13,936**	**0**	**(13,936)**
Surplus/Deficit)	**(1,391)**	**0**	**1,391**	**3,584**	**(21,517)**	**(25,101)**	**2,193**	**(21,517)**	**(23,710)**

For 2022/23, the full year (CCG 3 months; ICB 9 months) reported financial outturn position is a deficit of £21.5m which is £23.7m adverse against the plan of a £2.2m surplus. These values include an adverse variance for the system element of the plan for non delivery of the £13.9m efficiency stretch target (held by the ICB on behalf of the whole system).

For the nine month period to 31st March 2023 for the ICB, the reported financial outturn position is a deficit of £21.5m which is £25.1m adverse against the plan of a £3.6m surplus. These values include an adverse variance for the system element of the plan for non delivery of the £13.9m efficiency stretch target (held by the ICB on behalf of the whole system).

There are a small number of key drivers of increased expenditure for the ICB which have continued throughout the year:

- Increases to independent sector ophthalmology activity driven through patient choice and long waiting times at our main provider.
- Continued expenditure with Local Authorities on additional discharge support that is no longer nationally funded through the Hospital Discharge Programme.
- Increased package prices in Individual Commissioning.
- Increased prescribing prices due to Category M (Cat M) and No Cheaper Stock Obtainable (NCSO) national adjustments.

The full year financial position includes £8.6m of total efficiencies delivered in year, predominantly in Individual Commissioning and Medicines Management. For the nine month period to 31st March 2023 total efficiencies delivered were £6.5m of which £5.1m (80%) was recurrent.

Covid-19 expenditure

The ICB spent £0.3 million on COVID-19-related costs in the nine months from 1st July 2022 to 31st March 2023 primarily associated with the Covid Medicine Delivery Unit.

Shropshire, Telford & Wrekin Integrated Care System (ICS)

The Shropshire, Telford and Wrekin Integrated Care System (ICS) is part of the National Recovery Support Programme – Level 4 of the NHS England and NHS Improvement (NHSEI) System Oversight Framework. The System and ICB is therefore subject to significant scrutiny around finances and

financial decisions, with a specific requirement to develop an approach to recovering a deteriorating financial position.

A system financial framework was therefore developed and agreed by all organisations and all system partners have worked closely together to develop a roadmap for financial recovery.

All organisations agreed to:

- approve the approach of 'one model, one consistent set of assumptions' and recognise that the position of each organisation will evolve and change transparently
- mobilise and deliver the plan to enable the development and delivery of the financial strategy and Financial Improvement Framework as part of an Integrated System Strategy
- ensure the transparent and agile approach to financial planning and management continues across the system
- recognise the financial control totals in the Financial Improvement Framework with a commitment to agree organisational control totals once operational planning has commenced
- work together to use our resources flexibly and effectively, to deliver the system vision.

To ensure that all decision-making is open and changes are understood and approved by all, the system has been operating under the 'triple-lock' process and the '**moving** parts' principles. This means that decisions are made at local, ICS and regional level (triple lock) and that new expenditure can only be committed if it is backed by new income or efficiency ('moving parts'). The principles are designed to ensure decisions are owned by each organisation and at system level, overseen by NHSEI as required whilst the system remains in the Recovery Support Programme.

System Capital Resource

As part of the Health and Care Act 2022 (the 2006 Act) ICBs and partner NHS trusts and NHS foundation trusts are required to prepare joint capital resource use plans. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to ICBs is being prioritised and spent to achieve the ICB's strategic aims. This aligns with ICBs' financial duty to ensure that their allocated capital is not overspent and their obligation to report annually on their use of resources.

2022/23 is the first of a three-year ICS capital allocation. This means that we have a shared ICS level capital funding envelope for the full twelve months in 2022/23 and baseline envelopes for 2023/24 and 2024/25. A STW Capital Prioritisation and Oversight Group was established as a sub committee of the Finance Committee to monitor the system capital programme against the capital envelope, gain assurance that the estates and digital plans are built into system financial plans and to ensure effective oversight of future prioritisation and capital funding bids.

The System Capital Resource Plan can be viewed on the ICB website at:

Joint Resource Capital Plans - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

	CDEL	Plan Month 1-12 £'000	Expenditure Months 1-3 £'000	Expenditure Month 4-12 £'000	Total £'000	Narrative on the main categories of expenditure
Provider	Operational Capital	29,332	773	27,159	27,932	The 2022/23 operational capital programme for STW is comprised of essential Estates backlog, improvements in Digital Infrstructure and key System developments including the renal dialysis move to Hollinswood House, the new end of life suites at Whitchurch Hospital and the replacement of diagnositc equipment
ICB	Operational Capital	1,251	-	1,243	1,243	Investment in Primary Care
	Total Op Cap	**30,583**	**773**	**28,402**	**29,175**	
Provider	Impact of IFRS 16	7,079	389	3,666	4,055	This is the first year of adoption of the new accounting standard IFRS16 in the NHS. This means that leases are now held on the balance sheet and are included within the CDEL limits.
ICB	Impact of IFRS 16	-	-	-	-	
Provider	Upgrades & NHP Programmes	356	133	3,260	3,393	This relates to expenditure required to deliver the Hospital Transformation Programme Outline Business Case.
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)	26,676	546	43,130	43,676	This relates to national funding for the Elective Hub at PRH, the Community Diagnostic Centre at Telford and the theatre development programme at RJAH. It also includes national digital funding to help the ICS reach the minimum digitial foundations standard.
Provider	Other (technical accounting)	-	-	-	-	
	Total system CDEL	**64,694**	**1,841**	**78,458**	**80,299**	

Adoption of going concern basis

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

The ICB ended the nine month period to 31st March 2023 reporting a deficit of £21.5m deficit. The Shropshire, Telford and Wrekin System reported a £56.2m deficit in the nine month period to 31st March 2023.

Under new government legislation passed through Parliament, the new organisation 'NHS Shropshire, Telford and Wrekin Integrated Commissioning Board (ICB)' was created on 1st July 2022.

At the end of the financial period, it was judged that the going concern status of the organisation remained unchanged on the following basis:

- The formation of the new organisation (ICB), has been approved by NHS England (NHSE) and the services provided by the previous CCG transferred entirely to the new organisation together with its assets and liabilities;
- The ICB has taken steps to maintain business continuity for the finance function throughout the period in order that payments and collection of debt are not materially impacted. These steps include continuing with secure 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 ICB's aged debt and its continued high achievement against the Better Payment Practice Code.
- There is a presumption that ICBs are deemed to be a going concern because there is a statutory requirement to perform the commissioning function by a public body – and this determines the requirement to apply the going concern principle – not whether the specific ICB will be doing the function in future.

Although the financial position of the ICB and the issue of a Section 30 report by the Secretary of State for Health indicates some uncertainty over the ICB's ability to continue as a going concern, the

Governing Body, having made appropriate enquiries, have reasonable expectations that the ICB will have adequate resources to continue in operational existence for the foreseeable future.

Further, the ICB submitted its 2023/24 financial plan covering the 12 month period for the ICB on 30th March 2023. This plan was based on the allocations notified by NHSE for the full financial year of 2023/24.

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

Performance analysis

Performance dashboard

NHS
Shropshire, Telford and Wrekin

		Q2			Q3			Q4		
		2022/23	2022/23	2022/23	2022/23	2022/23	2022/23	2022/23	2022/23	2022/23
KPI	Title	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
EB3	18ww RTT: incomplete waits	58.3%	57.4%	56.0%	56.9%	56.9%	55.6%	56.7%	58.1%	59.2%
	18ww RTT: incomplete waits beyond 52 weeks	4422	4531	4654	4611	4697	4899	4345	3906	3615
	18ww RTT: incomplete waits beyond 78 weeks	788	727	650	614	652	765	630	407	97
	18ww RTT: incomplete waits beyond 104 weeks	55	52	44	30	20	14	16	10	3
EB4	Diagnostic waits >6 weeks	39.3%	44.6%	41.7%	39.5%	38.0%	42.0%	40.6%	33.3%	33.3%
EB6	CWT - 2-week cancer waits	79.1%	77.0%	69.3%	73.1%	74.0%	68.7%	80.3%	87.2%	72.2%
EB7	2-week breast waits	46.6%	40.9%	60.6%	40.6%	67.2%	63.5%	68.4%	80.3%	16.4%
EB8	CWT - 31 days to cancer treatment	93.4%	89.4%	84.0%	92.2%	79.6%	82.2%	77.1%	83.7%	83.2%
EB9	CWT - 31 days to treatment (surgery)	67.2%	81.8%	82.5%	63.0%	69.6%	65.9%	68.1%	76.6%	68.5%
EB10	CWT - 31 days to treatment (drugs)	96.4%	98.8%	93.3%	94.4%	94.4%	97.8%	94.3%	94.4%	91.7%
EB11	CWT - 31 days to treatment (radiotherapy)	88.3%	89.8%	87.0%	95.5%	92.6%	76.1%	75.5%	76.5%	57.5%
EB12	CWT - 62 days from referral to treatment	53.6%	51.6%	47.0%	47.8%	45.0%	46.4%	39.3%	36.0%	45.9%
EB13	CWT - 62 days to treatment after referral from screening	59.1%	47.4%	38.1%	28.6%	8.8%	22.7%	19.4%	8.7%	2.9%
	CWT - 62 days to treatment after consultant upgrade	77.3%	74.6%	61.3%	74.7%	72.6%	64.7%	62.7%	63.1%	79.2%
	CWT - 28 day diagnosis	64.4%	61.6%	55.7%	60.7%	58.0%	58.4%	60.7%	63.8%	57.9%
	A&E 4-hr waits for treatment/decision/discharge (SaTH)	51.9%	53.2%	51.1%	49.5%	48.8%	44.7%	55.2%	53.3%	54.1%
	A&E 12-hour waits for admission (SaTH)	649	585	632	972	1090	962	629	651	817
EAS1	Dementia diagnosis rates	58.7%	58.1%	58.1%	57.6%	57.9%	57.4%	57.8%	57.8%	58.0%
EA3a	Numbers beginning IAPT treatment (cumulative)	2765	3361	3986	4679	5437	5929	6672	7365	8115
EAS2	IAPT recovery rate	55.2%	53.8%	48.3%	44.8%	52.1%	44.5%	45.7%	40.6%	42.5%
EH1-A1	IAPT completion where RTT was within 6 weeks	96.8%	97.0%	95.7%	97.7%	95.7%	97.2%	90.5%	96.9%	96.4%
EH1-A2	IAPT completion where RTT was within 18 weeks	99.8%	99.6%	100%	99.8%	99.5%	100%	94.6%	99.8%	99.4%
EH4	EIP within 2 weeks (rolling year)		67%			83%			95%	
EH9	Access to CYPMH - number receiving 1+ contacts	4018	3983	3116	5035	5050	5115	5160	5255	*not yet available*
EH10	Routine Eating Disorders - seen within 4 weeks		48.0%			62.1%			64.7%	
EH11	Urgent Eating Disorders - seen within 1 week		56.0%			80.0%			33.3%	
EH12	Out of Area Placement bed days	790	815	785	720	650	590	500	395	*not yet available*
EH13	SMI patients have Annual Health Checks (rolling year)		1519			1566			2067	
EH15	Women accessing Perinatal Mental Health		238			247			249	
EK1a+b	IP care in LD/autism		20			20			20	
EK1c	IP care for CYP with LD/autism		1			0			3	
EK3	LD patients having Annual Health Checks (cumulative)		570			1105			1956	
EN1	Personal health budgets		268			273			278	
	GP appointments per 10000 weighted patients	4103.6	4215.7	4378.7	5232.7	4994.3	4241.4	4707.5	4376.6	4893.9
ET1	2-hour UCR first care contacts	1,430	1,365	1,295	1,455	1,255	1,420	1,285	1,140	1585
	UCR first care contacts in 120 minutes or less	98.8%	97.6%	98.8%	98.8%	98.8%	95.8%	99.0%	96.4%	95.2%
EO1	Wheelchair waits (children) within 18 weeks		95.3%			85.7%			79.4%	

Elective Care, Cancer & Diagnostics

22/23 has seen considerable improvement in the number of our patients having long waits for their treatment. STW reduced the numbers of patients waiting over 104wks by 95% and the remaining few will be treated early in the new financial year. Number of our patients waiting >78wks has also reduced by 88% and the system has plans to clear those remaining by the end of Q1 23/24. The system has also reduced its overall number of patients waiting over 52wks by 18% which puts us in a good position for further improvements on the next cohort of patients waiting over 65wks during 23/24.

NHS STW has not made the progress it expected in 22/23 and overall number of patients waiting over 62days ended the year as it began but having increased during the year. Our main hospital Shrewsbury & Telford Hospital NHS Trust struggled with capacity due to workforce for most of the year and also faced significant impact from industrial action in the last quarter. The system now has access

to additional third-party capacity to help reduce our backlogs in 23/24. STW also has a Community Diagnostic Centre (CDC) coming on line in Telford in the autumn which will help reduce diagnostic waits and improve cancer pathways. NHS STW had increased diagnostic capacity in 22/23 which it used to reduce waiting times and also brought in third party capacity to improve reporting times, this reduced the % of patients waiting over 6wks from over 50% down to ~30%. This reduction in backlog and the new CDC is expected to deliver an improvement in the overall referral to test time from current levels of~30% down to 15% by March 24.

Urgent & Emergency Care

The UEC improvement plan for 22/23 delivered some improvement in flow in the final quarter of the year after the implementation of the Acute Floor project at SaTH in December. The 95% national 4hr target for ED was suspended as systems recovered from the pandemic but the STW system continued to measure and report it and showed some improvement in performance to ~53-55% in Q4 from 47/48% in Q3. Ambulance handover delays also began to improve during Q4 and this improvement is expected to continue during 23/24. The focus continues to be on improving patient flow, reducing long waits in ED and on long waits for admission from ED and there were early signs of this in Q4 which will be built on in our improvement plans 23/24.

Mental Health

IAPT performance for 23/24 was mixed with access and recovery not achieving targets but as expected with the transformation of the service to one core model taking place during the year, it puts the system into a good place for achieving both these targets in 23/24.

Increasing the rate of dementia diagnosis held broadly flat in 22/23 but again the year has been about understanding the impact of the pandemic and planning improvement as a result of that learning for 23/24.

There was significant focus on improving access to eating disorder services for our CYP. This resulted in some improvement in the % CYP accessing routine appointment within 4wks (from 48% up to ~65%) and the access for urgent appointments increased from 56% to 80% in Q3 but then fell back dramatically in Q4. A deep dive has been requested on this drop in performance and will be presented to the ICB Quality & performance Committee in the new financial year 23/24.

Finally, the system also improved its levels of health checks for people with Serious Mental Illness to 2067 particularly in Q4 but still fell slightly short of the target. There is still more planned to do and further improvement is expected in 23/24.

Primary care

Primary Care Networks

The ICB has 51 GP practices which make up the membership of 8 PCNs. These are:

- North Shropshire PCN
- Shrewsbury PCN
- South West Shropshire PCN
- South East Shropshire PCN
- Newport and Central PCN
- Wrekin PCN
- South East Telford PCN
- Teldoc PCN

In addition to playing a key role in the delivery of the Covid-19 vaccination programme, our PCNs have continued to develop and implement plans to meet the service requirements in the national PCN Directed Enhanced Service contract.

These include:

- **Enhanced access** providing additional routine and same day appointments on weekday evenings 6.30pm – 8.00pm and on Saturdays 9.00am – 5.00pm from 1st October 2022
- **Structured medication reviews** (SMR) supported by the Medicines Management team to prioritise patients who benefit from an SMR
- **Enhanced Health in Care Homes:** providing a lead GP for each care home; create a simple plan with local partners as to how the care home multidisciplinary team will operate; introduce a weekly home round, building on the work from 2021/22 to establish a Care Home Enhanced Support team; development work has continued on a system approach to support care homes with integration into the work on Proactive Care
- **Early cancer diagnosis** including review of the referral practice for suspected cancers
- **Social prescribing and care co-ordination** taking a personalised care approach to supporting patients' non-clinical needs
- **Cardiovascular disease (CVD) prevention and diagnosis:** improving the diagnosis of hypertension and the number of blood pressure checks delivered
- **Tackling health inequalities:** identifying a population within the PCN who are experiencing inequality in health provision and/or outcomes and deliver a plan to tackle their unmet needs.
- **Proactive Care:** contributing to the development of ICS delivery plans.
- **Personalised Care**: Contributing to a targeted programme of social prescribing to an identified cohort with unmet needs.

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 (ARRS). Clinical pharmacists, social prescribing link workers, first contact physiotherapists and mental health practitioners have been the main roles to be recruited to with over 140 ARRS-funded staff now in post within the system.

Access to general practice

Despite delivering more appointments now than before the pandemic, access to general practice remains challenging due to a high demand for services. In particular, this Winter saw an

unprecedented demand due to Strep A, Flu and other viruses; practices had to prioritise same-day access over their routine work.

General Practice is optimising the way in which it uses its available capacity by undertaking clinical telephone triage and offering a range of modes of consultation including telephone, online, and utilising a range of different health and non-health professionals. Patients are therefore streamed to the most appropriate primary care worker to meet their needs, which often does not require a GP.

The Primary Care Team have continued to work with practices to increase the availability of alternative options for accessing services including on-line consultations and referrals to the Community Pharmacy Consultation Service (CPCS).

Integrated health and wellbeing centre - Shrewsbury

The planning for the Shrewsbury Health and Wellbeing Hub development – one of six national programme pilot sites – continued in 2022/23. This development could see the relocation of six South Shrewsbury GP practices into a state-of-the-art sustainable new build property co-located with a range of other health and wellbeing services. Subject to the approval of a Full Business Case, this development will bring significant investment in primary care estate. As securing the necessary capital funding allocation is tied into the Government 2024/25 spending review period, the expected timeline for build start is 2026.

In response to the significant concern expressed by patients and local councillors following the publication of Oteley Road as the preferred site last summer, after listening to feedback provided by patients and local councillors the project has rerun the site options appraisal to ensure that every possible potential site location has been explored. At the end of January 2023 NHS England requested that further work on Cavell pioneer projects be paused until the National Programme Business Case is approved. Given existing commitments, the decision was taken to honour contractual agreements and see the site options appraisal process completed. This allowed the local programme to be paused at a natural point in the project timeline. We are now waiting for clarification from NHS England to understand the implications of the pause so we can consider our next steps. We remain fully committed locally to the pioneer programme and will explore all possible options to ensure patients in Shrewsbury, and the surrounding areas, continue to gain access to high quality primary care provision.

Primary care workforce

Since the formation of the ICB there have been changes to the team supporting primary care workforce. Following a procurement exercise, NHS Shropshire, Telford and Wrekin emerged as preferred bidder to host the ICS Training Hub, a Health Education England (HEE) initiative which supports workforce transformation in primary care.

This has resulted in significant infrastructure investment over the next 5 years funding a core Training Hub team to support STW primary care workforce sustainability. There is now one cohesive ICB Workforce and Training Hub (WTH) team supporting a wide range of initiatives to strengthen the primary care workforce.

Furthermore, the HEE contract has provided the mechanism for further investment to transfer to the system for a variety of workforce transformation initiatives.

Below is an outline of progress across priority areas:

Recruitment and retention of Primary Care Workforce

There has been full utilisation of 2022/23 **Additional Roles Reimbursement Scheme (ARRS)** funding by PCNs which has resulted in the recruitment of over 250 ARRS funded staff working across the eight PCNs. This is contributing to the creation of multi-disciplinary teams creating capacity as well as supporting the right skill mix to serve population health needs of the residents of Shropshire, Telford and Wrekin.

The WTH team and programme of work is supported by several **clinical facilitators** each supporting different professional roles. Their role is to support supply and the transition into primary care so that new roles become embedded into teams and service delivery models. They offer valuable peer support and facilitate access to preceptorship programmes, clinical supervision and training and development opportunities.

A **General Practitioner (GP) Strategy** has been produced in consultation with practices and PCNs. The objectives are to improve recruitment and retention of GPs with delivery enhanced by six GP leads providing support in specific areas.

Initiatives include the STW GP Fellowship scheme, which supports over twenty newly-qualified GPs, the GP mentoring scheme, additional support for newly-appointed GPs in the early part of their careers, the roll-out of a digital staff locum platform and supporting practices to employ staff on Skilled Worker visas.

The STW **General Practice Nurse (GPN) Strategy** focuses on supply and retention through workstreams which encompass clinical supervision training opportunities, a career pathway for HCAs through to registered nurse, the development of registered nurses new to general practice/newly-qualified through a preceptorship programme, a broad 'continuing professional development' offer to upskill with opportunity for career progression to Advanced Practice (AP), active peer networks including supervision, updates, and trainee MSc Advanced Practitioner away days.

Non-clinical staff also have a comprehensive training and development offer. Protected Learning Time (PLT) sessions have been reinstated with face-to-face updates for GPs and APs as well as additional virtual updates and training being offered.

Training, Education and Development

A Primary Care Training Hub website has been developed to support recruitment and retention initiatives. All primary care staff can access information here about different roles and training offered.

There is a comprehensive **Training and Education Programme** providing upskilling and development opportunities for clinical and non-clinical staff groups. An annual Training Needs Analysis ensures the programme remains relevant and meets the requirements of the primary workforce to ensure delivery of quality patient care as well as supporting retention.

Learner Placement

Whilst **learner placement** numbers for non-medical staff groups remain low, activity is ongoing to support the development and expansion of high-quality clinical placements for all learners. This workstream supports workforce supply and the creation of multi-disciplinary teams. Student placement provides exposure to general practice and supports career choices into primary care.

A Multi-Professional Education Quality Lead has been appointed to progress the establishment of a quality learner environment framework across our practices. A more streamlined audit system for

placement providers will support creating capacity for all learner types. The team of clinical facilitators also support this area for their own professional groups.

The areas and activity outlined above are aligned with system 'People' priority areas. WTH team members attend system workforce groups where possible, representing primary care and ensuring system offers and initiatives are promoted to the general practice workforce.

Primary care estate

Work continues on the construction of a new health centre at Pauls Moss, Whitchurch (in collaboration with Shropshire Council and Wrekin Housing Trust) and the project is on target to complete the build phase by September 2024. In July 2022, the long-awaited new premises for Shawbirch Medical Practice was completed. Construction has also now begun on site for the new premises for Shifnal Medical Practice and completion of the build is due around January 2024.

The years' round of funding for improvement projects saw bids being submitted by several practices, with projects funded to provide IPC, DDA and building compliance as well as five larger projects to create additional clinical space in practices.

Digital

A comprehensive programme of IT & Digital projects has been successfully delivered this year. The aims of these projects have been to refresh and upgrade practice IT & digital systems and improve their cyber security. NHS Shropshire, Telford and Wrekin commissioned the following IT & digital projects from the MLCSU: -

- Zeus Domain – Implementation of a new secure Microsoft network domain called "Zeus" across all practices to replace old individual practice servers. This securely managed "Zeus" domain ensures that the latest versions of software and security upgrades can be quickly deployed to all practices by the MLCSU.

- Microsoft Office 365 – Deployment of the latest version of Microsoft Office 365 Applications for Enterprise to 2,200 practice staff, to replace old and no longer supported versions of Microsoft office software.

- IT Hardware – Deployment of new practice IT hardware including computers, laptops, monitors, consulting room printers and scanners to replace older and out-of-warranty IT hardware, as part of an annual practice hardware refresh programme.

- Enhanced Access Software – Deployment of new "EMIS Clinical Services" software to allow PCNs to provide Enhanced Access services effective from 1st October 2022. This software allows practices within each PCN to securely share patient data between themselves and provides clinicians with secure access to neighbouring practices patient records.

- Document Management Software – Implementation of Docman Share software to practices supporting PCN working and the delivery of the Enhanced Access service, by allowing practices secure access to electronic documents of patients not directly registered with the host practice of the Enhanced Access Service within a PCN.

- Digital Dictation Software – Implementation of a new secure cloud-based version of Speechwrite 360 software giving practice staff greater flexibility of where they can securely

dictate from. GPs can also use the Speechwrite 360 secure mobile app to carry out dictations which can then be securely uploaded and transcribed into patient records.

- Notes Digitisation Pilot – Enrolment of 8 practices in a national pilot project to digitise their Lloyd George patient records.

- New Practice Buildings – Implementation of all the IT & digital systems required for the new Shawbirch Medical Centre and Teldoc's new contact centre at Towergate House, including new IT network infrastructure, IT hardware, patient calling/check-in screens, wi-fi and cloud-based telephony. This includes the relocation of staff from existing premises and a smooth transition of services with no disruption to the existing practice.

Cancer care co-ordination

The Macmillan Team have worked with 20 STW practices taking a personalised approach to deliver holistic Cancer Care Reviews alongside the clinical element completed by practices to people living with cancer, within 12 months of their diagnosis. At the end of March 2023, 957 CCRs have been completed since January 2022, with 86 non-clinical CCR's completed by the team in March 2023 A patient feedback survey was launched in June 2022 giving all patients the opportunity to feedback on this experience. This is being collated into a formal independent evaluation report due April 2023. The pilot is due to close on 31st May 2023 with the learning shared across the system. PCNs are now themselves recruiting to cancer specific roles and work is underway to secure funding to support this work in terms of training for staff, peer support and enhancing expertise around inequalities.

Learning disability annual health checks

General Practice has continued to prioritise learning disability annual health checks throughout 2022-23 in line with the national guidance to reduce health inequalities and proactively engage those at greatest risk of poor health. General Practice have worked with MPFT to target efforts to reach patients who were overdue their health check as part of recovery from the pandemic and offer reasonable adjustments to encourage take up including home visits.

The 2022-23 end of year position shows that practices achieved over the 75% target and completed 77% of LDAHCs for people on the practice LD register.

For March 2023, STW practices showed an increase in the number of LDAHCs completed in comparison to previous years, as shown in the chart below. Practices completed a total of 1956 LDAHCs compared to 1577 in 2021-22. Special congratulations go to the 27 STW practices that achieved over 80% and the 7 practices that achieved 98% or 100%.

Veteran-friendly practices

There are now 28 STW practices accredited as Veteran Friendly with the ambition to get all practices accredited. This programme supports practices to deliver the best possible care and treatment for patients who have served in the armed forces. Working alongside partners, a targeted plan will be developed in Q1 2023-24 to accelerate accreditation through this next year.

Refugee relocation and Resettlement

In November 2022, the Home Office relocated asylum seekers to the Shropshire area. The GP practices in proximity registered the new residents and provided initial health checks.

Transformation and commissioning

Transformation and Commissioning Overview

In January 2019, the NHS Long Term Plan was published which set the strategic direction of travel for a number of services, including recommendations and guidelines on a review, redesign and transformation of services and pathways; pledging radical change for people requiring elective care, where too often people are travelling for hours to a hospital appointment that lasts only a few minutes when they could be saved time, cost and stress by the NHS doing things in a different way. It also aims to improve flow, safety, effectiveness, and efficiency across the system by making the best use of available resource.

The contents of the NHS Long Term Plan also helped shape the strategic aims and objectives of the local health and social care system during the integration of the CCGs coming together to work towards the same unified goals and vision. This included large-scale programmes of transformation including Mental Health and Dementia; Learning Disabilities and Autism; Children's Services; Hospital Transformation Programme; Urgent and Emergency Care; Cancer; Community and Local Care; and Elective Care transformation which includes outpatients, eye care, and musculoskeletal services.

In March 2020, as the COVID-19 pandemic began to have an impact on the local health and social care system, it required a rapid review of priorities and programmes of work. Many of them were paused to allow for staff to be redeployed into crisis response roles while the system navigated its way through a year of services being reduced or closed, and subsequent restoration and recovery planning.

As the impact of COVID-19 on the local system began to diminish, enabling a phased restoration of services, the system structured itself to once again revisit and re-start the various programmes of transformation, tapping into some of the accelerated innovation and collaborative working seen during our collective response to the pandemic.

The aims of the major transformation programmes were driven initially by national recommendations made in the NHS Long Term Plan but were localised to ensure challenges and issues relevant to our local population, and services were also reviewed and addressed as part of the work. These include recovery of existing waiting list backlogs and referral to treatment (RTT) performance for certain elective specialties, improved experiences and outcomes of services, a shift towards more locally available services, and improved running of services to ensure the most effective and efficient use of available resource.

In late 2020, the CCG and wider health and social care system agreed to re-start the agreed priorities for certain large-scale transformation programmes. A collaborative approach was established with resource from across the CCG and system provider organisations in forming programme boards and governance structures that would lead and take this work forward.

These areas, described in more detail below, include:

- Urgent and emergency care transformation

- Mental health transformation, including mental health, dementia, learning disabilities and autism
- Children and young people's services transformation
- Outpatient transformation
- Elective care transformation and recovery
- Cancer transformation
- Eye care transformation
- Musculoskeletal and pain transformation
- Community and local care transformation.

These are intrinsically linked with other interdependent and enabling programmes of work being led elsewhere in the system, and they include:

- Digital transformation
- Workforce transformation
- Hospital transformation
- Estate and space transformation.

These pieces of work and priorities continue in 2023 and beyond and are described below in more detail.

Urgent and emergency care transformation

The Shropshire, Telford & Wrekin Integrated Care System (ICS) has experienced a number of challenges over the last year in relation to the delivery of Urgent and Emergency Care (UEC). This has been exacerbated by unprecedented levels of demand, not only in UEC but also across the health and care sector. Within the last year we have seen the highest level of Covid-19 patients in our hospitals, the highest numbers of care homes closed to admissions and the highest numbers of staff sickness absence compared to any other time during the pandemic. This has exacerbated some of our underlying challenges and has informed the development of our UEC Improvement Plan for 2023/24.

The 2023/24 Shropshire, Telford & Wrekin Urgent and Emergency Care Improvement Plan, has been developed and agreed with our system partners. There has been excellent engagement from stakeholders and the areas agreed for inclusion were deemed to offer the best opportunity to positively impact UEC performance. The UEC plan focusses on Stabilising, Standardising and Sustaining a number of key UEC work programmes and improvements agreed by the system. Individual plans are in place to identify and tackle areas of service improvement, transformation and redesign as outlined in the overarching UEC Improvement Plan.

The plan is split into three key areas of improvement. These are Pre-Hospital, In Hospital and Discharge. These key areas are linked to linked to the NHS England 10-point UEC Action Plan and notes the links to wider schemes of local work that, whilst not formally falling under the remit of this programme, play an important role in supporting the delivery of these improvements. Each of the key areas has a number of core work programmes. In addition to this a set of improvement metrics have been agreed to support delivery. This plan is now moving into the implementation and monitoring stage.

Along with our Integrated Care System partners, we will work collaboratively to deliver the key elements outlined in the UEC improvement plan and will demonstrate compliance with the implementation of the NHS Long Term Plan (LTP).

- Providing a 24/7 urgent care service, accessible via NHS 111, which can provide medical advice remotely and if necessary, refer directly to Urgent Treatment Centres (UTCs), Primary Care (in and out of hours), and other community services (pharmacy etc.), as well as ambulance and hospital services.
- Implementing Same Day Emergency Care (SDEC) services across 100% of type 1 emergency departments, allowing for the rapid assessment, diagnosis, and treatment of patients presenting with certain conditions, and discharge home same day if clinically appropriate.
- Focusing efforts to reduce the length of stay for patients in hospital longer than 21 days, reducing the risk of harm and providing care in the most clinically appropriate setting.
- Working closely with primary and community care services to ensure an integrated, responsive healthcare service, helping people stay well longer and receive preventative or primary treatment before their condition becomes an emergency.

The interconnectedness of all elements of the UEC pathway means that pressures and blockages in any part of the pathway will inevitably cause an impact throughout and this often manifests in long ambulance handover delays. It is for this reason that a focused approach to improvement across the whole pathway is likely to give us the best outcomes.

The experience our patients, their families, friends, and carers, have with Urgent and Emergency Care Services is extremely important to us, that's why we are committed to involving and working in partnership with patients. We will make the most of every opportunity we have to listen, learn and improve to ensure that our patients receive the best possible experience of care in the right healthcare setting, first time.

Mental health, learning disabilities and autism

Mental Health Expenditure

	£000	
Financial Years	2021/22	2022/23
Mental Health Expenditure	91,497	98,003
ICB Programme Allocation	867,089	854,906
Mental Health Spend as a proportion of ICB Programme Allocation	10.55%	11.46%

Adult mental health

Community

Across Shropshire, Telford and Wrekin we have seen an increase in mental health professionals working closely with primary care to support services for people between GP practices and secondary mental health professionals. There is now an offer of Psychological support with groups available to learn more about depression, anxiety and how to cope with difficulties in life. These are run by psychologists with support from the third sector and those with lived experience. Mental health services are working more closely with GPs and the voluntary sector to ensure we can better support those individuals with severe mental illness. A key part of recovery from mental illness is the support to get into employment and we are widening our approach from those with severe mental illness to also support those with anxiety and depression as part of NHS Talking Therapies.

SMI (Severe Mental Illness) Physical Health Checks

A key focus for NHS Shropshire, Telford and Wrekin during 22/23 has been to ensure those individuals with severe mental illness have the opportunity for a physical health check each year. People with severe mental illness have higher levels of diabetes and heart problems relating to factors connected to their mental illness and if we fully understand the issue then we are better able to support and treat them where required. We are focused on increasing the uptake of SMI Physical Health Checks and improving the health inequalities of these individuals in line with the NHS England five-year plan. New roles are being developed to enhance the offer of support. There are 4 dedicated SMI Physical health care nurses based within Primary care to support health checks who continue to increase activity and are working within all GP practices. SMI clinicians as part of their clinic are completing medication/ mental health reviews and working with Advanced Pharmacists in secondary care.

There has been some improvement in the numbers of physical health checks undertaken during the last 12-18 months following the impact that the pandemic had, although it is likely to take more time to reach the national target for Shropshire Telford & Wrekin. Recent data shows monthly improvements which is expected to continue with the systems in place to support.

Community Mental Health Rehabilitation:

The ICB as part of the Mental Health Transformation Rehabilitation Pathway has commissioned a community mental health rehabilitation (multi-disciplinary) team locally to support individuals with

mental health rehabilitation needs. The team are working jointly across the system to improve patient flow, initially focusing on the high complexity high need service group (those placed out of area in rehabilitation beds) and strengthening the local community services. This work has included understanding the training needs of the mental health workforce and developing a plan to deliver/ensure opportunity to enhance skills and expertise.

The main priority for the team is to prevent admissions to out of area (OOA) mental health hospitals and to repatriate patients placed OOA hospitals back to their local community. Over the last 12 months there has been a significant impact from this work resulting in a reduction in OOA admissions and an increase in patients who were placed OOA being repatriated to community settings.

Crisis pathways

Non clinical alternatives:

Across Shropshire, Telford and Wrekin we now have calm cafes where people who require mental health support can talk to others and find additional support. These occur in Telford every night of the week and in Shropshire on three nights a week, with three clinics per night. Social workers support peer support workers in the cafes and are there for advice to all clients. Feedback from those attending the calm cafes has been very positive with individuals telling us that it has helped enable them to begin to build their life back.

Perinatal:

The Specialist Perinatal team are currently exceeding the national target of 10% access rates. Shropshire are currently at 15.58% and Telford and Wrekin at 17.85%.

The team has developed over the last 12-18 months and the feedback that has been received has been excellent.

We will now continue to increase our offer with our very successful specialist perinatal services to ensure they continue to meet access targets and widen the scope to ensure access to support for two years where required, and interventions for partners. We will review the demand and capacity of this service as access rates far exceed the national targets.

We have also developed our maternal mental health service (Lighthouse) and our plan is to ensure the longest wait for tokophobia (fear of childbirth) and bereavement and loss are 4 weeks from referral to assess and treatment. We will also continue to support when required those impacted by the Ockenden review

IAPT:

Over the last 12-18 months we have been working closely with NHS England Clinical Network and the provider of our IAPT services to undertake a service review so that we can understand the variation of the current services across Shropshire, Telford and Wrekin. The current IAPT models have been commissioned differently, and whilst both adhere to the national requirements of IAPT, they have interpreted the national IAPT manual in response to both the commissioning requirements and needs of the population at the time of establishment.

As part of the service review it has been identified that the key difference in the services is the level of complexity that is managed in the Shropshire service as patients present much later and have greater need for step 3 interventions. This has created an internal bottle neck for Patients waiting at step 3, due to this increased demand and the time it takes for some therapies to complete and for

patients to enter recovery. Through the IAPT forum we have been able to structure our approach in relation to moving to one core IAPT model. We have developed a roadmap to the new service with a clearly defined demand and capacity understanding. The implementation of the new model is now underway.

We will now continue to work as a system to achieve:

- As a minimum 12,948 individuals commencing treatment within the service
- Rebranding our local service into NHS Talking therapies
- Building pathways with respiratory and cancer teams

We will meet access targets with a single team with robust pathways and governance. We also will move to a core IAPT model proving the same provision across the county and relaunch the service with a new agreed name (NHS Talking Therapies).

Dementia

A new 'Dementia Vision' for Shropshire Telford and Wrekin has been co-produced with people living with dementia and their carers. The aim of the revised new model of care is to change service delivery so people and their carers benefit from an increasingly personalised journey which most suits their individual needs.

The Vision is not so much a pathway but linked to our flowers visual (see below). It's a variety of services and support which people affected by dementia can dip into and use as and when they need them.

There is no single route for the dementia journey; people can decline quickly or slowly, in steps or gradually, and people can improve for a time during the journey. As such, support and care services need to be agile and flexible to allow people affected by dementia to receive what they need, as and when they need it.

Pick your own Dementia Support

We have an established Dementia Steering Group (who oversee the implementation of the vision) which meets monthly and is chaired by George Rook who was diagnosed with dementia some years ago. They have also co-produced the new 'living plan' and a STW Dementia logo.

People living with dementia and their unpaid carers are enabled to live the lives they choose, enhancing and preserving their wellbeing.

As part of the vision, we have implemented the Shropshire Admiral Nurse Service which was launched in December 2022. This was a significant milestone for the organisation, as Telford and Wrekin have had this service in place for several years. We have also introduced the Dementia Link worker role across the County (hosted by Alzheimer's Society) which provides and creates opportunities for people living with dementia to connect into the community.

We will continue to deliver the dementia vision and strategy over the next 2 years which will include some reconfiguration of workforce and the introduction of some new roles across Shropshire, Telford and Wrekin. We will also be working more closely with Primary Care to support them in becoming more dementia aware.

We are further in the process of developing peer support groups across the county which will be co-ordinated, facilitated by the Dementia Link workers. Meaningful annual reviews will be implemented, where everyone involved in a person's care has the opportunity to contribute. We will also focus on improving our dementia diagnosis rates.

Children and young people (CYP)

Overall, our approach to Children and Young People's Mental Health follows the iTHRIVE model of care. It is a model that has at its heart all CYP in the area who need general messages of support in order to thrive. Around this are varying levels of support ranging from getting advice through to accessing help to receive crisis care. We know from a national survey ran by NHS England that between 2017 and 2022 we saw a 57% increase in those aged between 7 and 19 in Shropshire, Telford and Wrekin who had probable or possible mental health disorders (15,000 in 2017 to 24,000 in 2022).

The increase in problems amongst teenage girls is especially worrying. In addition, we have seen a doubling in the number of referrals for help and support during the post-Covid-19 period. As a result, much work is underway to work through solutions to the waiting list problems that have emerged, and how services can be restored to business as usual, responding quickly to those who need our help. Short term extra funding along with longer term increases to permanent funding are all under review.

Over the last five years investment in CYP mental health services has doubled from £5m to £10m per annum. The additional resources have been directed into expanding the eating disorders service, autism diagnosis, crisis care, support teams in schools, and inpatient services.

At the same time, we are redrafting our three-year CYP Mental Health Transformation Plan. This is an important document being produced collaboratively with input from all partners across Shropshire, Telford and Wrekin, including: local authorities, our service providers, patient representative groups

and many others. It will shape the way forward for all in the months and years ahead and give parents and CYP clarity of what support is planned to be available.

There are now three Mental Health Support Teams (MHST) in schools operational within our system, with a fourth one in training and a fifth one at the planning stage. By January 2025 around 50% of the Shropshire, Telford and Wrekin school population will be covered. These support teams are a priority and attract new funding into CYP mental health. The aim is to identify and support those CYP with mild/moderate mental health needs and to deliver broader whole school messages on mental health topics.

Embracing the digital age is an important method of supporting new ways of working. A number of areas around the country have been working together to develop a website called Healthier Together and Shropshire, Telford and Wrekin are part of this group. It is a website for parents, children and young people, and for clinicians. It is image-led, colour-coded and based on a simple user journey with the quick and concise delivery of information required. It will be especially valuable to provide additional support to those on waiting lists for assessment, diagnosis and treatment. The purpose is to provide education and support on CYP mental health and physical health conditions and cover pregnancy and the peri-natal period. In addition it offers consistent advice from health professionals.

The website went live on 27th March 2023 and the next phase of its development is to launch and publicise the website, and work with all partners in the Shropshire, Telford & Wrekin area to develop website content according to local needs. The website is available at the web address below:
www.stw-healthiertogether.nhs.uk

We are also working with a mobile phone app developer on a project to support for those CYP in mental health crisis or at risk of crisis. We are working alongside the development of a crisis care Dynamic Support Register which will help to identify those likely to benefit most from using the app. There are several similar apps in use elsewhere for lower intensity mental health conditions.

Future work for 2023/24

In 2023/24 we will continue to embed the good work commenced to increase access to those with severe mental illness including adult eating disorders, with an improved early intervention offer and an improved offer for those with long standing severe eating disorders.

We are working closely with West Midlands Ambulance Service to increase the training offered regarding mental health to all ambulance personnel, to have mental health clinicians in the control room to offer advice and guidance, and to have a dedicated mental health ambulance in Shropshire. In addition, we will be working with our 111 provider to ensure that when someone rings 111 they can opt for a direct mental health triage and support.

Learning Disabilities and Autism

Over the past year the Learning Disability and Autism Programme has been continuing to deliver the priorities set out in the 3-year roadmap, working with partners and stakeholder across the system. Supported by regional investment and resources, key areas of focus include:

- Reducing our reliance on specialist inpatient beds
- Building community infrastructure and support services
- Improving outcomes for children and young people

- Increasing autism awareness in schools through the autism in schools project
- Continuing to drive reduction in health inequalities and ensuring our workforce are supported and well trained
- Working with Parent Carer Forums and experts by experience
- Developing sensory adjustments in acute wards at The Redwoods Centre in Shrewsbury

A review of the current delivery model was undertaken in November 2022 in readiness for the final year of the road map delivery (23/24). This was in response to national requirements for further integration of health and social care service to support improved outcomes for patents and families following the establishment of Integrated Care Systems, but also to improve collaborative working across partners to reduce a growing trend in demand both within inpatient and community services in Shropshire, Telford and Wrekin.

Next year will see a focus on admission avoidance and supporting the discharge of patients from hospital through enhancement of care (education) and treatment reviews (CETR /CTR), more people being reviewed through the DSR process, and much closer working with our local authority housing partners to manage and safely discharge patients needing complex packages of ongoing care.

The challenge around growing waiting times for autism diagnosis is a key improvement priority across the system. We want to ensure patients that are waiting for a diagnosis "wait well" and are supported by effective pre diagnosis support in the community. We also need to ensure patients have access to post diagnosis support to ensure services join up and support patients to avoid unnecessary admission in to hospital. We have a strong foundation of support provided through local autism hubs and this will be strengthened through collaborative working with both statutory and voluntary sector providers.

We will continue to work closely with key partners and experts by experience on a number of service improvement projects, for example:

- Autism in Schools is a pilot project working with six pilot schools to develop new ways of supporting autistic children and their parents in the school setting, to ensure support is put in at the earliest opportunity and to prevent escalation of mental health difficulties. This work is being evaluated with a view to embedding the learning across all schools.

- The Keyworking project which is being delivered on our behalf by Barnardo's was launched in March 2023. Keyworkers work with those children and young people (0-25 years) with a diagnosis of learning disability and/or autism who are at high risk of admission to hospital or residential placement due to mental health issues or distressed behaviour. Keyworkers support children and their families to ensure the right support is in place and to enable the child/young person to stay at home wherever possible.

Transformation

Elective care transformation and recovery

The Covid-19 pandemic had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are being referred for or already waiting for treatment. At the beginning of 22/23 financial year our providers developed a 3-year plan in alignment with the NHS England Long Term Plan on how to rise to the challenges of addressing the elective backlogs that had grown during the pandemic through a combination of expanding capacity, prioritising treatment, and transforming delivery of services. As the Integrated Care System formed in July 2022, these plans have formed part of the system-wide elective recovery deliverables for this financial year.

Some of the approaches and new ways of providing Outpatients services to help recover some of the post-Covid-19 long waiting lists include:

- Addressing health inequalities as part of waiting list recovery
- Increased used of Advice and Guidance (and conversion to prevented face-to-face appointments)
- Virtual consultations (and conversion to prevented face-to-face appointments)
- Patient-initiated follow-ups (and conversion to prevented face-to-face appointments)
- Improved capturing and reporting of the above in system data
- Validation and review of waiting lists
- One stop clinics
- Nurse-led telephone follow ups
- Remote reviews
- Looking at ways of reducing missed appointments

During 22/23 providers worked hard through very challenging circumstances to deliver increased levels of activity throughout the year, compared to 21/22, and ensured that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – were and are prioritised. Steps have also been taken to ensure health inequalities within waiting lists are considered where possible and any identified impact addressed and minimalised.

Our ICS providers delivered maximum possible levels of inpatient, day case, outpatient, and diagnostic activities despite the increased numbers of Covid-19 cases. When there have been challenges with throughput, particularly at Shrewsbury and Telford Hospital NHS Trust (SaTH) due to emergency care pressures, we have also worked with several independent sector providers and utilised insourcing of support activity and diagnostics, in particularly for challenged specialities such as Gynaecology, Urology, ENT, and Trauma & Orthopaedics.

For Robert Jones & Agnes Hunt Orthopaedic Hospital (RJAH) the most challenged area has been spinal disorders due to the lack of capacity, case complexity and workforce challenges. To support with this, close working relationships were developed to enable a safe & effective transfer of spinal patients to the Royal Orthopaedic Hospital and Walton Centre NHS Trusts. Similar inter-system provider mutual aid arrangements were also established for trauma and orthopaedic patients between RJAH and SaTH for any Priority 2 patients/long waits where no high dependency unit capacity was required by the patient. In addition, to support with options around regional mutual aid in the West Midlands NHS England region, both SaTH and RJAH providers registered for the Digital Mutual Aid System (DMAS) where providers can support each other with mutual aid and transfer of patients in our most challenged specialities.

To further ensure the most efficient and effective use of available hospital capacity given the emergency care pressures, the ICS system was also asked to implement several recommendations made by the 'Getting it Right First Time' team (GIRFT) as part of the Midlands Elective Delivery Programme (MEDP). Good progress was made during the year in terms of deliverables such as the MSK transformation programme (provider collaboration for orthopaedics across the county, GIRFT best practice). The system is performing well for day case rates within the model hospital/GIRFT data for most specialties however Orthopaedic day case rates, length of stay for primary hip replacements, and primary knee replacements and urology procedures day case rates remain challenged. There are system plans and programmes in place to address these challenges for 23/24.

Theatre utilisation, which is essential to support activity, has been difficult at SaTH due to staffing, capacity, and equipment challenges. To support with productivity this year SaTH has successfully recruited internationally, implemented new theatre software, and are in the early stages of implementing GIRFT recommendations for optimising theatre utilisation and efficiencies, and best practice pathways.

Radiology has also been a key challenge in supporting with elective recovery and both SaTH and RJAH had to increase capacity through external support such as mobile scanners, operating 7 days a week and 12 hours a day to support with the demand and reduce the elective backlog. Through this extra capacity in the last three months of the year there has been a marked improvement in this diagnostics position at both providers.

To further support with the provision of timely diagnostics, the ICS Community Bid was approved during the year. The development of Community Diagnostic Centres (CDC) is a central pillar of the ICS strategy for integrated care and core to restoration and recovery of the NHS across the county. The first CDC in the county will be in Telford. As an ICS, it is important to note that the location for the elective surgery hub at PRH is aligned with the location for the initial CDC; work is proceeding on this facility, which is expected to be operational during 23/24. The type of tests and pathways to be provided within the CDC will be wide ranging focusing on respiratory, early diagnosis of CVD and cancers and MSK, but not limited to these pathways.

The CDC will support patients who require surgery by enabling their diagnostics to be undertaken earlier within their pathway and support their journey through the Elective hub. Additional MRI capacity will be introduced as part of the CDC from October 2023. Additional CT capacity will be introduced as part of the CDC from May 2023. The CDCs also contribute to that left shift of providing certain services in communities rather than general hospital settings, as part of moving towards more locally available services where clinically appropriate.

Funding was also approved during 22/23 for an Elective Hub at SaTH to increase capacity and deliver activity to help reduce the surgery backlog. Within the Hub there will be two theatres and an associated recovery area, which will re-provide the theatres currently located within the SaTH day surgery complex which are often closed due to escalation/non-elective pressures from October to April every year. Approximately 24% of elective day case and inpatient activity is typically lost to winter surges in demand and the lack of protected elective capacity.

This scheme will create a ring-fenced elective day-case facility bed base all year and will address the fact that day surgery effectively stops between October and April year on year as the current bed base is used to support increases in non-elective bed pressures. Below are the timelines for this work:

- Phase one of the scheme by July 2023 will provide eight trolley bases

- Phase two of the scheme by January 2024 will provide twenty-three ring fenced beds and four theatres (one of which is an additional theatre)

In addition, the creation of an additional theatre and associated recovery and facilities at The Robert Jones and Agnes Hunt Orthopaedic Hospital was also approved, with plans including:

- Construction planned to be completed by October 2023.
- The Theatre will be operational by January 2024. This capacity will enable RJAH to deliver an additional approximately 282 elective cases in 2023/24 and 1,200 elective cases recurrently thereafter.
- This will deliver 9% increase in elective activity for the delivery of additional spinal disorders and orthopaedic activity.

In terms of waiting list administration, the targets set by NHS England were also met to deliver validation every 12 weeks for those patients on long waiting lists e.g. 104 weeks, 78 weeks and 52 weeks. Validation cycles of work on our waiting lists continues in order to ensure pathways are reviewed at regular intervals with the support of a new system-wide Access Policy developed and implemented this year.

Robust governance and reporting structures exist within each of the provider organisations for the effective monitoring of this improvement and recovery work, as well as reporting into the NHS Shropshire, Telford and Wrekin and ICS committees and governance framework, along with NHS England assurance meetings. At an ICS level there remains a Planned Care Delivery Board in place which oversees and is accountable for the elective, cancer & diagnostics agenda for the whole Shropshire, Telford and Wrekin ICS and has membership from all system partners. This provides high level assurance and reports into a newly established Integrated Delivery Committee (IDC).

For the year ahead we plan to continue improving our elective recovery position, however this is dependent on a reduction in non-elective demand & pressures, workforce and staffing numbers improving, the availability of independent sector capacity, Elective Hub implementation, CDC implementation, reduction in numbers of those in hospital who are medically fit for discharge but require ongoing community packages of care, provider collaboration, and successful capacity deployment through the capital estates programme.

Linked to the NHS Long Term Plan, the broader programme of Elective Care Transformation is to lead and oversee transformative change on areas of elective care that will ensure individuals needing planned care see the right person, in the right place, at the right time (first and every time), and get the best possible outcomes, delivered in the most efficient way.

In addition, it sets out to address some of the known issues such as:

- suboptimal information flow and service pathways
- patients travelling to hospital, to wait for an appointment that may last only a few minutes, when we could save time, cost and stress by providing these services in a different way
- reducing the time to recovery for post-Covid-19 long waits that will help ensure the capacity we do have is utilised most efficiently, and that patients get to receive the care that they need, where when and how they need it.

Redesigning and transforming services where possible to be more efficient is a vital component in enabling effective recovery of the overall elective waiting list position. The programmes and the work being planned provides the opportunity to properly review and redesign elective care and move away from individual specialty appointments, and towards patient pathways, experience and journeys. This

is always with the patient at the centre, making outpatients and accessing care simple, effective and efficient – Right Care, Right Person, Right Place, Right Time. As broad high-level aims, it is expected that through Elective Care Transformation for the system we would:

- Better manage increasing demand for elective care services
- Improve patient experience and access to care
- Provide more integrated, person-centred care.

These high-level aims set the context for programmes of review, redesign, development and transformation, with additional aims to reduce the need for face-to-face outpatient appointments by a third over the next five years, along with a range of other benefits and intended outcomes including:

- Improved utilisation of secondary care resource – physical space and clinical time
- Optimised use of shared information and improved pathways
- Improved clinical outcomes through patients receiving expert advice more quickly and follow-ups based on clinical need – rather than arbitrary schedules
- Improved co-ordinated care for patients with multiple conditions
- Improved patient experience through improved timely access to the right service, more informed and more empowered
- Better use of patients' time through preventing what may be unnecessary trips to hospital
- Reduced environmental impact, through decreasing journeys to hospital therefore emitting fewer CO2 emissions, resulting in reduced environmental damage and risk of preventable deaths through air pollution
- Financial efficiency to patients through not having to travel, and to the system through improved efficiency and utilisation of existing resource.

Outpatients transformation

This 5-year programme of work continues to progress in terms of its scope and original planning and is within timescales; to transform the provision of Outpatient services in the county to be more effective & efficient, whilst generating efficiencies that help enable recovery of long elective waiting lists and waiting times through reutilisation of freed up capacity.

The ambition of the programme is to:

- Review and redesign services with service users and providers around patients' needs
- Provide high quality citizen-centred services
- Ensure timely, safe, effective, and sustainable care
- Provide a seamless care experience
- Ensure 'right time, right location, right person'
- Ensure integration across primary, community and secondary care
- Reduce duplication and improve resource efficiency, ensuring value for money

The programme is broadly structured into two core components:

- Focus on accelerated improvements around the utilisation of Advice & Guidance, Virtual Consultations and Patient Initiated Follow Up discharges. These alternative approaches enable the identification of effective pathways of care that may not really require a hospital referral, allowing patient access to care when it is needed as opposed to when the hospital will see you, and promoting the use of telephone and video consultations where clinically appropriate and suitable for the patient, where it is beneficial to do so. Much work is already underway to look at how these can be used effectively, and we have been involving patients,

public and clinical colleagues in those conversations. The work will continue at pace into 2023/24.

- Longer term transformation opportunities to optimise the use of digital innovation, develop new and improved pathways and service delivery models, contribute to the 'left-shift' of more locally available services in communities or people's homes and alleviate some of the demand from the acute Trust by reducing unnecessary hospital-based appointments.

Some of the high-level benefits expected from this programme of work are as follows:

- Patients & Carers
  - Safer and quicker care
  - Better experience
  - Seamless communication
  - Care that fits around you
  - Reduced travel/stress

- Primary Care & GPs
  - Manageable demand
  - Ability to target available resources
  - Supported, sustainable teams
  - Seamless communication

- Secondary and Hospital Colleagues
  - Safe care
  - Manageable demand
  - Ability to target resources
  - Supported, sustainable teams
  - Seamless communication

- Integrated Care System
  - Improved health & wellbeing of the local population
  - Better outcomes
  - Increased value
  - Less waste
  - More resources

As can be seen from the above, the work to transform Outpatient services is intrinsically linked with our ability to recover a lot of the significant elective care waiting lists through being more effective & efficient.

The overall Outpatients programme forms an integral part of the broader transformation agenda and 'roadmap to recovery' which also consists of a few other initiatives taking place in the background, with much work underway on:

- Validation of waiting lists through telephone and letter contact with patients resulting in a proportion of discharges or changed pathways such as converting to a virtual appointment
- Focus on reducing the numbers of patients who miss appointments or do not attend
- Where possible, re-offering the choice to patients of alternative providers

- Where possible optimising the use of available independent sector capacity
- Work to drive through the targets of achieving zero 104+ week waits and 78+ week waits by March 2023
- Background targets to the Outpatient programme are to increase productivity and maximise capacity compared to 19/20 baseline, reduce follow up waiting lists by 25%, and prevent 33% of face to face Outpatient activity compared to 19/20.

Within this significant and complex 'roadmap to recovery,' set down by NHS England there have also been several short-lived intensive initiatives called 'sprints,' where Integrated Care Systems are expected to put in place plans and galvanise the necessary resource to give an intensive burst of focus to a certain area over a two-week period. These 'sprints' have included:

- September 22: Super September
  - An intensive focus on validating waiting lists, including letters to patients to confirm and clarify status and provide several options, the use of independent sector providers to assist with waiting lists, and booking in of all spinal pathway 1 patients who would breach 78 weeks by March 2023 into clinic slots. The exercise was completed, and a regional evaluation showed significant impact and outcomes, with learnings to incorporate into other improvement plans.

- December 22: Referral Optimisation
  - A two-week period of training sessions, drop-in Q&A sessions, webinars and toolkits made available around maximising the use and benefit of advice & guidance and referral optimisation (pre and post referral), where advice between the referrer and an appropriate clinical professional at the right point can help put in place alternative suggestions for care and treatment and therefore prevent unnecessary hospital appointments. This also helps patients by not needing to wait for and attend a hospital appointment.

- January 23: Driving Down Unattended/Missed Appointments
  - An intensive focus on various methods and approaches for reducing unattended appointments as these are not only a waste of funded resource but also create unused appointments slots that could have been provided to someone else. These approaches include methods for auditing and determining some of the causes & triggers, to better understand some of the reasons for patients not turning up for their appointment. This additional intelligence will then inform further plans around how we communicate with patients to address some of those challenges.

- Planned for April 23 is another two-week intensive focus, focused this time on methods for identifying and addressing any inequalities in elective waiting list recovery.

The programme is progressing well, and a huge amount of progress has already been made in the areas described above. In parallel, the team has undertaken robust analysis of three years' worth of patient complaints and compliments relating to Outpatient services, run a public survey, and hosted a number of engagement sessions to harness the feedback and opinions from colleagues, stakeholders and the public on Outpatient services as well as suggestions for change and improvement. These are currently being consolidated, before undergoing thematic analysis, and will be used to produce an evaluation report, and inform further transformation and redesign opportunities.

One output of a shift towards alternative approaches and new ways of providing Outpatient services is a reduction in the number of times that a patient needs to visit hospital, which can lead to environmental benefits including:

- Reduced miles travelled by patients, and their family and carers
- Reduced CO2 emissions
- Reduced hospital car park use
- Reduced time needed for appointments (for virtual/telephone consultations)
- Increase to quality-adjusted life years saved

Cancer

Improving cancer pathways continues to be a priority and is at the heart of the ICS approach to recovery of cancer services. Key actions have been undertaken and are ongoing during 2022/23 which include the following.

- Additional commissioned capacity was secured for the implementation of the Faecal Immunochemical Testing (FIT) for all colorectal urgent suspected Cancer patients from 1st April 2022

- A new provider has been commissioned for the Faecal Immunochemical Testing service following a successful procurement with a commencement date of April 2023

- The rollout of a non-site-specific pathway has been delayed due to a number of recruitment challenges. Ongoing work continues, supported by the West Midlands Cancer Alliance to recruit into this position

- The Community Breast Pain Clinic established in November 2021, securing additional funding for a further 12 months. Work is being planned to determine the exit strategy /sustainability of this service going forward

- The 3-month Teledermatology pilot went live within the Shrewsbury Primary Care Network, across 15 GP practices at the end of January 2023. The aim of the project is to reduce inappropriate two week wait referrals into secondary care and ensure that patients are placed on the correct pathway. The pilot consists of a hybrid model; referrals with dermatoscopic images can be sent directly from primary care via a system called Accurx, or alternatively patients can be referred into a central hub where the images are taken. Referrals are then triaged by a secondary care consultant who may offer advice and guidance, inclusion on the dermatology pathway or progression to the two week wait pathway for cancer treatment.

- On completion of the pilot an options appraisal will be undertaken to assess the preferred model to be rolled out to across Shropshire, Telford and Wrekin, expected to start in June with the aim to include all GP practices by Autumn 2023

- Continued participation with the West Midlands Cancer Alliance as part of the 3-year Galleri blood test trials along with Cancer Research UK, Kings College London and the American company GRAIL. The trial is around undertaking diagnostic blood tests on individuals to identify any markers as early indicators of Cancer, enabling earlier interventions.

- Living Well sessions are being held both virtually and face to face.

- An App launched by The Shrewsbury and Telford Hospital NHS Trust (SaTH), has been developed in collaboration with people living with and beyond cancer, local NHS cancer specialists and other organisations who provide services for people affected by cancer. This can also be downloaded for people who are supporting people following a diagnosis as well as other healthcare professionals across the county.

- Operational performance moved into NHS England Tier 1 monitoring with increased focus on reducing the backlog and also to improve the Faster Diagnosis Standard performance.

- The Macmillan Cancer Care Review is on track to meet the objectives outlined within the pilot project plan before ending on 31 May 2023. A full evaluation will be available in April 2023 and learning shared across the system.

- Primary Care Network Cancer Leads have been identified who meet bi-monthly to share good practice, discuss issues and to link with the wider ICS Cancer Strategy and West Midlands Cancer Alliance work.

Eye care transformation

Running to 2025/26, this programme aims to review, and redesign integrated end-to-end eye care services and pathways across the county, spanning primary, community and secondary eye care provision.

With a scope including the same principles as the Outpatients transformation programme, it aims to improve referral processes and information sharing, shared decision-making, and reduce face-to-face outpatient activity and reduced unnecessary use of hospital for eye care appointments through methods including advice and guidance, remote consultations, one-stop clinics, community-based diagnostics, and nurse-led telephone follow-ups. It also includes several national recommendations around transforming eye care services and so has involved a clinically-led review and redesign of pathways; also considering learnings and recommendations that came out of stakeholder and public involvement and engagement sessions.

Some of the case for change and reasons why we need to improve eye care services include:

- Importance of earlier detection and prevention
- Anticipating predicted increasing need for services
- Providing more services closer to home and in people's own communities, when it is needed
- More joined up services across primary, community and secondary care
- Reducing unnecessary face-to-face Outpatient appointments
- Reducing travel to hospital and transport, which also reduces occupied parking spaces and CO2 emissions
- Making better use of new technologies and developments in eye care
- Making better use of data and tracking people's care.

The phases of the programme cover:

- Rethinking referrals and integrated eye care pathways (primary, community and secondary care)
- Outpatient transformation (eye care appointments)
- Multispecialty pathways (Giant Cell Arteritis and Hydroxychloroquine Monitoring etc)
- Low vision, dry eye, contact lenses and cataract direct to surgery listing (pre-op and consent in optometry)

All these phases will cut across eye care in general in terms of pathways, processes and ways of working, but include a specific focus on the following pathways:

- Cataract
- Glaucoma
- Medical retina
- Urgent eye
- Paediatric eye care

The programme launched November 2021 and undertook a period of comprehensive engagement, and this continues to form a continuous golden thread throughout the journey of the programme to ensure ongoing involvement, contribution and engagement.

Some of the groups actively involved and engaged in the programme of work are described below:

- Staff across whole health & social care system (mainly SaTH)
- Staff in community and primary care settings
- Patients, carers and general public
- Independent sector eye-care providers
- Local Optical Committee
- GPs
- Healthwatch
- Health & Wellbeing Board
- Community groups related to eye-care and vision
- Sight Loss Shropshire
- Telford and Shropshire Patient Groups
- NHS England
- Joint Health and Social Care Scrutiny Committee
- Town, County and Parish Councillors
- Voluntary and Community Sector

This engagement has allowed us to harness comments and feedback on current eye care services, as well as suggestions and recommendations for change and improvement. That, combined with a patient survey, and analysis of three years' worth of eye care complaints and compliments, and the national transformation recommendations, provided a wealth of information to help shape the design and development of a new improved integrated eye care model and pathways.

A piece of work was also completed to identify and analyse any associated inequalities, so that plans could be put in place to ensure these improvements to eye care would address any existing health inequalities and close gaps, and certainly ensure no new ones are created as a result.

Positive Impacts

- Improved access to timely care and support for those with mobility and/or transport issues through new innovative ways of providing appointments, for example virtual appointments

from your own home, removing the need for travel. Also, more locally available services through the provision of more eye care services from optical practices instead of hospital.

- Enhanced experience of eye care services for all in an equitable way through new more effective and innovative ways of working, and more integration between primary, community and secondary care – ensuring the person is seen by the right person, in the right place, at the right time, first time.

Negative Impacts and mitigations

- Potential risk of digital exclusion for those with limited or no access to technology and/or internet. The programme intends to also provide virtual consultations by telephone, and ensure that we still offer in-person traditional appointments.

A draft proposed integrated improved eye care model and pathways are now being developed, ready for a second round of engagement with the same groups to gather further feedback and comment. These will provide a more cohesive and collaborative eye care service across primary, community and secondary care, including the independent sector, that benefits patients, carers, and those working in eye care because of the improved pathways that will be more slick, efficient, effective, clearer and easier to understand and navigate.

The outputs from this second round of engagement will inform any necessary refining of the model before completing a business case for approval later in 2023. If approved it is hoped that a new improved model of eye care and pathways will go live from April 2024.

Meanwhile work continues on Outpatient eye care appointments, and identifying opportunities where possible, and where clinically appropriate, to maximise the use of tools like Advice & Guidance, remote reviews, and Virtual Consultations. This brings a broad range of benefits, not least preventing unnecessary travel for patients to hospital for appointments that can be provided safely & effectively in a different way.

As a key enabler of improving eye care referral pathways and processes, and an enabler of this model in general, the Shropshire, Telford and Wrekin system agreed to be an early adopter and one of the 11 ICSs in the West Midlands for the implementation of electronic eye care referrals. The software and digital provider have been commissioned by NHS England, with a project team and plan in place locally for the imminent implementation of this exciting change in how eye care referrals are made.

The system will provide an improved flow of direct referrals between optometrists, the Referral Assessment Service (RAS) and Telford Referral and Quality Services (TRAQS), GPs and secondary care with the ability to transfer high resolution digital images directly from optometrists to secondary care consultants and enabling effective virtual consultations to take place without the need for the individual having to visit hospital. It also speeds to the process of optometrists gathering advice and guidance from consultants through a remote review, and the ability to make direct timely referrals into ophthalmology without the need for having burden the GP in processing the referral.

The Electronic Eye Care Referrals system is planned for implementation later in 2023.

Musculoskeletal (MSK) transformation

The MSK transformation programme, aims to improve the MSK health of our local population, whilst ensuring when MSK care is required, that patients are cared for at the right time, in the right location by the right person.

The objectives of the programme are:

- Equity of MSK access and treatment
- Patients are cared for by the right clinician, and the right location at the right time with the right data
- Delivering high quality outcomes and patient experience
- Achieving outstanding patient safety
- Timely access to patient care
- Spending money wisely
- Improve citizen's MSK and pain health

It is a clinically-led, locally-owned review and redesign of MSK pathways; also considering the learnings and recommendations that will come out of the stakeholder and public involvement and engagement sessions, along with GIRFT, and best MSK recommendations.

Phase 1

Launched on the 13th February 2023. The initial phase involves establishing a single point of access for elective MSK (Elective Orthopaedics, MSK Therapy, MSK Interface, MSK Chronic Pain and Rheumatology) with standardized MSK triage and MSK pathways. We have consolidated and standardisation of community MSK provision.

We now have in place across Shropshire, Telford and Wrekin:

- Single point of access
- Standardized triage models
- Standardized pre-surgical pathways
- Single EPR for phase 1 (RiO)
- Single referral form for all GP's in STW
- Transparency of waiting lists and workforce from each provider which will support collaboration
- Technological developments (joint working) 'My Recovery App', infrastructure to support self-management being rolled out at RJAH and then across Shropshire (patients enabled to support their own health conditions)
- Shared access policy agreed localities for delivery
- Agreed initial workforce
- Patients' referral into MSST are no longer sent back to the GP's to be referred into another MSK service but be moved internally

Phase 2

Currently being planned and designed and includes the following services:

- Strengthening Orthotics
- Chronic pain services (as part of a large project including non MSK-pain and management of opioids prescription).
- Optimisation of Orthopaedic surgical services
- System MSK workforce planning
- Focus on patient-initiated follow-ups plus implementation of a standard interface model for referral and triage.
- Strengthening of rheumatology
- Outpatients improvement project (aligned to the transformation programme)
- Maturing of system provision to support primary care

- Falls, Fractures and Osteoporosis (dependent on decision on trauma scope)
- A decision to be made about whether trauma will be in scope for the programme

Also to be integrated

- Supporting those with long-term MSK conditions
- MSK population health related activity
- Development of self-management models.

Cardiology Transformation

Launched in December 2022, the Cardiology Transformation Programme is due to run until 2025/26 within the scope of working through the pathways that patients take from primary care through specialised services and back to primary and community care; from cardiovascular disease prevention and early diagnosis through to treatment and rehabilitation.

National context

An estimated 6.4 million people in England are currently living with cardiovascular disease (CVD). Mortality rates from CVD fell by 52% between 1990 and 2013 however CVD remains one of the biggest killers in the UK. Cardiovascular disease (CVD) is the second highest cause of premature death, after cancer, in England. Heart and circulatory diseases cause around a quarter (24 per cent) of all deaths in England; that's around 140,000 deaths each year – an average of 380 people each day or one death every four minutes.

The Cardiology transformation programme draws together the recommendations from the Cardiology GIRFT Programme National Specialty Report (Feb 2021), The Future of Cardiology, a paper produced by the British Cardiovascular Society Working Group on The Future of Cardiology, and significantly the Cardiac Pathways Improvement Programme. The Cardiac Pathways Improvement Programme (CPIP) brings together NHSE collective priorities set out in the Long Term Plan, and by GIRFT, Specialised Commissioning, and the National Outpatient Transformation Programme. The CPIP team works in alignment with existing national programmes, focusing on key goals and priorities, and supports Cardiac Networks and Systems to deliver a comprehensive approach to whole pathway improvement and transformation.

Local Context

In Shropshire Telford and Wrekin there are around 66,000 people living with heart and circulatory diseases. These heart and circulatory diseases cause 110 deaths each month in Shropshire Telford and Wrekin. Around 81,000 people in Shropshire Telford and Wrekin have been diagnosed with high blood pressure and 13,000 with Atrial Fibrillation.

Ambition

The ambition for the Cardiology Transformation Programme is to provide high-quality cardiology services for our patients, carers and their families in the right place, at the right time, in the right location delivering excellent patient experience.

Aims

The aims of the cardiology transformation work guided by NHSE's Cardiac Pathways Improvement Programme (CPIP) include:

- Reduce Cardiovascular disease related mortality
- Ensure high quality outcomes and safety of care across the pathway

- Improve and refine pathways and processes to provide clinically excellent cardiology services with restored services and reduced waits
- Improve integration of cardiology pathways across primary, community and secondary care to function collectively as one service with one common aim.
- Improved focus on preventative and proactive care
- Ensure value for money of commissioned services through provider collaboration.
- Providing increased support, development and accountability for the cardiology workforce
- Improve the flow, quality and use of information in order to optimise decision making; both operationally and strategically.
- Ensure the involvement and engagement of patients and public in the design and development of cardiology services
- Support the CVD prevention agenda

Since the commencement of the Cardiology Transformation Programme in December 2022

- There is an identified Clinical Lead for the programme who is funded through NHSE's Cardiology Pathways Improvement Programme (CPIP). He links into the regional and national CPIP clinical programmes as well as providing clinical input and leadership for the STW Cardiology Transformation Programme.
- The Shropshire Telford and Wrekin Cardiology Transformation Programme Delivery Group has been put into place to work through the cardiology pathways that patients take from primary care through specialised services and back to primary and community care; from cardiovascular disease prevention and early diagnosis through to treatment and rehabilitation. The group collaboratively reviews, redesigns, develops and transforms cardiology services to ensure that high-quality cardiology services are provided for our patients, carers and their families in the right place, at the right time, in the right location delivering excellent patient experience.
- A clinical advisory group with multi-professional representatives from across the ICS has commenced. The purpose of the Shropshire Telford and Wrekin Cardiology Clinical and Professional Advisory Group is to use its broad experience and expertise to provide clinical and professional advice to the Cardiology Transformation programme.
- The priorities for 23-24 for the Cardiology Transformation Programme have been agreed.

Local Care and Community Transformation

Overview

The Shropshire Telford and Wrekin (STW) Local Care Transformation Programme (LCTP) brings together a collection of transformation initiatives that will deliver more joined up, integrated and proactive care closer to home and in peoples' homes, supporting improved health and wellbeing for the STW population. The programme consists of initiatives that will deliver more care into the community achieving improved outcomes and experiences for patients, while also helping to relieve pressure on our acute hospital services so that those services are able to deliver quality services when people need them. Wrapped around these new models of care, will be new ways of supporting people who are vulnerable, frail or have a range of complex health and wellbeing needs.

System changes

At the heart of Local Care, is a person centred proactive approach to care that helps people to live well and stay well, maximising independence and fulfilment in life. In 2022/23, the programme has focused on three key initiatives – rolling out a 2 hour rapid response service; implementing an integrated discharge team to ensure timely discharge from hospital; and setting up a Virtual Ward to enable more patients to return to the place they call home to receive sub-acute medical care that would otherwise need to be delivered in an acute hospital. In 2022/23, the Virtual Ward has focused on developing integrated pathways for people with frailty, and will expand into respiratory and cardiovascular pathways in 23/24

During 2022/23, we have further developed the Integrated Discharge Team (IDT) to support patient flow and improve patient outcomes. The Shropshire Community Trust's (SCHT) Capacity Hub Team worked closely with the acute Hospital colleagues during the pandemic to respond to subsequent pressures, this approach demonstrated the enhanced benefits associated with integrating the discharge functions. Building on this approach in 2022/23 the SCHT Community Team co-located with the Hospital team based on the Shrewsbury and Telford Hospital site. This has strengthened and enabled clinical discussions in 'real time'. Advocating the home first principle ensuring patients are transferred home as soon as they are well enough. Where patients need additional support, the SCHT Capacity Hub Team will ensure that they are appropriately transferred to appropriate care required for rehabilitation and therapeutic care.

During 2022/23 system leads supported the development of a Virtual Ward Roll Out Plan. Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital. In a virtual ward, support can include remote monitoring using apps, technology platforms, wearables and medical devices such as pulse oximeters. Continuous Quality Improvement methodology and partnership working has supported learning, with monitoring arrangements and measure impact to demonstrate both performance and quality benefits for patients.

This programme has been led by our system Directors of Nursing and operationalised as part of the Local Care transformation programme future place based integrated model of care for community services, hubs and Virtual Wards. Phase 1 has commenced with the governance structure set up to oversee the programme and the development of the roll out plans. Phase 2 will include implementation and is expected to provide up to 250 virtual beds by March 2024.

Telford and Wrekin Integrated Place Partnership (TWIPP)

The Telford & Wrekin Integrated Place Partnership (TWIPP) has been in its current format since March 2019 and comprises of senior officers from Telford & Wrekin Council, NHS Shropshire, Telford & Wrekin, Primary Care Networks, Midlands Partnership NHS Foundation Trust, Shropshire Community Health Trust, Shrewsbury and Telford Hospital Trust, Healthwatch, Shropshire Partners in Care and the Voluntary Community and Social Enterprise sector.

The TWIPP vision is aligned to the Health and Wellbeing Strategy vision of: "**Working together for children, young people and adults in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"**

In order to achieve this vision the partnership has agreed a set of priorities that will be delivered in accordance with TWIPP's principles as illustrated in the diagram on the right.

TWIPP brings together a complex set of community centred approaches and activities under the same strategic vision and principles of working to achieve the following shared outcomes:

- Care closer to home
- Integrated and seamless services
- The right information and advice at the right time
- One conversation and one point of contact

TWIPP's strategic priorities are:

1. **Population Health** – supporting people to be healthier for longer with a focus on those who have the greatest need, whilst maintaining an effective universal offer for everybody.
2. **Prevention and Early Intervention** – working with people, families and carers to proactively prevent, reduce and delay reaching crisis and needing to access health and care services.
3. **Integrated response to inequalities** – working together to tackle inequalities – ensuring reducing inequalities is embedded in our strategic decision making, investment decisions and service delivery.
4. **Working together stronger** – delivering joined up, high quality, accessible health and care services which connect and empower children, young people and adults to stay healthier and more independent for longer.
5. **Primary Care Integration** – working together to support our Primary Care sector to meet demand and provide high quality accessible services.

See the following pages for a copy of TWIPP Strategic Plan for 2022-23.

TWIPP's strategic priorities are aligned to the Integrated Care Strategy as well as the Telford and Wrekin's Health and Wellbeing Strategy. It is worth noting that whilst the priorities, and associated deliverables, are looking to be delivered at place, **currently no delegation of budget or resources from the system is in place to enable this to happen. This is an identified risk to delivery.**

LIVE WELL TELFORD

Telford & Wrekin Integrated Place Partnership Strategic Plan 2022-2025 FINAL V5

Telford.

"Working together for children, young people and adults in Telford and Wrekin to enable them to enjoy healthier, happier and more fulfilling lives"

	Start Well	Live Well	Age Well	Areas of focus
1. Population Health Supporting people to be healthier for longer with a focus those who have the greatest need, whilst maintaining an effective universal offer for everybody				Reducing preventable diseases (coronary heart disease, diabetes and cancer) through early diagnosis, immunisations, screening and improving the reach of services
2. Prevention and Early Intervention Working with people, families and carers to proactively prevent, reduce and delay reaching crisis and needing to access health and care services.				Accessible information, advice and guidance
				Proactive Prevention approach
				Local prevention and early intervention services
3. Integrated response to inequalities Working together to tackle inequalities - ensuring reducing inequalities is embedded in our strategic decision making, investment decisions and service delivery.				Healthcare inequalities – including the Core 20Plus5 programme
				Reduce barriers to access (e.g. digital poverty and transport)
4. Working together stronger Delivering joined up, high quality, accessible health and care services which connect and empower children, young people and adults to stay healthier and more independent for longer				Best start in life including healthy pregnancy and delivery
				Transition to adulthood
				Learning Disability, Autism and Mental Health
				Older adults and dementia
				Local Care Transformation Programme
5. Primary Care Integration Working together to support our Primary Care sector to meet demand and provide high quality accessible services.				Supporting the development at place of the four primary care pillars highlighted in the Fuller report
				Access to primary care

Telford & Wrekin Council | NHS Shropshire, Telford and Wrekin | Shropshire Community Health NHS Trust | The Shrewsbury and Telford Hospital NHS Trust | Midlands Partnership NHS Foundation Trust, A Keele University Teaching Trust | Primary Care Networks | healthwatch Telford and Wrekin | Shropshire Partners in Care | COG Chief Officer's Group Telford & Wrekin

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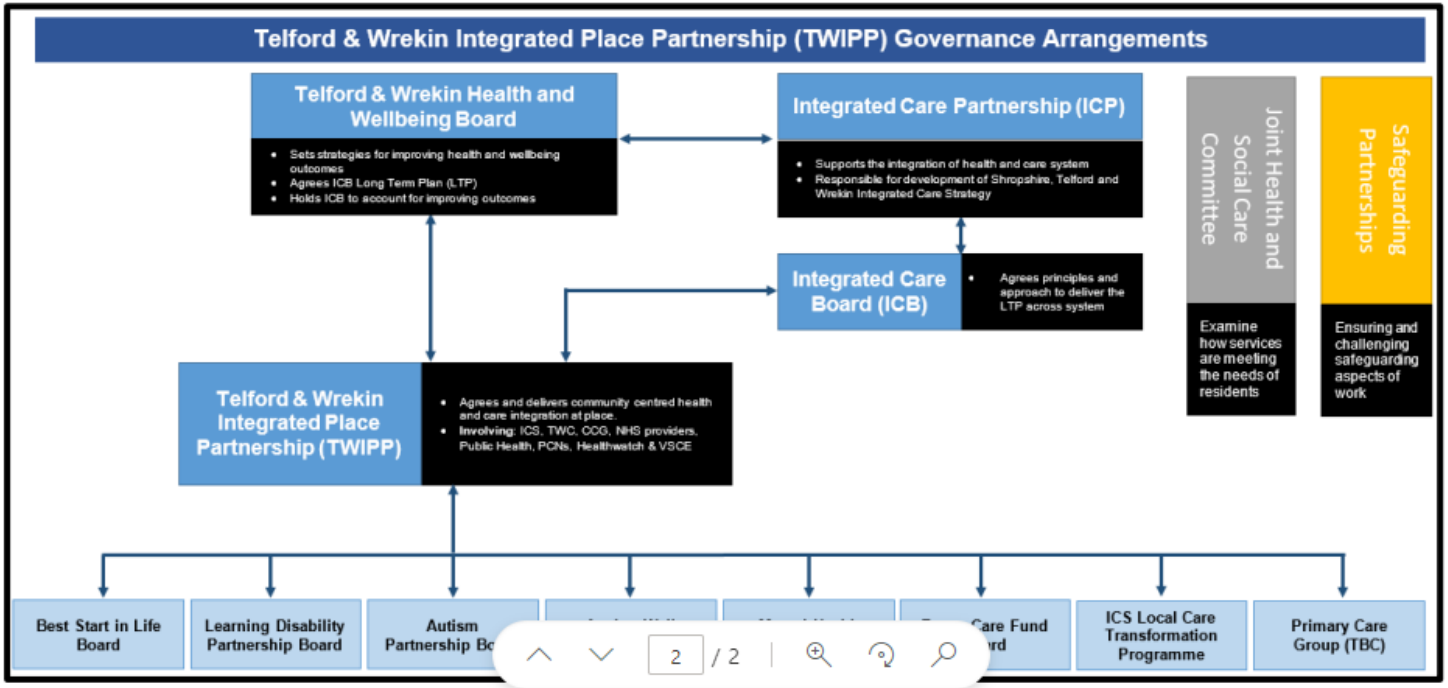
Place based delivery partnerships	• Best Start in Life Board • Learning Disability Partnership • Autism Partnership • Ageing Well Partnership	• Mental Health Partnership • ICS Local Care Transformation Programme Board • Better Care Fund Board	• Primary Care Group (TBC)
System Priorities	• Prevention • Transforming Clinical Pathways	• Hospital Transformation Programme (HTP) • Local Care Transformation Programme	• Workforce • Value for money
Our Enablers	• Workforce • Population and Business Intelligence • Digital and Technology Enabled Care	• Housing, Estates and Planning • Finance • Commissioning	• Quality Assurance • Communication and Engagement



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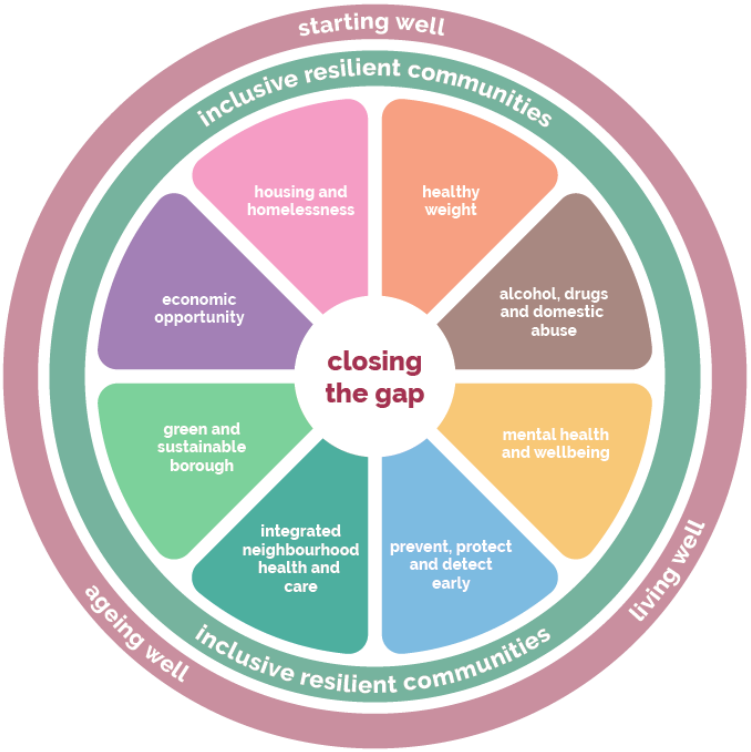
Telford and Wrekin Health and Wellbeing Strategy

Telford & Wrekin Health and Wellbeing Board is refreshing its strategy priorities and the updated strategy will be approved in June 2023. The priorities proposed (below) are based on engagement and insight with our residents and intelligence from the Joint Strategic Needs Assessment on local health and wellbeing outcomes and inequalities gaps.



As well as key local health and wellbeing challenges, the priorities recognise the wider determinants of health, including housing and homelessness, economic opportunity – poverty, employment and the cost of living, and the impact of living in our communities. The life course approach provides the opportunity to identify key improvements needed to improve outcomes for residents at all stages in their lives.

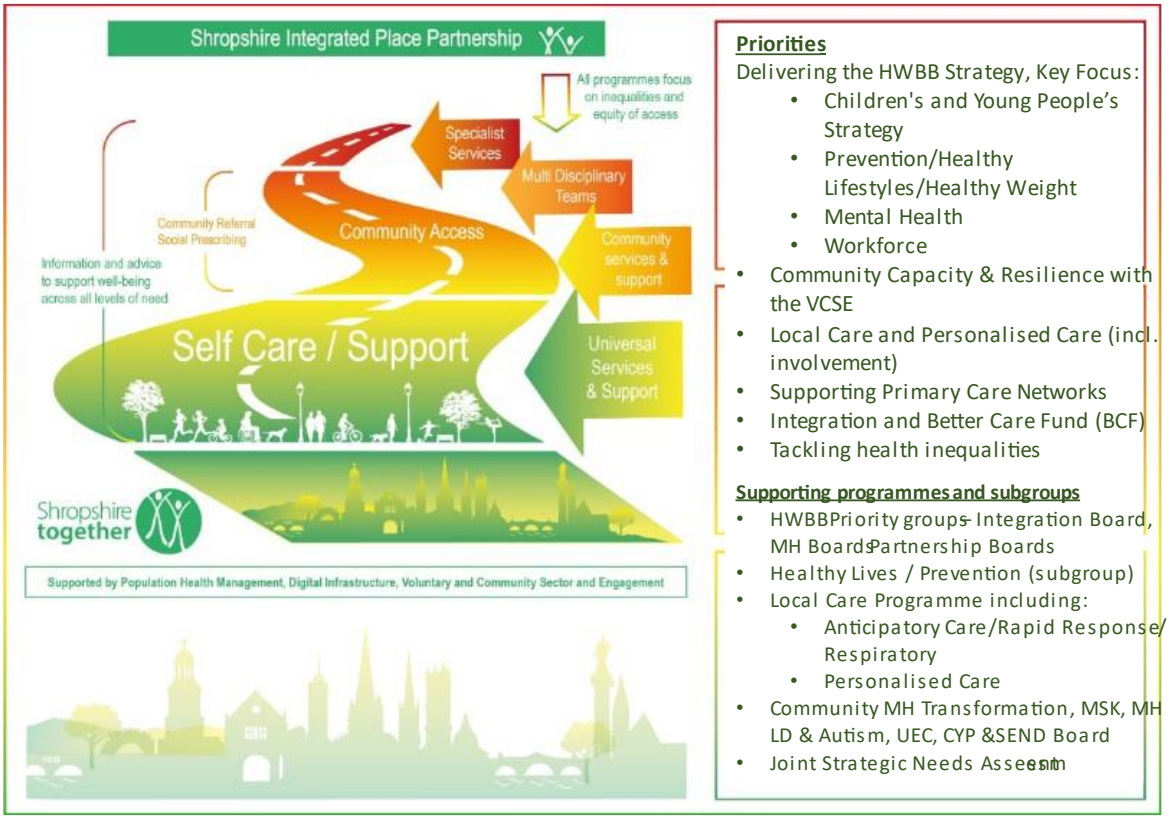
Delivery of these health and wellbeing strategy priorities is steered and overseen by the Telford & Wrekin Integrated Place Partnership (TWIPP), the Best Start in Life Board and the Community Safety Partnership.

The current strategy is available on Telford and Wrekin Council's website.

Shropshire Integrated Place Partnership (SHIPP)

As a subgroup of the Health and Wellbeing Board and the Integrated Care Partnership, the Shropshire Integrated Place Partnership (SHIPP) aims to work collaboratively to deliver the system priorities. It does this by working in partnership with shared collaborative leadership and responsibility. Clinical/care leadership is central to the partnership, to ensure that services provide the best quality evidence-based care and support for our people, improving outcomes and reducing health inequalities.

It is expected that through the programmes of SHIPP, and routine involvement and coproduction local people and workforce can feed ideas and information to inform and influence system strategy and priority development.



There is good alignment of our priorities across the system, as evidenced below.

System priorities and linkages across Boards

Shropshire, Telford & Wrekin ICS Pledges	Shropshire Health & Wellbeing Board (H&WBB) Priorities	Shropshire Integrated Place Partnership (ShIPP) Priorities
Tackling the problems of ill Health	Improving population Health	
Tackling Health Inequalities and access to Health Care	Reduce Inequalities	Tackling health inequalities
Creating system sustainability	Joined up working	Integration & Better Care Fund (BCF)
Delivering Improvements in Mental Health/learning disability autism provision	Mental Health	Mental Health
Workforce	Workforce	Workforce
Integrating services at place and neighbourhood level	Working with and building strong and vibrant communities	Community capacity & building resilience within the VCSE
Climate change	Children & Young People incl. Trauma Informed Approach	Children's & young peoples' strategy
Enhanced engagement and accountability	Healthy Weight and physical activity	Prevention/healthy lifestyles/healthy weight
Improving safety & quality		Supporting Primary Care Networks
Leadership & Governance		Local Care and Personalisation (incl. involvement)

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.

The medicines management team works collaboratively with local hospital trusts, specialist services, GPs, community pharmacy and patients in order to achieve these goals. We ensure that medicines prescribed are evidence-based, follow recommended clinical guidelines and provide good value. This helps to ensure that the healthcare services commissioned for our population, are cohesive across all settings, and make best use of medicines.

We have four key work programmes: Medicines Governance, Medicines Value, Workforce Development and Digital.

Medicines Governance

Our system takes an integrated approach to medicines governance and safety and we have a number of committees with membership from all of our providers including primary care and community pharmacy.

Pharmacy Leadership Group

This group consists of the senior pharmacy leaders from each organisation' Here we identify our overarching strategic vision and priorities within our medicines value programmes and our workforce development programmes described below.

Integrated Medicines Optimisation Committee

Medicines and prescribing guidelines are approved for use locally after careful consideration of the supporting evidence at our Integrated Medicines Optimisation Committee. When they are considered to offer clinical benefits over what is already available then they are included on a shared formulary, used by general practice and hospital specialists. Formulary medicines represent the best choice from a value perspective which means that they will achieve the best treatment outcome at the least cost, which is different from simply using the cheapest medicine.

Medicines Safety Programme

System oversight is provided by the Medicines Safety Group (MSG) which is made up of the medicines safety officers from the provider organisations and representatives from primary care, local authority social service departments, and the care home sector. The MSG receives summary reports from all the providers and considers whether medicines safety themes are emerging from routine medicines incident reporting.

This year's three key clinical safety priorities have been identified as anticoagulation, sodium valproate in pregnancy, high dose opioids.

Anticoagulants

As part of the Primary Care Network DES impact and investment fund indicators (IIF) 22/23, there are a number of indicators which relate to Direct Oral Anticoagulant (DOAC) prescribing to support the rollout of this national procurement and the quality and safety monitoring associated with their use. These indicators include a review of patients prescribed medicine combinations that increase the risk of bleeding and ensuring those patients prescribed DOACs are monitored correctly and treated in accordance with clinical guidelines to ensure patients get the benefit from their medicine whilst reducing risks of any adverse effects.

Throughout 2022/23 there has been ongoing practice support, quality and safety work in this area including the collaborative development of supporting guidelines and frequently asked questions as a Midlands region, delivery of education sessions alongside the West Midlands Academic Health Sciences Network (WMAHSN), ongoing weekly safety searches to identify high risk patients for review in addition to supporting data dashboards to highlight priority patients. Ongoing practice support is also being delivered by Medicines Management solutions clinical pharmacy service to conduct clinical and therapy reviews of patients with Atrial Fibrillation, and this work will continue into 23/24.

The Valproate Pregnancy Prevention Programme

This is being implemented to ensure patients of childbearing age have their treatment reviewed annually to consider whether their treatment can be changed to an alternative for epilepsy seizure control or an alternative to mood control in bipolar depression. Sodium valproate has a high risk of causing congenital problems in children born to mothers taking this medicine. This programme has identified all women of childbearing age within Shropshire, Telford and Wrekin and our specialists and GPs are working together to ensure all patients have access to the right support.

High Dose Opioids and Dependence Forming Medicines

Nationally and locally, prescribing of dependence forming medications or medications associated with withdrawal symptoms has seen an exponential increase, albeit there is a place for the prescribing of opioids, gabapentinoids, benzodiazepines and Z-drugs, and as a system we use more high dose oral morphine and dependence forming medications than other areas.

The High Dose Opioids programme began with a launch meeting in November 2022. This focussed on the challenges of reducing the use of high dose opioids by showcasing work that is underway in the South East Shropshire PCN to help patients taper doses and offer acceptance and commitment therapy (ACT) as an alternative to pharmacotherapy, and was the start of a series of continuing focussed education and learning events. Resources such as 'Live Well with Pain' which stress the importance of mindfulness and self-help techniques to reduce the need for pharmacotherapy are being promoted to support GPs to reduce unsafe use of opioids in pain management.

Changes in prescribing practice at initial consultation and review of treatment can help overcome issues of prescribing outside guidance, over prescribing and risk of dependence and symptoms of withdrawal. Practices have been provided with national data sets and clinical system searches to support with assessing their current prescribing position to determine areas of focused improvement. A system wide collaborative approach has been taken with the implementation of working groups aimed at reviewing, tapering and reducing the prescribing of dependence forming medications and the initiation of opioid containing medications.

Local Commissioned Service – Medicines Safety

In September 2022, the locally commissioned service for the safe prescribing of medicines was launched across all 51 GP Practices. We use a system called ECLIPSE Live Radar to help practices to identify patients at risk of harm from medicines.

This service supports GP practices with their systems for safe prescribing ensuring medicines safety monitoring happens in a timely manner, which reduces the risks and volume of medicine related hospital admissions. Since the advent of this new service there have been improvements with a marked reduction in the volume of Admission Avoidance Alerts seen.

Medicines Safety in Care Homes

Recent advancements in the reporting capability for medication related incidents have been made via an electronic secure web-based form. This enables care settings to have direct access to the Ulysses incident reporting system via a web-based link, allowing medication related incidents to be reported directly onto the system ensuring accurate, first-hand information is reported. With training, guidance and support, access to this incident reporting process and system has been rolled out to Telford and Wrekin care settings, with a further roll out to Shropshire care settings from May 2023.

Use of the Ulysses system will allow for trends and themes to be identified improving patient safety and inform medicines training and learning needs within our care settings.

Antimicrobial Strategy – reducing risks from antimicrobial resistance.

Our System Antimicrobial Strategy Group has successfully been developed with key stakeholders participating from across the system. Partners from across sectors including representation from PCN, acute and community trust are in attendance with regional and national updates provided by the Midlands NHS England team. This group aims to ensure patients have access to the right antibiotics at the right time whilst reducing inappropriate prescribing of antibiotics where they are not necessary.

The system antimicrobial strategy is currently being developed with a focus on diagnostic and stewardship strategies for primary care, behaviour change incentives such as CQUINS in secondary care and the creation of public information and engagement pieces to ensure the widespread communication of antimicrobial stewardship. The group are also in the early stages of developing an infection prevention control and antimicrobial stewardship training matrix to ensure the ongoing professional development of clinicians.

The group have been instrumental in ensuring that appropriate antimicrobial stewardship has been implemented in the newly created pathways for intravenous antibiotic administration under the virtual ward. The group will now ensure that all providers and sectors in our system co-create and regularly update universal antimicrobial guidelines. The group utilises both national guidance and local microbiological intelligence to ensure resistance patterns are accounted for and guide local prescribing to keep antibiotics working for longer.

Medicines Value Programme

The demand for healthcare is increasing due to a growing and ageing population. There are also newly emerging, highly effective treatment options continually being developed and made available to the NHS, advancing patient care and improving clinical outcomes. These new treatment options also present financial challenges, as often newly developed medicines are costly. As a result, the NHS increasingly faces challenges when trying to enable people to access treatment that is clinically

effective, based on the latest scientific discovery, at as low a price as possible. This describes medicines value.

Throughout 2022/23 the Medicines Management team has been working on a number of key Quality Innovation Productivity and Prevention (QIPP) programmes to continually support and deliver the medicines value agenda including:

- Cardiovascular disease (AF, lipid management, heart failure)
- Cost-effective medicines
- Clinical decision support software systems (CDSS)

Cardiovascular Disease

Continued work has been ongoing to support the NHS Long Term Plan in reducing cardiovascular deaths. Further work has been conducted on optimising the existing treatment of patients with Atrial Fibrillation (AF) in addition to commencing new treatment for patients with AF that were previously untreated, reducing their risk of stroke. There has also been an ongoing focus on lipid management across Primary Care, with NHS Shropshire, Telford and Wrekin recently being successful in being awarded a grant bid for funding via The National System Transformation Fund (STF). This will enable work to continue into 2023/24, with a focus towards practices where health inequalities may be present and have outlier data in relation to cardiovascular outcomes.

With recent emerging evidence and guidance around the use of a new class of medicines to improve the outcomes of patients with Heart Failure, Diabetes and Chronic Kidney disease, medicines management have worked with specialist clinicians at the Shrewsbury and Telford Hospital NHS Trust to develop guidance to support the implementation of these new treatments across the system. Across 2022/23 there has been a 44% growth in prescribing of these medicines. Part of medicines management role is to ensure these medicines are available to the right patients at the right time, ensuring best use of medicines and value from these treatments.

Cost Effective Medicines

Throughout 2022/23 the Medicines Management programmes are forecast to deliver £1.89million cost-efficiencies for the system. This continued work is essential for ensuring the system can continue to invest in these new, advanced and innovate medicines and technologies for patients.

Clinical Decision Support

Following a successful procurement process, we have moved to a single prescribing decision support system, with all GP practices now with this in place. This advises GPs on clinical, safety and cost-effective medicines choices at the point of prescribing. Scriptswitch continues to deliver significant prescribing efficiency savings, with this year being no exception, with savings of £500,000 forecast to be delivered for the full financial year.

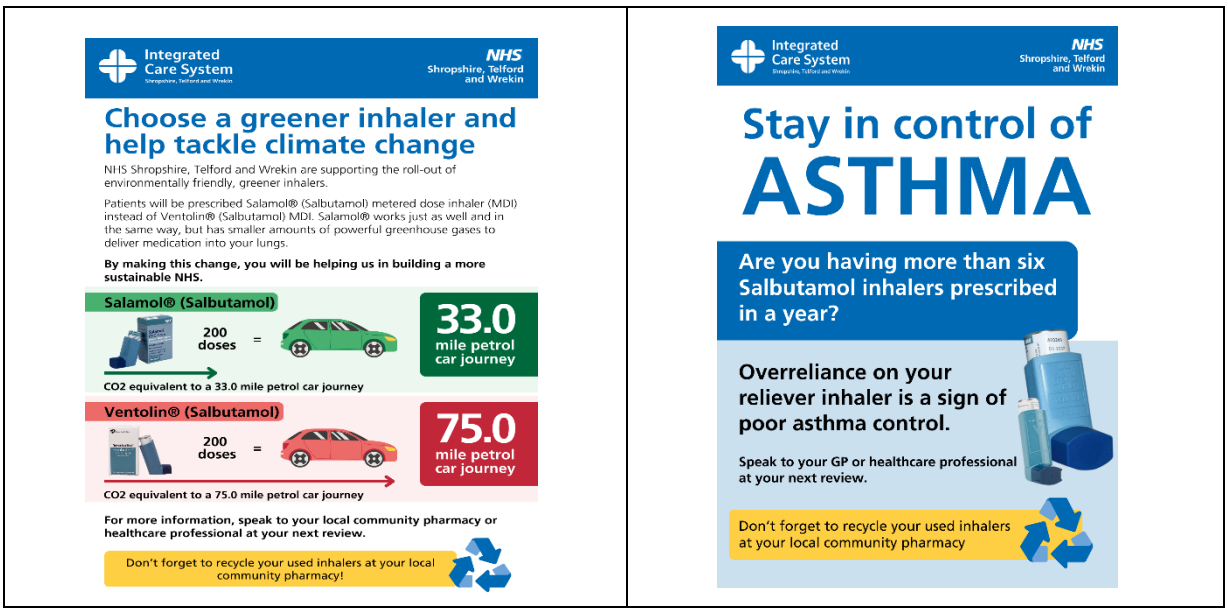
Environmental Impact of Medicines ('Green' medicines)

Respiratory inhalers are responsible for 3% of the NHS carbon footprint. Most of these emissions come from the propellants used in metered dose inhalers (MDIs) to deliver the medicine, rather than the medicine itself. To further support the ICB green inhaler plans, the respiratory section of the local health economy net formulary was revised with the incorporation of a traffic light carbon footprint key on each inhaler to highlight its carbon emission. The asthma treatment guideline has been developed with the support of clinicians across the system as part of our commitment to the Integrated Care

System Green Plan to build a more sustainable NHS and reduce the negative impact the NHS has on the environment for the emissions it controls directly and those it has influence on.

Data available from OpenPrescribing shows that NHS Shropshire, Telford and Wrekin is currently achieving the lower threshold target as at December 2022 at **21.05 kgCO_2e** compared to same period December 2021, **24.89 kgCO_2e.** This work will continue in 2023/24 for both reliever and preventer inhaler to further reduce the environmental impact of inhalers prescribed in Shropshire, Telford and Wrekin.

The key theme this year, on this sustainability workstream on improving the management of respiratory conditions, is to reduce the overuse of short-acting beta2 agonists (reliever inhalers), using lower carbon alternatives where clinically appropriate and safe disposal and reduction on medicine waste. We have active public engagement and awareness campaigns. The medicines management team participated in the last Shropshire Goes Green exhibition, climate and sustainability festival, held last September. Patient engagement promotion tools are being promoted via social media channels to help communicate and educate our patient population about some of the changes to their medicines.



Pharmacy Workforce

Recruitment and retention of pharmacy professionals is challenging in community pharmacies, hospital pharmacies and within GP practices nationally and locally. Demand for pharmacist roles is growing faster than the available workforce can support. Promoting pharmacy as a profession and supporting our existing workforce with education and training is a key focus across our whole system.

The STW Pharmacy Technician Leadership Group have been pro-actively promoting the pharmacy technician profession; producing a campaign for National Pharmacy Technician Day in October 2022 showcasing the interesting and varied careers available across all sectors in our system, and attending careers events across the county such as the ICS Apprenticeship, Employment and Skills Show.

Earlier this year, the Medicines Management Team created a Primary Care Pharmacy Professionals Forum to support pharmacy staff in the new Additional Roles Reimbursement Scheme (ARRS) in Primary Care Networks (PCNs). The forum has provided peer support and training and education sessions for the pharmacy professionals in these roles. The team assisted the Training Hub with recruiting a Pharmacy Facilitator, who will lead the forum and support with training and education of the PCN pharmacy workforce going forwards.

Community pharmacy teams make a significant contribution to the care of Shropshire Telford and Wrekin residents. The Medicines Management Team continues to support these community pharmacy professionals and their unique skills in the delivery of clinical services in the community. In order to achieve more effective working and improved outcomes, a deep level of integration between community pharmacy and the rest of the health service is needed. An ICS wide Community Pharmacy Clinical Lead has been appointed to lead on this integration by creating strong links between community pharmacies, GP practices and hospitals.

This year, the team has worked to increase the utilisation of the Discharge Medicines Service (DMS), Community Pharmacy Consultation Service (CPCS), and Community Pharmacy Blood Pressure Check Service (CP BPCS). The availability of these services in community pharmacy improves patient choice, widens access, reduces admission rates, and improves system capacity. By creating links between community pharmacy, GP practices, hospitals, and NHS 111 a greater uptake of these services has been achieved. Alongside these national services, the locally piloted Oral Contraceptive Management Service (OCMS) allows women to obtain further supplies of oral contraceptives from community pharmacies without a prescription. Further local community pharmacy clinical services are under development such as the Community Pharmacy Independent Prescriber Pathfinder Programme. This programme will allow treatments for minor ailment and preventative medicine to be delivered more effectively from community pharmacies, once again widening access and improving capacity.

A continuation of this work over the coming years, along with an increased focus on integration, upskilling and workforce planning, will prepare the pharmacy workforce to carry on delivering innovative clinical pharmacy services in a sustainable manner.

Digital

Implementation of the Vista risk stratification software system within ECLIPSE has increased data intelligence through the extraction of Hospital SUS data which provides GP practices with significant insight for enhanced clinical pathway management, transforming patient analysis to identify high risk patients at increased risk of harm. These patients can then be reviewed to ensure they have the right medicines, and that they are being used effectively and safely.

Environmental matters

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.

The NHS has now set itself a much more ambitious target to become net carbon zero by 2040. Just one year after setting out these targets, the NHS has reduced its emissions equivalent to powering 1.1 million homes annually. NHS Shropshire, Telford and Wrekin ICB has accepted this challenge and established a Climate Change Group to work across organisations to deliver an ICS Green Plan which was approved by the shadow Shropshire, Telford and Wrekin ICB in April 2022. More information on these measures is available on the Greener NHS website.

NHS Shropshire, Telford and Wrekin has started a process in 2022/23 to identify suitable estate to consolidate its staff onto one site that meets modern building standards, with lower running costs and a better environment to support staff to work in an agile way which will assist in meeting the NHS net carbon zero target. It is expected that this process will be fully realised in 2023/24.

Energy and Utility Costs 2021/22 and 2022/23

The ICB does not own or have control over any estate, other resources, natural capital or landowning that require reporting in this annual report.

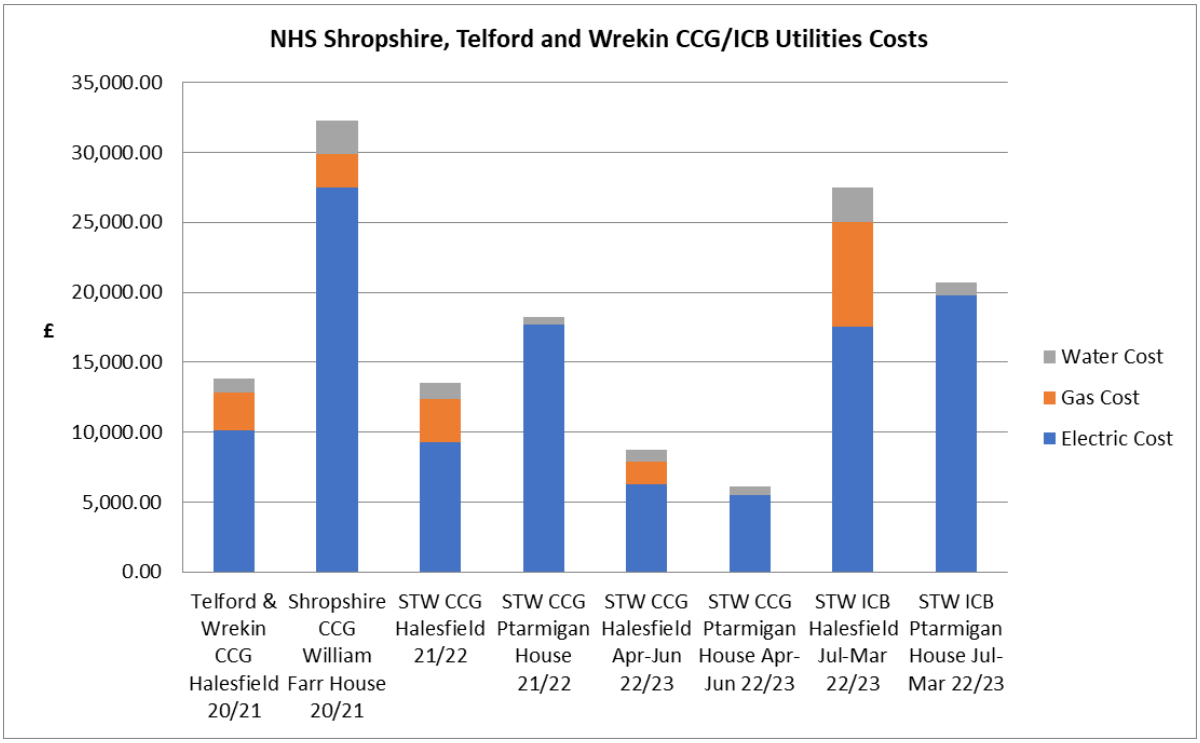
Energy

The graph below shows the position for the nine months to 31st March 2023, with comparative information for previous accounting periods of the predecessor organisation; NHS Shropshire, Telford and Wrekin CCG in 2021/22 and the two separate CCGs; NHS Shropshire and NHS Telford and Wrekin in 2020/21.

In 2020/21 two sites were occupied by the then separate CCGs, Shropshire CCG at William Farr House and Telford and Wrekin CCG at Halesfield. In May 2021 following the two CCGs being dissolved, a single CCG was created and staff based at William Farr House were moved to a new site at Ptarmigan House. From 1st July 2022 the CCG transferred all of its operations into the new ICB.

The graph below shows there has been a similar level of usage of energy at the Halesfield site in water costs, gas and electricity costs between 2020/21 and 2021/22. Two accounting periods in 2022/23 for the two different organisations also make it difficult to draw direct comparisons with 2021/22.

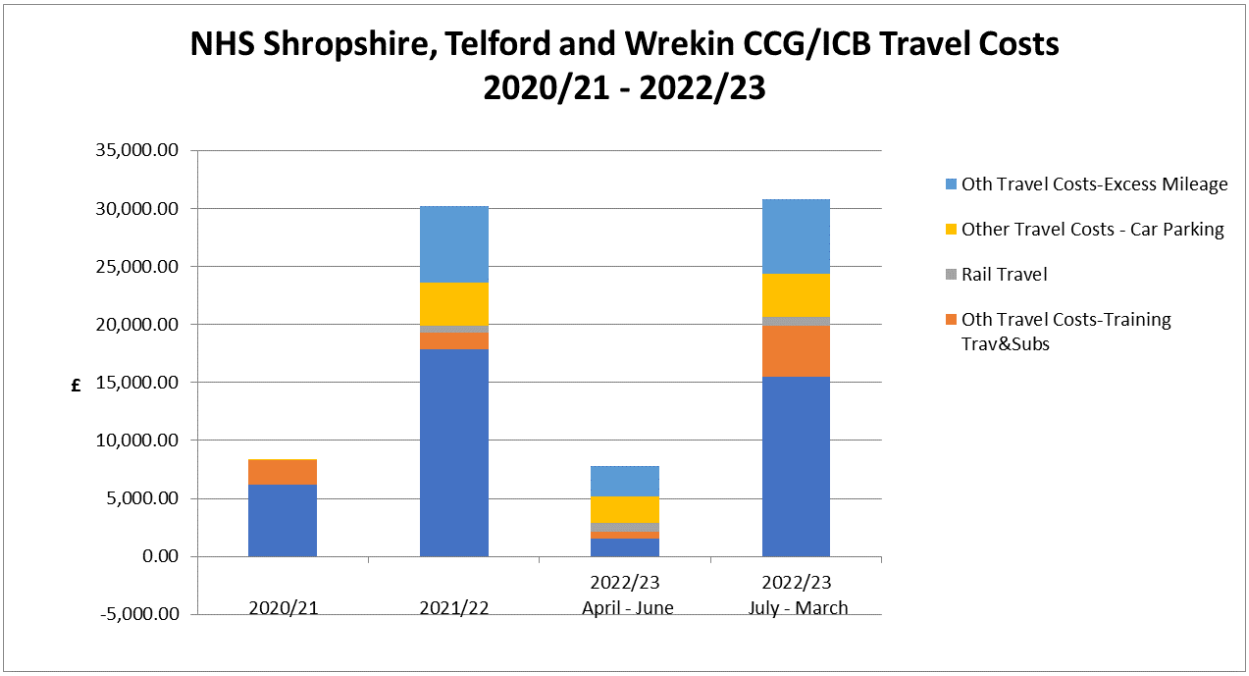
The landlord of Ptarmigan has been unable to provide the energy usage data for the building, so we are unable to make any direct comparisons with prior year figures and evaluate the impact of the relocation from William Farr House to Ptarmigan House.



Travel

The graph below shows an increase of travel costs from 2020/21 which reflects the relaxing of COVID 19 restrictions nationally. To support staff, the ICB has developed an agile working policy, which has enabled staff to continue to work from home wherever possible, to reduce staff travelling and enable them to have an improved work life balance.

The ICB does not own, hire or lease car fleets and none of our travel costs include any flights, either international or internal within the UK.



Consumables and waste management

During the period 1st July 2022 to 31st March 2023 the ICB used a total of 340 reams of paper, this is in comparison to a 75% proportion of 162.25 reams of paper from the total of 217 reams of paper used by the ICB's predecessor; NHS Shropshire, Telford and Wrekin Clinical Commissioning Group in 2021/22. This increase reflects the fact that more staff are working from the office following the relaxing of home working requirements which were put in place in response to the Covid pandemic.

Contracts for waste are overseen by landlords of each of the properties where ICB staff are based and so the ICB does not have access to waste management information for reporting purposes.

Procurement

The ICB through its procurement processes, ensures that all tenders issued have a sustainability clause included, and since the beginning of the year all authorities have to include social value (which encompasses sustainability) in their tender evaluations (minimum weighting of 10 per cent). Clause SC18 Green NHS and Sustainability is in the NHS Standard Contract 2022/23 Service Conditions which the ICB uses to contract for its services.

Efficiency programme

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

As part of the development of the system financial sustainability plan, the aim is that in 2022/23 all system organisations work to deliver a 1.6% internal efficiency target. For the ICB, this equates to a £7.3 million efficiency target. On top of this, the ICB is also working with healthcare system partners on the system transformation programme to meet a further savings target of £1.361m.

Improve quality

NHS Shropshire, Telford and Wrekin works with partners to improve quality of services and organisations. The Quality governance Structure of the ICS and quality function of the ICB works with organisations and senior leaders and the Care Quality Commission (CQC) and other external partners to address areas where quality improvement is required and where CQC have found concerns.

Current CQC ratings and conditions/concerns are listed in the table below.

Organisation	Rating	Conditions
Shrewsbury and Telford Hospitals NHS Trust (SaTH	Inadequate	1 condition relating to Regulated Activity : "Assessment or medical treatment 4 conditions relating to Regulated Activity : "Treatment of disease, disorder and injury"
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)	Good	None
Midlands Partnership NHS Trust (MPFT)	Good	Section 29A issues November 2022
Shropshire Community NHS Trust (SCHT	Good	None
Severn Hospice	Good	None

NHS Shropshire, Telford and Wrekin supports workstreams to improve and address areas of concern. In 2022/3 the following areas of collaborative work with partners has been undertaken

Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

- Supported in the removal of NHS Undertakings related to inadequate infection prevention and control infrastructure through joint leadership with NHSE. NHS have reduced their monitoring of IPC from intensive to routine.

Shrewsbury and Telford Hospitals NHS Trust

- Through ICS PeoLC steering group driving up quality of out of hospital care and processes to reduce hospital attendances at end of life and supportive of SaTH internal action plan. NHSE Midlands have reduced monitoring from intensive to routine monitoring.
- The ICB is part of immediate escalation process and works with the system and MH collaborative to ensure safe care at SaTH and appropriate Tier 4 bed.
- The ICB co-chairs the SaTH Quality Oversight Committee monthly and contributes to discussion on how to progress.
- UEC plan revised and continuously monitored Quality and Performance Committee and the and Urgent Care Board.

- ICB Quality Team identified differences at ED departments and made recommendations to improve the environment. Business case now reported by the Shrewsbury and Telford Hospital NHS Trust as approved. Progress monitored via action plans.

Midlands Partnership NHS Trust

- Supports current plan to improve restrictive practices, assessment prior to home leave and risk of self-harm though peer review.

Increasing focused support to the Shrewsbury and Telford Hospital NHS Trust to address the concerns of the section 31 relating to the treatment of children and young people with acute mental health conditions as well as sustaining and continuing existing support, where relevant, is a priority going in to 2023/24. In addition, as the cost of running care agencies and homes increases maintaining in a high standard of care though private providers is essential and partnership working with local authorities is underway to have a shared approach risk in this area, for example infection prevention and control post-pandemic, falls management and the deteriorating resident.

Learning from deaths (LeDeR programme)

NHS STW is fully committed to the Learning from the Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) Programme which aims to improve care, reduce health inequalities, and prevent people with a learning disability and autistic people from early deaths. To improve the timeliness and quality of reviews a new contract was put in place with Southwest and Central CSU (NHS SW&C CSU) to undertake the reviews followed by a further addendum due to the inclusion of autism resulting higher than predicted numbers. The inclusion of autism as well as NHS SW&C CSU staffing challenges had led to a slower recovery with the ICB performance now standing at 93%, short of the nationally expected 98%, but with an improving picture and recovery plan.

LeDeR is regularly reported to the System Quality Group and promoted amongst partners. Learning from LeDeR has also been shared with Local Governance Group and LeDeR Steering Group which include those with lived experience. There has been positive learning and areas of local challenge and improvement, see table below.

Areas of good practice identified from LeDeR reviews	Key learning points of feedback to health and care partners.	Areas requiring improvement identified from LeDeR reviews
• Well-coordinated care between services providing care, MDT meeting shared decisions. • Evidence of good access to specialist health professionals for people with epilepsy and dysphagia and support from the LD specialist team. • Some examples of very good hospital passport use.	• Importance of promotion of healthy lifestyle for those with weight management problems • Reasonable adjustments are needed to support better screening and improve access to health and social care services. • Access to routine Annual Health Checks needs further improvement. • Tools to support the identification and treatment of pneumonia	• Accessing information/records on time from GPs, secure services and archived records from providers. • Get the Structured Judgment Reviews (SJRs) completed on time. • Timely access to safeguarding investigations outcomes and reports. • Ensuring that all cases for people with autism are reported and for those people with

• End of life care in respite and hospice was very good.	including aspiration pneumonia are required. • To involve more families in decisions about care and treatment.	learning disabilities from ethnic minority groups.

The Local Area Contract has included all deaths caused by respiratory problems, sepsis, cancer and epilepsy to be all considered as focussed reviews in relation to themes of local area due to low numbers of ethnically diverse communities in Shropshire Telford and Wrekin.

ICS quality developments

The Shropshire Telford and Wrekin Intergraded Care System's quality function, with leadership from NHS STW, uses the NHSE publication on Quality Function and Responsibilities (NHSE, January 2022) as its framework. Strategic quality requirements during 2022/23 have been undertaken though the implementation of national guidance including that on System Quality Groups and risk escalation. These have been fully embedded and utilised with partner support.

Operational quality systems and assurance are in place through close liaison, and integration into quality functions in NHS trusts and at Place as well as through Safeguarding partnerships. Regular reporting against system risks and quality priorities are scheduled at both System Quality Group and the Quality and Assurance Committee of the ICB Board. These include patient safety and patient safety improvement programmes such as the Patient Incident and Response Framework (PSRIF), Learn from patient safety events (LFPSE) and Liberty Protection Safeguards (LPS). Patient safety programmes lead by the quality function of the ICS in 2022/23 have included,

- Quality Improvement project to improve quality of fast-track discharge (rapid home to die)
- Supporting improvements to Palliative end of life care
- Quality Improvement project to improve falls prevention and response
- Quality Improvement project to improve compliance with deterioration training and action in care homes
- Quality Improvement project to establish a meaningful experience of care function of the System Quality Group.

A Patient Safety Specialist (PSS) employed by NHS STW supports the consistent approach to patient safety approach across partner organisations with the newly appointed Director of Quality and Safety. The PSS leads a group of provider PSS who liaise nationally and are jointly leading the changes required to move from the Patient Safety Framework to PSIRF in 2023.

NHS STW was selected as one of five national pilot sites to test the NHSE self-assessment tool to support national guidance on Improving experience of care: a shared commitment for those working in health and care systems (NQB, 2022). Through this the methodology and approach has been critiqued and co-produced and fed back nationally, and this work continues in the 2023/24. Insight and feedback using locally and nationally sourced data has been maintained including themes and trends from NHS-to-NHS concerns. Complaints feed into this, however there is ambition to review complaints across the ICS to get a consistent overview of themes and trends across health and social care. The early communication events with the Experience of Care Group, with people with lived experience, are telling us this is needed.

Through integration with the system governance processes, the effectiveness of quality functions involving Getting it Right First Time (GIRFT), NICE appraisals and guidance and national clinical audits have been assured. Additionally, there is quality representation at all programme boards based on

national evidence, including for example, diabetes, children young people and families, palliative and end of life care.

Discharging Safeguarding responsibilities are monitored though the System Quality Group including the looked after children agenda. Further information on Safeguarding is provided later in this report. In addition, the Child Death Overview Processes (CDOP) are currently under review in the system to ensure they are robust, and have a supportive governance and escalation structure following the formation of the ICS.

Challenges continue and are monitored through a joint quality and performance risk register which forms the basis of the agenda for the Quality and Performance Committee of the ICB Board. Current risks and therefore areas of priory are,

- Improving access to children and young people's mental health services including supporting Shrewsbury and Telford NHS Trust in meeting the requirements of its undertakings in relation to inpatient mental health paediatric care.
- Ensuring safe and effective maternity care.
- Reducing elective delays including imaging and imaging reporting delays.
- Improving the safety and effectiveness of diabetes care.
- Improving the safety of the acute paediatric pathway.

Safeguarding

Safeguarding Children

The Safeguarding Children Team has continued to work in equal partnership with the Shropshire Safeguarding Community Partnership and the Telford and Wrekin Safeguarding Children Partnership (the Partnerships) through attendance at Board meetings and involvement in the continuing work streams of the two Partnerships. This includes:

- Suicide Prevention
- Neglect
- Child Exploitation
- Domestic Abuse
- Preventing Offending
- Domestic Abuse

The recognition of child neglect and appropriate early intervention has been a priority for Shropshire Safeguarding Community Partnership as this was the category with the greater number of children who are the subject of child protection plans. A neglect assessment tool with a 'Think Family' approach has been introduced with associated training for professionals across the Partnership and a significant reduction has been noted.

Independent Inquiry Telford Child Sexual Exploitation (IITCSE)

An independent inquiry into child sexual abuse in Telford was commissioned by the local authority and the report from this Inquiry was published in July 2022. The ICB is working with all partners to implement changes in line with the recommendations from this report. A working group is up and running with the Director of Quality and Safety/Deputy Chief Nursing Officer as chair and membership from the local authority and NHS England. A Primary Care CSE self-assessment audit form has been developed to help meet recommendations of the IITCSE report and gain assurance of the awareness of GP practice staff in relation to CSE, with actions fully supported by the ICB with close liaison with Telford and Wrekin local authority.

Children Safeguarding Assurance

Health Providers are asked to complete a quarterly Dashboard which provides data to the safeguarding team to gain assurance that the providers are meeting their responsibilities in relation to safeguarding children and young people. An important part of this dashboard is the assurance that staff are accessing appropriate training in safeguarding children. The table below shows current uptake of safeguarding children training.

	Level 1	Level 2	Level 3
Integrated Care Board	87.69%	92.5%	100%
Shrewsbury and Telford Hospitals	95%	89%	83%
Robert Jones and Agnes Hunt Hospital	95%	93%	93%
Shropshire Community Health	97.2%	95.7%	92.35
Midlands Partnership NHS Trust	96%	96%	83%
Combined average	94.18%	93.24%	90.27%

The children's safeguarding dashboards were updated and refreshed for 2022-2023 to include data on supervision for staff and children who were "not brought" for appointments.

Child Safeguarding Assurance visits have also taken place to gather further assurance of child safeguarding arrangements and practice and further improve the safeguarding service provision within the provider organisations. Monitoring of providers safeguarding service improvement following quality assurance visits is via internal provider quality / safeguarding meetings and supervision.

Safeguarding Adults

NHS Shropshire, Telford and Wrekin, along with the Police and Local Authority, are the three statutory partners for adult and children's safeguarding. The partnership approach is pivotal to achieving effective safeguarding, which is delivered in a fully integrated arrangement which reflects the ICS model as articulated in the recent Hewitt Report. For the ICB our partnership with NHS Trusts in ensuring people are safeguarded in health services is pivotal. The governance arrangements continue to be overseen by the independent chairs for Telford & Wrekin and Shropshire, and NHS England consistently rate the safeguarding arrangements as mature.

In the last year, a focus has been on enhancing the safeguarding assurance dashboards that are populated by our NHS Trusts. These provide detailed evidence around key activity to safeguard children and adults with care and support needs. There have been considerable developments in ensuring that workforce training is robust, that specialist safeguarding supervision is taking place and audits are helping demonstrate improvements, such as how the Mental Capacity Act is used to both empower and protect people.

The ICB has worked as part of both locality statutory safeguarding partnerships on several key priority areas for adults including domestic abuse, safer communities/crime, self-neglect and work with vulnerable people to prevent them getting involved in extremism.

Last year's annual report identified two overarching areas of activity. Firstly, preparation for the introduction of the Liberty Protection Safeguards and the ICS continuing to lead the system wide implementation group and ensuring a coordinated response to the draft Code. All partners are producing action plans to aid preparations whilst we await the delayed Government response to the consultation and confirmation of resources. Secondly, there has been a comprehensive audit of the ICB's safeguarding activity, including a re-audit of safeguarding. All actions are now closed, and evidence of full compliance is in place.

A key feature of the safeguarding work this Year has been a series of quality assurance visits. These have highlighted some good work and how vital priorities in the following areas are being addressed:

- MCA and DOLS compliance
- Person centred engagement when safeguarding adults and children.
- Supporting children at risk of exploitation
- Working with the Police when there are concerns about a person's welfare.
- Ensuring staff are receiving training, support and supervision.

Some of the priorities for next year include:

- Work to prepare for the Liberty Protection Safeguards
- Support for those who may be experiencing domestic abuse.
- The new partnership duty to better understand and reduce serious violence.

Safeguarding Annual Report

NHS Shropshire, Telford and Wrekin publish a report(s) which details our safeguarding practice reviews, and how effective our arrangements have been in practice.

These are available on our website at the weblink below:

https://www.shropshiretelfordandwrekin.nhs.uk/about-us/how-we-are-run/safeguarding/

Emergency Preparedness Resilience and Response (EPRR)

NHS Shropshire, Telford and Wrekin needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. This work is referred to in the health service as **E**mergency **P**reparedness, **R**esilience, and **R**esponse or EPRR.

A significant change in legislation has meant that in the last 12 months we have become a Category 1 responder. These are those organisations at the core of an emergency response and are subject to the full set of civil protection duties.

The ICB and our providers must now give due consideration to the potential impacts of any proposed service changes on the ability of the NHS to effectively plan for and/or respond to an incident or emergency. A set of core standards has been developed as a formal modelling exercise to identify any potential impact, and clear evidence of mitigating actions planned or undertaken to ensure effective EPRR is maintained for our organisation. Both us and our partner NHS-funded organisations will ensure robust and well-tested arrangements are in place to respond to and recover from emergency situations. The ICB has regularly participated in EPRR activities on a local and regional footprint, including testing and exercising our plans, training and debriefing to ensure all lessons learned are captured and inform improvements to our processes.

Working with people and communities

Working with people and communities in a meaningful way brings many benefits. It increases the legitimacy of decision making, builds the reputation of public bodies, and makes them more accountable and transparent. It is the right thing to do.

NHS commissioning organisations have a legal duty under the NHS Act 2006 to 'make arrangements' to ensure that individuals to whom services are being or may be provided and their carers/representatives are involved when commissioning services for NHS patients. For ICBs, this duty is outlined in section 14Z45 of the NHS Act 2006 (and for NHS England the duty is outlined in section 13Q).

To fulfil the public involvement duty, the arrangements must provide for the public to be involved in:

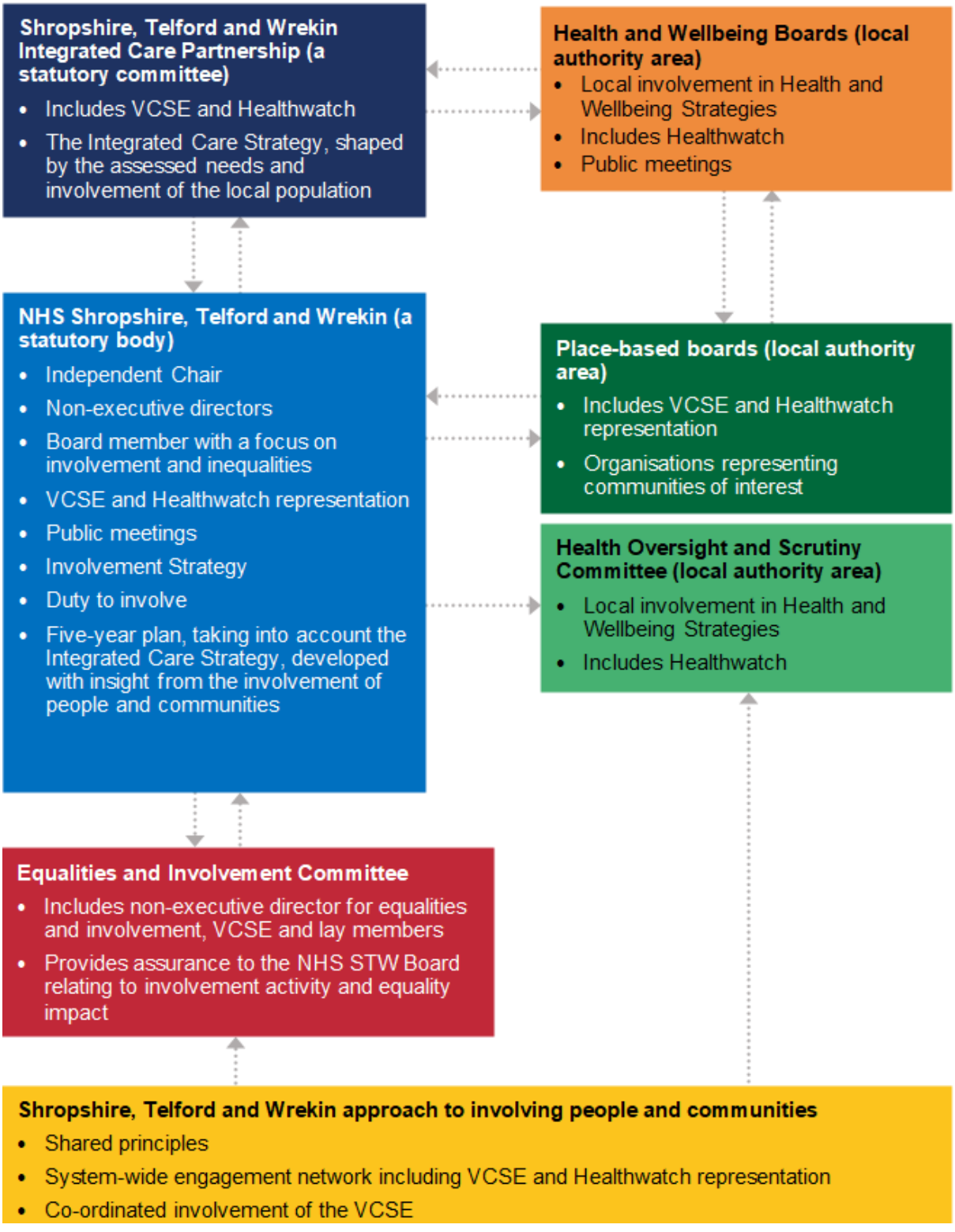
- the planning of services
- the development and consideration of proposals for changes which, if implemented, would have an impact on the manner or range of services, and
- decisions which, when implemented, would have such an impact.

We have made significant steps in developing our approach to involving people and communities but recognise that our approach will be refined over time with further input from our partners and the communities we serve.

To read our Involving People and Communities go to our website.

Governance and assurance information

The infographic below sets out how involving people and communities is embedded in the governance of our system:


Shropshire, Telford and Wrekin Integrated Care Partnership (a statutory committee)
• Includes VCSE and Healthwatch
• The Integrated Care Strategy, shaped by the assessed needs and involvement of the local population
Health and Wellbeing Boards (local authority area)
• Local involvement in Health and Wellbeing Strategies
• Includes Healthwatch
• Public meetings
NHS Shropshire, Telford and Wrekin (a statutory body)
• Independent Chair
• Non-executive directors
• Board member with a focus on involvement and inequalities
• VCSE and Healthwatch representation
• Public meetings
• Involvement Strategy
• Duty to involve
• Five-year plan, taking into account the Integrated Care Strategy, developed with insight from the involvement of people and communities
Place-based boards (local authority area)
• Includes VCSE and Healthwatch representation
• Organisations representing communities of interest
Health Oversight and Scrutiny Committee (local authority area)
• Local involvement in Health and Wellbeing Strategies
• Includes Healthwatch
Equalities and Involvement Committee
• Includes non-executive director for equalities and involvement, VCSE and lay members
• Provides assurance to the NHS STW Board relating to involvement activity and equality impact
Shropshire, Telford and Wrekin approach to involving people and communities
• Shared principles
• System-wide engagement network including VCSE and Healthwatch representation
• Co-ordinated involvement of the VCSE

Our Integrated Care Strategy and Joint Five Year Forward Plan

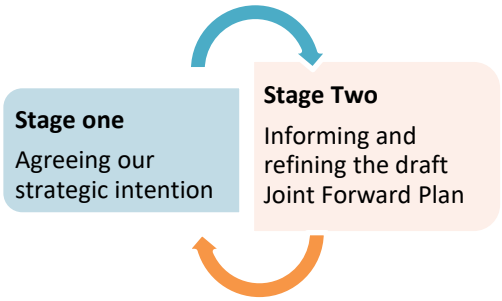
Integrated Care Strategy

A fundamental commitment to this has been development of the STW Integrated Care Strategy. The work, engagement and knowledge of our two Health and Wellbeing Boards have been consolidated as the foundation for further ICS development.

In developing our Integrated Care Strategy and Joint Forward Plan (JFP), we have been taking active steps to strengthen public, patient and clinical voices at place and system level by undertaking robust community and stakeholder engagement.

Stakeholder and public engagement sessions have taken place since mid-2022. Two stages of involvement have been undertaken:

- Stakeholder partner organisational engagement in agreeing strategic intent
- Public and stakeholder engagement in shaping the Joint Five Year Forward Plan.



Joint Forward Plan Engagement

Engagement with patients and our public to inform the Joint Five Year Forward Plan has been facilitated by widespread community-based listening events entitled “The Big Health and Wellbeing Conversations”. We have held public open meetings across the county. We started with identifying key areas experiencing diverse challenges, e.g. having equitable access to local services, areas of deprivation and poor health, rural communities.

Holding public meetings does not reach across with wider communities who use services. Therefore, in addition to the Big Health and Wellbeing Conversation events, targeted engagement with local groups, organisations, and community forums is underway. This approach is particularly important to reach into rural areas that are challenged in terms of transport to access services, engaging with people experiencing health inequalities, and/or living in areas of multiple deprivation and those who are under-represented groups.

We have developed a multi-agency group to plan the community engagement sessions and we have used our collective networks to share awareness of the engagement opportunities.

We have also launched an online survey to seek the views of people across the county and have provided a telephone service to support people who wish to share their views by phone in response to the survey. We have paper copies and a freepost service in place to ensure there are not cost implications to the public in sharing their views.

To support those with literacy barriers, we have easy read formats of the survey and we have linked in with community bilingual outreach services to support the engagement of non-speaking English members of the community.

To find out more about The Big Health and Wellbeing Conversation click here.

Partnership working

A core purpose of the Integrated Care Systems is to work collaboratively to tackle the health inequalities that exist within the system and ensure that access to health care is equitable and open to all.

Integrated Place Based Partnership

The way that health and care is planned and delivered is changing and more joint working is happening locally than ever before. Place-based partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a community.

In our system, the NHS and council already work well in partnership at a local level and have done for many years. The development of SHIPP and TWIPP is our collective opportunity to build on that and work even closer with communities to improve health and wellbeing.

There are two Integrated Place Partnerships. In Shropshire this is known as SHIPP, and in Telford and Wrekin it is known as TWIPP. Both partnerships involve the NHS, each respective Council, a wide range of voluntary sector organisations and each respective Healthwatch organisation. The SHIPP and TWIPP meetings take place monthly to discuss and focus on key health and care issues.

Focusing on places and neighbourhoods is enabling us to strengthen the way we work with the voluntary and community sector, empowering communities, placing more focus on prevention and supporting people to live well for longer.

We are already seeing great progress, including work around annual health checks for people with learning disabilities, physical care plans for children and young people, approaches to address drug and alcohol dependence, the development of Social Prescribing for adults, children and young people, as well as integrating with Primary Care services.

We are continuing to develop a wide-ranging programme of engagement which enables measurable involvement and ensures that the ICB listens to the views and experiences of our population to influence commissioning decisions.

Involving people and communities in our plans

We oversee a plan for NHS services, informed by the Health and Wellbeing Boards' Joint Strategic Needs Assessments (JSNA) and views and experiences of our residents across the county.

Our plan is influenced by the voice of local people and those experiencing the greatest health inequalities.

We delegate budgets to our two local 'Place-based Partnerships' (Shropshire, and Telford & Wrekin), so that they can determine locally how the money is best spent.

Most of the decisions about spending and services will be made by committees in our local place-based partnerships. Membership includes representation from local people, Healthwatch and the voluntary, community and social enterprise sector (VCSE) as key partners.

We have ten principles for involving people and communities, set out below. These were developed and shaped with partner organisations and residents of Shropshire, Telford and Wrekin.

1. Seek out, listen, and respond to the needs, experiences, and wishes of our communities to improve our health and care services

2. Ensure people are involved in everything we do as an ICS – from an individual's care, to service design and making decisions about health and care priorities

3. Relationships between our communities and health and care organisations are based on equal partnerships, trust, and mutual respect

4. Use existing and new knowledge about our communities to understand their needs, experiences and wishes for their health and care by developing methods for gaining insights

5. Involve people early and clearly explain the purpose of the involvement opportunities

6. Reach out to and involve groups and individuals who are often seldom heard by working with community partners

7. Make sure the communications and the ways people can get involved are clear and accessible

8. Record what people say and let them know what happened as a result

9. Ensure staff understand the importance of involving people in their work, and have the skills and resources they need to do it

10. Learn from when involvement is done well and when it could be improved.

Whilst we know we have more to do and our approach to involvement continues to evolve, we have made some good progress against these principles.

- **Using existing insight**

Within our Communications and Engagement Team, we have dedicated resource which supports insight and data analysis. This draws together existing insight and intelligence from our communities and partners and Patient Advice and Liaison Service and supports the gathering of further information where needed, to inform decision making, improve quality and patient experience.

We have developed an insight library to host intelligence and insight about communities produced by all our partners. This is accessible to all partners across the system to share insight and help improve and inform involvement activities.

- **Involvement Network**

We have established a system-wide Involvement and Insight Network to map out and identify the existing involvement infrastructure such as which stakeholders, partners, groups and communities we are currently involved with. The network identifies any gaps or groups that are under-represented and seeks to build relationships and connections to encourage their involvement.

This approach reduces duplication across the system, reduces the same groups of people being approached thereby creating consultation fatigue. Importantly, this approach highlights where there are gaps intelligence, or where protected groups have not been engaged. The outcome is ultimately to shape and inform future the communication and engagement plans.

- **Involving people in our programmes of work**

Across our improvement programmes, for example outpatients, eye-care, audiology and the Shrewsbury Health and Wellbeing Hub, we have involved people using multiple approaches, from listening to what people have already told us, surveys (with public input into the design), focus groups, outreach in communities and clinics and patient representation on programme meetings.

Information is offered in alternative formats, and we provide the ability to complete surveys over the phone when people need it.

Through our outpatients programme, people told us that the their needs aren't always understood when it comes to communications and accessing services. We have started working with the parent carer forums and some experts by experience to understand how we can best capture people's needs at the right time to improve their experience of care.

- **Involving People and Communities Workshop**

In February this year, we held a workshop bringing together partner organisations, members of the VCSE and representatives from communities to further develop our approach to involving people.

The purpose of the workshop was:

- to provide an overview of our approach to involvement and the progress we have made
- to identify what works well and what can be improved
- to develop an approach to measuring the impact of involving people and communities.

The outcome of this workshop will be the development of an evaluation framework to measure the impact of our future involvement activities.

- **How we work in Partnership with the Voluntary, Community and Sector Enterprise (VCSE)**

Shropshire, Telford and Wrekin we are fortunate to have two well-established, active and diverse VCSE networks. The sector brings considerable resource as well as influence – there are over 2,000 registered VCSE organisations in the county and over 1,800 small, unregistered community groups and organisations. The sector is a significant part of the local economy, employing approximately 3% of the workforce, with between 21% and 30% of the VCSE already providing health and wellbeing services. It has been described as the 'best first responder' and evidenced its huge influence during the heights of the coronavirus pandemic.

To solidify our commitment to collaborative working, we have co-produced and signed up to a Memorandum of Understanding. The next step was for the sector to develop a VCSE Alliance. The VCCA will include strategic representation from the VCSE sector and will build upon this partnership. This Alliance will be plugged into the governance of the ICB and will provide this crucial representation within major decision-making forums. In those areas of common interest, the two sectors will come together to effectively support each other and maximise all opportunities.

It is recognised that although there have been significant strides taken by the NHS in focusing on early intervention and prevention; it remains by and large a treatment service for people when they become ill. Likewise, since the beginning of the pandemic, health inequalities are widening and the demand on NHS services is relentlessly increasing. By way of combatting these serious issues, it is acknowledged that a new, equal partnership with the VCSE sector holds incredible opportunities. Through this initiative we have the chance to work differently, and more collaboratively, to improve health outcomes and reduce health inequalities for the people of Shropshire, Telford and Wrekin.

The Memorandum of Understanding, the VCSE Alliance, and a new role dedicated to leading this work (the Voluntary Sector Engagement and Partnership Lead) represents a significant opportunity to implement new, innovative ways of working together and to increase the health and wellbeing of the people who live and work in Shropshire, Telford and Wrekin.

How we work with Healthwatch

Healthwatch Shropshire and Healthwatch Telford & Wrekin have been effective partners in contributing to the development of our approach to communicating and involving people and communities. Their role is to provide a voice for local people in the planning and delivery of health and social care services.

To show our commitment to building on the strength of our existing relationship with both Healthwatch organisations, we have co-produced a Memorandum of Understanding (MoU). This MoU sets out how we will work together to achieve our shared ambitions to improve the health and wellbeing of the people of Shropshire, Telford and Wrekin.

Healthwatch Shropshire is currently involved in a pilot to create a self-assessment tool for how we use the experience of patients to improve care. As part of the pilot, we are working with experts by experience from across Shropshire, Telford and Wrekin.

Communicating and promoting opportunities for involvement

We use all our channels to regularly communicate and promote opportunities for people to get involved. This includes using our website, social media, newsletters, local media and partner organisations channels.

Our website is an important tool to inform our various stakeholders about our plans, activities, and opportunities to transform the health and care across Shropshire, Telford and Wrekin.

The new website has been developed through involvement with people from our communities, our staff and partners. The look, feel and content has been informed by what they have told us is important to them.

We created a Get Involved area on the website which includes our approach to involvement, opportunities for getting involved, events, 'you said, we did' and a toolkit we developed to support programme leads to plan and undertake involvement activity. To download the toolkit please click here.

We also promote opportunities such as Healthwatch, Maternity Voices Partnership, Patient Participation Groups and the Patient and Liaison Service.

- **The People's Network**

It is essential that we continue ongoing dialogue with patients, carers and the public. To support this, we are establishing our People's Network. This will primarily be an online engagement and

involvement tool for the community for local residents to have their say about health and care services.

The purpose is to continue to gather feedback on what we do well, what really matters to people, their families and your communities and what improvements could be made to local services.

We are encouraging people of all ages, genders, ethnicities and backgrounds from across Shropshire, Telford and Wrekin to register with the Network. We are raising awareness of the Network at each engagement event we attend, via ICS and partner organisation websites and social media channels.

Working with people and communities – Equality and Diversity

NHS Shropshire, Telford and Wrekin (NHS STW) is committed to promoting equality and diversity and eliminating discrimination as an employer.

What we mean by the term Equality and Diversity

Equality is not about treating everyone the same; Equality means that everyone in the care setting is given equal opportunities, regardless of their background, abilities or lifestyle.

Diversity means that differences between people should be appreciated and people's beliefs, cultures and values should be treated with respect.

The Public Sector Equality Duty (PSED), part of the Equality Act, came into force in April 2011. The PSED has three objectives that public bodies are required to meet and evidence:

1. **Eliminating unlawful discrimination**, harassment, and victimisation. This includes sexual harassment, direct and indirect discrimination on the grounds of a protected characteristic.

2. **Advancing equality of opportunity** between people who share a protected characteristic and people who do not share it. This means:
   - Removing or minimising disadvantage experienced by people due to their personal characteristics
   - Meeting the needs of people with protected characteristics
   - Encouraging people with protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

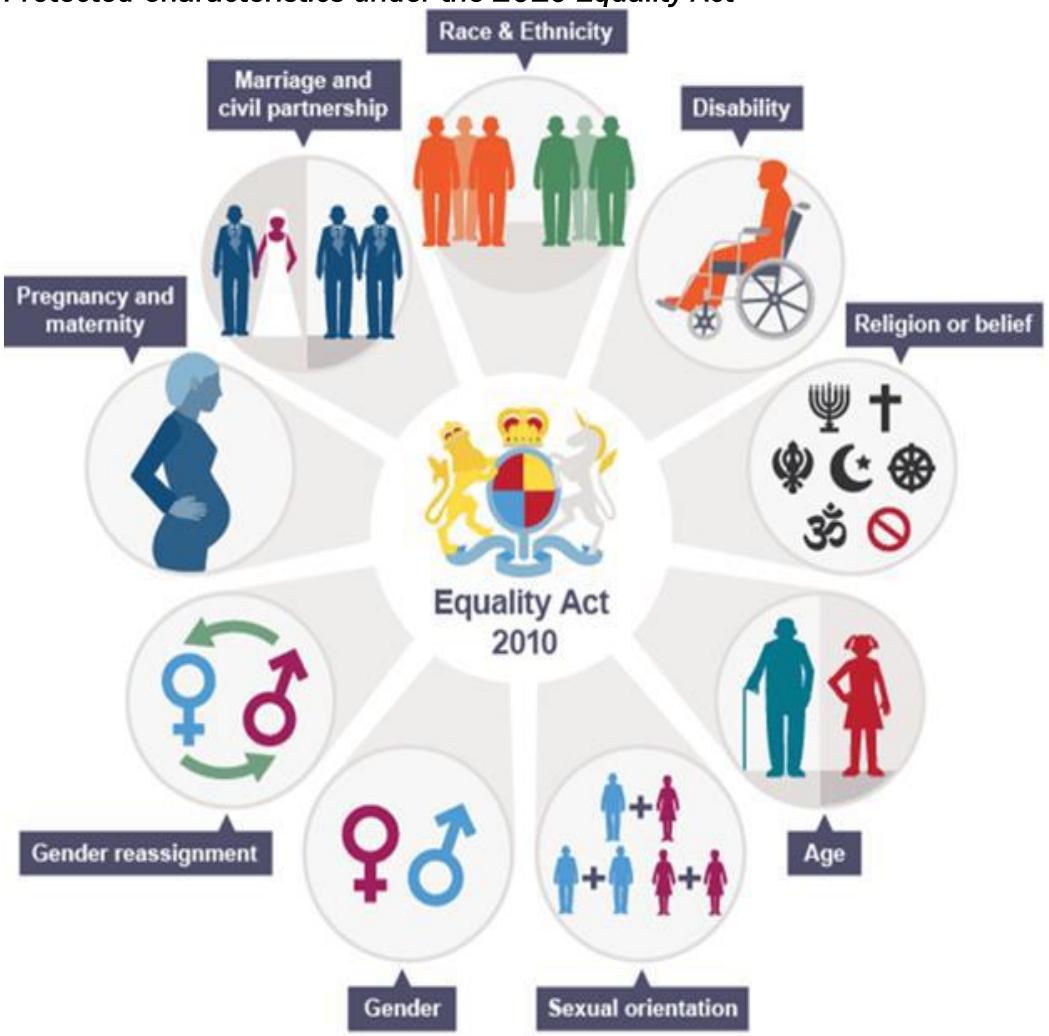
3. **Fostering good relations** between people who share a protected characteristic and people who do not share it, which means:
   - Tackling prejudice, with relevant information and reducing stigma
   - Promoting understanding between people who share a protected characteristic and others who do not. 'Due regard' is a legal requirement. Having due regard means considering the above in all decision making, including:
   - How the organisation acts as an employer
   - Developing, reviewing and evaluating policies
   - Designing, delivering and reviewing services
   - Procuring and commissioning
   - Providing equitable access to services

Public bodies should be consciously thinking about the three aims of the duty at all times, which means that equality issues must influence the decision-making process.

However, there is no prescribed process for assessing how and to what extent public bodies are to uphold the PSED.

The duty is designed to 'protect' individuals who share certain types of socio-demographic characteristics (protected characteristics) under the 2010 Equality Act. https://www.legislation.gov.uk/ukpga/2010/15/section/149

Protected Characteristics under the 2010 Equality Act



The NHS Constitution states that the NHS has a duty to "...pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population". This is reflected in the Health and Social Care Act 2012, which introduced legal duties to reduce health inequalities, with specific duties on Integrated Commissioning Boards (ICBs) as detailed within the Health and Care Act 2022.

Whilst deprived communities are not defined as a protected characteristic under the Equality Act legislation, NHS Shropshire, Telford and Wrekin follows good practice to include consideration of this

groups when transforming services due to the very well-documented links between socio-economic disadvantage and poorer health outcomes.

Focusing on Equalities and Engaging Communities in Change Programmes

We are committed as an organization to ensuring that the decisions we make fully consider impacts on protected groups and marginalized communities. A strong example of this activity has been the Shrewsbury Health and Wellbeing Hub.

Extensive engagement work has taken place to explore the views of residents and key stakeholder groups on the proposed development Health and Wellbeing Hub. The purpose was to share the opportunity of building a new Health and Wellbeing Hub and the potential services that could be co-located within. This included six GP practices, community services, out-patients, diagnostics and other NHS health services. In addition to third sector and Local Authority services (for example, social care and housing support). This will help to support the wider determinants of health across the region.

Patients and the public have been engaged over the past year and their views sought on the proposals. This has been through listening events, telephone interviews, online surveys, attending practice PPG's meetings, dedicated mailouts to all registered patients, information left at each practice. Clinical engagement with practices and provider partners.

A review of the engagement was undertaken to assess reach and identify areas of under-represented public views.

The gap analysis has enabled the ongoing targeted engagement of:

- Young people (16-24)
- Older people (8-+)
- Carers
- Disabled people
- Ethnic minorities
- Veterans
- Expectant and new parents

Formalising Engagement Channels

A Stakeholder Reference Group has been established acts as a critical friend to the Programme Team, including the communications and engagement activity, and specifically will inform consultation materials. Membership of the group comprises:

- Patients (with a range of protected characteristics)
- Practice managers
- A member of the practices' Patient Participation Group (PPG)
- Local councillors
- Local Healthwatch organisations
- The local LPC (Local Pharmaceutical Committee)
- VCSE
- Organisations who work with young people
- Organisations who work with older people
- Local Council reps working in engagement and feedback teams

What have patients and the public influenced

- The long list of potential options other than the developing a hub
- Criteria for site options appraisal
- Informed on 47 local sites to be included in appraisal process
- The future service model/configuration of services co-locating with the six practices
- Preferred site location will be informed by Stakeholder Reference Group

Robust Planning of Equality and Health Inequalities

Integrated Impact Assessment (IIA)

Shropshire Telford and Wrekin (STW) ICS has developed a system wide, standardised Integrated Impact Assessment (IIA) process to help partners consider these impacts, covering all stages from service development, service redesign, pre-consultation through to post consultation and decision making.

The IIA framework has been developed in conjunction with system partners, testing each stage of the development in terms of pragmatism of what required to be included in the IIA and how this relates to what system partners will need to adapt to. How commissioners and providers can effectively utilise the IIA to assist their plans for change and identify the negative and positive impacts of change.

The IIA requires programme owners to also assess their proposals with regards to socially excluded groups, climate change, health impact, patient/client/staff experience, quality of care, and workforce.

The purpose of the IIA is to:

- Identify the positive and any negative impacts for the local population as a result of the proposed change or new service.
- Identify which (if any) of the protected characteristics groups are more likely to be affected by the proposals due to their propensity to require different types of health services and what these impacts will be
- Identify the impact on staff from equality and protected characteristic groups
- Identify the impact that the proposals may have on a set of societal considerations, including climate change and social inclusion
- Develop an overall set of integrated conclusions on the comparative advantages and disadvantages of the different options
- Provide recommendations on ways in which positive impacts can be maximised for the population and for those with protected characteristics and ways in which to mitigate, or minimise, any adverse effects.

At an overall level, the framework seeks to:

- Deliver accessible and responsive services to customers and residents in their communities including those from protected characteristics
- Employ a workforce that reflects the diversity of the area they are serving
- Provide equality of opportunity for all staff
- Meet the requirements of the Public Sector Equality Duty (Section 2.2)

An IIA also offers mitigating actions and potential solutions to these challenges, founded in data insight and primary research.

The IIA process has three core stages, an initial screener tool, a Baseline Equality Report, and a full Integrated Impact Assessment. Upon completion, the programme/project will have fulfilled its statutory requirements regarding equality.

Previously, a statutory body may have carried out multiple assessments when reviewing options to make changes to a service. An IIA is a holistic framework which ensures that new policies and programmes have been considered through not only an equality lens, but also economic, environmental and health inequalities.

The IIA approach will be required in any project in which services or policies are being developed, redesigned or changed. As the approach is divided into four stages, it will need to be mapped against the timeline of the project and the activities for each stage should be built into the timeline.

Assuring our Engagement and Involvement Plans

The Equality and Involvement Committee (EIC)

The EIC has been established to provide assurance to the NHS STW Board that its strategies, plans, service designs and policy developments have adequately and appropriately:

- Considered and addressed the health and care needs and aspirations of residents in Shropshire, Telford and Wrekin who do, or may, experience inequalities in access to health services and health outcomes.

- Involved people who do, or may, use the services under consideration.

The committee reviews completed Integrated Impact Assessment Screener Tools to decide whether commissioners/providers have sufficiently scoped potential negative impacts on any protected characteristics and considered how they will involve people in the development of their plans.

In assessing how adequately and appropriately health equality and involvement has been considered and addressed, the EIC pays particular attention to the main duties on NHS bodies to make arrangements to involve individuals, their carers, and representatives, as set out in the National Health Services Act 2006 and amended by the Health and Care Act 2022:

- section 14Z45 for ICBs
- section 242(1B) for NHS trusts and NHS foundation trusts.

As well as other relevant legislation including, but not limited to, the Equality Act 2010.

The membership of the committee is comprised of:

- 8 to 10 Appointed Public Members to include representation from the voluntary and community sector
- Telford and Wrekin Council Public Health specialist
- Shropshire Council Public health specialist
- Other officers with specific expertise as required

- NHS STW Adviser on Equalities and Involvement.

Impact and Involvement plans reviewed to date:

- The development of the Integrated Impact Assessment
- Health and Wellbeing Hub
- Hospital Transformation Programme
- Local Care Programme
- Joint Forward Plan/Big Conversation Engagement
- Muscular Skeletal Service Change Programme

Supporting and pushing the boundaries to engage with under-represented groups

Understanding the wide range of people and their circumstances who use health and care services, is essential in ensuring our provision is responsive to the needs of people who may be vulnerable, at risk, and/or marginalised by volume compared to the wider population's health needs.

Those cohorts of residents are often not visible in regard to engagement and involvement activity. They rarely influence how services are shaped and delivered; share what their experience of using services has been or tell us what went wrong and where we need to improve.

Engagement with those groups must be tailored. We need to work in partnership to agree the most appropriate methods to in-reach to those individuals. We need to plan who from our partner network who can support this process having a trusted relationships already in place.

We need to consider the communication materials that are produced and that they are accessible to a wide range of needs. This can be supported with forward planning and the provision of easy read materials, large print, audio, translated languages. We do provide those offers but we need to work harder to ensure those who are very infrequently engaged have access to them.

Our approach is bringing together partner organisations to help our engagement to be customised and responsive in our communication. We need partners to sense check communication materials for suitability to the cohorts of people their organisations support. For example those with a learning disability, literacy barrier, sensory impairment, are non-English speaking etc. We work closely with Healthwatch organisations to sense check communication collateral.

To tailor our approach, we will include those detailed below and continue to have robust links with organisations who support those individuals.

- Homeless
- Gypsy and traveller families
- Asylum seekers/refugees
- Unpaid carers
- Mental health and physical disability
- LGBTQ+
- Services personnel & families and veterans
- Looked after children
- Ethnic minority groups

- Faith groups
- Prisoners and their families
- Service users of drug and alcohol support
- Youth offending teams
- Children and young people not in education, employment, or training
- Expectant parents

Good Communication and the foundations for engagements

The ICB continues to focus throughout the year celebrating the diversity of communities and sharing this across a wide range of networks and organisations. This year the ICB has covered:

- Ramadan piece for website and newsletters
- Black History Month piece for website and newsletters
- Communication and poster for Developing Aspirant Leaders Programme (for colleagues from an ethnic minority)
- Comms and poster for ICS Disability Network Meetings
- Cascade of EDI training offers to colleagues across the ICS
- Comms and poster for Ethnic Diversity Staff Network
- Pride Month comms: Collaborate piece, social media and newsletter items
- Comms for NHS Muslim Network e.g. support for colleagues affected by Pakistan floods
- Survey, repeated newsflashes to GPs, poster and comms for ethnic diversity research piece amongst GP practices
- Race Equality Week Comms, social media posts and website news story
- Comms for Identity, Privilege and Power training
- Inter Faith Week comms, website piece and social media
- LGBTQIA+ awareness videos: comms for newsletters, website and social media posts
- Neurodiversity awareness videos: comms for newsletters, website and social media posts
- Comms for International Recruits Focus Group
- Award submission comms for MIDAS Awards
- Personal pronouns comms

Social Media on Neurodiversity – Neurodiversity Awareness Video Series

These videos have been produced to help us all understand the basics of neurodiversity issues and build genuine and empathetic relationships with neurodivergent people.

Neurodiversity describes the differences in how all our brains process information. 1 in 7 people in the UK have neurodevelopmental differences, so it's likely we all know or work with someone who is neurodivergent. Examples include autism, ADHD, dyspraxia and dyslexia. Neurodivergent people, especially those who are autistic, sometimes face barriers to accessing healthcare services. Sometimes health professionals fail to understand their health needs, making their healthcare experience disproportionately worse.

Each short, animated video explores a different topic or issue, and includes interesting stories from people with lived experience to give you a new perspective. We look at the challenges neurodivergent people may face such as sensitivity to light and noise. Others may struggle to express their ideas and feelings or interpret those of other people. But the strengths of neurodiversity come from seeing the world differently.

Video series launched to increase awareness of LGBTQIA+

To provide an informative and empathetic insight into the lived experiences of LGBTQIA+ people working within our system, the Integrated Care System (ICS) launched a series of awareness-raising videos to celebrate LGBT+ History Month.

Thoughtfully developed to educate and inspire, these short, animated videos explore different topics affecting the community and feature real life stories from LGBTQIA+ people themselves.

Patient Services – Including Patient Advice and Liaison Services (PALS), Complaints, Compliments and MP Enquiries

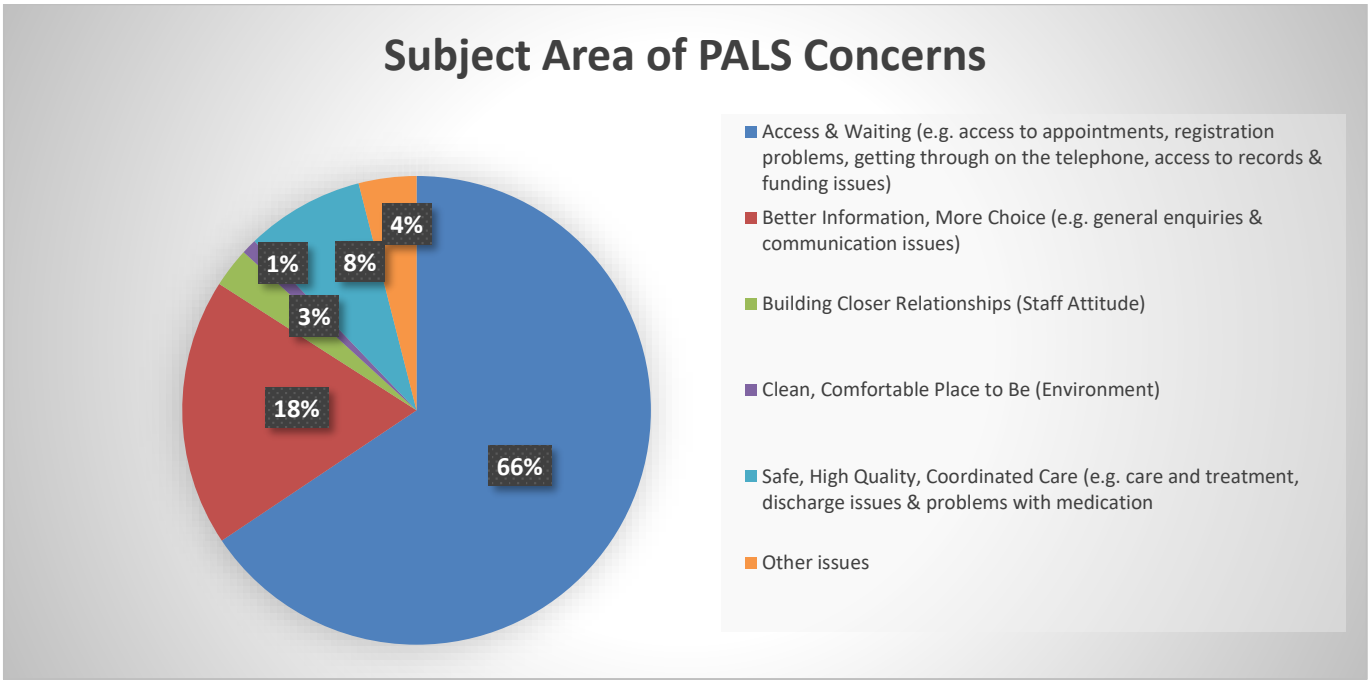
Patient Advice and Liaison Services (PALS)

PALS is integral to NHS Shropshire, Telford and Wrekin'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 the period from 1st July 2022 to 31st March 2023, NHS Shropshire, Telford and Wrekin Patient Services Team received 477 PALS enquiries. This is a decrease on the 669 PALS enquiries received across NHS Shropshire, Telford and Wrekin CCG for the same period of 2021/22.

The chart below illustrates the 'domains of patient experience' that the PALS enquiries received during the period from 1st July 2022 to 31st March 2023.

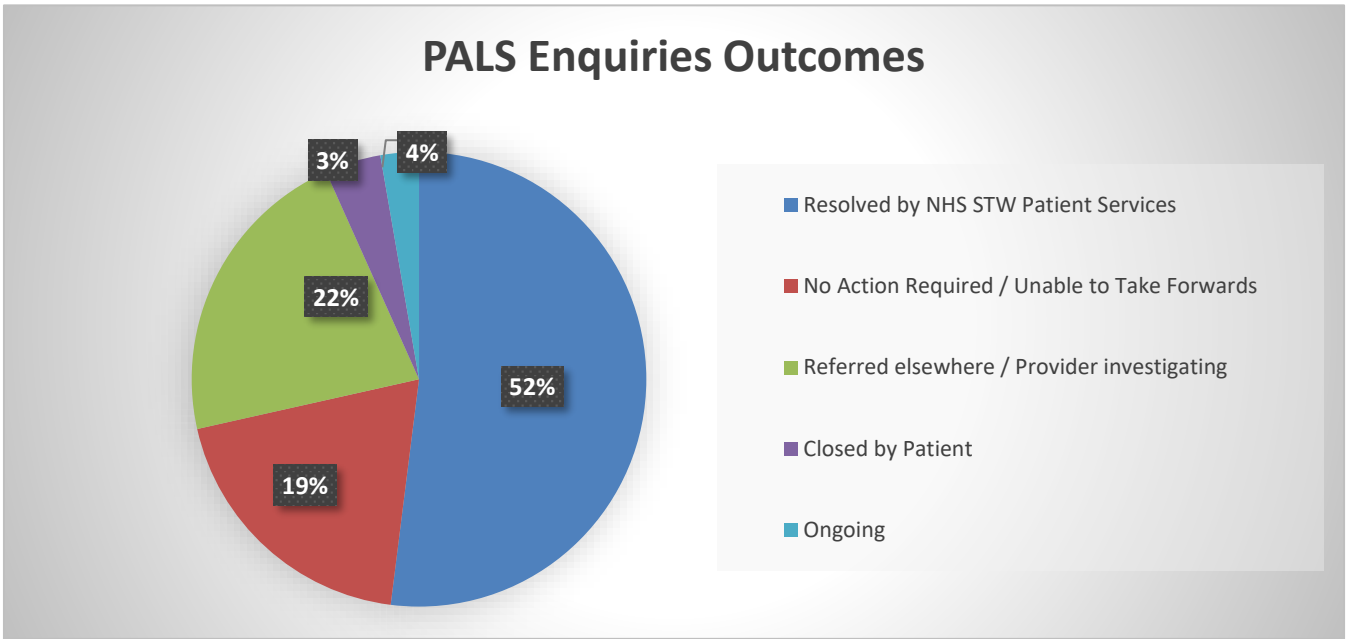


Similar to the previous year, more than half (313) of the PALS enquiries NHS Shropshire, Telford and Wrekin received were raising concerns around gaining access to services.

168 enquiries related to ICB services, with 31 of these being around Covid-19 and patients requesting general information around the vaccination process. 31 related to the Prescription Ordering Department and were mostly around access via the telephone. 23 related to Medicines Management and access to various medications. 15 enquiries related to the Continuing Health Care process, delays with assessments and poor communication around the delays. 14 enquiries related to GP commissioning. The rest of the enquiries were around commissioning decisions, relating to various services.

Of the total number of PALS enquiries received 140 related to GP Practices, 92 of which were around accessing appointments. There were 70 enquiries relating to hospital services, 44 of these were around access to appointments across several specialties.

The chart below shows what happened with the queries and concerns received by the NHS Shropshire, Telford and Wrekin Patient Services Team.



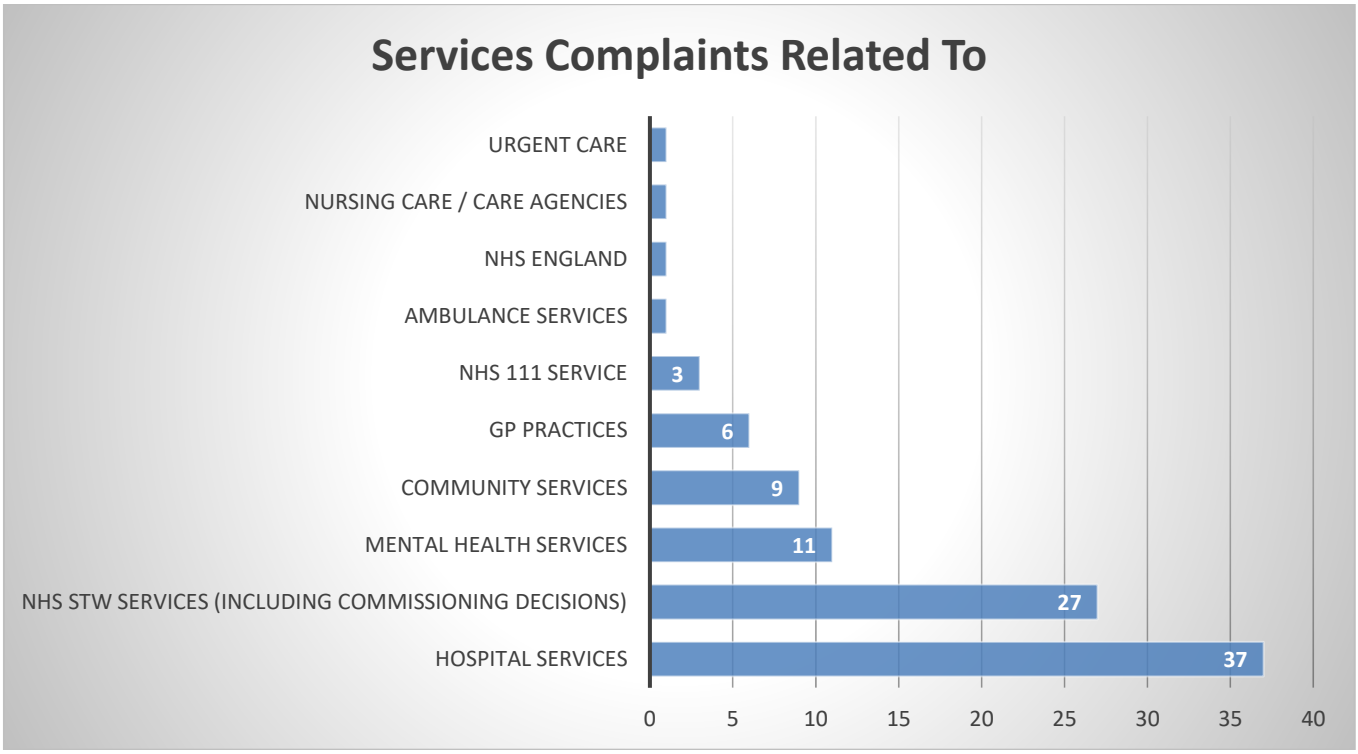
248 of the enquiries received were resolved by NHS Shropshire, Telford and Wrekin Patient Services Team.

Complaints

Complaints are a valuable source of feedback and were used by the NHS Shropshire, Telford and Wrekin to help improve services both within the organization, and in the organisations that we commission. NHS Shropshire, Telford and Wrekin has a clear complaint policy in place, which is in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

During the time period from 1st July 2022 to 31st March 2023, NHS Shropshire, Telford and Wrekin received 97 complaints, which is a slight decrease on the number of complaints received across NHS Shropshire, Telford and Wrekin CCG during the same times period in 2021/22.

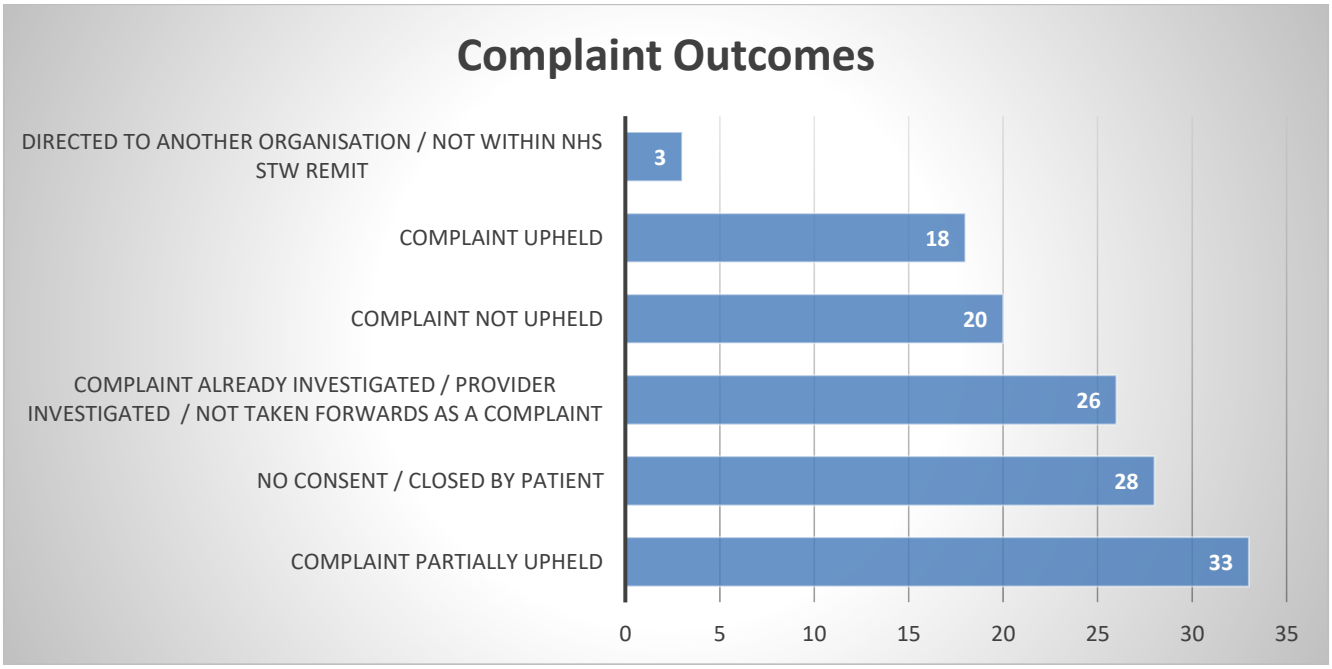
As shown in the graph below, in addition to complaints about NHS Shropshire, Telford and Wrekin itself, many of the complaints relate to providers of services commissioned by the NHS Shropshire, Telford and Wrekin.



Of the complaints received by NHS Shropshire, Telford and Wrekin NHS Shropshire, 37 related to hospital services; 19 of these were around accessing services.

There were 27 complaints relating to services provided by NHS Shropshire, Telford and Wrekin of these 9 related to the Continuing Health Care process. 10 were around the Prescription Ordering Service and were mainly around getting through to this service.

Of the 97 complaints received during the time period from 1st July 2022 to 31st March 2023, 23 are ongoing. The graph below shows the outcomes for complaints where the process has been completed during the period from 1st July 2022 to 31st March 2023.



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 NHS Shropshire, Telford and Wrekin's response. NHS Shropshire, Telford and Wrekin has been contacted by the PHSO in relation to 2 cases during the period from 1st July 2022 to 31st March 2023. Of these cases one is still ongoing, with the initial request from the PHSO being that NHS Shropshire, Telford and Wrekin provide a further response prior to them giving the case further consideration. With the case that has been completed, this related to a provider organisation who was also requested to provide a further response and this process has now been completed by the provider directly.

Data around the number of complaints received and accepted by the PHSO for all NHS organisations can be viewed on the PHSO website as follows:

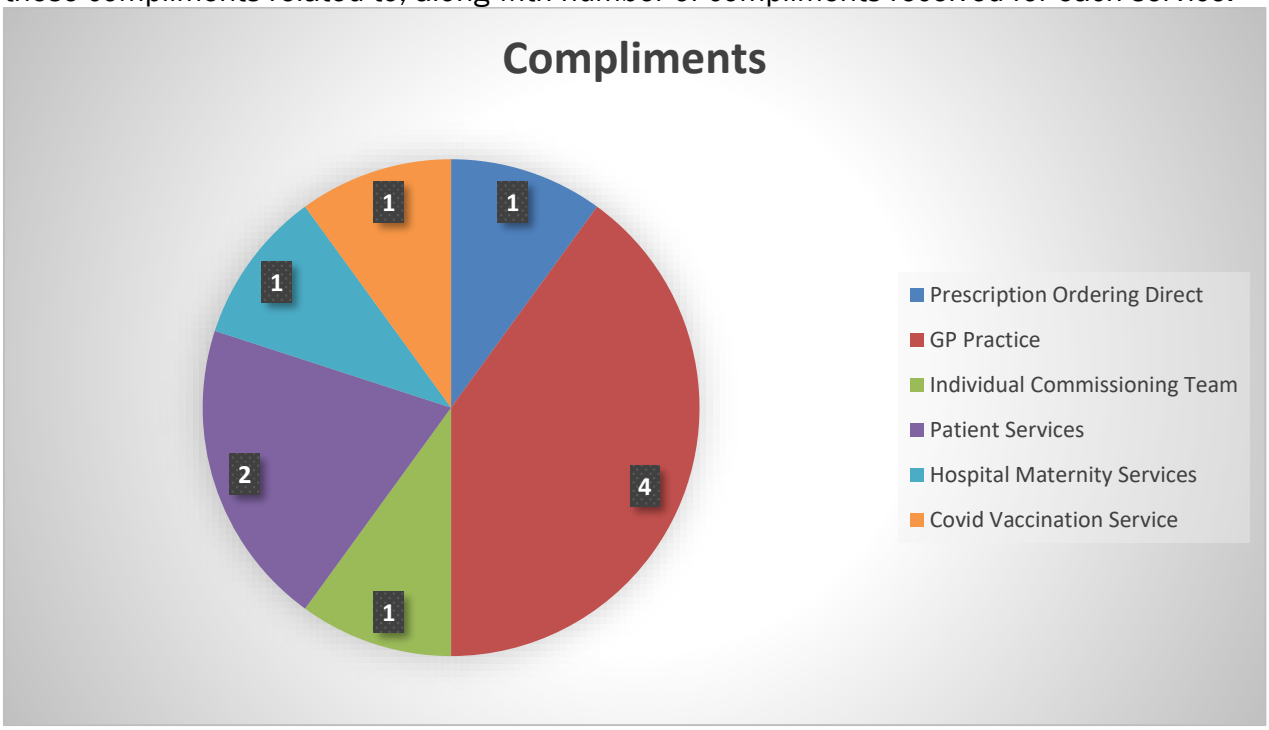
https://www.ombudsman.org.uk/publications/complaints-parliamentary-and-health-service-ombudsman-2019-20-and-2020-21

MP letters

During the time period from 1st July 2022 to 31st March 2023, NHS Shropshire, Telford and Wrekin received 118 letters/emails from local Members of Parliament (MPs) relating to the healthcare of their constituents. 33 of these enquiries related to access to services provided by NHS Shropshire, Telford and Wrekin and included issues with the Continuing Health Care process, access to medications, access to the Prescription Ordering Department. 27 enquiries related to GP Services and were mostly related to access to services, including getting through on the telephone and access to appointments. 26 Enquiries related to hospital services, 18 of which were around access to appointments. There were 9 enquiries around Ambulance services and 9 enquiries around Mental Health Services. Access to services was a theme throughout the MP enquiries received.

Compliments

In addition to managing complaints, concerns and enquiries, the NHS Shropshire, Telford and Wrekin also receives positive feedback in the form of compliments. 10 compliments were received during the period from 1st July 2022 to 31st March 2023 and the chart below highlights the services that these compliments related to, along with number of compliments received for each service.



Learning from Feedback received

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

What we Heard	What has Happened
Delays with discharge from hospital, which meant that patient was not able to go home to die, as per their wishes	Hospital worked hard with the family to try to facilitate discharge so that the patient could die at home, as per their wish, however care could not be secured. As learning from the complaint, staff at the hospital attended a discharge workshop and Fast Track improvement workshop. Details of this case was also shared to raise awareness. In addition to the above NHS Shropshire, Telford and Wrekin is working closely with all care providers and the Hospice to try to increase capacity within the community.
Concerns were raised by	The caller queue number has now been reinstated.

several patients that the caller queue number had been removed from the Prescription Ordering Service line.	
Access to pain medication – Concerns were raised by a patient who had called 111 around back pain and that poor advice around attending a pharmacy then led to delays in her getting medication for this.	On investigation it appeared that the 111 service were acting on the information that is on their system, but that there had been a misunderstanding around what the pharmacy could provide. The ICB facilitated a conversation between the pharmacy and the 111 service to ensure that this issue did not arise again.
Missed Fracture in Emergency Department (ED)	Hospital have now implemented a monthly teaching session for junior doctors, around management of common fractures, with posters in the department to serve as a visual guide for staff.

Reducing Health Inequalities

NHS General Duties

As a public sector organisation, NHS Shropshire, Telford and Wrekin must comply with specific equality duties that require it to evidence how it pays due regard to the needs of diverse and vulnerable groups in the exercising of its responsibilities.

For the purposes of this annual report, this includes compliance with the Equality Act 2010, Human Rights Act 1998 and relevant sections of the Health and Social Care Act 2012.

NHS STW is committed to ensuring that it demonstrates due regard to the general duty when making decisions about policies and services. We have embedded the requirement to undertake an equality analysis into our decision-making processes. This ensures that we continually work to understand and respond to the diversity of patient experience in health access, care and outcomes, and to recognise and value the importance of using equality analysis to address health inequalities.

In 2022/23 to further assure that we are addressing our inequalities duties an Equality and Involvement Committee was established chaired by one of our Non-Executive Directors.

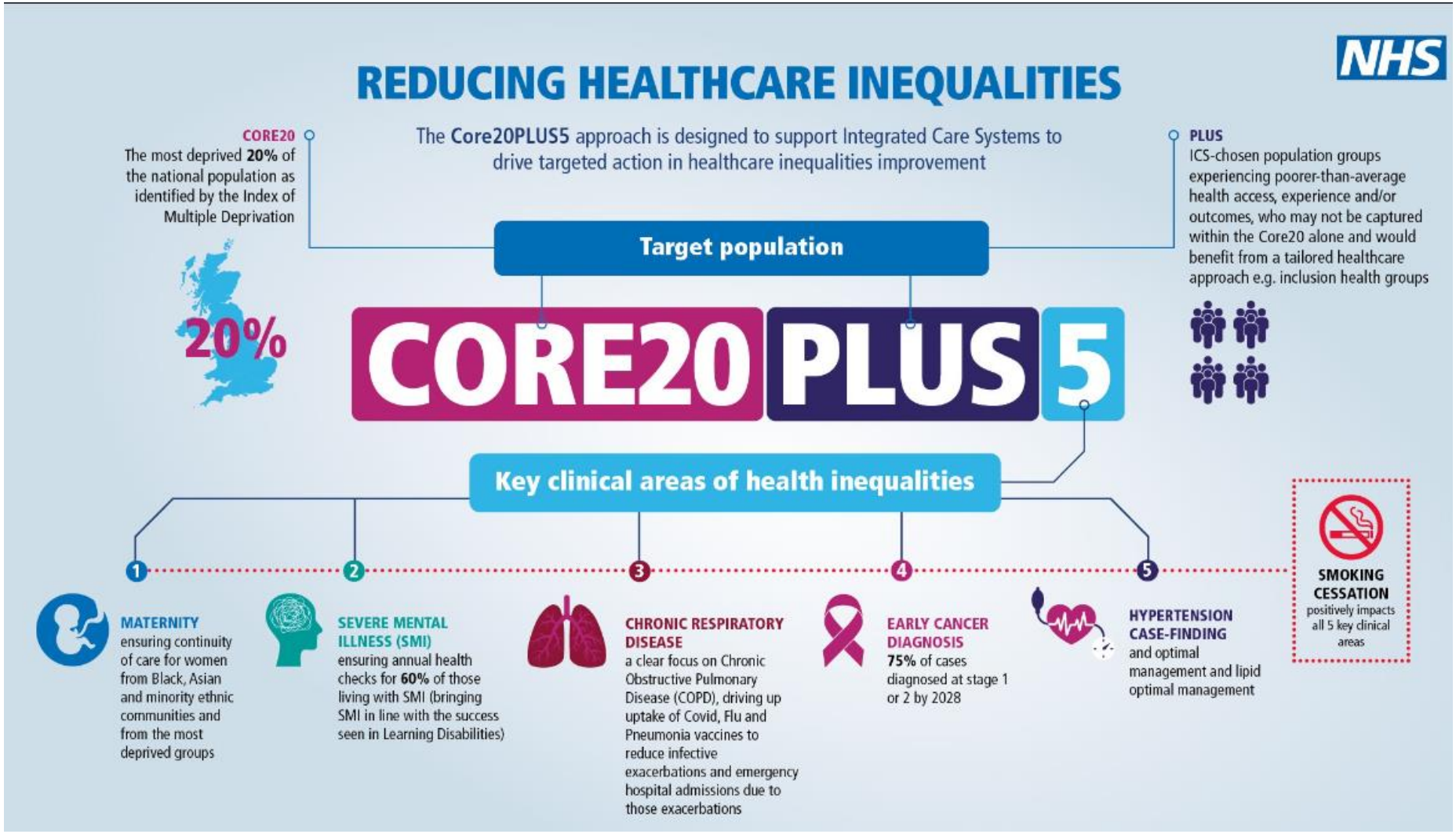
Addressing Health Inequalities

Tackling inequalities in outcomes, experience and access is one of the four key objectives for all ICBs. Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the ability to access care that is available to them. People living in areas of high deprivation, those from Black, Asian and minority ethnic communities and those from inclusion health group, for example the homeless, are most at risk of experiencing these inequalities.

1 Strengthen Leadership and Accountability	2 Mitigate Against Digital Exclusion	3 Restore NHS Services Inclusively	4 Ensure Datasets are Complete and Timely	5 Accelerate Preventative Programmes
• Executive-level Leadership • Standardised system Integrated Impact Assessments. • Strong governance and outcome-based reporting. • HI embedded into all decision-making, strategies and delivery plans.	• Contractual requirements for Providers to monitor the impact of digital access and provide alternative methods of access. • Development of the Digital Exclusion Programme within the Digital Operating Model.	• Development of a data management strategy led by Elective Care.	• Mandatory ethnicity data reporting. • Improved access to linked datasets.	• Healthier Lifestyles • Tobacco Dependence • Weight Management • Alcohol Dependence • Integrated Cancer Strategy • Core Connectors • Flu/C19 Vaccinations • Asthma Programme • Physical Health Checks for LD and SMI • ABC Management • CVD Prevention Plan • Hypertension case-finding and management • Diabetes Transformation • Rurality • Air Pollution

Covid-19 shone a harsh light on some of the health and wider inequalities that persist in our society. In response to this NHSE identified five key priority areas relating to reducing health inequalities in the 2022/23 Operational Planning Guidance.

These included addressing the 5 clinical areas in the Core20PLUS5.


NHS
REDUCING HEALTHCARE INEQUALITIES
CORE20
The most deprived 20% of the national population as identified by the Index of Multiple Deprivation
20%
The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement
Target population
CORE20PLUS5
PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups
Key clinical areas of health inequalities
1
MATERNITY
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups
2
SEVERE MENTAL ILLNESS (SMI)
ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
3
CHRONIC RESPIRATORY DISEASE
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4
EARLY CANCER DIAGNOSIS
75% of cases diagnosed at stage 1 or 2 by 2028
5
HYPERTENSION CASE-FINDING
and optimal management and lipid optimal management
SMOKING CESSATION
positively impacts all 5 key clinical areas

As a system we have collectively reviewed the achievement against 18 NHS led programmes to address these key priorities. The findings in brief were:

- 50% of the projects had achieved all the actions detailed in the high-level implementation plan, with a further 33% partially achieving the actions detailed.
- 17% of projects had yet to partially meet the actions detailed in the plan, although the process of this review has seen increased leadership and action in relation to the key area of a system wide inclusive elective care recovery approach.
- Key enablers were related to clear governance and knowledgeable leadership, additional dedicated roles to progress initiatives, collaboration with Telford and Wrekin and Shropshire Public Health teams, and direct engagement with stakeholders.

Conversely barriers to achievement including no dedicated leads, no resources to develop programmes, limits in the capacity of stakeholders to engage, access to data and historical issues relating to fragmentation of pathways.

Going forward into 2023/24 we aim to look at how we direct resources to support more co-ordinated leadership for this important area of intervention and improve our governance processes. This means that our Integrated Care Board will receive regular updates so we are more aware earlier where projects are not delivering what we planned for them to deliver

The review also indicated that we need to do more to identify how we can accurately collect data to enable us to demonstrate the changes we have made to those in CORE20Plus groups who we know are more likely to experience health inequalities.

Race Equality

There is clear evidence that racism and discrimination cause health inequalities, impacting our communities, patients and colleagues. The Covid-19 pandemic has brought this into sharp focus, along with social injustice and systemic discrimination.

There are countless examples that show inequality, racism and discrimination is still experienced by ethnic minorities across the world and that for many it is part of everyday life. The incidents at and after the Euro 2020 final form just one appalling example.

As an ICB/ICS, we are looking inwards and recognise that we all have a role in addressing these inequalities and structural racism. Now is the time to act and do things differently. We need to harness the collective will of our system and work together to make a significant and sustained change.

We are at a juncture where we can improve things or allow them to get worse. It is no longer enough for us to simply stand up and condemn racism, we must be actively anti-racist. We must work together with our communities across all sectors to create a better future in which everyone enjoys the same freedoms, rights and opportunities in Shropshire, Telford and Wrekin.

This means creating workplaces and services in which people of all backgrounds and cultures feel included, welcomed and valued. It also means ensuring that we collectively strive to meet the needs of ethnic minority staff and communities and to create conditions where all staff can reach their full potential.

We aspire to be recognised for positively promoting and delivering equality and inclusion for all groups in our leadership, our workforce and in the way that we carry out our work.

We recognise that equality, diversity and inclusion are multifaceted issues, and we need to tackle these subjects holistically. The power of our ICS comes from our ability to influence beyond health and social care. It is within our gift to also influence the socio-economic factors that are so important in tackling inequalities such as access to employment, education and housing.

As a system, we have committed to 10 overarching pledges which are the golden thread through all the work we deliver. This includes tackling the problems of ill health, health inequalities and access to health care, improving our leadership and governance and making our system a great place to work. We are now collectively committing consistent attention and actions which are visible and practical to tackle the deep-rooted issues that lie behind systemic racial inequalities.

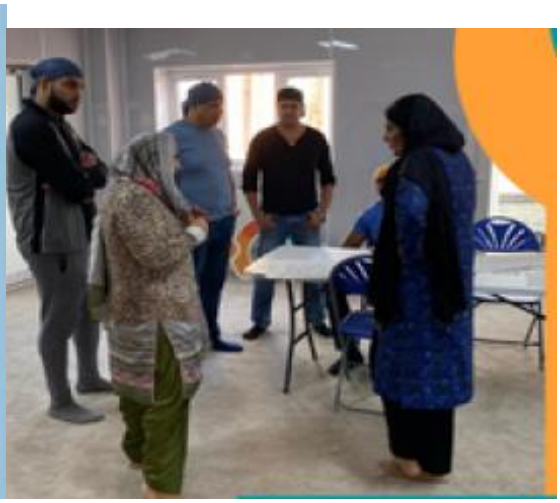
We acknowledge that these commitments are not the complete answer, but we believe they are important, concrete steps towards reducing inequalities, creating an atmosphere of inclusiveness in our workplaces, and cultivating meaningful change for our communities.

Core 20Plus Cancer Champions

In March 2022 STW ICS were successful as a wave 1 implementer site for the Core20PLUS Connectors Programme. The project is delivered in partnership between the ICB, Local Authorities and our Community and Voluntary Sector, with Lingen Davies Cancer Fund and Qube Oswestry Community Action as our lead community delivery partners.

Over 2022/23 the following progress has been made

- Launched Cancer Champions website www.cancerchampions.co.uk, including training bookings, on- line resources and multilingual Cancer Champion videos
- Videos created by Cancer Champion in Punjabi, Mandarin, Bulgarian, Ukrainian, and Polish (bowel, breast, cervical signs, and symptoms) Resource Videos – Cancer Champions
- Videos available on request videos by health and community partners organisation to use on though their own social media website/ patient TV screens etc.
- Recruited cancer champions through collaborative working with community organisations and partners.
- Delivered 7 half-day cancer champions training sessions held, training a total of 35 cancer champions
- Feedback from training is that it is informative and inspiring. Using a confidence scale of 1-10 to indicate how participants feel about having conversations and using what they have learned our scores are between 7 and 10 – (most confident is 10)
- Creation of 3 Levels of Cancer Champion to accommodate differing levels of commitment.
    - **Level 1:** Taking part in videos, social media posts.
    - **Level 2:** Trained and having conversations in their community.
    - **Level 3:** Community events, talks, radio (supported by coordinators & LiveLife LD staff.
- Cancer Champion newsletter produced and distributed for champions.



Equality, Diversity and Human Rights Report

The NHS Equality Delivery System (EDS2) was launched in November 2013 to help monitor how the NHS is working towards these functions. It is a toolkit designed to help NHS organisations and members of staff review performance for people with characteristics protected by the Equality Act as well as identify how improvements can be made.

The nine protected characteristics are as follows:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership (ICB)
- Pregnancy and maternity
- Race including nationality and ethnic origin
- Religion or belief
- Sex
- 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.

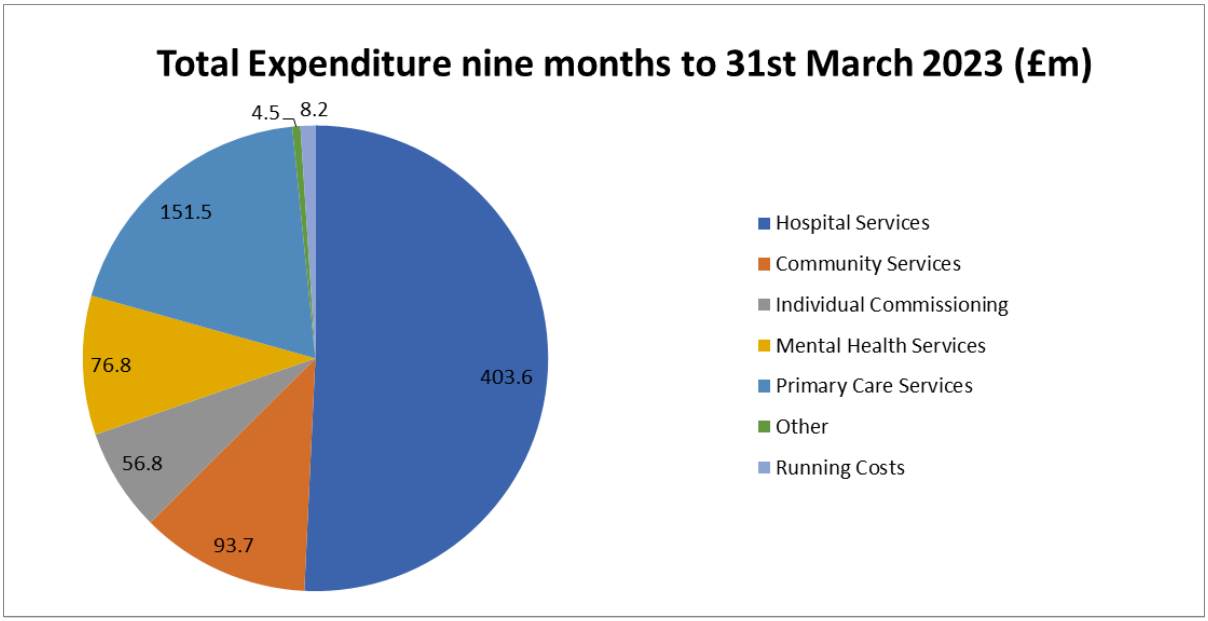
Organisations score themselves against the main functions within the assessment, more information of which can be found on the NHS England website.

NHS Shropshire, Telford and Wrekin have not finalised the external scoring of the EDS2 self assessment at the time of writing this report. However the draft self assessment which outlines the evidence collated can be viewed on the ICB's website here: Equality, Diversity and Inclusion – NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Financial review

In the nine months to 31st March 2023 the ICB received a total allocation of £774 million to spend on the healthcare of its residents. The chart below shows a breakdown of the ICB's expenditure for the period by spend type totalling £795m:

Expenditure nine months to 31st June 2023 (£795 million)



Further analysis of expenditure, by type for the nine months ended 31st March 2023:

	Period ended 31st March 2023 Total £'000
Pay	14,012
Purchase of goods and services	
Services from other ICBs and NHS England	5,239
Services from foundation trusts	124,713
Services from other NHS trusts	371,038
Purchase of healthcare from non-NHS bodies	116,570
Prescribing costs	72,349
General Ophthalmic services	655
GPMS/APMS and PCTMS	69,358
Supplies and services – clinical	1,349
Supplies and services – general	12,894
Consultancy services	296
Establishment	2,584
Transport	240
Premises	417
Audit fees	128
Other non statutory audit expenditure	
· Other services	18
Other professional fees	1,358
Legal fees	93
Education, training and conferences	712
Total Purchase of goods and services	**780,011**
Depreciation and impairment charges	
Depreciation	214
Total Depreciation and impairment charges	**214**
Provision expense	
Provisions	975
Total Provision expense	**975**
Other Operating Expenditure	
Chair and Non Executive Members	96
Grants to Other bodies	119
Expected credit loss on receivables	-
Other expenditure	-
Total Other Operating Expenditure	**215**
Total Expenditure	**795,427**

An analysis of the Statement of Financial Position, detailing assets and liability balances:

	31-Mar-23	30-Jun-22
	£'000	£'000
Total Non Current Assets	1,159	1,044
Current assets:		
Trade and other receivables	8,156	2,910
Cash and cash equivalents	286	104
Total current assets	**8,442**	**3,014**
Total assets	**9,601**	**4,059**
Current liabilities		
Trade and other payables	(61,002)	(61,172)
Lease liabilities	(913)	(1,046)
Provisions	(3,444)	(2,219)
Total current liabilities	**(65,359)**	**(64,437)**
Non-Current Assets plus/less Net Current Assets/Liabilities	**(55,758)**	**(60,378)**
Non Current Liabilities	-	-
Assets less Liabilities	**(55,758)**	**(60,378)**
Financed by Taxpayers' Equity		
General fund	(55,758)	(60,378)
Total taxpayers' equity:	**(55,758)**	**(60,378)**

ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

NHS Shropshire, Telford and Wrekin is an Integrated Care Board with a unitary Board and is part of the Shropshire, Telford and Wrekin Integrated Care System.

NHS Shropshire, Telford and Wrekin Board composition during the period 1st July 2022 to 31st March 2023 was as follows:

Board members from 1 July 2022 to31 March 2023	Board Role
Sir Neil McKay (voting)	Chair
Simon Whitehouse (voting)	Chief Executive
Professor Trevor McMillan (voting)	Non Executive Member and Deputy Chair
Roger Dunshea (voting)	Non Executive Member
Dr Niti Pall (voting)	Non Executive Member
Meredith Vivian (voting)	Non Executive Member
Alison Bussey (voting)	ICB Chief Nursing Officer
Gareth Robinson (voting)	ICB Executive Director for Delivery and Transformation
Claire Skidmore (voting)	ICB Chief Finance Officer
Mr Nicholas White (voting)	ICB Chief Medical Officer
Dr Ian Chan (voting)	Primary Care Member and GP in Telford and Wrekin
Dr Julian Povey (voting)	Primary Care Member and GP in Shropshire
Andy Begley (voting)	Local Authority Member and Chief Executive Shropshire Council
David Sidaway (voting)	Local Authority Member and Chief Executive Telford and Wrekin Council
Louise Barnett (voting)	Trust Member and Chief Executive, Shrewsbury and Telford Hospital NHS Trust
Neil Carr (voting)	Trust Member and Chief Executive, Midlands Partnership NHS Foundation Trust
Patricia Davies (voting)	Trust Member and Chief Executive, Shropshire Community Health NHS Trust
Stacey Keegan (voting)	Trust Member and Chief Executive, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Nicola Dymond (non voting)	Participant and Director of Strategy and Integration
Mark Docherty (non voting)	Participant and Executive Director of Nursing and Clinical Commissioning, West Midlands Ambulance Service University NHS Foundation Trust
Pauline Gibson (non voting)	Participant and Non Executive Director, Midlands Partnership NHS Foundation Trust
Nuala O'Kane (non Voting) – to 31st December 2022	Participant and Chair, Shropshire Community Health NHS Trust

Tina Long (non voting) – from 1st January 2023	Participant and Interim Chair, Shropshire Community Health NHS Trust
Dr Catriona McMahon (non voting)	Participant and Chair, Shrewsbury and Telford Hospital NHS Trust
Harry Turner (non voting)	Participant and Chair, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Cathy Purt (non voting) – from 1st December 2022	Participant, Chair of the ICB Strategy Committee and Non Executive Director, Shropshire Community Health NHS Trust
Lyn Cawley (non voting)	Healthwatch Observer and Chief Officer Healthwatch Shropshire
Barry Parnaby (non voting)	Healthwatch Observer and Chair Healthwatch Telford and Wrekin
Heather Osbourne – to 31st December 2022 (non voting)	VCS Observer and Chair Shropshire VCSA
Jackie Jeffrey – from 1st January 2023 (non voting)	VCS Observer and Vice Chair Shropshire, VCSA
Terry Gee (non voting)	VCS Observer and Chief Executive Officer Stay Telford

Committee(s) including Audit Committee

So that the Board of NHS Shropshire, Telford and Wrekin can provide strategic direction to the organisation and to assure itself of the ICB'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 first year of operation of NHS Shropshire, Telford and Wrekin has been used to develop the committee's individual ways of working and starting to develop how the inter-relationships and inter-dependencies between the Board committees will function. As part of this work we have commissioned the Good Governance Institute to review our progress to date and to help identify improvements for the future.

The composition of the Audit Committee was as follows:

Mr Roger Dunshea	Chair and Non Executive Member
Professor Trevor McMillan	Non Executive Member
Dr Niti Pall	Non Executive Member
Mr Meredith Vivian	Non Executive Member

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

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

Information governance incidents

NHS Shropshire, Telford and Wrekin has reported a total of 11 incidents during the period of 1st July 2022 to 31st March 2023. Of these incidents 10 were graded as non-reportable – very low risk with 1 being reportable to the Information Commissioner's Office (ICO).

Primary Care General Medical Services

The organisation has delegated commissioning responsibilities for primary care general medical services on behalf of NHS England. This includes commissioning 51 GP practices located within the geographical area coterminous with the boundaries of Shropshire Council and Telford and Wrekin Council.

The 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 4ENt
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
Charlton Medical Centre	Lion Street, Oakengates, Telford, TF2 6AQ
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
Court Street Medical Practice	Court Street Medical Centre, Court Street, Madeley, Telford, TF7 5DZ
Craven Arms Medical Practice	20 Shrewsbury Rd, Craven Arms, SY7 9PY
Dawley Medical Practice	Webb House, King Street, Dawley, Telford, TF4 2AA
Donnington Medical Practice	Wrekin Drive, Donnington, Telford, TF2 8EA
Highley Medical Centre	Bridgnorth Road, Highley, Bridgnorth, WV16 6HG
Hodnet Medical Centre	18 Drayton Road, Hodnet, Market Drayton, TF9 3NF
Hollinswood and Priorslee Medical Practice	Downmeade, Hollinswood, Telford, TF3 2EW
Ironbridge Medical Practice	Trinity Hall, Dale Road, Coalbrookdale, Telford, TF8 7DT
Knockin Medical Centre	Knockin, Oswestry, SY10 8HL
Linden Hall	Station Road, Newport, near Telford, Shropshire, TF10 7EN

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 and Worthen 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	Barker Street, Shrewsbury SY1 1QJ
Severn Fields Medical Practice	Severn Fields Health Village, Sundorne Road, Shrewsbury SY1 4RQ
Shawbirch Medical Practice	5 Acorn Way, Shawbirch, Telford, TF5 0LW
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
Stirchley Medical Practice	Sandino Road, Stirchley , Telford, TF3 1FB
Teldoc	Malinslee Surgery, Church Road, Malinslee, Telford, TF3 2JZ
The Surgery	Wellington Road, Newport, near Telford, Shropshire, TF10 7HG
Wem and Prees Medical Practice (Wem Site)	New Street, Wem, Shrewsbury, SY4 5AF
Wellington Medical Practice	The Health Centre, Victoria Avenue, Wellington, Telford, TF1 1PZ
Westbury Medical Centre	Westbury, Shrewsbury, SY5 9QX
Woodside Medical Practice	Woodside Health Centre, Wensley Green, Woodside, Telford, TF7 5NR

Modern Slavery

NHS Shropshire, Telford and Wrekin 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

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

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

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

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

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Shropshire, Telford and Wrekin Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

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

Disclosures:

- Section 30 letter issued by external auditors to the Secretary of State - NHS Shropshire and Telford ICB has reported a deficit of £21.5 million in its draft financial statements for the period ending 31 March 2023. This has resulted in the ICB overspending its revenue resource limit

by £21.5 million. As a result the ICB has taken a course of action that is unlawful and has caused a loss. The external auditors are required to refer this matter to the Secretary of State.

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

Simon Whitehouse

Accountable Officer

29th June 2023

Governance Statement

Introduction and context

NHS Shropshire, Telford and Wrekin is a body corporate established by NHS England on 1 July 2022 under the Health and Care Act 2022, which sets out the ICB's statutory functions.

The general function of NHS Shropshire, Telford and Wrekin is to arrange the provision of services for people for the purposes of the health service in England. The ICB 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 population.

Between 1 July 2022 and 31 March 2023, the Integrated Care Board was not subject to any directions from NHS England issued under Section 14Z61 of the of the National Health Service Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Shropshire, Telford and Wrekin'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 the NHS Shropshire, Telford and Wrekin's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Shropshire, Telford and Wrekin 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 ICB as set out in this governance statement.

Governance arrangements and effectiveness

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

NHS Shropshire, Telford and Wrekin is led by a unitary Board comprising a Chair and Chief Executive, Executive Directors, Non Executive Members and Partner Members composed of local GPs, local Trusts/Foundation Trusts and Local Authorities all located within the geographical area of Shropshire. The members of the Board are responsible for determining the governing arrangements of the organisation, which they are required to set out in NHS Shropshire, Telford and Wrekin's Constitution and Governance Handbook, which can be found on our website: Our Constitution - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Board

The composition of NHS Shropshire, Telford and Wrekin's Board is outlined in full within the Constitution.

The Board has met 6 times during the period 1st July 2022 to 31st March 2023 in total. The names of members and their attendance are listed below:

Board members from 1 July 2022 to31 March 2023	Board Role	Attendance
Sir Neil McKay (voting)	Chair	5 of 6
Simon Whitehouse (voting)	Chief Executive	5 of 6
Professor Trevor McMillan (voting)	Non-Executive Member and Deputy Chair	6 of 6
Roger Dunshea (voting)	Non-Executive Member	5 of 6
Dr Niti Pall (voting)	Non-Executive Member	5 of 6
Meredith Vivian (voting)	Non-Executive Member	6 of 6
Alison Bussey (voting)	ICB Chief Nursing Officer	4 of 6
Gareth Robinson (voting)	ICB Executive Director for Delivery and Transformation	5 of 6
Claire Skidmore (voting)	ICB Chief Finance Officer	6 of 6
Mr Nicholas White (voting)	ICB Chief Medical Officer	5 of 6
Dr Ian Chan (voting)	Primary Care Member and GP in Telford and Wrekin	6 of 6
Dr Julian Povey (voting)	Primary Care Member and GP in Shropshire	6 of 6
Andy Begley (voting)	Local Authority Member and Chief Executive Shropshire Council	6 of 6
David Sidaway (voting)	Local Authority Member and Chief Executive Telford and Wrekin Council	5 of 6
Louise Barnett (voting)	Trust Member and Chief Executive, Shrewsbury and Telford Hospital NHS Trust	4 of 6
Neil Carr (voting)	Trust Member and Chief Executive, Midlands Partnership NHS Foundation Trust	4 of 6
Patricia Davies (voting)	Trust Member and Chief Executive, Shropshire Community Health NHS Trust	5 of 6
Stacey Keegan (voting)	Trust Member and Chief Executive, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	5 of 6

Nicola Dymond (non voting)	Participant and Director of Strategy and Integration	4 of 6
Mark Docherty (non voting)	Participant and Executive Director of Nursing and Clinical Commissioning, West Midlands Ambulance Service University NHS Foundation Trust	2 of 6
Pauline Gibson (non voting)	Participant and Non Executive Director, Midlands Partnership NHS Foundation Trust	2 of 6
Nuala O'Kane (non Voting) – to 31st December 2022	Participant and Chair, Shropshire Community Health NHS Trust	5 of 6
Tina Long (non voting) – from 1st January 2023	Participant and Interim Chair, Shropshire Community Health NHS Trust	2 of 6
Dr Catriona McMahon (non voting)	Participant and Chair, Shrewsbury and Telford Hospital NHS Trust	6 of 6
Harry Turner (non voting)	Participant and Chair, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	4 of 6
Cllr Lezley Picton (non voting)	Participant and Leader of Shropshire Council	3 of 6
Cllr Shaun Davies (non voting)	Participant and Leader of Telford and Wrekin Council	1 of 6
Cathy Purt (non voting) – from 1st December 2022	Participant, Chair of the ICB Strategy Committee and Non Executive Director, Shropshire Community Health NHS Trust	0 of 6
Lyn Cawley (non voting)	Healthwatch Observer and Chief Officer Healthwatch Shropshire	5 of 6
Barry Parnaby (non voting)	Healthwatch Observer and Chair Healthwatch Telford and Wrekin	2 of 6
Heather Osbourne – to 31st December 2022 (non voting)	VCS Observer and Chair Shropshire VCSA	2 of 6
Jackie Jeffrey – from 1st January 2023 (non voting)	VCS Observer and Vice Chair Shropshire, VCSA	1 of 6
Terry Gee (non voting)	VCS Observer and Chief Executive Officer Stay Telford	4 of 6

Audit Committee

The Audit Committee provides assurance to the Board 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.

The Committee has met a total of 2 times during 2022/23, which is included in the attendance table below.

Audit Committee members	Meetings attended during 2022/23
Mr Roger Dunshea – Chair and Non Executive Member	2 of 2
Professor Trevor McMillan – Non Executive Member	1 of 2
Dr Niti Pall – Non Executive Member	1 of 2
Mr Meredith Vivian – Non Executive Member	2 of 2

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- financial sustainability;
- assurance gained from and further development of the Board Assurance Framework (BAF) and Executive Risk Register;
- assurance gained from overseeing the continued development and self-certification of the ICB against the Data Security and Protection Toolkit (DSPT);
- assurance on the ICB'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 gained from Internal / External Audit reports; and
- assurance on the content of the annual accounts and annual report audit by external auditors.

Extraordinary Remuneration Committee

Due to Conflicts of Interest with the agenda items to be considered, the Extraordinary Remuneration Committee has met 2 times during the year in total with a different configuration of membership as allowed under the ICB's Constitution and the Terms of Reference of the Remuneration Committee. The names and their attendance are listed below during the period 1st July 2022 to 31st March 2023.

Extraordinary Remuneration Committee members from 1st July 2022 to 31st March 2023	Meetings attended during 2022/23
Sir Neil McKay – ICB Chair	2 of 2
Claire Skidmore – ICB Chief Finance Officer	1 of 2
Dr Julian Povey – Partner Board Member and GP in Shropshire	1 of 2
Simon Whitehouse – ICB Chief Executive Officer	1 of 2
Andrew Begley – Partner Board Member and Chief Executive of Shropshire Council	1 of 2
Patricia Davies – Partner Board Member and Chief Executive of Shropshire Community Health NHS Trust	1 of 2
Stacey Keegan – Partner Board Member and Chief Executive of Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	1 of 2
Neil Carr – Partner Board Member and Chief Executive of Midlands Partnership NHS Foundation Trust	1 of 2

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- ICB Board Non-Executive Member Remuneration
- Expert Lay Advisor: Finance

Quality and Performance Committee

The QPC Committee oversees and provides assurance on performance and quality of commissioned services. The committee met 10 times as required during the period 1st July 2022 to 31st March 2023.

Quality and Performance Committee members	Meetings attended during 2022/23
Meredith Vivian – Chair and Non-Executive Director Member	10 of 10
Alison Bussey – ICB Chief Nursing Officer	6 of 10
Nick White – ICB Chief Medical Officer	6 of 10
Claire Parker – ICB Director of Partnerships and Place	4 of 10
Julie Garside – ICB Director of Planning and Performance	9 of 10
Liz Noakes – Director of Public Health representing Telford Local Authority	7 of 10
Rachel Robinson – Director of Public Health representing Shropshire Council	0 of 10
Hayley Flavell – Director of Nursing and Midwifery at Shrewsbury and Telford Hospital NHS Trust	4 of 10
Rose Edwards – Associate Non-Executive Director at Shrewsbury and Telford Hospital NHS Trust (from January 2023)	4 of 10
Liz Lockett – Member, Chief Nurse at MPFT	4 of 10
Jacqueline Small – Member, Non-Executive Director MPFT (to 31st December 2022)	4 of 10
Simmy Akhtar – Non-Executive Director MPFT (from 1st January 2023)	1 of 10
Clare Hobbs – Director of Nursing at Shropshire Community Health NHS Trust	3 of 10
Tina Long – Non-Executive Director at Shropshire Community Health NHS Trust (to 28th February 2022)	5 of 10
Jill Barker – Member, Associate Non-Executive Director at Shropshire Community Health NHS Trust (from 1st March 2023)	2 of 10
Sara Ellis Anderson – Chief Nurse representing Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	7 of 10
Ruth Longfellow – Medical Director at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust – deputising for Sara Ellis	4 of 10
Chris Beacock - Non Executive Director at Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2 of 10
Sonya Miller Assistant Director for Children's Social Care and Safeguarding – Shropshire Council – Senior Leadership representative	0 of 10
Jo Britton, Executive Director of Children's Services, Telford and Wrekin Council – Senior Leadership Representative	0 of 10

Lynn Cawley – Shropshire Healthwatch	10 of 10
Barry Parnaby – Telford and Wrekin Healthwatch or deputies	6 of 10

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- Performance Exception Reports
- Strategic Oversight and Assurance Group
- Local Maternity and Neonatal Services
- NICHE
- Learning Disability & Autism
- Infection, Prevention & Control
- Patient Safety
- Cancer Strategy
- System Quality Metrics
- System Risk Register
- Ockenden Review
- Independent Inquiry into Child Sexual Exploitation
- Dementia Services
- Palliative Care and End of Life Services
- Diabetes Services
- Quality Insight
- Safeguarding Adults and Children

Finance Committee

The Finance Committee Section One and Section Two oversees and provides assurance on the financial delivery of commissioned services. The committee met 7 times during 2022/23 as required during the period 1st July 2022 to 31st March 2023.

Finance Committee members	Meetings attended during 2022/23
Section One – Financial assurance for ICB as a statutory body	
Professor Trevor McMillan – ICB Non-Executive Member and Chair	7 of 7
Claire Skidmore – ICB Chief Finance Officer	7 of 7
Nicola Dymond – ICB Director of Strategy and Integration	4 of 7
Section Two – Financial assurance for ICS	
Professor Trevor McMillan – ICB Non-Executive Member and Chair	7 of 7
Claire Skidmore – ICB Chief Finance Officer	7 of 7
Nicola Dymond – ICB Director of Strategy and Integration	4 of 7
Helen Troalen – ICB Director of Finance for Shrewsbury and Telford Hospitals	5 of 7
Sarah Lloyd – ICB Director of Finance for Shropshire Community Health Trust	6 of 7

Craig McBeth – Chief Finance Officer for Robert Jones, and Agnes Hunt Hospitals Trust	6 of 7
Chris Sands – Chief Finance Officer for Midlands Partnership NHS Foundation Trust	5 of 7
Sarfraz Nawaz – Non-Executive Director for Robert Jones, and Agnes Hunt Hospitals Trust	1 of 7
Peter Featherstone – Non-Executive Director for Shropshire Community Health Trust	2 of 7
James Walton – Partner Organisation of Shropshire Local Authority	2 of 7
Ken Clarke – Partner Organisation of Telford & Wrekin Local Authority	3 or 7

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- Terms of Reference
- Monthly Position Update
- Finance Risk Register (BAF)
- 2023/24 Plan Update
- NOF4 Exit Criteria Action Plan – finance element
- Intelligent Fixed Payment Group Update - including Terms of Reference sign off
- Capital Prioritisation and Oversight Group – Terms of Reference sign off
- Capital Plan Update
- ICB 2023/24 Efficiency Plans Update
- 2023/24 System Contracts

The Strategy Committee

The Strategy Committee oversees the development of ICS 5 Year Forward Plan taking into account the Integrated Care Strategy. The Committee has met 4 times during the period 1st July 2022 to 31st March 2023 as required.

Strategy Committee members	Meetings attended during 2022/23
Cathy Purt – Chair of Strategy Committee	4 of 4
Nicola Dymond – Vice Chair of Strategy Committee	2 of 4
David Brown – Non-Executive Director of Shrewsbury and Telford Hospitals	4 of 4
Liz Noakes – Director of Public Heath, Telford and Wrekin Council	3 of 4
Mark Large – Non-Executive Director of MPFT	3 of 4
Nye Harries – NHSE National Improvement Team	3 of 4
Professor Paul Kingston – Non-Executive Director for Robert Jones, and Agnes Hunt Hospitals Trust	3 of 4
Peter Featherstone – Non-Executive Director for Shropshire Community Health Trust	2 of 4
Rachel Robinson – Director of Public Health, Shropshire Council	3 of 4
ICB Chief Finance Officer or Deputy – not yet nominated (from 1st February 2023)	0 of 2

ICB Chief Medical Officer or Deputy – not yet nominated (from 1st February 2023)	0 of 2
One representative of general Practice Primary care Providers vacancy – not yet nominated - (from 1st February 2023)	0 of 2
One representative from the VCS - vacancy – not yet nominated (from 1st February 2023)	0 of 2
Sara Lloyd, Senior Executive strategy lead from Shropshire Community Healthcare NHS Trust (from 1st February 2023)	1 of 2
Nigel Lee, Senior Executive strategy lead from Shrewsbury and Telford NHS Trust (from 1st February 2023)	2 of 2
Senior Executive strategy lead from The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (from 1st February 2023)	2 of 2
Steve Grange Senior Executive strategy lead from Midlands Partnership Foundation Trust (from 1st February 2023)	0 of 2

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- Declarations of Interest
- Development of the Integrated Care Strategy
- Joint Forward Plan
- System Utilisation Review
- SOF 4 Exit Criteria
- Committee Workplan
- Health Inequalities

Primary Care Commissioning Committee

The Primary Care Commissioning Committee oversees the commissioning of primary care standard general medical services (GMS) under delegated decision-making authority from NHS England.

The Primary Care Commissioning Committee has met 5 times during the period 1st July 2022 to 31st March 2023 as required.

Primary Care Commissioning Committee members	Meetings attended during 2022/23
Dr Niti Pall – Non-Executive Director, Chair	3 of 4
Nick White – Chief Medical Officer (Deputy Chair)	4 of 4
Simon Whitehouse – ICB Chief Executive Officer	0 of 4
Claire Skidmore – ICB Chief Finance Officer	3 of 4
Gareth Robinson – ICB Director of Delivery & Transformation	3 of 4
Nicola Dymond – ICB Director of Strategy & Integration	1 of 4
Alison Bussey – ICB Chief Nursing Officer	0 of 4
Roger Dunshea – Non-Executive Director	3 of 3

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- NHS STW ICB PCCC Terms of Reference
- Finance Report
- Primary Care Update Report
- GP Contract Arrangements
- GPN Strategy
- Ukraine Health Assessment LES
- Risk Register
- Practice Boundary Changes
- Shrewsbury Health & Wellbeing Hub
- 10 PCN Enhanced Access
- October Winter Plan
- GP Patient Survey
- Ethnic Diversity Survey
- Albrighton Medical Practice Boundary Change
- Workforce & Training Hub Report
- Delegation of POD and Changes to Terms of Reference
- Draft Comms Handling Plan
- eDec Report
- Highley Medical Practice Contract Award
- Primary Care Digital Programme & Budget 2023 – 24
- Performance & GP Access Improvement Plan

Integrated Delivery Committee

The Integrated Delivery Committee provides assurance oversight and support to the development and delivery of system transformation programmes and efficiency programme.

The Integrated Delivery Committee has met 7 times during the period 1st July 2022 to 31st March 2023 as required.

Integrated Delivery Committee	Meetings attended during 2022/23
Harry Turner – Chair of the Committee and Chair of Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	6 of 7
Claire Skidmore – ICB Chief Finance Officer	5 of 7
Alison Bussey – ICB Chief Nursing Officer	0 of 7
Gareth Robinson – ICB Director of Delivery & Transformation	5 of 7
Tanya Mills – Director of Adult Social Care, Shropshire	4 of 7
Dave Sidaway – Chief Executive, Telford and Wrekin Council	1 of 7
Jonathan Rowe – Director of Adult Social Care, Telford and Wrekin	5 of 7

Angie Wallace – Chief Operating Officer of Shropshire Community Health NHS Trust	4 of 7
Mike Carr – Chief Operating Officer of Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	6 of 7
Sara Biffen – Chief Operating Officer of Shrewsbury and Telford Hospitals	3 of 7

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- IDC Terms of Reference
- Local Care Deep Dive presentation
- Workforce Deep Dive
- Children and Young People Mental Health Commissioning Plan
- Financial Improvement Plan, and Efficiency Programme Update
- Local Care: Update on benefits realisation
- MSK Transformation Deep Dive
- Outpatients Transformation Deep Dive
- Proactive Prevention – a system wide case for change
- Equality and Involvement Committee
- IIA screener tool
- Investment Panel Update
- Hospital Transformation Programme Update
- NHS 111
- Direct Awards Contracts
- Local Care Benefits Realisation Paper
- 78 week waits
- ARMS Business Case
- Vaccination Update
- MSK Update
- Outpatients Transformation Update
- Provider Collaborative Business Case
- Digital Delivery Update and Digital Costed Plan
- Virtual Ward – Pharmacy and Primary Care related issues
- Local Care Benefits
- Financial Improvement Programme Update and Finance Plan 23/23 Update
- Policy for Joint Working with the Pharmaceutical Industry

System People Committee

The System People Committee provides assurance and oversight of the development and delivery of the system's People Plan.

The System People Committee has met 3 times during the period 1st July 2022 to 31st March 2023 as required.

System People Committee members	Meetings attended during 2022/23
Catriona McMahon – Chair and Chair of Shrewsbury and Telford Hospital NHS Trust	3 of 3
Alex Brett – Workforce Director	2 of 3
Alison Bussey – ICB Chief Nursing Officer	1 of 3
Clair Hobbs – Director of Nursing, People and Professional Standards, Nursing Council	1 of 3
Cathy Purt – Non-Executive Director	2 of 3
Denise Hurmin – Chief People Officer	0 of 3
Professor Paul Kingston - Non-Executive Director	2 of 3
Rhia Boyode – Director of People and OD	2 of 3
Stacey Keegan – Chief Executive, Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	2 of 3
Tracy Hill – ICB Interim Chief People Officer	3 of 3
Professor Trevor McMillan - Non-Executive Director	1 of 3
Teresa Boughey - Non-Executive Director	2 of 3

Throughout the period 1st July 2022 to 31st March 2023, the Committee has received reports on the following:

- Terms of Reference
- Preparation for a People Workshop
- 2022 STW People Plans
- ICB People Pledges
- ICB People Plan
- Annual report of the People Transformation Team 2022/23
- System Workforce Plan 1st Submission
- Staff Survey Results
- Draft System People Strategy 2023 - 2027

Integrated Care Partnership (ICP)

The Integrated Care Partnership is a joint committee created by NHS Shropshire, Telford and Wrekin, Shropshire Council and Telford and Wrekin Council. The role of the ICP is to bring together multiple system partners to develop an integrated care strategy for the whole population using best available information.

The Integrated Care Partnership has met three times during the period 1st July 2022 to 31st March 2023 as required.

Integrated Care Partnership members	Meetings attended during 2022/23
Cllr Shaun Davies, Leader of Telford & Wrekin Council (co-Chair)	0 of 3
Cllr Andy Burford, Portfolio holder Adult Social Care and Health, Integration and Transformation Telford and Wrekin Council – substitute for Cllr Shaun Davies	2 of 3

Cllr Lezley Picton, Leader of Shropshire Council (Co-Chair)	3 of 3
Simon Jones, Chair of Health and Wellbeing Board	1 of 3
Sir Neil Mckay, Chair of the Integrated Care Board	2 of 3
Cllr Angela McClements, Chair of Telford & Wrekin's Health and Wellbeing Board	2 of 3
Cllr Cecilia Motley, Chair of Shropshire Health and Wellbeing Board	2 of 3
Simon Whitehouse, Chief Executive of the Integrated Care Board	2 of 3
David Sidaway, Chief Executive of Telford & Wrekin Council	2 of 3
Andy Begley, Chief Executive of Shropshire Council	3 of 3
Vacancy - Primary Care representative from Shropshire Place Based Partnership	-
Vacancy - Primary Care representative from Telford and Wrekin Place Based Partnership	-
Liz Noakes, Director of Public Health of Telford & Wrekin	3 of 3
Rachel Robinson, Director of Public Health of Shropshire	3 of 3
Tanya Miles, Executive Director People, Shropshire Council	1 of 3
Jo Britton, Director of Children's services for Telford and Wrekin Council	2 of 3
Sarah Dillon, Director of Adult services for Telford and Wrekin Council	1 of 3
Alan Olver, Telford and Wrekin VCS	1 of 3
Terry Gee, Telford and Wrekin VCS	2 of 3
Jackie Jeffery, Shropshire VCS	0 of 3
Heather Osborne, Shropshire VCS	1 of 3
Lynn Cawley, Healthwatch Shropshire representative	3 of 3
Barry Parnaby, Healthwatch Telford and Wrekin representative	1 of 3

Throughout the period 1st July 2022 to 31st March 2023, the partnership has received reports on the following:

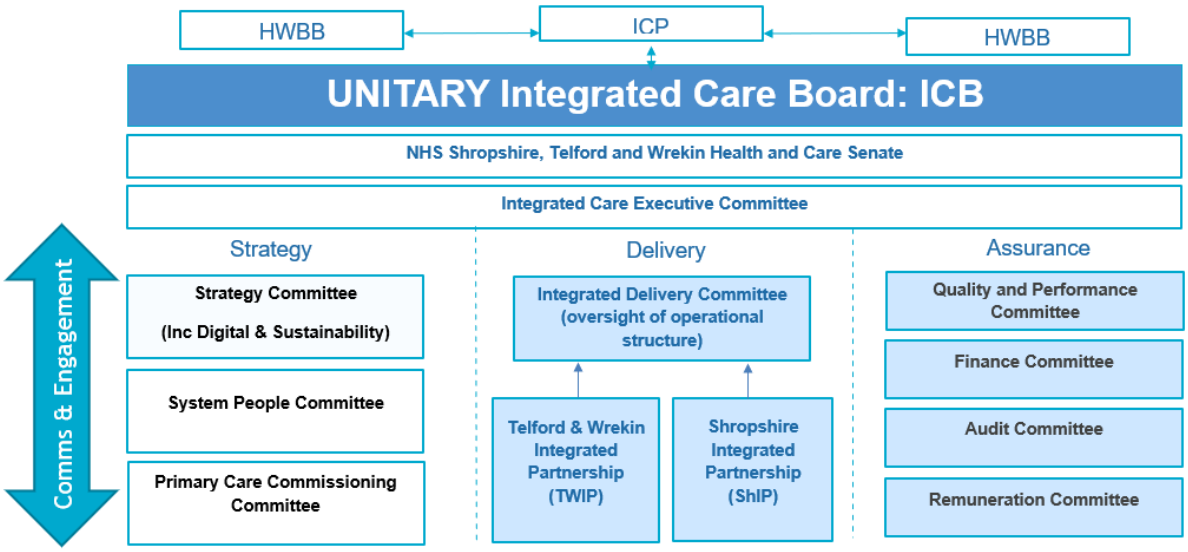
- Briefing on the content of the current Joint Strategic Needs Analysis and Health and Wellbeing Strategies for the respective local authority areas.
- Development and approval of the Integrated Care Strategy
- Update on development of the Joint Forward Plan and the engagement plan and delivery with the public and stakeholders.

Membership of the committees and sub-committees of the Board is outlined in respective terms of reference which are included in the Constitution and Governance Handbook. Attendance at these meetings is recorded in the minutes of each meeting.

The governance structure for NHS Shropshire, Telford and Wrekin (as described in the Constitution) is shown on the next page.

The organisation has reflected on its own effectiveness and performance as part the monthly assurance checkpoints undertaken by NHS England during 2022/23 and as part of the transition arrangements to the ICB. The outcomes of these reflections have been reported to the Board.

Governance Structure



UK Corporate Governance Code

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

Discharge of statutory functions

NHS Shropshire, Telford and Wrekin 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 organisation 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 the organisation's statutory duties.

Risk management arrangements and effectiveness

Corporate governance is the system by which the Board directs and controls the organisation at the most senior level, to achieve its objectives and meet the necessary standards of accountability and probity. Using a risk management mechanism, the Board brings together the various aspects of governance: corporate, clinical, financial, and information to provide assurance on its direction and control across the whole organisation in a coordinated way.

At the creation of ICBs in July 2022, NHS Shropshire, Telford and Wrekin adopted the risk management strategy of its predecessor CCG with a view to a revised risk management approach that would seek to identify and mitigate risk at a system level being developed during the first year of operation. This work has been taking place during this reporting period with a view to the Board adopting a revised approach for the next financial year 2023/24. The following information outlines the normal risk management practice NHS Shropshire, Telford and Wrekin has followed during 2022/23 and is based upon the inherited risk management strategy from the predecessor CCG.

NHS Shropshire, Telford and Wrekin received a level B assessment from its Internal Auditors which reflects that an Assurance Framework has been established but is not sufficiently complete to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks across all the main business activities. There were also two areas recommended by internal auditors for action which are being actioned in quarter 1 and 2 of 2023/24 financial year.

The coordinating body for receiving assurance on these strands of governance is the Audit Committee, which oversees integrated governance on behalf of the Board. In addition, the other committees also oversee the risks within their specific remits, providing assurance to the Audit Committee where appropriate.

NHS Shropshire, Telford and Wrekin prevents risk arising wherever possible by:

- applying policies and procedures for staff and contractors to follow;
- the Constitution and Governance Handbook;
- standing orders and standing financial instructions;
- the use of technical support external to the organisation (for example, legal, Information Governance and human resources advice); and
- internal audit.

The organisation also employs deterrents to risk arising (for example fraud and IT deterrents).

The system of risk control forms part of the organisation's system of internal control and is defined in the Integrated Risk Management Strategy, which is reviewed annually. The strategy defines the risk management responsibilities and common methodologies for the identification and assessment of risks for the whole organisation. It requires that risks are managed to a reasonable level, within the parameters of a defined risk appetite, rather than requiring the elimination of all risk of failure to achieve the organisation's objectives.

The risk control system facilitates the assessment of risk by:

- identifying and prioritising the risks to the achievement of the organisation's objectives
- evaluating the likelihood of those risks being realised and the impact should they be realised, and managing them efficiently, effectively and economically.

The Risk Management Strategy applies to all risks, whether these are financial, quality, performance, governance, etc.

The risk appetite was determined and approved by the Board and the strategy outlines the processes for maintaining and monitoring the Board Assurance Framework and the Directorate Risk Registers with due regard to this appetite.

Our risk appetite can be summarised as follows:

- we expect to fulfil our statutory and regulatory duties to maintain and improve quality and safety in our activities and those of the organisations we commission healthcare from
- to achieve this, we will maintain a lean and flexible governance and staffing structure, populated by people who think in a holistic, patient-focused way and with a keen sense of inventiveness
- we will accept risks graded as 'very low', avoid expenditure and use of resources on those graded 'low', manage in a cost-effective manner those graded moderate and enthusiastically seek to reduce those graded 'high'
- conversely, we will actively seek to implement actions to take opportunities graded 'high' and proportionately respond to those graded below this
- whilst we will ensure cost-effectiveness and a balanced budget, we seek quality and innovation towards best practice in patient-centred care.

Risk management is embedded in the activity of the organisation and can be demonstrated through:

- completion of equality impact assessments for reviewed or new policies
- incident and serious incident reporting is encouraged by the organisation and evident through the Ulysses reporting system
- Information Governance (IG), raising concerns and ensuring fraud awareness and training has been provided to senior managers and staff
- training for staff and Board members is mandated for particular areas: health and safety, IG, safeguarding, safer recruitment, fire safety, business continuity/emergency planning, Integrated Single Finance System (ISFE) and conflicts of interest
- intelligence gathering through quality and performance contracting processes with providers
- complaints and Patient Advice and Liaison Service (PALS) enquiries
- NHS-to-NHS concerns reporting via Ulysses
- national reviews, inspections and guidance.

Risks are identified, assessed and recorded in accordance with the Risk Management Strategy and Risk Assessment Code of Practice. The principal processes and the matrix described in these documents are applied to all risk registers, incident management and risk assessment activity across the organisations.

The following processes are used to identify risks:

- retrospectively following the occurrence of an adverse incident
- proactively to identify potential risks to service delivery
- during the development of new activities.

It is acknowledged that risks may be shared with other organisations that NHS Shropshire, Telford and Wrekin works with to jointly deliver services. Consequently, the BAF is discussed with risk management leads and reflects the identified strategic risks of these organisations where appropriate.

The following details are recorded for each recorded risk on a risk register:

- risk category/reference
- risk description
- existing controls/assurance
- risk grading with existing controls
- gaps in controls/assurance
- target risk grading
- actions to reduce the risk to an acceptable level
- amendments record.

Where necessary, actions include the identification of budgets and resources to facilitate their implementation. The organisation has given due regard to all national findings from quality reviews undertaken.

Our capacity to handle risk

Leadership is given to the risk management process by the Accountable Officer whose role is to own the System Board Assurance Framework (BAF). The BAF, which documents the principle risks to the system's objectives not being delivered, is underpinned by the Directorate Risk Register for the system and for the ICB as a corporate entity. This outlines the lower-level risks to each executive lead not meeting their specific remit objectives and, specifically, risks to the organisation not fully discharging primary care commissioning under its delegation from NHS England effectively. Each executive lead, or members of their respective teams, will inform the Directorate Risk Register. Both the Accountable Officer and directors are supported by the Director for Corporate Affairs. NHS Shropshire, Telford and Wrekin staff are provided with a risk assessment code of practice and receive support and training on risk management from the Director of Corporate Affairs where required.

A summary of the major risks identified in this interim BAF during 2022/23 is set out below, and the actions being taken to mitigate the risks. The major risks to the ICS and the organisation have been reviewed and revised bi-monthly where necessary.

Description of major risks added to the Board Assurance Framework during 2022/23	Existing controls	Further actions
1.System failure to deliver overall long-term financial sustainability.	Risk management framework in place across the system as part of development of system sustainability plan. System governance arrangements in place through Integrated Delivery Committee (IDC) and investment panel to ensure that new investments are not made unless recurrent resource is available.	1) A number of operational pressures are impacting on our system and the financial impact of these is manifesting in our expenditure run rate. We are working through a thorough review of anticipated spend and actions to mitigate costs for the rest of the year. (CS Oct 22) 2) Significant work underway across system to model long term plan. Modelling task and finish group assembled and reviewing system wide financial model. First cut of 23/24 plan to be completed by Dec 22, followed by full long term plan refresh. (JP Dec 22) 3) A full review of Diagnostic and Benchmarking activity has highlighted the potential for further programmes of work which will support the Financial Improvement Programme. IDC has requested immediate recovery of the position and COOs have been asked to set out the opportunities and approach to delivery by the end of Sept 22. (KO/ GR Sept 22) 4) IFP management group in place which reviews IFP arrangements including the risk management framework. This is a subcommittee of the Finance Committee. Timetable in place for review to conclude by end of December 2022 to inform the 23/24 contracting round (CS/LC Jan 23)
2. Quality and Safety Without a robust quality governance framework in place, the system will not be able to monitor quality and safety and mitigate risks in a timely manner. Patients may experience poorer outcomes and experience	1. Development of an ICS Quality and Safety Strategy, co-produced with system health and social care partners and patient representative groups. Approved by ICS Board June 2021. 2. Establishment of our ICS governance structure including Quality & Safety Committee (a sub-committee of the ICS Board) and System Quality Group (SQG) which provides quality surveillance and improvement. 3. STW LMNS function is developing to encompass the new responsibilities for PNQSG and ToR. The risk register has been revised in light of this requirement. 4. SaTH Safety Oversight and Assurance Group (SOAG) in place, co-chaired by NHSE/ICS lead and with system membership. 5. SI reporting in accordance with NHS SI Framework, monthly SI review meetings between commissioner/provider in place.	1. Further develop and embed the system-wide revised approach to quality governance during 2022/23, including quality governance at 'place'. Identify senior resource (DDoN) to lead this work. Q3 2. Continue to monitor quality risks and workforce plans at provider level through existing mechanisms including a presence at SaTH internal quality governance fora. (nb Workforce reported to ICS People Board which has agreed key priority areas for action). Ongoing 3. SaTH undertaking a programme of Quality Improvement Getting to Good Programme - reported

	6. Patient Safety Group in place with remit to ensure the NHS Patient Safety strategy is delivered across system. 7. System-wide IPC forum in place providing oversight and peer support. 8. Vaccination quality governance forum in place to oversee C-19 delivery programme. 9. ICB/ICS quality and safety monitoring and reporting arrangements will run in parallel during 2022/23. 10. The model for system governance is confirmed. 11. There as a programme for monthly quality assurance visits including for maternity MVP and LMNS representatives are included in the Maternity and Neonatal Safety Champion quality visits monthly. 12. SaTH real-time (unvalidated) data submissions to MBRRACE-UK accessible through specialist midwife and perinatal mortality tool. 13. All women now on badgernet platform. Medway system now read only (May 22). 14. Regional escalation tool in place for maternity closures (May 22) 15. Quality metrics agreed and included in System Quality metrics from June 22 for oversight.	monthly to SOAG for oversight & scrutiny. SOAG is co-chaired by ICS and NHSE/I directors. 4. Further develop the maternity metrics dashboard at LMNS level - developments made with LMNS dashboard working with SaTH and CSU to establish validated metrics. Data Quality position report received to LMNS board March 22, improvement expected by July 22. 5. Support to SaTH to further develop the content and accuracy of their internal maternity dashboard and improve exception reporting. 6. Continue to monitor Maternity service closure and impact, ensuring appropriate escalation process are followed in each occurrence. 7. Targeted quality improvement work relating to CYP MH in progress 8. Oversight of Safeguarding and LAC risks via system safeguarding assurance mechanisms. 9. Continue to monitor LAC standards (which are improving), supporting with revised referral processes. 10. Implement recommendations of CCG internal audit of Safeguarding Adult and Child processes. Oct 21 (June 22 completion) 11. Implement new statutory requirements for Liberty Protection Safeguards when national timelines and details are published. 12. System CYP MH Challenge event hosted jointly by SG partnership boards 13.06.22
3. Restoration of Services Post Covid-19 There is a risk that the restoration of health services following the Covid-19 pandemic will not keep pace with patient need resulting in patients suffering harm.	Demand and Capacity Modelling System Clinical prioritisation and approach to harm policy in place Development of digital and virtual capabilities Developing system infrastructure 2022/23 operational plan People Plan and workforce planning	1a) Elective Recovery trajectories set out in 2022/23 plan. Big 6 items outpatient transformation and MSK addressing elements of sustainability and transformation. 1b) Demand and capacity and performance monitoring ongoing to track progress and allow for early mitigation if deviation from plan is evident. 1c) Work ongoing on implementation of People Plan 2 &3) Ongoing dialogue with NHSE regarding equipment and estate
4.Population Health Needs There is a risk that the ICB fails to understand its population health needs and how this contributes to health inequalities across the footprint resulting in	Inequalities sits within the portfolio for Director of Planning and Partnerships and Population Health Management sits within the portfolio of the Director of Planning. JSNA work lead by Councils.	1) First phase review of capacity and capability completed. Analyst network in place to support sharing skills and expertise and supporting a system approach. 2 x PHM posts (joint with LAs) recruited to. Refresh of PH Strategy completed to ensure system BI capacity is wrapping around the correct priorities.

widening health inequalities.		Further mapping of progress of work programmes needed by end of May 22 2/3) PHM SRO within ICS structure but reporting lines and working group arrangements to be developed. Need for appropriate data sharing arrangements to be finalised to support this work by end of May 22. Further momentum needed in relation to digital developments. 4) 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 PHM SRO within ICS structure but reporting lines and working group arrangements to be developed 5) Funding requirement linked to output of the CSU Strategy Unit review
5. Risk of sustained UEC pressure There is a risk that demand for urgent and emergency care consistently outstrips capacity and that this will result in patients suffering harm.	Daily Silver Call Weekly Gold Call UEC Improvement Plan in place Significant cost pressure for WMAS already factored into 22/23 financial plan WMAS handover - quality issues - Alternative pathways in place using primary care and community services for assessment. The acute provider is undertaking harm assessments, ICB are included in terms of reference The Quality and Performance Committee received quality and performance data on which to gain knowledge and inform discussion. ICB Quality Team act on WMAS incidents to ensure lessons are learned and UEC leaders are aware to address performance to prevent repeat.	1a. Several improvement workstreams in place but capacity to deliver change has been limited due to the level of system pressure. There are signs that this is now beginning to ease. Learning from our current UEC improvement Plan and the approach to recent pressures has been consolidated and mapped into a refreshed UEC Improvement Plan which has been approved by the UEC Board. 1b. Work to finalise sub-work programmes to be completed by the end of May 22 Significant collaboration between partner agencies, including our LAs in addressing current pressures has show benefits 1c. Winter Comms plan in place, Winter Plan and specific winter schemes in place. Winter scheme evaluation to be completed by end of May 22 to inform planning for winter 22/23 which will commence in June 22 1d. CG UEC staffing resource structure developed and aged. Recruitment to commence in May 22 Specific development in place regarding discharge and attendance avoidance 2. WMAS handover costs will be monitored closely through regular communication with WMAS and lead commissioner contracting and finance teams 3.a. Monitor WMAS Serious incidents for themes monthly at system quality group - July 22 3b. ICB Quality Team monitor the timeliness of incident investigation to ensure immediate and longer-term actions are addressed in a timely way and learning is maximised. The SOP is updated and to be published – June 22 3c. Systems to monitor patient and family feedback in relation to ambulance delays are to be established - July 22

6. Net Zero Risk that the system does not comply with the NHS Net Zero commitment by 2030	NHS STW Greener Plan approved April 2022 Plan Workstream leads identified	1. Executive Director to agree and direct reporting lines 2. Lack of capacity and dedicated leadership raised with Executive Director for consideration
7.Governance Risk that the ICB and system fail to develop and sustain governance processes to support robust and transparent decision making	ICB Board ICB committees ICB sub committees Audit Committee ICB Constitution and Governance Handbook	1) Mapping work is continuing. Lack of capacity in ICB Corporate Affairs team resulting in slow progress. ICB looking at other sources of capacity to supplement this work. Linked to NOF 4 exit criteria 2) System discussions are taking place. NHSE launching Partnership Governance self-assessment Late April/early May 2023 with a view to the Chair and NHSE Regional Director agreeing areas of assessment and timelines. Linked to NOF 4 exit criteria
8. ICS Workforce There is a risk that the ICS will be unable to provide the workforce to deliver clinical and non-clinical services due to inability to recruit, retain, keep well and effectively deploy a workforce with the necessary skills & expertise that meet service requirements - resulting in a failure to deliver services.	Monthly workforce information dashboards to consider workforce information (sickness, turnover, vacancies, staff in post, Agency and bank usage etc) Annual operational workforce planning process to set direction of travel for next 12 months	1) Work to develop One People Strategy for all system employers is underway - to enable identification of key and agreed areas of priority for action 2) Work on the NHS E Operational Workforce Plan is in progress, enabling a more detailed and shared understanding of our system NHS workforce issues and building the case for collaborative cross-employer working to maximise our workforce availability. 3) The System people Team is bringing more robust project and programme management approaches to key portfolios and workstreams, enabling greater transparency and driving delivery. 4) System People Team actively exploring additional ways to resource prioritised programmes and facilitate delivery. 5) System People Team creating closer links with AHP Council, Pharmacy Faculty, Nursing Council and Primary Care teams to build consistency of approach and greater impact of interventions. 6) System People Team driving new ways of working, collaboration, system first approaches to do things differently for our workforce and patients.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place to ensure the organisation 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. There is appropriate monitoring of risks and the courses of action being employed to mitigate them.

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

Our Risk Management Strategy defines our commitment to ensuring that the organisation 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:

- risk management
- Constitution
- security management
- Counter Fraud Annual Plan
- Internal Audit Annual Plan
- performance monitoring of ICS providers and the organisation itself
- Data Security and Protection 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 the Board and its committees/sub-committees
- adult and children's safeguarding annual reports
- emergency and business continuity planning/core standards
- external regulator reports on providers.

Annual audit of conflicts of interest management

The organisation has a Conflicts of Interest Policy which governs the process for employees, Board members, Committee members, contractors and others undertaking functions on behalf of the organisation to declare their interests where these may conflict with those of NHS Shropshire, Telford and Wrekin. The Policy outlines a process for individuals both employed by the organisation or those not employed but acting on behalf of the organisation, to declare these interests to ensure that decisions made on behalf of NHS Shropshire, Telford and Wrekin are not compromised. The policy and registers can be found on the website: Conflicts of Interest - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest

management. To support ICBs to undertake this task, NHS England has published a template audit framework.

The organisation has carried out its annual internal audit of conflicts of interest at the end of 2022/23 and the audit provided moderate assurance, with some recommendations for further action. All recommendations have been fully accepted by the organisation and recommendations are being actioned in quarter one of 2023/24. Register of interests have been updated for Committees and Place based partnership meetings and training is being rolled out to key decision makers in the organisation.

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

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 organisation also uses NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) for provider information performance, quality and finance and therefore the organisation's contract with MLCSU outlines information reporting expectations. The data sources used by MLCSU is the national UNIFY system and Secondary Uses Service (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, particularly personal identifiable information. The framework is supported by a Data Security and Protection Toolkit (DSPT) and the annual submission process provides assurances to the organisation, other organisations and individuals that personal information is dealt with legally, securely, efficiently and effectively. The Data Security and Protection Toolkit submission is not due until 30th June 2023 and therefore final compliance cannot be reported in this annual report.

The organisation places high importance on ensuring there are robust information governance (IG) 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 DSPT. 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 the investigation of serious incidents. We have reported a total of 11 incidents during the period 1st July 2022 to 31st March 2023 and 10 of these incidents were graded as non-reportable – very low risk, with 1 reportable to the Information Commissioner's Office (ICO). We have developed an information asset register which enables the organisation to identify high-risk assets

through data flow mapping, and this ensures that an information risk culture is embedded throughout the organisation.

NHS Shropshire, Telford and Wrekin receives an Information Governance service from MLCSU. This enables us to receive a full, specialised service, which as a small organisation we could not reproduce in-house.

A work programme has been undertaken by MLCSU to ensure that the organisation is compliant against General Data Protection Regulations. As part of this, our information has been audited and staff training has been delivered.

Business-critical models

The organisation relies on centrally provided NHS business planning models to help it plan future strategy. NHS Shropshire, Telford and Wrekin has no business-critical models that it would be required to share with the Analytical Oversight Committee.

Third-party assurances

Third-party assurances are received annually from MLCSU for particular financial functions that 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 ICB's internal auditor, who includes a precis of the findings in the Head of Internal Audit Opinion, which is part of this statement.

Raising concerns – freedom to speak up

NHS Shropshire, Telford and Wrekin has a policy in place to support staff to raise concerns (sometimes referred to as 'whistleblowing'). There have been no concerns raised by staff to designated officers for investigation during the period 1st July 2022 – 31st March 2023. However five members of staff have raised concerns directly with the Freedom to Speak Up Guardian during the period, 4 of these members of staff chose to subsequently raise the concern with their line manager and the fifth chose not to take any further action. The organisation has appointed a Speak Up Guardian at Board level to support staff to raise concerns under the policy moving forward.

The Audit Committee gets an annual report on any concerns raised and action taken, protecting anonymity where required.

Control issues

The significant control issues that the organisation has been managing during the period 1st July 2022 to 31st March 2023 that would require reporting in this Annual Governance Statement are as follows:

1. Financial deficit

The 22/23 financial outturn reported position is a significant deficit for both the ICB itself and the Shropshire, Telford and Wrekin wider healthcare system. The system is part of the National Recovery Support Programme – Level 4 of the NHS England and NHS Improvement (NHSEI) System Oversight Framework. The system and ICB is therefore subject to significant scrutiny around finances and financial decisions, with a specific requirement to develop an approach to recovering a deteriorating financial position. A long term system transformation programme is under development which will underpin a system wide financial recovery plan and strategy.

2. Quality issues at local providers

The system continues to be below performance targets on most national criteria. The actions being taken to improve performance by providers and system partners are tracked through both their internal governance and through the respective system programme operational delivery or partnership boards as appropriate. Incidents arising from harm reviews and the assurance of the related processes are taken through the System Quality Group. This comes together with detailed assurance reports to be presented at the ICB's Quality and Performance Committee. This reports directly to the ICB Board.

Shrewsbury and Telford Hospitals NHS Trust (SATH) remains the most challenged provider and remain a cause for concern within the STW healthcare system. The ICB continues to work with the SaTH to manage significant performance and quality issues in year based on activity, patient feedback and quality themes & trends. The most significant issues are captured in the ICB Quality & Performance Risk Register, which forms the basis of monthly committee meetings. Our providers and the ICB maintain positive engagement with the CQC including the intelligence and information sharing.

3. Urgent and emergency care

The performance over winter has been very challenging across the system. STW, as the rest of the NHS, experienced extreme pressure across the system over the festive period. This led to large numbers of ambulance handover delays and high levels of patients waiting for beds (DTAs, Decision to Admit). This resulted in patients being cared for in sub-optimal settings.

However, a series of actions have taken place since November 2022 which when combined with lower levels of demand have allowed the system to be in significantly improved position in the care of our patients. These are:

- System Winter Flow Summit convened to provide oversight and focus for all organisations to daily responses, this has led to several key actions being agreed with associated impact which is being tracked via weekly winter flow dashboard
- Deployment of a system control centre to drive and oversee the system response
- Opened 26 additional beds through the acute floor reconfiguration
- Dedicated Ambulance Receiving Areas have been opened at RSH and PRH

- A Multi-Agency Discharge Event (MADE), involving Shropshire Community Trust and both LAs took place in December. Another MADE is being held in February.
- Use of additional social care discharge fund to increase complex discharges from approx. 15 per day to >25 per
- Increase in virtual ward capacity from 30–50 patients per day
- Single Point of Access increasing attendance avoidance from 6 to 25 per day.

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

The Finance Committee, Integrated Delivery Committee and Quality and Performance Committee give detailed consideration to the organisation's financial and performance issues to provide the 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 organisation's medium-term financial strategy and scrutiny of monthly financial reporting, including delivery of transformation schemes through the system Investment Panel, performance against central management costs and efficiency controls.

These committees report to the Board via a chair's exception report at each meeting. In addition, the Board receives summary financial, quality and performance reporting at each meeting.

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

Delegation of functions

NHS Shropshire, Telford and Wrekin 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 Accountable Officer, directors, Board 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 organisation, 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 Board for approval. The organisation remains accountable for all its functions – including those that it has delegated.

External audit fees, work and independence

The ICB's external auditors are Grant Thornton UK LLP, Colmore Plaza, 20, Colmore Circus, Birmingham, B4 6AT. The contract value was £100.8k excluding VAT. The contract included the core audit work of the financial statements and work on the economy, efficiency and effectiveness in the ICB's use of resources (Value for Money).

Counter fraud arrangements

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

The Government's Functional Standard (Govs13: Counter Fraud) was launched in October 2018 and is being implemented across all government departments and arms-length bodies, including the NHS who moved to adopt the new standards in 2021. The ICB Audit Committee receives a regular report from the LCFS which details activities undertaken against each of the Standards, and the LCFS produces an annual report detailing the year's activities. There is executive support and direction for a proportionate proactive work plan to raise awareness of the zero tolerance to fraud and to address identified risks.

The Chief Finance Officer, who is a member of the ICB 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. In addition, the LCFS role is further supported by a nominated Counter Fraud Champion who provides a senior voice within the organisation to champion the counter fraud agenda, and to enable and support the counter fraud programme of work.

Head of Internal Audit Opinion

The purpose of my annual HOIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board 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. This is an opinion on a developing organisation.
2. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes
3. 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.
4. Any reliance that is being placed upon third party assurances.

The Assurance Framework

I have reviewed the overall arrangements the Board has in place to conduct its review of the system of internal control. This has entailed reviewing the way in which the Board 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 Board, which informs the Board's assessment of the effectiveness of the organisation's system of internal control. I have taken a holistic approach to my assessment, reflecting on the development work done and the evolving nature of the organisation. I provided a 'Level B' year-end assessment for ICB Assurance Framework arrangements in the wider sense. I noted that positive steps have been taken to develop a system wide risk management framework. An approved and complete Board Assurance Framework (BAF) was not fully in place before the 31st March 2023. A draft ICB/ System BAF has been developed supported by a risk appetite methodology and Risk Management Policy. The ICB's intention is for updated its BAF to be taken to the next Board following agreement of risks within Directorate Risk Register by the relevant committees. We were advised that relevant risks were reported to Quality and Safety Committee and the Finance and Performance Committee during the year. There is plan for all corporate risks to be taken through the next committee rounds.

It is my view that an Assurance Framework has been established but is not yet sufficiently complete to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks across all the main business activities. This has been reflected in my overall moderate assurance Opinion.

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. An internal audit

plan 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:

Significant assurance

- Payroll, Debtors, Accounts Payable
- Better Care Fund
- Financial Ledger

Moderate assurance

- Conflicts of Interest Management

Other

- Adult and Children Safeguarding Follow Up report (DRAFT) improvements noted
- Financial Sustainability
- DSPT actions to complete the assessment before 30th June were noted
- Board Assurance Framework Level "B"

Other - Financial Position

The full year reported forecast outturn (FOT) as at month 10 is a deficit of £21.8m which is £24.0m adverse against the plan. The FOT was adjusted at M10 in line with the NHSE forecast change protocol. As at month 10 the ICB are reporting that of the £19m planned system deficit, the ICB planned deficit is £11.7m, or a £2.2m surplus once the £13.9m of system target savings is included. They have highlighted that due to the phasing of the plan, the ICB has a year to date (YTD) deficit plan at M10 of £1.4m. At M10 the ICB has a £17.2m adverse variance to that plan and is therefore showing a £18.6m deficit. The adverse variance YTD is broken down into £7.9m for the ICB position and £9.3m for the undelivered system stretch efficiency target.

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 are 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 assurance report.

Work in relation to the Single Primary Care Estates & Workforce Strategy is in progress and this action was carried forward from the CCG.

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 in the system despite previous actions taken for example in relation to system affordability and quality.

Reliance on third party assurances

In arriving at my overall opinion, I have sought to place reliance on third party assurances where appropriate. This is the case with services provided by the Midlands & Lancashire CSU. The third-party Type II service auditor CSU report for the period 1 April 2022 to 31st March 2023 did not identify any issues to highlight.

There are a number of significant and persistent quality challenges. These challenges have included amongst others Urgent and Emergency Care performance, RTT, Cancer waiting times and lack of staff in key areas at the main provider. In November 2021 CQC published their latest report on Shrewsbury and Telford Hospital NHS Trust (SaTH). The "inadequate rating" was assessed as remaining in place. The Final Ockenden Report (Independent Review of Maternity Services at SaTH) has been issued, which highlighted serious and persistent failings with maternity services with tragic impacts on patient care and outcomes. The report stated that "Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures this message was lost in a wider healthcare system which was struggling with other significant concerns". The report included Immediate and Essential Actions. The CCG had established a quality governance structure together with SaTH for the monitoring of Ockenden actions. The handover of this oversight and in particular staffing – continuity of carer and organisational culture were highlighted in the transition arrangements to the ICB. We also note that operationally the system is also struggling to cope with demand peaks.

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 ICB 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 ICB achieving its principle 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 reviews/assurance mechanisms.

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 the period to 31st March 2023 coupled with those posed by the continued need to respond to the COVID-19 pandemic.

However, during the year, 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 ICB staff to make the required improvements. Despite this progress, significant issues still remain and Shropshire, Telford and Wrekin ICB 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 continue to enhance and build on these foundations in order to ensure a robust internal system of control within the new Integrated Care Board (ICB) in 2023/24.

Conclusion

In conclusion, my review of the effectiveness of governance, risk management and internal control and the Head of Internal Audit Opinion have confirmed that the ICB maintains a generally sound system of internal control designed to meet the organisation's objectives, and controls are generally being applied consistently. Accepting the control issues identified above, and the actions that are being taken to address these and the results of the internal audit reviews undertaken during the year, I am confident that the organisation has appropriate mechanisms in place to deliver good governance.

Simon Whitehouse

Accountable Officer
29th June 2023

Remuneration and Staff Report

Remuneration Committee

The Remuneration Committee was established by NHS Shropshire, Telford and Wrekin 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 ICB Board.

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

Percentage change in remuneration of highest paid director - AUDITED

Nine months to 31st March 2023 2022-23	Salary & Allowances	Performance Pay & Bonuses
Highest Paid Director: % change from three months to 30th June 22	-2.67%	N/A
All Staff: % change from three months to 30th June 22	-1.56%	N/A

The decrease in the highest paid director salary reflects the appointment of a new Interim Chief Executive Officer for the ICB.

The decrease in all staff reflects the recruitment to several lower banded posts which were previously vacant and covered by interim staff.

As at 31st March 2023, remuneration ranged from £17k to £180k based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff).

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

Pay ratio information - AUDITED

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

	25th percentile	Median	75th percentile
'All staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£23,949	£37,506	£54,619
Salary component of 'all staff' remuneration based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff)	£23,949	£37,506	£54,619

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

The banded remuneration of the highest paid director/member in Shropshire, Telford and Wrekin ICB in the nine month period to 31st March 2023 was £180k to £185k and the relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile total remuneration ratio	25th percentile Salary ratio	Median total remuneration ratio	Median total remuneration ratio	75th percentile total remuneration ratio	75th percentile salary ratio
Nine months to 31st March 2023	7.6	7.6	4.9	4.9	3.3	3.3

In the nine month period to 31st March 2023 no employees received remuneration in excess of the highest-paid director/member.

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

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 the Remuneration Committee, with reference to recognised national NHS pay scales and benchmarking with other ICBs. 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. Midlands and Lancashire Commissioning Support Unit (MLCSU) provide independent advice and support to the ICB and the Remuneration Committee in relation to employment and remuneration matters.

These tables are subject to audit by our external auditor.

Senior manager remuneration (including salary and pension entitlements) - AUDITED

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)	Full Year Equivalent Salary £
Bussey *	Alison	Chief Nursing Officer	01/07/22 to	110-115	-	-	-	0-2.5	110-115	149,450
Chan	Ian	Partner Member for Primary Care/Clinical Lead	01/07/22 to	50-55	-	-	-	257.5-260	305-310	69,208
Dunshea *	Roger	Non Executive Director	01/07/22 to	5-10	-	-	-	-	5-10	13,000
Dymond	Nicola	Executive Director of Strategy & Integration	01/07/22 to	105-110	-	-	-	557.5-560	665-670	145,000
McKay *	Neil	Chair and GP/Healthcare Professional	01/07/22 to	45-50	-	-	-	-	45-50	65,000
McMillan *	Trevor	Non Executive Director	01/07/22 to	5-10	-	-	-	-	5-10	13,000
Pall *	Navnit	Non Executive Director	01/07/22 to	5-10	-	-	-	-	5-10	13,000
Povey *	Julian	Partner Member for Primary Care	01/07/22 to	10-15				-	10-15	15,208
Robinson	Gareth	Executive Director of Delivery & Transformation	01/07/22 to	110-115	-	-	-	35-37.5	145-150	147,000
Skidmore	Claire	Chief Finance Officer & Deputy Chief Executive Officer	01/07/22 to	115-120	-	-	-	100-102.5	220-225	157,583
Vivian *	Meredith	Deputy Chair, Lay Member for Patient & Public Involvement	01/07/22 to	5-10	-	-	-	-	5-10	13,000
White	Nicholas	Medical Director	01/07/22 to	95-100	-	-	-	157.5-160	255-260	132,222
Whitehouse	Simon	Chief Executive Officer	01/07/22 to	135-140	-	-	-	230-232.5	365-370	180,249

Pension benefits

Please note that the cash equivalent transfer value was calculated by the NHS Pensions Agency.

Pension entitlements of senior managers in the nine months to 31st March 2023 – Shropshire, Telford and Wrekin ICB - AUDITED

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 31st March 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31st March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31st March 2023 £'000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Bussey	Alison	Chief Nursing Officer	0-2.5	0-2.5	0-5	0-5	0	1	0	0
Chan	Ian	Partner Member for Primary Care/Clinical Lead	12.5-15	0-2.5	10-15	0-5	39	155	155	0
Dymond	Nicola	Executive Director of Strategy & Integration	25-27.5	67.5-70	25-30	65-70	137	534	549	0
Robinson	Gareth	Executive Director of Delivery & Transformation	0--2.5	0-2.5	10-15	10-15	132	12	160	0
Skidmore	Claire	Chief Finance Officer & Deputy Chief Executive Officer	5-7.5	7.5-10	55-60	110-115	754	75	863	0
White	Nicholas	Medical Director	5-7.5	10-12.5	50-55	95-100	747	111	877	0
Whitehouse	Simon	Chief Executive Officer	10-12.5	22.5-25	65-70	130-135	983	203	1,170	0

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

Shropshire, Telford and Wrekin ICB does not have any to report during the nine month period to 31st March 2023.

Payments to past directors - AUDITED

In the nine months to 31st March 2023 Shropshire, Telford and Wrekin ICB made one payment to a Director following approval by the Remuneration Committee. The payment reflected the ICB's contractual obligation to payment in lieu of notice and outstanding annual leave. The total payment was £83k. This does not fall within the definition of a Special Payment and does not require Treasury approval. NHSE were made aware of the approved payment.

Staff Report

Staff numbers and costs

Employee benefits - nine months to 31st March 2023

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	9,581	2,058	**11,639**
Social security costs	928	-	**928**
Employer Contributions to NHS Pension scheme	1,417	-	**1,417**
Other pension costs	-	-	**-**
Apprenticeship Levy	28	-	**28**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	-	**-**	**-**
Gross employee benefits expenditure	11,954	2,058	14,012
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	11,954	2,058	14,012
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	11,954	2,058	14,012

The above table has been audited.

There are no Covid-19 related costs included in the above.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. This has continued for the ICB in 2022/23. 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 4.4

Staff Analysis by Gender

	Headcount by Gender				% by Gender		
Staff Grouping	**Female**	**Male**	**Unknown***	**Totals**	**Female**	**Male**	**Unknown***
Governing Body	3	9	6	**18**	16.7%	50.0%	33.3%
Other Senior Management (Band 8C+)	26	5	0	**31**	83.9%	16.1%	0.0%
All Other Employees	194	43	0	**237**	81.9%	18.1%	0.0%
Grand Total	**223**	**57**	**6**	**286**	**77.97%**	**19.93%**	**2.10%**

*Gov Body (off payroll) pertains to Governing Body Members without a pay record in the ICB Electronic Staff Record (ESR) system. This applies to all tables hereafter.

Named Individuals categorised as Unknown are :-

Andy Begley
David Sidaway
Louise Barnett
Neil Carr
Patricia Davies
Stacey Keegan

Senior Staff Analysis by Band

Pay Band	Headcount
Apprentice	0
Band 1	0
Band 2	1
Band 3	63
Band 4	27
Band 5	21
Band 6	41
Band 7	33
Band 8 - Range A	34
Band 8 - Range B	17
Band 8 - Range C	7
Band 8 - Range D	6
Band 9	3
Medical	12
VSM	15
Gov Body (off payroll)	6
Grand Total	**286**

Staff Sickness Absence

Staff sickness absence 2022	2022 Number
Total Days Lost	2960.90
Total Staff Years	230.81
Average Working Days Lost	12.83

The sickness absence data for the ICB in 2022 was whole time equivalent (WTE) days available of 51932.97 and WTE days lost to sickness absence of 2960.9 and average working days lost per employee was 12.83 which was managed through the absence management policy.

Staff Turnover

ICB Staff Turnover 2022-23	2022-23 Number
Average FTE Employed 2022-23	235.13
Total FTE Leavers 2022-23	37.10
Turnover Rate	15.78%

The ICB Staff Turnover Rate for 2022-23 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The ICB's Total FTE Leavers in year was 37.1. The ICB's Average FTE Staff in Post during the year was 235.13. The ICB Staff Turnover Rate for the year was 15.78%

Expenditure on consultancy

The ICB spent £296,171 on consultancy services in the nine months to 31st March 2023. The majority of this spend related to payments to a consultancy firm for transforming care projects and performance improvement.

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, ICBs must publish information on their highly paid and/or senior off-payroll engagements. The tables below show the existing arrangements as of 31 March 2023.

For all off-payroll engagements as of 31st March 2023, paying more than £245* per day, lasting longer than six months and are new

For all off-payroll engagements agreed in the nine months to 31st March, for more than £245 per day:

	Number
Number of existing engagements as of 31st March 2023	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

*The £245 threshold is set to approximate the minimum point of the pay scale for a senior civil servant.

Shropshire, Telford and Wrekin ICB 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.

For all off-payroll engagements as at 31st March 2023 for more than £245* per day

For all off-payroll engagements between 1st July 2022 and 31st March 2023, for more than £245 per

	Number
Number of temporary off-payroll workers engaged between 1st July 2022 and 31st March 2023	0
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	
Of which: no. of engagements that saw a change to IR35 status following review	0

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

Off-payroll engagements and senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between 1st July 2022 and 31st March 2023

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1st July 2022 and 31st March 2023

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements	13

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages agreed in the Financial Period - AUDITED

Exit packages agreed in the nine months to 31st March 2023

Exit packages agreed in the financial period	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	1	82,367	1	82,367
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	2	320,000	-	-	2	320,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**320,000**	**1**	**82,367**	**3**	**402,367**

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook.

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

Redundancy and other departure costs have been paid in accordance with the provisions of NHSE guidance. Exit costs in this note are accounted for in full in the year of departure. Where the Shropshire, Telford & Wrekin ICB has agreed early retirements, the additional costs are met by the Shropshire, Telford & Wrekin ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**1**	**82**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval**	**0**	**0**
TOTAL	**1**	**82**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4 which will be the number of individuals.

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

**includes any non-contractual severance payment made following judicial mediation, and relating to non-contractual payments in lieu of notice.

There have been no non-contractual payments made to individuals where the payment value was more than 12 months’ of their annual salary.

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

Other employee matters

The ICB 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 the 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 ICB requires all 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, ICB staff briefings and staff newsletters.

The ICB has a recruitment policy which is based on NHS best practice. We use the recruitment service of MLCSU 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. We have a Training and Development Policy which seeks to ensure that all staff have equal opportunity and access to training and

development required by their role 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 ICB'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 ICBs's mandatory equality and diversity training includes awareness of a range of issues impacting people with disabilities.

Trade union facility time

For the period 1st July 2022 to 31st March 2023, we had no Trade Union officials within NHS Shropshire, Telford and Wrekin.

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 spent on facility 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 spent on facility time	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

Health and safety

The ICB takes the 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. These are then investigated, and action taken to help mitigate incidents reoccurring.

There were no health and safety incidents reported in the reporting period of 1st July 2022 to 31st March 2023.

Parliamentary Accountability and Audit Report

The ICB 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 15 and note 24.

An audit certificate and report is also included in this Annual Report at page 177.

ANNUAL ACCOUNTS

Please find a full copy of our annual accounts appended following this page.

Simon Whitehouse

Accountable Officer

29th June 2023

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the Nine month period ended 31 March 2023

	Note	Nine month Period ended 31st March 2023 £'000
Income from sale of goods and services	2	(14)
Other operating income	2	(360)
Total operating income		**(374)**
Staff costs	4	14,012
Purchase of goods and services	5	780,011
Depreciation and impairment charges	5	214
Provision expense	5	975
Other Operating Expenditure	5	215
Total operating expenditure		**795,426**
Net Operating Expenditure		**795,053**
Finance income		-
Finance expense	7	7
Net expenditure for the Year		**795,060**
Net (Gain)/Loss on Transfer by Absorption		-
Total Net Expenditure for the Financial Year		**795,060**
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 right-of-use assets		-
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		-
Total other comprehensive net expenditure		**-**
Comprehensive Expenditure for the year		**795,060**

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £'000	1st July 2022 £'000
Non-current assets:			
Property, plant and equipment	9	-	-
Right-of-use assets	10	1,159	1,044
Intangible assets		-	-
Investment property		-	-
Trade and other receivables	11	-	-
Other financial assets		-	-
Total non-current assets		**1,159**	1,044
Current assets:			
Inventories		-	-
Trade and other receivables	11	8,156	2,910
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	12	286	104
Total current assets		**8,443**	**3,014**
Non-current assets held for sale		-	-
Total current assets		**8,443**	3,014
Total assets		**9,601**	4,059
Current liabilities			
Trade and other payables	13	(61,002)	(61,172)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	10.2	(913)	(1,046)
Borrowings		-	-
Provisions	14	(3,444)	(2,219)
Total current liabilities		**(65,359)**	(64,437)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(55,758)**	(60,378)
Total non-current liabilities		**-**	**-**
Assets less Liabilities		**(55,758)**	(60,378)
Financed by Taxpayers' Equity			
General fund		(55,758)	(60,378)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(55,758)**	(60,378)

The notes on pages 6 to 30 form part of this statement

The financial statements on pages 2 to 30 were approved by the Board on 28th June 2023 and signed on its behalf by:

Simon Whitehouse
Accountable Officer

Statement of Changes In Taxpayers Equity for the Nine month period ended 31 March 2023

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for Nine month Period ended 31st March 2023				
Balance at 01 July 2022	-	-	-	-
Transfers by modified absorption to (from) other NHS bodies	(60,378)	-	-	(60,378)
Adjusted balance at 01 July 2022	**(60,378)**	**-**	**-**	**(60,378)**
Changes in ICB taxpayers' equity for Nine month Period ended 31st March 2023				
Net operating expenditure for the financial year	(795,060)			**(795,060)**
Net Recognised ICB Expenditure for the Financial year	**(795,060)**	**-**	**-**	**(795,060)**
Net funding	799,680	-	-	**799,680**
Balance at 31 March 2023	**(55,758)**	**-**	**-**	**(55,758)**

The notes on pages 6 to 30 form part of this statement

Statement of Cash Flows for the Nine month period ended 31 March 2023

	Note	Nine month Period ended 31st March 2023 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(795,060)
Depreciation and amortisation	5	214
Non-cash movements arising on application of new accounting standards		(250)
Interest paid		7
(Increase)/decrease in trade & other receivables	11	(8,156)
Increase/(decrease) in trade & other payables	13	61,002
Increase/(decrease) in provisions	14	1,225
Net Cash Inflow (Outflow) from Operating Activities		**(741,018)**
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		**(741,018)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		799,680
Other loans received		-
Other loans repaid		-
Repayment of lease liabilities		(218)
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		(1)
Net Cash Inflow (Outflow) from Financing Activities		**799,460**
Net Increase (Decrease) in Cash & Cash Equivalents		**58,442**
Cash & Cash Equivalents at the Beginning of the Financial Period		**-**
Movement due to transfer by Modified Absorption		(58,156)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Period	12	**286**

The notes on pages 6 to 30 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBS) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, 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 ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

The accounts are prepared for a nine month period to 31st March 2023 following the transfer of assets into the ICB on 1st July 2022. There are no prior year comparatives due to the ICB being a new organisation.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

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

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

When the clinical commissioning groups ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

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

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

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of modified absorption accounting. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Where assets and liabilities transfer under modified absorption accounting, the gain or loss resulting is recognised in Reserves.

1.4 **Pooled Budgets**

The ICB has entered into a pooled budget arrangement with Telford and Wrekin Local Authority [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for Better Care Fund (BCF), and the Transforming Care Programme (TCP). The TCP pool is hosted by the Local Authority and the BCF pool is jointly hosted.

The ICB has also entered into a pooled budget arrangement with Shropshire Council under a Section 75 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.
The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of these pooled budgets, identified in accordance with the pooled budget agreements. Note 18 to the accounts provides details of the income and expenditure for these arrangements.

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 ICB.

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

Notes to the financial statements continued

1.7 **Employee Benefits continued**

1.7.2 **Retirement Benefit Costs**

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

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 ICB 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**

1.9.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.9.2 **Measurement**

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.9.3 **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 ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB 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 ICB 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.

Notes to the financial statements continued

1.10 **Leases**

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

1.10.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

Notes to the financial statements continued

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 ICB's cash management.

1.12 **Provisions**

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

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 3.27% for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 3.51% for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 3.00% 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 ICB 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 ICB 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 ICB.

1.14 **Non-clinical Risk Pooling**

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

1.16 **Financial Assets**

Financial assets are recognised when the ICB 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.

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

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

1.16.4 **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 ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB 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 ICB 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 ICB 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 ICB 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.

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 ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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.

Notes to the financial statements continued

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

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 ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Critical accounting judgements in applying accounting policies and key sources of estimation uncertainty**
In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed and the only items worthy of note are disclosed below.

1.20.1 **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.

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 ICB'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 ICB 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 are two months in arrears. 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 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted.

2 Other Operating Revenue

	Nine month Period ended 31st March 2023 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	14
Recoveries in respect of employee benefits	-
Total Income from sale of goods and services	14
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	360
Total Other operating income	360
Total Operating Income	374

3 Contract Revenue

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

	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue						
NHS	-	-	-	-	-	-
Non NHS	-	-	-	-	14	-
Total	-	-	-	-	14	-

	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue						
Point in time	-	-	-	-	14	-
Over time	-	-	-	-	-	-
Total	-	-	-	-	14	-

3.2 Transaction price to remaining contract performance obligations

The ICB did not have any contract revenue in the nine month period to 31st March 2023 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1 Employee benefits	Total Permanent Employees £'000	Other £'000	Nine month Period ended 31st March 2023 Total £'000
Employee Benefits			
Salaries and wages	9,580	2,058	**11,638**
Social security costs	928	-	**928**
Employer Contributions to NHS Pension scheme	1,417	-	**1,417**
Other pension costs	-	-	**-**
Apprenticeship Levy	28	-	**28**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	(0)	-	**(0)**
Gross employee benefits expenditure	**11,954**	**2,058**	**14,012**
Less recoveries in respect of employee benefits (note 4.1.1)	-	-	**-**
Total - Net admin employee benefits including capitalised costs	**11,954**	**2,058**	**14,012**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**11,954**	**2,058**	**14,012**

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. This has continued for the ICB in 2022/23. 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 4.4

4.1.1 Recoveries in respect of employee benefits

The ICB has made no recoveries in respect of employee benefits in the nine month period to 31st March 2023.

4.2 Average number of people employed

	Nine month Period ended 31st March 2023		
	Permanently employed Number	Other Number	Total Number
Total	**235.13**	**35.00**	**270.13**
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	Nine month Period ended 31st March 2023 Compulsory redundancies		Nine month Period ended 31st March 2023 Other agreed departures		Nine month Period ended 31st March 2023 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	1	82,367	1	82,367
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	2	320,000	-	-	2	320,000
Over £200,001	-	-	-	-	-	-
Total	**2**	**320,000**	**1**	**82,367**	**3**	**402,367**

	Nine month Period ended 31st March 2023 Departures where special payments have been made	
	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	**-**	**-**

Analysis of Other Agreed Departures

	Nine month Period ended 31st March 2023 Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	1	82,367
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	**1**	**82,367**

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
Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms & Conditions of Service Handbook.
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.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	Nine month Period ended 31st March 2023 Admin £'000	Nine month Period ended 31st March 2023 Programme £'000	Nine month Period ended 31st March 2023 Total £'000
Purchase of goods and services			
Services from other ICBs, CCGs and NHS England	1,724	3,514	5,239
Services from foundation trusts	-	124,713	124,713
Services from other NHS trusts	-	371,037	371,037
Provider Sustainability Fund	-	-	-
Services from Other WGA bodies	-	-	-
Purchase of healthcare from non-NHS bodies	-	116,569	116,569
Purchase of social care	-	-	-
General Dental services and personal dental services	-	-	-
Prescribing costs	-	72,349	72,349
Pharmaceutical services	-	-	-
General Ophthalmic services	-	655	655
GPMS/APMS and PCTMS	-	69,358	69,358
Supplies and services – clinical	-	1,349	1,349
Supplies and services – general	(814)	13,708	12,894
Consultancy services	192	104	296
Establishment	493	2,091	2,584
Transport	1	240	240
Premises	(51)	468	417
Audit fees	128	-	128
Other non statutory audit expenditure	-	-	-
· Internal audit services	-	-	-
· Other services	-	18	18
Other professional fees	88	1,270	1,358
Legal fees	93	-	93
Education, training and conferences	(73)	785	712
Funding to group bodies	-	-	-
CHC Risk Pool contributions	-	-	-
Non cash apprenticeship training grants	-	-	-
Total Purchase of goods and services	**1,781**	**778,230**	**780,011**
Depreciation and impairment charges			
Depreciation	112	103	214
Amortisation	-	-	-
Impairments and reversals of property, plant and equipment	-	-	-
Impairments and reversals of right-of-use assets	-	-	-
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	**112**	**103**	**214**
Provision expense			
Change in discount rate	-	-	-
Provisions	(555)	1,529	975
Total Provision expense	**(555)**	**1,529**	**975**
Other Operating Expenditure			
Chair and Non Executive Members	96	-	96
Grants to Other bodies	-	119	119
Clinical negligence	-	-	-
Research and development (excluding staff costs)	-	-	-
Expected credit loss on receivables	-	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-	-
Inventories written down	-	-	-
Inventories consumed	-	-	-
Other expenditure	-	-	-
Total Other Operating Expenditure	**96**	**119**	**215**
Total operating expenditure	**1,433**	**779,982**	**781,415**

The above includes expenditure dealt with under pooled budget arrangements as set out in Note 18.

COVID-19 costs included in the above figures total £320k. The majority of these costs fall under Services from other NHS Trusts and Purchase of Healthcare from non-NHS bodies.

External Audit Fees are inclusive of VAT and include the following:
Statutory audit fees for the period to 31st March 2023 is £132k
Release of overaccrual of audit fees for the period to 30th June 2022 is £4k

The auditor's liability for external audit work carried out for the period to 31st March 2023 is limited to £1million.

The full year fee paid to external auditors disclosed within Other Services (review of MHIS compliance statement) was £20k plus VAT.

Internal audit and counter fraud services are provided by CW Audit who are part of a Foundation Trust. The cost of these services was £32k in the period to 31st March 2023, and is included within other professional fees.

6.1 Better Payment Practice Code

Measure of compliance	Nine month Period ended 31st March 2023 Number	Nine month Period ended 31st March 2023 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	28,907	225,759
Total Non-NHS Trade Invoices paid within target	28,755	217,907
Percentage of Non-NHS Trade invoices paid within target	**99.47%**	**96.52%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	649	506,926
Total NHS Trade Invoices Paid within target	635	506,015
Percentage of NHS Trade Invoices paid within target	**97.84%**	**99.82%**

The Better Payment Practice Code requires the ICB 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	Nine month Period ended 31st March 2023 £'000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	**-**

7. Finance costs

	Nine month Period ended 31st March 2023 £'000
Interest	
Interest on loans and overdrafts	-
Interest on lease liabilities	7
Interest on late payment of commercial debt	-
Other interest expense	-
Total interest	**7**
Other finance costs	-
Provisions: unwinding of discount	-
Total finance costs	**7**

8. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of modified absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions have not been restated. Modified 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 under modified absorption accounting, the gain or loss resulting is recognised in Reserves.

NHS Shropshire, Telford & Wrekin ICB received the following balances on 1st July 2022 from the predecessor clinical commissioning group of NHS Shropshire, Telford & Wrekin CCG.

	Nine month Period ended 31st March 2023			
	Total £'000	NHS England Parent Entities £'000	NHS England Group Entities (non parent) £'000	Non NHSE Group £'000
Transfer of property plant and equipment	-	-	-	-
Transfer of Right of Use assets	1,044	-	1,044	-
Transfer of intangibles	-	-	-	-
Transfer of inventories	-	-	-	-
Transfer of cash and cash equivalents	104	-	104	-
Transfer of receivables	2,910	-	2,910	-
Transfer of payables	(62,216)	-	(62,216)	-
Transfer of provisions	(2,220)	-	(2,220)	-
Net loss on transfers by absorption	**(60,378)**	**-**	**(60,378)**	**-**

As NHS Shropshire, Telford & Wrekin ICB is the recipient in the transfer of a function, it has recognised the assets and liabilities as at the transfer date. These balances are disclosed within the Statement of Financial Position as at 1st July 2022.

9. Property, plant and equipment

31 March 2023	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 July 2022	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	0	-	195	39	234
Adjusted Cost or valuation at 01 July 2022	**-**	**-**	**-**	**-**	**0**	**-**	**195**	**39**	**234**
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2023	**-**	**-**	**-**	**-**	**0**	**-**	**195**	**39**	**234**
Depreciation at 01 July 2022	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	0	-	195	39	234
Adjusted Depreciation at 01 July 2022	**-**	**-**	**-**	**-**	**0**	**-**	**195**	**39**	**234**
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2023	**-**	**-**	**-**	**-**	**0**	**-**	**195**	**39**	**234**
Net Book Value at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Asset financing:									
Owned	-	-	-	-	-	-	-	-	-
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 July 2022	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
Balance at 31 March 2023	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

10. Leases

10.1 Right-of-use assets

31 March 2023	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 01 July 2022	-	-	-	-	-	-	-	-	-	
Transfer (to) from other public sector body	-	1,110	-	-	-	-	-	-	1,110	654
Adjusted Cost or valuation at 01 July 2022	**-**	**1,110**	**-**	**-**	**-**	**-**	**-**	**-**	**1,110**	**654**
IFRS 16 Transition Adjustment	-	79	-	-	-	-	-	-	79	79
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-	0
Additions	-	-	-	-	-	-	-	-	-	0
Reclassifications	-	-	-	-	-	-	-	-	-	0
Upward revaluation gains	-	-	-	-	-	-	-	-	-	0
Lease remeasurement	-	-	-	-	-	-	-	-	-	0
Modifications	-	250	-	-	-	-	-	-	250	250
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	0
Derecognition for early terminations	-	-	-	-	-	-	-	-	-	0
Cost/Valuation at 31 March 2023	**-**	**1,438**	**-**	**-**	**-**	**-**	**-**	**-**	**1,438**	**983**
Depreciation at01 July 2022	-	-	-	-	-	-	-	-	-	
Transfer (to) from other public sector body	-	65	-	-	-	-	-	-	65	43
Adjusted Depreciation at 01 July 2022	**-**	**65**	**-**	**-**	**-**	**-**	**-**	**-**	**65**	**43**
Charged during the year	-	214	-	-	-	-	-	-	214	148
Reclassifications	-	-	-	-	-	-	-	-	-	0
Upward revaluation gains	-	-	-	-	-	-	-	-	-	0
Impairments charged	-	-	-	-	-	-	-	-	-	0
Reversal of impairments	-	-	-	-	-	-	-	-	-	0
Disposals on expiry of lease term	-	-	-	-	-	-	-	-	-	0
Derecognition for early terminations	-	-	-	-	-	-	-	-	-	0
Depreciation at 31 March 2023	**-**	**280**	**-**	**-**	**-**	**-**	**-**	**-**	**280**	**191**
Net Book Value at 31 March 2023	**-**	**1,159**	**-**	**-**	**-**	**-**	**-**	**-**	**1,159**	**792**

NBV by counterparty	
Leased from DHSC	0
Leased from the NHS England Group	0
Leased from NHS Providers	0
Leased from Executive Agencies	0
Leased from Non-Departmental Public Bodies	0
Leased from other group bodies	792
Net Book Value at 31 March 2023	**792**

10. Leases cont'd

10.2 Lease liabilities

	31 March 2023	1st July 2022
	£'000	£'000
Lease liabilities at 01 July 2022	-	-
IFRS 16 Transition Adjustment	-	(1,110)
Addition of Assets under Construction & Payments on Account	-	-
Additions purchased	-	-
Reclassifications	-	-
Interest expense relating to lease liabilities	(7)	(2)
Repayment of lease liabilities (including interest)	218	66
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	(1,125)	-
Other	1	-
Lease liabilities at 31 March 2023	**(913)**	(1,046)

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31 March 2023	**Of which: leased from DHSC group bodies**	1st July 2022	Of which: leased from DHSC group bodies
	£'000	**£000**	£'000	£000
Within one year	(285)	(194)	(266)	(90)
Between one and five years	(641)	(438)	(798)	(271)
After five years	-	-	-	-
Balance at 31 March 2023	**(926)**	**(632)**	**(1,064)**	**(361)**
Balance by counterparty				
Leased from DHSC		0		0
Leased from the NHS England Group		0		0
Leased from NHS Providers		0		0
Leased from Executive Agencies		0		0
Leased from Non-Departmental Public Bodies		(294)		(703)
Leased from other group bodies		(632)		(361)
Balance as at 31 March 2023		**(926)**		**(1,064)**

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	Nine month Period ended 31st March	
Nine month Period ended 31st March 2023	**2023**	1st July 2022
	£'000	£'000
Depreciation expense on right-of-use assets	214	65
Interest expense on lease liabilities	7	2

10.5 Amounts recognised in Statement of Cash Flows

	Nine month Period ended 31st March	
	2023	1st July 2022
	£'000	£'000
Total cash outflow on leases under IFRS 16	218	66

11. Trade and other receivables	Current 31 March 2023 £'000	Non-current 31 March 2023 £'000	Current 1st July 2022 £'000	Non-current 1st July 2022 £'000
NHS receivables: Revenue	863	-	78	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	-	-	4	-
NHS accrued income	885	-	1,791	-
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	4,923	-	362	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	799	-	126	-
Non-NHS and Other WGA accrued income	117	-	279	-
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	(62)	-	(21)	-
VAT	629	-	282	-
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	2	-	8	-
Total Trade & other receivables	**8,156**	**-**	**2,910**	**-**
Total current and non current	**8,156**		**2,910**	
Included above:				
Prepaid pensions contributions	-		-	

11.1 Receivables past their due date but not impaired

	31 March 2023 DHSC Group Bodies £'000	31 March 2023 Non DHSC Group Bodies £'000	1st July 2022 DHSC Group Bodies £'000	1st July 2022 Non DHSC Group Bodies £'000
By up to three months	(323)	4,338	(11)	212
By three to six months	10	5	6	-
By more than six months	(13)	-	-	9
Total	**(326)**	**4,343**	**(5)**	**221**

11.2 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 July 2022	**-**	**-**	**-**
Transfer from other public sector body under absorption accounting	(21)	-	**(21)**
Adjusted allowance for credit losses at 01 July 2022	**(21)**	**-**	**(21)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(41)	-	**(41)**
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	-	-	**-**
Transfer by Absorption from other entity	-	-	**-**
Other changes	-	-	**-**
Total	**(62)**	**-**	**(62)**

12. Cash and cash equivalents

	31 March 2023	1st July 2022
	£'000	£'000
Balance at 01 July 2022	-	375
Transfer from other public sector body under absorption accounting	104	-
Adjusted balance at 01 July 2022	**104**	**375**
Net change in year	182	(271)
Balance at 31 March 2023	**286**	**104**
Made up of:		
Cash with the Government Banking Service	286	104
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**286**	**104**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2023	**286**	**104**
Patients' money held by the ICB, not included above	-	-

The ICB does not hold any significant cash and cash equivalent balances that are not available for use by the organisation.

13. Trade and other payables	**Current 31 March 2023 £'000**	**Non-current 31 March 2023 £'000**	Current 1st July 2022 £'000	Non-current 1st July 2022 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	1,341	-	2,046	-
NHS payables: Capital	-	-	-	-
NHS accruals	3,324	-	6,643	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	18,540	-	14,469	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	15,140	-	28,842	-
Non-NHS and Other WGA deferred income	70	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	152	-	159	-
VAT	-	-	-	-
Tax	138	-	125	-
Payments received on account	-	-	-	-
Other payables and accruals	22,296	-	8,887	-
Total Trade & Other Payables	**61,002**	**-**	**61,172**	**-**
Total current and non-current	**61,002**		**61,172**	

Other payables include £1,059k outstanding pension contributions at 31 March 2023 (£902k at 30th June 2022)

14. Provisions

	Current 31 March 2023 £'000	**Non-current 31 March 2023 £'000**	Current 1st July 2022 £'000	Non-current 1st July 2022 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	0	-	0	-
Redundancy	-	-	359	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	154	-	349	-
Continuing care	3,040	-	1,511	-
Other	250	-	-	-
Total	**3,444**	**-**	**2,219**	**-**
Total current and non-current	**3,444**		**2,219**	

	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 July 2022	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Arising during the year	-	-	-	-	-	-	103	1,529	250	**1,883**
Utilised during the year	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	0	(359)	-	-	(299)	-	0	**(658)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	359	-	-	349	1,511	-	**2,219**
Balance at 31 March 2023	**-**	**-**	**0**	**-**	**-**	**-**	**154**	**3,040**	**250**	**3,444**
Expected timing of cash flows:										
Within one year	-	-	0	-	-	-	154	3,040	250	**3,444**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2023	**-**	**-**	**0**	**-**	**-**	**-**	**154**	**3,040**	**250**	**3,444**

The legal claims provision relates to ongoing legal cases outstanding at 31st March 2023, with the estimated costs to conclusion provided by the ICB's legal advisors. The ICB 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 2023 and these are expected to be processed within the new financial year.
The Other provision relates to Dilapidations arising following notice being served on one of the ICB's corporate offices. The provision is based on an external assessment of the costs and contractual commitment for dilapidations.

15. Contingencies

The ICB has no contingent assets or liabilities to disclose.

16. Financial instruments

16.1 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 the ICB 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 ICB 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 ICB in undertaking its activities.

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

16.1.1 Currency risk

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

16.1.2 Interest rate risk

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

16.1.3 Credit risk

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

16.1.4 Liquidity risk

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

16.1.5 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.

16. Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost 31 March 2023 £'000	**Equity Instruments designated at FVOCI 31 March 2023 £'000**	**Total 31 March 2023 £'000**	Financial Assets measured at amortised cost 1st July 2022 £'000	Equity Instruments designated at FVOCI 1st July 2022 £'000	Total 1st July 2022 £'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	1,634	-	1,634	1,157	-	1,157
Trade and other receivables with other DHSC group bodies	631	-	631	992	-	992
Trade and other receivables with external bodies	4,526	-	4,526	370	-	370
Other financial assets	-	-	-	-	-	-
Cash and cash equivalents	286	-	286	104	-	104
Total at 31 March 2023	**7,077**	**-**	**7,077**	2,623	-	2,623

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost 31 March 2023 £'000	**Other 31 March 2023 £'000**	**Total 31 March 2023 £'000**	Financial Liabilities measured at amortised cost 1st July 2022	Other 1st July 2022	Total 1st July 2022
Loans with group bodies	-	-	**-**	-	-	-
Loans with external bodies	-	-	**-**	-	-	-
Trade and other payables with NHSE bodies	914	-	**914**	1,190	-	1,190
Trade and other payables with other DHSC group bodies	3,752	-	**3,752**	7,831	-	7,831
Trade and other payables with external bodies	56,889	-	**56,889**	52,912	-	52,912
Other financial liabilities	-	-	**-**	-	-	-
Private Finance Initiative and finance lease obligations	-	-	**-**	-	-	-
Total at 31 March 2023	**61,554**	**-**	**61,554**	61,933	-	61,933

17. 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, Telford and Wrekin ICB this function is performed by the Board. The ICB considers it has a single operating segment; commissioning of healthcare services. Hence finance and performance information is reported to the Board as one segment. These Statements are produced in accordance with this position.

The values relating to this operating segment can be found in the SoCNE (page 2), and SoFP (page 3), and are summarised in the table below:

	Gross expenditure £'000	**Income £'000**	**Net expenditure £'000**	**Total assets £'000**	**Total liabilities £'000**	**Net assets £'000**
Shropshire, Telford & Wrekin ICB	795,212	(374)	**794,839**	9,601	(65,359)	**(55,758)**
Total	**795,212**	**(374)**	**794,839**	**9,601**	**(65,359)**	**(55,758)**

17.1 Reconciliation between Operating Segments and SoCNE

	Nine month Period ended 31st March 2023 £'000
Total net expenditure reported for operating segments	794,839
Reconciling items:	
Depreciation & Amortisation	214
Finance cost - IFRS16	7
Total net expenditure per the Statement of Comprehensive Net Expenditure	795,060

18. Joint arrangements - interests in joint operations

ICBs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

18.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY Nine month Period ended 31st March 2023 Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Shropshire LA	Commissioning of health and social care services under better care fund	0	0	0	26277
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Shropshire LA	Better care fund promoting integrated working	0	0	0	17304
Transforming care programme S75 arrangement	Shropshire, Telford & Wrekin ICB and Shropshire LA	The transforming care programme for people with learning disabilities	0	0	0	1742

18.2 Pooled budgets under the Better Care Fund

The ICB's contribution of the total value of these pooled budgets in the period ended 31st March 2023 was £44m. 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.

A summary of the schemes with each local authority is given below:

Shropshire Local Authority	Nine month Period ended 31st March 2023 £'000
Assistive Technologies	1,507
Care navigation/Co-ordination	1,489
Enablers for Integration	3,464
Integrated Care Planning	2,894
Intermediate Care Services	2,668
Personalised Healthcare at Home	217
L A Schemes	14,038
Total	**26,277**

Telford & Wrekin Local Authority	Nine month Period ended 31st March 2023 £'000
Management Charges	155
Shropshire Community Health Trust	3,100
Shrewsbury and Telford Hospital	1,499
LA Schemes	12,526
GP Practice Support	25
Total	**17,304**

19. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Ian Chan GP - Partner: Teldoc	64,429	-	-	-
Ian Chan - Clinical Director: Teldoc PCN	2,083	-	-	-
Roger Dunshea - Black Country Healthcare NHS FT: Non-Executive Director	143	-	-	-
Sir Neil Mckay - Strategic Adviser and Health Strategy Board Chair: Browne Jacobson LLP	4	-	-	-
Julian Povey - Partner: Pontesbury & Worthen Medical Practice	11,899	-	-	-
Julian Povey - Pontesbury & Worthen Medical Practice: Shrewbury PCN	5,313	-	-	-
Nicholas White - Consultant Plastic Surgeon: University Hospitals Birmingham NHS FT	2,597	-	-	-
Simon Whitehouse Spouse - Senior Staff Nurse: University Hospital of North Midlands	6,459	-	-	-
DHSC Related Party - Leeds Teaching Hospital NHS Trust	29	-	-	-

The Department of Health and Social Care is regarded as a related party. During the period the ICB has had material transactions with entities for which the Department is regarded as the parent Department. These include:

NHS Business Services Authority
NHS England
NHS Midlands & Lancashire CSU
NHS Property Services Limited
Midlands Partnership NHS Foundation Trust
Shrewsbury & Telford Hospitals NHS Trust
Shropshire Community Health NHS Trust
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
University Hospital of North Midlands NHS Trust
West Midlands Ambulance Service NHS Trust

In addition, the ICB 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, Telford & Wrekin Council and Welsh Government Bodies.

Payments were also made to GP practices in the period to 31st March 2023 in respect of GMS/PMS/APMS and enhanced services. Two general practitioners within these practices are also members of the ICB's Board.

20. Events after the end of the reporting period

There are no events after the end of the reporting period to report which would impact the financial statements. Commissioning for pharmacy, ophthalmology and dentistry (POD) services from NHSE has been transferred to the ICB with effect from 1st April 2023.

21. Third party assets

The ICB does not hold any third party assets

22. Financial performance targets

The ICB has a number of financial duties under the NHS Act 2006 (as amended).
The ICB performance against those duties was as follows:

	Nine month Period ended 31st March 2023 Target	Nine month Period ended 31st March 2023 Performance
Expenditure not to exceed income	773,917	795,433
Capital resource use does not exceed the amount specified in Directions	-	-
Revenue resource use does not exceed the amount specified in Directions	773,543	795,060
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	8,195	8,194

23. Analysis of charitable reserves

The ICB does not hold any charitable reserves.

24. Losses and special payments

The ICB did not incur any losses or special payments in the nine month period to 31st March 2023.

Independent auditor's report to the members of the Governing Body of NHS Shropshire Telford and Wrekin Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Shropshire Telford and Wrekin Integrated Care Board (the 'ICB') for the period ended 31 March 2023, 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 Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2023 and of its expenditure and income for the period 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 2022-23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

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 ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2022-23 that the ICB'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 ICB. 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 2022) 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 ICB and the ICB's disclosures over the going concern period.

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB'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.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

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

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

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022-23; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity 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

Under sections 223GB and 272(7) and (8) of the National Health Service Act 2006, as amended, NHS England directed that revenue resource for the ICB in 2022-23 should not exceed £773.5 million. The ICB's revenue resource use for 2022-23 was £795 million, thereby breaching the direction given to it by 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 ICB, or an officer of the ICB, 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 ICB 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 23 May 2023 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to NHS Shropshire, Telford & Wrekin ICB's breach of its revenue resource limit for the nine months ending 31 March 2023.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB'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 ICB 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.

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.

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.

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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 ICB 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 Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2022-23).
- We enquired of management and the Audit Committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, 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 posted by senior officers
- 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 large and unusual journals;
- 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. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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.
- Our 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 ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB 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 ICB's operations, including the nature of its other 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 ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework**.**

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.

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

Matter on which we are required to report by exception – the ICB'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 ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the period ended 31 March 2023.

Our work on the ICB'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 ICB's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, they will be reported by exception in a further auditor's report. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the period ended 31 March 2023.

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 ICB's resources.

Auditor's responsibilities for the review of the ICB'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 ICB 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 ICB'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 January 2023. 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 ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB 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 ICB 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 Telford and Wrekin Integrated Care Integrated Care Board for the period ended 31 March 2023 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 ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

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

Andrew Smith

Andrew Smith, Key Audit Partner

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

Birmingham

29 June 2023